



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

# Quality, Risk and Patient Safety Report

**Fiscal Year 2019-20, Fourth Quarter**

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

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## 1. PATIENT EXPERIENCES

### *Our Patients Said...*

In early April, just as the COVID-19 pandemic was making its introduction, a Tillsonburg resident experienced a fall in their group home and was transferred to a partner hospital for surgical intervention. This patient was repatriated to Alexandra Hospital, Ingersoll approximately 1 week following their surgery.

During this time, and as part of our COVID-19 response, the Ministry of Health strongly recommended that health care settings only allow essential visitors until further notice. They had identified essential visitors/exceptional circumstances as those who have: (1) a patient who is actively dying; and (2) a parent/guardian of an ill child or youth. As such, regular visiting and family presence policies in health care settings were placed on hold temporarily in order to reduce the risk of transmission of illness.

The isolation inadvertently created by these restrictions were felt by many of our patients; however, were most notable with this particular patient who was used to having the ongoing support of their care providers at the home as well as their devoted family. Approximately 1 week post admission, this patient was often found crying in their room and staff noted that the patient had begun refusing to eat as well as engaging in physical therapy – both which was necessary for their successful recovery and discharge.

### *We Did...*

Following a conversation with the patient's family, and with assistance from Information Technology and the patient's Nurse, AHI conducted our first 'virtual visit'; using an iPad and WebEx technology. Although this call only lasted approximately 5-7 minutes, the virtual connection with their loved one was exactly what this patient (and family) needed.

Within days of this call, the team noted a drastic change in the patient's demeanor. The patient was no longer crying in their room; were socializing more with staff outside of their room; had begun eating again; and, were actively participating in physical therapy. The improvement was so notable, that plans were being made for the patient's discharge back home.

In collaboration with the family, virtual visits were scheduled 3 times per week going forward. These ongoing visits have proven to be the motivation the patient needed and have been described by the family as 'gifts' for those not able to physically visit their loved ones in hospital.

A Virtual Visit program is now available, and being promoted, to all AHI and TDMH patients. The program continues to evolve based on feedback from our Patient Advisors, patients and their families. It is our goal to sustain this best practice well after the COVID-9 pandemic is over.

## 2. QUALITY AND RISK MANAGEMENT UPDATE

### a) Patient Advisors

We continue to be committed to Patient and Family Centred Care and infusing the patient voice in all aspects of program planning, service design and process improvements at AHI and TDMH. Over the last year, we have been successful in recruiting three new patient advisors who each bring a valuable patient and/or family perspective to the Hospitals. Our Advisors have become active members of the Inpatient and Emergency Department Advisory Committees, Integrated Ethics Committee and our operational Quality and Patient Safety Committee. Where applicable, Patient Advisors are invited to attend educational sessions provided by the Hospital to increase their knowledge of services and to provide input.

### b) Virtual Care Visits

At AHI and TDMH, it is our goal to create the best possible patient and family centered care experience. Over these last several weeks, as we have responded to the COVID pandemic and visitors have been restricted, we have been providing the opportunity for inpatients to virtually connect with friends and family outside of the hospital utilizing technology i.e. WebEx and Facetime app. These Virtual Visits are being initiated by the patient, anyone connected to the patient or a care provider in the hospital. This service is provided at no cost to the patient by AHI and TDMH and has been coordinated by members of the Virtual Visitor Team. To date we have had a number of patients accessing this service; sometimes on multiple occasions throughout their stay. This program has been well received by patients and their families and work is underway to sustain this best practice moving forward.

