Perth and Smiths Falls District Hospital

2020/21 Quality Improvement Plan
"Improvement Targets and Initiatives"

Patients and Families THE Heart OF Care

Perth And Smiths Falls District Hospital 60 Cornelia Street West, Smiths Falls , ON, K7A2H9

AIM		Measure									Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) C = custom (add any other indicators you are working on)															
Theme I: Timely and Efficient Transitions	**Efficient**	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 / Jul 2019 - Sep 2019	928*	37.68	30.00	To improve ALC days		1)Collaborate with the MOHLTC and SE LHIN to decrease ALC length of stay in hospital	Participate in ALC strategy discussions with MOHLTC and the SE LHIN	Opportunity to participate in 2 strategy sessions	PSFDH will participate in 2 ALC strategy sessions	
											2)Participate in complex rounds with our community partners	Monthly meetings are completed with our community partners to support transitions in care for complex patients	PSFDH will participate in these complex patient session	Improve communication and planning for ALC hospital transition	
											3)Continue to work on discharge pathways with an escalation framework to enhance patient flow for ALC	Work collaboratively with internal health care providers to implement a standardized discharge process	Percent of ALC patients that require escalation	Less than 5% of ALC patients will require escalation	
											4)To educate patients and families on the ALC process	Review ALC education materials for patients and families	PSFDH Patient and Family Advisory Council will review the education materials	Patient and family education materials will be reviewed by PFAC	
		Unconventional spaces	P	Count / All inpatients	Daily BCS / TBD	928*	1.5	0.50			1)Participate in Regional Bed Dashboard	Continue to participate in the implementation of a Regional Bed Dashboard	Regional Bed Dashboard will accurately reflect PSFDH patient care in unconventional beds	100% of additional beds will be represented as unconventional beds	
											2)PSFDH daily Bed Report will increase awareness by reflecting unconventional beds	Daily report will continue to outline unconventional beds	Maintain our current daily Bed Report to increase awareness	100% completion of the daily Bed Report to reflect unconventional beds	
											3)Record the utilization of Surge policy on daily Bed Report	Appropriately utilize PSFDH Surge policy to facilitate patient flow	Monitor utilization of Surge policy	100% of Surge policy activation will be recorded on the daily bed report	
											4)Educate clinical staff on the Surge policy	Educate clinical staff during onboarding on the Surge policy	Percentage of clinical staff will be educated on the Surge policy	100% of clinical staff will be educated on Surge policy during onboarding	
	Timely	Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital.	P	% / Discharged patients	Hospital collected data / Most recent 3 month period	928*	95	95.00	Maintain target		1)Implementation of Health Records staff editing transcription	Health Records staff will complete the editing process for transcription	The completion of transcription staffing to 7 days a week	The number of discharge summaries delivered within 48 hours of discharge will be maintained at 95%	
											2)Health Records Committee will review discharge summary delivery rates to Primary Care Providers within 48 hours	Results for delivery of discharge summaries will be reviewed on a quarterly basis	Percentage of discharge summaries that are delivered	Percentage of discharge summaries delivered within 48 hours to Primary Care Providers	
											3)To complete an audit on discharge summaries on a quarterly basis	An audit will be completed every quarter to determine root cause for the delay of a discharge summary	An audit of discharge summaries not completed in 48 hours to collect baseline data	A discharge summary audit will be completed every 3 months	

											4)Engage Primary Care Providers on the completion of discharge summaries within 48 hours	An information update will be provided to primary care providers on the completion of discharge summaries within 48 hours	Information update will be completed during a Medical Staff Meeting and will be sent electronically	100 percent of Primary Care Providers will receive an information update	
		The time interval between the Disposition Date/Time (as determined by the main service provider) and the Date/Time Patient Left Emergency Department (ED) for admission to an inpatient bed or operating room.	**M A N D A T O R Y**	**Hours / All patients**	**CIHI NACRS, CCO / Oct 2019– Dec 2019**	**928***	**16.23**	**6.00**	**Improve patient flow**		**1)Development of minor surge policy to enhance the flow of patients from ER**	**Implement minor surge policy to enhance patient flow**	**Utilization of minor surge policy**	**Percent of times minor surge was implented**	
											2)Increase awareness of community resources to support care outside of the ER	Increase awareness of community resources that may decrease the number of admitted patients in the ER	Develop and provide education / information sessions	Provide 2 staff education / information sessions for ER staff	
											3)Increase awareness to avoid potential ER visits	Provide a list of resources that are available in the community for patients and staff to access	Provide a list of community resources in each ER department to facilitate information sharing and avoid ER visits	A community resource list will be provided and updated each quarter	
											4)Provide patient flow education to staff during clinical on boarding	Education will be provided to staff during clinical on boarding	Percentage of clinical staff that received education	100% of clinical staff will receive education on patient flow during on boarding	
		Percentage of respondents who responded "completely" to the following question: 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 / Most recent 12 months	928*		95.00	Improve patient information on discharge		1)Implementation of increased pharmacy coverage over the weekends	Pharmacy staff will be available on the weekends to assist with pharmacy related questions	The number of pharmacy staff will increase their availability to support patient discharge	Percentage of improvement to the response to the question "did you receive enough information upon discharge"	
											2)Implementation of an ICU specific regional survey process	The implementation of this specific ICU survey will provide an opportunity to benchmark with other regional ICU's	This strategy will improve the transfer of knowledge upon discharge by measuring responses in the ICU	Percentage of improvement in the rate of response to the question "did you receive enough information"	
											3)Engage PSFDH Patient and Family Advisory Council with reviewing the responses to this survey question	Responses to the question " Did you receive enough information" will be reviewed with PFAC	Trending of Responses will be reviewed with PFAC on a quarterly basis	PSFDH Patient and Family Advisory Council will review responses on a quarterly basis	
											4)Develop internal survey for the Obstetrical unit to improve response rate	A survey will be developed specifically for the obstetrical unit	The question "Did you receive enough information: will be included	This survey will be completed on the day of discharge for obstetrical patients	
Theme III: Safe and Effective Care	**Effective**	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 / Oct 2019– Dec 2019 (Q3 2019/20)	928*	CB	80.00	Improve Medication Reconciliation rate		1)Pharmacy will provide coverage over the weekend	Pharmacy staff will be available to assist with questions and support the medication reconciliation process	Pharmacy availability will support staff and the medication reconciliation process	This strategy will increase the rate of medication reconciliation on discharge	
											2)Enhance physician adoption of the medication reconciliation process	Provide physician education on the in patient medication reconciliation process	Percentage of physicians who provide inpatient care that receive education	100 percent of physicians who provide in patient care will receive education	

