# 2016/17 Quality Improvement Plan
# Quality Improvement Targets and Initiatives
# Middlesex Hospital Alliance

| AIM | | Measure | | | | | | | Change | | | | |
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| **Quality dimension** | **Objective** | **Measure / Indicator** | **Unit / Population** | **Source / Period** | **Site** | **Current performance** | **Target** | **Target justification** | **Planned improvement initiatives (Change Ideas)** | Methods | Process measures | Goal for change ideas | Comments |
| **Effective** | **Reduce 30 day readmission rates for select HIGs** | Percentage of acute hospital inpatients discharged within specified diagnostic groups who have an unplanned readmission to any acute hospital within 30 days of the discharge. The diagnostic groups include adults with stroke, CHF, COPD, Pneumonia, Diabetes, Caredіovascular and GI disorders. | % / All acute patients | DAD, CIHI / July 2014 – June 2015 | SMGH | 14.52 | 16.56 | SWLHIN HSAA target 16.56 2015-16. | 1.Daily Bed Huddles with focus on planning and timing of discharge.<br>2.Diagnosis specific patient education focused on timely follow-up with family doctor, early symptom identification and physician visits, medication reconciliation and education including guidance regarding return to the 'Dr or hospital when....'.<br>3.Clinical pathway and order set use for stroke, COPD, and further development of others.<br>4.Improved discharge dictation times for earlier access by subsequent Health Care Providers . | Patient discharge planning begins on admission and continues throughout hospital stay.<br>Chart reviews of high readmission rates to identify areas of improvement.<br>Admission history to include physical triggers that cause a return of symptoms and readmission .<br>NP/CNS providing additional education and followup.<br>Accurate BPMH and medication reconcilation on admission and discharge.<br>Discharge Summary provided to patient with follow-up appointments, medications, self monitoring for early return of symptoms.<br>Monitoring of readmission rates for continued improvement.<br>Tracking of discharge dictation completion and send to family physician.<br>Follow-up with family physician within 7 days of discharge. | Maintain or improve current readmission rate. Review of high readmissions for findings and triggers. | The goal for reducing readmission rates is to ensure the patient is well prepared for discharge and supportive followup is available by the appropriate Health Care Provider.<br>Patient receives printed discharge plan with highlights regarding medications, appointments,and tests.<br>Use of QBP best practice guidelines to develop clinical pathways and education. | 30 Day Readmission in part reflects that the patient is receiving appropriate timely care. |
| | **Reduce readmission rates for patients with COPD** | Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with COPD (QBP cohort) | % / COPD QBP Cohort | DAD, CIHI / January 2014 – December 2014 | SMGH | 16.71 | 16.56 | New indicator. SWLHIN target 2015/16 16.56%. | 1.Daily Bed Huddles with focus on planning and timing of discharge.<br>2.COPD specific patient education focused on timely follow-up with family doctor, early symptom identification and physician visits, medication reconciliation and education including guidance regarding return to the 'Dr or hospital when....'.<br>3.Clinical pathway and order set utilization COPD.<br>4. Respirology followup assessments through Ontario Telehealth Network (OTN) by respirologist and NP/CNS. 5.Improved discharge dictation times for earlier access by subsequent Health Care Providers through physician engagement.<br>5. Referral for assessment and enrollment in COPD Telehome Care Program where appropriate.<br>6. Patient engagement focus group of recent COPD patients for additional feedback.<br>7. Pharmacist medication reconciliation on discharge.<br>8. MHA enrollment in the current Healthlinks for COPD patients in our region. | Patient discharge planning begins on admission and continues throughout hospital stay.<br>Chart reviews of COPD readmission rates to identify areas of improvement.<br>Admission history to include physical triggers that cause a return of symptoms and readmission .<br>NP/CNS, Respiratory Therapist providing additional education and followup.<br>Accurate BPMH and medication reconcilation on admission and discharge.<br>Discharge Summary provided to patient with follow-up appointments, medications, self monitoring for early return of symptoms.<br>Monitoring of readmission rates for continued improvement.<br>Revise COPD pathway as new practice recommendations emerge.<br>Number of COPD pathways completed/ Number of COPD admissions.<br>Track individual patient admission and readmissions to both inpatient and ED.<br>Tracking of discharge dictation completion and send to family physician.<br>Reinforce timeliness of discharge summary documentation completion which expedites availability of the patient information to the family physician.<br>First quarter patient focus groups. | 90% Use of COPD clinical pathway.<br>Monitor percentage of patients referred to COPD Telehome Care.<br>90% Medication reconciliation on discharge.<br>Discharge summary to family physician office within 2 days of dictation. | Goal for reducing COPD readmission rates is to ensure the patient is well prepared for discharge and supportive followup is available by the appropriate health care provider.<br>Patient receives printed discharge plan with highlights regarding medications, appointments, tests.<br>Use of QBP best practice guidelines to develop clinical pathways and education. | 30 Day COPD patient readmission in part reflects that the patient is receiving appropriate timely care. Not all readmission can be avoided.<br>End of life care of the COPD patient accomodated in the setting that patient and family are most comfortable. |

