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

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.**	M A N D A T O R Y	Hours / All patients	CIHI NACRS / October 2018 – December 2018	701*	35.1hrs	35.1	*MH will using this indicator to improve patient flow. The outcome of patient flow improvements will translate to better patient throughput and as a by-product decrease time to inpatient bed wait*		Establish Weekend Patient Flow process	Initiatives include: 1. Introduce weekend bed meetings, 2. Implentation of Patient Care Coordinator flow role on weekends	% patients discharged on weekends of total patients discharged	Increase by 10% from current state of 10% (20% target)	
											Establish Weekend Discharge Process on Medicine Units to facilate patient flow	1. Identification of weekend discharges in electronic medical record tracking board prior to the weekend (Friday), 2. Initiate Monday review and analysis of electronic medical record discharge list, 3. Develop escalation process for weekend barrriers to discharge 4. Develop weekly ALC rounds	% medicine patients discharged on weekends of total patients discharged. Number of patients designated ALC (Total % of ALC patients)	Increase by 10% from current state of 10% (20% target)	
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	701*	99%	100%	*MH currently meets the target for business days and will focus attention on the acknowledged to the individual who made a complaint within two business days*		Enhanced Program/Team communication, education & support	Faciliating sessions at the program and unit level on the subject title: Dealing with Difficult and Challenging situations. 2. Reintroducing AIDET as a communication framework for all healthcare professional	1. Number of programs or units who have completed the education.	Percent of programs with education completed June 2019	
											Review Patient Relations Program Goals and Objectives	Reivew current workflows and roles and responsibilities of staff withing patient relations department	Review programs goals and objectives using benchmark analysis to faciliate timely response rate.	100% Goals and Objectives reviewed and clarified by June 30th, 2019	
	Patient-centred	**During your hospital stay, did nurses and doctors try to understand what was important to you by listening and asking questions?**	C	% / discharged patients from population sampled	Vocantas automated phone survey October 2018-Dec 31 2018	701*	92%	90%			Develop process of feedback and actions that address Patient Feedback Reports	Action plans are created and based on patient feedback reports posted on unit quality board during huddles. Quality Improvement & Patient Safety Manager will monitor action plans by attending Program Quality Council Meetings	Percent of programs with completed action plans.	100% of action plans completed for each program by August 2019.	Specific action items will vary depending on the survey data and feedback provided by programs.
		During your hospital stay, did nurses and doctors show genuine appreciation for your situation?					89%	90%			Expand our Patient & Family Partners Program to increase patient/family involvement in hospital committees and initiatives.	Patient & Family Partners are recruited and embedded in hospital quality committees	Percent of increase in the number of trained patient/family partners2.)Percent of increase of the number of committees with patient/family members at the table,	20% increase of the number of trained patient/family advisors; 15% increase in the # of hospital committees with patient/family representatives by December 2017.	
		During your hospital stay, did nurses and doctors include you and/or your					91%	90%							
Theme III: Safe and Effective Care	**Safe**	**Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.**	M A N D A T O R Y	Count / Worker	Local data collection / January - December 2018	701*	83	80			Governance and Leadership	Corporate Commitment to a Culture of Safety: Hospital Workplace Violence Committee will ensure a safe environment and take every reasonable effort to identify all potential sources of violence with the focus on eliminating or mitigating risk.	Number of lost time incidents	Zero number of lose time incidents	
											Physical Environment Design	Completion of the Annual Workplace Violence Risk Assessment to identify potential hazardous situation, review available control measures and support implementation of corrective actions in al lareas of the hospital.	100% compliance in assessment completion	Completion of 100% of Annual Workplace Violence Risk Assessment by March 2019	
											Develop and UtilizeTools and Technology	Identification of Risk and Triggers: Utilizing our electronic medical record for screening and flagging of violent patients/visitors	Number of workplace violence incidents reported to the employer within 12 months	Less than 60 workplace violence incidents reported to the employer within 12 months	
											Develop and UtilizeTools and Technology	review and revise Annual Workplace Violence Risk Assessment tool - complete an external review of the assessement tools available	Review and revisions complete	Review and revisions completed by March 2020	
