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

way Carleton

Queensway Carleton Hospital 3045 Baseline Road

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
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Theme I: Timely and Efficient Transitions	**Efficient**	Average number of inpatients receiving care in unconventional spaces or ER stretchers per day within a given time period.	P	Count / All patients	Daily BCS / October - December 2018	777*	9.43	9.43	With the upcoming introduction of the electronic health record in the Emergency Department, we are anticipating a decline of efficiency until staff have internalized this technology into their practice. As such, we will be working hard to maintain the flow of patients through the ED while balancing these new practices.		1)Improve the correct identification of patients appropriate for the Acute Care of the Elderly (ACE) unit by increasing compliance with use of the ISAR tool by nursing staff in the ED.	Standard work will be developed for the ACE ACC clerk to review all ACE admissions from the ED for 1 day each month to determine a random sample for compliance with use of the ISAR tool. This will be reported to the Manager and Bed Flow Coordinator.	% completion of ISAR tool for all patients greater than 70 years old who are admitted to the ACE unit.	80% of all patients admitted to ACE will have a completed ISAR tool by December 2019	By ensuring appropriate identification of ACE patients, there will be a facilitated admission to the ACE unit. This process will be faster than is currently taking place.
											2)Measure and improve the time from notification of an inpatient bed being available to the time that the patient leaves the ED through process review and standardization of practices.	Data is available through Decision Support.	Average time for all ED admissions to leave the ED once a bed has been made available on an inpatient unit.	60 minutes by November 2019.	
		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 2018	777*	16.51	16.51	We have exercised opportunities with our more rural partner hospitals to move ALC patients out of the acute care setting. These efforts have resulted in maximal use of local beds. No other partner opportunities are available to improve this measure.	Arnprior and District Regional Health, Carleton Place and District Memorial Hospital, Almonte General Hospital	1)Partner with external facilities to re-house ALC patients, allowing the freeing of beds to admit acute care patients.	Social Work count of number of ALC patients transferred to other facilities.	Number of ALC patients transferred to other facilities to await Long Term Care placement between October and December 2019.	5 patients per month	Based on the average length of stay for ALC patients, this initiative carries a potential saving of over 300 hospital days.
											2)Prevent ALC designation by transitioning patients who meet specific criteria to the SAFE (Sub acute for Frail Elderly) unit at Perley/Rideau Veteran's Health Centre.	Number of patients transferred to SAFE is recorded by the Social Work Department	Number of patients transferred to the SAFE unit between October and December 2019	12 patients to be transferred to the SAFE unit.	This initiative carries an opportunity to defer approximately 420 ALC days.
	Timely	Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital.	P	% / Discharged patients	Hospital collected data / Most recent 3 month period	777*	75	76.00	Planned changes in physician documentation workflows this year are likely to be disruptive, and physicians will need time to adapt to new technology. For clarity, we are focusing on patients discharged from an inpatient stay. We will not include patients discharged from the Emergency Department.		1)Implement front-end self-editing dictation within the scope of Connected Care physician documentation project (PDoc)	A report will be created to identify the number of discharges and the number of discharge summaries that have been completed. For review by Decision Support.	% of discharge summaries completed through the PDoc front end interface for the immediate period following rollout (December 1 to January 30, 2020)	25% of all patient discharges will have discharge summaries completed in the electronic record immediately after launch	Implementation of PDoc will be in November 2019, and compliance is anticipated to be low at that time, but important to measure as a baseline.
											2)The Physician Documentation (PDoc) Implementation team will develop standardized discharge summary templates to improve timely completion of the discharge summary	A report will be generated to select from the electronic record a specific medical record document (MDR) that represents the standardized template for discharge summaries.	Number of discharge summaries developed with the standardized template in PDoc compared to the total number of discharge summaries in PDoc from December 1 to January 30, 2020.	75% utilization rate of discharge summary template	Implementation of the PDoc will take place in November 2019, but with the education provided prior to roll out, use of the discharge summary template should have good uptake.
		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**	**777***	**27.1**	**27.10**	**Attempting to maintain the performance on this indicator can be considered a lofty goal given the expected 4% annual increase in ED visits, which results in an expectation of one additional admission coming from the ED each day, placing additional stress on the system.**		**1)Improve compliance with a 1-hour turnaround time for transfer of patients between acute and sub-acute units through improving communication, building accountability for the Care Facilitators, and reporting compliance to stakeholders.**	**Data for time of bed availability (clean bed) and time of patient transfer is available through the Teletracking system.**	**% compliance with 1 hour turnaround time for the period October to December 2019.**	**70% of patients moving from an acute to a non-acute unit will be transferred within one hour of the bed becoming available.**	**Improving the time to move inpatients to non-acute beds allows earlier access to acute beds for transfer of patients awaiting admission in the ED. It is our unsubstantiated understanding that we have approximately 50% compliance with this measure currently. A report will have to be written to allow this data to be captured for easier analysis.**