### 3. OUR QUALITY IMPROVEMENT REPORT CARD

Indicator	What are we trying to measure?	Site	Target	Q4	Persons Impacted
<b>Timely &amp; Efficient Transitions</b>					
1 ED Wait Time <span style="color: blue;">★</span>	How long did Emergency patients wait for admission to an inpatient bed after the decision to admit?	AHI	4.9 Hrs	3.8	NA
		TDMH	6 Hrs	43.0	NA
2 ED Length of Stay <span style="color: blue;">★</span>	How long did our non admitted patients (CTAS 1-3) stay in the Emergency Department?	AHI	5 Hrs	5.5	NA
		TDMH	5.4 Hrs	6.3	NA
3 Conservable Bed Days	How many days are patients staying longer than necessary on the Inpatient Unit?	AHI	31.2%	49.6%	NA
		TDMH	31.4%	47.0%	NA
<b>Service Excellence</b>					
4 Patient Experience: ED <span style="color: blue;">★</span>	How many patients would return to our Hospital for Emergency Department care?	AHI	80%	98%	210
		TDMH	80%	67%	4
5 Patient Experience: IP <span style="color: blue;">★</span>	How many patients would return to our Hospital for Inpatient care?	AHI	80%	100%	1
		TDMH	80%	100%	26
<b>Safe &amp; Effective Care</b>					
6 Hand Hygiene Before Contact <span style="color: blue;">M</span>	How often did staff clean their hands before patient contact?	AHI	88.2%	100%	25
		TDMH	88.2%	97.0%	33
7 Hand Hygiene After Contact <span style="color: blue;">M</span>	How often did staff clean their hands after patient contact?	AHI	91.6%	100%	24
		TDMH	91.6%	100%	30
8 Hospital-Acquired MRSA Rate <span style="color: blue;">M</span>	How many patients acquired Methicillin-resistant Staphylococcus aureus (MRSA) while admitted?	AHI	0	0	0
		TDMH	0	0	0
9 Hospital-Acquired VRE Rate <span style="color: blue;">M</span>	How many patients acquired Vancomycin-resistant Enterococci (VRE) while admitted?	AHI	0	0	0
		TDMH	0	0	0
10 Hospital-Acquired VAP Rate <span style="color: blue;">M</span>	How many patients acquired Ventilator-Associated Pneumonia (VAP) while admitted?	TDMH	0	0	0

Indicator		What are we trying to measure?	Site	Target	Q4	Persons Impacted
<b>Safe &amp; Effective Care</b>						
11	Hospital-Acquired CLI Rate <b>M</b>	How many patients acquired Central Line-Associated Primary Blood Stream Infection (CLI) while admitted?	TDMH	0	0	0
12	Clostridium Difficile Infection <b>M</b>	How many patients acquired Clostridium difficile Infection (CDI) while admitted?	AHI	0	.49	1
			TDMH	0	0	0
13	SSC Compliance <b>M</b>	How many patients were screened using the Surgical Safety Checklist (SSC)	AHI	99.3%	NA	NA
			TDMH	99.3%	NA	NA
14	Falls Rate with Harm	How many Inpatients fell and were harmed?	AHI	TBD	.64	3
			TDMH	TBD	1.46	3
15	Medication Reconciliation Rate - Admission	How many patients have their medications reconciled at admission?	AHI	95%	89%	156
			TDMH	95%	77%	273
16	Medication Reconciliation Rate - Discharge	How many patients have their medications reconciled at discharge?	AHI	95%	91%	151
			TDMH	95%	84%	348
17	Care PowerPlans <b>★</b>	How many quality based procedure Powerplans have been implemented?	AHI	3	0	NA
			TDMH	3	0	NA
18	COPD Care PowerPlans <b>★</b>	How many patients with COPD have been admitted using a COPD Powerplan?	AHI	90%	40%	YTD
			TDMH	90%	40%	YTD

**Legend**

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

#### 4. FIVE-QUARTER TREND OF PERFORMANCE

#	Indicator	Site	Target	2018-19	FY 2019-2020			
				Q4	Q1	Q2	Q3	Q4
1	ED Wait Time: 90 <sup>th</sup> Percentile Date/Time Patient Left ED – Date/Time Disposition Decision. Admitted patients.	AHI	4.9 Hrs.	14.7	2.8	9.7	7.7	3.8
		TDMH	6 Hrs.	15.29	10.6	19.4	39.4	43.0
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	5.0	5.0	5.0	5.5
		TDMH	5.4 Hrs	6.6	6.2	6.9	6.2	6.3
3	Conservable Bed Days: # of discharges where actual length of stay exceeds expected length of stay/total # of discharges over a defined period of time.	AHI	31.2%	NA	47.7%	37.3%	43.4%	49.6%
		TDMH	31.4%	NA	53.0%	52.7%	59.7%	47.0%
4	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	99%	96.7%	96%	98%
		TDMH	80%	NA	40%	100%	100%	67%
5	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	100%	100%	NA	100%
		TDMH	80%	NA	97%	96%	100%	100%
6	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%	100%	85.7	100%	NA	100%
		TDMH	88.2%	NA	95.3%	NA	90.3%	97.0%
7	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%	100%	100%	100%	NA	100%
		TDMH	91.6%	NA	93.1%	NA	100%	100%
8	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
9	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
10	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
#	Indicator	Site	Target	Q4	Q1	Q2	Q3	Q4
11	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

