2019/20 Quality Improvement Plan
"Improvement Targets and Initiatives"

Perth And Smiths Falls District Hospital 60 Cornelia Street West

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	Average number of inpatients receiving care in unconventional spaces or ER stretchers per day within a given time period.	P	Count / All patients	Daily BCS / October - December 2018	928*	0.38	0.20	Implementation of Patient Flow process that will enhance communication and planning for transitions of care.		1)Facilitate the early identification of patients who require admission from the ER department	Develop a bed management process for Patient Flow to support early identification of patients who will be admitted	A monthly audit will be completed to determine that patient flow is notified upon the decision to admit	90% of admitted patients will be identified to the Patient Flow Coordinators by October	
											2)Participate in collaborative discussions with Community partners to facilitate transitions in care	Patient Flow coordinators will collaborate with Community partners to discuss potential community resources available to patients	Internal data will be tracked to monitor discussions and potential resource explored that would support the transition of patients into the community for treatment	Average number of admitted patients receiving care in unconventional spaces will decrease to 0.2 by March 2020	
											3)Implement enhanced Palliative care nursing resources	Develop a Palliative Care schedule that supports flexibility to facilitate Palliative Care assessments and transitions in care.	An audit will be completed quarterly to ensure that inpatient palliative care patients who are waiting for a bed have been assessed by palliative care	80% of Palliative care patients waiting for a bed will be assessed by Palliative care	
											4)Early identification of Health Links complex patients who have been admitted	Patient Flow will complete the early identification of Health Links and potential Health Links patients upon admission to support care coordination	A monthly audit of Health Links patients who have been identified and are admitted without a bed will be completed	100% of Health links patients will be identified upon admission	
		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 2018	928*	42.08	35.00	Bed management strategies to support transitions in care for ALC patients in collaboration with SE LHIN and LTC partners		1)Early identification of patients who are at risk for ALC designation	Develop an identification Patient Flow mechanism for inpatients who may qualify for ALC designation	A monthly audit will be completed to assess the early identification of patients	7% decrease in ALC days per quarter (35%)	
											2)Enhancing educating physicians on ALC designation and the resources available within the community to support transitions	An information session will be held at a Medical Staff meeting to review ALC designation and the resources available to assist them with this process	An information session will be completed for physicians to improve the quality of completion for the ALC process	This quality improvement initiative will be completed by November 2019	
											3)Implement Patient Flow weekend coverage to support appropriate discharge planning	Patient Flow coordinators will provide weekend coverage to facilitate discharge planning	Monthly audit to determine that ALC patients admitted over the weekend are being reviewed by Patient Flow	80% of ALC patients admitted over the weekend will complete planning discussion with Patient Flow	
											4)Utilize Patient Flow to assess and monitor potential and designated ALC with the SE LHIN to assess barriers to discharge	Daily update between SE LHIN and Patient Flow will be completed	Daily review of of ALC patients to assess for barriers to discharge	80% of ALC patients will be reviewed daily	
	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*	CB	80.00	Implementation of Quality Improvement strategies for Health Records to support Primary Care		1)Implementation of Auto fax for discharge summaries to Primary Care	IT and Health Records will develop a system that protects personal health information and provides discharge summaries within 48hours to Primary Care	Internal audit will be completed on a monthly basis	80% of physicians will receive their discharge summaries within 48hours by September 2019	
											2)Health Care Service Provider dictionary will be updated within Meditech to ensure the safe and confidential transfer of medical information to health care Service Providers	Health Records will work collaborative with IT using legislation to develop a process for the transfer of personal health information	Internal audit prior to implementation of process	100% of Discharge summaries will be delivered utilizing a system that protects personal health information	
											3)Work collaboratively with the Community Health Centers to ensure the effective transition of health records / discharge summary is completed	Meet quarterly with CHC's to determine efficiency of the delivery of health records - discharge summaries	Quarterly audit will be completed to ensure that Discharge summaries have been received within 48 hours	80% of discharges summary will be received within 48 hours by June 2019	
											4)Complete collaborative discussions with primary care regarding the delivery of Discharge summaries within 48 hours	Information will be distributed for discussion to all primary care physicians to engage them with this quality improvement initiative	An audit will be completed to determine that information was delivered to all physicians.	100% of primary care physicians in our catchment area by June 2019	

		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 / October 2018 – December 2018**	**928***	**6.53**	**4.00**	**Develop a bed management process that will identify bed availability and capture time frames for admissions**		**1)Develop patient registration organizational approach to capturing bed readiness and communicating this to the ER staff**	**Develop a tracking mechanism to communicate bed readiness to ER staff and patient and families upon admission**	**Internal audit will be completed on a monthly basis to ensure data is being captured appropriately**	**100% of beds will be identified when they are ready and communicated to ER staff, patients and families**	
											2)Match capacity and demand to align with system capacity with demands over changing time periods	Develop quality improvement process for patient flow to identify times of increased demand for bed capacity	Internal audit to determine that process has been developed and implemented to include all unit managers and patient flow	Increased demand for capacity is identified by a quality patient flow process by June	
