OSMH 2018/19 Quality Improvement Plan

"Improvement Targets and Initiatives"

AIM		Measure							Change				
Quality dimension	Issue	Measure/Indicator	Type	Unit / Population	Source / Period	Current performance	Target	Target justification	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) A= Additional (do not select from drop down menu if you are not working on this indicator) C = custom (add any other indicators you are working on)

Quality dimension	Issue	Measure/Indicator	Type	Unit / Population	Source / Period	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
	Effective transitions	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 / April - June 2017(Q1 FY 2017/18)				1)				This indicator will not be an improvement focus for OSMH in 2018-19.
		Rate of psychiatric (mental health and addiction) discharges that are followed within 30 days by another mental health and addiction admission	P	Rate per 100 discharges / Discharged patients with mental health & addiction	CIHI DAD,CIHI OHMRS,MOHTLC RPDB / January - December 2016	14.45			1)				This indicator will not be an improvement focus for OSMH in 2018-19.
		Risk-adjusted 30-day all-cause readmission rate for patients with CHF (QBP cohort)	P	Rate / CHF QBP Cohort	CIHI DAD / January - December 2016	23.6			1)				This indicator will not be an improvement focus for OSMH 2018-19.
		Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort)	P	Rate / COPD QBP Cohort	CIHI DAD / January - December 2016	16.88	16.88	*	1)Continued partnership	Continued partnership	monitor	monitor	We will continue to partner with our North Simcoe Muskoka LHIN partners to strengthen care at transitions for this patient population.

		Risk-adjusted 30-day all-cause readmission rate for patients with stroke (QBP cohort)	P	Rate / Stroke QBP Cohort	CIHI DAD / January - December 2016	7.36			1)				This indicator will not be an improvement focus for OSMH 2018-19
		Percent of patients with new pressure ulcers(stage 2 or higher) on S1, IMRS, C5 & ICU. This will be a cumulative quarterly point incidence rate using the measure of: total number of patients with new ulcers divided by the total number of patients reviewed in the quarterly incidence survey. This indicator is reported on a quarterly basis.	C	% / All acute patients	In-home audit / In house data collection Q4 17-18 to Q3 18-19	4.7	4.70	We expect that our 18-19 performance will range between 3.50% and 4.70%	1)Monitor	Monitor	Monitor	Monitor	No new change ideas in 2018-19. We will continue to monitor this indicator in 2018-19
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	P	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July - September 2017	19.71	20.20%	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%	1)monitor	monitor	monitor	monitor	No new change ideas in 2018-19. We will continue to monitor this indicator in 2018-19.
Patient-centred	**Person experience**	"Would you recommend this emergency department to your friends and family?"	P	% / Survey respondents	EDPEC / April - June 2017 (Q1 FY 2017/18)	56	58.00	*	1)Redesign and transform the ED to Improve patient flow	Teamwork between physicians and nurses has a positive association with patient satisfaction and outcomes. In 2018-19 investigate the feasibility of a physician-nurse dyad model in the OSMH ED	1. Feasibility study and decision made 2. Operationalize model pending decision to implement	Feasibility study complete and decision made by December 31, 2018.	

