2013/14 Quality Improvement Plans for the Atikokan General Hospital

Improvement Targets and Initiatives April 3/13 QIP III

Atikokan General Hospital, 120 Dorothy Street, Atikokan, Ontario

ATIKOKAN GENERAL HOSPITAL

AIM		MEASURE					CHANGE			
Quality dimension	**Objective**	**Measure/Indicator**	**Current performance**	**Target for 2013/14**	**Target justification**	**Priority level**	**Planned improvement initiatives (Change Ideas)**	**Methods and process measures**	**Goal for change ideas (2013/14)**	**Comments**
Safety	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. 2012, consistent with publicly reportable patient safety data	0 cases of nosocomial transmission of CDAD within the facility	0 cases	Historical data has reflected the effectiveness of infection control practices and good hand hygiene compliance. By measuring the effectiveness of containment practices demonstrates performance	3	Continue to educate staff with respect to hand hygiene and infection control best practices	The method will be to track the attendance at the monthly RICN webinars, over the number of webinars available for hand hygiene and/or best practice for environmental services.	The goal will be to keep staff informed of the best practice to achieve our target of 0 cases of CDAD nosocominal transmissions.	
							Conduct audits on housekeeping practices as per the toolkit from PHO.	PHO has various audit tools available on the website to utilize to ensure Best Practices are being followed	Investigate the PHO toolkit for environmental services for possible implementation.	This will require more involvement from the lead hand in a leadership role
		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 - Jan-Dec. 2013, consistent with publicly reportable patient safety data	80%	80% +/- 2%	There has been no change in the target. This is an aggressive target to ensure emphasis on compliance with hand hygiene and continue to minimize the risk to patient safety	1	Offer incentives for hand hygiene compliance	Conduct monthly audits to ensure our compliance rate remains at the target level throughout the year.	Conduct monthly audits for compliance.	
	Reduce incidence of new pressure ulcers	**Pressure Ulcers**: Percent of complex continuing care residents with new pressure ulcer in the last three months (stage 2 or higher) - Q2, FY 2012/13, CCRS	0 cases	0 cases	There has been no change in the target. This is a good indicator to reflect optimal patient care	2	A Wound Care Champion has been identified and will continue to provide training and as a resource to ensure we meet our target	Track the attendance at educational sessions to ensure all staff have completed training as per Best Practice	Educate the majority of staff including Physicians on Best Practice for wound care for prevention of pressure ulcers	
							Update our wound care products to reflect Best Practice	When using better products the pressure ulcers should healer faster. Track the healing time of a new pressure ulcer for the stage 2 or higher)		
	Avoid patient falls	**Falls:** Reduce the incidents of patient falls in all patient care units. Measured by the number of patient falls/1000 patient days	6.96	6.96	There has been no change in the target. The target is an aggressive target	2	Re-activate the falls prevention team to monitor all falls.	Measure the number of near miss falls over the number of actual falls to determine if the preventative measures are an improvement to our falls preventation strategies.	The goal would be to have strategies in place for high risk fall patients prior to a fall	
							Purchase additional alarm beds with funds raised through the Foundation.	The method will be to track the number of near miss falls with alarm beds over the number of actual falls reported.		
	Increase proportion of patients receiving medication reconciliation upon admission. PC NEW	**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 - Hospital-collected data, most recent quarter available (e.g., Q2 2012/13, Q3 2012/13). This will link with the Regional Quality Improvement indicator.	75%	80%	Medication reconciliation at admission is incorporated into our patient order sets and the admission package.	1	The Medication Reconciliation forms are attached to our electronic order sets, which are being implemented this year	The method and process measure will be the number of Medication Reconciliations completed at admission over the total number of admissions.	The goal would be to have all patient charts electronic, allowing for an improvement in efficiency and having patient information available when needed.	
Effectiveness	Improve organizational financial health	**Total Margin (consolidated):** Percent 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. Q3 2012/13, OHRS	0.97%	0.00%	Our target justification is based the HSAA agreement and attempting to maintain a balanced budget with no increase in global funding & increased expenses .	1	Continue to work with the NSC supply chain to reduce costs.			
Access	Reduce wait times in the ED	**ER Wait Times: 90th percentile ER length of stay for Admitted patients. Data from Q4 11/12-Q3 12/13.**	6.2 hours	6 hours	The target set by the data from HSAA is 8 hours. We currently exceed this set target. The NWLHIN target is 25 hours, which we exceed as well. The target is a slight improve however we are striving to maintain this improvement.	3	Implement electronic order sets for Physicians to improve efficiency and work flow.	The method and process measure will be the number of admissions using Electronic Order Sets over the number of total admissions. To demonstrate proper usage of software.	The goal would be to have all physicians utilize the electronic order sets to decrease the wait time in the ER.	
							Enhance the point of care processes for the nursing staff	This will be measured by the number of point of care procedures performed by the ER nurse over the number of lab exams that should have been performed by the Point of Care process.	The goal would be to have timely access to results for the Phyisican, reduce the number of unnecessary call backs for laboratory staff, and reduce return visits to the ER for followup testing.	

