2015/16 Quality Improvement Plan for Ontario Hospitals
"Improvement Targets and Initiatives"

Blind River District Health Centre
Pavillon Santé du District de Blind River

Blind River District Health Centre-Pavillion Sante 525 Causley Street P.O. Box 970

AIM		Measure							Change				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
Access	Reduce wait times in the ED	average wait time for complex non admitted patients triage 1,2,3	Hours / ED patients	HCD, DAD, NACRS / 13/14	2057*	4.95	4.95	the wait time is very dependent on number of admitted patients in the ER. Triage 1,2 patients often need to be transferred to a tertiary hospital. The time is dependent on availability of a bed and	1)review monthly reports provided by Decision Support Analyst(CNO, Chief of Staff, Manager) look for special cause or trends and do necessary investigation and follow up Develop and implement plans to maintain or improve current performance	monthly reports provided to CNO, Chief of Staff, Manager monthly analysis by CNO	Monthly reports monthly analysis and report	monthly reports and analysis done 100% of the time	the goal is to maintain current performance. The ER has seen increased workload and flow issues related to the overcapacity situation on the acute care floor.
		average wait time for complex non admitted patients triage 1,2,3	Hours / ED patients	HCD, DAD, NACRS / 13/14	4768*	9.15	9	This site has no inpatient beds. It is a 24 hour ER department. If a patient requires admission the patient is	1)monitor performance and investigate special cause variations to determine if wait could have been reduced.	monthly wait time reports from Decision Support Analyst	monthly report generated to Chief Nursing Officer, Chief of Staff, Medical site leader and Nurse Manager	monthly report received 100% of the time and reviewed for special cause 100% of the time	maintain current performance
		average wait time for complex non admitted patients triage 1,2,3	Hours / ED patients	HCD, DAD, NACRS / 13/14	4770*	6.93	6.93	documentation of times is not always accurate. The site is very small. A patient is moved to an inpatient bed in	1)monitor performance and investigate special cause. Encourage staff and physicians to document times on the ER sheets	monthly performance reports sent to Chief Nursing Officer, Chief of Staff, Medical site lead and Nurse Manager for review and action as required	monthly performance reports Monthly analysis	monthly performance reports received, reviewed 100% of the time	maintain current performance
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 FY 2014/15 (cumulative from April 1, 2014 to December 31, 2014)	611*	-0.14	1	The Blind River Hospital is experiencing high volumes related to ALC patients waiting in hospital for a Nursing Home bed. The average wait time is 3-4 years for a basic bed in the Blind River District Health Centre LTC home. The two small hospitals that came under the Blind River District Health Centre's administration have seen	1)Maximize co-pay revenues for ALC patients	restructure process for applying for a Nursing Home bed to be completed within 2 weeks of decision to apply for bed	# placement packages completed within 2 weeks from decision to apply for a home to assessment by NECCAC	100% of assessment for LTC bed completed within 2 weeks	
									2)reduce courier charges for Thessalon and Matthews sites	new courier service in place for past 4 months monitor monthly financial statements to determine if costs decreasing	number of trips using the taxi service this fiscal as opposed to 14/15	by the end of fiscal 15/16 there will be a 10% cost reduction in courier charges for the Thessalon site	
									3)reduce the amount of premium pay to registered nurses, registered practical nurses and Personal Support Workers	review the amount of annualized premium pay and hours per FTE review the number of Part time staff required to reduce premium	monthly report on premium by designation number of new hires to meet the required staffing compliment	By the end of fiscal 15/16 premium pay will be <2% worked hours By the end of fiscal 15/16 the appropriate ratio of FT to PT will be in place	difficult goal to meet as recruitment has been a challenge for the past two years.
