2019/20 Quality Improvement Plan for Ontario Hospitals "Improvement Targets and Initiatives"

WORKPLAN - ALC ACUTE CLINICAL

AIM		MEASURE						CHANGE				
Quality Dimension	**Objective**	**Measure/Indicator (Priority Indicator)**	**Unit / Population**	**Source/Period**	**Current Performance**	**Target**	**Target Justification**	**Planned Improvement Initiatives (Change Ideas)**	**Methods**	**Process Measures**	**Tasks Completed**	**Comments**
Efficient	Access to the Right Care	**% Alternate Level of Care Days (ALC)**	Days/Acute Inpatients	SOURCE: Bed Census data	8730 ALC DAYS / 38294 INPATIENT DAYS 22.8%	22.5% - 1% reduction	ALC at census continues to rise creating pressures on our beds. It is important to aim for a reduction however there are many barriers in our catchment to finding housing for our ALC patients.	ELOS process standardization	1) Continual PDSA of process 2) Ongoing education 3) Socialization of process to reach all patients 4) Work with communications team to broaden patient awareness through different forms of media 5) Socialize/educate concept of ELOS process to community groups (pre-hospital)	Measure compliance with the following process steps; 1) ELOS assigned to acute inpatient when admitted >80% completion in first year 2) BRASS score for all patients 65 and greater within 24 hours >80% completion in first year 3) whiteboard audits >80% completion in first year		
								Review patients at risk for ALC at complex discharge rounds	Work with multidisciplinary team to remove barriers to discharge prior to patients becoming ALC	5% increase in discharges of those patients currently identified as ALC		
								Bring community partner together at Right Place of Care Committee	1) Work with community teams to identify and work to remove barriers to discharge 2) IV Infusions in LTC - feasibility study 3) Empire Living pilot	1% decrease in ALC occupancy at NBRHC		

EFFICIENT	
Indicator	**Percentage Alternative Level of Care Days** **Acute and post-acute** ***Target: 1% reduction of baseline***
Definition	Total number of ALC days contributed by ALC patients within month/quarter using near-real time acute and post-acute information and monthly bed census data. Numerator: Total number of inpatient days designated as ALC in any given time (acute and post-acute) Denominator: The total number of inpatient days at a point in time. Calculation= Numerator/Denominator x 100
Current Performance Reporting Period	Most recent month available
Data Source	Bed Census Summary

WORKPLAN - ALC Mental Health

AIM		MEASURE						CHANGE				
Quality Dimension	**Objective**	**Measure/Indicator (Priority Indicator)**	**Unit / Population**	**Source/Period**	**Current Performance**	**Target**	**Target Justification**	**Planned Improvement Initiatives (Change Ideas)**	**Methods**	**Process Measures**	**Tasks Completed**	**Comments**
Efficient	Access to the Right Care	**% Alternate Level of Care Days (ALC)**	Days/Dual Diagnosis Unit Inpatients	SOURCE: Bed Census data	ALC Days 2083 / INPATIENT DAYS 3709 56%	51%(5% of reduction)	Although it is important to aim for a reduction, there are many barriers in our catchment to finding housing for our ALC patients	To establish a clear process for establishing the goals for admission to program.	Hospital staff and physicians are clear on how early discharge planning is incorporated into the admission process and monitored. Incorporation of new referral for admission to Regional MH program to identify goals for admission that are agreed upon by community partners, patient/family and hospital.	ALC Escalation Process developed and implemented (Monthly clinical team meetings including family (OPOP) and community partners to monitor progress and address issues/barriers as they arise. Identify community programs and services and additional funding required to support patients with transition.)		
								Establish a clear discharge destination prior to admission.	1) Social Work attends ALC rounds and comes prepared to participate in a discussion on the barriers to discharge for clients, and of potential discharge delays/issues. 2) Social Work to coordinate case conferences with family and community partners to ensure appropriate discharge destinations are remain secured for discharge. 3) Team to monitor and ensure care plan goals/objectives are progressing to support discharge plan. RAI CAPs used to guide care planning at OPOP meetings. RAI CAPs triggered will decrease quarterly to progress to discharge.	ALC Escalation Process developed and implemented (Evaluating new ALC standard work and escalation process that is in place. Advocate for support of existing services in addition to other MH programs and services by strengthening additional partnerships. Monthly case conferences are held with clinical team, family and community partners to prepare for transition to discharge destination.)		
								Avoidable admission to inappropriate bed.	1) Education to community and partners on programs and services offered at NBRHC. 2) Work with community partners to develop care plans while on waitlist to sustain patients in the community and avoid admission to inappropriate beds.	ALC Escalation Process developed and implemeted (Advocating for supports and funding in the community. Working in partnerships to ensure proper support in place while awaiting planned admission to Regional Bed)		

