Quality Improvement Plan DRAFT 2018/19
Workplan Improvement Targets and Initiatives
April 1, 2018

AIM		Measure								Change				
Quality dimension	**Issue**	**Measure/Indicator**	**Unit / Population**	**Source / Period**	**Organization Id**	**Current performance**	**Target**	**Target justification**	**Priority level**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**	**Comments**
Effective	**Effective transitions**	Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort)	Rate / COPD QBP Cohort	CIHI DAD / January 2017 – December 2017	1515	14.1	12.70%	HSAA target established by SWLHIN	Priority Indicator	1) Refresh of COPD Pathway ensuring consistency with current best practices, QBP recommendations, complex patient identification tool early in 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. • Adherence to Best Practice Guidelines - COPD, Dyspnea, Chronic Conditions • Early referral to H&CC re complex discharge, readmission risk, assessment for Health Links COPD program • Collaborative work with the SWLHIN H&CC to ensure the development and implementation of Coordinated Care Plans for appropriate patients • Include assessment of tobacco use within previous 6 months	Readmission Rate of COPD patients. Number of risk assessment tools completed for complex COPD patients. .	Rate 13.87 HSAA target SWLHIN Risk assessment tools completed 80% of admissions	
										2)Improve the patient ability to demonstrate their understanding 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 receive education re spirometry use and technique.	
										3)Increase the number of patients with COPD referred to SWH&CC OTN Telehomecare.	•Referral to H&CC • Incorporate into COPD Pathway	Number of patient referred	Collecting Baseline.	
										4) Participation in Ottawa Model of Smoking Cessation(OMSC) initiative to promote smoking cessation of patients with COPD .	• Identification and documentation of smoking status of all patients at admission or intake. • Ask every patient of any tobacco use in last six months • Provide strong personalized advice to quit smoking and offer support. • Consultation to and followup by Smoking Cessation Champion • Incorporate into COPD Pathway • Education for frontline staff (nursing, rehab, RT) , pharmacists, champions, physicians	Number of patient with 6 month use of tobacco Number of patients referred to smoking champions Number of patients participating in smoking cessation support	Collecting Baseline.	
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	% of Survey respondents	CPES / April - June 2017 (Q1 FY 2017/18)	4472	100%	80%	Early positive responses to discharge information, however small volume of responses. Gradually rising over subsequent	Priority Indicator	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 . • Continue review of Patient Education guides to ensure content includes the required information and appropriate language comprehension to enhance education.	% of patients survey responses with positive responses to specific survey response to receiving enough information .	80%	

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		treatment after you left the hospital?		MHA Internal Real Time Survey		Collecting Baseline	Collecting Baseline	over subsequent quarters.		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 Patient education guides, Pathways where applicable, discharge information and reevaluate. • Determine percent of positive responses over the total surveyed. • Transition current data collection to match survey reporting tool initiated by inpatient units.	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.	Program initiation Spring 2018
								Early positive responses to discharge preparations. Target 80%		3) To determine if discharge information during inpatient stay provides the patient with the information needed to address care needs following discharge and foster a smooth recovery.	• Seek out real time patient and family feedback on inpatient units • 100% of admitted patient on both inpatient units receives a paper patient survey at time of admission and communication with regards to filling out the survey and collection upon discharge • Patients are encouraged and reminded to complete before discharge • Surveys are collected at the nursing station and submitted by the unit manager to administrative support for date entry and summary of results. • Initiate implementation of internal survey to include FCHS	Number of survey with positive response to receiving enough information in preparation for discharge.	80%	
Patient Centered	Person Experience	"Would you recommend this emergency department to your friends and family?"	% / Survey respondents	EDPEC / April - June 2017 (Q1 FY 2017/18)	4472	83%	80%	Early Positive Responses to this Patient Experience Question with increasing response rates.	Priority Indicator	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. • Compliments and complaints shared with staff for improvement opportunities • Shadow staff at triage and provide real time feedback • Develop standardized scripting for staff to use at triage • NRC narrative comments shared with staff for improvement opportunities • One on one review of comments or concerns , feedback provided , action planning by ED manager • Reinforce Customer service approach through scripting of messages for ED staff eg ED triage reinforce expected wait, report to triage if you have not been seen or your condition has changed • Audit and results review process to assess performance • Results are shared and posted monthly on Emergency Department Message Boards • 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% positive responses	

