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

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Niagara Health System 1200 Fourth Ave

HOSPITAL

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	**Timely**	**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**	**962***	**64.48**	**64.48**	**Over the last 3 years wait time increased by 20% annually. The target is set to maintain current results to avoid another 20% increase.**		**1)Create and implement Standardized Work for all stakeholders related to admission process and patient transitions across the system**	**1. Implementation of standardized work (entry to ED to admission to inpatients and post-acute care) across all professions 2. Creation and monitoring of an accountability framework for standard work monthly through reports 3. Monthly meetings with directors and physician chiefs on compliance of standards of work**	**Time interval between disposition date/time and the date/time patient left ED**	**Maintain the current result of 64.48 hours**	**Implementation of the standardized work and having a structured accountability framework will contribute to maintaining performance and avoiding worsening as evidenced by our historical data**
											2)Create a 'central bed filling' structure for complex clients	1. Creation of a centralized intake structure for all 'potential admissions' to be captured 2. Creation of a triage decision tool for staff to reliably admit complex care patients 3. Education to all MRP's who admit using web based, in person and communication techniques.	% of complex care clients admitted through the centralized database, LOS for ALC patient, ALC Days in Acute care	baseline collection	While the process measures is to evaluate compliance, the change idea also contributes to the overall measure of reducing time waiting in the ED for admission to inpatients. Target to be determined as we are collecting baseline data
Theme II: Service Excellence	**Patient-centred**	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	962*	98.38	98.38	Continue to maintain the high standard of acknowledgement.		1)Implement phase one of the Patient Partnership and Relations services expansion across the large NH sites (Welland, Greater Niagara General)	1. Development of 'on-site' support structure and materials for managers/leaders/patients to access local patient relation services 2. Socialization of Patient Relations supports for patients and families at huddles and business meetings (local)	% of complaints acknowledged within 5 days	98.38% of complaints acknowledged within 5 days	
		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	962*	45.5	47.80	A 5% improvement as we move toward the large community and LHIN benchmark.		1)Co-Design Initiative with patients, families, Patient Partners and Staff to understand and identify 2 improvement initiatives that will support patients receiving enough information when they are discharged home	1. Leverage design thinking methodology to understand the experiential journey of patients and families when discharged as it relates to receiving enough information 2. Identify two improvement initiatives to be implemented across Niagara Health to impact the experience of clients and families receiving information 3. Leverage the Niagara Health Engagement Network (NHEN) roster to partner in the implementation of the improvement experiences.	1. Completion of co-design event using design thinking methodology 2. Identification of improvement initiatives	1. Completion of co-design 2. Two improvement initiatives	
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	962*	39.37	79.00	The target is based on quarterly achievement of Q1 at 65%, Q2 at 75%, Q3 at 85% and Q4 at 90% for an overall average of 79%. Note - Medication Reconciliation is applicable to patients with a length of stay greater than 24 hours.		1)Support prescriber on-boarding by ensuring they are informed about the required medrec process	1. Provide educational opportunities for all prescribers across Niagara Health surrounding the process and structures in place to enable medication reconciliation at discharge for all admitted patients. 2. Second Team Members to support change management process.	% of new prescribers completing medication reconciliation education at discharge	80% completion rate	Incorporated into onboarding process for all new prescribers. Education is multi-modal with emails, huddles, information sessions and real-time education for prescribers on the unit.
											2)Improve accountability at the program and prescriber level.	Creation of monthly reports for division chiefs providing details of medication reconciliation (person and service area) to monitor progress and create discussion opportunities for learning	% of prescribers meeting discharge target on monthly summary compliance report for medication reconciliation at discharge	75% meeting discharge target	This structure and process is new in creating an environment of conversation between division Chiefs and program physicians to understand the needs of prescribers and allow for adjustments in education.
		30 day hospital readmission rate for mental illness or addiction to own hospital.	C	% / Mental health patients	CIHI DAD and OHMRS / October 2017-September 2018	962*	14.2	13.50	The target is a 5% improvement on our current results.		1)Implementation of 'Phase 2' of the Wellness Recovery Integrated Coordinated Care (WRICC) program in Mental Health and Addictions	1. Conduct 'chart reviews' to evaluate the needs and interventions required by WRICC clients 2. Number of developed and charted coordinated care plans for WRICC clients 3. Development of a 'flagging' tool within Meditech to identify WRICC clients 4. Develop new documentation requirements in HIS for WRICC clients that is accessible by ED staff and PERT	1. % of chart reviews conducted using evaluation tool 2. % of care plans captured in the Health Information System (HIS) in WRICC 3. Completion of the 'flagging system' trigger in Meditech 4. Completion of documentation requirements	1. 80% 2. 80% 3. Q3 Fiscal Year 2019/20 4. Q3 Fiscal Year 2019/20	

