2016/17 Quality Improvement Plan
"Improvement Targets and Initiatives"

Niagara Health System
Système De Santé De Niagara

Niagara Health System, 1200 Fourth Avenue

AIM		Measure							Change				
Quality dimension	**Objective**	**Measure/Indicator**	**Unit / Population**	**Source / Period**	**Organization Id**	**Current performance**	**Target**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	Methods	Process measures	Goal for change ideas	Comments
Safe	**Avoid patient falls**	Percent of complex continuing care (CCC) residents who fell in the last 30 days.	% / Complex continuing care residents	CCRS, CIHI (eReports) / July – Sept 2015 (Q2 FY 2015/16 report)	962*	12.08	10.00	To align with LHIN average	1)Complex Care Clinical Protocol/Nursing Plan of Care: Falls Prevention	Develop and implement a Clinical Protocol that incorporates the NHS Falls Prevention Strategies & RNAO Best Practice Guidelines (BPG) for Falls Prevention	# Falls per unit per month	Reduction of Program falls by 2.1%	Reviewing current screening tools and processes Integrating Senior Friendly concepts &interventions into plan PEEK In hourly –initiative under discussion Post Fall Assessment tool to be adopted if approved by Falls Steering Committee
									2)Introduce Serious Injury Risk Screening and intervention concepts	Develop and implement a Clinical Protocol that incorporates the NHS Falls Prevention Strategies & RNAO BPG for Falls Prevention	# of serious injury Falls	Reduction of Program falls by 2.1%	Reviewing current screening tools and processes Integrating Senior Friendly concepts &interventions into plan PEEK In hourly –initiative under discussion Post Fall Assessment tool to be adopted if approved by Falls Steering Committee
		Acute inpatient falls per 1,000 acute inpatient days (harm level 3-6)	Rate per 1,000 / All acute patients	NHS Incident Reporting System / January - December	962*	1.77	1.69	A 5% improvement from 2015 baseline data.	1)Maintain standard that Falls Risk Assessment and Intervention Tool (FRAT) completed within 24 hours of admission	Regular FRAT audits to be completed (awaiting development of electronic audit tool)	Percentage of patients with a completed FRAT assessment within 24 hours of admission	Target of 100% of patients with a completed FRAT assessment within 24 hours of admission	
									2)Medicine Program- focus on reducing the average number of falls per month and reducing the severity of all fall incidents to L3 or less (Quality & Safety priority)	Metrics posted on unit Quality Boards and addressed at daily huddles. Monthly dashboard reviewed at Program Leadership	Case Debriefs – all high level falls reviewed through Reflective Reviews –recommendations to Falls Steering	Target of 100% of all high harm level falls reviewed	
									3)Work with Professional Practice to identify improvement opportunities related to: •Delirium Screening Tools •Use of Foley Catheters •Restraint Use •Medication Practices	Biweekly Falls Prevention Steering Committee meetings. Develop subgroups to facilitate: •Delirium Screening Tool •Strategy to ensure appropriate use of foley catheters •Least Restraint policy – plan for implementation •Review of frequently used medications associated with increased risk of falls (4 drug classes)			
									4)Maintain standard that Falls Risk Assessment and Intervention Tool (FRAT) completed within 24 hours of admission	Regular FRAT audits to be completed (awaiting development of electronic audit tool)	Percentage of patients with a completed FRAT assessment within 24 hours of admission	Target of 100% of patients with a completed FRAT assessment within 24 hours of admission	