12	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	.51	0	0	0	.49
		TDMH	0	0.24	0.25	.23	.42	0
13	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%	NA	NA	NA
		TDMH	99.3%	100%	100%	NA	NA	NA
14	Falls Rate with Harm: Number of Inpatients who fell and were harmed (Level 3+) x 1000 / Total number of patient days	AHI	TBD	2.05	2.46	2.57	3.50	.64
		TDMH	TBD	1.94	1.24	1.64	1.06	1.46
15	Medication Reconciliation – Admission: Total number of patients with medications reconciled / Total number of patients admitted to the Hospital	AHI	95%	84%	85%	88%	89%	89%
		TDMH	95%	78%	78%	76%	77%	77%
16	Medication Reconciliation – Discharge: Total number of patients with medications reconciled / Total number of patients discharged from the Hospital	AHI	95%	95%	93%	91%	87%	91%
		TDMH	95%	80%	78%	78%	82%	84%
17	Care PowerPlans: Number of quality based procedure PowerPlans implemented	AHI	3	-	5	1	1	0
		TDMH	3	-	5	1	1	0
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%	-			40%	
		TDMH	90%	-			40%	

				★	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

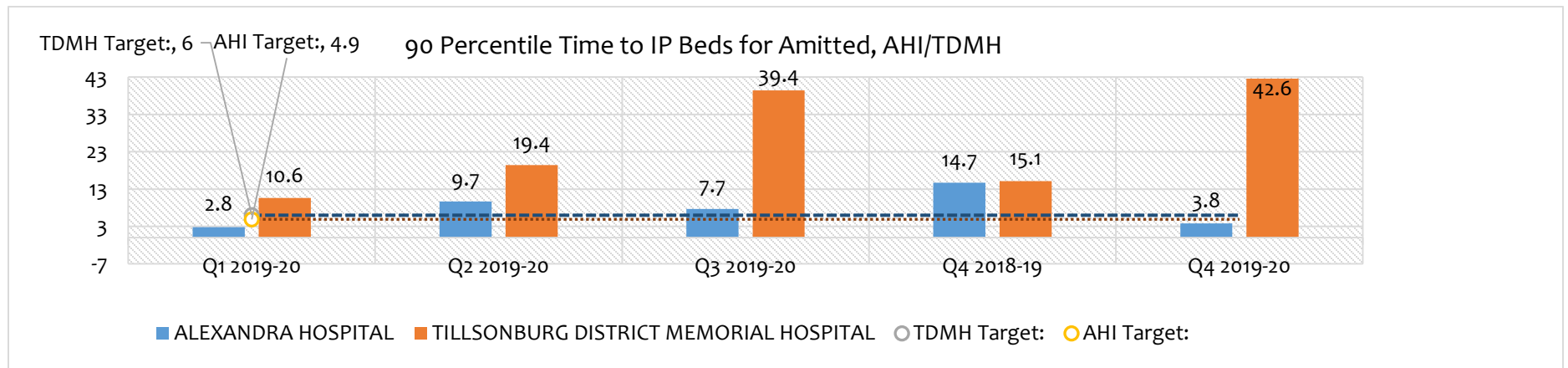
## 5. INDICATOR DEEP DIVE

### Timely & Efficient Transitions

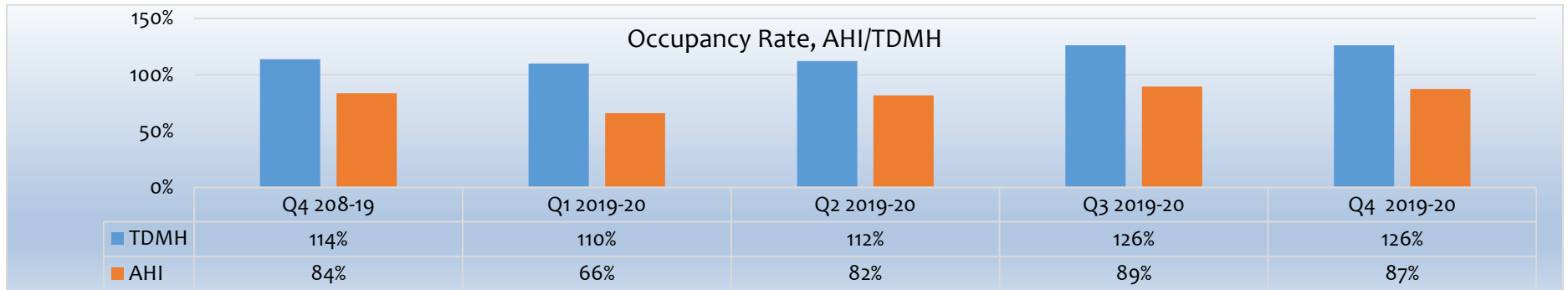
#### Indicator #1: ED Wait Time (TDMH)

