WORKPLAN

Campbellford Memorial Hospital 2014/15 Quality Improvement Plan for Ontario Hospitals Status: IN PROGRESS

To enter data in the Workplan, click on the cell or the "Add" button. In the Measure/Indicator column, the indicators that appear in red font are the priority indicators.

Organization: View All

EXPORT WORKPLAN

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ACCESS													
Reduce wait times in the ED	ED Wait times: 90th percentile ED length of stay for Admitted patients.	Hours / ED patients	CCO iPort Access / Q4 2012/13 – Q3 2013/14	624	17.58	17.00 ▲ BACK TO TOP ▲	CMH is well below the provincial average of 30.6 hours in 2011/12. It is expected we will continue to see improvement with the hiring of a second Nurse Practitioner, allowing for increased coverage. It will also improve patient flow and fast tracking of patients who triage as	Improve	1) Increase patient access, increase patient flow, decrease patient wait time by increasing Nurse Practitioner hours from 5 days to 7 days per week.	Measure wait times for triage levels 4 & 5.	Time the patient is triaged to the time the patient is discharged from the department.	90% of patients will be discharged from the department within four hours. 100% compliance by March 31, 2015.	Compliance is dependent on proposed increase Nurse Practitioner hours.
									2) Decrease the demands on the	Provide education	The number of appropriate CTAS	100% of patients with a CTAS Level of 4 or	There are strict

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							a level 4 and 5 and consequently improve patient satisfaction. This indicator is in alignment with the CE LHIN strategic plan, CMH strategic plan, Health Quality Ontario and Cancer Care Ontario.		ER physicians to see CTAS Level 4&5 patients who fall within the scope of practice of the RNEC by having the RNEC (Nurse Practitioner) work to full scope of practice.	and training for Nurse Practitioner to increase and sustain his/her scope of practice to provide the right care to the right patient at the right time.	Level 4&5 patients treated by the RNEC without referring to the physician divided by the total number of CTAS Level 4&5 patients seen by the RNEC	5 that are within the scope of practice of the RNEC are treated by the Nurse Practitioner when on duty by March 31, 2015	guidelines as to which patients must be seen by a physician even if they are a lower triage level (i.e. request for narcotics).
									3) To decrease the demand on the ER physician by allowing the RNEC to assess and treat CTAS Level 4&5 patients who present with fractures that are within the RNEC scope of practice.	Statistical reports of fractures treated will be run and reported quarterly. Random chart audits (10 per quarter)will be done to identify appropriate utilization of human resources in treating patients with simple fractures.	The number of appropriate Level 4 &5 patients who present with reduced, closed, un-displaced or stable fractures who are treated by the RNEC divided by the number of appropriate reduced, closed, un-displaced or stable fractures seen during the RNEC working hours	100% of CTAS level 4 & 5 patients that present with reduced, closed, un-displaced, or stable fractures that fall within the RNEC's scope of practice are assessed and treated by the RNEC by March 31, 2015.	The College of Nurses of Ontario standards for the RNEC are specific about what type of fractures the RNEC can treat.

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EFFECTIVENESS

Improve organizational financial health	Total Margin (consolidated): % by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expense, excluding the impact of facility amortization, in a given year.	% / N/a	OHRS, MOH / Q3 2013/14	624	-0.12	0.00	Target is set by the Ministry of Health and the CE LHIN. In alignment with LHIN strategy, CMH strategy, H-SAA, H-BAM, HSFR	Improve	1) Focus on a healthy workplace through empowering staff, providing ongoing education, supporting recognition programs, timely feedback, and improved communications. Support healthy lifestyles through accessibility to training sessions concerning healthy lifestyles, stress management and other self improvement activities.	Track and measure sick time for full-time employees. Participate in employee benchmarking through an annual survey.	Total number of sick time hours divided by the total number of worked hours. Overall engagement scores for employee satisfaction	ADD o see a 1% improvement in sick time by March 31, 2015. To sustain the employee engagement scores within the current levels by March 31, 2015.
									2) Review staffing workload and utilization to reduce overtime.	Monthly budget reports provided to managers electronically. Nursing algorithm in relation to	Overtime as a percentage of compensation reviewed monthly by Senior Team and the Finance Committee of the Board.	Goal is to have overtime reduced by 1% by March 31, 2015.	

