Temiskaming Hospital
2019-20 Quality Improvement Plan
Improvement Targets and Initiatives

AIM			MEASURE					CHANGE				
Quality Dimension	**Quality Issue**	**Objective**	**Measure/Indicator**	**Current Performance**	**Target**	**Target Justification**	**Executive Compensation**	**Planned improvement Initiatives (Change Ideas)**	**Methods**	**Process Measures**	**Target for Process Measure**	**Comments**
Effective	**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.	Collecting Baseline	90%	Accreditation Required Organizational Practice (ROP).		1) Implement sustainable discharge medication reconciliation process including computerized medication administration record/ redesigned standard tool for reconciliation processes and auditing.	1) Rollout discharge medication reconciliation process including computerized medication administration record for reconciliation processes.	1) Discharge Medication Reconciliation and cMAR will be fully implemented.	Discharge Medication Reconciliation and cMAR will be fully implemented by September 2019. 90% of patients will have had a completed medication reconciliation upon discharge from hospital.	
									2) Audit / Feedback Program development.	2)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.	
	Effective Transitions from Hospital to Home	**Reduce readmission rates for patients with Mental Health and Addictions**	Rate of mental health and addiction episodes of care that are followed within 30 days by another mental health and addiction admission.	9.72%	<10%	Maintain current performance whilst acknowledging constraints as our organization does not have mental health inpatient beds or a psychiatrist.		1) Improve supports to enable appropriate evidence-based opioid prescribing and management.	1) Implement overdose order set, suboxone order set and naloxone nursing medical directive.	1) Percentage of patients who have presented to the Emergency Department for the treatment of overdose or addictions where the order set/medical directive was initiated.	Initiation of order set/medical directive for 75% of patients who have presented to the Emergency Department for the treatment of overdose or addictions.	
									2) Evaluate and revise (where applicable) current policies, procedures, referrals and resources aligning with priority standards (action plan) from Health Quality Ontario's (HQO's) quality standard.	1) Policies and procedures reviewed and updated to reflect current best practice.	Process measures completed by November 2019.	
		Early Identification: Documented assessment of needs for palliative care patients	Proportion of hospitalizations in the most recent 6 months where patients where identified at risk of dying and in need of palliative care and had documented assessment of their palliative care needs in their hospitalizations records	Collecting Baseline	90%	Internal Target		1) Develop process to identify patients at risk of dying and in need of palliative care.	1) Implement early identification and prognostic indicator guide to provide guidance in order to support earlier identification of patients nearing end of life and could benefit from a palliative care approach.	1) Early identification and prognostic indicator guide implemented into practice.	Early identification and prognostic indicator guide implemented into practice by September, 2019.	Progressive, Life-Limiting Illness: affects a person's health and quality of life, that gets worse over time and can lead to death in the near future. Examples of illness that required a palliative approach to care - cancer, Alzheimer/Dementia disease, heart failure, COPD, kidney disease and the frail elderly.
									2) Ensure patients who were identified at risk of dying and in need of palliative care have a documented assessment of their palliative care needs (i.e. Palliative Performance Scale - PPS; Edmonton Symptom Assessment System - ESAS).	2) Track proportion of hospitalizations in the most recent 6 months where patients where identified at risk of dying and in need of palliative care and had documented assessment (PPS / ESAS) of their palliative care needs.	90% of hospitalizations in the most recent 6 months where patients where identified at risk of dying and in need of palliative care and had documented assessment (PPS / ESAS) of their palliative care needs.	

AIM			MEASURE					CHANGE				
Quality Dimension	Quality Issue	Objective	Measure/Indicator	Current Performance	Target	Target Justification	Executive Compensation	Planned improvement Initiatives (Change Ideas)	Methods	Process Measures	Target for Process Measure	Comments
Efficient	**Access to right level of care**	**Reduce unnecessary time spent in acute and post-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	46.9% (July-September 2018)	12.7%	Provincial & Local Integration Health Network (LHIN) Target outlined within Ministry-LHIN Accountability Agreement (M-LAA).		1) Develop balanced scorecard of top strategies related to ALC avoidance/management.	1) Pilot strategies from the "Right Place of Care Leading Practices and Improvement Strategies for NE LHIN Rural Hospitals" framework that is currently being developed.	1) Strategies piloted on Medical/Surgical and Complex Continuing Care Department.	Process measures completed by March 31, 2020.	