**Background:** Emergency Department (ED) wait time measures how long ED patients wait for an inpatient bed after the decision has been made to admit the patient. The quarterly corporate target for TDMH is 6 hours.

**How Are We Doing?** Over the last fiscal year, TDMH ED had seen wait times as low as 10.6 hours to as high as 42.63 hours. Wait times increased significantly during Q3 and Q4 (which is more than double the wait from the previous year). There is a direct correlation between wait time and inpatient occupancy which ranged from 110% - 126% during this same period. Alternate Level of Care (ALC) patients awaiting Long Term Care (LTC) accounted for a percentage of the patients occupying inpatient beds with the lowest rate being recorded during Q3 (13.8%) and the highest during Q4 (26.1%). Of the 1582 patients being discharged from TDMH during this fiscal year, 12.7% (201) were discharged by 1100 and 50.9% (805) by 1400. The remaining 36.4% (576) were discharged after 1400.







Quarters 2019-20	All Discharges	Discharge by 14:00 (Count)	% Discharge by 14:00	Discharge by 11:00 (Count)	% Discharge by 11:00
Q1	401	193	48.1%	52	13.0%
Q2	403	207	51.4%	58	14.4%
Q3	366	198	54.1%	48	13.1%
Q4	412	207	50.2%	43	10.4%
Yearly	1582	805	50.9%	201	12.7%

Indicator	Q1 2019-20	Q2 2019-20	Q3 2019-20	Q4 2019-20	Yr 2019-20
Census ALC Days	718	618	649	1227	3212
Census Patient Days	4027	4278	4707	4701	17713
%ALC Days	17.8%	14.4%	13.8%	26.1%	18.1%

*What Are We Going to Do to Meet Our Target?* In January 2020, physician and administrative leaders from AHI and TDMH met to facilitate the development of an AHI/TDMH inter-facility patient transfer policy which has received endorsement from the TDMH Medical Advisory Committee (MAC) and awaiting review by the AHI MAC. It is our goal that this voluntary collaboration between AHI and TDMH will support the timely transfer of patients between AHI and TDMH as well as within the region. We continue to work to advocate for additional access to LTC in the community. At the onset of COVID-19, and working with our LHIN Home & Community Care partner, AHI and TMDH successfully decanted ALC patients awaiting LTC to temporary transition beds (located in LTC/RH). Work is underway to increase availability of and to sustain access to these transition beds long term. We will investigate further the time it takes to transition patients home once a disposition order has been received and what impact, if any, this may have on inpatient bed availability.

