2019/2020 QUALITY IMPROVEMENT PLAN

Improvement Targets and Initiatives

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 1: Timely and Efficient Transitions

## Efficient

### Measure 1

* Measure/Indicator: Average number of inpatients receiving care in unconventional spaces or ER stretchers per day within a given time period.
* Type: P
* Unit/Population: Count/all patients
* Source/Period: Daily BCS/October – December 2018
* Organization ID: 777\*
* Current Performance: 9.43
* Target: 9.43
* Target justification: With the upcoming introduction of the electronic health record in the Emergency Department, we are anticipating a decline of efficiency until staff have internalized this technology into their practice. As such, we will be working hard to maintain the flow of patients through the ED while balancing these new practices.
* Change 1:

Planned Improvement Opportunities (Change Ideas): Improve the correct identifications of patients appropriate for the Acute Care of the Elderly (ACE) Unit by increasing compliance with use of the ISAR tool by nursing staff in the ED

Methods: Standard work will be developed for the ACE ACC clerk to review all ACE admissions from the ED for 1 day each month to determine a random sample for compliance with use of the ISAR tool. This will be reported to the Manager and Bed Flow Coordinator.

Process Measures: % of completion of ISAR tool for all patients greater than 70 years old who are admitted to the ACE unit.

Target for Process Measure: 80% of all patients admitted to the ACE will have a completed ISAR tool by December 2019.

Comments: By ensuring appropriate identification of ACE patients, there will be a facilitated admission to the ACE unit. This process will be faster than is currently in place.

* Change 2:

Planned Improvement Opportunities (Change Ideas): Measure and improve the time form notification of an inpatient bed bring available to the time that the patient leaves the ED through process review and standardization of practices.

Methods: Data is available through Decision Support.

Process Measures: Average time for all ED admissions to leave the ED once a bed has been made available on an inpatient unit.

Target for Process Measure: 60 minutes by November 2019.

### Measure 2

* Measure/Indicator: 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.
* Type: P
* Unit/Population: Rate per 100 inpatient days/all inpatients
* Source/Period: WTIS, CCO, BCS, MOHLTC/July – September 2018
* Organization ID: 777\*
* Current Performance: 16.51
* Target: 16.51
* Target justification: We have exercised opportunities with our more rural partner hospitals to move ALC patients out of the acute care setting. These efforts have resulted in maximal use of local beds. No other partner opportunities are available to improve this measure.
* External Collaborators: Arnprior and District Regional Health, Carleton Place and District Memorial Hospital, Almonte General Hospital
* Change 1:

Planned Improvement Opportunities (Change Ideas): Partner with external facilities to re-house ALC patients, allowing the freeing of beds to admit acute care patients.

Methods: Social Work count number of ALC patients transferred to other facilities.

Process Measures: Number of ALC patients transferred to other facilities to await Long Term Care placement between October and December 2019.

Target for Process Measure: 5 patients per month.

Comments: Based on the average length of stay for ALC patients, this initiative carries a potential saving of over 300 hospital days.

* Change 2:

Planned Improvement Opportunities (Change Ideas): Prevent ALC designation by transitioning patients who meet specific criteria to the SAFE (Sub Acute Frail Elderly) unit at Perley/Rideau Veteran’s Health Centre.

Methods: Number of patients transferred to SAFE is recorded by the Social Work Department.

Process Measures: Number of patients transferred to the SAFE unit between October and December 2019.

Target for Process Measure: 12 patients to be transferred to the SAFE unit.

Comments: This initiative carries an opportunity to defer approximately 420 ALC days.

## Timely

### Measure 1

* Measure/Indicator: Percentage of patients discharged form hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient’s discharge from hospital.
* Type: P
* Unit/Population: %/discharged patients
* Source/Period: hospital collected data/most recent 3-month period
* Organization ID: 777\*
* Current Performance: 75
* Target: 76.00
* Target justification: Planned changes in physician documentation workflows this year are likely to be disruptive, and physicians will need time to adapt to new technology. For clarity, we are focusing on patients discharged from the Emergency Department.
* Change 1:

Planned Improvement Opportunities (Change Ideas): implement front-end self-editing dictation within the scope of Connected Care physician documentation project (PDOC).

