2018/19 Quality Improvement Plan
"Improvement Targets and Initiatives"

Timmins And District General Hospital 700 Ross Avenue East

AIM		Measure								Change				
Quality dimension	Issue	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) A= Additional (do not select from drop down menu if you are not working on this indicator) C = custom (add any other indicators you are working on)														
Effective	Effective transitions	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 / April - June 2017(Q1 FY 2017/18)	907*	93	99.00	We set our target last year to 75% not having a baseline. As we are performing well in this category and we now have performance data to support this indicator, we feel confident that we can achieve a target of 99% for the upcoming year.	1)In order to implement effective change ideas, the team at TADH feels that a current state analysis of in patient units regarding discharge information (Medical, Surgical, Mental Health, OBS, ED and ICU) needs to be completed to review current processes.	We will review information provided to patients by unit, as well as discharge telephone call data to see what is provided to patients upon discharge.	Complete the current state analysis by Q2	Current state of all units complete - 100%	By completing a current state analysis we will be able to generate change ideas for the following years QIP 19/20.
		Rate of psychiatric (mental health and addiction) discharges 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 2016	907*	12.63	11.30	This is the first year we will be measuring this indicator, as such we will strive to achieve the provincial target of 11.3.	1)Currently involved in the IDEAS advanced program - change idea is that 100% of adults with major depressive disorder who are discharged from our hospital adult mental health unit, will have a plan of care which includes a coordination of services.	We will identify and review current processes and develop the care plan by Q1.	# of clients who have a completed care plan	80% of clients identified by the discharge planner in our adult mental health unit will have a plan of care upon discharge	
		Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort)	P	Rate / COPD QBP Cohort	CIHI DAD / January - December 2016	907*	26.62	19.90	Although the CIHI DAD data does not demonstrate improvement in this category, our internal data has demonstrated improvement and we feel we should be able to achieve a target of 19.9% as per the provincial average.	1)Audit and improve use of the COPD order set	Add prompts to the computer, re-education staff, including physicians in the ED and integrated medical.	Prompts and education to be completed by Q1 Regular snap shot audit performed per quarter: # of order sets completed/# of eligible patients	100% complete	
										2)Improve referral rate to COPD clinic	We will collect baseline data for this fiscal year 17/18.	# of referrals receives by quarter in 18/19	Increase referrals by 10% of the 17/18 baseline	
										3)COPD order set and pathway complete. Education package available but needs to be included on our LMS and shared with staff members of the integrated medical unit	Package to be revised and added to Learning Management System and staff to complete the education module	Education package to be included on the LMS by June 2018. We measure the number of staff on integrated medical who have completed the learning package/total number of staff on integrated medical.	Education package to be added to LMS 100% by June 2018. 90% of integrated medical staff to have completed the learning package by December 31, 2018 (end of Q3).	

Efficient	**Access to right level of care**	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 2017	907*	32.25	15.30	15.3 is the provincial target	1)Continue to spread our use of the HARP tool by improving the completion rate within medical B	The program educator will continue to monitor the completion of the HARP tool by the unit staff.	# of eligible patients with HARP completed/total number of eligible patients	Our current rate of completion on eligible patients is 71%, we would like to increase this to 80%.	Our target last year was 50% and we surpassed our target therefore we would like to increase our target this year to 80% completion rate for this
										2)Implement use of Blaylock tool on the Integrated Medical Unit	For ease of use we would like to have the Blaylock tool added in the Patient Care System (Meditech) we will then educate the staff on the use of the tool and monitor completion rates	Blaylock tool to be "built" in the Patient Care System by end of Q1 Educators to train staff on use of tool by end of Q2 Q3 and Q4 measure usage of the tool	75% completion rate of Blaylock tool in Q2 and Q3	
Patient-centred	**Palliative care**	Percent of palliative care patients discharged from hospital with the discharge status "Home with Support".	P	% / Discharged patients	CIHI DAD / April 2016 - March 2017	907*	75.51	80.50	We did not achieve our target last year as we had challenges in implementing our change idea. We hope that this year there will be movement on this item to ensure we can accurately measure and audit the coding of this indicator. The provincial average for this target is 85.1 % we will strive to increase our target by 5% this year in hopes to increase it further in 2019-20.	1)Our change idea will remain the same as last year as we did not achieve. In order to ensure proper coding from clinical areas we will ensure the the discharge disposition data is obligatory.	Works with IS/IT and the NEON group to ensure that the discharge disposition information is a mandatory field in the electronic chart.	IS/IT and NEON to review.	Change to mandatory field to occur by Q3	
	Person experience	"Would you recommend this emergency department to your friends and family?"	P	% / Survey respondents	EDPEC / April - June 2017 (Q1 FY 2017/18)	907*	59.3	75.00	We have seen a steady increase in positive response rate last year and we hope to continue in that direction therefore we are aiming for a target of 75% satisfaction with our surveys this year.	1)Implement added space in our ED to assist with surge capacity and increase patient flow with CTAS 4 and CTAS 5.	Add 3 ambulatory sitting area to provide care to CTAS 4 and 5 within existing space. Add 1 additional stretcher to assist with admitted patients awaiting a bed on our acute units. Add 5 additional waiting room seating area for CTAS 3, 4 and 5 patients awaiting lab and DI results	Added space in place by May 2018	To have 9 functional spaces implemented by April 2018.	

		"Would you recommend this hospital to your friends and family?" (Inpatient care)	P	% / Survey respondents	CIHI CPES / April - June 2017 (Q1 FY 2017/18)	907*	100	100.00	We will continue to maintain a target of 100% as we have good performance in this area. We do not collect this data through CIHI CPES but rather with our internal survey the same question is asked.	1)Continue to increase our number of concerns resolved by the Patient Experience Advisory Committee	We will continue to collect data on issues raised and resolved.	# of issues raised # of issues resolved	We will attempt to resolve 80 % of issues raised by this committee. To date for Q1 and Q2 of 2017-18 we have resolved 71 % of issues raised.	
Safe	**Safe care/Medication safety**	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 (Q3) 2017	907*	96	95.00	We will be collecting baseline as it relates to the calculation HQO had included in the QIP. At this time we are collecting internal data and our intent is to continue to collect data for the integrated medical unit.	1)Ensure that the discharge prescription is easily identifiable for the patient.	Will use a different color and border for the discharge prescription. Provide education to patients	Complete the change by end of Q2	100% complete	
	Workplace Violence	**Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.**	**M A N D A T O R Y**	**Count / Worker**	**Local data collection / January - December 2017**	**907***	**159**	**175.00**	**Increase the number of reported incidents by 10% because we feel that these types of events are believed to be under reported. We do not want to set an objective that is not achievable in our first year.**	**1)Increase the employee awareness by providing workplace violence prevention training including reporting requirements.**	**An education module will be created and this will be added to our Learning Management System with the expectation that all permanent employees review and complete**	**Education module will be finalized by April 1, 2018**	**100% of full time and part time workers will have completed the module by end of Q1 (end of June 2018) Excluding individuals on leave of absence.**	**FTE=393**
										2)Review and revise the Incident Management System reporting process to facilitate workplace violence incident reporting	We will complete a process review, current state analysis of what is being done.	Process review/current state analysis will be completed by end of Q2	Current state analysis complete	This will allow us to identify what changes need to happen to reduce the gaps - change ideas will be assessed and prioritized and may inform our QIP for 19/20. Our current FT complement is 393