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

St.Thomas Elgin General Hospital

St. Thomas-Elgin General Hospital 189 Elm Street

		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**	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	793*	88	90.00	Sustain previous performance from fiscal 2017.		1)1:1 discussions with Physicians not meeting targets. New Onboarding process to include education and expectation setting.	Metric tracked weekly at leadership huddle. Continue to follow-up with Departmental Chiefs and individual physicians to sustain and improve. Additional compliance measures to be instituted.	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.	90% of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital.	
											2)Create a policy on discharge summary expectations for all privileged Physicians.	Development of policy on completion of Discharge Summary for all privileged Physicians.	Completion of the policy.	90% of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital.	
											3)Weekly monitoring of compliance rates by Physician and by unit.	Metric tracked weekly at leadership huddle. Continue to follow-up with Departmental Chiefs and individual physicians to sustain and improve.	Weekly monitoring of compliance rates by Physician and by unit.	90% of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital.	
											4)Looking at alternate care delivery options for Clinical Associates to address work plan.	Review of Alternate Care Delivery options for Clinical Associates.	Review of Alternate Care Delivery options for Clinical Associates.	90% of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital.	
		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**	**793***	**0.95**	**1.00**	**We want to continue to meet the provincial target of 1.0 as our ER volumes continue to increase.**		**1)Sustain success with current STEGH admission policy. All admissions from ER need to be transferred to the admission unit within 60 minutes of the decision to admit time. If this can not be achieved the Manager on Call must be notified. If the admission time is going to be greater than 90 minutes, the Executive on Call must be notified.**	**Daily tracking of any ER admission that exceeds 60 and 90 is recorded and reviewed by all the areas. These metrics are reviewed by the leadership team at the weekly huddle and unit specific huddles.**	**Number of ER admissions with admission time greater than 60 and 90 minutes. The 90th Wait time is also tracked weekly and monthly for this indicator as part of our ER P4R Reporting.**	**We would like to continue to meet the 90th Wait time target of 1.0 hour.**	**ER volumes continue to rise.**
Theme II: Service Excellence	**Patient-centred**	Percentage of patients who responded "Completely" to the Patient Experience 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?"	C	% / All inpatients	In-house survey / April 2019 to March 2020	793*	84	85.00	We will create mechanisms to ensure we are sustaining the current target of 85%.		1)Standardize inpatient surveys and outpatient surveys to promote a process for staff to review patient feedback in order to ensure all units are able to drive improvement.	We will create mechanisms to ensure we are sustaining the current target of 85%, while also creating a feedback loop for our organization to engage with patients who do not answer "Completely" to this question. We will ensure all staff at different levels throughout the	1. 100% of leaders trained on how to provide feedback to their teams about the patient experience metric. 2. 100% of surveys are standardized to ensure a consistent method of feedback across all units to generate reliable information across the organization.	85% of Patients responded "Completely".	
											2)Clinical leaders are rounding on patients and will incorporate asking about preparedness for discharge. Implementation of AIDET	Documentation of rounding on patients.	Monitoring of number of employees trained in AIDET. Auditing of AIDET	85% of Patients responded "Completely".	
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	793*	CB	88.00	Same target as Best Possible Medication History Reconciliation.		1)Development of new medication reconciliation policy that clearly outlines expectations for medication reconciliation (including discharge for both inpatients and selected ambulatory clinics)	Assessing reasons for Physicians not completing Medication Reconciliation at Discharge. Metric tracked weekly at leadership huddle.	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% same as the target for Best Possible Medication History Reconciliation.	
											2)Educate physicians/providers on completion of Medication Reconciliation at discharge.	Education of physicians/providers on completion of Medication Reconciliation at discharge.	Audit and report results to physicians/providers and Leadership team	88% same as the target for Best Possible Medication History Reconciliation.	