									2)Provide cultural competency training to improve the knowledge, attitudes and skills of OSMH staff to meet the needs of our diverse patient population.	Phased roll out of cultural competency training - elearning module 2. Develop and conduct 2 cultural competency workshops (18-19 focus on inpatient and ED staff)	1. Phase 1 roll out completed 2. Provide in-house cultural competency workshop.	1. Phase 1 cohort education completed by March 31 2019. 2. Minimum of 2 cultural competency workshops held before March 31, 2019.	
		"Would you recommend this hospital to your friends and family?" (Inpatient care)	P	% / Survey respondents	CIHI CPES / April - June 2017 (Q1 FY 2017/18)	65.5	68.00	The National Research standard is Positive score to align with CAHPS standards. The positive score reflects the top box on the response scale, or a 9 or 10 for any question asking to rate from 0 to 10.	1)Improving the quality of professional transfer of accountability will increase patient safety and patient involvement in the coordination of care plans.	Create and implement an audit tool to improve sustainability of the practice of bedside shift report on inpatient units S1, IMRS and C5	1. Create audit tool 2. Establish audit and feedback program for the practice of bedside shift report	100% of scheduled bedside shift report audits are completed (using the new tool) by March 31, 2019	Continuation of 17-18 QIP initiative
									2)Delays in discharging patients can impact hospital and emergency department throughput. We will improve our 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. Evaluate the effectiveness of the change of Hospitalist Handover from Friday to Monday.	# of discharges occurring on weekends	Increase the number of weekend discharges	
									3)Provide cultural competency training to improve the knowledge, attitudes and skills of OSMH staff to meet the needs of our diverse patient population.	1. Phased roll out of cultural competency training - elearning module 2. Develop and conduct 2 cultural competency workshops (18-19 focus on inpatient and ED staff)	1. Phase 1 roll out completed 2. Provide in-house cultural competency workshop.	1. Phase 1 cohort education completed by March 31 2019. 2. Minimum of 2 cultural competency workshops held before March 31, 2019.	
	Palliative care	Percent of palliative care patients discharged from hospital with the discharge status "Home with Support".	P	% / Discharged patients	CIHI DAD / April 2016 - March 2017	95.73	95.73	*	1)monitor	monitor	monitor	monitor	This indicator will not be an improvement focus for OSMH in 2018-19

Safe	**Safe care/Medication safety**	Medication reconciliation at admission: The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital	A	Rate per total number of admitted patients / Hospital admitted patients	Hospital collected data / October – December (Q3) 2017	80	82.00	*	1)Identifying and implementing process improvements on the Paediatric and Obstetrics units would have a postive impact on our ability to meet our organization wide Med Rec at Admission target of 80%	Apply Lean process improvement methodology to current Med Rec at Admission process on the Paediatric and Obstetrics Units. Q1 identify and pilot process improvements. Q2 - Q4 Implement and monitor improvements for sustainability.	% Medication Reconciliation on Admission complete	80% Med. Rec. at Admission completed by March 31, 2019	The Med Rec on Admission process varies from other OSMH patient units on Paediatrics and Obstetrics. Best Possible Medication History (BPMH) vs.Admission Medication Orders (AMO) to identify and resolve discrepancies is completed by nursing staff not pharmacists on these units.
									2)Improved confidence in the data collection and regular monitoring of key med rec parameters will support sustained consistent performance and provide feedback to organization leadership and participating staff.	Examine current data collection and reporting methods to develop shared understanding and increase confidence that our reporting process reflects performance accurately. Q1 Examine current data collection and reporting methodology, establish set of key metrics. Q2-Q4 - Implement cascading reporting of key med rec metrics to stakeholders to identify, prioritize and act upon opportunities to improve efficiency and effectiveness of the process.	Regular, cascading reporting of key med rec metrics from Board to individual units.	Improved Med Rec data monitoring and reporting program in place by March 31, 2019	Electronic medical record (EMR) has helped standardize medication reconciliation, but data quality and technical issues continue to pose a challenges to effective medication reconciliation process management.
		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	72	80.00	*	1)The medication reconciliation process is the 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.	The physician champion of the Med Rec subcomittee provides education to OSMH credentialed staff	Education provided	Credentialed staff receive Med Rec process education.	

