Thunder Bay Regional Health Sciences Centre

2021/22 Quality Improvement Plan
"Improvement Targets and Initiatives"
Final - At 2021-05-07

AIM		Measure							Change				
Issue	**Quality dimension**	**Measure/Indicator**	**Unit / Population**	**Source / Period for Current performance**	**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**	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.	Hours / All patients	CIHI NACRS, CCO / Oct 2020– Dec 2020	18.6	25.0	Target based on fluctuating occupancy due to anticipated early fiscal Covid-related pressures. Target of 30 hours for Q1 and Q2, and 20 hours for Q3 and Q4.		1) Complete current state assessment of results and root causes for delays, identify, prioritize, plan and implement improvements.	1) Leverage recent current state assessments to inform ON Health Pay For Results funding requests. 2) Solicit improvement ideas from Hospital directors and use to inform ON Health Pay For Results funding request. 3) Continue use of rapid cycle improvement model to identify opportunities for ongoing improvement. Work with ED leadership and staff to enhance their skills and capacity to continue this work.	% of identified methods implemented	100%	
Theme II: Service Excellence	**Patient-centred**	Percentage of respondents who responded "completely" 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?	% of Survey respondents	CIHI CPES / Most recent 12 months	73.3%	73.8%	Target is a .5% stretch improvement on current results		1) Promote consistent use of PODS in preparation for patient discharge. 2) Improve patient understanding through modifications of the patient oriented discharge summary (PODS) tool.	1) Implement and leverage PODS diagnosis specific education tool to improve patient understanding. 2) Promote consistent use of diagnosis specific education tool and PODS by staff to support patient discharge planning.	% of identified methods implemented	100%	
Theme III: Safe and Effective Care	**Effective**	Medication reconciliation at admission: Total number of admitted patients for whom medication reconciliation was completed as a proportion of total number of patients admitted.	Rate per total number of admitted patients / Patient admissions	Local data collection / 20-21 Q1 - Q3	57.1%	57.5%	Target based on fluctuating pharmacy staff capacity due to anticipated early fiscal demand to support Covid vaccinations. Target of 40% for Q1 and Q2, and 75% for Q3 and Q4. During Q1 and Q2, medication reconciliation efforts will be targeted to high risk patients.		1) Sustain and strengthen current Pharmacy staffing model to ensure more consistent availability of staff to support medication reconciliation. 2) Given limited staffing resources, target higher risk patients and ensure medication reconciliation is completed for them. 3) Begin planning for and development of process to expand current efforts for medication reconciliation on discharge.	1) Monitor and report overall results to Hospital leadership (including Chief of Staff and Medical Advisory Committee) via balanced scorecard report. 2) Identify high risk patients and develop process to ensure their medication reconciliation on admission is prioritized and completed. 3) Assess current performance for medication reconciliation on discharge, identify options to prioritize and expand coverage, consult with Pharmacy staff and Hospital stakeholders (including physicians) regarding resourcing requirements, and develop expansion plan (including performance targets).	% of identified methods implemented	100%	
	Safe	Improve workplace violence, with specific focus on ED.	ED improvement initiatives	Local data collection / 20-21 Q1 - Q3	NA	5 initiatives (minimum)	In addition to initiatives currently underway, commit to 5 new improvement initiatives to be undertaken and completed during 21-22.		1) Continue enhancing current workplace violence prevention program & related initiatives.	1) Continue promoting incident reporting to staff, and continue tracking and reporting incidents, broken down by severe and near misses. Results to be reported on the Hospital's balanced scorecard. 2) Promote staff completion of Workplace Violence module in electronic learning management system. 3) Engage Environmental Services to ensure available security resources are deployed most effectively and where merited, to assist in requesting targeted security enhancements. 4) Leverage Risk Analysis Working Group and related sub-groups to identify root causes, and to plan and support ongoing improvement efforts. 5) Specific to the ED, leverage aforementioned root cause analysis to identify, assess and implement 5 new improvement intiatives during 21-22. Report status of initiatives quarterly to Hospital leadership and ED staff, physicians, etc.	% of identified methods implemented	100%	

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		Number of times that hand hygiene was performed before initial patient contact and after patient contact, divided by the number of observed hand hygiene opportunities.	# compliant audits / # total audits	Local data collection; 20-21 Q1 - Q3	67.0%	78.8%	Target based on ongoing improvement over 21-22 fiscal. Target of 65% for Q1, 75% for Q2, 85% for Q3, and 90% for Q4.		1) Continue advancing work of Infection Prevention and Control Committee (IPAC)	1) Leverage infection control software to capture and regularly report hand hygiene data to Hospital leadership (including Chief of Staff and Medical Advisory committee). 2) Promote improved hand hygiene awareness via consistent messaging and inclusion of results on unit-level performance boards or scorecards. 3) Gather lessons learned from units with high compliance and distribute to all to assist learning. 4) Work with Decision Support to assess current hand hygiene audit sampling and collection methodologies to ensure more consistent and reliable compliance reporting.	% of identified methods implemented	100%	
		Percentage of time that 1 or more inpatient units are in outbreak.	Rate / All inpatients	Local data collection; 20-21 Q1 - Q3	8.7%	16.0%	Target is based on advice from IPAC leadership and recent performance but recognizes lower occupancy during 20-21 Q1 - Q3 may not continue, and may make sustaining current performance very difficult. Target adjusted to be 4 outbreaks of 2 weeks each.		1) Maintain improvements realized through improved products, investigations, etc which were implemented in response to the Public Health Infection Control Resource Team. 2) Continue focusing on reduction of both outbreak incidence and duration.	1) Continue current efforts related to reducing bed moves, investigations, and adoption of lessons learned from same.	% of identified methods implemented	100%	
Equity	**Equitable**	Indigenous patient self-identification	NA	NA	Collecting baseline	Collecting baseline			1) Work with Information Systems to source Indigenous data and work with Decision Support to analyze available data to gain better insights into results and outcomes for Indigenous patients. 2) Share preliminary findings of analysis with Hospital leadership and use to adjust services where possible.	1) Continue engagement with Indigenous population on opportunity to self-identify, as well as reasons and benefits of doing so. 2) Source and review data and leverage it to inform Hospital leadership and to recommend required changes.	% of identified methods implemented	100%	

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)