											3)Improved transitions and post hospital care to reduce readmissions for high risk populations	Implement follow up phone calls from all inpatient units within the hospital to reduce ED visits, readmissions and demand for hospital beds	All inpatient units will be participating in follow up phone calls following discharge to assess patient condition and prevent ED visits and potential readmission to hospital	80% of discharged patients will receive a follow up phone call	
											4)Implement recommended quality patient flow metrics to monitor system performance at the department and unit level performance to manage flow in real time	Develop methodology to measure patient flow through out the organization and both sites in ensure appropriate patient flow strategies are being utilized and decrease bed waiting time	Patient flow process will be created utilizing a proven methodology to measure system flow	Patient flow will complete this process on daily basis commencing in June	
Theme II: Service Excellence	**Patient-centred**	Percentage of complaints acknowledged to the individual who made a complaint within five business days	P	% / All patients	Local data collection / Most recent 12 month period	928*	CB	90.00	Implement tracking process for patient complaints that will support acknowledgement within 5 days		1)Develop complaint organizational tracking process in collaboration with Patient Relations	Patient Relations will create a tracking log to capture complaints across the organization	Internal audit will be completed on a monthly basis commencing in May	90% of all patient complaints will be acknowledged within 5 days	
											2)Develop process to have patient complaints reviewed by the Patient and Family Advisor Council for Quality Improvement suggestions	Patient and family Advisor Council will receive report on Patient Complaints received in order to improve the services we provide	Patient complaints will be reported to the Patient and Family Advisory Council on a monthly basis to assist with quality improvement strategies	100% of Patient Complaints will be reported to PFAC in order to assist with improving the services we provide to our patients	
											3)Ensure that Patient complaints are registered utilizing categories and subcategories in order to determine improvement strategies	A method to formalize categories and subcategories will be developed to ensure that tracking of complaints is done appropriately to identify common themes and areas for improvement	All complaints will be categorized in order to determine areas for improvement	collecting baseline	
											4)The Patient and Family Advisor Council will support dissemination of quality improvement strategies for improving the patient experience.	Formalized summary will be completed with recommendations for improvement by PFAC biannually and reported to the Quality Committee of the Board.	Biannual report on Quality Improvement strategies	collecting Baseline	
		Percentage of respondents who responded positively 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 consecutive 12-month period	928*	CB	80.00	Determine that appropriate information regarding patient condition / treatment is given upon discharge to support a safe transition from hospital.		1)Patient oriented discharge summaries are completed for all in patient discharges	Nursing staff will utilize all patient orientated discharge summaries	Internal audits will be completed on a quarterly basis to determine the percentage of discharge patients who received a patient orientated discharge summary	90% of patients will receive a patient orientated discharge summary	
											2)Operating room and Diagnostic Imaging patient instruction sheets will be reviewed by Patient and Family Advisory Council	Written discharge information sheets will be reviewed by PFAC to support patient education upon discharge	All operating room and diagnostic imaging patient information documents will be reviewed by PFAC	This review will be completed by March 2020	
											3)All in patient units will complete a follow up phone call to determine if patients have been given the appropriate follow up information	Charge nurses will complete 7 days follow up phone call for all patients admitted longer than 24 hours to determine if all of the follow up information was provided upon discharge	80% of patients will receive a follow up phone call to determine if appropriate follow up information was completed	A quarterly audit will be completed to ensure that target patient population has received a phone call	
											4)Palliative care will participate in completing in patient follow up phone calls to ensure safe transition into the community	Palliative care nurse will complete follow up phone call within 48 hours of discharge to determine that appropriate instructions have been given to this specific target population	A quarterly audit will be completed to ensure that a safe transition on has been competed with the appropriate information	80% of palliative care patients who are transitioned into the community will receive a follow up phone call	
Theme III: Safe and Effective Care	**Effective**	Medication reconciliation at discharge: Total number of discharged patients	P	Rate per total number of discharged patients / Discharged	Hospital collected data / October - December 2018	928*	CB	80.00			1)Educate all clinical staff on the process for completing a discharge medication reconciliation process	Nursing and physicians will have further education on the medication reconciliation process which will include all in patient units	Monthly audits will be completed to determine completion	80% of patients discharged will receive a completed medication reconciliation upon discharge	

		for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged.		patients							2)Ensure information regarding the best possible medication list upon discharge is given at time of patient discharge	Medication information sheets will be included with any new medications upon discharge	Patient orientated discharge summary will also include information sheets on any medication	80% of discharged patients surveyed will have received medication information sheets for any new medications upon discharge	
											3)Ensure clinical staff have received the appropriate training upon organizational on boarding that support the safe medication reconciliation processes	Develop a new clinical orientation that will support the utilization of resources to support safe medication reconciliation processes	Audits will be completed on a monthly basis to measure compliance	100% of clinical staff will receive education prior to commencement of practice.	
