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

NORTHUMBERLAND HILLS HOSPITAL

Northumberland Hills Hospital 1000 DePalma Drive

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	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	% patients who received enough information on discharge	CIHI CPES / April - June 2017(Q1 FY 2017/18)	940*	63	68.00	5% improvement	1)Implement real-time patient satisfaction surveys to capture feedback in: 1) Emergency Department 2) Medical/Surgical Unit (2B) Utilize feedback to develop an action plan that drives quality improvement at discharge.	1. Survey Administration - One on one interview, paper-copies to be filled 2. Survey collection - volunteers, managers, directors, SMT 3. Survey input - volunteers, decision support 4. Reporting & Communication - posted on quality boards, reported to practice committees, reported to quality & safety of the board 5. Follow-up - discussed at monthly performance board huddles, immediate follow-up completed through a standard escalation process	% of patients that complete the survey (response rates) in: 1) Emergency Department 2) Medical/Surgical Unit (2B	By end of each quarter, 50% of patients surveyed will complete the survey in: 1) Emergency Department 2) Medical/Surgical Unit (2B) Minimum 30 per month per area (60 per month, 180 per quarter, 720 per year combined) By Q2, action items will be developed. By Q4, action items will be completed.	
										2)Implement a hardcopy of patient specific discharge instructions that can be generated by Meditech for Emergency Department patients.	Use of survey tool to monitor results. Same process as change idea #1	Positive response from real-time feedback survey - "Did you receive a hardcopy of your discharge instructions?"	By Q4, 100% of Emergency Department patients surveyed will indicate that they have received a hardcopy of discharge instructions.	
										3)Ensure inpatients on Medical/Surgical Unit (2B) leave with discharge material (hardcopy or reference to website).	use of survey tool to monitor results. Same process as change idea #1	Positive response from real-time feedback survey - "Prior to being discharged, did you receive or were provided access to discharge material?"	By Q4, 100% of Medical/Surgical Unit (2B) patients surveyed will indicate that they left with (or have access to) discharge material.	
	Wound Care	Percentage of patients receiving Post Acute care with a newly occurring Stage 2 or higher pressure ulcer	C	% patients in Rehab with a newly occuring Stage 2 or higher pressure ulcer	In-home audit / April 2018 to March 2019	940*	27.7	13.65	50% reduction	1)Percentage of patients receiving Post Acute care with a newly occurring Stage 2 or higher pressure ulcer. Implement weekly patient safety huddles on the Restorative and Rehabilitation Units to increase engagement by identifying improvement opportunities from frontline staff.	Director and Manager will audit huddle completion and idea boards.	% of huddles completed. % of ideas generated are implemented from frontline staff through safety huddles.	By Q4, >80% of scheduled huddles will be completed. By Q4, 100% of validated ideas generated will be implemented.	~Goal: 10 huddles per quarter, 40 per year ~6 ideas generated per quarter ~3 validated ideas implemented per quarter
										2)Ensure timely documentation of skin assessment occurs at point of admission.	Automated report will be sent to Manager/Director and shared with staff during huddles and at committees for review and feedback.	% of patients who have a Braden Risk Assessment* completed within 24 hours of admission.	By Q3, 100% of patients will have a Braden Risk Assessment completed within 24 hours of admission.	~ *The Braden Risk Assessment is a tool that assesses a patient's risk of developing a pressure ulcer by examining six criteria - sensory perception, moisture, activity, mobility, nutrition, friction and shear. ~A >95% performance threshold will be considered.
Efficient	Access to right level of care	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 2017	940*	31.6	26.60	5% improvement	1)Develop and implement an action plan through the completion of a Value Stream Mapping analysis of an ALC patient's journey.	1. Meet with stakeholders 2. Complete launch/preparation meeting 3. Develop action plan 4. Review updates of action plan at Quality Practice Committee	Value Stream Mapping is complete with a future state identified and an action plan developed.	By Q4, action items are developed and completed.	
										2)Implement an ALC specific discussion at daily bed huddles on the Medical/Surgical Unit (2B) to increase communication regarding the discharge destination. The proactive discussion should help reduce and/or eliminate the use of ALC-Unknown/ALC-TBD destination.	1. Automated reports are sent to the Access and Flow Specialist 2. Outcome of the reports and action items are discussed at daily bed huddles and at Home First Committee meetings.	% reduction in volume of open ALC with unknown/TBD destination. % reduction in total days of ALC with unknown/TBD destination.	By Q4, a >50% reduction in volume of open ALC with unknown/TBD destination. By Q4, a >50% reduction in total days of ALC with unknown/TBD destination.	

