Alexandra Hospital Ingersoll
Tillsonburg District Memorial Hospital
Partnering to keep healthcare close to home.

Quality, Risk and Patient Safety Report

Fiscal Year 2019-20, First Quarter

Presented By: Cheryl Pfaff – Chief Nursing Executive / Vice President Clinical, Quality & Safety

1. PATIENT EXPERIENCES

Our Patients Said…

We received a request to repatriate a patient to Tillsonburg District Memorial Hospital (TDMH) from London Health Sciences Centre (LHSC) as this was their home community and the family wanted them closer to home. The patient required support on continuous BiPAP machine due to a chronic palliative illness. In order to ensure that this patient could be cared for at TDMH, a multidisciplinary meeting was held between the TDMH and LHSC to identify required services. A plan was put in place and the patient was successfully transferred to TDMH.

Upon admission to the hospital, the patient and their wife were informed that TDMH was experiencing gaps in their Respiratory Therapy (RT) coverage. As a result, the patient and their family were concerned for the safety of the patient and requested that the patient be transferred back to LHSC or to another facility that had RT coverage.

We Did…

All attempts were made by TDMH to find RT coverage; however, due to unforeseen staffing issues it was not possible to cover with internal resources. The Regional Director at the Local Health Integration Network (LHIN) was contacted to discuss possible options for RT coverage for this patient. TDMH learned that there was a community service, currently contracted with the LHIN, who routinely cares for all patients requiring non-invasive and invasive breathing support in the community and had a previous relationship with this patient. After coordination of care, the service provider agreed to provide on-call coverage for this patient when there were gaps in RT coverage at the hospital. The LHIN agreed to provide the funding required for the on-call service.

Collaborating with our community partners allowed this patient to stay at TDMH closer to their family as per their wishes while ensuring they received safe, quality care and while optimizing the patient experience.

2. QUALITY AND RISK MANAGEMENT UPDATE

a) Accreditation

AHI will be participating in the Accreditation Qmentum Survey from September 9 – 11, 2019.

b) Quality Improvement Plan (QIP)

AHI/TDMH's 2019/20 QIP includes seven indicators and related directly to the following quality dimensions: effective, patient-centred, safe and timely. The AHI and TDMH QIP Narrative and Work Plan were approved by the Board of Directors and submitted to Health Quality Ontario for April 1, 2019. The status of this plan is incorporated into the quality dimension sections of this report.

c) Patient Satisfaction Surveys

AHI and TDMH have committed to providing a culture of patient and family centred care. As part of this commitment, we have updating our patient satisfaction surveying methodology in order to elicit timely feedback regarding the experiences of our patients and their families. This updated methodology has been deployed across both hospitals effective April 2019. Going forward, all discharged Inpatients patients and a select number of Emergency Department patients will be offered the opportunity to complete a survey (paper or electronic format). Survey boxes are now available in specific areas throughout the hospital. Surveys are collected on a weekly basis and work is underway to develop a tool track responses and to report to our staff, Physicians and Board of Directors.

d) Patient Advisors

Patient and family centred care is an approach to planning, delivery and evaluation of health care that is grounded in mutually beneficial partnerships among patients, families and health care. Patient and Family Advisor works in partnership with the hospital staff to support a truly patient centred experience by providing the patient and family perspective across a wide range of hospital initiatives, programs, services and policies. We are actively recruiting Advisors to be part of our team and have received a positive response to date. We look forward to continuing to incorporate their voice at the committee level.