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| **Efficient** | **Reduce unnecessary time spent in acute care** | Total number of ALC inpatient days contributed by ALC patients within the specific reporting period (open, discharged and discontinued cases), divided by the total number of patient days for open, discharged and discontinued cases (Bed Census Summary) in the same period. | % / All acute patients | WTIS, CCO, BCS, MOHLTC / July 2015 – September 2015 | SMGH | 17.5 | 13.75 | 10 % reduction target established by HSAA SWLHIN 2015-16. Year to date average performance 14.85. | 1)Review and implementation of new ALC rate indicator.<br>Await performance target from HSAA SWLHIN for 2016-17.<br>Optimize early ALC identification,assessment and process through daily unit and hospital wide huddles.<br>Senior friendly initiatives to promote continued mobility and activity, minimizing loss of mobility.<br>Tracking of patient volumes who are designated as ALC before Day 3 of admission.<br>Optimize timely transfers from acute care through individual patient and recieving facilities with outbreak barriers for timely individual return to LTC.<br>Continue to liase with CCAC ensuring that optimization of Home First Program is initiated and executed. | Daily inpatient unit huddles and hospital wide bed huddles to optimize patient flow. Timely and regular discussions with patients, families, CCAC,SW with evolving progress or concerns.<br>Monitor access to rehabilitation and complex continuing care. Promote hospital policy to select 5 placement options.<br>Tracking of outbreaks, LTC bed availability, time of referral to assessment to decision | Daily ALC patient volume and type review and confirmation of accuracy.<br>Monthly ALC rounds with all unit managers, CCAC case workers, SW and CCAC leadership. | 13.75 Stretch goal. | Limited access to palliative care. MHA hospitals border on and treat many patients from the neighbouring LHIN and find variations in CCAC client services that cause additional hospital ALC days. At times unable to transfer patients to vacant beds in thier LTC facility choice due to mismatch of accomodation type. |
| **Patient-centred** | **Improve patient satisfaction** | Positive Patient Satisfaction responses to selected questions for the MHA (Inpatient,Surgical Day Care,ED), add the number of responses who responded positively and divide by the number of respondentswho registered any response to this question. (Excluding non-respondents.) | % / All patients | Patient Satisfaction Survey (TBD) / Q2-3 2016-17 | MHA | 93.14 | 90.00 | MHA Current performance measured with previous NRC Picker survey results with a current performance of 93.14 %. Establish similar target with implementation of new survey tool, yet to be finalized. | 1)Patient Satisfaction Survey tool assessment and determination • NRC picker survey utilized to end of Q4 2014-15.<br>• Alternate survey option explored and developed through 2015-16 with emphasis on the elements of patient user friendly, timely, cost efficient, targeted brief questions.<br>• Review and comparison of newly released NRCC survey information.<br>• Final product selection and implementation<br>SWLHIN ED Knowledge Transfer initiative continuing to address wait intervals, improved satisfaction.<br>Education of all staff in 'Treating Patients with C.A.R.E'(Connect,Appreciate,Respond, Empower) underway at both MHA sites.<br>Patient Engagement and Activities underway in ED, COPD Readmission,Diabetes Education Program and Surgical Preadmission populations.<br>Sustain timely response to patient complaints and compliments within 2 business days and improve time to closure of concerns.<br>Update MHA Website information for patient compliments and complaints to include patient expectation for follow-up, process and resolution. | Final satisfaction survey tool product selection and implementation. Monitoring of results and follow-up plans with staff and patient engagement opportunities. Complete Treating with CARE education of all staff. Evaluate CARE course completion through patient satisfaction survey and results. Update MHA Patient Relations website information using OHA Patient Relations toolkit. | Implementation of selected survey tool by June 1, 2016 Patient satisfaction results review near real time.<br>Ability to benchmark with peer hospitals. | 90 % positive satisfaction of patients.<br>95 % follow-up to complaints or compliments within 2 business days | Early response and distribution of feedback to enhance improvements or areas of opportunity. |

