2020/21 Quality Improvement Plan
"Improvement Targets and Initiatives"

St. Thomas-Elgin General Hospital 189 Elm Street, St. Thomas , ON, N5R5C4

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)

AIM		Measure									Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	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	**Efficient**	Percentage of patients who responded "Yes Definitely" to the Patient Experience question: "When you left hospital, did the hospital make sure you had follow-up care with a doctor or other health care professional?"	C	% / All inpatients	In house data collection / April 2020 to March 31,2021	CB	75.00	The change in the patient experience question is intended to capture transitional experiences with a clear question. The intention with this new question is to determine how STEGH is serving patients during moments of transition to other care providers. The question is intended to capture transitional experiences with a clear question. The intention with this new question is to determine how STEGH is serving patients during moments of transition to other care providers. This question is currently included in the external patient survey by the National Research Council (NRC) and it will be added to STEGH's internal questionnaire. The question is new in use at STEGH and with less than a year of data available the hospital is recommending a target of 75%. For the two quarters of data available, the response rate to Yes, Definitely was 77%. The concern with a new question, known challenges regarding patient feedback and overall scores for patient experience, have all led the executive team to feel this is a realistic target for year one. The target was determined based on feedback from STEGH Patient Experience Specialist, the hospital Patient Experience Council and the NRC.			1)This question will be added to all internal Acute surveys for 2020/21 to monitor unit level performance.	Analysis of this question on unit level basis on a weekly basis.Followup phone calls will be made for patients who do not answer " Yes, Definitely" to this question.	The percentage of patients who responded " Yes Definitely" to the Patient Experience question "When you left hospital, did the hospital make sure you had follow-up care with a doctor or other health care professional?".	75 % of returned internal Acute surveys will respond " Yes Definitely" to the Patient Experience question "When you left hospital, did the hospital make sure you had follow-up care with a doctor or other health care professional?" by March 31, 2021.	
											2)Review of current organization discharges practices to ensure this question is included in the current in-patient discharges practices.	Review of current organization discharges practices for each Acute Care nursing unit to ensure follow-up care is included.	Number of Acute Care Nursing units with follow-up care with a doctor or other health care professional in the discharge process.	100% of all discharge practices for all Acute nursing unit will include follow-up care with a doctor or other health care professional.	
	Timely	Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within	P	% / Discharged patients	Hospital collected data / Most recent 3 month period	92	90.00	We have had difficulty in the past in maintaining a target over 90% with frequent changes in the medical staff.			1)Sustain physicians completing discharge summaries within 48 hours of discharge. Electronic system will automatically distribute the discharge summaries to the primary care providers.	Metric tracked weekly at leadership huddle. Chief of staff will continue to follow-up with individual physicians where performance is below target.	Number of discharge summaries completed within 48 hours of discharge.	For Fiscal 2020/21, 90% of Discharge Summaries will be completed within 48 hours.	
		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, CCO / Oct 2019– Dec 2019**	**0.97**	**1.00**	**We would like to sustain our performance at less than 1.0.**			**1)A robust escalation process remains in place for staff to follow when it is anticipated that an admitted patient may not have an inpatient bed available within the hour. This concern is escalated to the area leadership who will endeavor to address this issue as quickly as possible, with Senior Leadership being notified after 90 minutes. This process is discussed at bed huddles with specific cases being surfaced as a potential learning opportunity.**	**Daily and Weekly monitoring.**	**All cases where patients had delays of over 60 and 90 minutes are reviewed daily and weekly by the leadership team**	**Sustain performance of this metric at less than 1.0 hour.**	
Theme II: Service Excellence	**Patient-centred**	Three of six ER P4R measures will be at MOHLTC 90th target by March 2021.	C	90th percentile / ED patients	CIHI NACRS / April 2020 to March 31, 2021	50	50.00	Our goal is to sustain our performance with ever increasing ER volumes.			1)Implement the FIT to FIT program where Paramedics offload stable patients to wait in Emergency Room Waiting Room once COVID19 crisis has dissipated.	Train and communicate to paramedic programs the new criteria for leaving a stable ER patient in the Emergency Room Waiting Room.	Shorter (decreased) Ambulance Offload Time for ER.	Decrease in Ambulance Offload Times in ER for Fiscal 2020/21.	
											2)Commence the implementation of Computerized Order Entry for Physicians in the ER once the COVID19 crisis has dissipated.	Implement Computerized Order Entry for Physicians in the ER to reduce medication errors.	Reduction of medication errors in ER.	Improved length of stay in the ER for Fiscal 2020/21.	
											3)Actively explore physician alternatives and mid level providers to provide emergency care at STEGH once the COVID19 crisis has dissipated.	Number of physician alternatives or mid level providers providing emergency care at STEGH by March 31, 2021.	Improved length of stay and improved Physician Initial Assessment (PIA) times.	Three of the six Performance for Results (P4R) metrics will be at the MOHLTC 90th target by March 31,2021.	
Theme III: Safe and Effective Care	**Effective**	Medication reconciliation at discharge: Total number of discharged patients for whom a	P	Rate per total number of discharged patients / Discharged	Hospital collected data / Oct 2019– Dec 2019 (Q3 2019/20)	87	88.00	We feel this is reasonable target for this recently introduced Indicator.			1)Continue to educate physicians/providers on completion of Medication Reconciliation at discharge.	Audit and report results to physicians/providers and Leadership team on a weekly basis.	Number of completed Medication Reconciliation at Discharge. Patients who are Expired, Signout Against Medical Advice and Discharges with length of stay of 28 hours or less along with OB will be excluded from the calculation.	88% of discharged patients for whom a Best Possible Medication Discharge Plan was created will have a Medication Reconciliation at the time of discharge for Fiscal 2020/21.	