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										Nursing overtime is reviewed daily. Overtime communicated monthly at team meetings.			
									3) Implement new revenue opportunities.	Monitor the recovery and revenue on a monthly basis and report/track through the Finance Committee.	Annual ancillary revenue this year as compared to the prior year.	To increase ancillary revenue by $20,000 annually by the end of March 2015 as compared to the prior fiscal year.	
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Reduce unnecessary deaths in hospitals	HSMR: Number of observed deaths/number of expected deaths x 100.	Ratio (No unit) / All patients	DAD, CIHI / 2012/13	624	115.00		We are not including HSMR as an improvement because our qualifying numbers are small and should be interpreted with caution. We will continue to carry out HSMR audits on all death charts on a quarterly basis.		1)				
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INTEGRATED

Reduce unnecessary time spent in acute care	Percentage ALC days: Total number of acute inpatient days designated as ALC, divided by the total number of acute inpatient days.	% / All acute patients	Ministry of Health Portal / Q3 2012/13 – Q2 2013/14	624	20.07	12.80	CMH has set it's goal on the CELHIN target for ALC days and to exceed the provincial average of 14% (Q3 2011/12-Q2 2012/13). This indicator is in alignment with CE LHIN strategy, CMH strategy, Wait Time Information Strategy and Cancer Care Ontario.	Improve	1) Reduce the number of inpatient days designated as ALC days.	Daily meetings with CCAC, Community Care and Discharge Planning to discuss barriers to discharge.	Total number of acute inpatient days designated as ALC divided by the total number of acute inpatient days.	Reduce the number of inpatient days designated as ALC by 20% by March 31, 2015.	
									2) Early engagement with discharge planning to discuss discharge goals within 72 hours of admission.	Create data base using Excel to record data to allow for monthly analysis.	Total number of patients with early engagement consult divided by the total number of admitted patients with length of stay longer than 72 hours.	80% of patients with longer length of stay than 72 hours having an early engagement consult. 100% compliance by March 31, 2015.	Results will depend upon the availability of a Discharge Planner.
									3) Offer restorative care to as many frail seniors as capacity allows in order to promote a safe discharge home.	Daily data collection through Excel spreadsheet with information shared with Senior Team quarterly.	The total number of patients attending Restorative Care made ALC divided by the total number of patients discharged home from Restorative Care.	Restorative Care is offered to 100% of eligible patients with 80% of Restorative patients being discharged home by September 30, 2014.	Currently 75% of patients are discharged home.

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Reduce unnecessary hospital readmission	Readmission to any facility within 30 days for selected CMGs for any cause: The rate of non-elective readmissions to any facility within 30 days of discharge following an admission for select CMG's.	% / All acute patients	DAD, CIHI / Q2 2012/13-Q1 2013/14	624	19.02	15.00	Reviewed last year's results and made a decision to decrease by 20% to surpass the provincial average. This indicator is in alignment with CE LHIN strategy, CMH strategy, Hospital System Funding Reform and Quality Best Practice.	Improve	1) Provide all inpatients with an opportunity to participate in our Integrated Chronic Disease Management Program (ICDMP).	Collect and report the number of eligible patients who are invited and the number of patients who attend the ICDMP to the Quality Committee of the Board on a quarterly basis.	The total number of eligible patients who attend the ICDMP divided by the total number of eligible patients.	75% of eligible in-patients attend the ICDMP by March 31, 2015.	
									2) To have all COPD and CHF patients have	Chart audit of patients admitted	The number of patients who have a diagnosis of	100% of patients admitted with COPD and CHF have the	

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									an appropriate order set for their diagnosis completed on admission.	with COPD and CHF on a quarterly basis.	COPD or CHF and have a completed order set divided by the total number of patients admitted with COPD and CHF.	appropriate order set by September 30, 2014.	

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Improve patient satisfaction	From NRC Picker: "Would you recommend this hospital (inpatient care) to your friends and family?" (add together % of those who responded "Definitely Yes" or "Yes, definitely").	% / All patients	NRC Picker / Oct 2012- Sept 2013	624	92.10	92.50	To ensure patient needs are being met in terms of accessibility and quality. This indicator is in alignment with CE LHIN strategy, CMH strategy and Health Quality Ontario.	Maintain	1) Provide clear, written discharge instructions to patients regarding medication, aftercare instructions at home and follow-up plans.	Retrospective chart audit of representation of patient population concerning discharge information. Automated discharge phone call within 48 hours of discharge.	The number of patients surveyed who indicate that they received clear discharge instructions, divided by the total number of patients surveyed.	To improve clear, written discharge instructions for patients upon discharge by 5% by March 31, 2015.	
									2) To initiate an automated discharge call system that will monitor patient satisfaction within 48 hours of discharge.	Discharge call system will provide information in real-time concerning patient satisfaction. Data collected through Vocantus software. Continue to monitor NRC Picker patient satisfaction survey as to whether would recommend to family/friends.	The number of patients who would recommend this hospital to family and friends divided by the total number of patients surveyed.	To improve patient satisfaction by providing post-discharge follow-up (48 hours). Goals is to improve by 0.43% by March 31, 2015.	
									3) All patients who receive an automated discharge call and have a negative reply	Monitor Vocantus data base for negative answers for follow up.	The total number of patients who receive a follow up phone call divided by the total number of	100% compliance by March 31, 2015.	