								2) 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) Implement Blaylock Risk Assessment Screen Tool (BRASS) as part of admission process to identify patients who are at high risk for being designated ALC/increased length of stay. (upstream approach) 2) Continue to develop a forum through Rehabilitation/Restorative Care/Complex Discharge Rounds to discuss patients at high risk for ALC designation, barriers to discharge and work with LHIN home and community care to facilitate transition to home or to community beds.	1) Percentage of admissions from Emergency Department and direct admissions (excluding OBS) where the BRASS Screening was completed.	100% of patients admitted (excluding OBS) will have a BRASS Screening completed.	
								3) Embed evidence-based practices that actively mitigate the risk of deconditioning/functional decline and support optimal outcomes for seniors while in hospital.	1) Early Mobilization Initiative: As part of Temiskaming Hospital's Senior Friendly Hospital framework roll-out the Mobiliztion of Vulnerable Elders (MOVE) program that has been developed.	1) Percentage of patients who have a mobility status assessment completed will have an accompanying mobility plan of care.	100% of patients who have a mobility status assessment completed will have an accompanying mobility plan of care.	
		Decrease the number of inpatients receiving care in unconventional spaces	Average number of inpatients receiving care in unconventional spaces per day	0.1%	<0.1%	Internal Target		1) Keeping the patient at the center of their discharge plan while improving bed utilization processes, review Estimated Lengths of Stay (ELOS) for medical/surgical department inpatients.	1) Review Estimated Lengths of Stay/Actual Lengths of Stay (HIG Ratio) of top 20 HIGs at Medical Services Committee on regular basis to identify conditions where there is opportunity for improvement.	1) Track number of reports on Estimated Lengths of Stay/Actual Lengths of Stay (HIG Ratio) of top 20 HIGs that are presented at Medical Services Committee.	On a quarterly basis, reports on Estimated Lengths of Stay/Actual Lengths of Stay (HIG Ratio) of top 20 HIGs are presented at Medical Services Committee.	
									2) Review process of standardizing an Estimated Lengths of Stay and communicating Estimated Lengths of Stay to patients and families.	2) Track review milestones.	Milestones completed by March 31, 2020.	

AIM			MEASURE					CHANGE				
Quality Dimension	**Quality Issue**	**Objective**	**Measure/Indicator**	**Current Performance**	**Target**	**Target Justification**	**Executive Compensation**	**Planned improvement Initiatives (Change Ideas)**	**Methods**	**Process Measures**	**Target for Process Measure**	**Comments**
Patient-centered	**Person Experience** / **Effective Transitions from Hospital to Home**	**Ensure adequate information at discharge**	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?	96%	98%	Internal Target set 2% higher than previous year to ensure improvement.		1) Improve discharge patient information in Obstetrical Department.	1) Monitor implementation of Patient Oriented Discharge Summaries (PODS) in the obstetrical department.	1) Track percentage of patients who have had a PODS tool completed on discharge.	100% of patient discharged from the obstetrical department will have a PODS tool completed.	
								2) Review and refresh of Patient Whiteboard communication tools on inpatient units.	2) In collaboration with patients and families, a redesign of patient whiteboards will be completed to enhance communication between patients, families and providers. A working group will be established.	2) Audit of completion rates for admitted patients on a weekly basis. Education for providers on how to utilize the whiteboard.	90% of patients will have their whiteboard up-to-date/completed.	
								3) Revise Inpatient Experience Survey.	3) Implement revised inpatient experience survey including process to collate data as part of the linking quality to funding initiative.	3) Track revision and implementation of inpatient experience survey will be revised and implemented.	Process completed by April 30, 2019.	
								4) Improve patient health information materials provided on discharge and discharge telephone phone call process for COPD and CHF care pathways.	4) Review current discharge information to align with best practices/QBP handbook and discharge follow-up phone call implementation including documentation, consistency and value/feedback.	4) Track revision of COPD and CHF patient health information materials and percentage of patients with diagnosis of COPD or CHF who received a follow-up phone call within 24-72 hours of discharge by the registered Respiratory Therapist.	100% of patient health information materials related to COPD and CHF will be reviewed. 80% of patients identified will have a follow-up phone call within 24-72 hours of discharge.	
