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

ROSS MEMORIAL HOSPITAL
Kawartha Lakes

Ross Memorial Hospital 10 Angeline Street North, Lindsay , ON, K9V4M8

AIM		Measure										Change				
Issue	**Quality dimension**	**Measure/Indicator**	**Type**	**Unit / Population**	**Source / Period**	**Organization Id**	**Current performance**	**Target**	**Target justification**	**External Collaborators**	**MRP**	**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.	Priority	Rate per 100 inpatient days / All inpatients	WTIS, CCO, MOHLTC / Jul 2019 - Sep 2019	707*	32.45	31	The target is set at 8 ALC patients remaining offsite at retirement home	CELHIN, H&CC, RH	Carole McBride	1. Implement 90% of ALC Avoidance Leading Practice and Improvement strategy. 2 A . Continue working in partnership with RH for short stay transitional care model (STTCM) 2 B. Continue to advocate for funding to support STTCM. 3. Develop and implement a robust admission avoidance program. Working in collaboration with OHT 4. Work with external partners to implement high priority acute care beds in long term care.	1. Adherence to ALC Avoidance Leading Practice and Improvement strategy. 2 A. Explore further opportunities to increase ALC patients in STTCM. 2 B. Continue to track cost of STTCM with implications to the Hospital. 3. Enhance the multidiscipline wrap around team in the ED for admission avoidance. 4. RMH representative appointed to high priority acute	1. TRAC team to review best practice document. 2 A. Collaborate with RH to explore accepting patients that require more resources. 2 B. Analyze variance 3. Trial improvement processes utilizing PDSA cycle 4. Actively participate with regional task force	1. 75% of practices in the CCO ALC document will be met by Q4 2 A. - # of patients served and # of pts discharged from the RH. 2 B. Obtain 100% funding 3.Initiate data collection process for admission avoidance with a goal of 12 patients this year. 4. Attend 75% of meetings.	
	Efficient	The time interval between the Disposition and the Date/Time Patient Left Emergency Department (ED) for admission to an inpatient bed or operating room at 90th percentile.	MANDATORY	Hours / All patients	CIHI NACRS, CCO / Oct 2019– Dec 2019	707*	15.7 was Q3 results, however the average for 2019/2020 was 31.1	27.99	The average for last year was 31.1	CCSO	Carole McBride	1. Improve communication amongst the team to confirm steps completed for a safe and optimal discharge. 2. Enhance the use of EDD within our process and communicate the EDD on the patient's white board to allow for successful planned discharge. 3. Collaborate with physicians to facilitate an earlier discharge time. 4. Prioritize navigator role in ED to activities that decrease time to inpatient bed.	1. Discharge checklist implemented hospital wide checklist provides standardization and communication of the sequence of events in the discharge process 2. Improve communication to patients, families and caregivers of discharge time so transportation can be arranged earlier. 3. Work with Hospitalist group to perform discharges before admissions to facilitate the earlier discharge times. Organize a LEAN initiative to review and improve current process. 4. Review standard work of ED navigator.	1. Tool developed and utilized by the multidisciplinary team. 2. Enhance information on patient's whiteboards. 3. Set Daily Admitting Reporting Tool (DART) with a new target and all patient care managers to measure performance daily. 4. PDSA work activities of ED navigator to optimize performance.	1 A. 100% of inpatient staff will receive orientation on the new discharge tool. 1 B. Patient LOS to decrease by 5% in acute care to 5.8 days. 2. 75% of patients audited quarterly will have information on the patient's whiteboard. 3. 10% improvement on discharges by 11:00 on inpatient units. 4. Complete standard work of the navigator by Qtr. 1	
Theme II: Service Excellence	Patient-centered	Collection of family satisfaction from ICU	Custom	ICU patient family	The Provincial Electronic Family Satisfaction-ICU (PREF) initiative	707*	Data collection	Data collection	New Provincial Tool		Carole McBride	1. The FS-ICU is a validated family survey tool to obtain continuous feedback on family satisfaction with ICU care and decision-making. It provides mechanism for local feedback while also facilitating the analysis of provincial and regional scorecard metrics. 2. Implementation of the Electronic Family Satisfaction survey in the Intensive Care Unit	Develop project implementation plan in adherence with the Provincial Rollout of the Electronic Family Satisfaction (PREF) in ICU Identification of the Implementation Lead, Unit Champions, Team Members and familiarize with roles Embed the PREF information and expectations in the orientation of new staff Develop forum for monthly and quarterly performance sharing Test various changes and strategies using PDSA cycle to improve survey participation.	To provide timely data to identify opportunities for improvement. Review the data monthly and quarterly	100% of ICU staff participate in education. Target 65% for family completion of survey by Q4	
	Effective	Percent of unscheduled repeat emergency visits following an emergency visit for a mental health condition.	Priority	% / ED patients	CIHI NACRS / April - June 2019	707*	15.11	Data collection	Indicator has changed this year		Susan Grant	1. Decrease wait time for appointment with Psychiatrist. 2. Change crisis program to decrease patient re-visit to ED following ED visits in 30 days. 3. All patients presenting to ED 2 times in 30 days for MH/Additions will have the crisis care plan completed. 4. Review of LOS for all in-patients on a weekly basis for appropriate discharge plans.	1. Psychiatrist weekend clinics have been organized for short term intervention and consult. 2. Group classes changed to 6 weeks to improve throughput. 3. Return visit report sent to crisis nurse weekly, to review and ensure referral to H2H program and confirm follow-up support with discharge. 4. Crisis nurse to follow up in 1 week with patients discharged from MHIP with phone call. Consideration to broadening outreach portfolio to include post crisis support up to 3 sessions.	1. Weekend clinics are staffed and appointments are filled. 2. Wait time for classes tracked and monitored along with no shows. 3. Regular 6 month review of day program case load by manager. 4. Return visits to ED for MH and addictions within 30 days tracked weekly reported monthly	Develop action plans based on the results of the survey to improve family satisfaction levels.	