									2)The medication reconciliation process is the shared responsibility and requires an inter-professional team approach that includes pharmacists, physicians, nurses and other healthcare providers. Ensuring that an up to date med rec orientation package is available to onboarding and locum physicians is vital to the success of the program.	Develop an up to date comprehensive Med Rec orientation package for physicians.	Orientation package complete and available electronically.	Med Reconciliation orientation package is available to on boarding OSMH physicians by March 3, 2019	
									3)Improved confidence in the data collection and regular monitoring of key med rec parameters will support sustained consistent performance and provide feedback to organization leadership and participating staff.	Examine current data collection and reporting methods to develop shared understanding and increase confidence that our reporting process reflects performance accurately. Q1 Examine current data collection and reporting methodology, establish set of key metrics. Q2-Q4 - Implement cascading reporting of key med rec metrics to stakeholders to identify, prioritize and act upon opportunities to improve efficiency and effectiveness of the process.	Regular, cascading reporting of key med rec metrics from Board to individual units.	Improved Med Rec data monitoring and reporting program in place by March 31, 2019	Electronic medical record (EMR) has helped standardize medication reconciliation, but data quality and technical issues continue to pose a challenges to effective medication reconciliation process management.
		The number of antimicrobial-free days (both antibacterial and antifungal) in ICU for the reporting period	A	Rate per 1,000 patient days / ICU patients	CCIS / Most recent quarter available	337.48	337.48	Foundational work on data collection and reporting mechanisms will not impact this result in a measurable way in 2018-19	1)The OSMH Antibiotic Advisory Committee (AAC) meets regularly to monitor antibiotic use and identify quality improvement opportunities. In 2018-19 a sub committee will be formed to examine current data collection and reporting methods to increase the committee's confidence that our reporting process accurately reflects our performance.	Examine current data collection and reporting methods to develop shared understanding and increase confidence that our reporting process reflects performance accurately.	1. Examine current state data collection and reporting. 2. Sub-committee report to AAC 3. Standard work developed and implemented	Q1. Current state of CCIS (Critical Care Information System) data collection and reporting. Q2. Report back to OSMH Antibiotic Advisory Committee. Q3-Q4. Standard work developed and implemented for CCIS data review as standing agenda item at AAC meetings.	

Workplace Violence	**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 2017**	**87**	**104.00**	**Training in 18-19 will result in an increased awareness of what constitutes a workplace violence incident. We predict the number of" near miss" reporting will increase.**	**1)Reduce WPV incidents by developing and implementing a standardized approach to conducting post code white evaluations (violent patient incident). Sharing lessons learned, understanding root causes and data trends can prevent future incidents.**	**Code White sub-committee develop and implement a standardized debriefing tool**	**% Post Code White debriefs completed within 1 week**	**100% of code white incidents followed by debrief within 1 week.**	**FTE=892**
								2)Reduce WPV incidents by providing mandatory violence prevention and response training for all staff.	Ensure all staff receive appropriate training, low risktraining 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 probablity for staff and patient harm.	% of staff trained in violence prevention and response training	100% of staff trained by March 31, 2019	
								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	Conduct 4 Mock Code White (violent patient simulation) exercises and assess Code team performance and response by March 31, 2019	
								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, 2019.	

		Frequency of Injuries The number of Lost Time injuries due to WPV per 100 employees per year. Obtained by dividing the lost time injuries by paid hours worked and multiplied by 200,000. This indicator is reported as a quarterly value	C	Rate per 100 / Worker	In house data collection / Q3 2017-18	0.6	0.57	Considerable improvement effort continues to be focused on this indicator. We are predicting a 5% reduction from current performance (17-18 Q3)	1)Reduce the severity of WPV incidents by developing and implementing a standardized approach to conducting post code white evaluations (violent patient incident). Sharing lessons learned, understanding root causes and data trends can prevent future incidents.	Code White Sub-committee develop and implement a standardized de-briefing tool.	% Post Code white debriefs completed within 1 week	100% of code white incidents followed by debrief within 1 week	
									2)Reduce the severity of WPV incidents by providing mandatory violence prevention and response training for all staff.	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 probability for staff and patient harm.	% of staff trained in violence prevention and response training	100% of staff trained by March 31, 2019	Training in 18-19 will result in an increased awareness of what constitutes a workplace violence incident. We predict the number of" near miss" reporting will increase.
									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 assessment completed	Conduct 4 Mock Code White (violent patient simulation) exercises and assess Code team performance and response by March 31, 2019	
									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, 2019.	

