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

Orillia Soldiers' Memorial Hospital 170 Colborne Street West

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
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Theme I: Timely and Efficient Transitions	**Efficient**	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 2018	745*	23.21	19.20	This target has been set through H-SAA target-setting discussions with the NSM LHIN. This QIP target is in alignment with the 2018-19 H-SAA ALC rate target of 20.2%	Community Partners	1)Patients with responsive behaviors - build staff confidence in managing this population	1. Implement education for clinical staff teams 2. Implement changes to the physical environment to encourage safe behaviours 3. Evaluate the success of changes for future spread	1. GPA (Gentle-Persuasive Approaches) training for clinical staff 2. Environmental changes- "safe rooms" 3. Increased confidence among clinical staff in caring for behavioural patients. 4. Co-horting pilot project	1. 5 GPA training sessions per year for a minimum of 50 staff 2. Changes to create a safe room on IMRS by December 31st 2019 3. Improved confidence (based on baseline survey completed Dec 2018) among clinical staff in caring for behavioural patients. 4. Co-horting pilot trialed on IMRS by Dec 31, 2019	
											2)Improve Bed Transitions for ALC Unit	Build an effective and efficient standard of care for ALC patients; test the developed standard on a dedicated ALC unit; modify as appropriate for spread to other units that care for ALC populations.	1. Develop a Standard of Care for ALC patients 2. Implement and test the Standard of Care in the "Way Home" Unit (H2) 3. Roll out to S1, IMRS, C5 and C6 as applicable- December 31st 2019	1. Completed ALC standard of care - July 30th 2019 2. Evaluation of Standard of Care Pilot - September 30th 2019 3. Roll out to S1, IMRS, C5 and C6 as applicable- December 31st 2019	
											3)Continue to collaborate with our community partners at regular ALC rounds to enhance early identification and monitoring of our patients requiring discharge to alternate levels of care	Identify potential partners to develop collaborative strategies to address challenges related to ALC.	Identification of barriers and work with identified partners to mitigate challenges	Increased telehomecare referrals; increased Healthlinks referrals	

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	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.**	**M A N D A T O R Y**	**Hours / All patients**	**CIHI NACRS / October 2018 – December 2018**	**745***	**41**	**35.80**	**Time is crucial to the effectiveness and outcome of patient care, especially for emergency patients. In conjunction with other indicators, this can be used to monitor the inpatient bed turnover rate and the total length of time admitted patients spend in the ED in an effort to improve the efficiency and, ultimately, the outcome of patient care. This indicator measures the time interval between the Disposition Date/Time (as determined by the main service provider) and the Date/Time**		**1)ED-to-Admitted Meeting Identified Actions**	**Hold collaborative ED-to-Admitted Meetings that focus on making effective improvements to the timeliness of care for patients admitted through the Emergency Department**	**# of actionable items identified in regular ED-to-Admitted Meeetings; % of completed action items between ED-to-Admitted Meetings**	**90% identified Action Items complete by defined due date**	**Ongoing focus of ED-to-Admitted Meetings includes: 1. Improve communication between ED staff and inpatient units-regular committee aimed at decreasing LOS for admitted patients in the ED 2. Focus on communication with housekeeping, admitting 3. Focus on improving transfer of care accountability and timelines**
											2)Surge and Overcapacity planning	Develop commitment to surge and overcapacity plans that include the new ALC unit (H2), and regularly review the surge and overcapacity plans in alignment with local usage trends.	Capacity planning in alignment with Local Need	100% funded occupancy at midnight with no admissions in ED on a daily basis	
											3)Supporting ED Patients with flow guidance	Trial and evaluation of amended Emergency Department Navigator work hours; daily bed meeting at 8:30am to better facilitate patient flow; educating on the parameters of CDU for patient flow	Number of Admission Diversions; Number of Admission Avoidances per shift	Increase in Admission Diversions and Admission Avoidances per shift	
		Total ED length of stay (defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ED) where 9 out of 10 complex patients completed their visits	C	Hours / Patients with complex conditions	CIHI NACRS / January - December	745*	11.5	10.20	1% improvement over year-end performance		1)Improve the discharge process to ensure that patients who are ready for discharge can be discharged regardless of weekday or weekend. This will increase patient satisfaction as well as improve the flow of patients throughout the hospital.	1. Work with clinical teams to ensure that appropriate planning in advance makes weekend discharges possible. 2. Investigate patient flow navigators and HCC coordinators in-house on weekends.	# of discharges occurring on weekends	Increase the number of weekend discharges by March 31, 2020	
											2)Exploration of a more consistent Results Pending area.	Identify opportunities and barriers to maintaining a Results Pending area; develop a plan for a Results Pending area that aligns with available resources	Develop a plan for a Results Pending area; identifying a schedule to resource the Results Pending area.	Plan in place by Jun 30, 2019 Once Results Pending area in place, target 85%+ occupancy in area during open hours.	