	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.	Priority	Proportion / All patients	Local data collection / Most recent 6 month period	707*	97%	80%	Expanded corporate wide		Carole McBride	1. Spread the implementation of the Edmonton Symptom Assessment System (ESAS) tool to all inpatient units. 2. Incorporating of ESAS into nurse palliative triage assessment tool for off- service palliative patients.	1. Education on Edmonton Symptom Assessment System (ESAS) tool to inpatient nursing staff. 2. Daily compliance audits to ensure nursing is documenting the ESAS score on all palliative care patients .	1. Audits to be completed monthly on the number of staff educated . 2. Audits to be completed on the number ESAS tool completed daily and charted on palliative patients.	1. 60% of staff receive education by Q1 2. 60% of palliative patients complete the ESAS tool daily on the inpatient units by Q2. 3. 90% of patients complete the ESAS tool daily in the palliative care unit by Q2.	
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	707*	32	Data collection	The purpose is not to increase or decrease but to monitor the types of reported incidents and implement mitigation strategies.		Emma Elley	1. Continue to conduct and review departmental risk assessments for Workplace Violence & Harassment at a minimum annually. 2. Implement Code BERT (Behavioural Emergency Response Team)	1. Conducting departmental Workplace Violence & Harassment risk assessments improvement areas will be identified as medium to high risk hazards. 2 A. Develop the criteria for code BERT and response bag in Q.1. 2 B. Educate staff on Code BERT response in Q 2.	1. Any hazard identified as medium to high risk will require an action plan to mitigate the risk. 2A. Criteria being posted on the units and included in orientation packages by Q 3. 2B. Audit to be completed monthly of the number of staff educated on Code BERT response.	1. 80% of all action items shall be completed prior to year end. 2A.Audit presence of the criteria for Code BERT calls on all units. 100% compliance by Q3 2B. Educate 100% staff on Code BERT and the response options by Q 2.	Some action items may involve capital budget planning processes; thus may not meet the year-end deadline.