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

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

	Measure							Change			
Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure
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)											
Efficient	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.	60	75.00	LHIN average is 75%	1)Remind FHT physicians to notify admin of d/c patient from DRDH.	Admin receives discharge summary from HRM or communication from FHT physician and send message to nursing staff	Percentage of hospital discharged patients who receive a post discharge phone call follow up	75% of discharged patients will have received a phone call from nursing and completed the EA by end of Q4 19/20
								2)Ensure all discharge summaries received are followed up by nursing	Nursing to contact all patients within seven days post-discharge from hospital and complete medication reconciliation	Percentage of patients who receive a post discharge nursing phone call follow up	75% of discharged patients will have received a phone call from nursing and completed the EA by end of Q4 19/20

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								3)The need for a post-discharge appointment with a physician will be assessed and, if required booked.	The need for a post-discharge appointment with a physician will be assessed, triaged and booked by nursing.	Percentage of patients who receive a post discharge phone call follow up	75% of discharged patients will have received a phone call from nursing which includes assessing need for appointment and completed the EA by end of Q4 19/20
Patient-centred	# of Lodge At Home-long term care transformation milestones completed	C	Number / N/a	Local data collection / 0	0	4.00	Plan to complete minimum of 4 Lodge at Home milestones in 2019/20	1)LTC Transformation progression of Lodge at Home action plan	1. DINING: Pleasurable dining experience implemented 2. ENTRANCE: Physical Entrance refreshed to reflect Lodge/home entry & entry flow to LTC via front entrance 3. EDUCATION: Resident Centered Care philosophy education completed for all staff 4. STAFFING PATTERNS: Interdepartmental shift routines established to provide continuity of care	# of recommended modifications completed	4 milestones completed by January 31, 2020
	Percentage of long-term care home residents in daily physical restraints over the last 7 days	C	% / LTC home residents	In house data, interRAI survey / Q3 18/19	28.57	21.50	Target 25% below baseline	1)Improve supports to minimize resident responsive behaviours	Implement BSO communication/education at LTC departmental meetings	# of LTC departmental meetings that include BSO update/education	100% of LTC departmental meetings include BSO updates/education by Dec 31, 2019

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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	CB	100.00	Organizational policy reflects 5 day response	1)Implement electronic complaint tracking process	Develop complaint tracking tool on Surge	Surge complaint tracking implemented	Surge complaint tracking implemented by June 30, 2019
								2)Review and update policy to reflect feedback (complaint) process for organization	Policy and procedure reviewed to ensure reflect 5 day acknowledgement timing	Policy and procedure updated	Policy and Procedure will be updated by Sept 31, 2019
								3)Enhanced tracking and communication of feedback timelines responses	Develop monthly dashboard indicator for complaint acknowledgement	Dashboard indicators in place and completed monthly	Complaint acknowledgement timelines included on all dashboards by June 30, 2019
								4)Provide education for staff on customer service and feedback/complaint response process	Staff education regarding customer service and feedback/complaint process and electronic tracking tool/reporting of feedback	% of staff completed training on feedback / complaint process and electronic tracking tool	100% of staff completed training on feedback/ complaint process and electronic tracking tool by June 30, 2019
Patient-centred	Percentage of patients who responded positively to the question “the last time you were sick or were concerned with a health problem, were you able to get an	C	% / Survey respondents	In-house survey / 18/19	74.8	80.00	Would exceed LHIN average and demonstrate change effectiveness	1)Integrate patient engagement technology. Encourage patients to register for online portal to schedule an appointment for the date and time they want	% of patients registered for online portal	50% of patients will register for online booking portal by Q3	80% of patients responding positively to the survey question in Q4 19/20

