2020/21 Quality Improvement Plan
"Improvement Targets and Initiatives"

Erie Shores Healthcare 194 Talbot Street West

AIM	Measure						Change				
Quality dimension	Measure/Indicator	Unit / Population	Source / Period	Current performance	Target	Target Justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goals for change ideas	Comments
Efficient	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.	Rate per 100 inpatient days/All inpatients	WTIS, CCO, BCS, MOHLTC/ Quarter - July 2019-Sept 2019	11.53%	<=12.7%	Provincial Target	Pathways for COPD, CHF, Hospital Acquired Pneumonia	Education, Identifying trends when patient is progressing vs regressing. Educating patient to be aware of symptoms and symptom management. Nurses to review the pathway with patient/family. To ensure all COPD, CHF and Hospital Acquired Pneumonia patients get assessed to be put on pathway.	Internal audits for pathway use.	Reduction in re-admits and ALC's.	
							Optimize mobility	Education, demonstrate and early assessments to increase nurses knowledge and awareness of the importance of mobility during hospital stay. Nurses and Physiotherapist to discuss patients mobility status at daily care rounds and request physio referral if required. LHIN Coordinators and Rehab Team to assess what patients would be best candidates for Community Rehab Programs i.e.: E-Rehab, IHH Rehab vs Inpatient Rehab.	Track the number of ALC patients waiting for rehab and or number of ALC's due to mobility barriers that are not rehab candidates. Internal audits.	Reduction in ALC's and early identification.	
							Estimated discharge dates (EDD) for all acute patients within 24 hours of admission	Standardized a way of establishing EDD for acute patients, and to ensure process/responsibilities are clear to nursing staff/physicians. EDD is written on patients white boards, beginning of each shift nurse to review EDD and destination with Patient/Substitute Decision Maker. EDD will be documented on all LHIN referrals for pre-planning. Oversight by Access and Flow Manager and Director.	% of EDD given to Patient/Substitute Decision Maker and recorded in chart/total admissions. Internal chart audits, white board audits and patient audits to assess their awareness of their EDD.	Reduction in ALC's by pre-planning, and improve communication with patient/substitute decision maker and multidisciplinary team.	
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.	Hours/All patients	CIHI, NACRS, CCO/Quarter July 2019-Sept 2019	4.43 hours	<= 4.5 hours		Early identification of possible admissions communicated to the inpatient charge for bed allocation	Huddles q 2 hour between CRN and ERP for admit identification	90 percentile admit to ED dc is less than 4.0 hours	see measures	
							Dedicated Bed Phone at registration	Inpatient housekeeping and ED CRN to communicate frequently re: bed demands and bed availability.	90 percentile admit to ED dc is less than 4.0 hours	see measures	
							Streamline admission chart	Review of all processes and documentation that is needed for a patient to be admitted. Bed meeting twice a day. Discharges by 11 a.m. flow (sustain)	90 percentile admit to ED dc is less than 4.0 hours	see measures	
Patient-centred	Percentage of respondents who responded "completely" 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?	%/Survey respondents	CIHI CPES (NRC Picker) most recent 12 months - Jan 2019 - Dec 2019	51%	>=65%	Based on previous year 2019/2020 performance	Admission/Discharge/Transfer (ADT) RPN: increase coverage to 7 days a week	Hiring/assigning permanent Part Time position. Co-Health App Discharge reference document for patients	Expand coverage to ensure consistency with discharge support and education. Monthly audits of readmissions within 7 and 30 days.	90% of discharges completed by ADT RPN. Reduction of readmissions	
							Follow up discharge phone calls	Calls are to be completed by the ADT RPN 24-48 hours post discharge. Standard script to be used. Align question to NRCC for satisfaction.	Weekly audits of follow up phone calls. Audits will be used to create gap analysis	90% completion rate	Data from gap analysis will be used to create action items for improvement.
							Provide patient and family with EDD on admission. This will be supported by the implementation of clinical pathways for congestive heart failure, chronic obstructive pulmonary disease and community acquired pneumonia. Rehab care rounds - interdisciplinary with family. Expand to acute care.	Education and implementation is scheduled for April 2020.	Audit compliance of clinical pathway use by nursing staff	100% of appropriately assigned clinical pathways will be completed	

