Temiskaming Hospital
2021-22 Quality Improvement Plan (2020-21 Extended)
Improvement Targets and Initiatives

AIM			MEASURE						CHANGE				
Quality Dimension	Quality Issue	Objective	Measure/Indicator	Current Performance	Target 2021/22	2020-21 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**	Measures the total number of discharged patients for whom a Best Possible Medication Discharge Plan (BPMDP) was created as a proportion of the total number of patients discharged.	74%	80%	80%	Accreditation Required Organizational Practice (ROP).		1) Evaluation of discharge medication reconciliation process including printed physician medication reconciliation record at discharge	2) Refine audit/feedback tools for regular reporting. 2) Establish feedback tools to Professional Staff for regular performance updates and opportunities for further improvements toward compliance	2) Track number of patients who have completed medication reconciliation upon discharge. 2) Provides regular reports to Quality, Medical Audit, Tissue and Transfusion Committee, Medical Advisory Committee and Professional Staff Association	80% of patients will have had a completed medication reconciliation upon discharge from hospital.	
	Effective Transitions from Hospital to Home	**Reduce Repeat Emergency Department Revisits for patients with Mental Health Conditions**	Percentage of unscheduled repeat emergency visits for a mental health condition within 30 days following an emergency visit for a mental health condition.	28.1%	25.29%	36.50%	Internal Target 10% reduction		1) Improve collaborative efforts to ensure patients receive care in the most appropriate setting; ED diversion.	1) Continue to collaborate with Canadian Mental Health Association (CMHA) to sustain Integrated Mental Health and Addictions Navigator and facilitate a proactive joint response between CMHA and OPP, to divert ED visits, as safe and appropriate.	1) Track percentage of patients who were seen by the Mental Health and Addictions Navigator during a Emergency Department visit where an subsequent unscheduled repeat emergency visit followed.	<50% of patients who were seen by the Mental Health and Addictions Navigator during a Emergency Department visit will have a subsequent unscheduled repeat emergency visit within 30 days.	Collaborative Metric with Canadian Mental Health Association (CMHA)
	Palliative Care Early Identification Assessment	**Ensure documented assessment of palliative care needs among patients identified to benefit from Palliative Care.**	Measures the 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.	100%	>90%	80%	Internal Target		1) Develop process to identify patients with a progressive, life-limiting illness who are identified to benefit from palliative care have their palliative care needs assessed using a comprehensive and holistic assessment.	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. 2) Ensure patients with a progressive, life-limiting illness who were identified to benefit from palliative care have a documented assessment of their palliative care needs (i.e. Palliative Performance Scale - PPS; Edmonton Symptom Assessment System - ESAS). - Monitoring Change Idea (2019/20 implementation of assessments on order sets)	1) Early identification and prognostic indicator guide implemented into practice. 2) Track proportion of hospitalizations where patients with a progressive, life-limiting illness identified to benefit from palliative care had their palliative care needs assessed (PPS / ESAS)	Early identification and prognostic indicator guide implemented into practice by December, 2021. 90% of hospitalizations where patients with a progressive, life-limiting illness identified to benefit from palliative care had their palliative care needs assessed (PPS / ESAS)	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.

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Efficient	**Access to right level of care**	**Reduce unnecessary time spent in acute and post-acute care**	Measures the 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.	57.7%	54.8%	45%	Provincial & Local Integration Health Network (LHIN) Target outlined within Ministry-LHIN Accountability Agreement (M-LAA). Target - 12.5% 5% Reduction		1) 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) Implementation of standardized ALC/Complex Discharge rounds tool to identify barriers to discharge for patients with complex issues and action planning for discharge from hospital.	1) Conduct complex discharge rounds with hospital team, social work, and North East LHIN home and community care coordinators utilizing tool to identify barriers to discharge for patients with complex issues. Address barriers to discharge daily at the patient level with integrated care team. For community barriers identified, conduct timely discharge planning meetings with other community support services and community providers. as appropriate.	Standardized tool and barrier action planning will be implemented by September 2021.	
										2) Provide education on Blaylock Risk Assessment Screen Tool (BRASS) utilized as part of admission process to identify patients who are at high risk for being designated ALC/increased length of stay. (upstream approach)	2) Percentage of admissions from Emergency Department and direct admissions (excluding OBS) where the BRASS Screening was completed.	90% of patients admitted (excluding OBS) will have a BRASS Screening completed.	
		Decrease the number of inpatients receiving care in unconventional spaces	Average number of inpatients receiving care in unconventional spaces per day	Collecting Baseline*	Collecting Baseline*	Collecting Baseline*	Internal Target:		1) Keeping the patient at the center of their discharge plan while improving bed utilization processes, review Estimated Lengths of Stay (ELOS) initiative with focus on Medical/Surgical Department.	1) Implementation of Medical Services Committee scorecard to include Estimated Lengths of Stay/Actual Lengths of Stay of top 20 diagnoses with focus on identification of conditions where opportunity exist for care pathway improvement. (Development of Care Flowsheet/Pathway for Top 5 diagnoses).	1) Track number of reports on Estimated Lengths of Stay/Actual Lengths of Stay (HIG Ratio) of top 20 HIGs presented to Medical Services Committee. Care Pathways/Flowsheets will be implemented for Top 5 Diagnoses	On a quarterly basis, reports on Estimated Lengths of Stay/Actual Lengths of Stay (HIG Ratio) of top 20 HIGs will be presented at Medical Services Committee. Three care pathways/flow sheets will be implemented by March 31, 2021.	Indicator under revision with Ministry of Health to develop a measure that better reflects this issue. Recommended to select CB (Collecting Baseline).
										2) Establish process for communicating estimated length of stay to patients, families and the health care team.	2) Establish working to develop and implement process on Medical Surgical Department	By December 31 2021, process for communicating estimated length of stay to patients, families and the health care team	
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?	100%	≥95%	≥95%	Internal Target: Focus on maintaining performance		1) Improve discharge patient information.	1) Monitor implementation of Patient Oriented Discharge Summaries (PODS) in the Obstetrical and Medical/Surgical/Complex Continuing Care departments.	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)Improve communication strategies and information transfer with patients and families during hospital stay (i.e. goals of care, estimated length of stay etc.)	2) In collaboration with patients and families, a redesign of patient whiteboards will be completed to enhance communication between patients, families and providers through working group.	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) Standardize discharge process (template checklist and patient materials) of in-patients on medical surgical department focusing on the patients transition needs. (This includes patients receiving written information)	3) Working group to conduct current state analysis, identify areas for improvement, develop action plan and implementation/communication, involving patients and families in co-design.	3) Track project milestones completed	By December 2021, revised discharge process/materials will be implemented.	
	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%	100%	Current performance is meeting target. No improvements are required to maintain performance at target		Current performance is meeting target. No improvements are required to maintain performance at target	N/A	N/A	N/A	