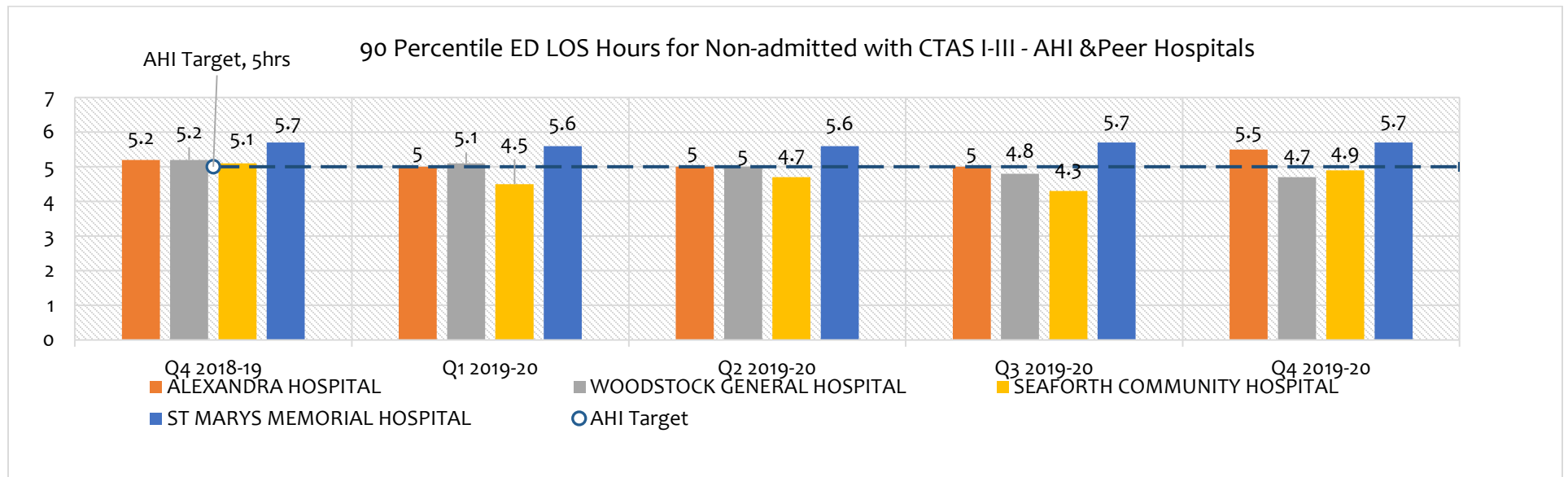
*Consequences If We Don't Get It?* The term “patient flow” refers to the ability of healthcare systems to manage patients effectively and with minimal delays as they move through stages of care. Good patient flow is central to patient experience, clinical safety, reducing the pressure on staff while achieving significant cost savings. Poorly managed patient flow in hospitals can lead to adverse health outcomes, including increased re-admissions and mortality rates. Successful patient throughput initiatives offer numerous clinical benefits for a hospital including improved capacity, length of stay and ED wait times.

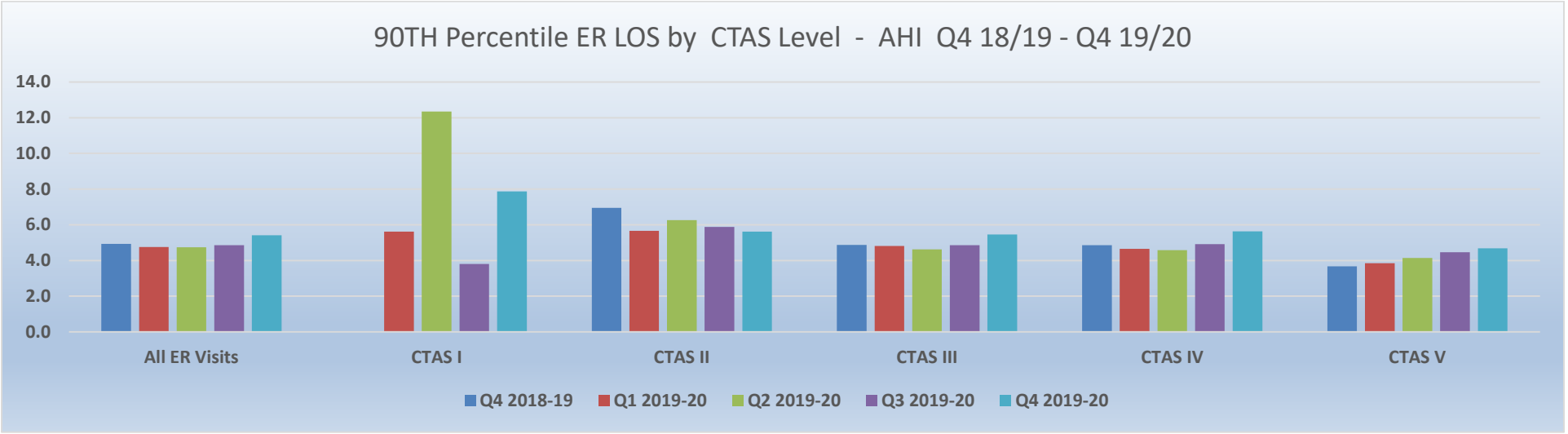
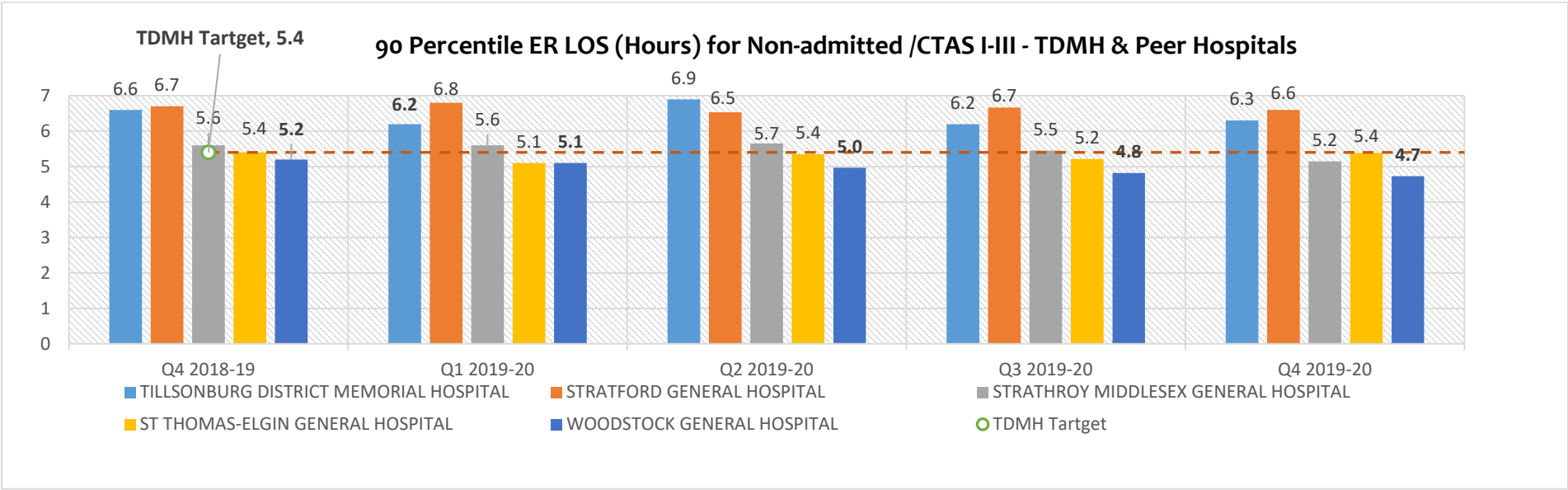
*Why is this important to you?* Quality, Risk & Patient Safety Committee members need to be aware of key patient access and flow principles and context if they are to effectively understand, monitor, and oversee patient access and flow elements of the organization.

