2019/20 Quality Improvement Plan
"Improvement Targets and Initiatives"
Erie Shores HealthCare 194 Talbot St. 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**	**Target for process measure**
Timely and Efficient Transitions	**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 / October 2018 – December 2018	6.3	4.6	Reduce by 1 hour 42 minutes. Target is achievable based on past performance. Focused resources will be implemented.	1) Transport Attendants	Transporters are an integrative team member within the Emergency Department. The primary purpose will be to focus on patient flow (ED to IP and ED to DI) and improvement of P4R targets/indicators.	Analyze ED diagnostic test turn around times monthly.	Decrease ED x-ray turn around times by 5%.
							2) Improved Emergency Department Flow and Access Initiatives	After Hours Managers to be implemented for oversight and collaboration the ED physicians, hospitalists, registration, nursing staff, etc. Fluid communication in regards to bed availability, capacity vs. demands.	Track the time of discharge order versus time patient actually left the inpatient unit.	5% Improvement over baseline collection.
								Smoothing process for admissions (minimizing batching).	Conduct time studies and track time between the decision to admit and the time patient left Emergency Department to inpatient bed.	Time from decision to admit to patient leaving Emergency Department - decrease by 1 hour 42 minutes from current performance.
								Leverage Occulys platform for housekeeping and registration for bed turn around times; access and utilization of beds.	Track the time patient left the unit to the time housekeeping is notified. Track the time housekeeping is notified to the time bed is ready for admission.	Improve performance over baseline collection.
							3) Assess documentation completed during the admission process to ensure a value-added approach to care planning.	Review needed documentation and duplicated documentation. (I.e. Medication Reconciliation, Assessment Tools).	Track time needed to complete current documentation and assessments. Assess which processes are duplicated and which have added value for patient care planning.	Reduce redundancies and time required to process admissions by 25%.
	90th Percentile ED ambulance offload time	The time from ambulance arrival date/time to ambulance transfer of care process date/time.	Oct - Dec 2018 CIHI	28 minutes	<= 24 minutes	Decrease current performance by 14%. Medium Volume Community Hospital Group YTD (April 2018-December 2018) is at 39 minutes. ESHC target for 19-20 is 24 minutes or less.	1) Transfer of Care (TOC) Initiative	Process development - Transfer of Care (TOC) between EMS and ESHC Nurse is noted through a standard process - removing the onus of EMS owning the transfer of care time. Coders will now use nurse documented TOC data.	ESHC RNs to input Transfer of Care times data.	Audit transfer of care times daily.
							2) Emergency Medical Services (EMS) Dashboard Initiative	Partnership with Windsor-Essex EMS. ESHC ED has access to the EMS platform that provides live data (ambulance en route to hospital, estimated time of arrival, offload clock, etc.). This is visible on a large TV for all physicians, front line staff and leaders which enhances our ability to forecast and plan accordingly for immediate offload. Leadership team has this platform assessable via mobile application as well.	ESHC ED staff can predict, prepare and monitor EMS arrivals and timelines.	Reduction of number of Code 7s. Reduction of transfer of care times by 5 minutes.
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 / July - September 2018	13.7	< = 12.7	17/18 Provincial Target is 12.7.	1) Optimize the use of the Daily Bullet Round model	Daily bullet rounds on inpatient units will allow for the early identification of complex patients as well as discussions around discharge plans earlier in the admission.	Track the total number of ALC Days monthly.	Reduction in ALC days - Less than or equal to 5%.
							2) Optimize the use of the weekly multidisciplinary rounds model.	Review the format of the weekly multidisciplinary rounds (CCAC, geriatric nurse, psychiatry, palliative care, etc.) to focus primarily on complex patients to ensure timely discharge with appropriate support.	Track the total number of ALC Days monthly.	Reduction in ALC days - Less than or equal to 5%.
							3) Social admission diversion initiative.	Ensure GEM/LHIN involved with all social admits. Review all 24 hour ALC designations for trends, gaps and improvement initiatives. Oversight by Access and Flow Manager and Director.	Track and review monthly volumes. Identify common themes to be able to implement change ideas and plans.	Audit 100% of Admissions made ALC within 24 hours. Discuss findings at monthly Care Team Meetings.
							4) Behavioural Supports Ontario (BSO) education for GEM Nurses.	GEM RN to attend BSO education conference.	GEM RN to provide education to other internal stakeholders.	100% of GEM RN BSO education to be completed by May 2019. Education of other stakeholders to be completed by December 2019.