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Safe	**Workplace Safety**	**Decrease the number of workplace violence incidents.**	Number of workplace violence incidents reported by hospital workers within a 12-month period. For quality improvement purposes, hospitals are asked to collect data on the number of violent incidents reported by workers, including physicians and those who are contracted by other employers (e.g., food services, security, etc.) as defined by the Occupational Health and Safety Act.	27	<27	<30	Accreditation Required Organizational Practice (ROP).		1) Continue to provide staff education and training on workplace violence.	1) Organizational workplace violence and Code White training: 'Non Violent Crisis Intervention' training for all staff.	1) All applicable staff and new hires will be trained in Violence prevention, bullying and harassment.	Staff training completed by March 31, 2021.	
									2) Implement organizational risk assessment focusing on 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 and action plan completion	Risks Assessments with Action Plans to be completed by October 31, 2021	
									3) Early identification of potentially violent workplace encounters - 'Alert for Behavioral Care'	3) Continue to work on implementation flagging process to identify patients that have had a previous incident of violent behaviour and are at risk of harming other patients or staff. Standardized 'Alert for Behavioral Care' screen for all patients with appropriate flagging system within Meditech and Call System.	3) Policy and flagging procedure created with education to applicable staff. Patients both in the emergency and inpatient departments screened for violence.	Go-Live by October 31, 2021	When 'Alert for Behavioral Care' screen is positive it will link to a mandatory intervention in Meditech.
									4) Improve patient and nursing staff communication systems including safety safeguards	4) Complete Risk assessment to review opportunities to expand the use of two-way communication badges (Vocera) within current system and with purchasing of additional licenses.	4) Complete Risk assessment to review opportunities to expand the use of two-way communication badges (Vocera) within current system and with purchasing of additional licenses.	Gap Analysis to be completed by October 31, 2021	
Timely	**Timely access to care/ services**	**Reduce Emergency Department wait time for inpatient bed**	90th percentile: 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	3.8	≤4 hours	≤4 hours	Internal Target: Maintain/Improve current performance		1) Standardize admission process, reviewing patient/staff work flows for an admission.	1) Complete Value Stream Mapping Event and review of current assessment/ documentation requirements, involving patients and families in co-design.	1) Engaging front-line staff in meetings to identify and address barriers and challenges to patient flow and opportunities for streamlined and standardized admission process.	Key barriers and challenges identified and action plan developed by November 2021.	
									2) Collaborative team approach to improving current bed management processes.	2) Implementation of critical overload response and patient flow procedures including NOW (no one waits) initiative to improve patient flow to inpatient departments following a decision to admit. Review current admission ordering practices in ED. Define trigger for approaching max target to admission time	2) Track project milestones completed	By November 2021, critical overload and improved patient flow processes will be reviewed with improvements identified implemented.	
		Ensure discharge summaries sent from hospital to community care provider within 48 hours of discharge	Measures the percentage of patients discharged from hospital for which discharge summaries are delivered to their primary care provider within 48 hours of patient's discharge from hospital.	82%	86%	82%	Internal Target Year 2 - 82% Year 3 - 86% Year 4 - 90%		1) 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.	1) Ensure quarterly audits are reviewed by leadership team, Medical Advisory Committee and Quality of Care/Medical Audit Committee.	1) Track and communicate performance of the 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.	90% of discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital.	
											2) Track turnaround times from patient discharge to dictation and dictation to transcription.		