2018/19 Quality Improvement Plan
"Improvement Targets and Initiatives"

Perth And Smiths Falls District Hospital 60 Cornelia Street West

AIM		Measure								Change				
Quality dimension	Issue	Measure/Indicator	Type	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?	P	% / Survey respondents	CIHI CPES / April - June 2017(Q1 FY 2017/18)	928*	65	80.00	Verbal communication with RN/physician re clinical indications to return to ED. Written confirmation on MD facesheet and/or nursing notes. With the new PODS initiative and revised patient information pamphlets in the EDs, all patients should receive	1)Facilitate identification and coordination of information for those patients identified as complex needs who are	Identify the solution that will facilitate Health Link patient identification through Med2020 data	PSFDH will provide an audit on a quarterly basis to assist with the identification of potential HL patients, who register in ER, to facilitate and support safe transitions from hospital to community.	By September 30th, 100% of these patients will be identified through the	
										2)Patient Oriented Discharge Summaries (PODS) will be given to all patients who are discharged home or to a retirement	Nursing staff will use the PODS for all patients discharged home as per the project parameters.	Internal audits will be done on a quarterly basis, to determine the percentage of discharged patients who received a PODS discharge plan.	80% of patients discharged will have evidence that they received PODs and additional	
										3)Review by patient and family advisory council (PFAC) of discharge information for all inpatients.	Collate all current written discharge information distributed to inpatients. share this information with PFAC for feedback. Appropriate changes will then be made.	Track the number of discharge information documents that have been reviewed	25 documents will have been reviewed by end of fiscal year.	
										4)Initiate a seven day follow-up phone call for those patients identified as at risk for readmission.	Inpatient charge nurses/palliative care nurses will be responsible for the follow-up phone calls, which will be identified through a custom built report.	An audit will be done quarterly to ensure follow-up calls are completed.	80% of patients identified through the custom report will have communication	
		Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort)	P	Rate / COPD QBP Cohort	CIHI DAD / January - December 2016	928*	16.89	15.00	This lag data for the current QIP, shows a marked improvement. We will strive for continual improvements as we are part of regional initiatives.	1)Early identification for enhanced Respiratory Therapist support	Respiratory Therapy will receive notification through an admission assessment tool of patients admitted with a COPD diagnosis. These patients will receive enhanced education prior to discharge from the RRT.	Through internal audits, 75% of patients meeting the criteria will receive enhanced education through with the RT, by July 2018.	Readmission rate reduced for patients with COPD diagnoses by 4% (from 25% to 21%)	
										2)Ensure safe transition to the community lung health program.	Working with our community partners, we will ensure patients with a COPD comorbidity, who agree, receive a referral to the Lung Health program upon discharge.	An internal audit will be done from the electronic data base (EHR) to determine the percentage of patients who received a referral. Data will also be collected by the community program to determine percentage of patients who actually enroll in the community program.	100% of patients admitted with a COPD comorbidity, who agree, will be referred to the	
										3)To participate in the collaborative community paramedicine program that is designed to facilitate smooth transition from	Patient personal health information will be shared, with consent, that will enable enrollment in this program.	Audits will be done to measure the percentage of patients who qualify and agree, and are enrolled in this program	100% of identified, consenting patients will be enrolled by Q4 of the 2018-19 Fiscal	
										4)Participate in the Assess and Restore pilot project. This initiative targets patients at discharge who require further	The three month pilot is underway. Successful completion of the three month pilot will lead to an understanding if this type of initiative benefits COPD patients. We will utilize the findings of the project to advocate for permanent implementation	The number of COPD patients enrolled and whether there was measured benefit to that patient population.	Target is based on predetermined pilot project.	
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	928*	27.07	24.00	this is aligned with our H-SAA	1)Identified complex patients with a stay of 90 days or greater, will have a pharmacist medication review.	There is an electronic pharmacy trigger that initiates a review.	Internal audits will be done by the Pharmacy Department to capture numbers of patients being appropriately reviewed.	80% of identified patients will have a pharmacy review by September 2018.	