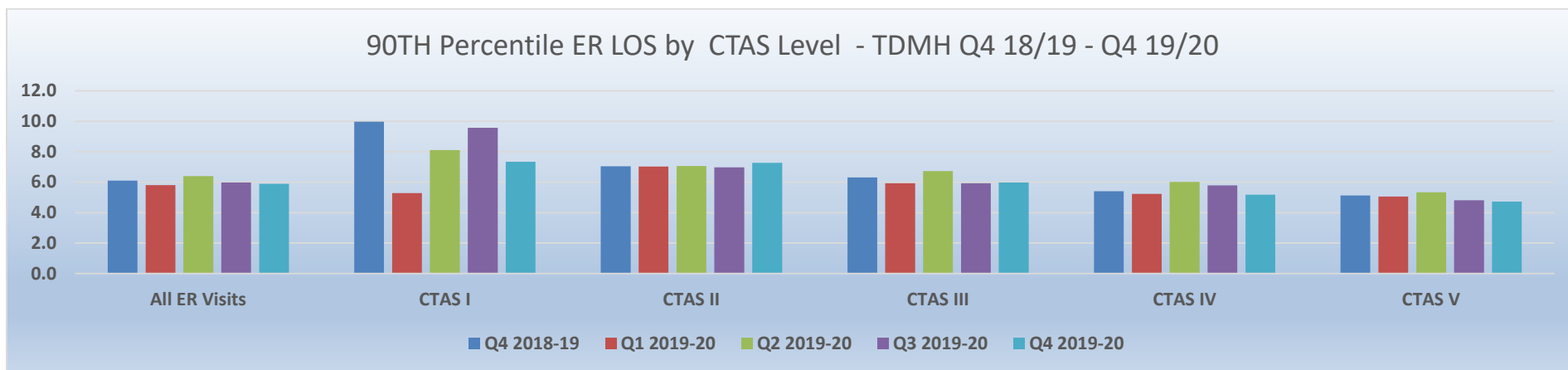
**Indicator #2: ED Length of Stay (AHI & TDMH)**

*Background:* ED length of stay (LOS) measures how long non-admitted patients (CTAS 1-3, 90<sup>th</sup> percentile) are waiting in the ED. ED LOS starts when the patient is triaged and ends when the patient leaves the department. There are many variables influencing this wait time, including the time it takes to triage, register and receive the patient (if arriving by ambulance). How quickly a patient can be seen by the ED Physician or Consultants, in addition to any follow up, also influences the ED LOS. The quarterly corporate/LHIN H-SAA target is 5 hours (AHI) and 5.4 hours (TDMH).