OUR QUALITY IMPROVEMENT REPORT CARD

	Indicator	What are we trying to measure?	Site	Target	Q1	Persons Impacted
Timely & Efficient Transitions						
1	ED Wait Time ☆	How long did Emergency patients wait for admission to an inpatient bed after the decision to admit?	AHI	4.9 Hrs	3.1	NA
			TDMH	6 Hrs	10.6	NA
2	ED Length of Stay ☆	How long did our non admitted patients (CTAS 1-3) stay in the Emergency Department?	AHI	5 Hrs	4.9	NA
			TDMH	5.4 Hrs	6.1	NA
Service Excellence						
3	Patient Experience: ED ☆	How many patients would return to our Hospital for Emergency Department care?	AHI	80%	99%	224
			TDMH	80%	40%	2
4	Patient Experience: IP ☆	How many patients would return to our Hospital for Inpatient care?	AHI	80%	100%	14
			TDMH	80%	97%	28
Safe & Effective Care						
5	Hand Hygiene Before Contact **M**	How often did staff clean their hands before patient contact?	AHI	88.2%	85.7%	NA
			TDMH	88.2%	95.3%	NA
6	Hand Hygiene After Contact **M**	How often did staff clean their hands after patient contact?	AHI	91.6%	100%	NA
			TDMH	91.6%	93.5%	NA
7	Hospital-Acquired MRSA Rate **M**	How many patients acquired Methicillin-resistant Staphylococcus aureus (MRSA) while admitted?	AHI	0	0	0
			TDMH	0	0	0
8	Hospital-Acquired VRE Rate **M**	How many patients acquired Vancomycin-resistant Enterococci (VRE) while admitted?	AHI	0	0	0
			TDMH	0	0	0
9	Hospital-Acquired VAP Rate **M**	How many patients acquired Ventilator-Associated Pneumonia (VAP) while admitted?	TDMH	0	0	0

	Indicator	What are we trying to measure?	Site	Target	Q1	Persons Impacted
Safe & Effective Care						
10	Hospital-Acquired CLI Rate **M**	How many patients acquired Central Line-Associated Primary Blood Stream Infection (CLI) while admitted?	TDMH	0	0	0
11	Clostridium Difficile Infection **M**	How many patients acquired Clostridium difficile Infection (CDI) while admitted?	AHI	0	0	0
			TDMH	0	0.24	1
12	SSC Compliance **M**	How many patients were screened using the Surgical Safety Checklist (SSC)	AHI	99.3%	100%	125
			TDMH	99.3%	100%	574
13	Falls Rate with Harm	How many Inpatients fell and were harmed?	AHI	TBD	2.46	4
			TDMH	TBD	1.24	5
14	Acute Length of Stay	How many Inpatients stayed longer than what was expected?	AHI	6.5	6 days	NA
			TDMH	6.6	7.2 days	NA
15	Medication Reconciliation Rate - Admission	How many patients have their medications reconciled at admission?	AHI	TBD	NA	NA
			TDMH	TBD	NA	NA
16	Medication Reconciliation Rate - Discharge	How many patients have their medications reconciled at discharge?	AHI	TBD	NA	NA
			TDMH	TBD	NA	NA
17	Care Powerplans ☆	How many quality based procedure Powerplans have been implemented?	AHI	3	5	NA
			TDMH	3	5	NA
18	COPD Care Powerplans ☆	How many patients with COPD have been admitted using a COPD Powerplan?	AHI	90%	NA	NA
			TDMH	90%	NA	NA
19	Violent Incidents ☆	How many staff members reported an incidence of workplace violence?	AHI	17	3	3
			TDMH	30	7	7

Legend

				☆	M	A
Meets or Exceeds Performance	Monitoring Required, Performance Approaching (Within 2%)	Performance Outside Acceptable Target Range, Action Plan Required	Not Available	*QIP Indicator*	*Mandatory Patient Safety Indicator*	*Accreditation Requirement*

3. INDICATOR TRENDS AND NOTES

Executive Summary

In the *Timely & Efficient Transitions* quadrant, TDMH continues to see an increased number of higher acuity patients visiting our ED as well as a higher inpatient occupancy resulting in increased bed blocking of admissions from the Emergency Department (ED). As a result, our ED patients are waiting longer. Being a small hospital, our Diagnostic Imaging Department does not operate 24/7. If imaging is required, these patients wait until 0800 to have testing done. We will continue to monitor our ED wait time and ensure that we maintain a laser focus on access and flow within this department.

In the *Service Excellence* quadrant, AHI and TDMH introduced a new surveying methodology in April 2019 in order to elicit timely feedback regarding the experiences of our patients and their families. As a result, and over the last quarter, a total of 305 TDMH Inpatients and 910 ED patients received surveys. At AHI, 111 Inpatients and 455 ED patients had an opportunity to complete surveys. Of those surveys, only 43 Inpatient surveys (14 at AHI; 29 at TDMH) and 232 ED surveys (227 at AHI; 5 at TDMH) were completed and returned. Of those patients returning their feedback, 100% (AHI) and 97% (TDMH) of our Inpatients and 99% (AHI) 40% (TDMH) and of our ED patients would return to our Hospital for care in the future.

