Temiskaming Hospital
2018/19 Quality Improvement Plan
Improvement Targets and Initiatives

AIM			Measure				Change			
Quality Dimension	**Quality Issue**	**Objective**	**Measure/Indicator**	**Current Performance**	**Target**	**Target Justification**	**Planned improvement Initiatives (Change Ideas)**	**Methods**	**Process Measures**	**Target for Process Measure**
Effective	**Effective Transitions**	**Reduce readmission rates for patients with Congestive Heart Failure (CHF)**	Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with CHF (QBP cohort)	7%	<21.2%	Below Health Quality Ontario 2016 provincial performance average 21.2%	1) Improve communication with Primary Care for patients at high risk of re-admission with having a follow-up appointment confirmed with their most responsible care provider within 7 days of discharge.	Continue to implement and improve the post discharge follow-up phone call process for patients with discharge diagnosis of Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF) which includes scripted questions provided by an assigned designate regarding follow-up appointment with most responsible provider.	% of patients with discharge diagnosis of COPD or CHF that have received a follow-up phone call within 48 hours of discharge.	100% of patients identified will have follow-up phone call scheduled within 72 hours of discharge by June 1, 2018.
							2) Continue implementation of standardized evidence-based order set/pathway for Congestive Heart Failure (CHF), aligning care to the pathways of the Quality Based Procedure handbooks.	Through applicable Medical Advisory Sub-committees, evaluate implementation of CHF order set/pathway with accountability for evaluation of utilization.	Track % of in-patients with CHF where a CHF admission order set/pathway was utilized/initiated.	90% of patients admitted with CHF will have had a CHF order set utilized on admission and pathway initiated.
							3) Conduct Readmission Root Cause Analysis for gap identification and mitigation strategies.	Conduct Readmission Root Cause Analysis through chart audits. Quality Coordinator will complete the audit of all readmitted patients with CHF and on a quarterly basis in 2018-19 report to Quality and Patient Safety Council.	Track % of chart audits completed of applicable patients discharged with CHF diagnosis that are readmitted within 30 days.	100% hospital inpatients discharged with CHF that are readmitted within 30 days will have a chart audit completed. Analysis completed Quarterly 2018/19.
		Reduce readmission rates for patients with Chronic Obstructive Pulmonary Disease (COPD)	Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with COPD (Quality Based Procedure - QBP- cohort)	8%	<19.9	Below Health Quality Ontario 2016 provincial performance average 19.9%	1) Implementation of Chronic Obstructive Pulmonary Disease (COPD) Discharge Action Plan and Educational resources.	All patients admitted to Temiskaming Hospital with COPD will be provided with a take home fact sheet on medication and administration devices, self management of COPD at home as well as an Action Plan if not already implemented.	Track the number of patients discharged with a COPD education package and action plan.	100% of inpatients discharged with a COPD education package and action plan.
							2) Development and implementation of pulmonary rehabilitation program pilot.	Work with district health care partners as part of sub-region health system planning to implement a standardized pulmonary rehabilitation program throughout the district with Temiskaming Hospital as a program site.	Track project milestones, implementation and performance metrics to be developed by partners (Sub-Regional Collaborative Problem Solving Group)	Pilot completed by June 2018.

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		Ensure adequate information at discharge	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?	100%	95%	Internal Target set 5% higher than previous year to ensure improvement.	1) Improve discharge patient information in Obstetrical Department.	Implement Patient Oriented Discharge Summaries in the obstetrical department as part of the year 2 spread initiative as per the agreement with University Health Network (UHN) and Adopting Research to Improve Care (ARTIC).	a) Track project milestones to ensure project on target for Go-Live. b) Track % of patients who have had a PODS tool completed on discharge.	Implementation of individualized PODS program with target patient population by May 2018. 100% of patient discharged from the obstetrical department will have a PODS tool completed.
							2) Encourage culturally sensitive care and discharge planning through Indigenous Hospital Liaison to improve patient centered coordination of services.	Increase the number of referrals to Indigenous Hospital Liaison through the Emergency Department and on admission through early self-identification.	Track number of referrals to Indigenous Hospital Liaison within 48 hours of admission.	100% of self-identified patients have been referred to Indigenous Hospital Liaison within 48 hours of admission.
		Reduce readmission rates for patients with Mental Health and Addictions	Rate of psychiatric (mental health and addictions) discharges that are followed within 30 days by another mental health and addiction admission.	9%	<11.3%	Below Health Quality Ontario 2015 provincial performance average 11.3%	1) Improve care coordination of mental health and addictions services in the Emergency and In-patient departments	The implementation of the Temiskaming Hospital Mental Health Application ("App") for health care providers which will assist in bridging communication, referrals and available services between hospital and community providers.	Mental Health App implemented.	Mental Health Application will be implemented by May 2018.
							2) Improve supports to enable appropriate evidence-based opioid prescribing when applicable	Evaluate and revise (where applicable) current policies, procedures, referrals and resources (i.e. Health Quality Ontario's Quality Standards currently in development) related to opioid prescribing, management and education for physicians, staff and patients. Evaluate current process related to the management of opioid physician/patient contracts including accessibility.	a) Policies and procedures reviewed and updated to reflect current best practice. b) Collaboration with community providers/services to validate current referral practices complete. c) Implement educational resources for physicians, staff and patients.	Process measures completed by October 2018.
Efficient	**Access to right level of care**	**Reduce unnecessary time spent in acute care**	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	18.9%	12.7%	Provincial & Local Integration Health Network (LHIN) Target outlined within Ministry-LHIN Accountability Agreement (M-LAA).	1) Implement strategy as part of Temiskaming Hospital's Senior Friendly Hospital framework to actively mitigate functional decline and support optimal outcomes for seniors while in hospital.	Continue to implement early mobilization initiative including a mobility standard of work for the senior in-patient population.	Percentage of patients who have an assessment completed of mobility status on admission and daily as required with accompanying mobility plan of care.	90% of patient will have an assessment completed with an identified mobility status level.
							2) Early discharge planning and identification of patients who are at high risk for being designated Alternate Level of Care (ALC) is embedded as part of Temiskaming Hospital's philosophy of care.	1) Develop process to identify patients who are at high risk for being designated ALC. 2) Develop a forum through ALC rounds to discuss patients at high risk for discharge planning, referral and evidence-based practices that actively mitigate the risk of deconditioning, falls and/or delirium.	a) Process developed and implemented into practice. b) ALC rounds will include proactive care planning for patients at high risk of being designated ALC.	Processes implemented by June 2018.
Patient-centered	**Person Experience**	**Improve patient satisfaction**	"Would you recommend this Emergency Department (ED) to your friends and family?"	84%	98%	Internal Target approaching theoretical best	1) Enhance effective communication between staff and patients in the Emergency Department	Provide service and skills training to Emergency Department staff (I.e. customer service; H.E.A.R.T) to improve communication with patients and families	Track staff attendance at education.	98% of staff will have completed training program.