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									will receive a follow up phone call from a 'live' person.	Monitor patient satisfaction results through NRC Picker patient satisfaction survey.	patients with a negative reply to the automated call.		
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Improve patient satisfaction	From NRC Picker: "Overall, how would you rate the care and services you received at the hospital (inpatient care)?" (add together % of those who responded "Excellent, Very Good and Good").	% / All patients	NRC Picker / Oct 2012- Sept 2013	624	89.00	93.20	Set target based on NRC Picker Ontario Hospital average. In alignment with CE LHIN strategy, CMH strategy and Health Quality Ontario.	Improve	1) Include a question concerning introduction of health care provider within the automated discharge call script (i.e. did the person providing care for you introduce themselves?)	Monitor the results of the automated discharge call and provide quarterly results to Patient Care Committee.	The total number of health care providers who introduced themselves to patients/family divided by the total number of patients surveyed.	50% compliance by September 30, 2014 and 60% compliance by March 31, 2015.	
									2) Increase in patient/family involvement in making decisions related to treatment plans and discharge.	Monitor NRC Picker patient satisfaction survey.	The total number of patients who respond 'Excellent, Very Good and Good' to rating care and services divided by the total number of patients surveyed.	To improve patient satisfaction by increasing patient/family involvement in care and treatment. Goal is to improve by 4.2% by March 31, 2015.	
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Improve patient satisfaction	From NRC Picker: Would you recommend this ED to your friends and family?" (add together % of those who responded "Definitely Yes" or "Yes, definitely")	% / ED patients	NRC Picker / 2013	624									

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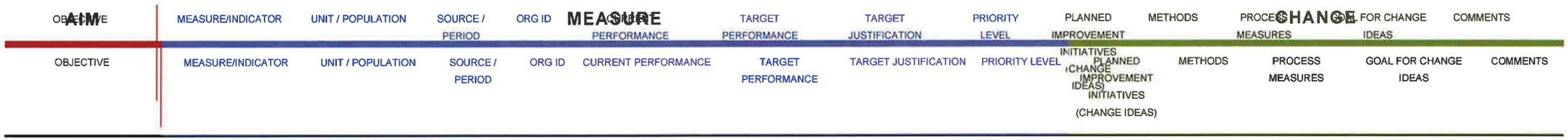
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Improve patient satisfaction	From NRC Picker: "Overall, how would you rate the care and services you received at the ED?" (add together % of those who responded "Excellent, Very Good and Good").	% / ED patients	NRC Picker / 2013	624									

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Improve patient satisfaction	In-house survey (if available): provide the % response to a summary question such as the "Willingness of patients to recommend the hospital to friends or family" (Please list the question and the range of possible responses when you return the QIP).	% / Other	In-house survey / Other	624									

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SAFETY													
Increase proportion of patients receiving medication reconciliation upon admission	Medication reconciliation at admission: The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital.	% / All patients	Hospital collected data / Most recent quarter available (e.g. Q2 2013/14, Q3 2013/14 etc)	624			We have not selected this indicator as we continue to exceed our performance target.	Maintain	Add New Change Idea				

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Reduce hospital acquired infection rates	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1,000 - Average for Jan-Dec. 2013, consistent with publicly reportable patient safety data.	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / 2013	624	0.61	0.00	Given our low critical mass, one case puts us well above the provincial average, therefore we have set our target to be 0. This indicator is in alignment with CE LHIN strategy, CMH strategy, Accreditation Canada and Provincial Infectious Disease Advisory Committee.	Improve	1) Maintain compliance to the antibiotic stewardship program.	Daily review of pharmacy alerts for targeted antibiotics. Chart audit of the patients who were prescribed targeted antibiotics.	The total number of orders for restricted antibiotics that follow the algorithm divided by the total number of orders for restricted antibiotics.	100% compliance with the algorithm
									2) To use higher potency cleaners routinely during pneumonia season.	Audit cleaning process weekly during pneumonia season.	The number of inpatient rooms cleaned with high potency cleaner divided by the total number of inpatient rooms cleaned.	100% compliance during pneumonia season starting October 2014.
									3) Increase the reporting of	Monthly reports	The number of reports forwarded	100% of C Diff indicator reports are

