Ross Memorial Hospital: 2019/20 Quality Improvement Work Plan

AIM		MEASURE				CHANGE	
Theme	Goal	Measure / Indicator	Current Performance	Target	Target Justification	Planned Improvement Initiatives (Change Ideas)	Methods
Timely and Efficient Transitions	**We will enhance Communications and Care Continuity from Hospital to Primary Care Team**	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. (% / Discharged patients)	78	90	The target is based on a 15% improvement over current performance.	1. Analyze the current state to understand why the discharge summaries are not delivered to Primary Care Provider in 48 hours. 2. Develop action plan based on reasons dictation did not occur. 3. Review expectations of all discharge summaries dictated within 24 hours to physicians. Share information with physicians on current state. 4. Education will be provided to the physicians who do not dictate their discharge summaries within 24 hours. 5. Review current discharge template to ensure it meets current standards and harmonize information with the SMART Discharge and Home and Community Care where possible. 6. Explore the possibility of scheduling a follow up appointment with our patients' Primary Care Provider prior to leaving the hospital.	*Sustain project accomplishments through continued auditing, evaluation and celebration of successes. *Evaluate the satisfaction of our patients, Primary Care Physicians and in patient physicians with improved transitions of care. *Monthly reports to track compliance with discharge summaries being delivered within 48 to Primary Care Physicians. *Continue to have summaries available on Health Care Connect. *Continue to provide and audit patients with SMART discharge documents and fax copies of discharge tools and prescription to Primary Care Physicians on discharge.
	We will advance Appropriate Care in the Appropriate Care Place	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. (Hours / All patients)	31.77 hours	28.59 hours	Target is based on a 10% decrease from current performance.	1. To refocus on the discharge process on inpatient units to improve the bed turnaround time.	*Revitalize the changes implemented from recent Kaizen on discharge process. *Institute the tracking of the changes to the EDD and reasons for discharge delay. *Develop a discharge checklist for all acute inpatients implemented within 2-4 days of admission.
		Average number of inpatients receiving care in unconventional spaces or ER stretchers per day within a given time period. (Count / All patients)	4.75	4.75	Current performance is not reflective of fiscal year; the average is 6. This needs to be adjusted.	1. To track, trend and share data with inpatient units and physicians.	* To develop a report trending the current number of patients receiving care in unconventional spaces. *Review and revise our bed surge practice. * Improvement of discharge processes to improve the bed turnaround time to facilitate admission.

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		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. (Rate per 100 inpatient days / All inpatients)	32.23	32.23	For our target, we want to maintain our performance of 32.23 while working on identifying the barriers to decrease our ALC rate.	1. Continue to review the complex patients through the interdisciplinary team TRAC and Home First philosophy. 2. Continue the Implementation of ALC best practices.	*Improve the compliance with white board discharge information within 2-5 days of admission. *Develop a process and role responsibility to resolve patient individual barriers to discharge. *Continue to engage the Hospital and Home & Community Care Senior Team in all ALC LTC patients.
		The average length of stay (LOS) for typical acute inpatients (Q3 year to date). (Acute IP days (excluding ALC days) / Typical Acute IP discharges)	4.8 days	< = 4.6 days	This is based on the Ontario 50th percentile.	1. To decrease length of stay for all acute patient.	*Continue to implement the ALC Best Practices. *Enhance our current discharge process and role responsibilities. *Provide education to physicians and staff regarding required documentation; ALC designation and Case Mix Groups and Best Practices.
		The median number of days patients waited to be placed in a long-term care (LTC) home from the date of ALC LTC order. (All Acute and Post-acute patients designated as ALC-Long Term Care)	Collecting Baseline	Collecting Baseline	We are collecting baseline data. The target will be determine once the baseline is established.	1. Continue to promote Home First approach to all complex patients. 2. Develop a process to track and report at TRAC.	*Continue to monitor ALC rates on daily basis. *Continue to evaluate with multidisciplinary team (TRAC) patient status and options prior to classifying as ALC. *Continue to work with Home and Community Care for discharge/care options.
		Percentage of complaints acknowledged to the individual who made a complaint within five business days. (% / All patients)	Collecting Baseline	80	We are currently collecting baseline data.	1. Align our Complaints Management program with the OHA Patient Relations Best Practices.	*Add in additional mandatory fields such as Satisfaction to improve the end to end patient relations management process. *Develop an escalation process and information package for the 'dissatisfied' complainant.
						2. Evolve our Complaints Management Process and Training & Education.	*Revise our existing Patient Relations P&P and the RL6 Tracking and Reporting template. *Develop Training & Education material for all new and existing staff.