	Reduce unnecessary deaths in hospitals	HSMR: Number of observed deaths/number of expected deaths x 100.	Ratio (No unit) / All patients	DAD, CIHI / April 1, 2013 to March 31, 2014	611*	107	107	not tracked by small hospitals	1)review all critical incidents as per usual process	medical advisory committee reviews all deaths	deaths reviewed by Medical advisory committee	100% of deaths reviewed by Medical Advisory committee	not applicable to small hospitals
		HSMR: Number of observed deaths/number of expected deaths x	Ratio (No unit) / All patients	DAD, CIHI / April 1, 2013 to March 31, 2014	2057*	139	130	not applicable to small hospitals	1)as per 611	as per 611	as per 611	as per 611	not applicable for small hospitals
		HSMR: Number of observed deaths/number of expected deaths x	Ratio (No unit) / All patients	DAD, CIHI / April 1, 2013 to March 31, 2014	4768*		10	unknown target as not tracked	1)as per 611	as per 611	as per 611	as per 611	not applicable for small hospitals
		HSMR: Number of observed deaths/number of expected deaths x	Ratio (No unit) / All patients	DAD, CIHI / April 1, 2013 to March 31, 2014	4770*	74	74	not tracked by small hospitals	1)as per 611	as per 611	as per 611	as per 611	not applicable for small hospitals

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. *100	% / All acute patients	Ministry of Health Portal / Oct 1, 2013 - Sept 30, 2014	2057*	36.53	36.53	maintain present performance. There are not enough Nursing Home beds in the district. The patients waiting in acute care will wait 3-5 years for a basic bed in their facility of choice. The patients are assessed by the NECCAC, the MAPLE scores are reviewed. If low MAPLE score, consideration for community is undertaken. There are limited resources in the community to maintain complex frail persons in their homes for an extended period while waiting for a bed. This is an issue for over 20 months now.	1)engage the LHIN in discussions about shortage of LTC beds in the district	Provide the LHIN consultant with data of impact on the organization by not being able to discharge to LTC	Provide quarterly report to the LHIN consultant on ALC waiting LTC placement	quarterly report provided to the LHIN consultant 100% of the time	There is little interest in the MOHLTC to increase the number of permanent LTC beds. However, in this catchment area there are significant challenges in providing supports for the frail elderly to be maintained in there homes. The Blind River District Health centre does admit frail elderly as respite to decrease the burden of care of the care provider and to try to prevent a permanent admission to acute care
									2)Explore option of having interim LTC beds located in the district	Engage the LHIN in discussions of feasibility of this option	Meeting with the LHIN to introduce the concept Explore physical space in the community to house interim beds Write a proposal to request interim beds	by the end of Q3 the feasibility of having interim beds will be determined and a potential plan in place for consideration	
									3)Use the CCAC RAI assessment data to determine if patient can be cared for in the community while waiting for a LTC bed. Inform patient and families of where the person is on the wait list for their chosen home(s) to try to encourage choosing more than one home.	CCAC RAI assessment data is provided to the Chief Nursing Officer and discharge team on a weekly basis.	Weekly ALC placement list is received every Friday The wait list data is shared with the patient and/or families at time of application and monthly thereafter	The weekly ALC placement list is received weekly 100% of the time Every new applicant who applies for a bed while in hospital is informed of the wait time for a LTC bed 100% of the time	to date the patient/families have not been influenced to consider choosing another LTC home other than the one in Blind River despite the fact that it is realistically a 3-5 year wait. Maintaining current performance is a high stretch goal as there are many high risk seniors living in the community
		Percentage ALC days: Total number of acute inpatient days designated as ALC, divided by the total number of acute inpatient days. *100	% / All acute patients	Ministry of Health Portal / Oct 1, 2013 - Sept 30, 2014	4770*	42.51	42.51	The number of ALC patients is directly related to lack of Nursing Home beds in the district for people	1)Communicate the impact of the growing number of ALC placement patients who are living in an inpatient bed to the NE LHIN consultant for the area	ALC weekly report has the necessary data to report to the NE LHIN	ALC weekly data is summarized and sent to the NE LHIN on a quarterly basis	the NE LHIN receives a summary of the ALC data on a quarterly basis 100% of the time	

								requesting a basic bed. The patients have high MAPLE scores and cannot be managed in the community on the complex frail elderly services. Maintaining current performance is a high stretch goal	2)The leadership will become more informed on the avenues that can be pursued to move a patient who is waiting placement in an acute care bed ahead on the wait list e.g. crisis designation and what the potential wait time is for a bed in the chosen nursing home(s).	The site Manager will contact the NE CCAC placement coordinator to discuss options to pursue when a placement patient is not able to be managed in this small site and to request wait list information.	Manager connects with the NECCAC placement services to discuss options and wait times	Every placement patient will have a clear plan of care related to access to a nursing home bed.	