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| **Safe** | **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 | MHA | 85 | 90.00 | The MHA sites have maintained or improved over the past year with less variation in quarterly results. The goal is to meet or the exceed target. | ● Improve participation, engagement and accuracy of Best Possible Medication Hospital (BMPH).<br>● Focus on Quality of BPMH and resulting med reconciliation through education to all end user nurses and pharmacy technicians.<br>● Training of pharmacy technicians and nurse staff FCHS completed; SMGH nurse training underway.<br>● Medication reconciliation completion following admissions most accurate when completed by Pharmacist or Pharmacy technician.<br>● Operating Budget request for additional pharmacist.<br>● Daily review of new admission orders by pharmacist.<br>●A University of Waterloo Pharmacy student provided BPMH training in the Emergency Department along with conducting patient interviews (BPMH) for inpatients during the 4 month co-op placement. | Ongoing monitoring and review of statistical data available through Electronic Patient Record (EPR). Each occurrence of a medication administration is tracked.<br>●Review for medication reconciliation accuracy, process improvement, and elimination of errors.<br>● Quarterly reporting to Medical Advisory Committee through Pharmacy and Therapeutics Committee.<br>●Medication Reconciliation errors reported in occurrence reporting system with followup by managers with patient and staff. | Review of administration and errors by number,medications, users, severity,doses etc .<br>Monthly monitoring and reporting of medication reconciliation compliance. | 90 % completion of Medication reconciliation for all admitted patients.<br>Improved knowlege, engagement and accuracy . | MHA has seen modest improvement in quality of med reconcilation with improved reporting of the concise list of medications, however some errors in dose and frequency.<br>Completion of accurate BPMH directly correlates to MRP physician accuracy and timeliness of its completion.<br>Medication reconciliation errors are corrected in a timely fashion and no adverse effects to patients.<br>This process has validated the need to have Pharmacy presence in the Medication Reconciliation process.<br>This initiative is recognized as an Accreditation Required Organization Practice (ROPS), and will be up for review again in 2017. |
| | **Reduce hospital acquired infection rates** | CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI during the reporting period, divided by the number of patient days in the reporting period, multiplied by 1,000. | Rate per 1,000 patient days / All patients | Publicly Reported, MOH / January 2015 – December 2015 | MHA | 0.22 | 0.27 | MHA target set to continue to perform below the provincial average. Current performance reflects less than 5 cases,low volume of patient days skew result. | 1)Antibiotic Stewardship(ABS)<br>● Optimizing use of preset HUGO antibiotic care plans<br>● Pharmacist review of most common pathogens seen specific to MHA and development of antibiogram listing the most sensitive antibiotics completed. Provides ability to target antibiotic subscribing prior to receipt of organism identification results. Available in electronic antibiogram tab<br>● Pharmacist enrolled in an Antimicrobial Stewardship Certificate Program through the Society of Infectious Diseases Pharmacists, which involves a skills component requiring the pharmacist to implement a stewardship initiative at MHA.<br>● Twice weekly antibiotic report to assess need for step-down (IV to PO, and narrowing spectrum)<br>● Investigate an alert pop-up for physicians when Clindamycin is ordered in CPOE<br>● Implement for physicians, a process for automatic substitution +/- justification for use of high risk medications . | ● Retrospective study of defined daily doses (DDD) from I.V. to Oral on targeted broad spectrum antibiotics to develop base line. Quarterly reports to the Infection Control Committee and Pharmacy and Therapeutic Committee (P&T)<br>● The pharmacist reviews utilization and outcomes to meet the following objectives:<br>Implement interventions to improve patient care, minimize resistance and cost, and prolong the longevity of antimicrobials.<br>Evaluate the effectiveness of an antimicrobial stewardship program through the measurement of outcomes.<br>● Medical Grand Rounds- Antibiotic Sterwardship with excellent physician attendance. | ●Assess understanding and compliance with best practice antibiotic medication orders<br>●Provide recent MHA evidence and further education as necessary.<br>● Adopt an antimicrobial program<br>● Evaluate the effectiveness of an antimicrobial stewardship program through the measurement of outcomes. | ● 20% decrease in the Defined Daily Dose(DDD) in IV antibiotic usage<br>● 20% decrease in usage of targeted ( i.e. Meropenum) broad spectrum antibiotics | ● Microbiology lab traces organism antibiotic sensitivities in a real time,update the antibiogram on an quarterly basis.<br>● The CDI cases continue to be reviewed on a case by case basis with the ICP (Infection Control Practitioner) and Pharmacist<br>● Quarterly reports to the Infection Control Committee and Pharmacy and Therapeutic Committee (P&T)<br>● The pharmacist reviews utilization and outcomes to meet the following objectives:<br>Implement interventions to improve patient care, minimize resistance and cost, and prolong the longevity of antimicrobials. |