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)

	Safe	**Number of workplace violence incidents reported by hospital workers (as 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**	**793***	**CB**	**CB**	**Continue to encourage all violence incidents to be reported.**		**1)Educate staff on what is workplace violence.**	**Using Risk Monitor Pro to report incidents of staff violence.**	**Number of workplace violence incidents broken down by verbal abuse and physical.**	**No target chosen. Continue to promote reporting of all violence incidents.**	**FTE=625**
											2)Initiate Workplace Violence Prevention Committee.	Using Risk Monitor Pro to report incidents of staff violence.	Number of workplace violence incidents broken down by verbal abuse and physical.	No target chosen. Continue to promote reporting of all violence incidents.	
											3)Implement all Workplace Violence Risk Assessment Action Plans.	Using Risk Monitor Pro to report incidents of staff violence.	Number of workplace violence incidents broken down by verbal abuse and physical.	No target chosen. Continue to promote reporting of all violence incidents.	
											4)Assess which departments are under-reporting.	Using Risk Monitor Pro to report incidents of staff violence.	Number of workplace violence incidents broken down by verbal abuse and physical.	No target chosen. Continue to promote reporting of all violence incidents.	
Equity	**Equitable**	75 Percent of +FOBT/FIT Colonoscopy Patients will meet 56 days or less target. The wait period is from Date of Referral from GP to date of Colonoscopy.	C	% / +FOBT/FIT Colonoscopy Patients	DSP reporting / April 2019-March 2020	793*	74	75.00	This is the Cancer Care Ontario target for +FOBT/FIT Colonoscopy Patients. We are currently not meeting this target.		1)Allocating 4 hours to endoscopy schedule.	Adding 4 hours to the endoscopy operating room schedule.	Additional 4 Hours of Endo time added to OR Schedule.	We should be performing at or better than the Cancer Care Ontario established target. To be performing to at least 75% by March 2020.	
											2)Bringing together an endoscopy working group between surgery and endoscopy.	Development of an endoscopy working group between surgery and endoscopy.	Development of an endoscopy working group between surgery and endoscopy.	We should be performing at or better than the Cancer Care Ontario established target. To be performing to at least 75% by March 2020.	
											3)Working with endoscopists to receive monthly referral times by physician.	Monthly review of referral times by physician.	Monthly report to Physicians with Physician specific monthly referral times.	We should be performing at or better than the Cancer Care Ontario established target. To be performing to at least 75% by March 2020.	
											4)Referrals from primary care for positive FOBT to be immediately prioritized for colonoscopy.	Immediate prioritization of referrals from primary care for positive FOBT/FIT for colonoscopy by general surgeons and gastroenterologist.	Process change at surgeon's office.	We should be performing at or better than the Cancer Care Ontario established target. To be performing to at least 75% by March 2020.	
											5)Education of the surgeons and surgeon's office of the importance of the wait time target of 56 days.	Education plan for surgeons and surgeon's office.	Implementation of Education plan.	We should be performing at or better than the Cancer Care Ontario established target. To be performing to at least 75% by March 2020.	
		Improving transitions to home for CHF and COPD patients. Total number of Coordinated Care Plans put in place.	C	Number / COPD and CHF inpatients	In house data collection / April 2019 to March 2020	793*	CB	CB	New preventative program for STEGH.	Elgin Health Links and SWLHIN Home and Community Care Partners	1)Implementation of the PREVENT = Preventing Readmissions and Emergency Visits in Elgin through Novel Transitions Program	Tracking the number of completed coordinated care plans for COPD and CHF patients	Number of patients enrolled in the PREVENT Program. Number of Coordinated Care plans developed for COPD and CHF patients.	Implementation of the PREVENT program.	
											2)Training for Clinical Resource Nurses to facilitate coordinated care plans	Tracking the number of completed coordinated care plans for COPD and CHF patients	Number of patients enrolled in the PREVENT Program. Number of Coordinated Care plans developed for COPD and CHF patients.	Implementation of the PREVENT program.	
											3)Creation and daily use of a Standard Operating Procedure to facilitate the project	Tracking the number of completed coordinated care plans for COPD and CHF patients	Number of patients enrolled in the PREVENT Program. Number of Coordinated Care plans developed for COPD and CHF patients.	Implementation of the PREVENT program.	
											4)Meeting IDEAS core team – community partners and STEGH meet bi-weekly	Tracking the number of completed coordinated care plans for COPD and CHF patients	Number of patients enrolled in the PREVENT Program. Number of Coordinated Care plans developed for COPD and CHF patients.	Implementation of the PREVENT program.	
											5)Trial of an RT assessing each patient in the program and providing teaching	Tracking the number of completed coordinated care plans for COPD and CHF patients	Number of patients enrolled in the PREVENT Program. Number of Coordinated Care plans developed for COPD and CHF patients.	Implementation of the PREVENT program.	