Methods: a report will be created to identify the number of discharge summaries that have been completed. For review by Decision Support.

Process Measures: % of discharge summaries completed through the PDoc front end interface for the immediate period following rollout (December 1 to January 30, 2020).

Target for Process Measure: 25% of all patient discharges will have discharge summaries completed in the electronic record immediately after launch.

Comments:

* Change 2:

Planned Improvement Opportunities (Change Ideas): the Physician Documentation (PDoc) Implementation team will develop standardized discharge summary templates to improve timely completion of the discharge summary.

Methods: a report will be generated to select form the electronic record a specific medical document (MDR) that represents the standardized template for discharge summaries.

Process Measures: number of discharge summaries developed with the standardized template in PDoc compared to the total number of discharge summaries in PDoc from December 1, 2019 to January 30, 2020.

Target for Process Measure: 75% utilization rate of discharge summary template

Comments: implementation of the PDoc will take place in November 2019, but with the education provided prior to roll out, use of the discharge summary template should have good uptake.

### Measure 2

* Measure/Indicator: 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.
* Type: MANDATORY
* Unit/Population: hours/all patients
* Source/Period: CIHI NACRS/October 2-18 – December 2018
* Organization ID: 777\*
* Current Performance: 27.1
* Target: 27.10
* Target justification: Attempting to maintain the performance on this indicator can be considered a lofty goal given the expected 4% annual increase in ED visits, which results in an expectation of one additional admission coming from the ED each day, placing additional stress on the system.
* Change 1:

Planned Improvement Opportunities (Change Ideas): Improve compliance with a 1-hour turnaround time for transfer of patients between acute and sub-acute units through improving communication, building accountability for the Care Facilitators, and reporting compliance to stakeholders.

Methods: Data for time of bed availability (clean bed) and time of patient transfer is available through the Teletracking system.

Process Measures: % compliance with 1-hour turnaround time for the period October to December 2019.

Target for Process Measure: 70% of patients moving from an acute to a non-acute unit will be transferred within one hour of the bed becoming available.

Comments: Improving the time to move inpatients to non-acute beds allowed earlier access to acute beds for transfer of patients awaiting admission in the ED. It is out unsubstantiated understanding that we have approximately 50% compliance with this measure currently. A report will have to be written to allow this data to be captured for easier analysis.

* Change 2:

Planned Improvement Opportunities (Change Ideas): Measure and improve the time from notification of an inpatient bed being available to the time that the patient leaves the ED through process review and standardization of practices.

Methods: Data is available through Decision Support Team.

Process Measures: Average time for all ED admissions to leave the ED once a bed has been made available on an inpatient unit.

Target for Process Measure: 60 minutes average time for ED admission to leave the ED by November 2019.

Comments: a 60 minute time frame coincides with the expectations for transfer from one unit to another on the inpatient units.

Theme 2: Service Excellence

## Patient-centered

### Measure 1

* Measure/Indicator: Percentage of complaints acknowledged to the individual who made a complaint within five business days.
* Type: P
* Unit/Population: %/all patients
* Source/Period: Local data collection/most recent 12 month period
* Organization ID: 777\*
* Current Performance: 98.79
* Target: 98.79
* Target justification: In the coming fiscal year, there will be no change in this activity that would impact this factor.
* External Collaborators:
* Change 1:

Planned Improvement Opportunities (Change Ideas): N/A

Methods: N/A

Process Measures: N/A

Target for Process Measure: N/A

Comments: Given our current rate of compliance that is exceeding 98%, we will concentrate our energies on quality improvement in other areas.

### Measure 2

* Measure/Indicator: 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?
* Type: P
* Unit/Population: %/survey respondents
* Source/Period: CIHI CPES/most recent consecutive 12 month period
* Organization ID: 777\*
* Current Performance: 66.49
* Target: 70.00
* Target justification: We are hoping to achieve a 5% relative increase in the target through the expansion of use of the new patient discharge handbook.
* Change 1:

Planned Improvement Opportunities (Change Ideas): Continue to expand reach to ensure follow-up appointments are made with the family physician while the patient is in the hospital.

Methods: Information is coded through Decision Support.

Process Measures: % Medicine patients discharged from QCH who had a follow-up appointment with the family physician documented in their patient chart for October to December 2019.

