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

Deep River And District Hospital

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	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
Effective	Coordinating care	Percentage of patients identified as meeting Health Link criteria who are offered access to Health Links approach	A	% / Patients meeting Health Link criteria	In house data collection / most recent 3 month period	92292*	CB	CB	Health Links Coordinator newly embedded in NRFHT; Coordinator to collect baseline data	1)Define Health Links target population in EMR and identify patients in EMR	Build EMR query to extract patients who meet defined criteria. Health Links Coordinator to review patient list and identify patients by August 2018	Percentage of patients out of total population identified as meeting Health Links criteria	Baseline percentage of patients identified as health links based on current population established by December 2018	Identifying patients using the Health Links criteria will provide the Health Links Coordinator with a real time list of potential Health Links patients and can monitor patients' health status with the patients family physician
										2)Patients identified as Health Link Candidates will be referred to NRFHT Health Links Coordinator	Practitioners to refer identified patients to Health Links Coordinator by Decmeber 2018	Percentage of patients referred to Health Links	100% of Patients identified as Health Link Candidates will be referred to NRFHT Health Links Coordinator by March 31 2019	
	Effective transitions	Percentage of those hospital discharges (any condition) where timely (within 48 hours) notification was received, for which follow-up was done (by any mode, any clinician) within 7 days of discharge.	P	% / Discharged patients	EMR/Chart Review / Last consecutive 12 month period	92292*	CB	CB	Minimal historical data to collate. Focus on data collection and work flow	1)Collaborate with DRDH regarding communication of patients discharged and establish work/communication flow	Program Coordinator to establish communication and work flow with DRDH Discharge Planning once patient discharged by September 2018	Percent of FHT patients discharged from DRDH for which notification was received same or next day	Notification will be received for 100% of FHT patients discharged from DRDH same or next day by March 31, 2019	
										2)Improve transition from hospital to home	Program Coordinator to call patient and implement Post Discharge Follow-Up Phone Call Questionnaire by June 2018	Percentage of discharged patients by quarter with completed Post Discharge Follow-Up Phone call Questionnaire	50% of discharged patients in Quarter 2 will have a completed post discharge questionnaire; 75% of discharged patients in Quarter 3 will have a completed post discharge questionnaire;	
	Wound Care	Percentage of residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a	A	% / LTC home residents	CIHI CCRS / July - September 2017	54420*	X	7.00	Current average rate Q1-Q3 2017 is 9.5%. Aim to achieve sustained rate of 7%.	1)Implement revised, evidenced based skin integrity promotion program.	Evidence based program developed, educated on for all staff and in use. Annual evaluation of program is completed.	Program developed, approved and reviewed.	Program will be approved and in place by September 30, 2018.	

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		stage 2, 3 or 4 since their previous resident assessment								2)Identify and develop Skin Integrity/Wound Care Champions	Identify and develop 2 Nursing Skin Integrity/Wound Care Champions to lead skin integrity / wound care initiatives, provide education and build organizational capacity.	Champions identified, capacity building activities completed.	2 nursing wound care champions will receive training on best practices in wound care and skin integrity promotion; Champions support clinical teams in wound care and review of prevention strategies by March 31, 2019	
Efficient	*Actions identified to document ongoing work under Efficient Quality Domain in 2018-19 narrative progress report.*													
Equitable	*Actions identified to document ongoing work under Equitable Quality Domain in 2018-19 narrative progress report.*													
Patient-centred	*Actions identified to document ongoing work under Patient-Centred Quality Domain in 2018-19 narrative progress report.*													
Safe	**Medication safety**	Percentage of residents who were given antipsychotic medication without psychosis in the 7 days preceding their resident assessment	P	% / LTC home residents	CIHI CCRS / July - September 2017	54420*	38.3	28.50	Movement towards provincial baseline.	1)Increase formal review of anti-psychotic medication utilization	1) Initiate quarterly review of medication utilization and related quality indicators at multi-disciplinary LTC Liaison committee 2) Coordinate behaviour charting with multi-disciplinary medication review and utilization	# residents receiving anti-psychotic medication with multi-disciplinary review per quarter	100% of residents receiving anti-psychotic medication with multi-disciplinary review per quarter	
	Safe care/Medication safety	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 (Q3) 2017	646*	CB	100.00	All inpatients discharged will have a Best Possible Medication Discharge Plan as part of discharge.	1)Revision of medication reconciliation documentation/forms	Electronic medication reconciliation forms to be implemented to provide Best Possible Medication Reconciliation at all points of care transfer, including discharge from inpatient unit.	Revised medication reconciliation forms developed, trialed and in use	Revised medication reconciliation forms in use at all points of transfer	
										2)Implement evidenced based Patient Orientated Discharge Summary (PODS)	Patient Orientated Discharge Summary (PODS) to be developed and implemented on medical inpatient unit.	PODS completed per number of discharges per quarter	75% medical inpatients will have PODS completed by December 31/18; 100% medical inpatients will have PODS completed by March 31/19	
	Workplace Violence	**Number of workplace violence incidents reported by hospital workers (as by defined by**	**M A N D A T**	**Count / Worker**	**Local data collection / January - December 2017**	**646***	**CB**	**0.00**	**Unknown baseline data - new reporting and tracking methods to be implemented.**	**1)Provide Crisis Prevention Intervention (CPI) Training to all staff**	**1) 2 DRDH staff to complete CPI Instructor Training 2) DRDH CPI Training Program Development 3) All staff to complete DRDH CPI Training**	**% of DRDH staff having completed CPI training program**	**100% of DRDH Staff will have completed CPI training by December 31, 2018**	**North Renfrew Health Campus (including Deep River and District Hospital, The**

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		OHSA) within a 12 month period.	**O R Y**						**Aiming for prevention to limit incidences.**	2)Implement Workplace Violence Reporting System	1) Electronic incident reporting system to be implemented to track incidences of workplace violence. 2) Documentation and tracking on monthly departmental dashboard of incidences of violence. 3) Initiate reporting of trends, analysis and resulting actions to leadership and governance.	# summary reports provided to governance tracking incidences of workplace violence	Reports to governance will be provided twice per year on incidences of workplace violence	**Four Seasons Lodge and the North Renfrew Family Health Team) FTE for tracking of Incidences of Workplace Violence = 81.3**
										3)Violence risk flagging will be implemented across all areas of the organization	1) Education to all departments/staff on violence risk tools and flagging system 2) Implement audit process for flagging system	% DRDH staff completed education on violence risk flagging and interventions	100% of DRDH staff completed education on violence risk flagging and intervention by Decembe 31, 2018	
Timely	**Timely access to care/services**	Percentage of patients and clients able to see a doctor or nurse practitioner on the same day or next day, when needed.	P	% / PC organization population (surveyed sample)	In-house survey / April 2017 - March 2018	92292*	45.98	55.00	Incremental progress toward provincial average	1)Change distribution methods of survey to increase response rate of survey	1) Patients with signed email consent will receive a link via email to the survey 2) Patients will be offered tablets to fill out survey	Increase in response rate by completion of survey	25% increase in response rate by completion of survey in Jan 2019	
										2)Track Third Next Available Appointment for all practitioners and report to each practitioner	Continuing to track third next available appointment by ED and reporting to practitioners will prompt changes in addressing addition of clinic days or reducing backlog quarterly	% patients who respond positively to patient sanctification survey when asked about availability of same day next day access appointments	30% increase by 2018/19 Patient Experience Survey	