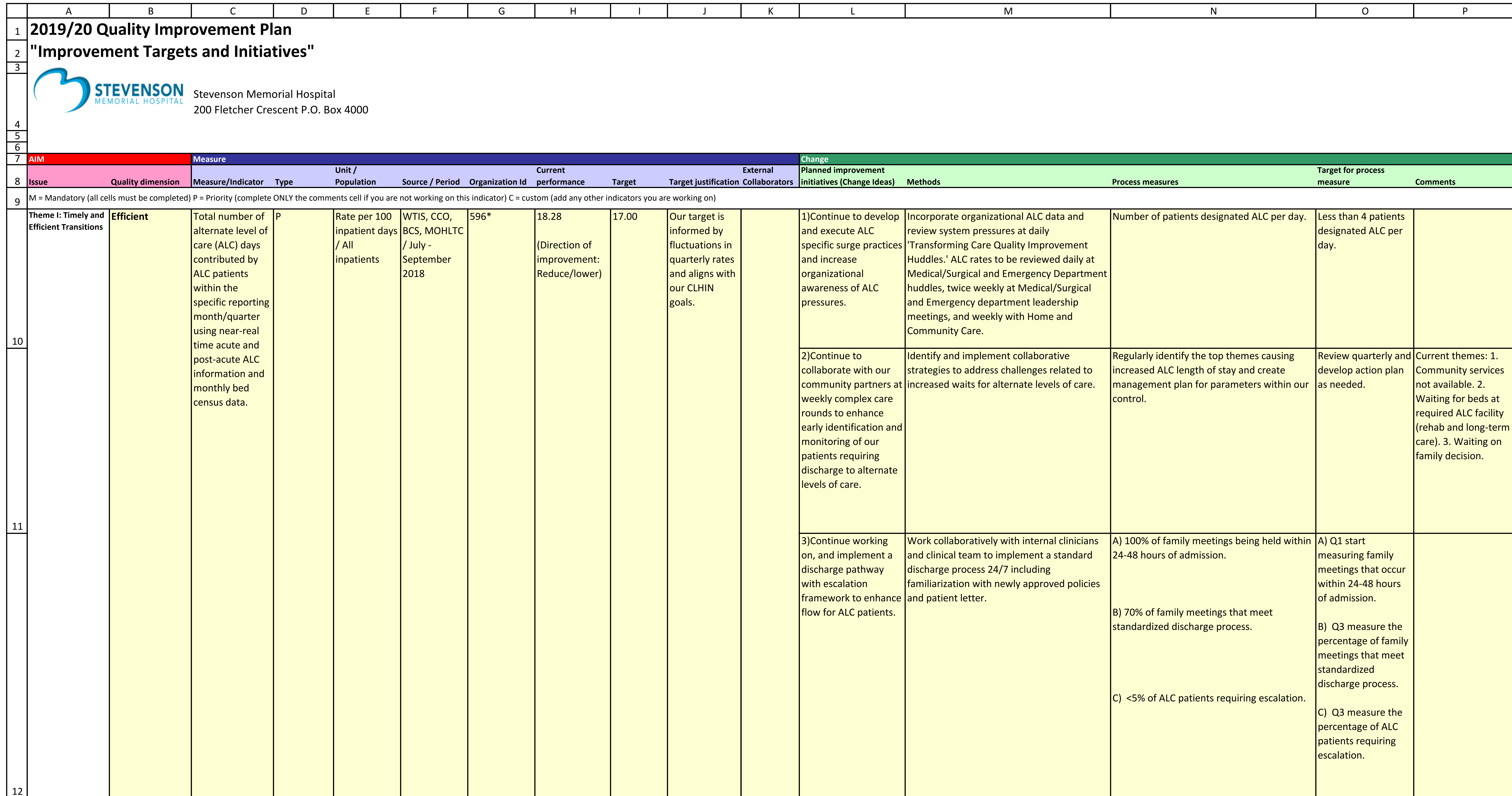
2019/20 Quality Improvement Plan
"Improvement Targets and Initiatives"