EFFICIENT	
Indicator	**1. Percentage Alternative Level of Care Days Acute and post-acute** **2. Percentage Alternative Level of Care Days Mental Health** ***Target: 5% reduction of baseline***
Definition	Total number of ALC days contributed by ALC patients within month/quarter using near-real time acute, post-acute and mental health information and monthly bed census data. Numerator: Total number of inpatient days designated as ALC in any given time (acute and post-acute, mental health) Denominator: The total number of inpatient days at a point in time. Calculation= Numerator/Denominator x 100
Current Performance Reporting Period	Most recent month available
Data Source	Bed Census Summary

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WORKPLAN - Time to Inpatient Bed

AIM		MEASURE						CHANGE				
Quality Dimension	**Objective**	**Measure/Indicator (Priority Indicator)**	**Unit / Population**	**Source/Period**	**Current Performance**	**Target**	**Target Justification**	**Planned Improvement Initiatives (Change Ideas)**	**Methods**	**Process Measures**	**Tasks Completed**	**Comments**
Timely	Patient	**Time to Inpatient Bed**	Emergency Department	Meditech	21.3 hours (Q3 18/19 for the 90th Percentile)	21.1 hours (1/% reduction)	A small percentage of patients remaining in the ED for 21 hours. Although it is important to aim for a reduction, the organization must first understand the current situation and processes in order to drive change and make sustainable improvements	Discover and explore the barriers that contribute to increased length of stay in the ED	1) Collect baseline data 2) Conduct an analysis 3) Stakeholder review of the facts/ challenges	100% of data analysed by May 2019		
								Select initiatives to address identified barriers	Conduct root cause analysis	Rapid Improvement Event completed by July 2019		
								Develop Workplan for improvements	Based on root cause analysis select improvements and develop workplan	Workplan developed by Sept 2019		
								Implement 1 change idea	TBD based on change idea(s)	TBD based on selected initiative(s)		

TIMELY	
Indicator	**1. Time to inpatient bed** ***Target:*** ***To be determined after review of the baseline data***
Definition	Time interval between decision to admit and date/time patient left the Emergency Department for admission to an inpatient bed. 90th percentile means: Of 90 percent of our patients the maximum wait time. Calculation= Length of stay equals time to inpatient bed in hours and scheduled ER visitor indicator
Current Performance Reporting Period	Maximum wait time for 90% of our patients is 19.9 hours. This represents the 10% of our patients who are waiting 19.9 hours.
Data Source	Meditech

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Patient Experience - Enough Information at Discharge

AIM		MEASURE						CHANGE				
Quality Dimension	**Objective**	**Measure/Indicator (Priority Indicator)**	**Unit / Population**	**Source/Period**	**Current Performance**	**Target**	**Target Justification**	**Planned Improvement Initiatives (Change Ideas)**	**Methods**	**Process Measures**	**Tasks Completed**	**Comments**
Patient-Centred	Partnerships with Purpose	**Did you receive enough information when you left the hospital?**	Inpatient Medicine and Surgery	CPES-IC survey question #38	72%	80%	The organization wishes to promote a culture of patient engagement ensuring that they are adequately prepared for transitions by receiving the information they need.	Develop reporting process to Inpatient Medicine and Surgery	Develop report and mechanism to share it with the managers.	80% of positive responses		
					NA	12	Currently results show positive responses. This is an opportunity to celebrate the units' successes and encourage idea generation.	Survey results shared at huddle	Report delivered to managers in format that is easily shared with frontline staff.	# of times survey results shared at huddle		

