Let’s Make Healthy Change Happen.

Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

Hôpital général de Nipissing Ouest
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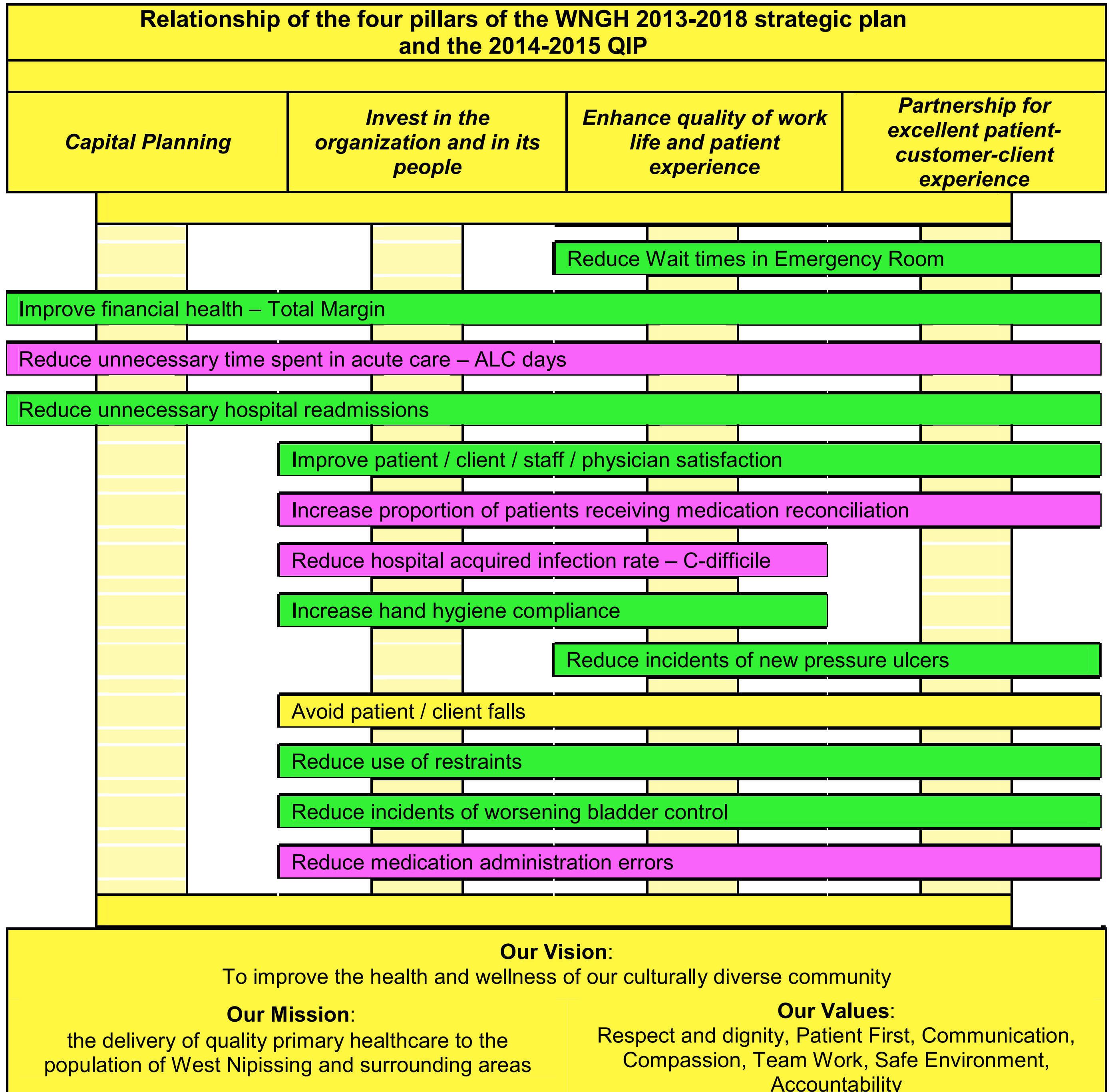
This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a quality improvement plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to HQO (if required) in the format described herein.