Stevenson Memorial Hospital
200 Fletcher Crescent P.O. Box 4000

AIM		Measure									Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	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.	P	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July - September 2018	596*	18.28 (Direction of improvement: Reduce/lower)	17.00	Our target is informed by fluctuations in quarterly rates and aligns with our CLHIN goals.		1)Continue to develop and execute ALC specific surge practices and increase organizational awareness of ALC pressures.	Incorporate organizational ALC data and review system pressures at daily 'Transforming Care Quality Improvement Huddles.' ALC rates to be reviewed daily at Medical/Surgical and Emergency Department huddles, twice weekly at Medical/Surgical and Emergency department leadership meetings, and weekly with Home and Community Care.	Number of patients designated ALC per day.	Less than 4 patients designated ALC per day.	
											2)Continue to collaborate with our community partners at weekly complex care rounds to enhance early identification and monitoring of our patients requiring discharge to alternate levels of care.	Identify and implement collaborative strategies to address challenges related to increased waits for alternate levels of care.	Regularly identify the top themes causing increased ALC length of stay and create management plan for parameters within our control.	Review quarterly and develop action plan as needed.	Current themes: 1. Community services not available. 2. Waiting for beds at required ALC facility (rehab and long-term care). 3. Waiting on family decision.
											3)Continue working on, and implement a discharge pathway with escalation framework to enhance flow for ALC patients.	Work collaboratively with internal clinicians and clinical team to implement a standard discharge process 24/7 including familiarization with newly approved policies and patient letter.	A) 100% of family meetings being held within 24-48 hours of admission. B) 70% of family meetings that meet standardized discharge process. C) <5% of ALC patients requiring escalation.	A) Q1 start measuring family meetings that occur within 24-48 hours of admission. B) Q3 measure the percentage of family meetings that meet standardized discharge process. C) Q3 measure the percentage of ALC patients requiring escalation.	

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
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13		Timely	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.	P	% / Discharged patients	Hospital collected data / Most recent 3 month period	596*	CB (Direction of improvement: Increase/ higher)	CB	For appropriate care to be provided and the plan of care to be continued, follow-up in the community is a necessity which requires access to the discharge summary within 48 hours.		1)Add three questions to 3M coded data allowing collection of baseline data: A) Was the discharge summary completed? B) Did the primary care provider receive it within 48hrs? C) If primary MD did not receive it in 48 hours, why?	HIS team lead to work with '3M' to add required fields to the database. Train/educate staff on the addition of data being collected.	100 % of staff educated on data required when coding charts.	Q2 All fields to be added and staff educated on collecting the data.	
14												2)Collect and analyze the top three reasons why primary care providers have not received discharge summaries within 48hrs.	Create process for pulling report of data collected, with a focus on 'If primary care provider did not receive discharge summary within 48hrs, why?'. Analyze top three reasons and make an action plan accordingly.	A) Three clear reasons for primary care providers not recieving discharge summaries defined. B) Action plans developed to solve the clearly defined problems.	A) Q3 Clear reasons for not receiving discharge summaries identified and defined. B) Q4 Action plan with timelines to solve the identified reasons developed.	
15			**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.**	**MANDATORY**	**Hours / All patients**	**CIHI NACRS / October 2018 – December 2018**	**596***	**7.43** **(Direction of improvement: Reduce/ lower)**	**6.5**	**Quality care for our patients. Right patient, right bed, right time.** **(Data received from Cancer Care Ontario)**		**1)Initiate standardized admission process 24/7.**	**Educate staff on standardized admission process.**	**A) Number of staff educated on standardized admission process.** **B) Percentage of admitted patients where admission was done according to standard process.**	**A) Q3** **B) Q3 and Q4**	
16												**2)We will track system flow through the use of our daily monitoring tool(DART) in unit-level performance huddles, discharge rounds, and daily bed meetings and will increase data review at program and leadership level.**	**Engaging front-line staff in blended Emergency and Medical/Surgical quality meetings to identify and address barriers and challenges to patient flow. Daily monitoring of patient flow metrics in relation to targets.**	**A) Data updated on huddle boards regularly.** **B) Minutes reported to board from blended emergency/medicine quality meeting.** **C) Key barriers and challenges identified and action plan developed.**	**A) Q1** **B) Q1** **C) Q2**	

