2023/24 Mississipi River Health Alliance Quality Improvement Plan

AIM		Measure										Change			
Quality dimension	**Issue**	**Measure/Indicator**	**Unit / Population**	**Source / Period**	**Current performance**	**Target**	**Target justification**	**Q1**	**Q2**	**Q3**	**Q4**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**
Safety	Workplace Violence Prevention (WVP)	1. Number of reported workplace violence incidents by hospital workers (as defined by OHSA) within a 12 month period	Total count of reported incidents	Local data collection 23/24	AGH 3 CPDMH 2 FVM 15	10 10 20	Promote a culture of reporting to advise appropriate interventions supporting a safe workplace					1. Identify gaps in aggressive patient interventions and enhance staff training. 2.Train Behavioural Support (BSO) champions on M/S, CCC and ED 3. Expand NVCI training to include ED physicians 4. Identify and remove barriers to WPV incident reporting (implement electronic reporting at CPDMH) 5. Monthly monitoring of open PRIMS reports at AGH which extend beyond 30 days	1. Post incident analysis of aggressive patient interactions and interventions. 2. Review staff training focusing on mandatory/recommended requirements. 3. Provide recommendations for additional or enhanced training. 4. Provide Leaders with weekly reports on events approaching 30 days open*	1. Gaps in aggressive patient interventions identified and target training to enhance staff competencies by role and department. 2. Training plan implemented to target identified needs. 3. Percentage of WPV reported at AGH (PRIMS) and CPDMH which have been closed within 30 days.	1. Any gaps in aggressive patient intervention identified and implemented to enhance staff training by March 31, 2024 2. Training matrix developed by September 1, 2023. 3. Electronic reporting implemented at CPDMH by Q4.
Patient Centered	Resident Experience	Percentage of residents responding affirmatively that they were informed about changes in their condition.	FVM Residents who are capable of participating in care conferences	Local data collection FVM Resident Survey 23/24	65%	80%	To promote a culture of information communication between resident, nurse, and physicians					Identify gaps in information transfer and improve the transfer of info from physician and nursing staff to residents.	1. Provide education to Registered staff regarding informed consent. 2.Resident rounding by DOC/ADOC/Team Lead 3.Staff to check in with residents following physician rounds to ensure they understood info provided	1.Regular resident rounding achieved 2.Demonstrated resident understanding of information provided by physicians and nursing/allied health staff	80% of residents report that they were informed about changes in their care on the 2023/24 FVM Resident Survey.
	Patient Experience	Percentage of respondents who respond "completely" to "Did you receive enough information from hospital staff about what to do if youwere worried about your condition or treatment after you left the hospital?"	% of survey respondents	Local data collection-post discharge calls 23/24 Patient experience tool	AGH NA CPDMH NA	75%	To promote a culture of information communication between patient, nurse, and physicians					1. Identify appropriate nursing staff to act as discharge champions on their units. 2. Review and revise current discharge package to include individualized patient transition tool 3. 4. Develop discharge checklist tool for emergency patients	1. Provide discharge training to nursing, including consideration of patient's cultural needs 2. Provide education to patient and family in plain language regarding patients' condition, discharge process and next steps throughout hospital stay 3. Implement discharge checklist for Emergency pts.	1. Audit discharge conversations with patients	75% of respondents will respond by Q4.
