2017/18 Quality Improvement Plan

Workplan Improvement Targets and Initiatives
April 1, 2017

AIM		Measure							Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
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?	% / Survey respondents	CIHI CPES / April - June 2016 (Q1 FY 2016/17)	4472*	Collecting Baseline	Collecting Baseline	Reestablish baseline following evaluation of existing survey tools.	1)Seek timely early patient response through twice monthly survey submission through electronic survey	• Evaluate percent of positive responses and volume of email survey responses. • Evaluate by patient care area to determine areas of improvement . • Review of Patient Education guides to ensure content includes the required information and language comprehension to enhance education.	% of patients survey responses with positive responses to specific survey response to receiving enough information .	Benchmarking year with projected target of 80%	
									2)To determine if discharge information following Same Day Surgery provide patient with the information needed to address care needs and a smooth recovery.	• Add this question to current Same Day Care Post-op Day 1 telephone follow-up. • Record results, comments and feedback in survey database. • Utilize patient feedback to inform necessary changes in discharge information and reevaluate. • Determine percent of positive responses over the total surveyed.	Percentage of patients surveyed with new question. Percentage of positive responses. Number of changes to discharge information based on patient feedback.	80% positive responses to information provided. 100% review of comments and associated revision as necessary of patient discharge materials.	
		Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort)	Rate / COPD QBP Cohort	CIHI DAD / January 2016 – December 2016	1515*	10.4	13.87	HSAA target 2016-17 Ensure performance continues to exceed HSAA target	1)Review and revise COPD Pathway consistent with best practices, QBP recommendations. Revise to include complex patient identification tool early following admission, qualification for Health Links program ,high risk of readmission tool and follow-up appointment information at time of discharge.	• Monitor number of COPD admissions and readmissions, completion of risk assessment tools for complex patient and risk for readmission. • Adherance to Best Practice Guidelines • Early referral to CCAC re complex discharge, readmission risk, assessment for Health Links COPD program	Readmission Rate of COPD patients. Number of risk assessment tools completed for complex COPD patients. .	Rate 16.56 HSAA target SWLHIN Risk assessment tools completed 80% of admissions	
									2)Improve the patient ability to demonstrate their understand of the benefits and use spirometry device.	• Education of nursing and physio staff by respiratory therapist. • Enhance existing education material with input from patents. • Seek feedback regarding educational material from patients and staff for effectiveness. • Ensure patient are able to Teach Back and demonstrate proper use and understanding of the spirometry device. • Evaluate through patient feedback following Teach Back and patient assessment of knowledge and performance.	Patient will demonstrate appropriate use of the spirometry device.	90% of COPD patients recieve education re spirometry and demonstrate understanding of technique and reasons for use of spirometry.	This is change idea for 2017-18 and would strive for 100% in future.

