2018/19 Quality Improvement Plan
"Improvement Targets and Initiatives"

niagarahealth
Extraordinary Caring. Every Person. Every Time.

Niagara Health System 1200 Fourth Ave

AIM		Measure								Change				
Quality dimension	Issue	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	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) A= Additional (do not select from drop down menu if you are not working on this indicator) C = custom (add any other indicators you are working on)														
Effective	**Effective transitions**	Rate of psychiatric (mental health and addictions) discharges that are followed within 30 days by another mental health an addictions admission to a Niagara Health site.	C	Rate per 100 discharges / Discharged patients with mental health & addiction	CIHI DAD,CIHI OHMRS,MOHTLC RPDB / January-December 2017	962*	Proxy 12.3%	Proxy 9.8	Maintain 2017/18 target as move towards benchmark	Expand Rapid Access Addictions Medicine (RAAM) clinic	1. Addition of FT NP to augment SCS coverage to 5 days per week 2. Introduction of RAAM at WHS and GNG 3. Addition of BSW position for patient support and ensuring linkages with other supports/services 4. Recruitment of additional Addictions Medicine physician underway	Time from referral to initiation of service	90% of patients seen within 3 days of referral	
										Introduce weekly report that identifies emerging need(s) clients according to 3 ED visits and 1 inpatient admission	1. Designated IMPACT team staff will connect with identified clients to identify the reason(s) for the ED visits/readmission 2. A collaborative plan of care will be developed that addresses the identified need(s) 3. Clients will be linked with appropriate follow-up resources/services as required 4. Services will be coordinated as per the Health Links Model	Monitoring of readmission rates	5% reduction	
										Introduce NP urgent access stream within IMPACT team	1. Promoting ED physician referrals for clients who are coming back to the ED 2. The goal is for NPs to see clients within 5 business days 3. Coordination of care and engagement of other services/supports to avoid repeat ED visits and readmissions to hospital	Monitoring urgent access capacity on an ongoing basis	90% of patients seen within 3 days of referral from ED	
										Brief Intervention Psychotherapy Team	1) This team will use an evidence-informed psychotherapy model to work with clients who are frequenting ED with readmissions to the MH program 2. The intent of the intervention is to help the client work through issues and arrive at the underlying reason for ED visits/readmissions	Monitoring of readmission rates	5% reduction	
	Wound Care	Percentage of patients receiving complex continuing care with a newly occurring Stage 2 or higher pressure ulcer in the last three months.	A	% / Complex continuing care patients	CIHI CCRS / July - September 2017	962*	7.89%	7.50%	5% improvement on current results as move towards benchmark	Monitor compliance of turning and repositioning process/forms completed	Develop audit tool. Complete quarterly audits of 10 charts across the Complex Care Program.	Record audit results and report compliance of documentation. Provide real time feedback (positive and negative) to the assigned staff and Clinical Manager on unit.	100% compliance for 10 charts audits	
										Monitor Braden Assessment compliance as per policy	Develop audit tool. Complete quarterly audits of 10 charts across the Complex Care Program.	Record audit results and report compliance of documentation. Provide real time feedback (positive and negative) to the assigned staff and Clinical Manager on unit.	100% compliance of charts audited	
										Standardize wound care products and develop a standardized process/algorithm for bed and surface rentals.	Coordinate an audit to of current wound care product usage to develop action plans for product and wound care cart standardization on each unit. Coordinate a one time audit of beds and surfaces to determine current state/inventory and ordering practices.	Standardization of wound care products and carts across the organization to support best practice. Develop an algorithm for staff to reference to ensure proper surfaces are being utilized to promote good skin integrity.	100% standardization of wound care products and carts Monthly review of bed/surface rentals to ensure compliance to algorithm	
										Implement Skin Assessment for all new admissions within 12 hours of admission.	Develop audit tool. Complete quarterly audits of 10 charts across the Complex Care Program.	A head to toe skin assessment must be completed and documented in the Admission data base to record any wounds or pressure ulcers identified on admission	100% compliance of charts audited	

