2017/18 Quality Improvement Plan
"Improvement Targets and Initiatives"

Tillsonburg District Memorial Hospital
Partnering to keep healthcare close to home.

Tillsonburg District Memorial Hospital 167 Rolph Street

AIM		Measure							Change				
Quality dimension	Issue	Measure/Indicator	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**	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.	% / Discharged patients	Hospital collected data / Most recent 3 month period	824*	25.5	32.00	Stretch target of 25% improvement.	1)Collaborate with primary care provider to ensure discharge summaries are dictated and authenticated within 48 hours	Manual chart audits to flag potential root causes. Develop action plans to further prevent delay in transmission. Monitor trends at physician forums.	# of discharge summaries dictated and transmitted to family physician within 48 hours	32%	
		Percentage of acute hospital inpatients discharged with selected HBAM Inpatient Grouper (HIG) that are readmitted to our own facility for non-elective patient care within 30 days of the discharge for index admission.	% / Discharged patients with selected HIG conditions	CIHI DAD / July 2015 - June 2016	824*	12.6	10.50	LHIN H-SAA Target	1)Implement a standardize review process for readmitted patients to determine reasons for readmissions	Manual chart audits to identify root causes for readmission to our or any facility. Develop action plans to further prevent readmissions. Monitor trends at leadership forums.	% of readmitted patients for which a standardized review was completed	80%	Jan - Dec 2016
									2)Use predictive models i.e. LACE tool to enhance discharge process and prevent unplanned readmissions	LACE tool utilized during patient rounds. Interdisciplinary approach to discharge planning initiated when positive score	# of patients flagged as high risk for readmit who are scheduled an appointemnt with primary care provider prior to discharge	90%	
									3)Implement patient-centred transfer of accountability reporting so that patients and families participate in their plan of care	Conduct audits to confirm transfer of accountability is occurring	# of transfers of accountability completed	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	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July – September 2016 (Q2 FY 2016/17 report)	824*	19.62	17.30	LHIN H-SAA Target	1)Conduct interdisciplinary team review for any admitted patient who exceeds estimated Length of Stay (LOS)	Complete rounds in collaboration with CCAC on an appropriate basis	Relative Length of Stay (LOS)	Relative LOS less than or equal to 1	
									2)Collaborate with CCAC to review discharge plans of all ALC designated patients	Complete weekly discharge rounds with CCAC and Leadership	% of discharge rounds completed	100%	

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		data							3)Investigate approach to managing ALC	Conduct review of current best practice i.e. William Osler approach to ALC management. Implement improvements where applicable.	Process review completed by June 1, 2017	100% completed	
Patient-centred	Palliative care	Percent of palliative care patients discharged from hospital with the discharge status "Home with Support".	% / Palliative patients	CIHI DAD / April 2015 – March 2016	824*	84.62	95.00	LHIN Hospice Palliative Care Dashboard	1)Collaborate with Most Responsible Physician (MRP) and interdisciplinary team to identify patients with discharge plan/diagnosis of "Palliative Care". Assess and document plan of care on discharge	Conduct Review at interdisciplinary rounds and flag patients with potential need for palliative care at discharge. Document a plan that includes patient/family, CCAC and/or Oxford Palliative Care Outreach Team. Education regarding available services will be provided to team members.	% of palliative care patients that are discharged home with support offerred.	100%	
	Person experience	In house survey: What number would you use to rate this Emergency Department visit?	Positive Score / ED patients	In-house survey / Q1 and Q2 cumulative	824*	93.1	95	Continue to sustain gains achieved in 2016/17	1)Improve ability to understand Patient/ Family experience	Continue exploring survey tools that are patient-friendly and effectively measure patient and family experience. Continue to develop Patient and Family Centred Care strategy. Educate all team members on the principles of Patient and Family Centered Care.	Survey tool updated and deployed.	Improve ability to understand Patient/ Family experience	
		In-house Inpatient survey: What number would you use to rate this hospital stay?	Positive Score / All acute patients	In-house survey / Q1 and Q2 cumulative	824*	92.6	95	Continue to sustain gains achieved in 2016/17	1)Improve ability to understand Patient/ Family experience	Continue exploring survey tools that are patient-friendly and effectively measure patient and family experience. Continue to develop Patient and Family Centred Care strategy. Educate all team members on the principles of Patient and Family Centered Care.	Survey tool updated and deployed. % of Team Members that complete education on the principles of Patient/Family Centered care	Improve patient and family experience.	
Safe	Medication safety	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	Rate per total number of admitted patients / Hospital admitted patients	Hospital collected data / Most recent 3 month period	824*	92.1	93	Continue to sustain gains achieved in 2016/17	1)Review current process and resources for Med Rec on admission	Interdisciplinary team to review and outline further opportunities to streamline the process	Review of admission process and physician completion by December 31, 2017	100% completed	
									2)Continue to monitor the completion of Best Possible Medication History (BPMH) on admission to the hospital (through Emergency Department and direct admits).	Measure and report on % of BPMH completed on admission through QA. Audit results are given directly back to staff who complete the BPMH for improvement purposes.	# of audits completed in ED and Inpatient units.	20 audits for each target area / per quarter	
Timely	Timely access to care/services	ED Wait Times: 90th percentile ED length of stay for admitted patients.	Hours / ED patients	CCO iPort Access / January 2016 - December 2016	824*	22.1	20.50	16/17 H-SAA	1)Expedite time to Inpatient bed for patients admitted in the ED	Utilize surge and gridlock guidelines. Leverage ALC reduction strategies. Conduct informal audits during periods of high occupancy to ensure above strategies are consistently utilized.	# of times surge/gridlock guidelines utilized when threshold met	100%	April - December 2016

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									2)Continue to develop ongoing and trigger communications within the ED especially during times when wait time is at risk of exceeding LOS target for each patient.	Continue to conduct interdisciplinary rounds daily to assess utilization of beds. Collaborate with Inpatient unit to understand discharge expectations.	Daily and trigger rounding implemented by December 31, 2017.	100% complete	
									3)Develop guidelines for patient transfer to parnter hospitals during surge.	In collaboration with partners, develop guidelines for patient transfer during surge. Implement following education. Evaluate effectiveness.	Process review completed by June 1, 2017	100% completed	