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Theme II: Service Excellence	**Patient-centred**	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	745*	57	60.00	3% improvement over year-end performance		1)1)Explore opportunity for post-Discharge follow-up phone calls to reinforce instructions and address opportunities for improvement by the Admission Discharge Transfer nurse and/or modified staff.	1) Develop Discharge Phone Call Standard Procedure (SOP) 2) Pilot process on Medicine inpatient unit 3) Review pilot process 4) Develop method to track themes and opportunities related to discharge process 5) Reinforce commitment to existing Depart Tool.	Develop SOP by Q1 2019-2020; % of Discharge calls completed for Medicine Patients in Q3 2019-2020	100% SOP developed by Q1 2019/2020; 50% Discharge Calls completed based on number of Medicine patients discharged per quarter	
											2)Reinforce commitment to Estimated Date of Discharge practices	EDD clearly displayed in patient care area	Audited compliance to Estimated Date of Discharge practices	90% Audited Compliance by October 2019	
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	745*	83.28	82.00	Maintain baseline improvement over year-end performance and encourage month-to month performance consistency.		1)The medication reconciliation process is a shared responsibility and requires an inter-professional team approach that includes pharmacists, physicians, nurses and other healthcare providers. Providing up to date education on the process is vital to a successful program. Ongoing education has shown success as illustrated. Focus now is to keep on target	The physician champion of the Medication Reconciliation Sustainability Committee provides education to OSMH credentialed staff; regular cascading reporting of key metrics from Board to individual units.	Ensure training/ education is incorporated into onboarding.	New applicable credentialed staff receive Med Rec at Discharge training within 60 days of onboarding.	Patients excluded: Newborns, Deaths, Patients with less than 24 hours length of stay
											2)The Med Rec Sustainability Committee is focusing on areas of concern and working with front line staff to determine why the discharge report is not in the patient's chart and next steps, one area for improvement identified is to change the Med Rec at Discharge Report.	1. Implement upgraded Med Rec at Discharge Report 2. Educate all applicable credentialed staff on updated tool and process	1. New report deployed 2. Ongoing use of updated reporting tool to drive Med Rec at Discharge compliance rate	1. New report deployed Q1 2. 90% applicable credentialed staff trained in use of new reporting tool by Q3	
	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**	**745***	**70**	**92.00**	**Training will result in an increased awareness of what constitutes a workplace violence incident. We predict the number of "near miss"**		**1)Develop and implement a standardized debriefing tool**	**Code White sub-committee in collaboration with PE, OHS develop and implement a standardized debriefing tool**	**Development, implementation and training on standardized debriefing tool % Post Code White debriefs completed within 1 month**	**100% of managers with employees in "high-risk" areas trained to use debrief tool. 90% of code white incidents followed by debrief within 1 month.**	**FTE=867**

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									near miss reporting will increase.		2)Staff Training on the prevention and management of aggressive behaviour	Non-violent crisis intervention module 1. Provide 2-day classroom training to staff in high risk areas on the prevention and management of aggressive behaviour 2. Create a business case for resources to continue with ongoing education model to maintain competency for all staff based on their needs.	1. Training completion rates for staff in "high-risk" areas. 2. Time to complete training after onboarding or expiry of previous training module (if applicable)	1. 100% of staff in "high-risk" areas (as of March 31, 2019) to have training complete by October 2019 2. 95% of new staff complete training module within 60 days of Orientation.	
											3)Staff Training on incident management and incident reporting . Just culture	Ensure all staff receive appropriate training on risk assessment, risk management, incident reports and incident management. Teach & train the staff on reporting system, encourage them to report near mess, promote for just culture.	Number of applicable staff trained in violence incidents management and response training	90%+ of applicable staff trained in violence incidents management and response training by March 2020.	
		The number of lost time incidents due to workplace violence injury	C	Count / Worker	OHS / Apr 2019 - Mar 2020	745*	10	8.00	Training will result in an increased awareness of what constitutes a workplace violence incident. We predict the number of days lost due to work place violence will decreased		1)Patient identification and care planning	Develop a standard violence assessment tool for assessing clients in ED or on admission to be accessible electronically • Develop flagging system such as coloured wristband, door signs etc.	% compliance with completion of tool; Reduction in WV incidents	100% compliance with completion of risk assessment tool	
											2)Staff Training on the prevention and management of aggressive behaviour	Ensure all staff receive appropriate training, low risk training for staff with little to no direct patient or family contact, moderate risk training for staff in areas that may have potential for aggression and violent behaviour and high risk training for staff in areas of high frequency and intensity of behavioural episodes and high probability for staff and patient harm.	1. Training completion rates for staff for e-learning module 2. Training completion rates for staff in 2-day training 3. Time to complete training modules after onboarding or expiry of previous training module (if applicable)	1. 100% of staff in (as of March 31, 2019) to have e-learning training complete by October 2019 2. 95% of staff in (as of March 31, 2019) to have 2-day training complete by October 2019 3. 95% of new staff complete training module within 60 days of Orientation.	
											3)Provide opportunities for interprofessional learning by simulating a violent patient incident (mock code white)in a environment that closely resembles real clinical situations.	Under the direction of the Code White Sub-Committee, conduct quarterly Mock Code White exercises followed by assessment of code team performance and response	# of code white exercises held and follow up assessment completed	4 Mock Code White (violent patient simulation) exercises complete by March 31, 2020 4 Assessments of Code team performance and response by March 31, 2020	

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											4)Flagging patients identified in workplace violence incidents will provide the staff caring for these patients with information that could prevent further incidents.	Ensure that all patients identified in workplace violence incidents are appropriately flagged post incident in our electronic medical record.	% of patients involved in workplace violence incidents flagged appropriately in EMR (post incident)	100% of patients identified in workplace violence incidents are appropriately flagged (post-incident) in our EMR by March 31, 2020.	
											5)Communication and education of zero-tolerance for violence to staff, patients, families, visitors	Develop a poster/signage for waiting areas that encourages a respectful environment free of violence - Revise all patient materials including the intranet	Identify priority locations for sign-posting; develop signage; patient awareness of zero-tolerance expectations	100% completion on signage developed and posted Increased awareness of zero-tolerance expectations	
											6)Workplace Violence risk assessments	Revised tool for Managers to complete annually • Coaching/Support sessions offered to Managers on assessing risk of violence in their areas	% of completed assessments; # of departmental controls developed	Managers will have completed risk assessments by March 2020	