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

TILLSONBURG DISTRICT MEMORIAL HOSPITAL
Partnering to keep healthcare close to home.

Tillsonburg District Memorial Hospital 167 Rolph Street

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)

AIM		Measure									Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Theme I: Timely and Efficient Transitions	**Timely**	The time interval between the Disposition Date/Time (as determined by the main service provider) and the Date/Time Patient Left Emergency Department (ED) for admission to an inpatient bed or operating room.	M A N D A T O R Y	Hours / All patients	CIHI NACRS / October 2018 – December 2018	824*	6.77	6	Reduce by 10%		1)Examine opportunities between the ED and the inpatient units to promote flow of the admitted patients.	Create an ED Advisory Committee to track ED metrics related to Time to Inpatient Bed. Define a target for these patients and measure and examine outliers on a regular basis to identify improvement opportunities.	90th percentile time in hours of time to inpatient bed tracked daily on ED huddle boards and monthly on Emergency Department Advisory Committee Scorecard.	By July 1, 2019	
											2)Examine processes related to consult response time to improve admission practices.	Facilitate a process mapping exercise between Emergency Department and Inpatient Units to identify waste and improvement opportunities along the patient journey.	Process mapping exercise complete	By July 1, 2019	
											3)Continue with Home First Refresh strategies in order to expedite time to inpatient bed for admitted patients, thus providing timely access to care for non-admits.	Bi-Weekly ALC review and referral to appropriate programs to free up acute care beds occupied with ALC to LTC patients.	# of successful referrals that prevent ALC to LTC designation in hospital.	Aim for 100% of potential ALC LTC patients to be considered for referrals.	
		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 non-admitted complex patients (CTAS I, II, or III) completed their visits.	C	Hours / Patients with complex conditions	CIHI NACRS / Last 3 Quarters	824*	5.8	5.40	LHIN H-SAA Target		1)Examine opportunities to maximize patient flow in the ED (medical directives, fast track, etc.).	Continue to work with unit based council and physician partners to implement CTAS IV and V focused medical directives and care pathways to enhance flow through the ER	Development of 3 CTAS IV care pathways. Development of 3 CTAS V care pathways.	Reduce number of patients leaving without being seen by 5%	
											2)Create a trigger for calling in the 2nd physician on call	Continue to work with physician partners to establish an algorithm to guide decision making and identify guiding principles for calling in the 2nd on call physician.	Department audit for incidences of algorithm use and outcome tracking.	2nd on call physician is called in appropriately 100% of the time based on established guiding principles	
Theme II: Service Excellence	**Patient-centred**	In house ED survey: If you had to come back to a Hospital, would you return to our Hospital?	C	% / ED patients	In-house survey / April 1 to March 31	824*	CB	100.00	Theoretical Best	Alexandra Hospital	1)Offer Patient Satisfaction surveys to registered ED patient daily.	Patient Satisfaction surveys will be offered to registered ED patient daily (both in paper or online). Upon receiving consent, a patient who answers “no” to question will be contacted directly for further feedback and ideas/opportunities for feedback.	# of surveys offered daily	10/day	

											2)Ensure patient and family feedback forms/links to the survey are available on each unit with a secured lock-box to submit feedback. This information will be collected and followed up by the Director of Patient Relations or delegate.	Survey forms/links and secured lock-box will be available on each unit. This information will be collected, reviewed and followed up by the Director of Patient Relations, or delegate.	Forms available and lock-box installed by April 1, 2019.	Forms available and lock-box installed by April 1, 2019.	
											3)Implement process for reporting feedback on an ongoing basis.	All feedback received from the surveys or the leadership rounding will be reported to the Emergency Department Advisory Committee and Patient Family Centered Care Committee to monitor for any trends or opportunities for improvement.	Reporting structure implemented by July 1, 2019.	Reporting structure implemented by July 1, 2019.	
		In house IP survey: If you had to come back to a Hospital, would you return to our Hospital?	C	% / All inpatients	In-house survey / April 1 to March 31	824*	CB	100.00	Theoretical Best	Alexandra Hospital	1)Offer Patient Satisfaction survey to all in-patients on the day of discharge.	Offer survey both in paper and an on-line format. Upon receiving consent, a patient who answers "no" to question will be contacted directly for further feedback and ideas/opportunities for feedback.	% of inpatients being discharged receiving survey	100%	
											2)Ensure patient and family feedback forms/links to the survey are available on each unit.	Survey forms/links and secured lock-box will be available on each unit. This information will be collected, reviewed and followed up by the Director of Patient Relations, or delegate.	Forms available and lock-box installed by April 1, 2019.	Forms available and lock-box installed by April 1, 2019.	
											3)Implement daily Leadership rounding.	Implement daily Leadership rounding ensuring that any issues are addressed in the moment versus after the patient is discharged. Rounding will focus on safety and communication.	% of Leadership rounds conducted per month.	80%	
											4)Implement process for reporting feedback on an ongoing basis.	All feedback received from the surveys or the leadership rounding will be reported to the Inpatient/ICCU Advisory Committee and Patient Family Centered Care Committee to monitor for any trends or opportunities for improvement.	Reporting structure implemented by July 1, 2019.	Reporting structure implemented by July 1, 2019.	
Theme III: Safe and Effective Care	**Effective**	Number of Care Pathways and Powerplans implemented.	C	Count / COPD QBP Cohort	In house data collection / April 1 to March 31	824*	0	3.00	New best practice initiative. We are targeting the implementation of 3 care pathways over the next year	Alexandra Hospital	1)Create and implement care pathways/powerforms according to the QBP standards to assist nursing and allied health in patient flow for selected diagnoses.	Research QBP recommendations and review existing plans from other sites to incorporate into the nursing care and allied health documentation standards and care planning for patients with select diagnoses.	All care pathways/powerforms to be implemented.	By December 31, 2019	
		Percentage of COPD patients who are being treated utilizing a COPD Care Pathway.	C	% / COPD QBP Cohort	EMR/Chart Review / April 1 to March 31	824*	CB	90.00	Best Achieved Internally	Alexandra Hospital	1)Implement process to ensure patients who are admitted with COPD care are admitted with appropriate Powerplan.	Provide education to physicians and consultants on the proper use of Powerplans. Track the usage of Powerplans for all patients who are admitted with a diagnosis of COPD.	% of patients admitted with COPD Powerplan	Process implemented and tracking initiated by April 2019.	
	Safe	Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12	MANDAT	Count / Worker	Local data collection / January - December 2018	824*	30	30.00	Not to Exceed Current Performance	Alexandra Hospital	1)Provide training on violence awareness, prevention and reporting. Clearly define "violence" when reporting.	Provide training on violence awareness, prevention and reporting. Clearly define "violence" when reporting.	% of team members trained	85%	FTE=213

		month period.	O R Y							2)Update process for reporting workplace violence	Work with JHSC and Occupational Health to implement RL6 Employee Reporting Form. Establish process for monitoring effects of workplace violence on staff mental health and wellness.	Form implemented in collaboration with the JHSC by June 1, 2019.	Form implemented in collaboration with the JHSC by June 1, 2019.	