		Severity of Injuries The number of days lost per 100 workers due to workplace accidents occurring this year. Obtaining by dividing the number of days lost by paid hours work and multiplied by 200,000.This indicator is reported as a quarterly value.	C	Rate per 100 / Worker	In house data collection / Q3 2017-18	11.6	11.04	Considerable improvement effort continues to be focused on this indicator. We are predicting a 5% reduction from current performance (17-18 Q3)	1)Reduce the severity of WPV incidents by developing and implementing a standardized approach to conducting post code white evaluations (violent patient incident). Sharing lessons learned, understanding root causes and data trends can prevent future incidents.	Code White Sub-committee develop and implement a standardized de-briefing tool.	% Post Code white debriefs completed within 1 week	100% of code white incidents followed by debrief within 1 week	
									2)Reduce the severity of WPV incidents by providing mandatory violence prevention and response training for all staff.	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 probability for staff and patient harm.	% of staff trained in violence prevention and response training	100% of staff trained by March 31, 2019	Training in 18-19 will result in an increased awareness of what constitutes a workplace violence incident. We predict the number of" near miss" reporting will increase.
									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 assessment completed	Conduct 4 Mock Code White (violent patient simulation) exercises and assess Code team performance and response by March 31, 2019	
									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, 2019.	

Timely	**Timely access to care/services**	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	A	Hours / Patients with complex conditions	CIHI NACRS / January - December 2017	9.8	9.50	*	1)Delays in discharging patients can impact hospital and emergency department throughput. We will improve our 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. Evaluate the effectiveness of the change of Hospitalist Handover from Friday to Monday.	# of discharges occurring on weekends	Increase the number of weekend discharges by March 31, 2019.	
									2)Redesign and transform the ED to Improve patient flow	Operationalize a “results pending” area for low-acuity patients who are unlikely to be admitted to await diagnostic results and be actively monitored by a dedicated nurse so ED rooms and beds may be utilized for higher acuity patients.	Conduct a trial of the use of a "results pendings" area to move low-acuity patients who are waiting on diagnostic results or who require further observation to a dedicated space actively monitored by a dedicated staff	PDSA trial of "results pending area" in the ED complete by Sept 30,2018. Evaluationof the trial completed by Dec 31, 2018. Pending successful trial, results pending area operational by March 31, 2019.	
									3)Redesign and transform the ED to Improve patient flow	Focus on overcapacity planning as well as surge planning to improve the flow of admissions out of ED to allow capacity for more timely care of our ED patients.	Progress to project milestones	100% of project milestone on track by March 31, 2019	
									4)Redesign and transform the ED to Improve patient flow	Teamwork between physicians and nurses has a positive association with patient satisfaction and outcomes. In 2018-19 investigate the feasibility of a physician-nurse dyad model in the OSMH ED	1. Feasibility study and decision made 2. Operationalize model pending decision to implement	Feasibility study complete and decision made by December 31, 2018.	

									5)Streamline the process on the day of discharge by implementing a discharge lounge. Discharge lounges allow resources to be freed up for new admissions thus reducing wait times for incoming patients.	Conduct a trial of the use of a discharge lounge for patients who have a planned discharge arranged and can be transferred to the lounge to complete the discharge process. Ie) transportation needs, receiving medication from the pharmacy, completing discharge paperwork.	PDSA trial of discharge lounge. Evaluation of trial and Senior Management Team (SMT) decision whether or not to implement on a permanent basis.	PDSA trial of discharge lounge complete by June 30, 2018. Evaluation and SMT decision to implement by Sept 30, 2018.	Implementing a discharge lounge can have both positive and negative effects on the organization. It can allow beds to be freed up sooner to increase capacity but can also lead to increased workload and resource requirements. This trial and evaluation by itself will not impact ED LOS but if implemented after October 1, 2018 could have an impact in 2018/19.