AIM		Measure								Change				
Quality dimension	Issue	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	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) A= Additional (do not select from drop down menu if you are not working on this indicator) C = custom (add any other indicators you are working on)														
Patient-centred	**Person experience**	"Would you recommend this emergency department to your friends and family?"	P	% / Survey respondents	EDPEC / April - June 2017 (Q1 FY 2017/18)	962*	41.50%	51.70%	Maintain 2017/18 target as move towards benchmark	Conduct a regular review of patient complaints and compliments from Patient Relations to identify specific trends.	Addition to and implementation of standard program wide scorecard related to patient experience. Program development of an action plan.	Population and review of scorecard at ED Program Steering Committee Meeting. Development of an action plan.	100% Review Monthly	
										Pilot the addition of a Volunteer Welcome Desk within the St. Catharines Site ED.	Addition of a volunteer within the ED to assist waiting patients with information and wayfinding.	Pilot project is implemented.	Pilot implemented by September 1, 2018	
										Implement Fit2Sit in the ED.	Fit2Sit is a joint NH and Niagara Emergency Medical Services (NEMS) initiative where mobile patients brought in by ambulance await treatment in the ED waiting room instead of a stretcher. It has been implemented to ensure timely access to both ED and NEMS services and to provide appropriate and safe care for patients.	The number of Fit2Sit patients taken to the waiting room. The time from EMS arrival to transfer of care for Fit2Sit patients (ambulance offload time).	Increase the number of Fit2Sit patients to waiting room to 10% by May 2018 (Test phase Feb 2018 – May 2018). Decrease ambulance offload time to under 30 min. at the 90th percentile for Fit2Sit patients by May 2018.	
										Continue with public education campaign to support appropriate use of the ED, Urgent Care Centers and Family Physicians.	Expand current ED/UCC waiting room content to support appropriate use of ED and UCC. Include ED use messaging in corporate TV campaign.	Content development and implementation. Completion of Niagara Health TV series with ED/UCC focus.	Completion of NH TV series focus on ED/UCC.	
										Regular review of patients utilization of ED wait time information to assess effectiveness, impact on system and inform public education strategy.	Revitalize oculys program scorecard quarterly to assess access to wait time information.	Establish process for quarterly review of Predict utilization at ED Program Steering Committee.	Increase wait time clock access by 5%.	
		"Would you recommend this hospital to your friends and family?" (Inpatient acute)	C	% / Survey respondents	In house data collection / January-December 2017	962*	81.50%	83.90%	3% improvement on year current performance	Real time patient satisfaction survey	Niagara Health Volunteers will continue to actively engage patients with real time satisfaction surveys conducted on electronic tablets and contribute to a real time dashboard. Concerns raised during the survey will trigger the clinical manager to follow up with the patient in a timely manner	Monitor satisfaction on a monthly basis. Post the results on a monthly basis to the unit huddle board for review & discussion. We expect to expand to additional units during 2018/19. Evaluate the current success/limitations of our current patient survey process. Evaluation of the current process to include shadowing the volunteer by Quality & Safety Specialist with an IEQUIP student for improvements and sustainability.	100% of huddle boards monthly for inpatient patient satisfaction results posted for families/ patients & staff	
										"We Rounding" on inpatient units	Units will implement an interdisciplinary approach to purposeful "rounding" which includes assessment of patient's "pain, possessions, personal needs, positioning and pumps"	We Rounding has now been implemented through out the hospital-monitor unit compliance- Identify opportunities for improvements through unit based teams. Establish a formal audit process (tool & timelines) to monitor compliance with "we rounding" process.	100% daily rounding	
										Establish and evaluate Unit Based Teams	Establish unit-based teams to develop the ability of staff, physicians and leaders to undertake improvement action in their respective work areas.	Monitor Unit Based Team activity for 8 implemented improvement ideas per 12 month period - the idea may directly/indirectly affect patient care on the 25 units with current teams, and evaluate effectiveness of existing program model.	Unit based teams implement eight improvement ideas per year	

AIM		Measure								Change				
Quality dimension	Issue	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	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) A= Additional (do not select from drop down menu if you are not working on this indicator) C = custom (add any other indicators you are working on)														
Safe	Safe care/Medication safety	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 (excluding patients discharged within 24 hours of admission).	C	Rate per total number of admitted patients / All inpatients	In house data collection / January-December 2017	962*	86.9% restated (excl 24 hour discharges)	90%	Med rec fully implemented with 90% compliance target in all programs	Implement a Best Possible Medication History (BPMH) form that acts as the admission order form	The BPMH becomes admission orders, making the process more efficient while minimizing risk of transcription errors	BPMH used upon admission (excluding patients admitted and discharged within 24h)	90%	
										Introduce pharmacy technicians in ED for BPMH support	Pharmacy technicians scheduled to work in the ED to support BPMH process	ED tech schedule coverage	ED rotations covered 100% of budgeted shifts	
										BPMH quality audits	Manual review of previously completed BPMH	# of quality audits completed	250 quality audits/quarter	
		Medication reconciliation at discharge. Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created (excluding patients discharged within 24 hours) as a proportion of the total number of patients.	C	Rate per total number of discharged patients / All inpatients	In house data collection / January-December 2017	962*	5.9% (mental health only)	55.90%	Set at 90% compliance target as programs are implemented (62% of discharged patients in implemented units)	Introduce Best Possible Medication Discharge Plan (BPMDP) Meditech report that acts as discharge prescription	BPMDP pulls active medications into a report format that prompts the reconciliation process. This report also acts as the discharge prescription allowing for a more efficient process while minimizing risk of transcription errors	BPMDP used at discharge (excludes patients admitted and discharged within 24 h)	as per roll-out plan targets	
										Prescriber education	One-on-one prescriber review of process; presentations at program meetings	# of physicians receiving education	75% of physicians that normally discharge patients will have discharge medrec awareness	
										Direct BPMDP process through any discharge order sets	BPMDP direction on discharge order sets	# of discharge order sets that make reference to BPMDP	100% of current and future discharge order sets to have BPMDP direction (as appropriate)	
	Workplace Violence	**Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.**	**MANDATORY**	**Count / Worker**	**Local data collection / January - December 2017**	**962***	**Collecting Baseline**	**Collecting Baseline**	**N/A Standardized to HQO definition, increase in reporting with purchase service staff added and increased awareness.**	Capture baseline data for total violent incident reporting	Change reporting to include all staff, physicians and affiliates (including Purchase of Service agencies), and to include only incidents that meet the definition of violence per the Occupational Health and Safety Act (OHSA).	New hires receive workplace violence/respectful workplace and reporting training	100% of new hires receive workplace violence/respectful workplace and reporting training	Incidents Related to: Staff 3,355 FTEs Physicians 296 (excl locum) Purchase Service 144 FTEs
										Improve communication about respectful workplace and the importance of reporting	Update all learning modules (respectful workplace, code white, violence prevention) to include the importance of reporting. We have initiated an on-going Be Kind campaign that includes increased communication regarding respectful workplace and incident reporting. This includes posters throughout the organization, communication via all on-site screens (staff and visitors), messaging at site huddles and on the NH intranet page.	All staff complete the 3 training modules annually	50% of staff comlete the 3 training modules	first year target