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									indicators for C difficile from quarterly to monthly to Medical Advisory Committee.	prepared by the Infection Control Practitioner for Infection Control Committee, Medical Advisory Committee and Nursing Advisory Committee.	monthly to MAC divided by the number of MAC meetings annually.	forwarded monthly to MAC.	
									4) To implement changes to the physical plant in the inpatient unit to improve the number of rooms with bathroom facilities compared to the present.	Weekly monitoring of the construction process until final completion. Construction progress will be reported to Senior team by the Facilities Manager.	The number of patient rooms on the Medical-Surgical Unit with a bathroom divided by the number of patient rooms on the Medical-Surgical Unit	To have increased the number of patient rooms on the Medical-Surgical Unit that have a bathroom by 7.5% by March 31, 2015.	This excludes the Special Care Unit.

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Reduce hospital acquired infection rates	Hand hygiene compliance before patient contact: The number of times that hand hygiene was performed before initial patient contact divided by the	% / Health providers in the entire facility	Publicly Reported, MOH / 2013	624			We have not selected this indicator as we continue to exceed our performance target.						

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	number of observed hand hygiene indications for before initial patient contact multiplied by 100 - consistent with publicly reportable patient safety data.												

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Reduce hospital acquired infection rates	VAP rate per 1,000 ventilator days: the total number of newly diagnosed VAP cases in the ICU after at least 48 hours of mechanical ventilation, divided by the number of ventilator days in that reporting period, multiplied by 1,000 - consistent with publicly reportable patient safety data.	Rate per 1,000 ventilator days / ICU patients	Publicly Reported, MOH / 2013	624			We have not selected this indicator as we do not have ventilators.						

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Reduce hospital acquired infection rates	Rate of central line blood stream infections per 1,000 central line days: total number of newly diagnosed CLI cases in the ICU after at least 48 hours of being placed on a central line, divided by the number of central line days in that reporting period, multiplied by 1,000 - consistent with publicly reportable patient safety data.	Rate per 1,000 central line days / ICU patients	Publicly Reported, MOH / 2013	624			We have not selected this indicator as we do not provide central lines.						

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Reduce incidence of new pressure ulcers	Percent of complex continuing care (CCC) residents with a new pressure ulcer in the last three months (stage 2 or higher).	% / Complex continuing care residents	CCRS, CIHI (eReports) / Q2, 2013/14	624			We have not selected this indicator as we do not have complex continuing care.						

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Avoid Patient falls	Percent of complex continuing care (CCC) residents who fell in the last 30 days.	% / Complex continuing care residents	CCRS, CIHI (eReports) / Q2 2013/14	624			We have not selected this indicator as we do not have complex continuing care patients.						

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OBJECTIVE	MEASURE/INDICATOR	UNIT / POPULATION	SOURCE / PERIOD	ORG ID	CURRENT PERFORMANCE	TARGET PERFORMANCE	TARGET JUSTIFICATION	PRIORITY LEVEL	PLANNED IMPROVEMENT INITIATIVES (CHANGE IDEAS)	METHODS	PROCESS MEASURES	GOAL FOR CHANGE IDEAS	COMMENTS
OBJECTIVE	MEASURE/INDICATOR	UNIT / POPULATION	SOURCE / PERIOD	ORG ID	CURRENT PERFORMANCE	TARGET PERFORMANCE	TARGET JUSTIFICATION	PRIORITY LEVEL	PLANNED IMPROVEMENT INITIATIVES (CHANGE IDEAS)	METHODS	PROCESS MEASURES	GOAL FOR CHANGE IDEAS	COMMENTS
Reduce rates of deaths and complications associated with surgical care	Rate of 5-day in-hospital mortality following major surgery: The rate of in-hospital deaths due to all causes occurring within five days of major surgery.	Rate per 1,000 major surgical cases / All patients with major surgery	CIHI eReporting Tool / 2012/13	624					We have not selected this indicator as we do not perform major surgery.				