In the *Safe & Effective Care* quadrant, we have included a number of mandatory public reporting indicators including the Clostridium Difficile infection rate for both hospitals. In addition, we have committed to monitoring a number of indicators that assist each organization in aligning with Accreditation Canada best practice standards.

TIMELY & EFFICIENT TRANSITIONS

4. FIVE-QUARTER TREND OF PERFORMANCE

#	Indicator	Site	Target	FY 2018/19 Q1	FY 2018/19 Q2	FY 2018/19 Q3	FY 2018/19 Q4	FY 2019/20 Q1
1	ED Wait Time: 90th Percentile Date/Time Patient Left ED - Date/Time Disposition Decision. Admitted patients.	AHI	4.9 Hrs.	3.2	3.4	5.6	14.7	3.1
		TDMH	6 Hrs.	4.0	4.7	6.8	15.29	10.6
2	ED Length of Stay: The total ED length of stay* where 9 out of 10 complex (all non-admitted Triage CTAS I, II and III patients) completed their visits. *ED Length of Stay defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ED	AHI	5 Hrs	5.2	5.4	5.5	5.2	4.9
		TDMH	5.4 Hrs	5.6	5.7	5.9	6.6	6.1
3	Patient Experience ED: Number of survey respondents who answered "yes" to the following survey question: If you had to come back to a Hospital, would you return to our Hospital?	AHI	80%	NA	NA	NA	NA	99%
		TDMH	80%	NA	NA	NA	NA	40%
4	Patient Experience IP: Number of survey respondents who answered "yes" to the following survey question: If you had to come back to a Hospital, would you return to our Hospital?	AHI	80%	NA	NA	NA	NA	100%
		TDMH	80%	NA	NA	NA	NA	97%
5	Hand Hygiene Before Contact: Hand hygiene before initial patient/patient environment contact by combined health care provider type / Total number of observed hand hygiene indications	AHI	88.2%	Annual 94.4%				85.7%
		TDMH	88.2%	Annual92.6%				95.3%
6	Hand Hygiene After Contact: Hand hygiene after initial patient/patient environment contact by combined health care provider type / Total number of observed hand hygiene indications	AHI	91.6%	Annual 94.4%				100%
		TDMH	91.6%	Annual 95.7%				93.5%
7	Hospital-Acquired MRSA Rate: Number of new cases of MRSA-bacteraemia associated with the reporting facility x 1000 / Total number of patient days	AHI	0	0	0	0	0	0
		TDMH	0	0	0	0	0	0
8	Hospital-Acquired VRE Rate: Number of new cases of VRE-bacteraemia associated with the reporting facility x 1000 / Total number of patient days	AHI	0	0	0	0	0	0
		TDMH	0	0	0	0	0	0
9	Hospital-Acquired VAP Rate: The number of VAP cases that developed in the ICU / Total number of mechanical ventilator days	TDMH	0	0	0	0	0	0
10	Hospital-Acquired CLI Rate: The number of CLI cases that developed in the ICU / Total number of central line days	TDMH	0	0	0	0	0	0

