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

Norfolk General Hospital 365 West Street,Simcoe, Ontario

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	ED Wait times: 90th percentile ED length of stay for Admitted patients.	Hours / ED patients	CCO iPort Access / Jan 1, 2014 - Dec 31, 2014	804*	22.9	15	HSAA Target	1)Maintain standardize bed management process	Daily reported bed management indicators	Using LEAN approach improve communication on inpatient units through the use of whiteboards, discharge rounds and bed navigation strategies	Improve flow of information within and across services	Strategic Plan
									2)Maintain gains in reducing the time to initial physician assessment	Physician Assistant in the ED and Nurse Practitioner role	Maintain wait time under 3 hours	Continue to maintain the gains we have made in reducing the PIA time.	
									3)Admission avoidance	Number of referrals	Number of patients who are assessed and referred to CCAC in the ED to ehance services in the community and avoid an admission	10% improvement in assessments completed and forwarded to CCAC in the ED	
Effectiveness	Improve organizational financial health	Total Margin (consolidated): % by which total corporate (consolidated) revenues exceed or	% / N/a	OHRS, MOH / Q3 FY 2014/15 (cumulative from April 1, 2014 to December 31,	804*	-0.45	0	HSAA	1)Adjust staffing levels to conincide with occupancy	Worked hours per patient day	% improvement	Reduce worked hours per patient day	
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	804*	23.12	11	HSAA Target	1)LHIN-wide refresh of Home First Philosphy	# patients discharged with support of Home First Program	Develop a standardized approach for challenging discharges founded on Home First Philosphy	Reduce ALC rate by 1%	
									2)Participation in Integrated Funding Model Project to promote a seamless model of care from hospital to home	Chart audit and participate in the LHIN based Steering Committee	Develop a standardized review of the uptake of Quality Based Procedures (COPD) by reviewing each component for utilization	Increased referrals to Community Based programs for patients living with COPD	
	Reduce unnecessary hospital readmission	Readmission within 30 days for Selected Case Mix Groups	% / All acute patients	DAD, CIHI / July 1, 2013 - Jun 30, 2014	804*	18.84	16.45	Multi year improvement target. Maintain our path to improvment	1)Improve opportunities for patient education related to self care management	Maintain our practice of a Teach Back approach to patient engagement	Patients wil identify that they understand how to care for themselves upon discharge. Data will be collected from a "real time" discharge survey.	All clinical staff will use a Teach Back Methodology to support patients and their families	
									2)Maintain current practice in communicating to the next care provider and Family Physician through warm handover when	Chart audit	Discharge information provided to Family Physician and next care provider	Maintain communication between care providers as patients transition	LHIN discharge bundle initiative
									3)Enhanced partnership with Health Links for patients diagnosis of CHF or COPD	Formalized referral process	# referrals	Positive impact on readmission patterns for identified patient population	

									4)Participation in Integrated Funding Model Project to promote a seamless model of care from hospital to home	Chart audit and participation in LHIN based Steering Committee	Develop a standardized review of the uptake of Quality Based Procedures (COPD) by reviewing each component for utilization	Increased referrals to community based programs for patients living with COPD	
Patient-centred	**Improve patient satisfaction**	From NRC Canada: "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 / October 2013 - September 2014	804*	91.2	91.8	Health Quality Ontario Target	1)Senior Sensitivity Training for all staff (GPA)	NRC: Treated with dignity and respect. Current performance is 75.4%	Gentle Persuasive Approach education for staff is part of our Strategic Plan. We are entering into our second year and this will be an ongoing educational programs embed into orientation for new staff	100% of staff will be trained in GPA	Approach the NRC High Performer of 97.8%
									2)Service Excellence Training for all staff	% staff attending training	Focused Service Excellence Training is provided to all staff. This will be embed into our orientation program	Alll staff will be trained in Service Excellence	Strategic Plan
									3)Purposeful Rounding on all inpatient units and in the Emergency Department	Leadership audit/patient interview	Staff will be educated in standardized approach to purposeful rounding	All clinical staff will particpate in education about puroseful rounding	
									4)Patients will identify that they have been included in their plan of care. Supporting our patient/family centered	NRC: Respect for patient preferences. Current performance is 76.2%	% improvement	Guiding principles of Patient and family centered care are promoted across the	Approach the NRC High Performer of 90.3%
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.	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / Jan 1, 2014 - Dec 31, 2014	804*	0.38	0	Strategic Priority	1)Unit specific infection rates reported quarterly	Quarterly reports to each unit	improvement in rate	Enhanced awareness of infection rates by service	
									2)Continue to review case of CDI to enhance learning across the organization	Review of all cases of CDI at the Infection Control Committee	improvement in CDI rate	Involving front line staff and physicians in case review and shared learning	
		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	% / Health providers in the entire facility	Publicly Reported, MOH / 2015	804*	89	100	Strategic Plan	1)Leadership Walkabouts	Quarterly walkabouts that are focused on patient safety initiatives	Improvement in hand hygiene rates	Leadership walkabout to include hand hygiene discussion with front line	
									2)Maintain practice of unit specific quarterly reporting on hand hygiene rates	Quarterly reports that are unit specific	Improvement in hand hygiene rates	All units updated on quarterly hand hygiene rates	
	Increase proportion of patients receiving medication reconciliation at transition in service	Medication Reconciliation at transition in service	% / ICU patients	chart / 2015 16	804*	CB	100	Best Practice	1)Standardize approach to medication reconciliation at transfer between services	Chart audit	Develop a process for medication reconciliation when patient transferred from ICU	All transfers to inpatient services from ICU will have medication reconciliation	Enhance the medication reconciliation practice to inlcude patients