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											2)Measure and improve the time from notification of an inpatient bed being available to the time that the patient leaves the ED through process review and standardization of practices.	Data is available through Decision Support team	Average time for all ED admissions to leave the ED once a bed has been made available on an inpatient unit.	60 minutes average time for ED admission to leave the ED by November 2019.	A 60 minute time frame coincides with the expectations for transfer from one unit to another on the inpatient units.
Theme II: Service Excellence	**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	777*	98.79	98.79	In the upcoming fiscal year, there will be no change in activity that would impact this indicator.						Given our current rate of compliance that is exceeding 98%, we will concentrate our energies on quality improvement in other areas.
		Percentage of respondents who responded positively to the following question: 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 / Most recent consecutive 12-month period	777*	66.49	70.00	We are hoping to a achieve a 5% relative increase in the target through the expansion of use of the new patient discharge handbook.		1)Continue to expand reach to ensure follow up appointments are made with the family physician while the patient is still in hospital.	Information is coded through Decision Support.	% Medicine patients discharged from QCH who had a follow-up appointment with the family physician documented in their inpatient chart for October to December 2019.	80 percent of all inpatients will have a follow-up appointment with the family physician documented in their inpatient chart	Currently, only the ACE unit achieves this goal. Their methodology will be rolled out to the other medicine units.
											2)Fully distribute the revised generic medicine GAP (Guidelines Applied in Practice) discharge tool.	Results of the NRCC Patient satisfaction survey "Do you know what to do is you are worried about your condition or treatment?"	% positive response to NRCC patient satisfaction survey question for Medicine patients.	75% positive response in the "top box"	The current "top box" response is 68% for Medicine patients.
											3)Patient education booklet with a discharge action plan to be finalized and a process established for distribution of the booklet and education of all patients.	Results of NRCC Patient satisfaction survey question "Did you receive information in writing about what surgical or health problems to look for after you left hospital".	Percent positive response to NRCC question	80% on all medical units	
Theme III: Safe and Effective Care	**Effective**	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 2018	777*	77.78	82.00	The majority of education will take place as we embark on computerized order entry for the physician group. This will be introduced in February 2020, so the impact on this indicator will be minimal for the 19/20 fiscal year.		1)Conduct a survey of physicians to understand the current use of Meditech's discharge prescription.	Survey tracking will be done within the pharmacy administration resources	% of physicians who complete the survey	50% of privileged physicians will complete and return the survey	This is an aggressive target for an anonymous survey.
											2)Develop a video-taped interim learning package for physicians concerning the discharge medication prescription.	Tracking of access to the video-learning will be via automated email response to the Pharmacy from physicians who have watched the short video.	% of privileged physicians who view video-learning package in the second and third quarter of 2019/2020	50% of privileged physicians will view the video learning from June to December 2019	The video package will be developed for release in June 2019, and tracking will begin them to determine how many physicians have been able to view the information.
											3)Develop and/or review standard work for Administrative Control Clerk (ACC) to ensure that a signed discharge prescription is reaching both the patient and the chart.	Pharmacy will work with Nursing Managers and ACC to standardize the process. Education will be provided at unit huddles and via written communication in April. At the end of May 2019, a survey will be provided to ACC and Nursing Managers to determine if the standard work is in use.	Number of units with ACC clerks who are properly using standard work for distribution of the discharge requisition by May 2019.	9 inpatient units will have ACC clerks applying standard work to the distribution of the discharge prescription.	There is a gap in information sharing that the ACC clerk can fill by ensuring appropriate distribution of the prescription.
		Proportion of hospitalizations where patients with a progressive, life-threatening illness have their palliative care needs identified early through a comprehensive and holistic assessment.	P	Proportion / at-risk cohort	Local data collection / Most recent 6 month period	777*	CB	CB	We are collecting baseline data on this indicator and will only be able to set a target once we understand our current practice results.		1)Build a new report to identify Health Links patients for Social Work team to consult palliative care.	Social work will track how many patients identified on the new report are provided a palliative care consult.	% of Health Links patients with palliative care consults	100% of Health Links patients will be given a palliative consult.	Patients who are identified as Health Links candidates may have progressive, life-threatening illnesses. Last year 15% of health links patients passed away.
											2)Secure increased resources for physician coverage for continuity of palliative care by September 2019	Medical Affairs to monitor number of physician FTE for palliative care	Physician FTE for palliative care to be 1.0 by September 2019	1 FTE palliative physician	This addition would grow our capacity for seeing palliative patients.
		Rate of mental health or addiction episodes of care 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 2017	777*	9.89	9.40	While we have already seen a substantial decline in readmission of mental health/addictions patients through our use of the Crisis Nursing team, we are aiming to decrease this by a further 5%.		1)Develop and begin to distribute Mental Health discharge tool	Manual review of all patients' discharge documentation to ensure discharge tool is complete and provided to the patients. Staff to complete tracking sheet held at ACC desk.	Number of patients receiving discharge tool	100% of patients who are discharged home will receive a discharge tool	The denominator will not include patients who are discharged to another facility.
											2)Develop a "Working with Emotions" outpatient group to assist patients identified with personality disorders	Data collected by Decision Support team.	Number of readmissions of patients identified with personality disorder.	Collecting Baseline rate. Expect a 10% improvement from baseline in this fiscal year.	Patients with personality disorders tend to have higher readmission rates, particularly for short stay admissions.
											3)Increase number of psychologist-led psychotherapy groups to address long wait times.	MELISSA PLEASE HELP ME OUTLINE HOW WE WILL TRACK THIS	Number of patients seen in the out patient psychotherapy group.	Collecting baseline. Increase the number by 50% from October to December 2018 versus October to December 2019.	Participation in the outpatient psychotherapy group helps to reduce the risk of admission to hospital.

