2018-19 Quality Improvement Plan (Workplan)

AIM		Measure						
Quality dimension	**Issue**	**Measure/Indicator**	**Type**	**Unit / Population**	**Source / Period**	**Organization Id**	**Current performance**	**Target**
Effective	**Effective transitions**	Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?	P	% / Survey respondents	CIHI CPES / April - June 2017(Q1 FY 2017/18)	596*	47.9	50.30

		Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort)	P	Rate / COPD QBP Cohort	CIHI DAD / January - December 2016	596*	21.82	15.20
Efficient	**Access to right level of care**	Total number of alternate level of care (ALC) days contributed by ALC patients within the specific reporting month/quarter using near-real time acute and post-acute ALC information and monthly bed census data	P	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July - September 2017	596*	13.18	15.10

Patient-centred	**Person experience**	"Would you recommend this emergency department to your friends and family?"	P	% / Survey respondents	EDPEC / April - June 2017 (Q1 FY 2017/18)	596*	56.5	65.00

		"Would you recommend this hospital to your friends and family?" (Inpatient care)	P	% / Survey respondents	CIHI CPES / April - June 2017 (Q1 FY 2017/18)	596*	45.1	52.00

Safe	**Safe care/Medication safety**	Medication reconciliation at 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.	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / October – December (Q3) 2017	596*	66.27	72.00

Workplace Violence	Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.	M A N D A T O R Y	Count / Worker	Local data collection / January - December 2017	596*	CB	CB

Timely	**Timely access to care/services**	ED Wait times: 90th percentile ED length of stay for Admitted patients	C	90th percentile / ED patients	CCO iPort / Q3 2017/18	596*	15.4	12.00

	Change			
Target justification	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**
This represents a 5% improvement on current performance	1)Implement Discharge follow-up phone calls to reinforce discharge instructions and address opportunities for improvement by the Admission Discharge Transfer nurse and/or modified staff.	1) Develop Discharge Phone Call Standard Operating Procedure (SOP) 2) Pilot process on Medicine inpatient unit 3) Review pilot process 4) Develop method to track themes and opportunities related to discharge process	Develop SOP by Q2 2017/18 % of Discharge calls completed for Medicine Patients in Q3 2018/19	100% SOP developed by Q2 2017/18 50% Discharge Calls completed based on number of Medicine patients discharged per quarter
	2)Enhance communication with patients and families that helps navigate hospital discharge and patient experience.	1) Review and update existing patient communication brochures and tools to standardize into one handbook 2) Provide discharge education training using Patient-Oriented Discharge Summary (PODS) to staff 3) Create and implement formal patient sign-off process indicating they received information.	Review and Update communication handbook by Q2 2018/19 % staff completed discharge education % of patients with discharge summary completed and signed off on discharge	100% of staff will be trained by Q3 2018/19 75% of patients will sign off on discharge process

This represents a 30% improvement	1)Provide Chronic Obstructive Pulmonary Disease (COPD) Pathway education to staff including early initiation in Emergency Department (ED)	1) Monthly audit to review pathway and process for admitted patients using random identification process by clinical coordinator and/or Manager. 2) Review of cases excluding pre-printed orders and COPD Pathway to identify process or pathway opportunities for improvement	% of pre-printed orders and COPD Pathways completed for admitted COPD patients Identify and action process improvement and pathway opportunities	80% of COPD patients will have pathway completed
Our target is informed by fluctuations in quarterly rates and aligns with our Central Local Health Integration Network goals	1)Develop ALC specific surge practices and increase organizational awareness of ALC pressures.	Incorporate organizational ALC data and review system pressures at daily Transforming Care Quality Improvement Huddles	Number of patients designated ALC per day	Less than 4 patients designated ALC per day
	2)Continue to collaborate with our community partners at weekly Complex Care rounds to enhance early identification and monitoring of our patients requiring discharge to alternate levels of care	Identify and implement collaborative strategies to address challenges related to increased waits for alternate levels of care	Top themes for increased ALC length of stay	Identify top three themes for ALC length of stay

