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

Woodstock General Hospital

AIM		Measure							Change				
Issue	**Quality dimension**	**Measure/Indicator**	**Type**	**Unit / Population**	**Source / Period**	**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) C = custom (add any other indicators you are working on)													
Theme I: Timely and Efficient Transitions	**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	32%	65%	This is a new initiative and we have just implemented changes to the process for delivery of dictated discharge summaries to primary care provider. Process is still being tested and may change based on Primary Care feedback.	1)Discharge summary to be delivered to primary care provider within 48 hours of discharge. They will be sent unauthenticated with auto signature. The summaries will not be sent if more than 5 blanks and a process to add an addendum if an error is found once the summary has been reviewed by the Primary Care Provider.	Have worked with our partners at London Health Sciences to support IT functionality that allows discharge summaries to be auto signed and sent unauthenticated. Have developed process based upon model of SWLHIN partner STEGH	Quarterly evaluations of number of discharge summaries delivered with target of 65%by March 31st 2020.	65% of discharge summaries delivered to primary care provider within 48hours of discharge by March 31, 2020	Support for this initiative was received by Medical Audit Committee; Medical Advisory Committee and Board of Directors
		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.	**MANDATORY**	**Hours / All patients**	**CIHI NACRS / October 2018 – December 2018**	**1.33 hrs.**	**1.50 hrs.**	**TTIB set at 90 minutes which is a 50% reduction from when we first embarked on Pay for Performance in 2014. Presently ranking # 2 in the province out of 74 hospitals; 90 minutes is our Pay for Results target, targets to align**	**1)Dedicated staffing to surge unit on medicine year round. Initiatives with Home and Community Care partners and Retirement Homes to reduce ALC patients waiting for nursing home in hospital: review successful partner models; collaboration with RH to reduce admissions for long term care and to increase increased service plans**	**Daily TTIB times sent out by health records to targeted individuals ie. Directors, patient flow. All barriers to admissions reviewed by Flow and FLIP team, strategies discussed with key stakeholders. Discussed at daily Huddles to keep at forefront to of frontline staff**	**monitor 90% TTIB for 90 minutes, as well as, % TTIB meeting less than 75 minutes and 60 minutes to continuously monitor progress**	**April 2020 - 90 minutes**	**Pre-existing quality indicator for Pay for Results initiative; currently ranking 2nd out of 74 Ontario hospitals**
Theme II: Service Excellence	**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?	P	% / Survey respondents	CIHI CPES / Most recent consecutive 12-month period	67%	75%	This indicator has been on our QIP for the past year. We have struggled to increase the number of respondents that have completely agreed that they received enough information from hospital staff upon discharge. We have recently implemented Patient Oriented Discharge as an organization strategy in medicine and mental health to improve the knowledge transfer between patient and staff upon discharge	1)Include patient advisors on discharge planning teams to ensure a collaborative approach to development of Patient Oriented Discharge(POD) template	Patient and family advisor education session to improve knowledge of discharge planning process 2 patient and Family advisors to attend educational conference with staff members on POD	Education to patient and family advisors to be completed by April 2019 POD template customized and presented at Patient and Family Advisory Committee June 2019 meeting	100% of PFAC team to have received information and education on POD model by June 2019	
Theme III: Safe and Effective Care	**Effective**	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	50%	75%	Palliative Care program readily identifies patients with cancer and develops early comprehensive assessment of their needs. We will be targeting COPD and CHF patients at end of life to ensure they are identified early and comprehensive care plans are developed to meet their needs	1)Patients that are admitted with to medicine program with COPD or CHF will have early identification of palliative care needs using the SPICT tool and an associated referral to palliative care coordinator or social	SPICT tool has been enabled in electronic documentation; SPICT tool is being added to clinical pathways for COPD and CHF; added to the front of the ICP for staff awareness and ease of coders to capture; SPIT tools will print with each admission for these diagnosis; education to all staff to be completed	Number of assessments to be measured each quarter in relation to number of admissions with target diagnosis	65% of qualifying patients will be identified and assessments completed by Sept31, 2109; 75% of qualifying patients will be identified with assessment completed by March 31, 2020	Education to staff ongoing and will be discussed at daily Huddles to engage staff and promote early assessment for this targeted group.
	Safe	**Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.**	**MANDATORY**	**Count / Worker**	**Local data collection / January - December 2018**	**67 incidents**	**60**	**We have had a very successful past year with an overall reduction by 50%. As a Schedule One facility we have a high risk population. Most of the year our beds at been over census which can attribute to aggressive and unpredictable behaviours. Building upon the success of last year our target we will continue with supporting resources towards non violent crisis training for all high risk areas and 30% of lower risk areas.**	**1)All code whites debriefed and reviewed for opportunities for additional staff resources and/or training** **2)Provide non violent crisis intervention training (NVIC) to 100% staff in high risk areas; 30% of staff in lower risk areas yearly**	**Risk Manager reviews all codes on an ongoing basis and ensures follow up occurs as required** **Additional educators trained to provide NVIC with more flexible hours and classes**	**Specific incidents discussed at Daily Huddles pertaining to the unit; reported at monthly management meetings;** **Quarterly reporting at Occupational Health and Safety Committee; yearly reporting at union association meetings; staff injuries reported at monthly management meetings**	**100% of incidents to be reviewed and analysis by Risk manager for educational opportunities** **100 % of staff in high risk areas to receive training within 3 months of commencing position in high risk areas**	**FTE=880**