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	Reduce the LOS for all CTAS IV and V ER visits 	LOS for CTAS IV and V ER visits: The average LOS for all CTAS IV and V ER visits over the average of all ER visits.	1.7 hours is the high end of our current baseline	2.5 hours	By decreasing the LOS in the ER Department will demonstrate better efficiency and patient flow. Allowing staff more time for more critical patients. The number of CTAS IV and V visits cannot be reduced, however the LOS these patients spend in our ER can be reduced for better patient satisfaction. The target is the lower time set by HSAA. As we already exceed that aggressive target, we want to maintain our improvements through sustainable measures.	2	Audit the accuracy of the triage process for appropriateness	The method and process measure will be the numbers of appropriate triage coding over the total number of triage coding for similar CTAS categories	The goal will be to have consistency with triage codes	
Patient Centered	Improve patient satisfaction	**From Emergency Services IN House Survey:** "Would you recommend this hospital to your friends and family?" (add together percent of those who responded "Yes" or "Yes, most definitely") - Range is "No, definitely not; No not really; Maybe; Yes; Yes most definitely".	100%	98% +/- 2%	Historical data has shown high performance in this area which we will continue to strive to achieve	3	Will continue to provide in house surveys, as the return rate has increased compared to using an external company.	Surveys are sent out to patients twice a year. This time frame will allow areas requiring improvement to be assessed and improvements made in a timely manner to ensure patient satisfaction.		
		From Acute Care In House Survey: "Overall, how would you rate the overall level of satisfaction with the quality of care you received at this hospital?" (add together percent of those who responded "Satisfied and Very Satisfied") Range is "Completely Dissatified; Dissatified; Neither Satisfied or Dissatisfied, Satisfied; Very Satifsfied".	100%	98% +/- 2%	Historical data has shown high performance in this area which we will continue to strive to achieve	3	Will continue to provide in house surveys, as the return rate has increased compared to using an external company.	Patient centre care will be evaluated using this question. To ensure we have a high quality of care from admission to the discharge transitions.		
Integrated	Reduce unecessary time spent in acute care	**Percentage ALC days:** Total number of inpatient days designated as ALC, divided by the total number of inpatient days. Q3 2011/12 – Q2 2012/13, DAD, CIHI	12.04%	11.30%	This target is a reflection of the HSAA target and in line with the NWLHIN standard.	3	Continue to work with external partners to ensure there are services available and alternative levels of care for our patients.			
							Continue to work towards the construction of additional long term care beds within our facility			
	Reduce unnecessary hospital readmission	**Readmission within 30 days for selected CMGs to any facility:** The number of patients with select CMGs readmitted to any facility for non-elective inpatient care within 30 days of discharge, compared to the number of expected non-elective readmissions - Q2 2011/12 – Q1 2012/13, DAD, CIHI 	13.25%	15%	The target set by the NWLIHN.	3	Continue to work with community and regional stakeholders to ensure discharge plan summaries are complete to demonstrate high performance in the transition of care	Percentage of discharged patients for whom a comprehensive discharge summary was completed over the number of patient discharges.	Partnership have already been formed with the local FHT/ CCAC for weekly discharge planning transitions.	
							In software that has been purchased there is a section for discharge planning to ensure better transition of care, which should reduce the number of readmission within 30 days.	Once the software is operational we will conduct audits to demonstrate that all necessary information is being recorded and shared with the appropriate external partners		