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Patient-centred	**Person experience**	"Would you recommend this emergency department to your friends and family?"	P	% of patients who would recommend the NHH ED to their friends and family	EDPEC / April - June 2017 (Q1 FY 2017/18)	940*	52.3	57.30	5% improvement	1)Implement patient satisfaction surveys to capture real-time feedback in the Emergency Department. Utilize feedback to develop an action plan that drives quality improvement.	1. Survey Administration - One on one interview, paper-copies to be filled 2. Survey collection - volunteers, managers, directors, SMT 3. Survey input - volunteers, decision support 4. Reporting & Communication - posted on quality boards, reported to practice committees, reported to quality & safety of the board 5. Follow-up - discussed at monthly performance board huddles, immediate follow-up completed through a standard escalation process	% of patients that complete the survey (response rates).	By end of each quarter, 50% of patients surveyed will complete the survey. Minimum 30 per month, 90 per quarter, 360 per year) By Q2, action items will be developed. By Q4 action items will be completed.	
										2)Increase administration and patient/family communication by enhancing rounding with the use of real-time patient satisfaction survey. Utilize feedback to develop an action plan that drives quality improvement.	As stated above.	% of patients surveyed have their survey administered through an interview (by a charge nurse /manager/director).	By Q4, >30% of patients surveyed have their survey administered through an interview (>=10 per month) By Q2, action items will be developed. By Q4 action items will be completed.	
		"Would you recommend this hospital to your friends and family?" (Inpatient care)	P	% who would recommend this hospital to their friends and family	CIHI CPES / April - June 2017 (Q1 FY 2017/18)	940*	66	71.00	5% improvement	1)Implement patient satisfaction surveys to capture real-time feedback in the Emergency Department. Utilize feedback to develop an action plan that drives quality improvement.	1. Survey Administration - One on one interview, paper-copies to be filled 2. Survey collection - volunteers, managers, directors, SMT 3. Survey input - volunteers, decision support 4. Reporting & Communication - posted on quality boards, reported to practice committees, reported to quality & safety of the board 5. Follow-up - discussed at monthly performance board huddles, immediate follow-up completed through a standard escalation process	% of patients that complete the survey (response rates).	By end of each quarter, 50% of patients surveyed will complete the survey. Minimum 30 per month, 90 per quarter, 360 per year) By Q2, action items will be developed. By Q4 action items will be completed.	
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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	A	Rate per total number of admitted patients	Hospital collected data / October – December (Q3) 2017	940*	58	85.00	Same target as 2017-18	1)Implement a bi-weekly idea board huddle within the pharmacy department to increase engagement and develop opportunities to improve from frontline staff.	Manual audit of huddles completion will be completed by Manager and report reviewed with staff and at committee.	% of huddles completed. % of ideas generated are implemented from frontline staff through idea board huddles.	By Q4, >80% of scheduled huddles (24 per year) will be completed. By Q4, 100% of validated ideas generated will be implemented.	~Goal: 6 huddles per quarter ~6 ideas generated per quarter ~3 validated ideas implemented per quarter
		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	Hospital collected data / October – December (Q3) 2017	940*	95	95.00	Maintain current performance	1)Implement a bi-weekly idea board huddle within the pharmacy department to increase engagement and develop opportunities to improve from frontline staff.	Manual audit of huddles completion will be completed by Manager and report reviewed with staff and at committee.	% of huddles completed. % of ideas generated are implemented from frontline staff through idea board huddles.	By Q4, >80% of scheduled huddles will be completed. By Q4, 100% of validated ideas generated will be implemented.	~Goal: 6 huddles per quarter ~6 ideas generated per quarter ~3 validated ideas implemented per quarter
	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	940*	CB	CB	Will review FY1718 dataset to set targets	1)Enhance reporting of workplace violence incidents through education of workplace violence and through supporting staff with input into the reporting system.	Automated reporting through our incident management system. Data distributed to managers and reviewed with staff and at committees monthly.	% increase in reporting for workplace violence incidents.	By Q4, there will be a >20% increase in reporting of workplace violence incidents.	412 FTE
										2)Create an active shooter training program.	Monthly review of current violence action plan with all stakeholders has a standard review of the progress in the training program. Attendance will be recorded after training is complete. Attendance will be reviewed with Manager and reported at committees.	% of staff who complete an active shooter program.	by Q4, >75% of staff will complete an active shooter program.	412 FTE