PATIENT-CENTRED	
Indicator	Did you receive enough information when you left the hospital – CPES-IC survey question #38. ***Target: 80% positive responses***
Definition	Percentage of respondents who responded "completely" to the question above. The data captured is for **medicine and surgery** only as this is these are the required population to sample for linking quality to funding.
Current Performance Reporting Period	Most recent consecutive 12 month period. We will report quarterly to be more confident in our results.
Data Source	Currently positive responses are 77% with a margin of error of 12% due to current small sample size.

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WORKPLAN - Workplace Violence Prevention

AIM		MEASURE						CHANGE				
Quality Dimension	**Objective**	**Measure/Indicator (Priority Indicator)**	**Unit / Population**	**Source/Period**	**Current Performance**	**Target**	**Target Justification**	**Planned Improvement Initiatives (Change Ideas)**	**Methods**	**Process Measures**	**Tasks Completed**	**Comments**
Safety	People	Number of workplace incidents reported which resulted in injury at First Aid, Medical Aid or Death	All staff	iReport	1258 **BASELINE data** total number of incidents (regardless of severity) April 1, 2018 - March 31, 2019	1258 (baseline)		1) Annual WPVP mandatory education 2) Ireport QRM 3) Risk reassessments as below	1) eLearn annually 2) Data reporting within event reporting system - new reporting system to be implemented in the fall 2019 3) Engaging employees in risk reassessment processes	1) 100% of mandatory eLearns complete 2) Implementation of Quality Risk Module by April 2020 I 2) 100% of total risk reassessments complete (N=68)		
		Number of workplace incidents reported which resulted in first aid, medical aid, lost time or death	All staff	iReport	109	At or below		1) Implementation of NEW staff duress dystem 2) Electronic Security Indicator 3) Workplace Violence Prevention Posters	1a) Establish implementation committee with robust stakeholder membership to develop a plan and oversee progress of the implementation of the Stanley Personal Alarm System 1b) needs assessment for off site locations 2) Implementation of MEDITECH 6.1 3) Across entire organization	1) Implementation of the new staff duress system by Fall 2019 2) Implementation of Meditech 6.1 by Ocyt 2019 3) Posters visibly displayed across the organization by summer 2019		
		% of Violence Risk Re-Assessments completed this fiscal year. Compensable metric.	All organizational programs	manual tracking	0%	100%	This emphasizes to the organization that completion of these risks assessments on a regular basis is top priority for Senior Team.	Re-evaluation of the existing risk assessments	1) Establish 2019-20 Risk Assessment schedule across the organization 2) Work place violence incident data analysis (workplace violence dashboard) 3) Coach and support each team in the re-evaluation of their 2018-19 risk assessment; 4) Centralized Risk Assessment Tracker	100% of total risk reassessments complete (N=68) by March 2020		

SAFETY	
Indicator	**Number of workplace violence incidents reported by hospital workers** ***Target: Collect baseline again this year***
Definition	Number of workplace violence incidents reported by hospital workers within a 12-month period.
Current Performance Reporting Period	Most recent month available
Data Source	iReport (electronic reporting system)

SAFETY	
Indicator	**Percentage of workplace violence incidents reported which resulted in injury at First Aid, Medical Aid or Death.** ***Target: 0***
Definition	Percentage of workplace violence incidents reported which resulted in injury within a 12-month period.
Current Performance Reporting Period	Most recent month available
Data Source	iReport (electronic reporting system)

SAFETY	
Indicator	**Percent of Violence Risk Assessments completed this fiscal year.** ***Target: 100%***
Definition	Percentage of workplace violence risk assessments completed throughout the organization.
Current Performance Reporting Period	6%
Data Source	Manual tracking