| | | | | | MHA | | | | 2)Hand Hygiene<br>●Hand hygiene continues to be a corporate priority<br>●Refresh of current hand hygiene audit program practices | ● Continue to utilize the Mariner -online program to track and report compliance numbers<br>● Quarterly Hand Hygiene audit and reporting through Mariner of all employee groups and physicians | ● Explore opportunities for improvement that other hospitals have adopted with success<br>● Report quarterly to Board Quality and Provincial Patient Safety(SRI) | Maintain the >90% hand hygiene compliance goal before and after hand washing previously established | ● Consult with management to review present auditing process.<br>● Consult with peer hospital and HQO Navigator site to explore new change ideas and suggestions for improvement |

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| | | | | | MHA | | | | 3)Cleaning Practices<br>● continue to monitor use of bleach cleaner in CDI rooms through the CDI checklist and ATP testing. Have expanded the use of bleach product to use as the cleaner for walls and floors<br>● Continue to report of audit results to Infection Control Committee | Continue to use the CDI checklist and ATP monitoring for CDI room cleaning monitoring | ● Monthly C Difficile reporting<br>● Every terminal clean room is audited, recleaned until passed.<br>● Explore strategy of ""no touch"" cleaning equipment to do the job | ●100% compliance with cleaning protocols for CDI terminal clean as reflected in meeting the ATP parameters for clean<br>●Less than 0.27 rate if hospital acquired transmission<br>● Explore strategy of ""no touch"" cleaning equipment to do the job | ● Investigating the use of a hydrogen peroxide -based biodisinfectant spray to augment process for terminal clean of CDI rooms<br>● Continue to use the bag waste disposal system for containment of infective body fluids in the room<br>● Cleaning protocol performed according to Provincial Infections Diseases Advisory Committee (PIDAC) and verified through a cleaning checklist |
| **Timely** | **Reduce wait times in the ED** | ED Wait times: 90th percentile ED length of stay for Admitted patients. | Hours / ED patients | CCO iPort Access / January 2015 December 2015 | SMGH | 10.3 | 9.00 | Provincial target of 9 hour length of stay given numerous process improvements and year over year progress. | SMGH Continues to participate in the SWLHIN Knowledge Transfer Initiative. Through sharing and learning from our partners, the goal is to initiate strategies to realize improved ED LOS for the admitted patient. The following initiatives will be sustained and/or be implemented:<br>• Improved medical inpatient patient rounds to determine readiness for discharge and discharge planning<br>• Continued participation in ""ALC"" rounds with CCAC Sustain daily bed meeting structure<br>o Utilizing standard operating procedure<br>o Ensure better focus on patient flow<br>o Ensure better focus on evaluation of previous day's flow for adjustments in current & future day's strategies<br>• Sustain and improve utilization of white boards in the inpatient areas to assist with predictable discharge expectations, communication pathways<br>• Enhancement of our patient centered care focus with staff, managers and Clinical Leaders<br>• Utilization of the DART information to help understand/predict heavy discharge and admission days to help with bed management/ decrease ALC patient days/Implement Home First<br>• Improvement in the utilization of our CCAC partners/continue with daily huddles on Inpatient areas. | ●Implementation of white boards in the inpatient areas to assist with predictable discharge expectations, communication pathways<br>●Enhance our patient centered care focus with staff, managers and Clinical Managers<br>●Utilize the DART information to help understand/predict bed management challenges / decrease ALC patient days/Implement Home First<br>●Better utilization of our CCAC partners/continue with daily huddles on Inpatient Areas<br>●Ensure adoption of the bed flow management algorithm<br>●Utilization of bed meeting information trends | Daily tracking of ED admitted LOS Expected Discharges and admission ALC volumes Time to admit within one hour notification | 90th Percentile ED ADM LOS 9.0 hours. | Great focus by the entire organization to decrease wait times in the ED. Need to concentrate on strategies to maintain momentum during the week carries on into the weekend. Good collaboration between all managers and frontline staff to manage these goals.<br>It is a challenge in the ED with single Physician coverage.<br>Need to work also on decreased 'batching' of inpatient admission orders.<br>Efficient ED admitted patient flow is also influenced by the flow of patients out of the inpatient units (discharges). We also need to focus efforts in this area as well: efficiency of discharge planning, ALC strategies. |

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| **Equitable** | | | | | | | | | | | | | MHA is engaged in several initiatives which support equity. Some of these initiatives include C.A.R.E. ( Connect,Appreciate, Respond , Empower) training for all staff near completion, Indigenous Cultural Competency Training underway for all managers and completed by Diabetes Education Program staff ; Translation services for patients throughout the journey; Translation of many hospital pamphlets in Portugese; Compliance with AODA ( Accessibility for Ontarions with Disability Act ) training, facilities requirements and supporting policy and procedure . eg Clients with service animals. |