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.	Rate per total number of discharged patients/ discharged patients	Hospital collected data/ Quarter - Oct 2019 - Dec 2019	93% - excluding Newborn, stillborn, OB, LTC, hospice and deaths	>=90%	Improvement to Current Organizational Performance. Increase by 1% next year and by 5% the following year.	Discharge medication/reconciliation and information through Cerner Millennium beginning June 2020	Number of discharged patients for whom a Best Possible Medication Discharge Plan (BPMDP) was created. Excludes hospital discharge that is death, newborn, stillborn and OB.	# BPMDP/# discharged patients (excluding deaths, stillborn, newborn and OB)	Maintain current level of discharge medication information to patients when transitioning to Cerner Millennium	Consideration to include OB patients 2021/22
Effective	Percent of unscheduled repeat emergency visits following an emergency visit for a mental health condition.	% ED Patients	CIHI/NACRS/ Quarter April - June 2019	21.79%	20%	reduce by 10%	PAN nurse	Continuing education by involvement with Regional Groups relating to addictions..i.e., Treatment and Recovery Working Group from HDH.	% MH return visits within 30 days	improve return visits by 15%	
							Partnership & committee development - Police, EMS, hospital & mental health agencies.	Quarterly meetings to discuss and develop processes for seamless care journeys for MH patients.	% MH return visits within 30 days	improve return visits by 15%	
							Community Resource Referrals	Refer and educate re: -Walk in Counselling locally -Family Health Team -Social Workers -CMHA -Withdrawal Management at HDH -Community referrals for Withdrawal Management -Windsor Essex Community Health Unit -Erie St. Clair Addictions Clinic -Detox	% MH return visits within 30 days	improve return visits by 15%	
Safe	Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.	Count/worker	local data collection/ calendar year Jan - Dec 2019	54	<= 50	Anticipate we will continue to see an increased uptake in reporting coupled with improvement.	Safety Huddle	Inpatient, Perioperative Services, Allied Health Services and Emergency Department leaders huddle with staff daily – at which time, any concerns are flagged and discussed for ongoing supportive and preventative measures to be implemented.	Track and review incidents reported monthly. Track % of WPV incidents closed as per policy. Review at monthly Joint Health and Safety Committee meeting.	100% of monthly WPV incidents acknowledged with 24 hours and closed within 5 days of incident date (unless extenuating circumstances) as per policy.	
							Crisis Intervention Training	In-person, 1 day training Peer Support Training in partnership with EMS and Dr. Lori Gray	All new and existing staff will receive this training. Reviewed on an annual basis.	All existing staff to be trained by April 2020. New hires will receive training at orientation.	
							Code of conduct training	Staff have received via email the Standards of Behaviours, Code of conduct and Workplace Violence Harassment Prevention Program Policy for Human Resources.	Meetings have occurred with staff within two units. Meetings will occur as the need arises.	Review workplace violence and harassment incidents received to look for trends and meet with staff as needed.	
							Employee Assistance Program	Provide information in an on-line format for employees to be able to access in private at home.	Track the number of visits recorded to EAP.	Review visits recorded quarterly and look at trends to initiate health promotion to staff.	
							RL6 Reporting Training	RL6 is an on-line program accessed by staff to report any workplace illness, injuries, violence and harassment. Every staff member will know how to access RL6 and select the appropriate category to document the workplace incident.	All staff will be trained how to properly use RL6 to reflect the workplace incident and have this directed to the right person for follow-up as per policy.	Training to take place on an ongoing basis for new hires at orientation.	
Effective	Early treatment of sepsis: percentage of Emergency Department (ED) patients identified at triage to be at high-risk for sepsis who receive first-dose antibiotics within 1 hour	Rate of pts identified who receive 1st dose antibiotics within 1 hour	Internal audits	Collecting Baseline (CB)	>=25%		Sepsis Campaign - 1. Orderset development 2. Screening tool 3. Flagging/ priority alert - MD/pharmacist	Utilize the revised sepsis screener for every emergency visit adult.	% of sepsis diagnosis where a triage screener was completed.	Improvement >=25%	
							Visual indicator for positive Sepsis Screeners	If positive Sepsis Screener, utilize a red 'flag' card with the time of triage clearly marked, placed on the chart.	Audit charts in real time for visual indicator used.	Improvement >=25%	
							High prioritization for positive Sepsis Screeners	Communicate with the Charge Nurse and the Emergency Physician re: the positive Screener.	% of sepsis diagnosis where first dose antibiotics are used with in the first hour.	Improvement >=25%	

Safe	Reduce Number of Patient Falls	Rate per 1000 patient days/ All patients	In house collection - January 2019-December 2019	12.17	10.5	To meet current baseline standard	Weekly Falls Audits taking place by CPM's, AHA and identified floor staff to ensure that entire Fall bundle is in place.	In-person 1:1 review of patient information and falls interventions in place with immediate correction and education taking place with staff members	Staff will have a 100% compliance rate of fall risk assessments and bundle implementation by December 2020.	Improvement in monthly fall numbers by 15% and a decrease in patient harm incidents related to falls.	
							In-depth literature and review of best practice methodologies and interventions in place at other high performing institutions with similar levels of resources.	Use of nursing, allied health and medical databases to collect peer-reviewed and best practice literature	Identification of alternative methods and best practices for fall prevention. Incorporation of these findings into policy and procedure by June 2020.		
							Increasing engagement of staff in all patient care areas of the hospital to recognizing falls risks to mitigate increasing numbers of falls.	Monthly Falls occurrences being publically posted on units to raise awareness of falls numbers in addition to daily unit huddles for staff to discuss patients at high risk for falls. Additional education and awareness being completed in outpatient areas with staff to raise awareness that falls prevention takes a team approach.	100% of staff will voice an awareness of fall risk factors and be able to identify preventative measures to put in place for high risk patients.	Improvement in monthly fall numbers by 15 % by December 2020.	