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Safe cont'd	**Increase proportion of patients receiving medication reconciliation upon admission**	Medication reconciliation at admission: The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital	% / All patients	Hospital collected data / most recent quarter available	962*	12.6	43.40	To achieve a 90% compliance rate based on 48% of admissions	1)Introduce Pharmacy Technicians into ED for purposes of Best Possible Medication History (BPMH) gathering and documentation as per budget allocation	MedRec Pharmacist certifying technicians to include competency validation	% of existing technicians (by site) certified in BPMH gathering and documentation	Initial goal: 4 certified technicians for each of GNG and WHS; 6-7 technicians at SCS	Final goal is that all staff technicians are certified
									2)MedRec Quality audits with feedback to programs	MedRec Pharmacist validates BPMHs to identify quality issues	# of quality audits (10-20 per program per month)	Improved quality audit results Improved communication with programs	Pro-active approach to validating quality of information and documentation accuracy
									3)Introduction of BPMH process in surgical program	Standard BPMH process and form introduced into existing surgical processes. Staff education.	Review existing home medication documentation sources and change to use BPMH form. % of surgical staff completing MedRec education.	All existing home medication documentation refers to the BPMH. 95 % compliance by April 2016.	
	Reduce hospital acquired infection rates	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI during the reporting period, divided by the number of patient days in the reporting period, multiplied by 1,000.	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / January 2015 – December 2015	962*	0.45	0.41	To achieve a 10% reduction	1)Root cause analysis of all Hospital Acquired Iinfection (HAI) CDI cases	HAI CDI critical incident debrief process for all HAI CDI cases	# of HAI CDI cases reviewed	Initiate HAI CDI critical incident debrief process by March 31, 2016. Develop process improvements based on the root cause analysis data	
									2)Continue to provide appropriate cleaning practices using cleaning agents that provide Sporicidal properties to reduce hospital acquired CDI infection rates, train and audit performance of Support and Clinical Staff through improved cleaning audit compliance and awareness to changes in process.	Verification and posting to SourceNet of site and unit specific audits: •Observational •ATP •Dye marker	Cleaning audit compliance New cleaning process for non- support staff	Total cleaning audit compliance to NHS established results Observational = > 85% ATP = 90%	Senior Team and IPAC support will be needed as new non-support and Clinical process are rolled out to reduce hospital acquired CDI infection rates
									3)Antimicrobial stewardship interventions to optimize antimicrobial use	Continue prospective audit or antimicrobial use and provide consultation and feedback to prescribers Continue to participate in order set review and development where antimicrobial therapy is required Promote use of ASP antimicrobial handbook	Broad-spectrum antimicrobial use (measured in DDD (defined daily dose)/1000 patient days	Continue to optimize antimicrobial use	
									4)Collect baseline data for proton pump inhibitor (PPI) use	Infection Prevention and Control (IPAC) team to identify a way to collect and prospectively track/audit utilization of PPIs	Have baseline data for 2016/2017 on PPI use to identify potential next steps for 2017/2018 QIP	Baseline data/audit data collected and analyzed by December 31, 2016	
									5)Improve hand hygiene compliance to moment #1- before patient/patient environment contact	Staff and patient awareness campaign	Hand Hygiene audit results for moment #1 reported on unit specific IPAC scorecard	To strive for the stretch target of 100% HH compliance at moment 1 before patient/patient environment contact	

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Timely	Reduce wait times in the ED	ED Wait times: 90th percentile ED length of stay for Admitted patients.	Hours / ED patients	CCO iPort Access / January 2015 - December 2015	962*	41	28.00	To align with HSAA target.	1)Implementation of Timed Up and Go initiative in ED.	Implement a standardized testing tool for front line ED staff to assess mobility and discharge safety. Educate staff on the tool.	Number of patients with completed testing. Number of ANB patients discharged from ED.	Provide staff with a validated tool to assess patient mobility and discharge safety. Reduce OT & PT referrals from ED for mobility assessment.	
									2)Develop discharge criteria to be used on medical units to determine readiness for discharge.	Develop, review and implement standardized medical unit discharge criteria.	Proportion of patients discharged before 1100. Increase portion of predicted/actual discharges.	Improve teams ability to predict discharges through “day ahead” strategy.	
									3)Develop Quick Response Team (QRT) in ED.	Identify roles, responsibilities, processes and tools for a rapid response team to admit avoid in ED.	Number of completed QRT assessments in ED. Number of patients identified as “admission avoided”.	Variability in discharges directly from ED due to non-standardized work. Opportunity identified to influence the admission rate for patients who could likely be discharged and supported in the community.	
									4)Systemic approach and implementation of “Estimated Date of Discharge (EDD)” tactic.	Establish a commitment to consistent process and expectations regarding all aspects of EDD identification, monitoring and actions.	% of patients with recorded EDD. % of patients with EDD established within 48 hours of admission.	Opportunity identified to develop a standardized process and responsibility for setting and monitoring EDD.	