2017/18 Quality Improvement Plan
"Improvement Targets and Initiatives"

Deep River And District Hospital

Deep River and District Hospital

The Four Seasons Lodge

North Renfrew Family Health Team

Sectors:

Deep River and District Hospital
North Renfrew Family Health Team
The Four Season Lodge
All Sectors

AIM		Measure							Change				
Quality dimension	**Issue**	**Measure/Indicator**	**Unit / Population**	**Source / Period**	**Organization Id**	**Current performance**	**Target**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**	**Comments**
Effective	**Effective transitions**	Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort)	Rate / COPD QBP Cohort	CIHI DAD / January 2015 – December 2015	646*	36.86	22.11	A reduction of 40% is a stretch target given small in-patient population and predicable patient population and demographics;	1)Implementation of COPD Quality Based Order Set	Medical Records to provide monthly records of diagnosis of in-patients with COPD; Team Lead to compare QBP COPD order set utilization against current eligible patient population monthly;	Number of COPD QBP Order Sets Utilized (Acute In-Patient)/Number of eligible acute in-patients	100% of acute in-patients diagnosed with COPD will have a QBP COPD order set initiated	
									2)Staff Education on COPD	Nursing medical floor staff will receive education on COPE QBP Clinical Handbook; Multi-disciplinary staff to complete in-service education to support COPD patient care	Number of nursing medical floor staff completed educational review of COPE QBP Clinical Handbook per quarter; Number of staff participated in patient care COPD educational opportunities:number of patient care education sessions related to COPD	100% of nursing staff working on Medical Floor receive education on QBP COPE	
									3)Implement Structured Discharge Phone Calls	Nursing Staff will complete structured discharge phone calls for COPD patients within 72hours of discharge; Completion of discharge calls will be reported with clinical outcomes and plan for further follow up/support	Number of structured discharge phone calls completed for acute COPD in-patients within 72hours of discharge / Number of discharged acute COPD patients per quarter	60% discharged acute COPD in-patients will have completed structured	
	Population health - cervical cancer screening	Percentage of women aged 21 to 69 who had a Papanicolaou (Pap) smear within the past three years	% / PC organization population eligible for screening	See Tech Specs / Annually	92292*	70.9	80.00	Increase of 13% building on current successes achieved in previous years.	1)Patient call reminders.	Nursing to pull lists from EMR quarterly Nursing to review patient chart, call patient and book appointment	Percent of women aged 21 to 69 who are due for a Papanicolaou (Pap) smear in the next three months who have been contacted to schedule an appointment.	95% of women aged 21 to 69 who are due for a Papanicolaou (Pap) smear in the next	
									2)Provide monthly evening PAP clinics	Nursing to monitor the number of scheduled patients for clinics, and monitor number of patients attending	Number patients scheduled for evening PAP clinics	40% of women who require routine PAP testing will be completed by August 2017	
	Population health - colorectal cancer screening	Percentage of Ontario screen-eligible individuals, 50-74 years old, who were overdue for	% / PC organization population eligible for screening	See Tech Specs / Annually	92292*	30	25.00	Target builds on previous successes to enhance current performance	1)Patient call reminders	Nursing to pull list from EMR quarterly. Nursing to review patient chart, call patient and book appointment with nursing. After third reminder call nursing to advise patient will be referred for colonoscopy	Percentage of Ontario screen-eligible individuals, 50-74 years old who have been contacted to schedule an appointment with nursing to pick up their FOBT kit	90% of eligible patients who are due for a colorectal screening will be	
		Percentage of screen eligible patients aged 50 to 74 years who had a FOBT within the past two years,	% / PC organization population eligible for screening	See Tech Specs / Annually	92292*	35	45.00	Target builds on previous successes to enhance current performance	1)Patient call reminders	Nursing to pull list from EMR quarterly. Nursing to review chart and book appointment with nursing. Phone calls to occur twice.	Percentage of Ontario screen-eligible individuals. 50-74 years old who have been contacted to schedule an appointment with nursing to pick up FOBT kit	90% of eligible patients will be contacted for an appointment	
	population health - influenza vaccinations	Percentage of people/patients who report having a seasonal flu shot in the past year	% / PC organization population eligible for screening	EMR/Chart Review / Jan 1, 2016 to Dec 31, 2016	92292*	62	70.00	Improvement of current performance challenged by tracking of flu shots given by external providers/reporting of patients. Target to	1)Establishment of process for data collection of seasonal flu shot information using Ocean tablets.	Nursing staff will establish processes to ensure flu shot information is collected and validated using Ocean Tablets during each office visit.	Progression of development and implementation of processes to collect flu shot information using the Ocean tablet in office.	Established process in place to collect flu shot information using the Ocean tablet in	
									2)Patient call reminders for target population	Nurses will identify patients in target population and initiated reminder calls to facilitate provision of flu shots.	Percent of patients 65 years and over who have been contacted regarding an influenza vaccine.	75% of patients 65 years and over will have been contacted regarding an	
	Population health - diabetes	Percentage of patients with diabetes, aged 40 or over, with two or more glycated	% / patients with diabetes, aged 40 or over	ODD, OHIP-CHDB,RPDB / Annually	92292*	83	90.00	Target builds on previous success to enhance current performance.	1)Patient Compliance to Annual Diabetic Check	Nursing to compile list of patients identified with ICD 9 code 250 the month prior to patients birth month Nursing to call patients and advise pt to pick up annual DM requisition and book annual DM appointment when pt picks up requisition Pt to complete lab work prior to	Percent of patients diagnosed with diabetes who have picked up their lab work requisition per month	85% of patients diagnosed with diabetes will have picked up their lab work requisition	