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Theme III: Safe and Effective Care	**Effective**	Medication Reconciliation at admission.	C	% / All inpatients	In house data collection / January-December 2018	962*	89.5	90.00	The target is a continuation of the 2018/19 QIP target for a 90% compliance in all departments. Note - Medication Reconciliation is applicable to patients with a length of stay greater than 24 hours.		1)Sustain Medication Reconciliation on admission for all of our patients admitted to Niagara Health through the ED through augmented scope of practice	Continue to effectively utilize the scope of practice of Pharmacy Technicians by supporting the completion of BPMHs for patients admitted to Niagara Health through the ED.	% of BPMH completed by Pharmacy Technicians for patients admitted through the ED	40% of BPMH completed	BPMH certification process has been created and education will be provided to Pharmacy Technicians, Nurses, Pharmacists and Physicians (i.e. BPMH is a shared responsibility) for BPMH completion to create standardization in quality expectations.
											2)Evaluate, and improve as needed, the quality of BPMH	Ensure BPMH forms, randomly selected, have met all the quality criteria identified to reduce error and augment safety.	% of BPMH meeting all quality criteria	80% of BPMH meeting quality criteria	
	Safe	**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 2018**	**962***	**1664**	**1664.00**	**Maintain current results while expecting an increase in reported incidents while maintaining a culture of self reporting.**		**1)Create a safe culture of workplace violence reporting for all staff and affiliates to allow Niagara Health to understand the current environment**	**1. Acknowledge and follow up on each staff IRS report to create a culture of reporting. 2. Education on the importance of incident reporting in mandatory training events for staff 3. Provision of Crisis Prevention and Intervention training to mandatory departments (Mental Health, Urgent Care and ED)**	**1. % of IRS reports followed up within 5 business days 2. % of workplace violence and/or respectful workplace training events provided that include the reporting process and importance of reporting 3. % of staff trained in mandatory departments**	**1. 90% of IRS reports followed up 2. 100% of workplace violence training events include reporting process and importance of reporting 3. 50% of staff trained in mandatory departments**	**FTE=3586**
											2)Implement violence prevention and respectful workplace e-learning modules on an annual basis to ensure the skills and tools are available for staff to reduce harm	Mandatory e-learning modules developed for staff and available annually 2. Annual update of violence prevention and respectful workplace modules	% of full-time staff completing modules 2. % of modules reviewed annually	75% of full-time staff completing modules 100% of modules reviewed annually	
											3)Build a resilient workforce through the development of a respectful culture	1. Identify the most appropriate method of follow up (e.g. coaching, facilitation, investigation) to address individual situation. Where appropriate, coach and develop skills for staff to resolve future conflicts independently 2. Visible messaging of 'violence will not be tolerated' to all staff, visitors, community on all big screens in public areas	1. % of staff provided follow-up 2. implemented	1. 90% of staff provided follow-up 2. Implemented by Q1 2019/20	
		Pressure ulcers - Percentage of residents who had a new, worsened or existing stage 2 or higher pressure ulcer (rolling 12 months)	C	% / Residents	CIHI CCRS / October 2017-September 2018	962*	8.78	7.50	The target is set at a 5% improvement from the 2017/18 results.		1)Enhance Best Practices of clinical staff in skin assessments (initial and ongoing).	1. Complete baseline data collection for number of skin assessments complete upon admission and quality of the assessment. 2. Provide weekly huddles with staff to review and discuss importance of skin assessments. 3. Provide an overview of skin assessment techniques to all nursing staff. 4. Complete random chart audits (5 monthly) per complex care unit and share results with the teams.	1. Number of patients with skin assessments completed upon admission. 2. Number of quality skin assessments completed upon admission.	Q1 - 10% improvement Q2 - 15 % improvement Q3 - 20% improvement Q4 - 25% improvement	5% improvement every quarter to total a 25% improvement overall
											2)Enhance the culture of using evidence based outcome tools for pressure injury/skin wound prevention.	1. Provide education to all nursing staff in complex care on the accurate completion of the Braden Risk Assessment Scale. 2. Incorporate review of risk into weekly patient rounds with the interprofessional team.	1. Number of nurses who completed the education for the Braden Risk Assessment Scale 2. Number of weekly huddles wherein pressure injury risk is discussed.	1. 50% of nursing staff will have completed the education by the end of Q4. 2. 100% of patients discussed in weekly rounds will have pressure injury risk addressed by end of Q4.	
											3)Embed the 'Safe Information Exchange' into practice using We Rounds through interprofessional teams.	1. Clinical Managers and Nurse Educator will remind all staff of the accountability of completing We Rounds at a minimum of every 2 hours. 2. Clinical Managers and Nurse Educator will complete 5 random audits with patients and families per month to determine if We Round is occurring. 3. Compliance data will be shared with the teams to generate improvement ideas.	1. Number of patients/families reporting completion of We Round with a positive experience. 2. Staff will generate and implement improvement ideas to increase compliance and quality of We Round.	1. 25% of patients/families report completion by Q1, 50% by Q2, 75% by Q3, 100% by Q4. 2. 1 staff generated idea per unit will be implemented by Q4.	