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							2) Improve communication, resources and supports related to the Emergency Department's physical environment, flow and accessibility.	1) Improve communication of wait times and available resources in the Emergency Department through Temiskaming Hospital Website, inclusive of a virtual tour. 2) Patient and Family Advisory Committee will conduct value stream mapping exercise related to patient flow from patient perspective to identify improvements related to the patient experience.	a) Website Updated and communicated. b) Patient and Family Advisory Committee value stream mapping exercise and improvement identified with action plan completed.	Website will be updated by April 2018. Value Stream Mapping completed by September 2018.
			"Would you recommend this hospital (In-Patient Care) to your friends and family?"	100%	100%	Internal Target; theoretical best	1) Continue implementation of the Mealtime Assistance Program.	Implement Mealtime Assistance Program fully through collaboration of Speech Language Pathologist and Dietician to improve psychosocial and nutritional status of in-patient departments.	Program fully implemented.	100% implementation by June 2018.
							2) Improve awareness and communication of patient experience data in the inpatient departments.	Managers engage staff of feedback received from patients and families regarding their experience through departmental meetings.	Departmental meetings are held bimonthly which includes review of patient experience data.	100% of held departmental meetings have documented review of patient experience data with staff.
Safe	**Medication Safety**	**Increase proportion of patients receiving medication reconciliation upon discharge**	Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion of the total number of patients discharged.	Baseline	90%	Internal Target	1) Review discharge medication reconciliation process and implement computerized medication administration record for reconciliation processes and auditing.	1) Pharmacy and Therapeutics Committee will review discharge medication reconciliation process and implement computerized medication administration records for reconciliation processes and auditing. 2) Education will be provided on process and as part of maintaining compliance with the medication reconciliation process.	Track number of patients who have completed medication reconciliation upon discharge.	90% of patients will have had a completed medication reconciliation upon discharge from hospital.
	Workplace Safety	**Increase the number of reported incidents by improving organizational culture of reporting.**	Number of workplace violence incidents reported by hospital workers within a 12-month period.	15 incidents	>19	Internal Target set to increase reported incidents by 25%	1) Provide staff education and training on workplace violence.	Organizational workplace violence and Code White training: "How empathy and leadership can help deescalate difficult behavioral situations" will be provided to staff and incorporated in to the organization's corporate orientation.	All staff and new hires will be trained in Violence prevention, bullying and harassment.	All staff trained by December 2018.
							2) Perform organizational risk assessment related to workplace violence vulnerabilities.	Current state assessment with program development to address gaps, raise awareness and promote early identification of potentially violent workplace encounters.	a) Organizational risk assessment completed. b) Workplace Violence program developed (code white inclusive). c) Awareness campaign launched for reporting workplace violence. d) Early identification of potentially violent workplace encounters in place.	Initiatives 1-4 implemented by June 2018.
							3) Develop a culture of support.	Develop a culture of support for staff involved in workplace violence by developing a process for debrief and support service/resource coordination.	Formalized post-workplace violence support process implemented.	Program in place by September 2018.

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Timely	**Timely access to care/ services**	**Reduce Emergency Department Length of Stay for Complex Patients**	Total Emergency Department (ED) length of stay (defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ED) where 9 out of 10 complex patients completed their visits.	6.1	8 hours	Provincial & Local Integration Health Network (LHIN) Target outlined within Ministry-LHIN Accountability Agreement (M-LAA).	2) Assess **work** flow in the Emergency Department (E.D.) and at transitions in care.	Improve workflow through conducting process mapping of diagnostic imaging and laboratory processes related to the E.D. to mitigate any potential delays in initiation or result of ordered tests. i.e. Status Boards.	Lean process mapping and corresponding action plans for both departments completed.	Process mapping completed by July 2018.
							2) Assess **patient** flow in the Emergency Department (E.D.) and at transitions in care.	Review responsibilities of the admission/discharge nurse position related to role in patient flow in order to facilitate more efficient and effective transition of care for admitted patients.	Track time between the decision to admit and the time patient left Emergency Department to inpatient bed.	Time from decision to admit to patient leaving Emergency Department to Inpatient bed decreased by 20% (2.8 hours)