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		"Would you recommend this hospital to your friends and family?" (Inpatient care)	% / Survey respondents	CPES / April - June 2017 (Q1 FY 2017/8)	4472	100%	80%	Early Positive Responses to this Patient Experience Question with limited responses for the interval selected, with gradually increasing response rates.		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. • Compliments and complaints shared with staff for improvement opportunities • NRC narrative comments shared with staff for improvement opportunities • Results are shared and posted quarterly on inpatient units. • 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?"	80% positive responses.	
		"Would you recommend this hospital to your friends and family?" (Inpatient care)	% / Survey respondents	MHA Internal Real Time Survey	4472	Collecting Baseline	80%	Inpatient survey in progress since Q2 2017-18. Would you recommend question added in Q4 2017-18		2. Enhance patient and family feedback opportunities for the inpatient population through internal confidential real time survey.	• Seek out real time patient and family feedback on inpatient units • 100% of admitted patient on both inpatient units receives a paper patient survey at time of admission and communication with regards to filling out the survey and collection upon discharge • Patients are encouraged and reminded to complete before discharge • Surveys are collected at the nursing station and submitted by the unit manager to administrative support for date entry and summary of results. •Results are shared and posted quarterly on inpatient units. • Review of comments to assess whether patient has provided their name and have requested like follow-up	% of patients survey responses with positive responses to " Would you recommend this hospital (Inpatient) to family and friends?"	80% 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 patients admitted to the hospital	Rate of completion per total number of admitted patients / Hospital admitted patients	Hospital collected data from electronic documentation/ Most recent 3 month period October to December 2017	4472	88.17	90.00	Rounding the corner on stretch target of 90%. Focus on target achievement, accuracy and sustainability.	Priority Indicator	1) Improve medication safety through improved BPMH and medication reconciliation upon admission to hospital.	•Accurate completion of BPMH by nursing staff using a minimum of two reliable information sources. • Training of all new nursing staff at orientation by pharmacy. • Refresh BPMH training of all nursing staff. •Provide physicians with training and expectations for completion of med rec on admission. •Continue to provide physician with med reconciliation on admission performance reports	% Medication reconciliation completed within 24 hours of admission.	90% completion of med reconciliation on admission.	Challenges: patients with stays shorter than 24 hours or during off peak times with limited staff/access to resources
										2) Reduce medication errors related to BMPH or medication reconciliation errors.	• All medication occurrences reported and reviewed at Pharmacy and Therapeutics Committee Meetings • 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. Number of occurrence reports related to medication errors related to BPMH and medication reconciliation.	90% or greater	QI's stable at SMGH & improved at FCHS with pharmacist presence working with 2 NP's on site.
		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 of completion per total number of discharged patients / Discharged patients	Hospital collected data from electronic documentation/ Most recent 3 month period October to December 2017	4472	87.21	90.00	Significant improvement over previous year. Approaching stretch target of 90%. Focus on target achievement, accuracy and sustainability.	Priority Indicator	1) Ensure medication reconciliation at discharge.	• Builds upon accurate completion of BPMH and med rec on admission. • Accurate completion of discharge medication reconciliation by physicians. • Training of all new and existing nursing staff on 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. • Continue to provide physician with med reconciliation at discharge performance reports	Percent of medication reconciliation completed at discharge.	90% completion of med reconciliation at discharge.	Challenges: timely notification of pharmacist when a patient is being discharged and requires med rec/education

