# 2018/19 Quality Improvement Plan
# "Improvement Targets and Initiatives"

Norfolk General Hospital 365 West Street

| AIM | | Measure | | | | | | | | Change | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Quality dimension | Issue | Measure/Indicator | Type | Unit / Population | Source / Period | Organization Id | Current performance | Target | Target justification | 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) A= Additional (do not select from drop down menu if you are not working on this indicator) C = custom (add any other indicators you are working on) | | | | | | | | | | | | | | |
| **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) | 804* | 64.7 | 65.70 | Top Box | 1)Using LEAN methodology map the discharge process for in-patients | In partnership with patients/families and staff map the inpatient experience to identify gaps where information should be shared prior to discharge | Quarterly Canadian Patient Experience Survey | Understood what symptoms to watch for: 83.1% | Eliminate preventable harm |
| | | | | | | | | | | 2)Standardized practice of discharge rounding | Clinical Practice Lead will round with all patients prior to discharge | Number of discharged patients who have an opportunity to share their experience through rounding practices | 100% of Clinical Practice Leaders trained in Rounding with patients and | Exceptional patient experience |
| | | | | | | | | | | 3)Patient oriented discharge summary | With input from patients/families identify information needed at the time of discharge to support their ongoing care after leaving the hospital | Discharge summary developed and provided to patients at discharge | 100% of patients receive a discharge summary at the time of discharge | Patient engagement |
| | | | | | | | | | | 4)Bedside whiteboard includes patient centered information about discharge | Update the content of the bedside whiteboard with input from patients/families | Bedside whiteboards will include discharge information and space to communicate with the care team | 100% of bedside whiteboards will include discharge information for patient and family | Patient engagement |
| **Patient-centred** | **Person experience** | "Would you recommend this hospital to your friends and family?" (Inpatient care) | P | % / Survey respondents | CIHI CPES / April - June 2017 (Q1 FY 2017/18) | 804* | 42 | 78.70 | Top Box | 1)Hardwire AIDET into daily practice | Audit AIDET practice | % of audits using all AIDET practices | 80% audits identify full use of AIDET required practices | Strategic priority in improving patient experience |
| | | | | | | | | | | 2)Patients identify they have been treated with courtesy and respect | Patient experience survey CPES-IC | Nurses treated patient with courtesy/respect Physicians treated patient with courtesy/respect | Top Box Nurses: 85.7% Physicians: 88.8% | Patient Experience Survey CPES-IC |
| | | | | | | | | | | 3)Always Practice: Rounding with patients who are being discharged | Develop a standardized practice for Clinical Practice Leads that includes rounding with all patients prior to discharge. | Educate all Clinical Practice Leads on Discharge Rounding | 100% of Clinical Practice Leads trained in discharge rounding | Strategic priority |
| | | | | | | | | | | 4)Engage the interprofessional team in educational opportunity to elevate therapeutic relationships | Provide self learning opportunity during skills fair | Pre and post testing for therapeutic relationship building exercise | 100% of staff attending the skills fair will complete a therapeutic relationship | Staff engagement |
| **Safe** | **Safe care/Medication safety** | Medication reconciliation at discharge: Total number of discharged patients | P | Rate per total number of discharged patients / Discharged | Hospital collected data / October – December (Q3) 2017 | 804* | CB | CB | Best Practice | 1)Best Possible Medication History at admission | Educate nurses in Best Possible Medication History at the time of admission | Number of nurses trained in collecting BPMH | 80% of nurses trained | Best Practice |

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| | | for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged. | | patients | | | | | | 2)Improved medication reconciliation documentation at all transition points of patient journey | Using LEAN methodology map the medication reconcilation process at admission | Develop an improved medication reconciliation documentation format | 100% of admitted patients have new process for medication reconcilation | Best Practice |
| | | | | | | | | | | 3)Partner with patients and families regarding medication knowledge at discharge | Standardize practice for nurses to round with patients prior to discharge regarding medications included on their discharge medication prescription | Patient has clear understanding of medications | 81.8% of patients will have a clear understanding of medications | Patient engagement |
| | | Hand Hygiene compliance before patient contact | C | % / Health providers in the entire facility | Hospital collected data / October to December 2017 | 804* | 74 | 100.00 | Theoretical best | 1)Yearly staff education focus on hand hygiene | Develop an electronic educational presentation | Easy access to educational opportunity for all staff | 85% of staff complete the hand hygiene education electronically | Unwavering focus on eliminating preventable harm |
| | | | | | | | | | | 2)One to one instruction in hand hygiene practices | Develop a team to provide one to one hand hygiene education to front line clinical staff | 100% of Clinical Leads educated in providing one to one instruction to clinical staff | 85% of front line clinical staff receive one to one instruction in hand hygiene practice | Unwavering focus on eliminating preventable harm |
| | | | | | | | | | | 3)Hand Hygiene module included in yearly skills fair | Teach back for hand hygiene competency | Number of staff demonstrating proper technique for ABHR | 100% of staff attending skills fair will complete hand hygiene application | Influencer Model |
| | | | | | | | | | | 4)Integration of Hand Hygiene conversation as daily practice | Standardized unit based huddle that includes hand hygiene as safety strategy | Daily huddle with Clinical Practice Leader includes conversation regarding hand hygiene | 100% of daily huddle agenda includes hand hygiene convervation | Influencer Model |
| | **Workplace Violence** | **Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.** | **M A N D A T O R Y** | **Count / Worker** | **Local data collection / January - December 2017** | **804*** | **CB** | **CB** | **Strategic Plan 240 FTEs** | **1)Non violent crisis intervention training for all staff** | **Provide monthly NVCI training classes in-house** | **Number of staff trained in NVCI** | **Zero lost time workplace injury** | **Strategic Priority** |
| | | | | | | | | | | 2)Improved incident reporting system | Review current practice of reporting workplace violence | Develop a robust incident reporting strategy to capture all workplace violence episodes | Increased incident reporting | Strategic Priority |
| | | | | | | | | | | 3)Staff engagement in workplace violence incident reporting | Education for staff about reporting a workplace incident | Develop education and communication strategy for all staff | 80% of staff participate in workplace violence incident reporting education | Strategic Priority |
| **Timely** | **Timely access to care/services** | Emergency Department length of stay for complex patients (CTAS 1-3). | C | Hours / ED patients | CIHI DAD / October to December 2017 | 804* | 9.7 | 8.00 | Provincial target | 1)Identify barriers to patient flow with consistent assessment of CTAS 1-3 | Develop a standard practice of hourly rounding on all CTAS 1-3 | Percentage of CTAS 1-3 who receive hourly rounding | 80% of CTAS 1-3 will receive hourly rounding with their care providers in the ED | Patient Flow initiative |
| | | | | | | | | | | 2)Using an interdisciplinary team, identify root causes to increased length of stay for the complex patient population | Using LEAN methodology process map the journey of complex patients and with the interdisciplinary team identify various touchpoints where service may be interupted | Number of touchpoints that impact length of stay | Action plans for the various challenges that impact length of stay | |