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

CAMPBELLFORD MEMORIAL HOSPITAL

Campbellford Memorial Hospital, 146 Oliver Road, Campbellford, ON K0L 1L0

| AIM | | Measure | | | | | | | | | Change | | | | |
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| 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 |
| 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) | | | | | | | | | | | | | | | |
| **Theme I: Timely and Efficient Transitions** | **Efficient** | Average number of inpatients receiving care in unconventional spaces or ER stretchers per day within a given time period. | P | Count / All patients | Daily BCS / October - December 2018 | 624* | 1.01 | 0.80 | This is a new indicator for CMH. With the new changes with EDD's and patient flow we are aiming for a 20% improvement in Year I. | | 1)Remodeling discharge rounds to improve patient flow as well as implementation of an electronic bed board that will display EDD's. | Measuring length of stay for top three CMG's (CHF, COPD, CAP)on a quarterly basis with reduction in length of stay by two days. | Follow up satisfaction survey with inter-disciplinary team with 100% satisfaction of remodeled discharge rounds by December 31, 2019. Will see a 10% reduction in the unconventional spaces or ED stretchers by December 31, 2019 and an additional 20% reduction by March 31, 2020. | Bed tracking board activated by March 31, 2019. 100% compliance of remodeling of discharge rounds by September 30, 2019. | |
| | | 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 data | P | Rate per 100 inpatient days / All inpatients | WTIS, CCO, BCS, MOHLTC / July - September 2018 | 624* | 33.56 | 30.00 | With an improved discharge planning team reduction in ALC days related to more timely family and patient discharge plans. | | 1)Remodeling of the discharge process and implementing best ALC practices /strategies. | Establishment of ALC weekly meetings that will be done by the interdisciplinary healthcare team. Continue with best practices re. identification of high-risk ALC within 72 hours. | Quarterly review of ALC days. Implementation of ALC best practice strategies. | 80% of all admissions have a discharge plan in place within 72 hours. Reduction of length of stay by two days for the top three CMG's. | |
| | | | | | | | | | | | 2)The implementation of the Behavioral Support Ontario (BSO) initiative to reduce ALC length of stay. | Education of all inpatient staff in Gentle Persuasion Approaches (GPA). Establish a consultative process for the BSO support. Establish front-line staff champions with additional education in PIECES and Montessori techniques. | Number of staff attending non-violent crisis intervention quarterly. Number of staff attending GPA training quarterly. Number of consultations for BSO support will be monitored quarterly. Length of stay for ALC will be monitored quarterly. | Achievement of 80% of all front-line staff trained by September 30, 2019. Establishment of a consultative process for BSO by March 31, 2019. 100% of front-line champions by November 30, 2019. | This is a new initiative supporting the reduction of ALC length of stay. We are still collecting baseline data for the BSO program. |
| | **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.** | **M A N D A T O R Y** | **Hours / All patients** | **CIHI NACRS / October 2018 – December 2018** | **624*** | **16.08** | **14.00** | **An improved discharge planning process will improve flow out of the Emergency Department earlier.** | | **1)The implementation of an electronic tracking board which includes length of stay and EDD and daily review during rounds.** | **The discharge planner and/or team leads will enter EDD on admission within 48 hours. The discharge planner will review daily any EDD's expected within the next 48 hours. On a quarterly basis actual length of stay for top three CMG's will be monitored for reduction.** | **Daily review of 100% compliance of EDD on the tracking board. Documentation of delays in discharge over the EDD. Review quarterly top three CMG length of stay and outliers.** | **100% of EDD are entered onto the bed board by March 31, 2019. 90% of identified delays of discharge have been documented and reviewed by the healthcare team by September 30, 2019. 100% of outliers of the top three CMG's length of stay are reviewed on a quarterly basis.** | **The bed board and EDD are new initiatives for CMH.** |
| **Theme II: Service Excellence** | **Patient-centred** | Percentage of complaints acknowledged to the individual who made a complaint within five business days | P | % / All patients | Local data collection / Most recent 12 month period | 624* | CB | 100.00 | As part of service excellence and patient/family experience we need to acknowledge both complaints and positive feedback within a reasonable time. | | 1)Standardize the patient complaint process organization-wide to an electronic tracking system. | Review current policy and procedure with the Management team. Training for relevant staff on the electronic incident reporting system. | All relevant staff are trained on the electronic system by March 31, 2019. Review quarterly all complaints to ensure a five day response target is achieved. | 100% of complaints are responded to within 5 business days by May 31, 2019. | |

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| | | Percentage of respondents who responded positively to the following 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? | P | % / Survey respondents | CIHI CPES / Most recent consecutive 12-month period | 624* | CB | 100.00 | We would expect 100% satisfaction with discharge information. We have access to this information so will begin to collect baseline in quarter one of 2019/20. | | 1)Review on a quarterly basis the NRC data. Based upon results, develop initiatives to improve positive response rates. | Review NRC surveys by department. | Significant number of returned quarterly surveys from NRC. | We expect 40% response rate of all NRC distributed on a quarterly basis. | |
| | | | | | | | | | | | 2)Full implementation of the PODS project in acute medicine. | Chart audits upon discharge for confirmation of PODS completion. | The number of PODS completed on discharge divided by the total number of inpatient discharges. | 50% completion of PODS by August 31, 2019 and 100% completion of PODS by March 31, 2020. | |
| **Theme III: Safe and Effective Care** | **Effective** | 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. | C | Rate per total number of admitted patients / Hospital admitted patients | Hospital collected data / Data will be collected quarterly | 624* | 100 | 100.00 | This is an expectation of CMH that we continue to maintain 100% compliance with medication reconciliation. | | 1)To incorporate daily audits of the completion of the Best Possible Medication History to ensure maximum 24 hour completion. | Incorporate daily audit of all new admissions to ensure BMPH completed within 24 hours of admission. | The number of completed BPMH's within 24 hours of admission. | 80% completed by September 30, 2019 and 100% completed by March 31, 2020. | |
| | | Percentage of acute care patients who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4 | C | Rate per 100 inpatient days / All inpatients | In-home audit / Measure quarterly | 624* | 13 | 0.00 | This is an in-hospital adverse event and our goal is to eliminate any stage 2 or greater ulcers. | | 1)To develop unit champions in wound care and implement weekly skin rounds. | Data will be obtained through weekly audits. | The number of inpatients with a hospital acquired pressure ulcer, divided by the total number of inpatients. | 75% of inpatients will have a documented care plan in place by September 30, 2019 and 100% by March 31, 2020. | |
| | **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** | **624*** | **18** | **12** | **We have a 'no violence' workplace policy. We aim for 0% of any employee workplace violence.** | | **1)Training of all staff in non-violent crisis intervention.** | **Quarterly review of all staff who have attended monthly non-violent crisis intervention training. Tracking will be completed by Human Resources and reported to Occupational Health & Safety Committee.** | **The number of workplace incidents quarterly.** | **Reduction of workplace violence incidents to 0% by March 31, 2020.** | |
| | | | | | | | | | | | 2)Implementation of the BSO program in the inpatient unit. | Training of the BSO Team by March 31, 2019 | Completion of educational programs for the BSO Team by March 31, 2019. | Reduction of reactive behavior incidents by 80% by March 31, 2020. | |
| | | | | | | | | | | | 3)Training of Med/Surg front-line staff in GPA techniques. | Education and certification in GPA training for Med/Surg front-line staff. | The number of full-time and part-time Med/Surg staff certified in GPA training. | 50% of Med/Surg staff trained by September 30, 2019. 80% of Med/Surg staff trained by March 31, 2020. | |