										2)To implement the restorative mobility pilot program that identifies patients at risk of returning to hospital and becoming	The patient flow coordinators,resource nurses and therapy staff will identify patients who could benefit. They will be enrolled in the restorative mobility pilot program by the Access and Restore Project Lead	Number of patients who participated by July 2018.	12 patients will have participated by July 2018.	
										3)PSFDH will participate in the Identified Seniors at Risk housing program.	There will be a developed consultation criteria for referral to this program that would identify patients at risk.	Identification of the consult criteria will be developed.	Consult criteria for hospital use will be developed by January 2019	
										4)Implementation of a new Flow coordinator checklist that includes community resources that can support patients with earlier	During rounds a checklist is utilized to assist with earlier discharge planning for patients who are, or at risk of becoming ALC.	Utilization will be measured by random audits.	100% of the audited charts will have a completed flow coordinator checklist by end of	
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)	928*	61.9	70.00	We feel this is an achievable target and maintains our position as better than provincial average.	1)The validated Health IM interRAi electronic mental health assessment will be started in the community with Police Services. This	The Smiths Falls Police will do the in-field assessment on every mental health patient they bring to the Emergency room. The assessment will arrive prior to the patient as it is electronic.	We will look at the number of mental health patients in crisis, arriving with SF Police, who have a completed interRai, prior to arrival, over the total number of MH patients arriving with Police escort.	80% of MH patients arriving with police will have an interRAI completed prior to	
										2)ED nursing and patient registration staff will ensure every patient registered in the ED is on the e-tracker from arrival to discharge.	Patient registration and ED staff will be responsible for placing every patient into the e-tracker. Data on compliance will be reviewed by the ED and Patient Registration managers. there will be a working ED tracker with tests in process, and a public tracker to	Will look at the number of patients on the e-tracker over the number of patients registered to the ED. This will be done on a quarterly basis by the ED manager	100% of patients in the ED will be in the e-tracker by July 2018.	
										3)COPD is one of the top 5 reasons for hospital visits and has a major impact on the ED. Doing a medication reconciliation for this group	Patients identified as having COPD as part of their diagnosis, will receive a paper based med-rec at discharge with one copy remaining on the ED chart. This med rec will be shared with the patients pharmacist and primary health care provider.	the number of patients with COPD as a primary diagnosis or co-morbidity will be audited quarterly and looked at as a percentage.	By July 2018,70% of patients whose primary diagnosis is COPD, or have the co-morbidity of	

M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) A= Additional (do not select from drop down menu if you are not working on this indicator) C = custom (add any other indicators you are working on)

										4)Post-discharge telephone calls will be piloted in the ED. Post-discharge telephone follow-up calls has been documented to	We will develop a standardized questionnaire for the post discharge phone calls, re care provided in the ED. It will be retrievable in the EHR. Phone calls will be done by ED staff or charge nurse.	Quarterly, we will look at the number of ED patients contacted by telephone over the total number of ED patient visits.	By July 2018, 60% of ED patients will received a followup call within 24-48 hours of discharge.	
Safe	**Safe care/Medication safety**	Further engagement of our staff, physicians, patient and family advisers and governors in quality improvement initiatives regarding patient safety and patient experience.	C	% / All inpatients	NRC Picker / 2018/19	928*	70.6	75.00	Although our current overall inpatient satisfaction is well above provincial average, we believe we can continue to improve through engagement strategies.	1)Implementation of Daily visual management boards (DVM) in all inpatient units.	Each patient care unit will install and customize a DVM board which will be the focus of Quality Safety Huddles. The information displayed will include patient safety metrics as well as patient experience feedback.	The process measure is overall patient satisfaction as quantified through NRC Picker. As we further engage our people in quality and safety, it is believed this will positively effect the satisfaction of our patients.	100% of inpatient units will be utilizing DVM boards by June 2018.	
										2)Patient experience stories will be shared at staff team meetings.	Nursing leadership will identify appropriate patients and/or families to share their experience with staff.	One patient experience story will be shared on each unit, at staff team meetings, by December 2018. This will occur after the planned education for staff which highlights the importance of hearing directly from patients and families regarding their experience.	One in each unit by December will allow the education to be put into action.	
