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

Chatham-Kent Health Alliance

AIM		Measure									Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Theme I: Timely and Efficient Transitions	**Timely**	**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**	**981***	**12.92**	**8.00**	**this target is set for Chatham location only as Wallaceburg Campus times can be effected by delays in transportation from site to site for admission.**		**1)Admission orders from the ED Physician will be in effect for 24 hours or less.**	**Implement "Rapid ED Admission" Order sets. Order sets will be completed/vetted/approved by appropriate stakeholders by May 31st/2019.**	**Patient Charts will be audited for percentage of charts that have no continuation orders after the 24hr Rapid Admission Orders.**	**100% of charts will have continuation orders after the 24hr Rapid Admission Orders have ended.**	**Current admission order sets are very lengthy and cover beyond the initial 24hrs of admission.**
											2)Increase percentage of inpatient discharges that occur before 11am.	Unit Clinical leader in collaboration with home and community care staff will perform predictive discharge exercise daily on all patients at "bullet rounds". Patients deemed eligible for discharge within 72 hours will have a checklist completed to determine discharge needs.	Patient Flow Manager will monitor daily the percentage of patients discharged before 11am from inpatient Medicine and Surgical units. Once target is achieved monitoring will decrease to weekly.	We are targeting to increase the percentage of inpatient medical/surgical patients discharged by 11 am to 50 % by October 2019 and to 75% by April 2020.	Current percentage of discharges before 11am is less than 25%

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)

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		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.	M A N D A T O R Y	Hours / All patients	CIHI NACRS / October 2018 – December 2018	4869*	6.92	0.00	Reporting under corporate ID # 981.		1)Reporting under corporate ID # 981.	Reporting under corporate ID # 981.	Reporting under corporate ID # 981.	Reporting under corporate ID # 981.	Reporting under corporate ID # 981.

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Theme II: Service Excellence	**Patient-centred**	From NRC Canada "Using any number from 0 to 10, where 0 is the worst care possible and 10 is the best care possible, what number would you use to rate your care during this emergency room visit?" - ED at Chatham and Sydenham Campus (add together % of those who responded 9 or 10	C	% / ED patients	NRC Picker / 2018	981*	53.1	56.10	Target based on Ontario Community Hospital ED 75th percentile as per NRC.		1)Nurse Manager implementing 'High-Impact Patient Storytelling".	Design with patient relations specialist a process to facilitate story submissions from patients. Develop a process to ensure consistent story dissemination. Effectively Leverage stories to drive improvement.	Number of patient complaints in the ED related to attitude and courtesy reported quarterly will decrease number of patient stories shared by Manager to all staff per month.	Complaints related to attitude and courtesy will decrease by 10% per quarter. ED Manager will share two patient stories per month with staff.	Nurse Manager will capture a large number of patient stories and widely share patient stories that reflect the breadth and diversity of patient stories.
											2)Implementation of two-way individual patient communication boards in the ED	Gather frontline and former patient input on proposed communication board elements Implement communication boards and develop a structured method to audit communication board completion with frontline staff input	Communication Boards will be fully implemented Audit completion method identified	Communication Boards will be implemented by September 30, 2019 Audit completion method will be identified and implemented for Oct 1, 2019	
		From NRC Canada: "Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?" - For inpatient Med/Surg (add together % of those who responded with score 9 or 10)	C	% / Discharged Med/Surg patients who receive and respond to NRC survey	NRC Picker / 2018	981*	57.5	63.30	Target based on Ontario community hospital IP 75th percentile as per NRC.		1)Hourly Comfort Rounds Implemented on Inpatient Medicine Unit.	Medicine Unit Manager and Medicine Professional Practice Group will initiate frontline working group April 2019 to develop action plan for implementation of comfort rounds. Frontline working group will design structured compliance auditing method.	Frontline staff collaborate with manager to design a structured method to audit compliance with hourly comfort rounding.	Method for auditing will be developed and implemented by September 30, 2019. Audit process will be completed as scheduled Hourly Comfort Rounds will be implemented into daily care delivery by September 30th 2019.	

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		Staff Engagement	C	% / Worker	NRC Picker / 2018	981*	57.9	76.00	CKHA target of 76% represents the midpoint of NRC average top Quartile at 80.8% and normal NRC average of 71.2% average.		1)Develop a strategy to improve mental health in the workplace.	Provide a safe space for staff for reflection and to remove oneself from workplace stress. Manager-triggered, voluntary psychological first aid - staff don't have to seek it out on their own.	A quiet, private room will be identified and furnished for staff seeking a break from workplace stress. Formal leaders in the organization will attend mental health first-aid training.	All formal leaders will be required to attend Mental health first aid training. The Quiet Room will be completed by June 2019.	
Theme III: Safe and Effective Care	**Effective**	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 2018	981*	39	40.00	this target was chosen as CKHA is implementing a new health information system 2020 with functionality that will achieve 100% medication reconciliation . 2019/20 initiatives will be focused on change management related to new HIS system and electronic medication reconciliation		1)Target to be maintained at 40%. Review CKHA Discharge Med Rec Plan in full to ensure organization-wide process is supported and sustained through new HIS roll-out in spring 2020.	Via mapping and gap analysis, review organizational-wide variances in process to ensure all work is being captured and is translatable in an electronic system.	HIS Pharmacy, Physician and nursing working group representatives be identified by April 30, 2019.	HIS Pharmacy, Physician and nursing working group representatives be identified by April 30, 2019.	
											2)Engaging others in the discharge med rec process, ie Elston's, community pharmacy, FHT, HACC.	Despite new HIS to enhance infrastructure and IT support for med rec, continue to investigate opportunities to engage stakeholders to ensure quality med rec for all patients being discharged from CKHA.	By 2019-20 Q3: Assuming a thorough understanding of the new HIS capacity and functionality around med rec, connect with partners to gain an understanding of capacity and willingness to share discharge med rec workload.	Completion of working meeting/mapping session with potential partners.	

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Safe	**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 2018**	**981***	**CB**	**CB**	**CKHA will continue to collect baseline data through 2019-20.**		**1)Formal, documented "Safety Review" after any incident that results in physical violence.**	**A senior leader will conduct a formal, documented safety review. Documentation will include a description of event, key findings and an associated action plan to prevent future incidents.**	**Number of incidents investigated within 5 business days. Number of incidents that have a documented action plan.**	**100% of workplace violence incidents that result in physical violence will be investigated within 5 days of occurrence. 100% of workplace violence incidents that result in physical violence will have a documented action plan.**	**CKHA FTE = 967**
										2)Implementation of a staff duress system.	RFP initiated and selection of system will be vetted by Workplace Violence Committee.	RFP process initiated Staff Duress system installed.	RFP process initiated by April 1, 2019.	Implementation date TBD.
	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 2018**	**4869***	**CB**	**CB**	**CKHA will continue to collect baseline data through 2019-20.**		**1)Reporting under corporate ID # 981.**	**Reporting under corporate ID # 981.**	**Reporting under corporate ID # 981.**	**Reporting under corporate ID # 981.**	**FTE count 967**

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		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 2018	4871*	CB	CB	CKHA will continue to collect baseline data through 2019-20.		1)Reporting under corporate ID # 981.	Reporting under corporate ID # 981.	Reporting under corporate ID # 981.	Reporting under corporate ID # 981.	FTE count 967