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

North Wellington Health Care | 630 Dublin Street | Mount Forest, ON | N0G 2L3

AIM		Measure								Change				
Quality Dimension	**Issue**	**Measure/ Indicator**	**Unit / Population**	**Source / Period**	**Organization Id**	**Current performance**	**Target**	**Target justification**	**Priority level**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**	**Comments**
Safe	**Patient Falls**	Falls causing harm	Rate per 1000 patient days All inpatients (excluding newborns)	Hospital collected data. Most recent quarter available.	963	NWHC - 4.5 (Q3'18 rate per 1,000 patient days; YTD18'19 rate 4.0 per 1,000 patient days)	NWHC - 2.6	Internal target. Current YTD'18 performance is flat on FY17'18 performance. Internal target based on further 35% improvement over current performance YTD18'19 rate of 4.0 per 1,000 patient days of inpatient falls resulting in harm (severity level 2-5).	Internal indicator	1) Implement communication whiteboards in all inpatient rooms by end of Q2'19 2) Updated education of all staff on falls prevention by end of Q1'19	Data collected from RL6 Patient Safety Reporting system, event type "Patient Fall", "Severity" level 2, 3, 4, or 5 for all inpatient locations. Measure excludes newborns. Reported quarterly by Manager, Quality and Patient Safety.	Rate of falls causing harm per 1,000 patient days. Numerator: Number of patient falls severity 2-5 on inpatient units in time period. Denominator: Number of inpatient days.	Internal target: 20% reduction in the rate per 1,000 patient days of inpatient falls resulting in harm (severity level 2-5).	
	Medication Safety	Medication reconciliation (discharge)	% completion All inpatients (excluding newborns, acute transfers or mental health transfers)	Hospital collected data. Most recent quarter available.	963	NWHC - 96.2% (Q3'18 performance; YTD18'19 cumulative performance is 93.4%)	NWHC - 98%	Internal target. NWHC was has made significant gains to achieve and sustain the current target in FY18'19. Target reflects ongoing improvement trend and an improvement goal of 5% on current quarter Q318'19 performance.	Priority indicator	1) Implementation of Patient Keeper electronic physician order entry platform to enhance the workflow of the discharge medication reconciliation process by end of Q3'19 2) Continued monthly monitoring of indicator documentation and timely follow up education and investigation of outliers	Data collected by decision support from Meditech NUR discharge documentation screen question "Discharge Med Rec completed by physician". Positive response is answer of "Yes". If answered "No", HIM confirms the presence of a signed, reconciled discharge prescription and if present, patient is included in numerator. If answered "No" and no reconciled discharge prescription in health record, medication reconciliation is considered incomplete. Reported quarterly by Manager, Health Information Management.	Percentage of eligible discharged patients who had medication reconciliation completed on discharge in time period. Numerator: Number of discharged patients with medications reconciled. Denominator: Number of patients discharged from the hospital.	NWHC - Increase completed medication reconciliation target on discharge to 98%.	
		Medication incidents reaching the patient (level 1-5)	Rate per 1000 patient days All inpatients (including newborns)	Hospital collected data. Most recent quarter available.	963	NWHC - 7.5 (Q3'18 rate per 1,000 patient days; YTD18'19 rate 8.7 per 1,000 patient days)	NWHC - 6.9	Internal Target. NWHC met indicator target for first time in Q3'18 following implementation of several improvement strategies. Target reflects a further 21% reduction in the rate of medication errors reaching the patient from YTD18'19 cumulative performance as the progress achieved in Q3'18 is sustained.	Internal indicator	1) Implementation of Patient Keeper electronic physician order entry platform to reduce need for transcription, telephone orders, etc. by end of Q3'19 2) Continue to require all new nursing staff to complete medication administration learning package 3) Ongoing monitoring of change initiatives implemented in Q2'19 to identify opportunities for improvement and to adapt workflows to Patient Keeper implementation needs	Data collected from RL6 Patient Safety Reporting system, event type "Medication/Fluid", "Severity" level 1, 2, 3, 4, or 5 for all inpatient locations. Includes newborn, acute and CCC. Reported quarterly by Manager, Quality and Patient Safety.	Rate of inpatient medication incidents reaching the patient (severity levels 1-5) per 1,000 patient days in time period. Includes acute, newborn and CCC. Numerator: Number of medication incidents severity 1-5 on inpatient units. Denominator: Number of inpatient days.	30% reduction in the rate of medication errors reaching the patient from previous fiscal YTD actual performance.	
	Workplace Violence	Number of workplace violence incidents (overall)	Count of actual number of incidents All hospital workers as defined by the OH&S	Hospital collected data. Most recent quarter available.	963	NWHC - 5 (YTD18'19 actual number)	NWHC - 6 NWHC FTEs - 143.4	Internal target reflecting an indicator goal with alliance partner GMCH.	**Mandatory indicator**	1) Continuation of the CARE training partnership with Homewood Health ongoing in 19'20 2) Continuation of workplace violence education in General Orientation 3) Annual review, update and re-education of workplace violence and harassment policies by end of Q2'19 4) Development & implementation of debrief process for emergency codes, including Code White by end of Q3'19	Data for workplace violence incidents collected from RL6 Patient Safety Reporting system, event types "Respectful Workplace Complaint" and "Employee Event - Injury from Patient Action", all severity levels. Reported quarterly by Human Resources/OH&S.	Actual number of workplace violence incidents reported by hospital workers in time period. % of workers completing CARE training.	Actual number of workplace violence incidents reported by hospital workers in time period will not increase from previous performance.	CARE training target TBD.
Timely	**Time to Inpatient for Admitted Patients in ED (90th Percentile)**	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.	Time in hours All admitted inpatients in ED	Hospital collected data; CIHI NACRS database. Most recent quarter available.	656	NWHC - 3.3 (Q3'18 time in hours at 90th percentile)	NWHC - 3.0	Internal target reflecting a 9% improvement in hours at the 90th percentile. Target reflects recent actual performance.	Internal indicator	1) Data analysis and process review to identify trends/themes in transfer delay by end of Q1'19, focusing on opportunities to improve flow when a bed is available for admission versus when there is not 2) Ongoing work with WWLHIN partnered to manage ALC patients and support timely patient discharge to community, to manage occupancy pressures 3) Review of length of stay (LOS) data and trends to identify any outliers (conditions or physicians) by end of Q2'19	90th percentile LOS [Date/time Patient Left ED minus ED Registration Date/time]for Admitted patients-Disposition 06 and 07, excludes missing date/time cases. ED Visit Indicator= Y.	1) Bed Availability - Conversable days – Avoidable admissions, Readmission rate, LOS performance as compared to the ELOS - ALC management – overall ALC rate, % patients ALC, ALC designation 24 hours - Bed turnover rate – time of discharge to time bed available - Isolation – Provincial ED advisory waiting for approval/direction from MoH to mandate collection probably April 1 – will give us the ability to drill into impact on LOS 2) Resources - Depart ED timeliness when bed available/communication - Review impact of shift change 3) Process - ED admit process, physician practice variation, identify interruptions in work flow (see above impact shift change) - Time of day variance	9% reduction in time to inpatient bed at the 90th percentile	Note - indicator is not mandatory for NWHC as organization does not submit data through the ERNI database. Indicator is included to align with alliance partner GMCH and reflects improvement of shared processes and the commitment to timely patient care across the alliance.