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	Departmental Dashboard Integrated into Practice	Monthly departmental dashboards completed for all departments	# departments submitting completed departmental dashboards on time / month	Internal Monitoring System / 2017-18	646*	X	100.00	Implementation of departmental dashboards will support achievement of strategic priorities	1)Complete education for leadership and staff on departmental dashboards	Executive Team to determine plan for completion of education for leaders to complete dashboards; Identify support pre and post implementation	Number of departments submitting departmental dashboards / month	100% of department leaders will be trained in departmental	
									2)Develop monitoring system for completion and tracking of departmental dashboards	Executive team to implement tracking system for submission, monitoring and review of monthly departmental dashboards	Number of departments utilizing system to submit, monitor and review departmental dashboards	100% of departments will submit monthly departmental dashboard reports	
									3)Develop communication and reporting of results of Departmental Dashboards	Review and analysis of monthly departmental dashboards to be completed monthly by department head; Trends, risk and analysis based on departmental dashboard data to be communicated to Quality & Patient Safety and related Board Committees quarterly	Number of quarterly report from CNO to Quality and Patient Safety committee based on trends and analysis of departmental dashboard data	1 report per quarter to QPS Committee	
	Operational Plan Progression	Percentage of items completed on operational plan	% completed items / all items on operational plan	Internal Monitoring System / 2017-18	54420*	X	100.00	Completion and monitoring of operational plan achievements supports	1)Tracking and reporting of operational plan progression	Tracking of operational plan progression through ELT monthly; Reporting at least quarterly through board committees; Share with Leadership Council	Number of items completed on operational plan in accordance with timelines	80% of items on operational plan will be completed on time	
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	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July – September 2016 (Q2 FY 2016/17 report)	646*	42.68	34.00	A reduction of 20% is achievable given predicable patient population and demographics, and small in-patient population. No increase in external services to support care for non-acute patients outside	1)1)Each request for patient designation as ALC will be escalated and reviewed for appropriateness to place in an acute inpatient bed or	All potential ALC patients will be reviewed monthly at CCAC/Hospital Planning meeting prior to designation to identify and address potential discharge challenges; All current ALC patients will be reviewed monthly in the same venue with the bed the patient was assigned to to	Number of in-patients with discharge challenges reviewed at monthly CCAC/Hospital meetings	All patients in-patients potentially or currently with ALC status will be reviewed monthly	
									2)Increase the number of patients for whom an "Estimated Discharge Date" (EDD) was determined at least 48 hours prior to	Each physician to identify an estimated discharge date and document on the physicians' order section of the health record; Achievement of assessed EDDs will be tracked monthly on departmental dashboards, and a compliance rate will be determined.	Estimated discharge date determined at least 48 hours prior to discharge / Total number of patients discharged in a month	At least 60% of all acute inpatients will have an estimated discharge date	
									3)Collaborate with CCAC Health Link to improve and decrease the length of stay (and subsequently the patient days) by identifying	Measure the number of inpatients who are referred to Health Links monthly on departmental dashboard.	Number of eligible in-patients referred to Health Links per month.	Minimum of 8 in-patients will be identified and referred by March 31, 2018.	2016/17 Average was 1-3 in patients per quarter for eligible patients
Safe	**Medication safety**	Percentage of residents who were given antipsychotic medication without psychosis in the 7 days preceding their resident assessment	% / LTC home residents	CIHI CCRS / July - September 2016	54420*	40.38	29.00	29% is the provincial average for anti-psychotic use per HQO	1)To review and evaluate all residents anti-psychotic medications quarterly and determine if there is a need for ongoing use.	Documentation RPN evaluates all antipsychotic medications quarterly by reviewing documentation of resident behaviours and considering risk management. Pharmacist to provide recommendations; RPN and physician collaborate on the decision to maintain,	Number of quarterly reviews completed per quarter with pharmacy and nursing recommendations	60% quarterly reviews completed with pharmacy and nursing recommendations	
									2)To conduct education for all RPN staff on FSL on antipsychotic medication use.	Team Lead to coordinate education and supporting resources from BSO and Pharmacy to develop training for RPNs on FSL in appropriate use and alternatives to anti-psychotic medications.	Number of RPNs having completed anti-psychotic education program	80% of RPNs working on FSL have completed anti-psychotic education program	
									3)Provide alternative approaches to dementia care through inter-disciplinary incorporation of purposeful activities for	Provide Montessori and leisure resources on the unit to support evening and weekend staff in purposeful interactions with residents; Incorporate into annual training for FSL staff alternative approaches to Dementia through Montessori methods	Number of residents on quarterly RAI assessment as having experienced behavioural symptoms during last 7 days;	45% of residents on last quarterly RAI assessment documented as having experienced	