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	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**	**777***	**235**	**223.00**	**With effective implementation of education, assessment, debriefing and reporting of violent incidents, our goal turns to having a decrease in the number of incidents that are experienced in our hospital. Our target is 5% lower than last year.**		**1)Education of staff in electronic platform for Client Violence Risk Assessment.**	**PCS training will be documented through nursing professional practice and will include the Client Violence Risk Assessment Tool (VAT**	**% of Full Time Equivalent nursing (RN/RPN) staff completing electronic violence risk assessment (excluding Ambulatory Care, Operating Room and Endoscopy/Cystoscopy).**	**75% of those eligible to be trained in PCS education.**	
											2)Increase reach of Violence Prevention Training based on risk assessments to include 100% of staff employed in highest risk areas (ED, MH, ALC).	Number of staff trained compared to the number of staff employed in the highest risk areas. Data is collected in the Human Resources Information System (HRIS).	% completion of Non-Violence Crisis Intervention (NVCI) training for high risk areas.	90% of all staff in high risk areas will completed NVCI training by December 2019	
											3)Continue to improve percent of Code White events that are followed with a formal debrief to help learn from each incident.	Manual count of Code White Debrief forms that are completed compared to the number of Code White events recorded in the security logs and Employee incident reports.	% Completion Code White debrief forms	100% of Code White debrief forms completed from June to December 2019	