										3)Patient and family advisers make quality and safety rounds and interact with providers on a scheduled basis.	Committee members will make rounds on a scheduled basis to talk and interact with care providers regarding quality and safety. This rounding will be led by nursing leadership and will take place around unit "How we Measure Up" white boards displaying the units quality	One rounding session at each hospital site will occcur by September 2018.	As this is a new initiative,one rounding session in each unit will give nursing leaders a	
										4)Board and Governors make quality and safety rounds and interact with providers on a scheduled basis.	Directors of the Board will make rounds on a scheduled basis to talk and interact with care providers regarding quality and safety. This rounding will be led by nursing leadership and will take place around unit "How we Measure Up" white boards displaying the units quality	One rounding session at each hospital site will occur by September 2018.	The target is based on ensuring Board members have the opportunity to see our quality and	
		Reduce the number of narcotic related medication incidents.	C	Number / All inpatients	In house data, InterRAI survey, NHCAHPS survey / January 1, 2018 to December 31, 2018	928*	CB	0.00	Medication errors involving narcotic mix-ups are one the most frequently reported medication incidents at PSFDH, with the highest risk potential for harmful patient safety events.	1)Create information posters, outlining the different narcotic dosages. These will be placed on all in-patient units and ED's	A poster will be developed with input from pharmacy and nursing.	Information posters will be available and in place in each medication preparation area.	By September 2018, an audit will be conducted and posters will be available in 100%	
										2)To improve compliance with independent double check of narcotics delivered by CADD pump. This will be done through a revision of	CADD flow sheet will be revised with input from pharmacy and nursing.	Audits will be done post revision, at a minimum on a quarterly basis to monitor improvement with documentation of the independent double check.	There will be documented evidence that documented double check has	
										3)To implement a forced function via physical separation of from injectable morphine.	Separate and colour coded containers will be sourced and distributed to all areas where narcotic medications are stored.	Through an audit process, all areas where medications are stored will have the proposed physical separation to improve forced function and visual management regarding hydromorphone and morphine storage.	By September 2018, 100% of targeted areas will have the physical, colour coded	
										4)To improve nurses understanding of the difference in potency between morphine and hydromorphone, through	Education sessions will be provided for nursing staff who may be administering narcotic medication. In addition, a pictogram which will provide a standard volume chart for usual doses of hydromorphone will be displayed in all medication preparation areas.	A knowledge assessment test (ISMP HYDROmorphone) will be administered to nursing and pharmacy staff post education. The purpose of the test will be to improved knowledge and recognize personal remediation requirements.	The knowledge assessment test will be completed by 100% of the targeted staff by	
	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**	**928***	**31**	**35.00**	**We are establishing baseline numbers. PSFDH wants the number of reported incidents to increase.**	**1)Promote a culture of workplace violence reporting to maintain a safe work environment.**	**Education sessions will be rolled out to all staff to reiterate the importance of using the online reporting tool for workplace violence incidents**	**Number of incidents will be collated monthly and by unit looking for trends and opportunities. We are looking for an increase in reporting, specifically in the Emergency department.**	**There will be a 15% increase in workplace violence incident reporting by December 2018, across all units.**	**FTE=406 The intent is to increase reporting of workplace violence incidents, so that we can monitor and remedy issues, that will**
										2)Develop a training powerpoint for the LMS system on workplace violence and reporting.	Power point will be developed and made available to all staff. This will be done by Occupational Health, Human Resources and Manager of Risk	Percentage of staff viewing the learning package will be audited by January 2019	70% of staff will view the online learning for workplace violence reporting, by	
										3)Data will be reported back to staff, along with improvement initiatives from the data. This will encourage staff to report as	A dashboard will be developed, showing reporting by unit biannually. It will be posted where it is visible to staff and in the online staff education folder. Results will be discussed with staff at staff meetings.	This will be posted in all staff areas and online by the beginning of Q2 (July 2018).	Data is posted on all Quality Boards by July 2018 and every 6 months thereafter.	
										4)The online reporting tool will be revised in consultation with staff and the JHSC, to ensure that it is an effective system for	Staff will be surveyed for feedback on the RL6 data collection tool, via an email survey.	80% of necessary changes will be implemented by July 2018, as determined by PSFDH staff and the RL solutions team.	15% increase in workplace violence reporting by December 2018.	