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	Safe care	Percentage of residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4 since their previous resident assessment	% / LTC home residents	CIHI CCRS / July - September 2016	54420*	X	7.00	Small population size influences ability to achieve provincial target. Current target is to achieve a 50% or better decrease in current performance.	1)All direct care staff will attend mandatory training on continence care and wound prevention.	Wound care prevention and continence care eduation will be provided as part of mandatory training for all staff	Number of staff having completed annual training on continence care and wound prevention	100% of direct care staff will have received training on continence care and wound	Training content will be incorporated into orientation for all direct care staff
									2)Evaluate incontinence care product usage in the home to ensure most appropriate products are provided and used in	Nursing team to lead review and evaluate current usage/provision of incontinence products with input from residents/family/staff; Evaluate current system against best practice guidelines and ensure gaps are addressed and system is integrated to meet resident	Number of residents/family/staff input received on incontinence products; Review of incontinence management system completed	50% of residents/family and 60% direct care staff provided with input by Sept	
									3)Integration of FSL Skin and Wound Management program into practice	Documentation RPN to provide ongoing support for program to ensure completion of resident risk identification and prevention methods into care plans and practice; Monthly tracking and reporting of FSL skin integrity issues on departmental dashboard; Annual	Number of residents with risk identification completed and results integrated into care plan on quarterly basis; Reporting of skin issues on monthly dashboard completed;	100% of residents will have skin assessment and care planned interventions as	
		Percentage of residents who were physically restrained every day during the 7 days preceding their resident assessment	% / LTC home residents	CIHI CCRS / July - September 2016	54420*	51.85	25.00	Small, stable patient demographics in FSL limit mobility of this indicator	1)Establish and implement program to minimizing use of restraints	Review of current restraint policies; Development of inter-disciplinary program to minimize restraint use in the home;	Development and implementation of restraint minimization program	Formal program established and implemented with education provided to all	
									2)All direct care staff will attend training on minimization of restraints	Minimize restraint education, including alternatives to restraints and responsive behaviour management, education will be provided as part of mandatory training for all staff	Number of staff having completed training on minimization of restraints	100% of direct care staff will have receive training by Dec 31, 2017	
									3)Establish system for regular review and evaluate of restraint use	Care team will evaluate all restraining devices at least quarterly to determine alternatives and if restraint criteria is being met; Nursing staff will perform weekly assessment of all residents documented as having a restraint in place;	Number of residents with quarterly documentation of restraint evaluation / Number of residents identified as having a restraint in place; Number of residents with weekly assessment of restraint / Number of residents identified as having a restraint in place;	80% quarterly restraint evaluation completed by Sept 30, 2017 - 100% by	