Overview

The mission, vision and values of the West Nipissing General Hospital serves as the foundation for the development of our Quality Improvement Plan and as a guide to move our organization forward to ensure excellent quality patient care through the allocation of strategic priorities.

The WNGH has identified four pillars of excellence as our strategic planning focus. Our Quality Improvement Plan aligns with these pillars as demonstrated below.



Moving forward, the hospital is committed to our tag line "**Together we can make a difference; this is our Community Hospital",** which clearly demonstrates our pledge to the key attribute of quality care and shifts the patient to the center of the health care system – a patient centered approach!

Note: The QIP is applicable to our 50 beds acute care unit and our 48-bed Interim Long-Term Care unit.

Note: Indicators not applicable to the West Nipissing General Hospital (WNGH) include:

Indicators	Reason for omission (not applicable)
HRMR	WNGH do not have 1000 deaths/year thus do not qualify for this calculation
VAP rate per 1,000 ventilator days	WNGH patients requiring ventilator are transferred to other facility
Rate of central line blood stream infection per 1,000 central line days	WNGH does not insert/manage central lines
Rate of 5-day in-Hospital mortality following major surgery	WNGH does not perform major surgery

QIP Objectives to improve quality of service and patient care

The West Nipissing General Hospital has developed the Quality Improvement Plan with a strong focus on improvement indicators while continuing to focus on the five key attributes of quality care; access, effectiveness, integration, patient centered care and safety. The QIP is regularly monitored by the Quality Committee, Board of Directors, Medical Staff, President and CEO, senior team and management team with front line staff involvement. The Hospital's executive compensation is linked to the achievement of quality improvement goals.

The West Nipissing General Hospital has chosen targets according to the following algorithm:

- The best theoretical results (ex. 100% or 0)
- At least equivalent to the best result obtained
- Reduce or eliminate waste (ex. 50%)
- Median or average
- The equivalent of the improvement make elsewhere

Over the next fiscal year, we plan to address the following for improvement:

Quality Factor	Objective	Change Initiative	Priority
Integrated	Reduce unnecessary time spent in acute care - Reduce ALC days from 43.7 to 39.33 – representing a 10% decrease	• Thorough study of ALC in acute and complex care • Liaise with same size and proximity hospital to identify other initiatives • Review our discharge process and liaise with Community partners for early return home • Trial discharge planning process in Emergency Department for at risk patients	Improvement

Patient Safety	Reduce the rate of *Clostridium difficile-associated diseases* (SDAD) developed at WNGH from --- to --- per 1000 patient days	▪ Video to be played on TVs in waiting area to increase awareness to visitors, patients and staff of the importance of hand hygiene ▪ Ministry of health - Core Competency Training on Hand Hygiene ▪ Portable automatic dispensers for hand sanitizer strategically placed during outbreak season and/or outbreaks ▪ Poster campaign in all staff washrooms on Routine Practices including Hand Hygiene ▪ Implementation of bedpan/commode hygienic covers with absorbent pad instead of bedpan cleaning wands to rinse bedpans ▪ Review of infection prevention and control and environmental services policies related to hospital acquired infections ▪ Antibiotic Stewardship Program ▪ Hand Hygiene Compliance	Improvement
	Hand hygiene compliance before patient contact	Hand Hygiene is used as an initiative for the reduction of hospital acquired infection rate of C-difficile	Improvement
	Reduce medication administration errors	▪ Review errors to determine which area requires re-education, re-enforcement and/or training ▪ Introduction of unit dose medication dispensing ▪ Implementation of primary care nursing in acute care	Improvement
	Avoid patient falls – Complex Continued Care	▪ Ensure initial 'Falls Assessment' done at admission ▪ Ensure ongoing 'Falls Assessment' for admitted patients ▪ Identification of all patients at risk of falls using color coded bracelets ▪ Bed Alarms	Improvement
	Increase proportion of patients receiving medication reconciliation upon admission	▪ Re/instruction of HFO physicians regarding medication reconciliation at admission ▪ Re-instruction to staff regarding medication reconciliation process. Charts of patients without prescribed medication should indicate reconciliation completed.	Improvement

West Nipissing General Hospital quality culture

The model for improvement used to effectively analyze and implement changes is the Deming Cycle "Plan, Do, Study, Act" (PDSA) Model. This model is used to address and mitigate our potential and actual challenges.