	Reduce unnecessary hospital readmission	readmissions within 30 days all cases	% / All acute patients	In-house survey / 14/15 Q1,2,3	2057*	5.5	5.5	maintain. Good performance. Given the elderly population and the complex discharge plans, this is a high stretch goal for a	1)Develop a proposal to implement the Rural Framework and submit to the LHIN	Consult with Wawa community as to how they developed their proposal which was funded consult with the LHIN officer as to feasibility of funding Develop a small steering committee to support the development of the proposal Seek Board approval to submit the proposal	LHIN consultant provided direction Steering committee in place Board approval obtained Proposal submitted	by the end of Q2 the LHIN will have given feedback on feasibility to move forward with the proposal	
		readmissions within 30 days all cases	% / All acute patients	In-house survey / 14/15 Q1,2,3	4770*	7.19	3.61	the sample size is small as this is a 4 bed inpatient unit. Previous fiscal year performance was 3.61. this fiscal year there was only one month that had a high readmission rate (special cause) but impacted the performance due to the small sample size used to calculate	1)maintain 13/14 performance. Identify opportunities to work with the Algoma Manor nursing home on management of end of life and chronic disease management strategies to decrease the need to transfer the patient to the hospital	gather data on transfers from the Nursing Home to Hospital. Use CIHI data put together a working group comprised of Algoma Manor and Thessalon Hospital leadership to develop an improvement plan. Engage the physicians to provide input into the plan	# of home to hospital emergency visits and admissions for ambulatory sensitive conditions	by the end of Q3 a plan will be in place to reduce the # of nursing home transfers to hospital	the data may not show that the biggest opportunity for improvement is in decreasing the number of readmissions of patients from the Nursing Home. If that perception is unfounded, other opportunities for improvement will be looked at
Patient-centred	**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 / October 2013 - September 2014	2057*	97	97	small sample size. one negative response impacts results.	1)Maintain current process of gathering data (Manager calls each patient at home within 72 hours of discharge)	Discharge phone calls	number of discharge calls made	Every patient discharged from the hospital will receive a discharge telephone call.	maintain present performance. All patients who are discharged home receive a telephone call. There are times when the manager is unable to reach the patient at home after three attempts
		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 / October 2013 - September 2014	4770*	100	100	maintain response rate for inpatient survey. Top performer from National Research Corporation Canada is 97.2 %. This site exceeds the top performer in this data base	1)maintain present process.	Manager calls each patient who is discharged	# of calls made	Every patient will receive a discharge telephone call.	small sample size. telephone survey done for each discharge. At times there is no response after 3 attempts. The call is then deleted from the data collection
		Overall how would you rate the services you received at the ED. Add together excellent, very good, good	% / ED patients	In-house survey / 14/15	4768*	100	100	maintain. The top performer hospital in the National Research Corporation Canada data base for 13/14 is	1)continue with the present process but attempt to send out a larger number of mail out surveys	increase the number of mail outs	# of mail outs increased to 25/month	25 mail outs/month will be sent out 100% of the time	small sample size. telephone survey and mail out. very low response rate to mail out