*How Are We Doing?* Over this last fiscal year, AHI has consistently met their intended target with exception of Q4 when the ED LOS was 5.5 hours. When broken down by CTAS level, patients triaged as CTAS I – III were waiting 3.8 – 7.9 hours (up to 12.4 hours in Q2) while CTAS IV – V were waiting 3.9 – 5.6 hours. TDMH has consistently exceeded their intended target of 5.4 hours. Over the last fiscal quarter, patients triaged as CTAS I – III were waiting 5.3 – 9.6 hours while CTAS IV – V were waiting 4.7 – 6.0 hours.







*What Are We Going to Do to Meet Our Target?* We will further analyze the ED journey understanding the time it takes to transition through each part of this journey i.e. time to triage, time to register, initial physician assessment, etc. From there, it is our goal to identify where in the journey patients are waiting the longest and dive deeper to identify barriers and opportunities.

*Consequences If We Don't Get It?* The term “patient flow” refers to the ability of healthcare systems to manage patients effectively and with minimal delays as they move through stages of care. Good patient flow is central to patient experience, clinical safety, reducing the pressure on staff while achieving significant cost savings. Poorly managed patient flow in hospitals can lead to adverse health outcomes, including increased re-admissions and mortality rates. Successful patient throughput initiatives offer numerous clinical benefits for a hospital including improved capacity, length of stay and ED wait times.

*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 understand, monitor, and oversee patient access and flow elements of the organization.

### **Indicator #3: Conservable Bed Day (AHI & TDMH)**

*Background:* Conservable bed days equates to the number of discharges where the actual length of stay (LOS) exceeded the expected length of stay (ELOS). The quarterly corporate target is 31.2% (AHI) and 31.4% (TDMH).

*How Are We Doing?* In 19-20, AHI and TDMH consistently exceeded their annual target. Over this last fiscal year, AHI’s conservable bed rate ranged from 36% to 41%. Of the 183 discharges in Q4, 117 (64%) of these discharges had a LOS which was less than or equal to the ELOS and 66 (36%) of the discharges had a LOS which exceeded the ELOS. Over this last fiscal year, TDMH’s conservable bed rate ranged from 48% to 58% with the greatest conservable bed rate in Q4 (58%). Of the 386 discharges in Q4, 162 (42%) of these discharges had a LOS which was less than or equal to the ELOS and 224 (58%) of the discharges had a LOS which exceeded the ELOS.

*What Are We Going to Do to Meet Our Target?* Further analysis is required to understand why patients are staying longer than expected and what factors may be contributing to patients being discharged earlier than expected.

*Consequences If We Don't Get It?* Good patient flow is central to patient experience, clinical safety, reducing the pressure on staff while achieving significant cost savings.

*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 understand, monitor, and oversee patient access and flow elements of the organization.

### **Service Excellence**

#### **Indicator #4: 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?* This quarter, only 6 surveys were distributed through the ED. Only 4 surveys were completed and returned. As a result the quarterly result was 67%.

*What Are We Going to Do to Meet Our Target?* Our follow-up is twofold. Firstly, we will take an opportunity to learn from other organizations 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 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 #12: Clostridium Difficile Infection – CDI (AHI)**

*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 AHI. This represents 1 infection out of 2049 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 and the Microbiologist 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 #15: Medication Reconciliation – Admission & Discharge (AHI & TDMH)**

*Background:* Medication reconciliation is the process of creating the most accurate list possible of all medications a patient is taking (including drug name, dosage, frequency and route) and comparing that list against the physician's admission, transfer and/or discharge orders. The goal is to provide the correct medications. These indicators measure the total number of times a patient's medications are reconciled when they are admitted to and discharged from the hospital.