Methodology:
A questionnaire was developed using a modified version of the Accreditation Canada patient satisfaction survey.

The criteria used were:

- Evidence based practices
- Team work
- Security
- Accessibility
- Tools and methods
- Evaluation by indicators
- Efficiency, Effectiveness
- Continuity of Care
- Work-life
- Population Focus
- Financial Incentives
- Leadership and Governance

Improvement strategies:

- staff must greet clients with respect
- Educate the population on the ways to access the services offered at the WNGH and identify support groups in the community
- Bilingualism with front line staff is strongly encouraged
- Improve communication, coordination and continuity between departments
- Continuing education on quality provision of care
- Use of evidence based practices
- Review the quality improvement process
- Decrease the wait times to access the in-house specialists
- Improve the internal signage system
- Address ethical issues as they occur
- Maintain confidentiality

Communication of the improvement strategies occurs by:

- Publication of the QIP on Quality bulletin board for employee and public to access
- Publication of the QIP on WNGH website for public access
- Publication of the QIP on the intranet for employee access

Front line workers are informed of initiative progress by:

- Discussions at staff meetings (general and departmental)
- Publication of the QIP Progress Report on Quality bulletin board for employees
- Publication of the QIP Progress Report on the intranet for employee access
- Periodic report of progress to all staff via e-mail

Integration & Continuity of Care

The West Nipissing General Hospital QIP is directly linked to the daily operations and governance of the hospital. The QIP for the WNGH aligns with our Accreditation Canada report as well as the H-SAA, M-SAA and L-SAA which ensures the hospital is accountable for access, financial health, security, integration, effectiveness, transparency and quality care indicators. The following links will further validate our commitment to excellence, quality, safety and patient care:

West Nipissing General Hospital web site http://www.wngh.ca/

Patient Safety web site http://www.health.gov.on.ca/patient_safety/index.html

Hand Hygiene http://www.health.gov.on.ca/patient_safety/public/hh/hh_pub.html

OHA website http://www.myhospitalcare.ca

The West Nipissing General Hospital also integrates this process with other component plans such as:

- Operating Plan and the Hospital Service Accountability Agreement with the Northeast Local Health Integration Network (NELHIN), as well as agreements with the Health Science North Cancer Program, Ontario Laboratory Accreditation, Accreditation Canada and all other agreements with financial obligations and/or quality indicators to meet
- Human resources plan
- Medical workforce plan
- Information system plan
- Capital and equipment acquisition plan
- Professional development and continuing competency plan

Challenges, Risks & Mitigation Strategies

Potential Challenges	Risks & Rate		Mitigating Strategies
• Aging population • Predominantly francophone and native • Chronic diseases incidences without a primary care practitioner • Lack of community resources to support patients upon discharge	• Increased demands on ALC, LTC beds • Obtain care in the language of choice and cultural influences • Chronic issues with no practitioner to follow up on issues and/or care • Affect our ability to meet provincial targets for access, ER wait times, re-admission rates and ALC pressures.	High risk with various impact on patient outcome	• Continue to partner with community, district and regional services to ensure proper repatriation and coordinated patient care • Proposal for a local Health Links in West Nipissing that will support two (2) Nurse Practitioners for system navigation and enhanced access to primary care in the right location • Continue to work with University and colleges to improve recruitment efforts for Health Care Practitioners • Continue to work with partners and NELHIN on district ALC pressures • Adopting best practices and evidence based practice • Implementing a 'SleepLab' to enhance access and reduce wait times • Implementing a BSO nurse to assist with acute, LTC and Au Chateau
• Resistance to change	• Changing the culture takes years of solid direction, leadership and effort	Medium risk with low impact on patient outcome but could have high impact for employee satisfaction	• Build the QIP into our fall strategic plan to improve buy in for change • Continue to engage staff, physicians, management and patients using surveys, committees, group meetings • Continue to measure and monitor outcomes

				related to care and disease processes • Regular communication of hospital successes/outcomes • Continued transparency of Hospital data • Ongoing education at all levels regarding changes to our health care system and hospital

Information Management Systems

The West Nipissing General Hospital has implemented an EMR system as of October 1, 2013. We will be working towards producing meaningful data from the information management system to understand the needs of the clients we serve.