		Overall, how would you rate the services you received at the ED. Add together excellent, very good, good	% / ED patients	In-house survey / 14/15	2057*	97	98	maintain. The top performer for this question in the National Research Corporation data	1)increase the sample size by sending out 25 mail outs/month	admitting staff will send out 25 per month	# of mail outs	25 mail outs/month 100% of the time	telephone survey and mail out. very low response rate to mail out
		Overall,how would you rate the services you received at the ED. Add together excellent, very good, good	% / ED patients	In-house survey / 14/15	4770*	100	100	maintain. The National Research Corporation Canada 13/14 report for this	1)maintain present processes. increase # mail out surveys to 25/month	Mail out surveys sent out by admitting staff	3 of mail outs sent out	25 mail outs/month sent out by admitting staff 100% of the time	telephone and mail out survey. very low response rate and sample size
	improve sleep hygiene on acute care unit	percent of patients with sleep hygiene as part of their care plan	% / All acute patients	In-house survey / Q4 15/16	2057*	CB	50	new initiative related to senior friendly acute care. No benchmark available	1)increase knowledge of implementing a quality improvement project and change management methodology	attendance at the Senior Friendly Leadership training course April 29-May 1, 2015	number of team staff attending the training session	4 team members will attend the training session and complete the 3 day course	this is a senior friendly initiative
									2)team will use the knowledge gained at training to develop a sleep hygiene program	The team will research evidence based strategies to develop the program The team will schedule the BSO training related to sleep to develop the content of the program and to increase knowledge	sleep program developed BSO education program delivered to team and other staff	By the end of October 2015 the team will have developed the sleep hygiene program and protocols	
									3)provide education to staff about sleep program and protocols	provide education sessions for staff provide overview of the program and protocols to physicians to elicit support	number of staff attending the education sessions number of physicians who endorse the program and protocols	100% of staff will attend the education sessions 100% of physicians will provide feedback and endorse the initiative	
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	2057*	100	100	maintain. Have been at 100% for past three years	1)				maintain.
									2)monitor performance	incident report generated when medication reconciliation is not done	% medication reconciliations done on admission	100% of admissions have a medication reconciliation completed	implementing a new pharmacy software program that may impact results if process changes.
		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	4770*	100	100	maintain. Have been 100% for past 20 months	1)				maintain performance
									2)monitor performance	incident report generated if medication reconciliation is not completed	% of medication reconciliations completed on admission	100% medication reconciliations completed on admission	implementing a new pharmacy software program that may impact performance if significant change to the process
	Increase proportion of patients receiving medication reconciliation upon discharge	Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged.	% / All patients	Hospital collected data / Most recent quarter available	2057*	100	100	at maximum now.	1)continue to monitor and follow up when missed	manager does monthly review	number of reviews	100% of patients receive a medication reconciliation upon discharge	maintain performance. Implementing a new electronic pharmacy system. Will need to ensure new processes are working.