											6)Creation of COPD teaching package	Tracking the number of completed coordinated care plans for COPD and CHF patients	Number of patients enrolled in the PREVENT Program. Number of Coordinated Care plans developed for COPD and CHF patients.	Implementation of the PREVENT program.	
											7)Creation of CHF teaching package	Tracking the number of completed coordinated care plans for COPD and CHF patients	Number of patients enrolled in the PREVENT Program. Number of Coordinated Care plans developed for COPD and CHF patients.	Implementation of the PREVENT program.	
		Three of six ER P4R measures will be at MOHLTC 90th target by March 2020.	C	90th percentile / ED patients	CIHI NACRS / April 2019 to March 2020	793*	66.7	50.00	Continue to improve and sustain ER Pay for Performance Results (P4R). Three of six ER P4R measures will be at MOHLTC 90th target by March 2020.		1)The Emergency Department Assistant (EDA) is a role that was recently implemented last year. The purpose of this role is to provide additional support to nursing and physician teams working in the Emergency Department (ED). The EDA performs non-nursing duties such as patient transportation, stretcher cleaning, care space preparation, as well as providing nursing and physician assistance. This resource allows both physician and nursing staff to focus on patient care prioritization and creates workload efficiencies that help to address the overall provincial metrics and times assigned to the ED. This new role remains in an ongoing cycle of evaluation. Area leadership continue to engage with frontline staff on ideas that could further enhance this resource, allowing all disciplines to work to their full scope of practice increasing efficiencies and improving patient satisfaction.	Area leadership to set up a small series of staff feedback sessions on the EDA role to determine if this resource can be further enhanced. To be completed by August 2019 Measure the six P4R measures 90th percentiles in comparison the provincial target for each of these measures.	90th percentiles for all six P4R metrics in comparison the provincial target for each of these measures.	To meet the provincial target for at least 3 out of 6 measures by March 2020.	
											2)Area leadership will continue to review and finesse triage practices and processes, whilst working with frontline care providers on how best to utilize assessment space in order to improve operational efficiency and patient satisfaction.	Small staff focus group meetings will be determined to obtain feedback on triage practices and space utilization. To be completed by July 2019	90th percentiles for all six P4R metrics in comparison the provincial target for each of these measures.	To meet the provincial target for at least 3 out of 6 measures by March 2020.	
											3)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	This process is discussed at bed huddles with specific cases being surfaced as a potential learning opportunity.	Measure 90th time to Inpatient Bed.	To meet the provincial target by March 2020.	
											4)The Results Pending Waiting Room is a recent initiative implemented as a strategy to create capacity within the ED. Lower acuity patients that are likely to go home pending laboratory tests can wait in this area freeing up stretcher space for other patients. This allows physicians to see patients quicker, positively impacting Physician Initial Assessment (PIA) time. This area continues to be monitored for utilization.	A patient tracking sheet was implemented in January 2019 to determine space utilization. Area leadership will review tracking results and space utilization during huddles with staff. This work is to continue throughout 2019/20	90th percentiles for all six P4R metrics in comparison the provincial target for each of these measures.	To meet the provincial target for at least 3 out of 6 measures by March 2020.	
											5)Area leadership will explore if there is further opportunity to increase the number of patients offloaded to the waiting room. This will be a collaborative discussion with physician and operational leaders. If it is determined that this is an area of improvement opportunity a clinical pathway for offload patients should be considered for development.	Area leadership will meet in April 2019 to determine if additional innovative strategies could be implemented to increase the number of patients offloaded to the waiting room in order to address capacity and Offload times	90th percentiles for all six P4R metrics in comparison the provincial target for each of these measures.	To meet the provincial target for at least 3 out of 6 measures by March 2020.	