We will be using this system to enhance our:

- Analysis of data to determine compliance and alignment with best practices, provincial averages and improvement targets
- No blame approach for incident reporting to ensure capture of incidents and allow for the opportunity of lessons learned

Engagement of Clinical Staff & Broader Leadership

The West Nipissing General Hospital engages clinical staff, management team and Board of Directors in an ongoing manner with respect to quality. Our board agenda is comprised with greater than 25% of the agenda focused on Quality. Our Quality Committee of the Board of Director is solid, strong and much focused on quality improvement.

Clinical staff and medical staff are involved in quality issues and quality solutions at all levels. Our QIP coincides nicely with our 2013-2018 Strategic Plan which reinforces our initiatives, our goals and objectives to meet our quality initiatives and coincidentally, our Strategic Plan.

The medical staff members are engaged through Board meetings, medical staff and MAC meetings and via the implementation of QBPs, Patient Order Sets and with the QIP and Strategic Planning.

We ensure quality is a top priority at all levels within West Nipissing General Hospital.

Accountability Management

The purpose of performance-based compensation is related to Excellent Care For All Act (2010) which drives accountability for the delivery of quality improvement plans. Performance-based-compensation can help organizations to achieve both short and long-term goals. By linking achievement of goals to compensation, the West Nipissing General Hospital increases motivation to achieve these goals.

Performance-based compensation will enable the WNGH to:

1. Drive performance and improve quality
2. Establish clear performance expectations
3. Create clarity about expected outcomes
4. Ensure consistency in the application of performance incentives
5. Drive transparency in the performance incentive process
6. Drive accountability with respect to the delivery of the Quality Improvement Plan
7. Enable team work and a shared purpose

Organizational positions for which performance-based compensation applies includes:

- President & Chief Executive Officer
- Chief Nursing Officer
- Chief Financial Officer
- Chief of Staff

Linking compensation to the Quality Improvement Plan

Our 2013-2014 Pay for Performance Plan complies with ECFAA and the Public Sector Compensation Restraint to Protect Public Services Act, 2010.

For the above executives, **5%** of their current base salary is **at risk** and linked to the WNGH Quality Improvement Plan. The Pay for Performance is specifically linked to the following quality dimensions and objectives:

Quality Dimension	Objectives	Percentage of at risk pay
Access		
Effectiveness		
Integrated	Improved ALC days - Reduce unnecessary time spent in acute care	1.0 %
Patient-centered		
Safety	Reduce hospital acquired infection rates – C-difficile	1.0 %
	Reduce medication administration errors	1.0 %
	Avoid patient falls – Complex Continued Care	1.0 %
	Increase proportion of patients receiving medication reconciliation upon admission	1.0 %

Health System Funding Reform

As a small rural hospital, it is vital that we embrace HSFR, which ensures evidence based quality patient care. Although West Nipissing General Hospital is currently exempt from QBP's and HBAM, we are applying and utilizing evidence based practices to meet the needs of our population, improve access and improve outcomes in a fiscally responsible manner.

Although, as a small rural hospital, we are often not able to realize the same efficiencies as larger organizations, we maintain a balanced budget without service or program cuts for the past several years.

We are adopting best practices, Patient Order Sets and QBP data to further improve our medical procedures, medical treatments and endoscopy services. We are currently adopting recommendation for COPD, CHF, GI Endoscopies and TIA. Our Board of Directors and Medical Staff are supportive of quality patient care that is standardized for our patients. HSFR shifts culture and behavior through change management and data quality, which meets our goal to provide quality patient care and improve the patient experience.