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									3)Increase the number of patients with COP referred to SWCCAC OTN Telehomecare.	• Referral to CCAC Incorporate into COPD Pathway	Number of patient referred	Collecting Baseline to ensure all COPD patients are assessed for eligibility of this service.	
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	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / (Q3 FY 2016/17 report)	1515*	23.23	13.38	HSAA target established by SWLHIN	1)Improved patient flow from admission to discharge through frequent,regular patient reviews with patients and acute and post acute care providers.	•Daily unit huddles with unit multidisciplinary hospital and CCAC staff. • Regular updating of patient and family through family meetings and whiteboards to enhance communication of discharge plans. • Weekly Complex patient and ALC patient discharge multidisciplinary rounds assessing current plans ALC and discharge plans, evolving changes. • Early team focus on complex patients who are not yet ALC. • Actions plans from complex patient rounds distributed to ensure timely follow up. • Improved consistency and accessibility to CCAC providers.	ALC rate. ALC length of stay in acute care bed Number of patients admitted to idle beds. Number of patients identified as ALC within 24 hours admission and not previously connected to CCAC.	13.38	
									2)Improved communication of acute ALC information.	• Monthly reporting and review of ALC rate to Complex and ALC Discharge multidisciplinary rounds, MHA Leadership and CCAC leadership.	ALC rate of acute ALC days Patient distribution by discharge destination.	13.38	
Patient-centred	**Palliative care**	Percent of palliative care patients discharged from hospital with the discharge status "Home with Support".	% / Palliative patients	CIHI DAD / April 2015 – March 2016	4472*	Collecting Baseline	Collecting Baseline	New indicator. Collecting Baseline	1)Development of this new indicator and change ideas as performance is understood. Ensure that palliative patients choosing to be discharged home receive support if desired. Explore alternate palliative indicators for organization 'fit'	• Collect Baseline information and track performance. • Report to Board Quality quarterly.	Percent of palliative patients discharge home with support.	Collecting Baseline	
	Person experience	"Would you recommend this emergency department to your friends and family?"	% / Survey respondents	EDPEC / April - June 2016 (Q1 FY 2016/17)	4472*	Collecting Baseline	Collecting Baseline	New indicator and new CIHI EDPEC survey process.	1)Enhance organizational and patient awareness of new email satisfaction survey to obtain patient feedback.	• Patients receiving verbal and written communication at time of registration regarding the email survey. • Training of all Registration staff to provide explanation and obtain,enter or remove email contact information. • Initiate email survey and review results. Community and staff promotion through media release, internal website and newsletters. • Explore opportunity to include volunteers in assisting with real time patient experience feedback	Percent of patients providing email addresses from number of patients registered. Percentage of positive responses to "Would you recommend this emergency department to friends and family?"	80%	
		"Would you recommend this hospital to your friends and family?" (Inpatient care)	% / Survey respondents	CIHI CPES / April - June 2016 (Q1 FY 2016/17)	4472*	Collecting Baseline	Collecting Baseline	New indicator and new CIHI CPES survey process.	1)Enhance organization and patient awareness of new email satisfaction survey to obtain patient feedback.	• Patients receiving verbal and written communication at time of registration regarding the email survey. • Training of all Registration staff to provide explanation and obtain,enter or remove email contact information. • Initiate email survey and review results. Community and staff promotion through media release, internal website and newsletters. • Explore opportunity to include volunteers in assisting with real time patient experience feedback	Percent of patients providing email addresses from number of patients registered. Percentage of positive responses to "Would you Recommend this hospital to friends and family?"	90% positive responses.	
Safe	**Medication safety**	Medication reconciliation at admission: The total number of patients with medications reconciled as a proportion of the total number of	Rate per total number of admitted patients / Hospital admitted patients	Hospital collected data / Most recent 3 month period October to December 2016	4472*	86.5	90.00	Approaching stretch target.	1)Improve medication administration safety through improved BPMH and med reconciliation on admission to hospital	• Accurate completion of BPMH by nursing staff using at least two information sources. • Accurate completion of Medication Reconciliation by physicians. • Training of all new nursing staff. • Refresh BPMH training of all PT and FT nursing staff. • Provide physicians with tips and expectations for completion of Med Rec on Admission.	% Medication reconciliation completed on admission	90% completion of med reconciliation on admission.	

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		patients admitted to the hospital							2)Reduce medication errors related to BMPH or medication reconciliation errors.	• All medication occurrences reported and review through Pharmacy and Therapeutics. • Monitor and report number of medication occurrences and/or near misses related to BPMH and medication reconciliation errors.	Number of medication reconciliations which occur on admission.	90% or greater	
		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.	Rate per total number of discharged patients / Discharged patients	Hospital collected data / Most recent quarter available	4472*	71.8	90.00	New indicator.	1)Improve medication reconciliation at discharge	• Builds upon accurate completion of BPMH by nursing staff using at least two information sources at time of admission. • Accurate completion of Medication Reconciliation by physicians. • Training of all new and existing nursing staff of the medication reconciliation process at discharge. • Provide physicians and nurse practitioners with suggestions and expectations for timely completion of Med Rec on Discharge. • Reinforce expectations for completion at Discharge	Percent of medication reconciliation completed at discharge.	90% completion of med reconciliation at discharge.	
									2)Focus on patients with high risk medications and/or significant medication changes from admission prior to discharge.	• Pharmacist review of high risk patient medications to assess for risks and contraindications, duplication or drug interactions. • In addition, request for pharmacist review by care providers for high risk patients.	Number of medication occurrences related to medication reconcilation on discharge. Number of medication occurrences with poly pharmacy as a contributing factor.	90%	
									3)Improve the accuracy of medication reconciliation on discharge to on local Long Term Care Home.	• Develop pilot strategy,BOOMR,in collaboration with local Long Term Care facility and pharmacy. • Project involves early notification of impending transfer from hospital to Long Term Care, which begins the early med reconciliation process with final med rec process to be completed at time of transfer. • Feedback will be provided to the hospital if any medication discrepancies are noted. Any discrepancies will be recorded in incident management system.	Number of patient transitions communicated to local Long Term Care. Number of medication reconciliations completed by pharmacist. Number of medication discrepancies identified.	Collecting Baseline for project.	
Timely	**Timely access to care/ services**	Total ED length of stay (defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ED) where 9 out of 10 complex patients completed their visits	Hours / Patients with complex conditions	CIHI NACRS / January 2016 – December 2016	1515*	6.32	8.00	New indicator with provincial target of 8.0 hours.	1)Ensure current performance continues to exceed provincial target.	• Reporting of all necessary parameters for ED visit - CTAS score, admission status, Time to triage, time to Physician Assessment, Disposition and Discharge and Length of Stay. • Review longest waits for visit type, diagnosis, intervals of care to identify areas of improvement.	Total length of stay in the ED for complex, CTAS 1,2 or 3 patients.	8.00 hours or less.	Performance to be measured against provincial target vs HSAA target for this new indicator.