NOTRE-DAME HOSPITAL (HEARST)
Excellent Care for All

Quality Improvement Plans (QIP) 2012/13: Progress on QIP Year One (2011/12)

Template for Reporting

The following template has been provided to assist with completion of the Progress Report on Year 1 QIP. Please review the information provided in the first row of the template which outlines the requirements for each reporting parameter.

	Priority Indicator (year 1)	Performance as stated in the year 1 QIP	Performance Goal as stated in the year 1 QIP	Progress to date	Comments
Guidance for completing the Performance Report	State the name and definition of the priority level 1 indicator listed in the hospital's year 1 QIP. Reporting on progress of other priority indicators (i.e. levels 2 and 3) is optional.	State the performance associated with the priority indicator that was included in the hospital's year 1 QIP.	State the performance goal that was included in your hospital's year 1 QIP. The stated performance goal indicates the outcomes that the organization expected it would be able to achieve for each priority indicator by the end of the 2011/12 fiscal year, i.e. March 31, 2012.	For each of the indicators listed, state the organization's current data associated with the priority indicator. Reporting periods should align with the periods used to develop the year 1 QIPs. Refer to Appendix 1a of the guidance document for recommended reporting periods for core indicators.	Hospitals should use this section to explain how the performance goals stated in their year 1 QIPs could be improved, describe the challenges faced with meeting their targets, and generally comment on the organization's commitment to meeting the performance targets outlined in their 2012/13 (year 2 QIP).
PRIORITY 1 INDICATORS:					
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 before initial patient contact multiplied by 100 - 2009/10, consistent with publicly reportable patient safety data		67% (2010)	85%	80,8% (2011)	Our Hospital has not met the target of 85%. However, we have seen a significant improvement over the previous year due to the numerous initiatives (education and training of all staff, audits, 13 additional hand washing stations, dynamic and

				creative presentations to staff). The hand hygiene compliance remains a high priority for our organization.
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 2010/11, OHRS	-1.03 (2009-10)	-1.5%	-0.4% (Q3 2011-12 YTD)	Our Hospital has made some significant efforts to ensure a balanced budget in these challenging times. We have been successful in meeting our objectives due to disciplined spending strategies including reduction of travelling and administration costs and the salary freeze of non-unionized employees. Significant efforts have also been deployed to increase revenues through the Foundation as well as the Information Technology and Respiratory Therapy departments. It is expected that it will become increasingly difficult to balance the budget.
Patient survey: "If you have to go to hospital again, would you choose to come to this hospital?" (add together percent of those who responded "Yes")	100% (2010)	100%	100% (2011)	Our organization is extremely proud of the fact that all of the respondents to the survey have answered that they would choose our Hospital again. In order to maintain a high patient satisfaction level, we have very dedicated personnel who respond quickly to the patients' needs and comments (involvement in patients and families in planning process, regular ombudsman visits, creation of the Aboriginal Navigator position, liaison committee with Constance Lake reserve, patient questionnaires, multidisciplinary meetings, etc…). The patient satisfaction is an extremely important measure of our success.
PRIORITY 2 INDICATORS				
Falls: Percent of patients on complex continuing care unit	No data available	Benchmark to be determined	5%	We have seen an unusually high number of

who do not have a recent history of falling, but fell in the last 90 days - FY 2009/10, CCRS			(YTD – Q3 2011)	falls and serious injuries in the last months even though there have been significant efforts to avoid such falls (e.g. training of staff, assessment of patients, purchase of new beds, alarms, hipsters, falls prevention program, involvement of families, etc…). Efforts will continue to ensure the focus on this important aspect of our services.
Readmission within 30 days for selected CMGs to any facility: The number of patients with specified CMGs readmitted to any facility for non-elective inpatient care within 30 days of discharge, compared to the number of expected non-elective readmissions - Q1 2010/11, DAD, CIHI	17.1%	14,3%	7.4% (YTD – Q3 2011)	Readmission rates for selected CMG's have decreased significantly in the last year. This may reflect our institution's varied use of best practices information. The changes to the discharge planning process (inclusion of aboriginal navigator and aging-at-home coordinator) as well as the discharge phone calls are action items that have contributed to this improvement.
Percentage ALC days: Total number of inpatient days designated as ALC, divided by the total number of inpatient days. Q2 2010/11, DAD, CIHI	37%	17% (as per LHIN's target)	40.2% (YTD – Q3 2011)	The ALC days in a small rural community hospital like ours are excessively high due to the fact that the services in the community are practically non-existent. Over the last 18 months, our hospital has taken the leadership in the Aging-at-home program in our community to help seniors remain at home. The ALC days will continue to remain a high priority for our organization.
ER WAIT TIMES:				
(1) **90th Percentile Emergency Room (ER) Length of Stay for Admitted Patients:** The total ER length of stay where 9 out of 10 admitted patients completed their visits. Target < 8hrs as per ERNI Access to Care.	18.1	17,5	18.7 (YTD – Q3 2011)	The quality of the services in our hospital's ER exceeds patient expectations. The numbers don't account for the fact that we do not have a dedicated ICU or clinical observation unit. In fact, patients who are kept under observation for longer periods of time are kept in the ER. Therefore, the statistics for wait-times are skewed. At this
(2) **90th Percentile Emergency Room (ER) Length of Stay for Non-Admitted (CTAS I-III) Patients:** The total ER length of stay where 9 out of 10 non-admitted	13.58	12	14.9 (YTD – Q3 2011)	

complex (CTAS levels I, II and III) patients completed their visits. Target < 8hrs as per ERNI Access to Care.				point, we do not foresee an important change to the numbers for complex conditions. The numbers for minor or uncomplicated condition meet the provincial targets.
(3) **90th Percentile Emergency Room (ER) Length of Stay for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients:** The total ER length of stay where 9 out of 10 non-admitted minor/uncomplicated (CTAS levels IV and V) patients completed their visits. Target < 4hrs as per ERNI Access to Care.	3.1	3,1	3.0 (YTD – Q3 2011)	