Sign-off

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan

Board Chair – Collin Bourgeois ____

Quality Committee Chair – Sylvie Belanger ____

Chief Executive Officer – Cynthia Desormiers____

Instructions: Enter the person's name. Once the QIP is complete, please export the QIP from Navigator and have each participant sign on the line. Organizations are not required to submit the signed QIP to HQO. Upon submission of the QIP, organizations will be asked to confirm that they have signed their QIP, and the signed QIP will be posted publically.

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

West Nipissing General Hospital 725 Coursol Road

AIM		Measure								Change				
Quality dimension	**Objective**	**Measure/Indicator**	**Unit / Population**	**Source / Period**	**Organization Id**	**Current performa**	**Target**	**Target justificati**	**Priority le**	**Planned improvement initia**	Methods	Process measures	Goal for change ide	Comments
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	881*	11.52	11.52	Maintain our below provincial average for 90th Percentile ED length of stay	Maintain					
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	881*	0	0	Implementation of a balanced budget	Maintain					
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	881*	45.39	38.58	Reduction of 15% with aim to reach Provincial average of 14.0%	Improve	1)Thorough study of ALC in acute and complex care.	Chart review.	# patients classified as ALC divided total number of patients in acute care and complex continued care	Aim to reduce by 15% of current rate by March 31, 2015	
										2)Liaise with same size and proximity hospital to identify other initiatives.	Site visits, conference calls.	Data gathering	Exploration of new ideas, explanation of current situation, implementation of	
										3)Review our discharge process and liaise with Community partners for early return home	Face to face and conferences with discharge planners and community partners	Data gathering	Implement initiatives for early and safe discharge home	
										4)Trial discharge planning process in Emergency Department for at risk patients	Documentation of face to face and telephone follow up.	Chart audits. # patients receiving follow up divided by # patients identified at risk	80% compliance by December 31, 2014.	
	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 CMGs.	% / All acute patients	DAD, CIHI / Q2 2012/13-Q1 2013/14	881*	16.36	16.3	To maintain current performance at provincial average of	Maintain					
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 / Other	881*	97.1	97.1	Question: 'Would you recommend this hospital to your friends and	Maintain					
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)	881*	94.7	100	Ensuring patient safety and well being by allways performing medication reconsiliation at admission.	Improve	1)Re/instruction of HFO physicians regarding medication reconsiliation at admission.	Chart audit	# medication reconciliation at admission divided by # admissions	100% compliance by September 30, 2014	
										2)Re-instruction to staff regarding medication reconsiliation process. If patient has no prescribed medications, the chart	Chart audit	# medication reconciliation at admission divided by # admissions	100% compliance by September 30, 2014	
	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	881*		0	To decrease current performance of 0.30 - at provincial	Improve	1)Video to be played on TVs in waiting area to increase awareness to visitors, patients, staff of the importance of hand	Utilization of hand sanitizer in common areas	# hand sanitizer containers utilized during campaign divided by the # hand sanitizer used same period last year	Increase in the utilization of hand sanitizers	

