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

North Shore Health Network 525 Causley Street P.O. Box 970

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)

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
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)	611*	CB	90.00	ability to manage self care is important in preventing readmissions. 75% of persons in Ontario who left the hospital had written material	1)Improve Data collection	develop process to address question at the bedside at time of discharge to support real time data collection and encourage consistency in response	number completed vs number of patients discharged home	100%	
										2)develop staff skill and consistency in providing patient focused education that engages them as partners in care verses	1) create teach back Teaching tool kit and educate all staff on use 2) develop mandatory patient education components that apply to all discharges 3) commence providing a fact sheet specific to the admitting diagnosis at time of discharge 4) consider " stop light" discharge	"stop light" visual aid implemented for all discharges	80%	
	Wound Care	Percentage of residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4 since their previous resident assessment	A	% / LTC home residents	CIHI CCRS / July - September 2017	53695*	X	1.20		1)maintain current and evidenced based practice and process for all residents	1) ensure annual update of policy and process 2) support ongoing staff development and education with at least one education event offered per year	education event offered once annually to all staff	100%	
										2)Proactively manage wound risk and active wounds	1) complete wound and skin assessment within 24 hrs of admission to determine risk 2) update care plans proactively to manage risk 3) apply interventional strategies at first sign of skin redness	all care plans up to date	100%	
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	611*	24.5	30.00	rate of ALC has progressively increased over the last 3 quarters. In the last 18 months the census had been low, also keeping the ALC rate low. This has recently changed and is progressing toward the ALC	1)maximize use of inter-collaborative team meeting weekly to support the transition of ALC patient to the most appropriate	1) education with team members of what is Alternate level of care 2) regular review of acute care patients to ensure timely transfer to ALC status 3) utilizing family conferences to optimize all patient supports	number of inter-collaborative team meetings annually	99%	
										2)Discharge planning that starts at admission	1) develop standardized process for discharge planning - such as PODS or SMART discharge tool or make full use of the existing Blaylock form 2) consider risk stratifying at admission to better determine ALC potential - examples might be LACE tool, TRST tool 3) actively	selection and development of a formalized discharge planning process	in development	
										3)Maximize use of evidenced based practice in managing patients with dementia	1) utilize the clinical guide as developed by HQO Dementia clinical guide 2018 addressing components of a) comprehensive assessment b) individualized care planning c) maximizing non-pharmacological interventions d) appropriate psychotropics e) titration	fully outlined care plan that is up to date on all ALC dementia patients	100%	
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	611*	66.67	90.00	supports the increased focus on good palliative care that provides patient choice as they near end of life	1)Communication and education with all collaborating agencies to maximize integrated palliative supports	support ongoing staff education for acute care staff and community support services on palliative care 2) education with providers re referral process and ensuring proper supports 3) education with Health Records staff to maximize correct data capture	education provided to staff with at least 50% of staff attending one training session on palliative care services	50%	
										2)Mandatory referral to home and community care services for any patient deemed palliative at time of Discharge	1) staff education on process to ensure active advocacy with provider	referral completed	100%	

	Person experience	"Would you recommend this emergency department to your friends and family?"	P	% / Survey respondents	EDPEC / April - June 2017 (Q1 FY 2017/18)	611*	97.8	95.00	method of data collection will be changed to collect information at the time of the visit verses a mail out survey. It is felt that the feedback will be	1)Develop customer centered care model	1) identify customer care champions to lead by example 2) initiate phone or direct follow up within 3 days of receiving a concern 3) collaborate with family and patient council to explore opportunities for continued improvement 4) consider standardized communication	Percent of concerns follow up within 3 days of receipt	100%	
										2)Increase survey response	1) implement a simple tool that captures data in real time while patient in ER - examples "happy or Not", Poker chip selection 2) work with ward clerk during days to provide survey to ER patients	real time process developed and implemented	100%	
		"Would you recommend this hospital to your friends and family?" (Inpatient care)	P	% / Survey respondents	CIHI CPES / April - June 2017 (Q1 FY 2017/18)	611*	98	95.00	the provincial average in 14-15 was 75%. Other like facilities have noted a target range of 83-100%. Indicating a target of 100% suggests there is no room for improvement.	1)Develop customer centered care model	1) identify customer care champions to lead by example 2) initiate phone or face to face follow up within 3 days of receipt of complaint 3) collaborate with family and patient council to explore opportunity for continued improvement 4) explore opportunity for "touch base"	follow up of patient concerns within 3 days from receipt of concern for all concerns expressed in writing	100%	
										2)Increase survey response	1) implement a simple tool that captures data in real time while patient on ACC 2) work with ward clerk during days to provide survey to ACC patients	Real time process developed and implemented	100%	
										3)Purposeful rounding utilized as a standard of care on acute care	regular rounding on all acute care patients addressing pain, possessions, pumps, personal needs, and positioning.	all staff consistently apply process as per a check sheet kept in the patient room	80%	
	Resident experience: "Overall satisfaction"	Percentage of residents who responded positively to the question: "Would you recommend this nursing home to others?" (NHCAHPS)	P	% / LTC home residents	In house data, NHCAHPS survey / April 2017 - March 2018	53695*	81.82	90.00	in line with targets set by like agencies. NSHN has a mandate of ongoing improvement.	1)Continue to build on a customer centered model of care	1) identify customer care champions to lead by example 2) initiate phone or face to face follow up within 6 days of receipt of complaint 3) collaborate with family and patient council to explore opportunity for continued improvement 4) explore opportunity for "touch base"	Follow up of concerns within 6 days of receiving concern	100%	
										2)Foster involvement and engagement of resident and family council to facilitate improvement	1) bring trends of care concerns to Council with action plan for additional input / review / brainstorming 2) continue to use satisfaction surveys at family events to garner their input and perspective	Annual review of resident survey with Council	100%	
										3)All staff completed required education that fosters a senior friendly environment	completion of required education including a) resident bill of rights b) restorative therapies c) GPA d) managing behaviours	all education completed	100%	
Safe	**Workplace Violence**	**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 2017**	**611***	**13**	**7.00**	**Employee safety is a priority for NSHN**	**1)Increased awareness and knowledge of what is work place violence**	**1) required education for all staff on work place violence**	**number of staff receiving education**	**100%**	**FTE=158**
										2)Organizational processes support and facilitate reporting of work place and prevention actions are in place	1) policies are updated and widely circulated 2) annual education or review for all staff on the policy and process for reporting 3) clarity in the reporting process and lines of responsibility	all policies up to date	100%	
										3)Organizational change to promote staff safety	1) all ER departments ensure controlled patient flow with safe room for staff identified 2) code Silver, Code Black and Code purple policies and processes up to date and practiced as required by OH&S 3) injury prevention actions completed with in 2 weeks of need being	safety walks occur as scheduled by the senior team	100%	
										4)staff engagement in work place violence prevention	1) ensure full communication of actions post event and update on changes made 2) complete staff satisfaction survey 3) publically post patient safety action plan and update at least monthly	staff satisfaction survey completed	100%	