11	Clostridium Difficile Infection: Number of new CDI cases associated with the reporting facility (i.e., symptoms not present on admission and >72 hours after admission or at time of admission but related to a previous admission to the facility) x 1000 / Total number of patient days	AHI	0	0	0.54	1.05	.51	0
		TDMH	0	.44	.50	1.65	0.24	0.24
12	SSC Compliance: The number of times all three phases of the surgical safety checklist was Performed / Total number of surgeries	AHI	99.3%	100%	100%	100%	100%	100%
		TDMH	99.3%	97%	100%	100%	100%	100%
13	Falls Rate with Harm: Number of Inpatients who fell and were harmed (Level 3+) x 1000 / Total number of patient days	AHI	TBD	1.16	2.16	3.15	2.05	2.46
		TDMH	TBD	1.99	1.76	2.12	1.94	1.24
14	Average Length of Stay: Acute length of stay for each discharged patient / number of patient discharges	AHI	6.5	6.4	6.5	6.7	6.3	6.0
		TDMH	6.6	7.1	6.3	6.4	6.5	7.2
15	Medication Reconciliation – Admission: Total number of patients with medications reconciled / Total number of patients admitted to the Hospital	AHI	95%	96%	91%	88%	84%	NA
		TDMH	95%	90%	88%	77%	78%	NA
16	Medication Reconciliation – Discharge: Total number of patients with medications reconciled / Total number of patients discharged from the Hospital	AHI	95%	94%	92%	92%	95%	NA
		TDMH	95%	76%	82%	77%	80%	NA
17	Care Powerplans: Number of quality based procedure Powerplans implemented	AHI	3	NA	NA	NA	NA	5
		TDMH	3	NA	NA	NA	NA	5
18	COPD Care Powerplans: Number of COPD patients where a COPD Care Powerplans has been implemented / Total number of patients with primary diagnosis of COPD	AHI	90%	NA	NA	NA	NA	NA
		TDMH	90%	NA	NA	NA	NA	NA
19	Violent Incidents: Number of workplace violence incidents reported by hospital workers	AHI	17	3	7	2	3	3
		TDMH	30	11	10	4	4	7

Legend

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Meets or Exceeds Performance	Monitoring Required, Performance Approaching (Within 2%)	Performance Outside Acceptable Target Range, Action Plan Required	Not Available	*QIP Indicator*	*Mandatory Patient Safety Indicator*	*Accreditation Requirement*

5. INDICATOR 1: *DISCHARGE SUMMARIES* DEEP DIVE

Timely & Efficient Care

Indicator # 1: ED Wait Time (TDMH)

Background: This indicator measures the 90th percentile time from decision to admit to inpatient bed in hours. This LHIN H-SAA target is 6.0 hours.

How Are We Doing? In 2018/19, TDMH's average Emergency Department (ED) wait time was 6.9 hours. During our first quarter of implementation (19/20 Q1), we saw an increase to 10.6 hours.

What Are We Going to Do to Meet Our Target? TDMH continues to struggle with higher acuity patients visiting our ED as well as a higher inpatient occupancy resulting in increased bed blocking of admissions from the ED. As a result, our ED patients are waiting longer. Being a small hospital, our Diagnostic Imaging Department does not operate 24/7. If imaging is required, these patients wait until 0800 to have testing done. We will continue to monitor our ED wait time and ensure that we maintain a laser focus on access and flow within this department.

Consequences If We Don't Get It? Increased wait times impacts our ability to see patients in a timely manner and contributes to our patient's experience.

Why is this important to you? Quality, Risk & Patient Safety Committee members need to be aware of key patient access and flow principles and context if they are to effectively respond to patient feedback regarding their experiences while a patient at our Hospital.

Indicator # 2: ED Length of Stay (TDMH)

Background: This indicator measures the total ED length of stay where 9 out of 10 complex (all non-admitted Triage CTAS I-3 patients) completed their visits. ED Length of Stay defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ED. This LHIN H-SAA target is 5.4 hours.

How Are We Doing? In 2018/19, TDMH's average ED wait time was 5.8 hours. During our first quarter of implementation (19/20 Q1), we saw an increase to 6.1 hours.

What Are We Going to Do to Meet Our Target? As above, TDMH continues to struggle with higher acuity patients visiting our ED as well as a higher inpatient occupancy resulting in increased bed blocking of admissions from the ED. As a result, our ED patients are waiting longer. We will continue to monitor our ED wait time and ensure that we maintain a laser focus on access and flow within this department.

Consequences If We Don't Get It? Increased wait times impacts our ability to see patients in a timely manner and contributes to our patient's experience.

Why is this important to you? Quality, Risk & Patient Safety Committee members need to be aware of key patient access and flow principles and context if they are to effectively respond to patient feedback regarding their experiences while a patient at our Hospital.

Service Excellence

Indicator # 3: Patient Experience: ED (TDMH)

Background: This indicator measures the number of survey respondents who answered "yes" to the following survey question: *If you had to come back to a Hospital, would you return to this Hospital?* The data source is the Patient Experience Survey results and the quarterly corporate target is 80%.