	Person Experience	**Ensure complaints acknowledged in a timely manner**	Percentage of complaints received by the hospital that were formally acknowledged to the individual who made a complaint within 5 business days.	100%	100%	Internal Target - aligned with regulatory requirement 188/15; and expanding current process		1) Commit to responding to complaints/concerns within 5 business days.	1) Expand the current monitoring and tracking process of the complaint acknowledgement time to include those beyond the patient relations office.	1) Percentage of complaints received by the hospital that were formally acknowledged to the individual who made a complaint within 5 business days.	100% of complaints received by the hospital were formally acknowledged to the individual who made a complaint within 5 business days.	Exclusions are complaints which are not documented through the organizations complaints process, complaints resolved immediately, or complaint did not require any added intervention. Repeated complaints (same individual/same complaint) and complaints that involved numerous issues will be tracked as one complaint.
									2) Provide leadership team with education and associated resources to adequately respond to complaints in a timely manner.	2) Leadership team provided with education and associated resources.	Completed by April 30, 2019.	

AIM			MEASURE					CHANGE				
Quality Dimension	**Quality Issue**	**Objective**	**Measure/Indicator**	**Current Performance**	**Target**	**Target Justification**	**Executive Compensation**	**Planned improvement Initiatives (Change Ideas)**	**Methods**	**Process Measures**	**Target for Process Measure**	**Comments**
Safe	**Workplace Safety**	**Decrease the number of workplace violence incidents.**	Number of workplace violence incidents reported by hospital workers within a 12-month period.	42	<31	Internal Target; Reduce by 25%		1) Continue to provide staff education and training on workplace violence.	1) 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.	1) All staff and new hires will be trained in Violence prevention, bullying and harassment.	All staff trained by March 31, 2020.	
								2) Implement organizational risk assessment items related to workplace violence vulnerabilities.	2) Continue to review current state assessment with program development to address gaps, raise awareness and promote early identification of potentially violent workplace encounters.	2) Track organizational risk assessment action plan implementation.	Initiatives 1-4 implemented by September 2019.	
								3) Promote early identification of potentially violent workplace encounters.	3) Implement flagging process to identify patients that have had a previous incident of violent behaviour and are at risk of harming other patients or staff.	3) Policy and flagging procedure for registration created with training to all staff.	Initiatives implemented by March 31, 2020.	
								4) Organizational change to promote staff safety.	4) Code Silver, Code Black, Code White and Code Purple policies and processes will be reviewed/revised with training/mock codes completed with staff.	4) Track completion of code reviews and mock exercises.	Initiatives implemented by March 31, 2020.	
Timely	**Timely access to care/ services**	**Reduce Emergency Department wait time for inpatient bed**	90th percentile: Internal 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	3.69 Hours Nov YTD / (3.12 2017/18)	<3.7 Hours	Internal Target; Maintain/Improve current performance		1) Assess **patient** and **work** flow in the Emergency Department (E.D.) when a patient has been determined to be admitted.	1) Review responsibilities of the admission process related to roles in patient flow in order to facilitate more efficient and effective transition of care for admitted patients.	1) 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% (<3.7 hours).	
								2) Assess documentation and assessments completed during the admission process to ensure Value-Added approach to care planning.	2) Review needed documentation vs duplicated documentation. (I.e. Medication Reconciliation, assessment tools).	2) Track time needed to complete current documentation and assessments and assess which processes are duplicated and which have added value for patient care planning.	Reduce redundancies and time required to process admissions by 10%.	
		Ensure discharge summaries sent from hospital to community care provider within 48 hours of discharge	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	75%	90%	Internal Target		1) Improve turnaround time of dictation/transcription.	1) Assess front-end dictation Voice Recognition solution/pilot project.	1) Assess turnaround time for discharge summary completion before/after voice recognition.	Completed by March 31, 2020.	Capital Investment/ Physician Training Required
								2) Monitor discharge summary 48 hour turn around time, reporting on relevant time intervals which includes discharge to dictation, dictation to transcription and transcription to delivered time.	2) Conduct monthly audits with review by leadership team and Medical Advisory Committee.	2) 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 3) Turnaround time from patient discharge to dictation and dictation to Transcription will be tracked	90% ofdischarge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital.	