											3) Standardize new physician onboarding process for medication reconciliation.	Embed medication reconciliation training into new physician onboarding process.	Quarterly review of new physicians who completed onboarding	100% of new physicians on-boarded has received a standardized medication reconciliation training	
											4)Medication Reconciliation Committee to review potential opportunities of incorporating clinical pharmacists in the Medication Reconciliation process	Current-state workflow assessments to review the potential for process change for pharmacists	Percentage of pharmacist that could support the medication process	Completion of the formal pharmacist process review	
		Percent of unscheduled repeat emergency visits following an emergency visit for a mental health condition.	P	% / ED patients	CIHI NACRS / April - June 2019	928*	25.17	20.00	Enhance collaboration with Lanark County Mental Health		1)Review LCMH and ER effectiveness and utilization	Complete a process review of patient visits	Completion of review to trend reason for visit	Process review will be completed in identify root cause of visits	
											2)Improve access to social worker in hospital	Implementation of a social worker program in hospital	Social worker services can be accessed within the ER	Percentage of mental health visits where a social worker has been utilized	
											3)Quarterly review of mental health visits between ER and LCMH	Quarterly meeting between LCMH ED and Manager of ER to review Mental health visits	Quarterly meeting will facilitate discussion for quality improvement strategies	Number of strategies implemented in each quarter to improve access to mental health services	
											4)Educate ER staff on mental health strategies	Improve education of ER staff to decrease rate of unscheduled re visits to ER	An education will be provided by LCMH to support ER staff	Education session will be completed	
		Proportion of hospitalizations where patients with a progressive, life-limiting illness, are identified to benefit from palliative care, and subsequently (within the episode of care) have their palliative care needs assessed using a comprehensive and holistic assessment.	P	Proportion / All patients	Local data collection / Most recent 6 month period	928*	CB	CB	To increase access to care for Palliative care patients		1)Process for identifying patients would benefit from a Palliative Care Assessment	Update the most responsible physician on the Palliative Care Referral process	Most responsible physician will identify the role of Palliative Care	85% of Patients with a progressive, life limiting illness are identified to benefit from a Palliative Care Assessment	
											2)Palliative Care will participate in bed management calls	Palliative Care will participate in bed management call to facilitate awareness of patients wo may require Palliative Care support	This participation should support the increase in Palliative Care patient involvement	To increase the number of Palliative Care referrals	
											3)An interdisciplinary Palliative Care Committee will continue to review Palliative Care Best Practices	Palliative Care Committee will complete a Palliative Care best practice review on a quarterly basis	Number of changes that are made related to implementation off best practices	Number of best practices changes made to Palliative Care process	
											4)Review MAiD policies and procedures with PSFDH Patient and Family Advisory Council	Review and update MAiD policies and procedures	Percentage of policies and procedures reviewed by PFAC	100% of MAiD policies and procedures will be reviewed by PFAC	
	Safe	**Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.**	**MANDATORY**	**Count / Worker**	**Local data collection / Jan - Dec 2019**	**928***	**62**	**65.00**	**Increase workplace violence awareness**		**1)Increase workplace violence awareness with PSFDH Emergency patients**	**Implementation of the violence flagging system on the ER tracker system**	**percentage of patients that are flagged**	**100% percent of violent patients will be flagged**	
											2)Provide Crisis Prevention Intervention Training sessions	Crisis Prevention Intervention training will be provided to all staff	2 sessions will be offered to increase staff safety	The completion of 2 Crisis Prevention Intervention Sessions	
											3)Identify violent admitted patients with signage	Violent patients who are admitted will be identified with signage	Percentage of violent patients who are admitted	100 percent of violent inpatients will be identified	
											4)Provide code white simulation training for new staff	Code white simulation training will be provided during hospital orientation	Percentage of new hires that receive code white training	100 percent of new hires will receive code white simulation training	