	Safe	**Number of patients newly diagnosed with hospital-acquired Clostridium Difficile Infection (CDI)**	C	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / January 2018– December 2019	701*	0.17	0.16	Previous target was 0.16. Considerable progress was made in previous year and target		Implement new multi-step diagnostic testing algorithm for Clostridium difficile infection	1) Introduce new laboratory diagnostic testing algorithm: GDH/EIA, flex to PCR 2) Develop EPIC lab reporting capability for new testing methodology 3) Provide frontline stakeholder education on new testing algorithm	Work with the lab, antimicrobial stewardship, iCAT and IPAC to develop testing algorithm and education plan.	GDH/EIA, flex to PCR used to test all C. difficile specimens and reported in EPIC	

								year and target was almost achieved. Continue to strive for previously established target of 0.16.		Review and evaluate new non-touch vapour disinfection technology with efficacy against C. difficile	1) Review literature and complete a market scan for available technology to enhance the current disinfection program 2) Trial new technology, develop an implementation plan for use, which includes updating the C. dfficile policy 3) Update EPIC to capture use and compliance with both UV and newly added vapour techology	Track percent compliance with vapour use in rooms with previous C. difficile patient	100% compliance with vapour use in rooms with previous C. difficile patient	
										Complete an environmental scan and ongoing practice audit of the Intensive Care areas to ensure IPAC best practices are followed.	1) Use various audit tools (IPAC Canada etc) to review environment of ICU to provide recommendations for improvement 2) review of ICU level care policies and procedures for practices impacting on IPAC	Summary and recommendations for 1) environmental, and 2) practice improvements presented to IPAC Committee and other associated committees for implementation	100% adoption of recommendations	
	Safe	**Falls rate per 1000 patient days (HQO)**	C	Adult Inpatients	Hospital collected data / 2018/19 fiscal year	701*	3	4	Falls Program Goal is to reduce number of injuries related to falls		Continue to enhance corporate Falls Prevention Program through the consistent monitoring and application of Fall Prevention intervention strategies	1) Program/team focus on the implementation of Rounding, Mobilization, Least Restraints, Prompted Voiding and Updated IPASS 2) Create with the help of ICAT an audit report for weekly assessments	1) % of all in-patients have a completed fall risk assessments completed on admission, weekly, if change in status and post fall/near miss 2) % of all in-patient IPASS current and contain Fall prevention Intervention strategies	1) 95% complete 2) 95 % complete	
											Enhanced Program/Team communication, education & support	1) Patient Safety Incident reports and Post Fall reviews completed after each Fall/Near miss event 2) Managers to share Patient Safety Incident reports with Clinical teams 3) Support team with feedback of audits and incidents 4) Provide education to address gaps	1) % post-fall incident reviews completed	1) 100% fall incident reviews completed, shared with team and education support provided	
											Quality and Risk to continue to monitor Patient Safety incident System and elecronic medical record data for accuracy; implement improvement strategies as required.	1) Collaborate with Quality and Risk Department to monitor falls incidents for common themes, location of falls, time of day and severity of injury 2) Provide feedback to Programs/Teams 3) Create an audit report on location of falls, time of day and severity of fall injuries	1) % of all staff receive training on Reporting system (RL) 2) % new staff obtain education on falls prevention and management 3) % of fall incident reports reviewed for data collection	1) 100% of all staff trained on RL Reporting system 2) 100% of new staff trained on Falls Prevention and Management during Interprofessional Orientation. 3) 100% of fall RL reports reviewed	
											Development and implementation of a Corporate Interprofessional Fall Prevention Working Group	1)Monitor data/outcomes, & research best practices. 2)Engage clinical teams in providing feedback on improvement initiatives. 3)Share successes corporately to enhance knowledge translation.	Monthly Meetings with a Corporate focus on Knowledge translation.	Agenda, minutes of meetings/ number of education opportunities provided, number of quality improvement initiatives spread corporately.	
	Effective	**Medication reconciliation at admission: Percentage of admissions where all of the patient's medications were reconciled**	C	Rate per total number of admitted patients / admitted patients	Hospital collected data /April - December 2018	701*	43%	75%	Mackenzie Health will focus on optimizing our electronic medical record and improving medication reconciliation on admission.		Create Electronic Medical Record alerting mechanisms for physicans when a retrospective Best Possible Meciation History (BPMH) needs to be reconciled	1. Pharmacy specific sticky note to alert physician. 2. Best Practice Advisory (BPA) in the orders activity to alert the physician, which links directly to the Admission Navigator where the physican can complete reconciliation. 3. Add med list status column to physicians' patient list as an indicator which links to the Admission Navigator where physician can complete reconciliation. "	1. Development and implementation of physican alerting mechanisms described in methods by June 2019.	1. All Physician alerting mechanisms fully implemented in electronic medical record by June 2019.	