Target for Process Measure: 80% of all inpatients will have a follow-up appointment with the family physician documented in their inpatient chart.

Comments: Currently, only the ACE unit achieves this goal. Their methodology will be rolled out to the other medicine units.

* Change 2:

Planned Improvement Opportunities (Change Ideas): Fully distribute the revised generic medicine GAP (Guidelines Applied in Practice) discharge tool.

Methods: Results of the NRCC Patient satisfaction survey “Do you know what to do if you are worried about your condition or treatment?”

Process Measures: % positive response to NRCC Patient satisfaction survey question for Medicine patients.

Target for Process Measure: 75% positive response in the “top box”

Comments: The current “top box” response is 68% for Medicine patients.

* Change 2:

Planned Improvement Opportunities (Change Ideas): Patient education booklet with a discharge action plan to be finalized and a process established for distribution of the booklet and education for all patients.

Methods: Results of NRCC Patient satisfaction survey question “Did you receive information in writing about what surgical or health problems to look for after you left the hospital?”

Process Measures: % positive response to NRCC question.

Target for Process Measure: 80% on all medical units.

Comments:

Theme 3: Safe and Effective Care

## Effective

### Measure 1

* Measure/Indicator: 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.
* Type: P
* Unit/Population: Rate per total number of discharged patients/discharged patients
* Source/Period: Hospital collected data/October – December 2018
* Organization ID: 777\*
* Current Performance: 77.78
* Target: 82.00
* Target justification: The majority of education will take place as we embark on computerized order entry for the physician group. This will be introduced in February 2020, so the impact on this indicator will be minimal for the 19/20 fiscal year.
* Change 1:

Planned Improvement Opportunities (Change Ideas): Conduct a survey of physicians to understand the current use of Meditech’s discharge prescription.

Methods: Survey tracking will be done within the pharmacy administration resources.

Process Measures: % pf physicians who complete the survey.

Target for Process Measure: 50% of privileged physicians will complete and return the survey.

Comments: This is an aggressive target for an anonymous survey.

* Change 2:

Planned Improvement Opportunities (Change Ideas): Develop a videotaped interim learning package for physicians concerning the discharge medication prescription.

Methods: Tracking of access to the video learning will be via automated email response to the Pharmacy from physicians who have watched the short video.

Process Measures: % of privileged physicians who view video learning package in the second and third quarter of 2019/2020

Target for Process Measure: 50% of all privileged physicians will view the video learning from June to December 2019.

Comments: The video package will be developed for release in June 2019, and tracking will begin then to determine how many physicians have been able to view the information.

* Change 3:

Planned Improvement Opportunities (Change Ideas): Develop and/or review standard work for Administrative Control Clerk (ACC) to ensure that a signed discharge prescription is reaching both the patient and the chart.

Methods: Pharmacy will work with Nursing Managers and ACC to standardize the process. Education will be provided at unit huddles and via written communication in April. At the end of May 2019, a survey will be provided to ACC and Nursing Managers to determine if the standard of work is in use.

Process Measures: Number of units with ACC clerks who are properly using standard work for distribution of the discharge requisition by May 2019.

Target for Process Measure: 9 inpatient units will have ACC clerks applying standard work to the distribution of the discharge prescription.

Comments: There is a gap in information sharing that the ACC clerk can fill by ensuring appropriate distribution of the prescription.

### Measure 2

* Measure/Indicator: Proportion of hospitalizations where patients with a progressive, life-threatening illness have their palliative care needs identified early through a comprehensive and holistic assessment.
* Type: P
* Unit/Population: Proportion/at-risk cohort
* Source/Period: Local data collection/most recent 6 month period
* Organization ID: 777\*
* Current Performance: CB
* Target: CB
* Target justification: We are collecting baseline data on this indicator and will only be able to set a target once we understand our current practice results.
* Change 1:

Planned Improvement Opportunities (Change Ideas): Build a new report to identify Health Links patients for Social Work team to consult palliative care.

Methods: Social Work will track how many patients identified on the new report are provided a palliative care consult.

Process Measures: % of Health Links patients with palliative care consults.

Target for Process Measure: 100% of Health Links patients will be given a palliative consult.

Comments: Patients who are identified as Health Links patients may have progressive, life-threatening illness. Last year 15% of Health Links patients passed away.

