2014/15 Quality Improvement Plan for Ontario Hospitals
"Improvement Targets and Initiatives"

Hôpital de Mattawa Hospital 217 Turcotte Park Road P.O. Box 70

AIM		Measure								Change				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performa	Target	Target justificatic	Priority le	Planned Improvement Initia	Methods	Process measures	Goal for change ide	Comments
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	724*	0	0		Maintain	1)Continue to implement operational efficiencies in support and administration to offset uncontrollable cost pressures (collective agreement impacts, drugs, utilities, etc)	Assess additional integration opportunities with the local nursing home, realign internal processes, leverage resources for tennant cost recovery.	Total margin	Balanced position by March 31, 2015	Will use regular monthly reporting and opportunity analysis to stay on target for 0% year end margin.
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	724*	40.48	40	Be a part of the solution in reducing ALC patients at NBRHC by accepting ALC transfers into our underutilized acute care beds.	Maintain	1)Continue to work with NBRHC by accepting transfers into our acute care beds when our cencus is low. This will not reduce our ALC numbers but will help by ensuring acute care beds are free at NBRHC to service acute care patient within the district	Work with NBRHC Discharge planning to determine patients that would be best suited to transfer.	Calculate the number of patients transfered to Mattawa annually from other hospitals who are designated ALC.	Communicate with NBRHC daily	Our target is higher than the provicial average as we are trying to be part of the solution within the district by keeping the tertiary care centre ALC numbers low in order to service the community and district in a more efficient manner.
										2)Train staff on discharge planning process and options available to reduce length of stay and avoid patients being designated as ALC	Implement education process.	Record number of staff trained	100 % of staff trained by December 2014	
										3)Engage patients and family in discharge planning process to ensure they are aware of all options and support for patient upon discharge home.	Family conference on all patients who no longer require acute care and there is a potential for difficult transition back home.	Number of family conferences held on patients that fall in this category	Successful transition to home with CCAC support.	
Patient-centred	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	724*	93.17	95	90th percentile among peers	Improve	1)Provide education to staff on dealing with difficult people	Provide Non-violent crisis intervention training	100 % staff trained	Training Completed by December 2014	We utilized an in-house patient satisfaction survey as our community is too small to provide statistically significant data via NRC Picker.
										2)Develop stategies to increase family involvment in discussions regarding patient care	Hold family meetings and conferences. Ask patient and family for their opinion and suggestions for improving care plan	Family meeting arranged for all patients with LOS greater than 1 week.	Improve patient and family involvment in care planning.	

										3)Educate staff on discharge process and ensure that they provide through written discharge instructions and educational material on patients illness.	Develop handouts for patients Review discharge summary Inservice staff	100 % of staff to be educated	Education completed by December 2014 Handouts developed and available for staff by December 2014	
		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	724*	92.4	94	90th percentile among peers	Improve	1)Public Education re Triage levels how they may affect patient wait time.	Signage within ER department Staff to educate public during ER visits.	100 % staff re-educated on process Signage posted in department	September 2014 completion	
										2)Public education re on call process for ER physician	Educate staff to inform ER patients on process ER signage to help clarify	Provide review on process to staff Hang signage	Completed by September 2014	
										3)Work with North Bay Mental Health Service partners to increase mental health and addiction services within the Mattawa community	Approach Mental Health and Addiction Service Providers and NELHIN to advocate for more service to Mattawa	Proposal for increased services to Mattawa community submitted to NELHIN for consideration	February 2015	
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)	724*	94	95	Best practice Accreditation Canada Requirement	Improve	1)Train relief staff to complete Admission BPMH.	Schedule training day for casual employee	100 % relief staff Trained	Training completed by June 2014	Mattawa Hospital uses total number of patients reconciled as a proportion of the total number of patients with a LOS greater than 72 hours. Our pharmacy is not open on weekends therefore we use 72 hours as our target to offset the lack of staff over the weekend.
										2)Educate physicians on importance of reviewing and signing off on Admission BPMH.	Take this issue to MAC to ensure all physicians aware of importance of this process.	Add to MAC agenda	Discussed at MAC by June 2014	
										3)Medical records staff to monitor compliance of Admission BPMH physician sign-off.	Audit all discharge charts for completion and sign-off of Admission BPMH.	100% compliance in physician sign-off	All charts audited monthly	
	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	724*	0	0	Provincial Benchmark	Maintain	1)Continuous improvement of IPAC practices through annual education program	Continued education around Routine Practices and through self directed learning modules by ICP.	Staff Completion of Rountine Practices, Donning and Doffing PPE, Chain of Transmission and Hand Hygiene education training.	95 % completion by December 2014	
										2)Prevention of transmission through application of environmental cleaning best practices	Annual review of environmental cleaning best practices	Self directed learning module on cleaning in a hospital environment	100 % compliance by all environmental staff	
										3)Appropriate use of antibiotics	Participation on the Antimicrobial Stewartship Committee at NBRHC	Adding Antimicrobial Stewartship as standing item to MAC and P&T Committee Agendas	Added to agenda 100 % of the time and discussed as an important change idea	
		Hand hygiene compliance before patient contact: The number of times that hand hygiene was performed before initial patient contact divided by the number of observed hand hygiene indications for before initial patient contact multiplied by 100 - consistent with	% / Health providers in the entire facility	Publicly Reported, MOH / 2013	724*	84	87	Continue to improve our performance	Improve	1)Change Antibacterial hand sanitizer from get to foam	Replace existing wall mounted sanitizer stations with automatic foam dispensing sanitizers	100 % of sanitizers changed	Change completed by July 2014	