*How Are We Doing?* *Admission:* At AHI, medications were reconciled 89% of the time (156/177). There were 8 medication reconciliations that were not started and 13 which were partially started. 154/156 or 99% of the time, medications were reconciled within 48 after admission. At TDMH, medications were reconciled 77% of the time (273/361). There were 30 medication reconciliations that were not started and 58 which were partially started. 254/273 or 93% of the time, medications were reconciled within 48 after admission.

Nurse Unit	# Admissions/Transfers to Location	# Admissions Med Rec Not Started	# Admissions Med Rec Partial	# Admission Med Rec Completed	% Complete	Complete within_48 Hours
AH-70S WING	70	2	3	65	92.86	65
AH-90S WING	58	3	3	52	91.23	50
AH-EDINPT	5	1	0	4	80.00	4
AH-SCU	44	2	7	35	79.55	35
<b>TOTAL</b>	<b>177</b>	<b>8</b>	<b>13</b>	<b>156</b>	<b>88.64</b>	<b>154</b>

Nurse Unit	# Admissions/Transfers to Location	# Admissions Med Rec Not Started	# Admissions Med Rec Partial	# Admission Med Rec Completed	% Complete	Complete within_48 Hours
TG-1S	14	0	3	11	78.57	10
TG-1S ACUTE	12	0	5	7	58.33	7
G-2N	93	10	19	64	70.33	59
TG-2S	177	14	25	138	78.86	125

TG-EDINPT	65	6	6	53	82.81	53
TOTAL	361	30	58	273	76.69	254

Discharge: At AHI, medications were reconciled 91% of the time (151/166). There were 10 medication reconciliations that were not started and 5 which were partially started. At TDMH, medications were reconciled 84% of the time (348/413). There were 34 medication reconciliations that were not started and 31 which were partially started.

Nurse Unit	# Discharges from Location	# Discharges Med Rec Not Started	# Discharges Med Rec In Progress	# Discharges Med Rec Completed	% Complete
AH-70S WING	69	3	2	64	92.75
AH-90S WING	50	1	1	48	96.00
AH-EDINPT	5	3	0	2	40.00
AH-SCU	42	3	2	37	88.10
TOTAL	166	10	5	151	90.96

Nurse Unit	# Discharges from Location	# Discharges Med Rec Not Started	# Discharges Med Rec In Progress	# Discharges Med Rec Completed	% Complete
TG-1S	14	0	1	13	92.86
TG-1S ACUTE	8	0	1	7	87.50
TG-2N	98	4	7	87	88.78
TG-2S	171	9	15	147	85.96
TG-EDINPT	67	12	4	51	76.12
TG-ICU	55	9	3	43	78.18
TOTAL	413	34	31	348	84.26

*What Are We Going to Do to Meet Our Target?* Further understand barriers inhibiting physicians from starting or completing the medication reconciliation process. Do these barriers differ across departments? Detailed reports, including individual physician practices, are available and will be reviewed to identify trends. Further, the reports will be shared with the respective program Chiefs for direct follow up with applicable physicians.

*Consequences If We Don't Get It?* A large portion of medication errors are believed to result from inadequate reconciliation in handoffs during admission, transfer and discharge of patients. Of these errors, portions are believed to result in harm. Many of these errors would be averted if effective medication reconciliation processes were in place.

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

**Indicator #18: COPD Care PowerPlans (AHI and TDMH)**

*Background:* This indicator measures the number of patients with the primary diagnosis of Chronic Obstructive Pulmonary Disease (COPD) where a standardized/electronic COPD PowerPlan (or order set) has been used to plan and manage patient care. The quarterly corporate target is 90%.

*How Are We Doing?* A COPD PowerPlan was used for 17 of the 43 (40%) qualified patients across AHI and TDMH.

<b>Diagnosis</b>	<b>COPD PP Ordered</b>	<b>Total Patients</b>
Chronic obstructive pulmonary disease with acute exacerbation, unspecified	10	33
Chronic obstructive pulmonary disease with acute lower respiratory infection	3	6
Other Diagnosis	4	4
<b>Grand Total</b>	<b>17</b>	<b>43</b>

*What Are We Going to Do to Meet Our Target?* Conduct a comprehensive chart audit which includes cross referencing with physician schedules. A targeted education and awareness campaign will follow.

*Consequences If We Don't Get It?* PowerPlans are based on best practice guidelines and usage can be attributed to better patient outcomes as well as a reduced length of stay.

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