	3)Implement Discharge Pathway with escalation framework to enhance patient flow	Work collaboratively with internal clinicians and clinical team to implement standard processes to align with the Central (LHIN) Discharge Pathway Improvement Toolkit. Implement Family meetings within 24-48 hours Implement Substitute Decision Maker/Escalation standard framework, including a joint family meeting between Hospital Admission Discharge Transfer Nurse and/or Clinical Coordinator and Community Hospital Care Coordinator. Finalize and implement the escalation process to ensure all steps have been taken to divert ALC and determine ALC designation Obtain final approval on the Escalation framework	# Family Meetings within 24-48 hours per month % of family meetings that met the Pathway criteria within 24-48 hrs for Q2 and Q3 2018/19 % of ALC patients escalated to step 2 of escalation framework	100% of family meetings that met the Pathway criteria will be scheduled within 24 – 48 hours of admission Less than 5% of our ALC patients escalate to Step 2 of the escalation framework
This represents a 15% improvement	1)Evaluate ED patient experience feedback results. Improve transparency of sharing patient experience data and embed in the unit based Transforming Care Quality Improvement Huddles	Review Patient Experience Survey results and complaint themes to promote discussion and inform change in practice.	% patient would recommend this ED to patient and families # of themes and progress of action plans per quarter Quarterly Patient Feedback Report reported at Departmental and Board Quality Meeting	1) Quarterly target of 65% of emergency patients will recommend this hospital to family and friends by Q3 2018/19 2) Top three themes will be reviewed and an action plan developed each quarter by Q1 2018/19

	2)2)We will build upon the improvement strategies identified in our mapping process and continue to track system flow through the use of our daily monitoring tool (DART), in unit-level performance huddles, Discharge Rounds and Daily Bed Meetings. By engaging frontline staff and leaders, we are better able to identify challenges and barriers. We will increase data review at program and leadership level.	Daily Monitoring of Patient Flow Metrics (DART) meeting targets - daily, weekly and monthly review Monthly NRC Patient Survey Results Quarterly Patient Experience Reports Weekly review of Value Stream Map Activities	Daily Monitoring of Patient Flow Metrics (DART) meeting targets - daily, weekly and monthly review Monthly NRC Patient Survey Results Quarterly Patient Experience Reports	Daily Review of DART at ED and Inpatient Transforming Care Quality Improvement Huddle 100% Quarterly Patient Experience Reports 100% NRC Patient Surveys circulated to Program Manager
	3)ED program will develop and implement action plans to create improvement aligned to two key driver associated with the overall rating of care.	Identify 2 key drivers for overall rating of care; identify leading practices that would impact each of the key drivers identified; select one key driver and develop an action plan to create improvement; implement the action plan; evaluate the impact on the key driver by monitoring patient experience measurement results.	2 Key Drivers identified and action plan developed through ED Quality Committee by Q1 2018-19 2% improvement in related Patient experience measurement results on NRC survey by Q3 2018-19"	100% (2 key drivers) will be identified for monitoring by Q1 2018-19 A 2% improvement in key driver performance will be measured on the NRC survey by Q3 2018-19

This target represents a 15 % improvement based on current performance	1)Evaluate Medicine Unit patient experience. Improve transparency of sharing patient experience data and embed in the unit based Transforming Care Quality Improvement Huddles	1) Review and share Patient Experience Survey results/themes and complaint themes to inform change in practice. 2) Continue to support and audit the use of the 2-way communication boards and Intentional Rounding framework to improve patient and family communication/experience	1) % patients that responded Yes definitely 2) Post and discuss qualitative and quantitative feedback from patient and family through survey feedback 3) Develop action plans that incorporate feedback and evidence based practices based on identified themes 4) % of 2-way communication boards completed	1) Quarterly target of 52% of inpatients will recommend this hospital to family and friends 2) Top three themes will be reviewed and an action plan developed each quarter 3) Random audits of 2 way communication boards - target 90% updated as per Standard Operating Procedure by Q3 2018/19
	2)Real Time in patient experience survey. Leverage PFAC members across every committee and within every quality improvement	Develop a Standard Operating Procedure to continue to actively engage inpatients with real time satisfaction surveys conducted on electronic tablets or paper surveys	# real time surveys completed per month/quarter Monitor and action identified themes and incorporate into action plans Report at Departmental Quality Committee on a monthly/quarterly basis	Determine with the PFAC a minimum number of surveys per month by Q1 2018/19