How Are We Doing? During our first quarter of implementation (19/20 Q1), 910 surveys were provided through the ED. Only 5 surveys were completed and returned (1 in April, 2 in May and 2 in June). 1 person in May and 1 in June stated that they would not return to the ED. As a result the quarterly result was 40%.

What Are We Going to Do to Meet Our Target? Our follow-up is twofold. Firstly, we will take an opportunity to learn from AHI who distributed 455 ED surveys and had 227 complete and return these surveys. We will seek to understand which strategies have been deployed and what they might be doing differently to positively impact their response rate. Secondly, the Patient Experience Lead will take an even deeper dive into the 2 surveys completed by patients identifying as not returning to TDMH for care in the future. Through this deep dive, we seek to understand the patient's experience and what could be altered to improve future experiences of others.

Consequences If We Don't Get It? It is our goal to provide Exceptional Care. Every patient. Every time. By everyone.

Why is this important to you? Quality, Risk & Patient Safety Committee members need to be aware of key patient experience principles and context if they are to effectively understand, monitor, and oversee the patient experience elements of the organization.

Safe & Effective Care

Indicator #5: Hand Hygiene before Contact (AHI)

Background: This indicator measures the number of times healthcare providers performed hand hygiene before initial patient or patient environment contact versus the number of opportunities there were to perform hand hygiene before initial patient or patient environment contact. The quarterly corporate target is 88.2%.

How Are We Doing? In the last fiscal year, AHI healthcare providers performed hand hygiene before initial patient or patient environment contact 94.4% of the time. In this quarter (2019/20 Q1) 6 out of the 7 people observed performed hand hygiene as per best practice. One healthcare provider did not. The smaller sample size impacts the overall percentage for this quarter.

What Are We Going to Do to Meet Our Target? To increase their knowledge of hand hygiene and its impact on infection control, the Infection Control Lead will continue to offer annual/mandatory as well as in the moment education to healthcare providers.

Consequences If We Don't Get It? Although hand hygiene seems simple, it is a complex cultural change to establish. Improved hand hygiene reduces the likelihood of, as well as the harm associated with, health-care associated infections.

Why is this important to you? Quality, Risk & Patient Safety Committee members need to be aware of key patient infection control principles and context if they are to effectively understand, monitor, and oversee the infection control elements of the organization.

Indicator #11: Clostridium Difficile Infection – CDI (TDMH)

Background: This indicator measures the number of new CDI cases associated with the reporting facility (i.e., symptoms not present on admission and >72 hours after admission or at time of admission but related to a previous admission to the facility) / Total number of patient days. The quarterly corporate target is 0.

How Are We Doing? 1 patient acquired CDI while a patient at TDMH. This represents 1 infection out of 4049 patient days for the quarter.

What Are We Going to Do to Meet Our Target? Clostridium difficile is a bacterium that causes an intestinal illness called CDI. It is commonly acquired in hospital and transmission occurs via contaminated surfaces or equipment and poor hand hygiene. The Infection Control Lead will continue to monitor infection rates and work with the teams to ensure that appropriate infection control practices are followed.

Consequences If We Don't Get It? Clostridium difficile can cause severe illness resulting in death.

Why is this important to you? Quality, Risk & Patient Safety Committee members need to be aware of key patient infection control principles and context if they are to effectively understand, monitor, and oversee the infection control elements of the organization.

Indicator #14: Acute LOS (TDMH)

Background: This indicator measures the acute length of stay for each discharged patient divided by the number of patients discharged. The quarterly corporate target is set at 6.6 hours and is based on the 2018-19 year to date average.

How Are We Doing? During our first quarter of implementation (19/20 Q1), we saw an increase to 6.1 hours.

What Are We Going to Do to Meet Our Target? TDMH's Hospital coverage is stabilizing and we continue to see benefits to this new physician model. The interdisciplinary team continues to plan for discharge upon admission and utilizes the "bullet rounds" to identify care plans and provide updates.

Consequences If We Don't Get It? An increased acute length of stay can negatively impact the patient experience as well as place a burden on resources.

Why is this important to you? Quality, Risk & Patient Safety Committee members need to be aware of key patient access and flow principles and context if they are to effectively respond to patient feedback regarding their experiences while a patient at our Hospital. In addition, it is important to understand how an increased LOS impacts the resources of an organization.