AIM		Measure								Change				
Quality dimension	**Objective**	**Measure/Indicator**	**Unit / Population**	**Source / Period**	**Organization Id**	**Current performa**	**Target**	**Target justificatio**	**Priority le**	**Planned improvement initia**	Methods	Process measures	Goal for change ide	Comments
								average of 0.3 (Jan-Dec 2012)		2)Ministry of health - Core Competency Training on Hand Hygiene	Mandatory compliance of all staff to complete the training - includes current staff and new staff (done during orientation)	# employees complying with training requirement divided by the # employees	100% compliance by December 31, 2014.	
										3)Portable automatic dispensers for hand sanitizers strategically placed during outbreak season and/or outbreaks	Increase in hand sanitizer utilization	Data collection	Increase in hand sanitizer utilization	
										4)Poster campaign in all staff washrooms on Routine Practices including Hand Hygiene	Survey staff on awareness of poster and change in behaviour attributed to posters	# staff stating posters changed their behaviour divided by # of survey answered	Culture change	
										5)Implementation of bedpan/commode hygienic covers with absorbent pad instead of bedpan cleaning wands to rinse bedpans	Utilization of bedpan/commode hygienic covers Decommissioning of bedpan cleaning wands	Audits on compliance to policy # bedpan hygienic covers utilized divided by # patients using bedpan	100% compliance by September 30, 2014	
										6)Review of infection prevention and control and environmental services policies related to hospital acquired infections	Review dates indicated on policies. Implement changes to job routines to reflect changes in policies.	# policies and job routines revised divided by # applicable policies	Ensure utilization of best practices	
										7)Antibiotic Stewardship Program	Review/revise and implement best practices standards for IV antibiotic use	# patients on 'Antibiotic Stewardship Program' divided by # patients qualifying for 'Antibiotic Stewardship Program'	80 % compliance by December 31, 2014	
										8)Hand Hygiene Compliance	Hand Hygiene Audits as per MOHLTC	Data entry into MOHLTC provided program	Increase from 84% before pt/pt environment contact to 86%	
		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 publicly reportable patient safety data.	% / Health providers in the entire facility	Publicly Reported, MOH / 2013	881*	84	86	To improve or maintain current performance above provincial average of	Maintain					
	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	881*		0	To maintain current performance	Maintain					
		Percent of Long Term Care (LTC) residents with a new pressure ulcer in the last three months(stage 2 or higher).	% / LTC residents	Hospital collected data / Q2 FY 2013/14	881*	0	0	To maintain current performance	Maintain					
	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	881*		5	To meet or better provincial average of 9.7% and benchmark of 5.0 % (Currently - 2 patients / 19 patients = 10%)	Improve	1)Ensure initial 'Falls Assessment' done at admission.	Audit admitted patient's chart	Number of Falls Assessments done divided by the number of patients admitted	100 % compliance by September 1, 2014	
										2)Ensure on going 'Falls Assessment' for admitted patients	Chart audit	Number of 'Falls Assessment' done divided by the number of patients on the unit	100% compliance by Sept 1, 2014	
										3)Identification of all patients at risk of falls using color coded bracelets.	Audit of compliance with identification policy	# patients with color coded bracelets divided by the # of at risk patients	100% compliance by September 1, 2014	

AIM		Measure								Change				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performa	Target	Target justificati	Priority le	Planned improvement initia	Methods	Process measures	Goal for change ide	Comments
		Percent of Long Term Care (LTC) residents who fell in the last 30 days.	% / LTC residents	Hospital collected data / Q2 FY 2013/14	881*	0	0	To maintain current performance level.	Maintain					
	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	881*		100	To maintain current performance in line with provincial	Maintain					
	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	881*		0	To maintain current performance level.	Maintain					
		Physical Restraints: The number of Long Term Care (LTC) residents 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.	% / LTC residents	Hospital collected data / Q2 FY 2013/14	881*	0	0	To maintain current performance level.	Maintain					
	Reduce incident of worsening bladder control	Percentage of Long Term Care (LTC) residents with worsening bladder control during a 90-day period.	% / LTC residents	Hospital collected data / Q2 FY 2013/14	881*	0	0	To maintain current performance level.	Maintain					
	Reduce medication administration errors	Medication incidents: Total number of medication incidents divided by the total number of medication prescribed multiplied by 100.	% / All acute patients	Hospital collected data / Q2 FY 2013/14	881*	0.29	0.25	To improve current performance level. Medication incidents did not have adverse effect or consequences to patients.	Improve	1)Analysis of errors to determine which area requires re-education, re-enforcement and/or training	In-House audit of incident reports	Measure frequency and determine contributing factors	Continual decrease in medication errors	
										2)Introduction of unit dose medication dispensing	Implementation of unit dose medication in the pharmacy department	# dispensing errors divided by the # dispensed medication	Zero medication dispensing errors by May 31, 2014.	
										3)Implementation of primary care nursing in acute care	Patient assignment will consist of 1:5 nurse/patient ratio. Assignment based on acuity of care.	# medication errors divided # medication administered	Reduction by 50% of current rate by May 31, 2014.	