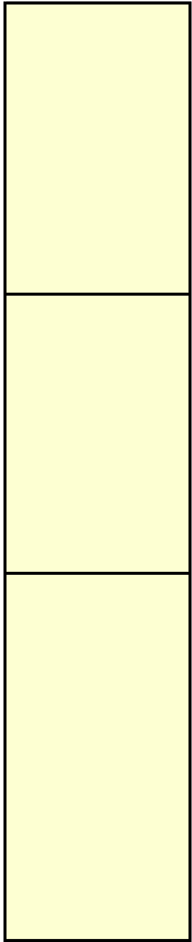
	3)The Inpatient program will develop and implement action plans to create improvement aligned to two key driver associated with the overall rating of care.	Identify 2 key drivers for overall rating of care; identify leading practices that would impact each of the key drivers identified; select key driver and develop an action plan to create improvement; implement the action plan; evaluate the impact on the key driver by monitoring patient experience measurement results.	2 Key Drivers identified and action plan developed through Medicine Quality Committee by Q1 2018-19	100% (2 key drivers) will be identified for monitoring by Q1 2018-19 A 2% improvement in key driver performance will be measured on the NRC survey by Q3 2018-19
We are expanding to include medicine and surgical patients.	1)We are expanding to include patients on our medicine short stay unit and surgical patients	Develop process and training to include inpatient surgical discharges and patients on Medical Short Stay unit. Include processes and education to capture patients after hours.	% Medicine Patients with Medication Reconciliation on Discharge % Surgical Patients with Medication Reconciliation on Discharge % Medical and Surgical Patients with Medication Reconciliation on Discharge	Staff and Physicians will be trained to complete Medication Reconciliation on Discharge by end of Q1 2018/19 72% of identified population will have a completed Medication Reconciliation on Discharge by Q3 2018/19

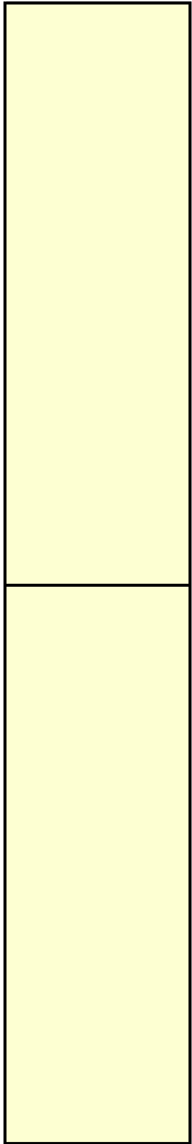
As a new indicator, we will be collecting baseline to improve our understanding of this indicator	1)Develop and implement Violence risk screening questionnaire at triage to identify patients that can be aggressive/violent towards staff	Provide training for staff outlining new violence identifier policy	Number of staff trained on risk assessment screening by Q1 2018-19 in the Emergency Department	90% of training by end of Q1 2018-19
	2)Reduce Workplace violent incidents by developing and implementing a standardized approach to conducting post code white evaluations (violent patient incident) to share lessons learned, identify root causes and trends to reduce future incidents.	The Emergency Planning Committee will develop and implement a standardized de-briefing tool to be conducted post codes.	"% Post Code white debriefs completed per quarter # of workplace violence incidents categorized to themes and departments"	100% of code white incidents followed by debrief
	3)Reduce number of workplace violence incidents by providing mandatory violence prevention and response training to identified staff.	Provide appropriate level of staff training based on identified levels of risk. E.g. Staff with little to no direct patient or family contact, moderate risk training for staff in areas that may have potential for aggression and violent behavior and high risk training for staff in areas of high frequency and intensity of behavioral episodes and high probability for staff and patient harm.	% of staff trained in violence prevention and response training	30 ED and Facilities FT and PT staff will be trained by March 31, 2019