Effective	Care	Choosing Wisely Daily Blood Work	Rate of total number of patients	Local data collection 23/24	AGH NA CPDMH NA	1. CBC 10% 2. Electrolyte 22%	To reduce unnecessary daily blood work or repetitive blood work when values are normal					1. Determine baseline values 2. Rate of normal CBC and electrolyte repeat results within 24 hrs on inpatients when initial results were normal.	1. Reduce hospital acquired anemia based on best practice recommendations	1. Audit for orders that are repeated on normal values for CBC and Electrolytes	1. To reach both targets set by Q4

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Effective	Care	Choosing Wisely Blood Transfusions	Rate of total number of patients	Local data collection 23/24	AGH NA CPDMH NA	1. 65% 2. 80%	1. To reduce the number of units transfused. 2. To reduce patients that have been transfused red blood cells in asymptomatic, non bleeding patients with a hemoglobin greater than/equal to 80g/L hemoglobin					Implement two recommendations: 1. Don't transfuse more than one unit of PRBC's at a time when transfusion is required in stable, non-bleeding patients or residents 2. Do not transfuse red blood cells in asymptomatic, non bleeding patients with a hemoglobin greater than/equal to 80g/L	Blood transfusion should not be given if other safer non-transfusion alternatives are available	1. Choosing Wisely guidelines: "Do not transfuse red blood cells in asymptomatic, non bleeding patients with a hemoglobin greater than/equal to 80g/L". 2. Audit Number of units and hemoglobin levels.	1 .65% of transfusions are single unit (inpatients only) by Q4 2. 80% of transfused patients had an initial hgb result of <80 g/L by Q4
		Implement individualized holistic palliative care approach for FVM residents	FVM residents requiring palliative care	Local Data collection 2023/24	FVM NA	80%	To determine palliative care needs of residents for better qulaity of life and to support end of life care					Initiate Interdiciplinary assessments to determine a resident's palliative care needs including: quality of life improvements, pain & symptom management, pshychosocial support & end of life care	1.Education regarding palliative and end of life care provided to staff 2. Development of Interdisciplinary palliative care team 3.Availability of palliative and end of life resources for families and residents 4.Discussions regarding palliative care to be introduced during admission care conference for new residents or during annual care conferences for current residents.	1. Barriers to providing holistic palliative care identified & plan developed to address 2. Education plan implemented for staff to support program 3.Audit of residents care plans who have been identified as requiring palliative care	80% patients that are identified requiring palliative care by Q4.
	Medication Safety	1. Percentage of completed error free admission Best Possible Medication History (BPMH) 2. Percentage of completed Best Possible Medication History on admission to Obstetrical Unit	Rate per total number of admitted patients	Local data collection 23/24	1. AGH ER: 50% 2. AGH OB : 10% 1. CPDMH MS: 15%	80%	Target set high based on significance of completing this practice					1. Review & revise medication reconcilliation P&P 2. 1:1 training for nursing / physicians with pharmacist 3. 1:1 training for nursing / physicians with pharmacist 4. Real time audits and feedback	1. Track and optimize the number of patients who have error free BPMH completed on admission to MS(AGH & CPDMH) OB (AGH) 2. Implement OB medical directive allowing nursing to sign off pre-natal / multi vitamins 3. Real time audits and feedback regarding errors Support OB nursing and physician engagement - identify barriers to completion & provide ongoing support as required.	1. Percentage of error free BPMH completed 2. Total number of OB patients for whom a BPMH was completed is proportional to the total number of admissions.	All at 80% Q3 & Q4.
Care	Patient/ Resident Falls	Reduce number of inpatient falls per 100 patient days Reduce number of resident falls in the last 30 days	AGH MS & CCC CPDMH MS (falls per 100 patient days rate 4.8 - 8.8) FVM Residents (falls per 30 days)	Local data collection 23/24 RAI	AGH MS: 5.9 CCC: 4.7 CPDMH MS: 8.8 FVM: 16.8	AGH 4.8 CPDMH 6.0 FVM 15.3	To reduce falls in each area in order to promote the decrease of risk of injury.					1. Review & revise Fall prevention policy 2. implement harm reduction strategies to decrease risk of injury related to falls 3.integrate bed exiting alarm into nurse call system	1. Falls risk assessments on every admission 2.Timely referrals to physio 3.pharmacy consult (polypharmacy) 4.Provide training r/t lifts, transfers and locomotion 5. Encourage resident participation in walking program and exercise classes 6. Intentional rounding (pain, positioning, toileting)	1. Total number of patient falls 2. Total number of resident falls in last 30 days FVM	Average over the four quarters.