* Change 2:

Planned Improvement Opportunities (Change Ideas): Secure increased resources for physician coverage for continuity of palliative care by September 2019.

Methods: Medical Affairs to monitor number of physician FTE for palliative care.

Process Measures: Physician FTE for palliative care to be 1.0 by September 2019.

Target for Process Measure: 1 FTE palliative physician.

Comments: This addition would grow our capacity for seeing palliative patients.

### Measure 3

* Measure/Indicator: Rate of mental health or addiction episodes of care that are followed within 30 days by another mental health and addiction admission.
* Type: P
* Unit/Population: Rate per 100 discharges/discharged patients with mental health and addiction
* Source/Period: CIHI DAD, CIHI OHMRS, MOHTLC RPDB/January – December 2017
* Organization ID: 777\*
* Current Performance: 9.89
* Target: 9.40
* Target justification: While we have already seen a substantial decline in readmission of mental health/addictions patients through our use of the Crisis Nursing team, we are aiming to decrease this by a further 5%.
* Change 1:

Planned Improvement Opportunities (Change Ideas): Develop and begin to distribute Mental Health discharge tool.

Methods: Manual review of all patients’ discharge documentation to ensure discharge tool is complete and provided to the patients. Staff to complete tracking sheet held at ACC desk.

Process Measures: Number of patients receiving discharge tool.

Target for Process Measure: 100% of patients who are discharged home will receive a discharge tool.

Comments: The denominator will not include patients who are discharged to another facility.

* Change 2:

Planned Improvement Opportunities (Change Ideas): Develop a “Working with Emotions” outpatient group to assist patients identified with personality disorders.

Methods: Data collected by Decision Support team.

Process Measures: Number of readmissions of patients identified with personality disorder.

Target for Process Measure: Collecting Baseline rate. Expect a 10% improvement from baseline in this fiscal year.

Comments: Patients with personality disorders tend to have higher readmission rates, particularly for short stay admissions.

* Change 2:

Planned Improvement Opportunities (Change Ideas): Increase number of psychologist-led psychotherapy groups to address long wait times.

Methods:

Process Measures: Number of patients seen in the outpatient psychotherapy group.

Target for Process Measure: Collecting baseline. Increase the number by 50% from October to December 2018 versus October to December 2019.

Comments: Participation in the outpatient psychotherapy group helps to reduce the risk of admission to hospital.

## Safe

### Measure 1

* Measure/Indicator: Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.
* Type: Mandatory
* Unit/Population: Count/worker
* Source/Period: Local data collection/January – December 2018
* Organization ID: 777\*
* Current Performance: 235
* Target: 223.00
* Target justification: With effective implementation of education, assessment, debriefing and reporting of violent incidents, our goal turns to having a decrease in the number of incidents that are experienced in our hospital. Our target is 5% lower than last year.
* Change 1:

Planned Improvement Opportunities (Change Ideas): Education of staff in electronic platform for Client Violence Risk Assessment.

Methods: PCS training will be documented through nursing professional practice and will include the Client Violence Risk Assessment Tool (VAT).

Process Measures: % of Full Time Equivalent nursing (RN/RPN) staff completing electronic violence risk assessment (excluding Ambulatory Care, Operating Room and Endoscopy/Cystoscopy).

Target for Process Measure: 75% of those eligible to be trained in PCS education.

* Change 2:

Planned Improvement Opportunities (Change Ideas): Increase reach of Violence Prevention Training based on risk assessments to include 100% of staff employed in highest risk areas (ED, MH, ALC).

Methods: Number of staff trained compared to the number of staff employed in the highest risk areas. Data is collected in the Human Resources Information System (HRIS).

Process Measures: % completion of Non-Violence Crisis Intervention (NVCI) training for high risk areas.

Target for Process Measure: 90% of all staff in high risk areas will complete NVCI training by December 2019.

* Change 3:

Planned Improvement Opportunities (Change Ideas): Continue to improve percent of Code White events that are followed with a formal debrief to help learn from each incident.

Methods: Manual count of Code White Debrief forms that are completed compared to the number of Code White events recorded in the security long and Employee Incident reports.

Process Measures: % completion Code White debrief forms

Target for Process Measure: 100% of Code White debrief forms completed from June to December 2019