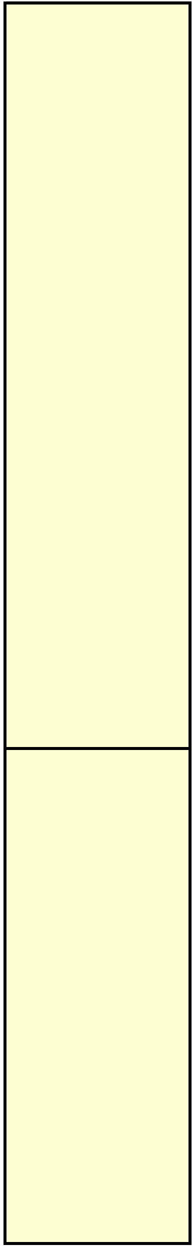
	4)Provide opportunities for interprofessional learning by simulating a violent patient incident (mock code white)in an environment that closely resembles real clinical situations.	Under the direction of the Emergency Planning Committee, conduct quarterly Mock Code White exercises followed by assessment of code team performance and response	# of code white exercises held and follow assessment completed	Conduct 2 Mock Code White (violent patient simulation) exercises and assess Code team performance and response by March 31, 2019
	5)Assessment and flagging patients identified in workplace violence incidents will provide the staff caring for these patients with information that could prevent further incidents.	Ensure that all patients identified in workplace violence incidents are appropriately flagged post incident in our electronic medical record.	% of patients involved in workplace violence incidents flagged appropriately in EMR (post incident)	100% of patients identified in workplace violence incidents are appropriately flagged (post-incident) in our Electronic Medical Record

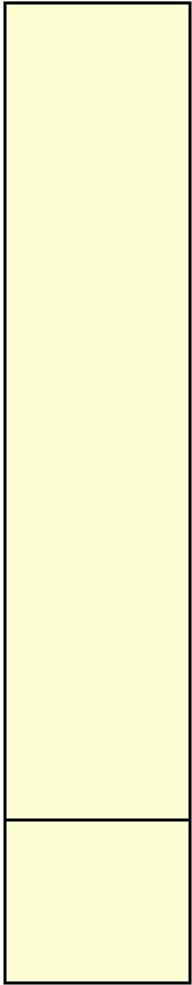
This represents a 22.1% improvement on current performance	1)Continue to implement Transforming care Quality Improvement Huddles across the organization to discuss opportunities for improvement	1) Maximize staff roles and resources to support patient flow 2) Engage in discussions with interdisciplinary staff focusing on quality improvement ideas and track progress on the "PICK" board 3) Continue to address improvement ideas identified during the Value Stream Mapping session with the interdisciplinary team	# of Transforming Care Quality Improvement Huddles implemented each quarter Each department will monitor quality improvement items and actions on the PICK board Weekly review of the Value Stream Mapping Session action items	Transforming Care Quality Improvement Huddle will be implemented each quarter A minimum number of PICK tickets will be determined by the respective department by Q1 2018/19 100% weekly review of outstanding Value Stream Map action items Q1 2018/19
	2)Examine opportunities to expand the role of volunteer supports to improve patient flow in the ED	1) Review and maximize staff roles and resources to support patient flow 2) Engage in collaborative discussions with interdisciplinary staff and volunteers focusing on quality improvement ideas and track progress on the "PICK" board relating to volunteer support role	Review roles by Q1 2018/19 Track quality improvement ideas and actions on PICK board	100% of roles will be reviewed by end of Q1 2018/19 PICK quality improvement actions will be monitored at Transforming Care Quality Improvement Huddles daily

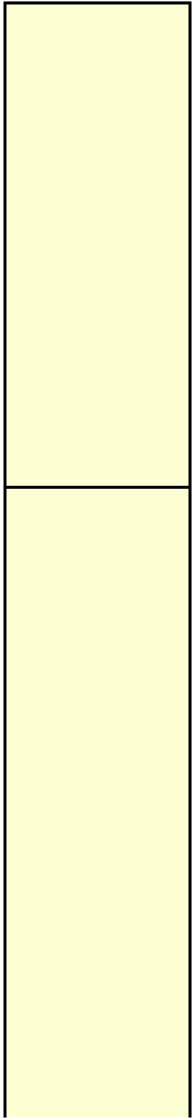
Comments











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Staff appropriately trained in violence prevention will have the skills necessary to de-escalate potentially violent situations.