							5) Provide all patients/SDMs with Estimated Date of Discharge (EDD) in writing shortly following admission and also documented on chart per best practice leading principles.	Draft a sample letter ensuring standardized way of establishing EDD is use, and process/responsibilities are clear and established for completing and distributing letters. Oversight by Access and Flow Manager and Director.	% of EDD given to Patient/Substitute Decision Maker and recorded in chart/total admissions. (Inpatient Rehab and Complex).	Audit that 100% of EDD sample letters are provided to patient/substitute decision maker. (Intake office to audit).

Patient-centred	**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?**	% / Survey respondents who responded "Completely"	CIHI CPES / Most recent consecutive 12-month period (January - December 2018)	58.42%	> = 65%	Improve performance by 3% from ESHC 18-19 forecast of 63%. NRC Average is 58.2% - January 2018-December 2018. Target is set better than NRC average.	1) Introduce Discharge RN	Effective discharge planning can decrease the chances of a patient being readmitted to the hospital, and can also help in recovery, ensure medications are prescribed and given correctly, and adequately prepare the patient and/or family to take over their loved ones care. Evaluation of the patient by qualified personnel. Discussion with the patient or their representative; Planning for homecoming or transfer to another care facility; Determining whether caregiver training or other support is needed; Referrals to a home care agency and/or appropriate support organizations in the community; Arranging for follow-up appointments or tests.	Review current discharge information to align with best practice. Monthly reporting of NRC Inpatient results at Care Team meetings. Leadership rounding on the inpatient units.	Audit 100% of inpatient readmissions on a monthly basis to identify common themes and implement change ideas and changes in process to reduce readmissions. Weekly completion of leadership rounding on inpatient units, identifying patient concerns/comments.
							2) Provide all patients/SDMs with Estimated Date of discharge (EDD) in writing shortly following admission and ensure this is documented on chart per best practice leading principles.	Draft a sample letter ensuring standardized way of establishing EDD is use, and process/responsibilities are clear and established for completing and distributing letters. Oversight by Access and Flow Manager and Director.	Audit of completion rates for admitted patients on a weekly basis. Education for providers on how to best use the whiteboard.	90% of patients will have their white board up-to-date/completed.
Safe	**Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.**	Count / Worker	Local data collection / January - December 2018	41	< = 50	Anticipate we will continue to see an increased uptake in reporting coupled with improvement.	1) Safety Huddle Initiative.	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.	100% of monthly WPV incidents acknowledged with 24 hours and closed within 5 days of incident date (unless extenuating circumstances) as per policy.
							2) Code White Training.	"Code White" refers to a trained team response to a disturbance that is a behavioural emergency involving clients in healthcare settings. A core team at ESHC was trained as leaders within the organization. In 2019-2020 this team will oversee the Non-Violent Crisis Intervention training across the hospital.	All staff to be trained in Code White.	100% of staff trained by April 2020.
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 / October - December 2018	Collecting Baseline	> = 90%	90% of patients will have had a completed medication reconciliation.	1) Internal assessment of Discharge Medication Rec. Ensuring that we are have an comprehensive and standardized stat collection process.	1) Value Stream Mapping and analysis. 2) Identify and implement process improvement strategies. 3) Audit compliance and accuracy monthly.	% of Medical/Surgical patients with medication reconciliation completed at discharge. Transitioning to complete auditing procedure on the total number of discharges versus sample.	Discharge Medication Reconciliation and cMAR will be fully implemented by September 2019. 90% of patients will have had a completed medication reconciliation.
	Reduce % Repeat Visits within 30 days following a mental health visit.	Total unscheduled ED Mental Health Visits/total repeat visits within 30 days following a mental health visit	NACRS	Q1 - Q3 YTD 2018/19 - 19.51%	< = 16%	Reduce %. ESHC LHIN target in FY 2018-19 is 16%. This is a priority health care initiative within the ESC LHIN and Province.	1) Improve care coordination of mental health and addictions services through collaboration and integration with community partners.	1) Regional meetings monthly. 2) PAN Nurse outreach and engagement with community partners.	Review ED revisits on a monthly basis to determine common themes. Identify process improvements and implement change idea plans.	100% of repeat visits audited monthly.
							2) Assess and evaluate re-visits for MH patients within 30 days to identify potential preventative measures and opportunities for improvement.	1) Develop a standardized tool to perform and monitor re-visits. 2) Reporting structure at Care Committees for review of potential preventative and improvement measures.	Establish a flagging process to identify when patients are re-admitted so deep dive can be completed.	Complete deep dive on 100% of patients.
							3) Ensure proper information and communication is available to patients/family at discharge from the ED.	1) Revise the current discharge checklist to align with community resources, outreach, etc. 2) Develop discharge instructions for mental health and additions patients. 3) Develop a standard transfer of accountability to enhance reporting between ESHC and Schedule 1 hospital(s).	Discharge checklist revised and implemented into practice.	Use of revised discharge checklist for 100% of patient discharges. (Audit processes to be established).