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		discharged.								2) Focus on high risk patients with significant medication changes from admission prior to discharge.	• Pharmacist review of high risk patient medications to assess for indication, efficacy, safety and compliance risks (including duplications or drug/disease/lab interactions). • Health care staff to request pharmacist review or education for high risk patients.	Number of medication occurrences related to medication reconciliation on discharge. Number of occurrences with medication-related errors as a contributing factor.	90%	
										3) Improve the accuracy of medication reconciliation on discharge through local Long Term Care Homes and pharmacies.	• Continue to foster established collaboration with local Long Term Care facilities and pharmacy. • Hospital Pharmacist contact information provided directly to local pharmacists and Long Term Care homes to pharmacist enhances timely access for any clarifications and feedback. • Detailed Med reconciliation printed at discharge . Includes physician decision to continue or stop a medication and the rationale. Also includes follow-up appointment and sent directly to the Long Term Care home or discharge destination to help coordinate care. • Feedback will be provided to the hospital if any medication discrepancies are noted. Any discrepancies will be recorded in incident management system.	Number of discharge medication reconciliations completed by pharmacist. Number of discharge medication discrepancies identified.	Collecting baseline	
Safe	**Workplace Violence**	Number of workplace violence incidents (overall) (defined as any incident, occurrence, report or investigation involving verbal or physical abuse/assault) # FTE = 316	Number of workplace violence incidents reported by hospital workers	In house data collection from Employee incident reports, Code White, V as RL Solutions, Parklane Systems, etc. from January - December 2018	4472	Collecting Baseline	Collecting Baseline	To enhance education, support and volume and process of reporting of Workplace violence injury and report quarterly	Mandatory Indicator	1) Establish MHA Workplace Violence team with support of Senior Leadership and Board Quality	1) Review of 2017 staff survey results for areas of focus , concern 2) Education of team members and hospital staff of legislation and QIP 3) Identify opportunities for improvement action planning to address workplace violence and staff safety 4) Implement approved action planning	Quarterly Report to SLC and Board Quality	Fall 2018 Progress Report	
										2) Establish a single source of reporting workplace violence according to legislated OCH&S definitions.	1) Team review of legislated definitions 2) Investigate current reporting avenues,forms and documents 3) Develop single reporting portal and confirm feasability to capture all current and potential workplace violence issues. 4) Early communication through automatic alerts , review and debrief of workplace violence incidents with action planning 5) Education of human resources and managerial staff to provide appropriate followup and support of workplace violence incidents 6) Revise current workplace violence policy and procedure to reflect changes and clarity of definitions 7) Education and training for all staff	Establish reporting tool. Total workplace violence incidents in the MHA	Collecting baseline	
										3) Clinical implementation of a risk assessment pre-screening of both inpatients and outpatients to determine risk for aggression/ violence	1) Workplace Violence Team clinical informatics representatives support to implement a regional pre-screening risk of violence/aggression assessment for all admitted and outpatient individuals 2) Finalize a policy and procedure which provides explicit instructions to front line clinical and support staff about how to report risk of aggression/violence 3) Train Staff on the policy and procedure of how to recognize the risk so as to take appropriate precautions when a patient has an existing behavior risk dealing with a previously flagged individual	Total assessments performed in a month or in a quarter	Collecting baseline	Currently screening is not performed across the board and not in a proactive manner

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										4) Clinical implementation of a Behaviour Alert flagging process activated by front line direct and indirect patient care staff that alerts staff to the potentially aggressive/violent patients	1) Workplace Violence Team with clinical informatics support, to participate in evolving adjustments to current violent /aggressive patient alert process 2) Monitor and report on frequency and severity of patient Behaviour Alert events monthly and quarterly. 3) Finalize a policy and procedure which provides explicit instructions to front line clinical and support staff about how to report incidents of aggression/violence and to ensure that alert is applied appropriately 4) Train Staff on the policy and procedure of how to recognize the Behavior Alert so as to take appropriate precautions when dealing with a previously identified individual	Total flags applied monthly and quarterly.	Collecting baseline	Currently the ability to apply a patient flag is held by a single individual and completion not conducive to alerts being available in the moment.