		publicly reportable patient safety data.								2)Annual training for all staff on Hand Hygiene, Chain of Transmission and Routine Practices	Designate month of April for infection control training.	100 % of staff trained in all three modules	All staff Trained by April 2014	
										3)Perform regular hand hygiene audits (4 moments of hand hygiene).	Audit all hospital staff on hand hygiene on a regular basis and use this opportunity as a teaching tool if they are not performing hand hygiene correctly.	Perform 50 audits per month	Increase compliance before patient contact by 3%	
		Hand hygiene complienace after patient contact: The number of times hand hygiene was performed after patient contact divided by the number of observed hand hygiene indications for after patient contact multiplied by 100 -consistent publicly reportable patient saftey data.	% / Health providers in the entire facility	Publicly Reported, MOH / 2014	724*	87	89	Continue to improve on our performance	Improve	1)Change Antibacterial hand sanitizer from gel to foam dispenser	Replace existing wall mounted snaitizer stations with automatic foam dispensing sanitizers	100% sanitizer dispensers changed.	All changed by July 2014	
										2)Annual training for all staff on Hand Hygien, Chain of Transmission and Routine Practices	Designate month of April for infection control training	100 % of staff trained in all three modules	All staff trained by December 2014	
										3)Perform audits on hand hygiene (4 moments of hand hygiene).	Audit all hospital staff on hand hygiene on a regular basis and use this opportunity as a teaching tool if they are not performing hand hygiene correctly.	Perform 50 audits per month	Increase compliance of hand hygiene after patient contact by 2%	
	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	724*		1	Would like to be above provincial benchmark	Maintain	1)Education to all nursing staff on pressure ulcer prevention	Self Directed Learning module on pressure ulcer prevention.	100 % of nursing staff have completed learning module	February 2015	We will be utilizing all of our beds (acute and CCC) because our volumes in CCC are too small to be a fair representation of this indicator (Fiscal year 2013/14 CCC patients to date = 0).
										2)Completion of skin assessment intervention on all CCC patients on admission.	Chart review to ensure that intervention completed.	Audit 100 % of CCC charts for compliance	Annual submission of audit results to Patient Care Team and Hospital Quality of Care Committee.	
	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	724*		9.7	Provincial Benchmark	Maintain	1)Fall risk assessment done on admission on all CCC patients and weekly update as per hospital standards	Audit patient charts for compliance	Audit 100% of CCC patients.	Report results annually to Patient Care Team and Hospital Quality of Care Committee.	We will be utilizing all of our beds (acute and CCC) because our volumes in CCC are too small to be a fair representation of this indicator (Fiscal year 2013/14 CCC patients to date = 0).
										2)Utilization of assistive devices	Review with staff all available resources to help prevent a fall.	100 % of nursing staff educated	Completion by December 2014	
										3)Ensure physician physiotherapy referral for mobility on all CCC patients	Take issue to MAC to ensure all physicians aware of issue	Add to MAC agenda	Discussed at MAC by June 2014	
	Complete implementation on Unit Dose System	Dispensing Unit Dose medications from Pharmacy: All non ward-stock medications will be in unit dose packaging.	% / All non ward stock medications	Hospital collected data / 2014	724*	60	90	Match the rate of improvement attained by other leading organizations	Improve	1)Change Night Cupboard Medications from existing dispensing system to unit dose.	Purchase containers to store each individual medication in the night cupboard. Remove old medication vials and replace with unit dose medication.	All medication vials removed and replaced with unit dose medications	Fully implemented by August 31, 2014	

										2)Change existing non-ward stock medications in ER from existing dispensing system to unit dose.	Meet with maintenance department to determine shelving system to store new unit dose dispensing system. Build shelving unit. Remove medication vials and replace with unit dose dispensing system	Shelving unit has been built and is ready for use Unit dose dispensing system implemented	100% Compliant by December 2014	
	Increase proportion of patients receiving medication reconciliation upon discharge	Medication at discharge: The total number of patients with medications reconciled as a proportion of the total number of patients discharged from the hospital	% / All patients	Hospital collected data / 2014	724*	95	98	Best Practice	Improve	1)Train relief staff to complete Discharge BPMH	Schedule training for casual employee	100% relief staff trained	Completed by May 2014	
										2)Review with nursing staff how to complete and check Discharge BPMH during off hours and weekends	Arrange for inservice for all nursing staff	100% of nursing staff re-educated	Complete education by June 2014	
										3)Work with new consulting pharmacist to improve Discharge BPMH document utilizing the Meditech system	Schedule dates with pharmacisits to review Meditech System and Current System and plan improvements to document	Dicharge BPMH Document revised	October 2014	