2016/17 Quality Improvement Plan
"Improvement Targets and Initiatives"

Tillsonburg District Memorial Hospital 167 Rolph Street

AIM		Measure							Change				
Quality dimension	**Objective**	**Measure/Indicator**	**Unit / Population**	**Source / Period**	**Organization Id**	**Current performance**	**Target**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	Methods	Process measures	Goal for change ideas	Comments
Effective	**Improve Home Support for Palliative Patients**	Number of Palliative Patients (inpatient acute care) discharged home from hospital with support, divided by the number of home discharges in the reporting period with a hospital admission that indicates that the patient is receiving palliative care.	% / Palliative patients	DAD, CIHI / April 2014 - March, 2015	824*	CB	80.00	Some patients may refuse homecare and this is not captured in the data.	1)Work with Physicians and discharge planning team to identify patients with discharge plan/diagnosis of "Palliative Care" to assess and document plan of care on discharge.	Review at discharge/patient rounds to flag patients with potential need for palliative care at discharge Provide education to Physicians and Interdisciplinary Team on this new QIP indicator Documentation of palliative plan for patients discharged that includes CCAC and/or Palliative Care Outreach Team Oxford Palliative Care Outreach Team will be a new additional support for our patients. Team will provide education to hospital Team Members on the services they are able to provide for patients.	Percentage of palliative care patients that are discharged home with support. Data provided from LHIN Hospice Palliative Care Network Dashboard. We did have a few patients refuse.	We reduce the number of palliative patients sent home without support.	
	Reduce 30 day readmission rates for select HIGs	Percentage of acute hospital inpatients discharged with selected HBAM Inpatient Grouper (HIG) that are readmitted to any acute inpatient hospital for non-elective patient care within 30 days of the discharge for index admission.	% / All acute patients	DAD, CIHI / July 2014 – June 2015	824*	18.45	17.53	5% improvement over current performance.	1)LACE Tool (Scoring tool for risk assessment of hospital readmission). Telephone contact with patients within 48 hours of discharge. Discharge summaries <48hrs. Booked appointment (for patients discharged home) with Primary provider within 10 days of D/C (warm hand off). Discharge Medication Reconciliation.	Use of LACE tool in patient rounds Care planning with early CCAC involvement i.e. at admission Propose phone contact with patients 48 hours after discharge to CCAC (awaiting CCAC approval). New voice recognition software should help to meet this target Unit Clerk to book appointment at discharge See Medication Reconciliation strategy	Tool used for all patient discharges Early referal orders placed in Cerner to consult CCAC Discharge notes completed within timeframe Appointments scheduled	Improve patient readmissions	

Efficient	**Reduce unnecessary time spent in acute care**	Total number of ALC inpatient days contributed by ALC patients within the specific reporting period (open, discharged and discontinued cases), divided by the total number of patient days for open, discharged and discontinued cases (Bed Census Summary) in the same period.	% / All acute patients	WTIS, CCO, BCS, MOHLTC / July 2015 – September 2015	824*	21.3	20.24	5% improvement over current performance.	1)Utilize services and CCAC Programs to expedite discharge of ALC designated patients	Continued participation in Regional Bed Access work Monthly ALC reviews CCAC Care Coordinator to begin day in the ED to provide support to patients with the intent to avoid admission	Percentage of ALC days	Our goal is to reduce the percentage of ALC days.	
Patient-centred	**Improve patient satisfaction**	Improve Patient/Family experience.	Positive Score / ED patients	In-house survey / Q1 and Q2 cumulative	824*	92.1	90.00	Continue to Utilize In-house Accreditation Canada Survey	1)Improve Patient/ Family experience.	Align survey with Canadian Patient Experience Survey—Inpatient Care (CPES-IC) Educate all team members on the princples of Patient and Family Centered. Establish a Patient and Family Centred Care Steering Committee that includes patient/family representatives. Make in house Patient Experience Survey Electronic	Survey Aligned % of Team Members that complete education on the principles of Patient/Family Centered care and Senior Friendly Hospital Committee established Survey developed and strategy developed to deploy its use.	Improve patient and family experience.	
		In-house survey (if available) What number would you use to rate this hospital stay?	Positive Score / All acute patients	In-house survey / Q1 and Q2 cumulative	824*	93.25	90.00	Continue to Utilize Inpatient In-house Accreditation Canada Survey	1)Improve Patient/Family Experience	Align survey with Canadian Patient Experience Survey—Inpatient Care (CPES-IC) Educate all team members on the princples of Patient and Family Centered. Establish a Patient and Family Centred Care Steering Committee that includes patient/family representatives. Make in house Patient Experience Survey Electronic	Survey Aligned % of Team Members that complete education on the principles of Patient/Family Centered care and Senior Friendly Hospital Committee established Survey developed and strategy developed to deploy its use.	Improve patient and family experience.	
Safe	**Increase proportion of patients receiving medication reconciliation upon admission**	Medication reconciliation at admission: The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital	% / All patients	Hospital collected data / most recent quarter available	824*	94	90.00	Target reflects patients admitted as repatriation from other facilities.	1)Continue to use CPOE along with mandatory medication reconciliation on admission.	Compliance reports from Cerner. Data reviewed bi-monthly at SME meetings.	Percentage Compliance.	Increase the number of patients who get a medication reconciliation.	

	Reduce hospital acquired infection rates	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI during the reporting period, divided by the number of patient days in the reporting period, multiplied by 1,000.	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / January 2015 – December 2015	824*	X	0.25	Based on three cases per year	1)Continued surveillance and use of Infection Prevention and Control best practices.	Increase environmental audits from 4 per month to 8. This will increase awareness and include teaching moments for the housekeeping team Increase hand hygiene audits from 4 audits to 6 audits per month to increase awareness and include teaching moments to all team members providing patient care Spring cleaning all areas of the hospital. Will be completed in all clinical areas by May 2016. Education to nursing team members regarding the transfer of information to patients and their families when added precautions are necessary. This includes providing written information to the family and documenting in the Kardex that the education is complete. Daily change of bed linen and clothes or gowns for all patients that are in precautions.	Monthly Environmental Audit score >90% Audit Rates	Reduce hospital acquired infections.	
Timely	**Reduce wait times in the ED**	ED Wait times: 90th percentile ED length of stay for Admitted patients.	Hours / ED patients	CCO iPort Access / January 2015 - December 2015	824*	23	20.70	LHIN H-SAA target 2016/17	1)Expedite time to inpatient bed for patients admitted in the Emergency Department	Utilize Surge and Gridlock guidelines Leverage ALC reduction strategies Audit periods of high occupancy to ensure that appropriate surge and gridlock processes were followed	Length of stay for admitted patients in the ED Develop change strategies for processes that are not being followed	Reduce wait times in ED	