		Best Possible Medication Discharge Plan was created as a proportion the total number of patients		patients						2)Communicate with physicians when their performance is below target.	Chief of Staff with follow-up with individual physicians where performance is below target.	Number of physicians whose performance is below 88% for Medication Reconciliation at Discharge.	88% of discharged patients for whom a Best Possible Medication Discharge Plan was created will have a Medication Reconciliation at the time of discharge for Fiscal 2020/21.	
		Reduction in COPD Readmission Rate to STEGH.	C	% / COPD QBP Cohort	CIHI DAD / April 1, 2020 to March 31, 2021	25.72	15.72	Expanding on our IDEAS program (PREVENT)from last year which improved transitions to home for Congestive Obstructive Pulmonary Disease (COPD) patients. Coordinated Care Plans were put in place for this patient population and we feel we can reduce the readmission rate for this population by 10% from our current performance.	Elgin Health Links, Home and Community Care Partners	1)Electronic referral is initiated to an RT for all COPD patients entering the program.	All COPD patients enrolled in the PREVENT (Preventing Readmissions and Emergency Visits in Elgin through Novel Transitions) Program will have a RT assessment. The RT will also provide the teaching.	# of RT Assessments for COPD Patients in the PREVENT (Preventing Readmissions and Emergency Visits in Elgin through Novel Transitions) Program	100% of COPD Patients enrolled in the PREVENT Program will have RT Assessment and Educational Teaching.	
										2)Each patient admitted with COPD is identified on the bullet round board. Each case is reviewed at bullet rounds for entry into the program.	COPD patients in the PREVENT program will be less likely to be readmitted to the hospital because of their coordinated care program.	The readmission rates for all COPD patients.	There will be a 10% reduction in the readmission of COPD patients for Fiscal 2020/21.	IDEAS team will continue to meet bi weekly to review the COPD Coordinated Care plans.
	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 / Jan - Dec 2019**	**66**	**70.00**	**Less than 70 incidents for Fiscal 20/21.**		**1)Reviewing departmental workplace violence risk assessment plans that are greater than 1 year old and undertaking a full workplace violence risk assessment where required.**	**Review of departmental workplace violence risk assessment plans that are greater than 1 year old.**	**Number of departmental workplace violence risk assessment plans requiring a full workplace violence risk assessment.**	**Completion of all full workplace violence risk assessments by March 31, 2021.**	
										2)Implement Workplace Violence Risk Assessment in pandemic related department and roles - door screening, assessment centre and pre-triage space.	Implementation of Workplace Violence Risk Assessment pandemic related department and roles.	Number of Workplace Violence Risk Assessments implemented in pandemic related department and roles.	All pandemic related departments will have Workplace Violence Risk Assessments implemented by March 31, 2021.	