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Service Excellence	We will continue to provide Service Excellence and Exceptional Care Together					3. Improve the accessibility of our Patient Relations Program.	*Create accessible avenues such as an audio clip to describe our patient relations program. *Engaging the Accessibility Committee.
		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? (% / Survey respondents)	57	62.7	Target was set based on a stretch target of 10% increase from current performance.	1. To ensure the diagnosis discharge information sheets are utilized with teaching.	*Review the use of the diagnosis sheets with the nursing staff. *Audit the use of the sheets in the discharge package. *Consider adding a question on the rounding tool to be able to catch a need for further education to patient and family prior to discharge. *Share results of NCR survey with staff at huddles.
		Improve overall patient experience - Emergency. “Would Recommend to family & friends". (% / ED patients)	68	70	We are going to continue to build on the progress made last year and to sustain our enhanced performance.	1. Continue to focus on the key components of the service excellence education and involve front line staff, patients and family in solution driven improvements.	*To continue to include regular reminders in huddles on service excellence components and suggestions for improvements. *Sharing of the patient and family complaints and compliments. *Continue Patient Experience Partners rounding with patients.
		Improve overall patient experience - Medicine/Surgery. "Would Recommend to family & friends". (% / All acute patients)	68.6	70	We are going to continue to build on the progress made last year and to sustain our enhanced performance.	1. To standardize the approach and standard of care, quality initiatives.	*The medical and surgical program team meetings will be combined to promote team work and a focus on standards of care between units and quality improvement initiatives. *To continue to include regular reminders in huddles on service excellence components and suggestions for improvements. *Continue with Patient Experience Partners Survey.
Safe and Effective Care	We will continue to improve med rec across the continuum of care	The total number of acute patients with medications reconciled by Pharmacy within 24 hours of admission as a proportion of total patients admitted through Emergency Department. (% / All acute patients)	95	95	The target was selected to sustain improvements achieved previous fiscal year.	1. Compliance rate is high; develop and implement a quality audit for BPMH done by staff outside of the pharmacy department.	*Expand admission documentation to include non-pharmacy generated BPMH. Engage Decision Support to determine optimum number for review.

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		The total number of acute patients with medications reconciled by Pharmacy within 24 hours of transition within the Hospital. (% / All acute patients)	58	65	This target is based on a 12% increase from current performance.	1. Define specific patient transitions which require medication reconciliation to be performed. Review the definition of compliance. Identify barriers to process at transitions.	*Increase audit volume/frequency for Med Rec at transitions. Engage stakeholders to review current process. Include Med Rec as a standing agenda item. Implement staff re-education.
		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 per total number of discharged patients / Discharged patients)	95.99	96	Target set to sustain improvement achieved in fiscal 2018/19.	1. Pharmacist involvement in discharge medication reconciliation for high-risk cases, such as: medications requiring therapeutic drug monitoring; patients seeing multiple health care providers, patients requiring device teaching and support.	*Identify high-risk situations where pharmacist should be involved in discharge medication reconciliation.
	We will proactively identify and effectively manage patients at risk for deterioration	The number of Medical Emergency Team (MET) call patients transferred to the ICU with a noted deterioration 24 hours prior to the call. (% / All acute patients)	12	10	We are going to continue to build on the progress made last year and to sustain our enhanced performance.	1. Decrease the incidences of undetected early deterioration in patients.	*Steering committee to oversee NEWS2 spread and monitor and evaluate through audits and feedback.
						2. Implement NEWS2 on the inpatient Units with a clear direction on how to respond to the needs of a patient who is observed/scored to have a decline in their clinical condition.	*Review NEWS2 at inpatient unit huddles and enhance situational awareness and identification of patients at risk.
						3. Enhance knowledge of sepsis recognition with escalation of care.	*Ensure compliance with the Sepsis Order Set. Review sepsis 1 hour bundle at daily huddles. Use of educational tools.

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	We will continue to improve palliative care management	Proportion of hospitalizations where patients with a progressive, life-threatening illness have their palliative care needs identified early through a comprehensive and holistic assessment.	Collecting Baseline	Collecting Baseline	This is a new measure and we are collecting baseline data.	1. Ensure all patients admitted to the Palliative Care Unit with a progressive, life limiting diagnosis will be identified and assessed regularly using a validated tool.	*Development of a working group of frontline staff, management and data support to create, develop and implement a successful roll out of this quality improvement plan for palliative care management by Q1 2019/20. *Utilizing the Edmonton Symptom Assessment System (ESAS) staff will identify early each patient's palliative care needs in a comprehensive, holistic approach. *The working group will identify ways to implement standard practice into daily work flow to facilitate early identification of each patient's palliative care needs by Q1 2019/20.
	We will continue to provide a safe workplace	Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.	160	0	The purpose is not to increase or decrease but to monitor the types of reported incidents and implement concrete mitigation strategies.	1. Continue Workplace Violence and Harassment Steering Committee to oversee Prevention Program. 2. Implement Workplace Violence and Harassment Prevention Program Policy.	*Complete annual Workplace Violence departmental and direct care risk assessments with corrective action plans. *Roll out to all areas the Violence and Aggression Checklist and the Identification of Patients at Risk for Violence (Flagging) policies. *Include patient's risk for violence communication at each time of Transfer of Accountability – internal and external.
Equity	**We will advance integrated care management for patients with addictions and homelessness**	Rate of mental health or addiction episodes of care that are followed within 30 days by another mental health and addiction admission.	12.29	10.0	We are aiming for 10% reduction.	1. Request a weekly 30 day print of patients discharged from MHIP and ED who represent to the ED and/or admitted.	*RNs to collaboratively create crisis care plans based on the RNAO BPG Crisis Intervention for Adults Using a Trauma-Informed Approach: Initial Four Weeks of Management for clients presenting to the ED with suicidal thoughts and/or substance use that are not admitted to hospital. *All clients discharged from the Mental Health Inpatient Unit will be contacted via telephone by the Crisis RN within 7 days. *Cultural safety education for effectively caring for patients with addictions.

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						2. Crisis/Safety Plan developed for discharged individuals who re-present to ED and/or admitted.	*Crisis RN in collaboration with Hospital to Home Mental Health and/or Addiction Worker to develop RNAO BPG Crisis Safety/ Plan Template. *Clients admitted to RMH for mental health and/or addictions that are referred to MHOP for assessment will also be supported in the creation of an individualized crisis care plan. *Crisis Safety plan to be shared with community partners (with consent) and kept on patient's medical record.