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17	**Theme II: Service Excellence**	**Patient-centered**	Percentage of complaints acknowledged to the individual who made a complaint within five business days.	P	% / All patients	Local data collection / Most recent 12 month period	596*	CB (Direction of improvement: Increase/ higher)	CB	Mandated in our policy and procedure to respond within 48 hours with hopeful resolution in two weeks. Extenuating circumstances may take longer with notification of the individuals involved.		1)Staff education.	Patient experience conference or like education.	Completion of education.	Q4	
18												2)Develop and implement a clear process for processing patient experience complaints.	Present developed process flow map to leadership for feedback and change process as needed for ease of use. Update policy and procedures as required.	A) Number of policies and procedures updated. B) Number of chart reviews and recommendations being tracked with patient experience process where acknowledgement has occurred within 5 business days.	A) 100% completed by Q4. B) Baseline % of chart reviews and resulting recommendations being tracked though process by Q2.	
19			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?	P	% / Survey respondents	CIHI CPES / Most recent consecutive 12-month period	596*	61.39 (Direction of improvement: Increase/ higher)	65.00	Patient satisfaction and knowledge transfer.		1)Standardize the discharge process of in-patients on all units throughout the hospital. (This includes patients receiving written information and follow-up post discharge.)	A) Develop and implement a standardized discharge process. B) Discharge phone calls to be completed with the standard operating procedure already in place. C) Printable discharge form to be developed, approved, and created in Meditech.	A) Number of staff trained on standardized discharge process. B) Number of discharge phone calls completed. C) Discharge form accessible in Meditech and the number of patients that receive form at discharge.	A) 80% of staff trained by Q3. B) 15 calls per month starting Q1. C) Q2 discharge form accessible via Meditech. Q3/Q4 printable discharge form used for 70 % of discharges.	

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20	**Theme III: Safe and Effective Care**	**Effective**	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.	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / October - December 2018	596*	66.26 (Q2 2018/19) (Direction of improvement: Increase/ higher)	72	We are expanding to include patients on our obstetrical and surgical unit.		1)We are expanding to include patients on our Obstetrical unit, Surgical unit, and patients in medical overflow beds on the Obstetrical unit.	Train the staff on the standardized process already implemented on the medical unit.	Number of patients discharged with a completed medication reconciliation form.	Q3 80% of staff trained in standardized discharge process. Q4 70% of patients discharged with medication reconciliation form completed.	
21		**Safe**	**Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.**	**M A N D A T O R Y**	**Count / Worker**	**Local data collection / January - December 2018**	**596***	**10** **(Direction of improvement: Increase/ higher)**	**13**	**Increased reporting of incidents inline with HRO standards. Staff to demonstrate understanding of a violent incident through reporting of no-harm and harm events.**		**1)Install a new call bell system equipped with a Code White function and develop new violence policy with signage. Policy to include mandatory 'None Violent Crisis Intervention' training for all staff interacting with patients.**	**Mandatory Code White training of the new system. Attendance in the 'None Violent Crisis Intervention' training course.**	**A) Staff education of new call system.** **B) Violence policy updated and rolled out with emphasis on reporting incidents.** **C) Attendance in the 'Non Violent Crisis Intervention' course.**	**A) 80% by Q2** **B) Q2** **c) 80% by Q4**	
22												**2) Standardized 'Alert for Behavioral Care' screen for all patients with appropriate flagging system within Meditech.**	**When 'Alert for Behavioral Care' screen is positive it will link to a mandatory intervention in Meditech.**	**90% of patients both in the emergency and inpatient departments screened for violence.**	**Quarterly**	