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	able to get an appointment on the day they wanted"							2)Monitor ED visits and report patient usage to physicians quarterly.	# of ED visits quarterly. An increase in ED visits will prompt practitioners to incorporate more urgent care slots	Reduction in # of ED visits by Q4	80% of patients responding positively to the survey question in Q4 19/20
								3)Monitor third next available (TNA) for all practitioners	Monthly feedback of TNA to physicians and provide opportunities to adjust schedule	TNA for all practitioners will be <=5 by Q4	80% of patients responding positively to the survey question in Q4 19/20
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**	**15**	**12.00**	**25% lower than baseline**	**1)Build staff capacity & knowledge to avoid/minimize workplace violence**	**Provide all staff with in house Non-Violent Crisis Prevention education**	**% of DRDH staff having completed CPI education**	**100% of DRDH staff will have CPI education by Dec 31,2019**
								2)Build staff capacity & knowledge to avoid/minimize workplace violence	Provide LTC staff with Gentle Persuasive Approach (GPA) education	% of LTC staff having completed GPA training	100% of LTC staff will have GPA training by Mar 31, 2020
								3)Improve awareness and recognition workplace violence incidents and reporting	Improve staff awareness and knowledge on the Surge Workplace Violence incident report tool	Number of Workplace Violence incidents reported monthly	100% of staff complete workplace violence education on hire and participate in annual education updates by Dec 31, 2019

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								4)Improve awareness and recognition workplace violence incidents and reporting	Spot light workplace violence in Zinger quarterly	Number of Quarterly spotlight education provided in Zinger	4 quarterly spotlight sections will be provided in the Zinger by March 31, 2020
								5)Improve awareness and recognition workplace violence incidents and reporting	Create debriefing tool and provide support for staff	#1 Debriefing tool in place; #2 # of occurrences tool was used	Debriefing tool in place and used for any incidents of violence with staff injury by Sept 30, 2019
								6)Improve awareness and recognition workplace violence incidents and reporting	Quarterly Reporting of Workplace Violence incidences to JHSC, QRS and ELT	Number of Quarterly Reports provided	3 quarter end reports provided by Jan 31, 2020
								7)Develop Emergency Response procedures and education for violence related emergencies	Build Code White response capabilities- perform regular mock code white drills (minimum 2 annually);	Number of mock code white episodes called	At least 2 mock code whites held by Dec 31, 2019
								8)Develop Emergency Response procedures and education for violence related emergencies	Develop, train and implement Code Silver and Purple	Number of Code Policies Approved	Code Silver and Code Purple Policies approved and education provided by Dec 31, 2019

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Safe	Hand Hygiene Compliance Before and After Patient Contact	C	Count / Worker	Local data collection / 19/20	CB	100.00	Hand hygiene should be completed at all stages to prevent the spread in infection and maintain patient safety	1)Implement hand hygiene program	Implement hand hygiene program	Hand hygiene program implemented	Hand hygiene program implemented by October 1, 2019
								2)Monthly hand hygiene audits to be tracked on departmental dashboards	Implement monthly hand hygiene audits and track on departmental dashboards	% of departmental dashboards that are tracking monthly hand hygiene audits	100% of clinical departments tracking monthly hand hygiene audits on departmental dashboards
								3)Hand hygiene education to staff on hire and annually	Implement on hire and annual hand hygiene education	% of employees with on hire and annual hand hygiene education	100% of employees will have hand hygiene education on hire and annually by October 1, 2019
Safe	Medication reconciliation at admission through ER	C	Count / N/a	Local data collection / Q1 19/20	CB	90.00	Due to limitations in ability to contact	1)Processes established for standardized medication	Improve communication with local pharmacies and standardize process/request for medication lists	Process established for sourcing of medication information established	90% of patients admitted through ER will have a medication

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							external resources after hours most patient admitted through ER should have a medication reconciliation completed at time of admission to create a BPMH	2)Processes established for standardized medication reconciliation based on BPMH – including generation of orders	Medication reconciliation policy and procedure established and communicated to team	Policy established and communicated to team	90% of patients admitted through ER will have a medication reconciliation completed at time of admission by October 31, 2019