									2)monitor performance	Manager who does the discharge calls uses the medication discharge plan as part of the follow-up with all patients discharged home from the facility	% medication discharge plans completed	!00% of patients have a medication discharge plan in place	implementing a computerized discharge medication plan. Performance may slip during the implementation period due to new process

	Total number of discharged patients for whom a Best Possible Medication Discharge Plan was	% / All patients	Hospital collected data / Most recent quarter available	4770*	100	100	Implementing a new pharmacy system and new discharge medication plan	1)monitor present performance	Discharge medication plan completed. Manager has copy of the plan when making the discharge phone calls	% of discharge medication plans completed and provided to the patients	each patient discharged from the site will have a medication discharge plan	new pharmacy software being implemented April 1. May impact the usual
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 -	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / Jan 1, 2014 - Dec 31, 2014	2057*	0	0	maintain	1)Maintain current practices related to evidence based infection control measures. Evidence based antibiotic prescribing is part of the antimicrobial stewardship program	Follow up forms completed by Manager and ICP	% follow up forms completed	maintain current practice	maintain. have had 2 years without CDI
	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / Jan 1, 2014 - Dec 31, 2014	4770*	0	0	maintain	1)maintain current practices based on evidence based infection control practices including the antimicrobial stewardship initiatives of	follow up forms completed by Manager and ICP Data on use of antibiotics for specific infections sent to physicians and clinical leaders	# of follow up forms completed # of monthly reports sent	follow up forms completed 100% of the time monthly ICP report sent 100% of the time	no CDI reported in 3 years. Stringent isolation practices in place
	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 / Jan 1, 2014 - Dec, 31, 2014	2057*	86.7	90	At provincial average. Set 90% as goal for 14/15 but did not achieve.	1)Continue with 1:1 feedback when non-compliance is observed Twice/year ICP will use glow to test for hand hygiene compliance	ICP will adjust audit forms to indicate staff feedback provided ICP will develop a plan to conduct test for hygiene compliance	number of staff provided with feedback when non-compliant number of tests for hygiene compliance performed	75% of non compliant staff will receive 1:1 feedback 2 tests for compliance to hand hygiene will be done	
	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 -	% / Health providers in the entire facility	Publicly Reported, MOH / Jan 1, 2014 - Dec, 31, 2014	4770*	92.4	93.5	well above provincial target	1)monitor. Congratulate staff on compliance	Manager to include hand hygiene audit results at staff meetings Manager to post audits and provide positive comments related to results	hand hygiene results on the staff meeting agenda quarterly when results are available audits results posted in staff and physician lounge	hand hygiene audits are on the staff meeting agenda every quarter 100% of the time Audit results are posted on the quality board every quarter 100% of the time.	

	Avoid Patient falls	Rate of falls acute care unit	Rate per 1,000 patient days / All acute patients	In-house survey / 14/15	2057*	8.93	6	previous performance over previous two years.	1)Ensure all patients have mobility plans in place.	weekly audit of patient care plans written mobility goals on white boards	# of updated standardized mobility plans in place # of white boards with mobility goals written	100% of patients with Morse fall scales >45 will have mobility plans in place 100% of patients with Morse Fall scales >45 will have mobility goals written on the patients' white boards	
									2)use safety equipment to prevent falls	patients at risk for falls will have appropriate alarms in place on chairs and beds	daily review of compliance with falls risk reduction plan re: equipment to prevent falls	100% of patients at risk for falls will have the appropriate alarms in place	
	increase early mobilization of acute care patients	patients mobilized within 24 hours of admission	% / All acute patients	In-house survey / Q4, 2015/16	4770*	CB	50	no benchmark available. Have no baseline data. Have done some education on early mobilization in preventing falls, delirium, functional decline. Senior Friendly strategy	1)Educate a team on quality improvement and change management methodology	send a team of nurses and manager to training session-Senior Friendly Leadership training in Toronto April 29-May 1, 2015	attendance at the training	a team of three will attend the training session and complete the three days of training	
									2)Implement evidence based strategies	Implement the MOVE ON program	MOVE ON program implemented	by end of July, 2015 the team will have researched and developed a plan to implement the MOVE ON program	
									3)development of measurement tools to document and support the early mobilization initiative	Research the MOVE ON program and applicability for implementation Determine what relevant information needs to be documented Use resources available to see what other organizations have done in relation to implementing the program (senior friendly LHIN network, research articles related to reducing falls, delirium, preventing functional decline)	the documentation tools and resources for MOVE ON is developed	By the end of July 2015 the team will have developed the documentation tool and resources for MOVE ON	Senior Friendly strategy
									4)evaluate the effectiveness of the early mobilization program	the effectiveness of the program will be evaluated using the Barthell tool to measure functional decline or improvement from admission to discharge The rate of falls will be monitored to see if program reduces falls and serious injury	number of patients who have a completed barthell scoring done on admission and discharge rate of falls	100% of all admitted patients will have a Barthell done on admission and discharge rate of falls will decrease by 5%	