											Optimize Electronic Medical Record for Prior to Arrival (PTA) Medication List	1. Create a "Pharmacy comment order" that will not need to be reconciled and may be used to provide information to the physician about PTA medications. Presently use the unable to find feature which still requires reconciliation on PTA screen.	1. Pharmacy Comment Order created by June 2019.	Zero percent unreconciled "unable to find" medication entries used for communication notes in PTA list by September 2019.	
											Create pharmacist medical directive for vitamins and herbals.	1. Create a medical directive which allows pharmacists to reconcile over-the-counter medications which have not been ordered on admission, in situations when all other medications have been reconciled and timing verifies that physician would have seen those medications.	Pharmacy Medical Directive developed and implemented by end of December2019.	100% of pharmacists trained and using vitamins and herbal medical directive by end of December 2019.	
											Physician education program	1. Create Med Rec boot camp session for physicians highlighting: - importance of completing medication reconciliation using Epic features - link to reconciliation home screen from summary activity - med list status on patient list - features from EMR alert mechanisms 2. Provide physician training at departmental meetings 3. Incorporate material into physician pharmacy onboarding orientation session.	Percentage of physicians completed MedRec training session by September 2019. Provider-specific feedback implemented.	80% of physicians involved in patient admission completed MedRec training by September 2019. Provider-specific feedback implemented by end of Q2 2019/20.	

										Revise workflows for L&D patients who are discharged within 24 hours	Explore feasibility of creating special order sets that allow for discharge reconciliation immediately post-partum, similar to short stay surgery patients.	1. L&D physician team engaged in exploring feasilibilty.	Order set implementation with L&D pyhysicians.	
										Explore increasing staffing.	Explore increasing staffing to faciliatate a higher number of best possible medication histories being completed prospectively.	Review staff model using benchmark analysis to faciliate prospective best possible medication history completion.	Staff model and external review complete by March 2020.	
	Effective	**Medication reconciliation at discharge: Percentage of discharges where all patient's medications were reconcilied.**	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / October - December 2018	701*	86%	100%	Mackenzie Health will use this indicator to continue to improve medication reconciliation on discharge.		Monitor and assess current medication reconciliation on discharge process	Continue to monitor and assess any opportunities to increase rate of medication reconciliation on discharge.	Review and analyze trends of medication reconciliation on discharge for all areas in scope on a monthly basis	Continuous monitoring of discharge rate trends in place	
	Effective	**Number of patients with stage 2 to 4 pressure injuries.**	C	All inpatients excluding those in the mother/ baby program and mental health program.	Local data collection / Last fiscal period	701*	20	10	Pressure injuries are considered a Never Event patient safety incident that can be prevented (Canadian Patient Safety Institue), our goal is to reduce our number of pressure injuries to 0 over the next three years		Implement recommendations from Hillrom's Prevalence &Incidence Survey conducted March 2019. Explore implementation of an internal bi-annual P&I survey.	Review and implement recommendations from HillRom's Prevalence and Incidence Survey and internal Bi-annual P&I survey.	Number of recommendations implemented by March 2020	100% of recommendations implemented by March 2020	
											Review frequency of mandatory braden scale assessment and documentation with a target of assessment to be completed every 24 hours.	Collaborate with stakeholders and EPIC analystics to develop a braden scale report to evaluate timely braden scale assessments	Number of braden assessements completed every 24hrs	100% of braden scale assessments and skin assessments in Electronic Medical record	
											Establish a wound care working group	Wound care working group to review mandatory elements of wound care documentation including nutritional screening assessment compliance and frequency.	Quarterly audit of mandatory elements of wound care completed	Complete quarterly audits	
											Review therapeutic surfaces throughout the organization	Replace all damaged mattress and those greater than 5 years of age with new mattresses to ensure all patients are on therapeutic surfaces.	Review all mattresses in the organization that are damaged or greater than 5 years	Complete therapeutic surface audit by March 2019.	