											4)Engage with patients to develop the Best Possible Medication Discharge plan in advance of the actual day of discharge	Clinical staff will conduct a medication reconciliation close to time of discharge in advance of the actual day of discharge when possible	A monthly audit will be completed to determine to if the medication reconciliation process is completed in advance of the actual day of discharge	This is a new initiative and we will be collecting baseline data	
		Proportion of hospitalizations where patients with a progressive, life-threatening illness have their palliative care needs identified early through a comprehensive and holistic assessment.	P	Proportion / at-risk cohort	Local data collection / Most recent 6 month period	928*	CB	90.00			1)An interdisciplinary Palliative Care committee will be created that includes committee partners to assist with transitions to the community for patients with palliative care needs	Interdisciplinary Palliative Care Committee will meet on a monthly basis to assess the quality of palliative care and transitions of car with community partners	The number of patients transitioned into the community to receive palliative care will be tracked and transitions of care assessed to determine areas for improvement	Collecting baseline data	
											2)Palliative care nursing hours will be adjusted to meet the needs of Palliative Care patients on the weekends and after hours	Palliative care nursing hours will be adjusted to evolve around the care needs of this patient population	Nursing will assess Palliative Care patients within 2 days of their admission to improve the quality of care that patients are receiving	90% of Palliative Care patients will complete a comprehensive assessment by September	
											3)Palliative care education will be provided to all clinical staff	Palliative Care education will provided to clinical staff upon hire	Internal audit will be completed to determine number of education sessions completed	4 sessions will be completed by November 2019	
											4)Improve the organizational understanding of Palliative Care	"2" annual Palliative care education sessions will be held organizationally to support awareness regarding palliative care	An education session will be held for PFAC and Board Quality	By November 2019	
	Safe	**Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.**	**MANDATORY**	**Count / Worker**	**Local data collection / January - December 2018**	**928***	**44**	**55.00**	**Continue to increase organizational awareness regarding workplace violence**		**1)Increase awareness of workplace violence through education**	**Education sessions will be held for all staff to review the definition of workplace violence and support the importance of reporting all incidents**	**This education will result in an increase in the number of workplace violence reports that are generated.**	**workplace violence incident reports will increase by 11% by March 2020**	
											2)Update the workplace violence LMS to reflect new security policy and procedures	LMS will be reviewed and updated to reflect quality improvement strategies that have been implemented to improve security	Percentage of staff viewing the LMS system will be audited	80% of staff will review the online LMS by November	
											3)Information collected from workplace violence incidents that can support quality improvement and safety will be reported back to staff and the JHSC	Occupational Health will provide quarterly updates to staff on workplace incidents to support the ongoing education of staff.	An audit will be completed quarterly to ensure completion	Completed each quarter with an end date of March 2020	
											4)Crisis Prevention Institute non violence training will be provided for staff	CPI training will be offered to all staff within the organization to support the education of staff who maybe in a high risk violence situation	All staff in in Patient Registration and emergency department will attend training	100% of staff in high risk patient areas for violence such as Registration and Emergency will receive this non violence training	