GBGH 2018/19 Quality Improvement Plan

"Improvement Targets and Initiatives"

Hôpital général de la baie Georgienne
GEORGIAN BAY
General Hospital

AIM		Measure							Change				
Quality dimension	**Issue**	**Measure/Indicator**	**Type**	**Unit / Population**	**Source / Period**	**Current performance**	**Target**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**	**Comments**
Effective	**Effective transitions**	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 / April - June 2017(Q1 FY 2017/18)	66.4% Top Box Result 73.8% Postive Response Result	80.00	Target of 80% based on performance trends of % positive response. For historical data purposes we will continue to track % positive as opposed to Top Box.	1)Spread the use of the Patient Oriented Discharge Summary (PODS) tool to all patients discharged from GBGH.	1.Refine the PODS tool design through PDSA cycles to ensure it meets the needs of all of our inpatient population. 2.Conduct PDSA cycles to define the process for populating discharge information into the PODS tool and delivering the completed PODS to all discharged patients.	Percentage of inpatients discharged with a completed Patient Oriented Discharge Summary.	By March 31, 2019 100% of discharged patients will receive a patient oriented discharge summary (PODS).	This is a continuation of a 17-18 QIP change initiative. In 18-19 we will build on our success by scaling improvements to all discharges on all inpatient units and all patient discharges.
									2)Ensure timely, complete inpatient discharges by spreading the use of the standardized discharge checklist to all inpatients discharged from GBGH.	1.Refine the discharge checklist design through PDSA cycles to ensure it meets the all of our inpatient population needs. 2.Conduct PDSA cycles to define the process for the expanded use of the discharge checklist.	Percentage of inpatient discharges completed using the standardized discharge checklist.	100% of all inpatient discharges will be completed using the standardized discharge checklist.	This is a continuation of a 17-18 QIP change initiative. In 18-19 we will build on our success by scaling improvements to all inpatient units.
		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.	A	% / Discharged patients	Hospital collected data / most recent 3 month period	50.9	60.00	We have had significant success with this indicator in 2017-18 . We are targeting a range of 60-65% by March 31, 2019	1)Improve consistency in information sharing between GBGH and primary care providers.	1. Implement a standardized discharge summary template for use by physicians. 2. Provide education on the use of the template.	1. Discharge summary template completed. 2. Education developed and delivered	1. PDSA trial of discharge summary template complete by June 30,2018 2. Education developed and delivered by Sept 30, 2018	
									2)Extending current transcription coverage from current 5 day week model to 7 days a week will improve our ability to ensure that discharge summary transcription happens in a timely way regardless of day of week.	Conduct pilot project of weekend transcription coverage in Health Records Dept.	1. Pilot project evaluation complete 2. Decision whether or not to proceed with model change	1. Pilot project evaluation complete by June 30, 2018 . 2. Model change decision made by Senior Management by Sept 1, 2018.	
									3)Develop a clinical documentation completion policy to ensure Most Responsible Provider (MRP) accountability for the timely accurate completion of all discharge summaries.	Develop and implement a clinical documentation completion policy in consultation with Medical Advisory Committee.	1. Policy developed and approved. 2. Approved policy roll out/education complete	1. Policy developed and approved by June 30, 2018 2. Policy roll out and education complete by Sept 30, 2018.	

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		Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort)	P	Rate / COPD QBP Cohort	CIHI DAD / January - December 2016	18.66	15.50	Taking into account the significant data lag on this indicator, we predict that our collaborative cross sector work in 2017-18 and beyond will enable us to reach our performance target.	1)monitor	monitor	monitor	monitor	
Safe	**Safe care/Medication safety**	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 (Q3) 2017	43	80.00	HQO definition excludes discharge that is death, newborn or still born. Additional GBGH exclusions include Obstetrics patients and patients that leave against medical advice.	1)Develop and implement a robust auditing and feedback program to regularly assess the quality of medication at reconciliation at discharge. Purpose: to identify barriers, improvement opportunities and to celebrate success.	1. Develop an audit tool to evaluate the quality of medication reconciliation at discharge. 2. Collect baseline data (1 month) 3. Develop and implement a cascading reporting program to include relevant committees, working groups, point of care staff and patients and families.	1. Audit tool developed 2. Baseline data collected 3. Reporting schedule established	1. Audit tool developed by June 30, 2018. 2. Baseline data collection completed by Sept 30, 2018. 3. Results reporting begins October 1, 2018 and continues based on established reporting schedule.	
									2)Making the GBGH Medication Reconciliation process easy to follow with clear role expectations, timelines and standard work templates will improve the consistency of the practice and the improve the quality of the information.	Develop medical staff learning package, including standard work practices for Medication Reconciliation processes.	Learning package developed and approved for use.	learning package developed and approved for use by June 30, 2018.	

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									3)Gather patient perspective on current Medication Discharge Plan/Prescription form by engaging the GBGH Patient and Family Advisory Council (PFAC)to provide feedback.	Take Medication Discharge Plan/Prescription form to the Patient and Family Advisory Council for feedback.	Feedback from PFAC received and where appropriate feedback incorporated in form redesign	PFAC feedback received by September 30, 2018	
	Workplace Violence	**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 2017**	**Collecting Baseline**	**Collecting Baseline**		1)Provide Nonviolent Crisis Intervention training to equip all health care providers (HCPs) with strategies for safely diffusing hostile or violent behaviour at the earliest possible stage.	1. Provide CPI training opportunities for all full time and part time HCPs and all Chiefs of Service. 2. Provide compliance rates to managers for regular follow up and tracking.	Percentage of HCPs who have completed CPI training	Minimum of 50% of HCPs have completed CPI training by March 31, 2019	
									2)Maximize the capability of electronic incident management system (EIMS) to capture WPV events and generate a meaningful report.	1. PDSA of employee incident form modification in electronic incident management system 2. Provide credentialed and GBGH staff education WPV definition and how to document a WPV incident in the EIMS.	1. Modification to current EIMS to enable capture of all GBGH work place violence incidents and generate meaningful report. 2. Education complete	1. PDSA trial of EIMS form modification complete by June 30, 2018 2. Education provided to all credentialed and GBGH staff by Sept 30, 2018	Increase awareness of work place violence definitions combined with education on EIMS reporting procedures will result in an increase in total work place violence incidents reported in 2018-19.
									3)Engage and educate the public in their role in workplace violence prevention and hospital expectations for a workplace that is free from workplace violence	Communicate the hospital's expectations and policies via posted signage and other means such as brochures and one-on-one conversations.	1. Patient and family WPV prevention communication plan developed with input from GBGH joint health and safety committee and GBGH Patient and Family Advisory Council. 2. Communication plan roll out complete	1.Communication plan developed by June 30, 2018 2. Communication plan roll out complete by December 31, 2018.	