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OBJECTIVE	MEASURE/INDICATOR	UNIT / POPULATION	SOURCE / PERIOD	ORG ID	CURRENT PERFORMANCE	TARGET PERFORMANCE	TARGET JUSTIFICATION	PRIORITY LEVEL	PLANNED IMPROVEMENT INITIATIVES (CHANGE IDEAS)	METHODS	PROCESS MEASURES	GOAL FOR CHANGE IDEAS	COMMENTS
Reduce rates of deaths and complications associated with surgical care	Surgical Safety Checklist: number of times all three phases of the surgical safety checklist was performed ('briefing', 'time out' and 'debriefing') divided by the total number of surgeries performed, multiplied by 100 - consistent with publicly reportable patient safety data.	% / All surgical procedures	Publicly Reported, MOH / 2013	624	99.31		We have not selected this indicator as we continue to exceed the target.		Add New Change Idea				

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Reduce use of physical restraints	Physical Restraints: The number of patients who are physically restrained at least once in the 3 days prior to a full admission divided by all cases with a full admission assessment.	% / Mental health/addiction patients	OMHRS, CIHI / Q4 2010/12 - Q3 2012/13	624									We have not selected this indicator as we do not have inpatient mental health. If our patients are Form 1 they are transferred out to our regional centre.

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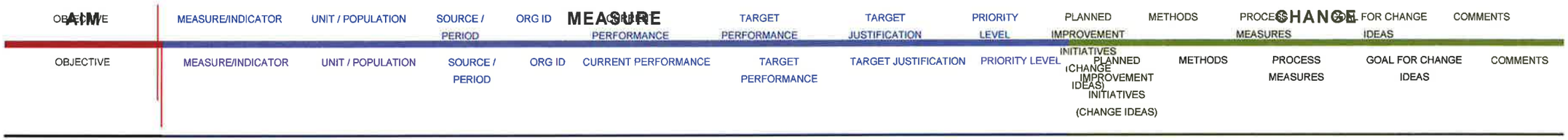
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Increase screening of inpatients over 65 years who experience delirium	The percentage of inpatients 65 years and older receiving delirium screening using a validated tool on admission to hospital.	% / All inpatients >65 years	EMR/Chart Review / 2014-15	624	91.00	100.00	Based on RNAO best practice guidelines. Participated in a provincial pilot targeting CAM and Barthel. Provincial report with participating hospitals due imminently. This indicator is in alignment with CE LHIN strategy, CMH strategy, Senior Friendly Hospital strategy, Regional Geriatric Program Ontario and CE Regional Specialized Geriatric Services Group strategy.	Improve	1) Screen all inpatients > 65 years on admission with a CAM assessment tool.	Quarterly chart audit of inpatient charts.	The total number of patients > 65 years screened on admission using the CAM assessment tool divided by the total number of patients who qualify for CAM screening on admission.	100% compliance to CAM assessment screening by December 31, 2014.	
									2) Assess and detect new onset delirium.	Monthly inpatient chart review.	The total number of daily CAM assessments completed divided by the total number of inpatients's length of stay (30 patients per quarter).	100% compliance to CAM assessment daily screening by March 31, 2015.	

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OBJECTIVE	MEASURE/INDICATOR	UNIT / POPULATION	SOURCE / PERIOD	ORG ID	CURRENT PERFORMANCE	TARGET PERFORMANCE	TARGET JUSTIFICATION	PRIORITY LEVEL	PLANNED IMPROVEMENT INITIATIVES (CHANGE IDEAS)	METHODS	PROCESS MEASURES	GOAL FOR CHANGE IDEAS	COMMENTS
Prevent physical functional decline in admitted patients	Barthel assessment within 48 hours of admission and upon discharge.	% / All acute patients	EMR/Chart Review / 2014/15	624	96.60	100.00	Target based on RNAO best practice guidelines and regional geriatric practice of Ontario. This indicator is in alignment with CE LHIN strategy, CMH strategy, Senior Friendly Hospital strategy, Regional Geriatric Program Ontario and CE Regional Specialized Geriatric Services Group strategy.	Improve	1) To provide education and training to multidisciplinary staff in order that assessments can be carried out 24/7.	Organize and implement education sessions to multidisciplinary staff.	The total number of inpatient multidisciplinary staff trained in using the Barthel assessment tool divided by the total number of inpatient multidisciplinary staff.	95% of multidisciplinary staff are trained in using the Barthel assessment tool by March 31, 2015.	
									2) Upon admission and discharge every patient will be assessed using the Barthel assessment tool to detect and document any functional improvement and decline.	Quarterly chart audits.	The total number of patients > 65 years screened on admission and discharge using the Barthel assessment tool divided by the total number of admitted patients > 65 years who qualify for Barthel	100% of appropriate patients to be assessed upon admission and discharge using the Barthel assessment tool by March 31, 2015.	Palliative patients are excluded.

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											screening on admission.		

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