2024/25 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	50 50 80	More reports allow for better analysis of events and actions to take for prevention					1. Electronic incident reporting in place to simplify capture of violent incidents 2. Provide training in NVCI and GPA across all sites including recertification. 3. Train BSO champions in M/S , CCC and ED in both hospitals. 4. Implement initiative with OPP for standard transition process for Mental Health patients brought to the ED.	1. Place stats on huddle boards to ensure visibility and priority of this work 2. Measure completed training rates. 3. Advocate with Behaviour Supports Ontario for more resources for creating champions. 4. Training to be completed by RNs in the ED on OPP MH project.	1. Completion of analysis of workplace violence within 30 days of reporting. 2. Ensure SURGE learning utilization addressed at performance reviews and updated quarterly to managers. 3. Number of recommendations made to Leadership Team through analysis of reported violent incidents. 4. Track training completion by RNs in the ED on OPP MH project.	1. increase in reporting expected due to electronic platform established. 2. Examine utilization of security guards and the timeliness of their implementation. 3. Review at every huddle any staff safety concerns. 4. Have 90% of RNs trained in MH transitions process with OPP
Patient/Resident Centered	Resident Experience	2. Percentage of residents reporting worsening pain on the MDS-RAI assessment.	All FVM Residents who report worsening pain	MDS-RAI data quarterly for 24/25	FVM 14.77%	9% based on average from MDS-RAI data	management of pain improves quality of life for residents					1. Complete PPS (palliative performance scale) on admission and with change of condition for all residents so that baseline is established 2. Identify residents reporting worsening pain and ensure pain medication matches demand. 3. Work with newly established Nurse Practitioner to assess residents with worsening pain to ensure gaps identified.	1. Provide LEAP training in pallaitive care to 5 registered staff by year end. 2. Ensure post PRN medication assessment completed to determine efficacy of medication administered. 3. New electronic MAR processes in place including indication for pain medication captured.	1. Education applied to practice in addressing pain medications. 2. MDS-RAI data analyzed monthly. 3. Total count of residents reporting worsening pain decreased	1. Ensure pain data captured accurately on MDS-RAI assessments 2. Audit completion of PPS scores on admission and at least annually afterwards with care conferences. 3. Decrease worsening pain reporting by March 31, 2025
	Patient Experience	3. Percentage of respondents who respond "completely" to "Did you receive enough information from hospital staff prior to discharge>	Discharged patients on Med/Surg units	Qualtrics Patient Satisfaction	AGH CPDMH	75%	New survey process in place thus determining baseline data					1. Continue with post discharge phone calls and compare this data to the new patient satisfaction data. 2. The team leaders will work on a discharge transition tool to send home with patients that will include follow up needed, education, medication review, etc. 3. Incorporation of community resources into education for all departments to ensure successful re-integration post-discharge	1. Provide discharge training to nursing teams. 2. Implementation of whiteboards on M/S units to enhance communication with patient/family/care team. 3. Match post discharge phone calls data/feedback with patient satisfaction data to identify gaps that can be addressed prior to discharge	1. Number of nursing staff educated. 2. Audits of whiteboards for completion and accuracy of information. 3. Completion of discharge phone calls. 4. Analysis of new patient satisfaction processes and data as compared to previous years.	1. Post discharge phone call data should align with patient satisfaction data. 2. Analysis of ED return visits and admissions to determine gaps in community referrals. 3. Monitor readmission rates to ensure they remain below benchmark 4. Geriatric care pathway action items implemented across all facilities
												1. Determine baseline for AGH data with new L to L interface in Cerner by end of Q2 2024. Target to achieve will be determined to	1. Reduce hospital acquired anemia based on best practice recommendations. 2. EORLA will have report created in	1. Audit for orders that are repeated on normal values for CBC and electrolytes. 2. Conduct a review of all	Calculated by dividing total normal/normal values by total tests repeated. We will determine baseline data for both sites by end of Q2 and

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Effective	Care	4. Choosing Wisely Daily Blood Work	Total percent of patients who have bloodwork repeated when the previous results were normal	Local data collection 23/24 from CPDMH, new data for AGH in 24/25	AGH NA CPDMH NA	1. CBC TBD 2. Electrolyte TBD	To reduce unnecessary daily blood work or repetitive blood work when values are normal					work towards by end of 24/25.. 2. Examine 2023 data for CPDMH which already captures total # of repeats and which were appropriate in order to set a baseline value. Target to attain will be set by end of Q2 to work towards by end of 24/25. 3. Conduct a review of all order sets containing labwork orders to ensure items are not pre-checked or are enhanced with stronger guidance when initial results might be normal.	CERNER once the L to L interface is completed so that this data can be tracked efficiently.	order sets to ensure not pre-populated and revise as needed. 3. Share themes with Chiefs of Staff for review at medical staff meetings	then to set targets to work towards by end of Q4 for both hospitals. Alberta achieves a CBC repeat rate of 5% and an electrolyte repeat rate of 35% as reported in 2022.
Effective		5. IV pump safety	Percent of drug overides utilized in IV smart pumps	IV pump reports obtained via pharmacy	ED, M/S, OBS	Target: below 30% in each department for utilizing "fluid only" feature	To improve the rate that the proper drug is chosen on IV smart pumps in order to capture safety features embedded in the pump					1. Determine baseline data for both hospitals and share results with the front line nursing team. 2. Conduct weekly spot audits to determine whether the proper settings on the pumps have been initiated. 3. Provide on-the-spot feedback to the nurse in charge of the IV. 4. Empower staff to check on each other and promote best practices.	1. Improve the rate that the proper drug is selected for the infusion which will improve patient safety with checking limits on infusion rates of medications.	1. Currently most infusions are run under IV fluid and not under the drug that is infusing. By choosing the drug it allows for proper parameters for the infusion to be selected and followed to ensure patient safety checks occur.	1. Nurses have discovered that by choosing fluid only they can adjust the rate and administer the medication with their manual calculations. Fluid only we estimate should only be used 30% of the time or less. 2. Reports run quarterly by pharmacy from the IV smart pumps will indicate drug override or fluid only rates. 3. Spot audits completed weekly by Team Leaders, Managers, Pharmacy or Peers and analyzed for patterns and trends
Effective	Patient / Staff Experience	6. Percentage of staff who complete Diversity, Equity, Inclusion and Belonging education on SURGE learning platform	Full time and part time staff across MRHA	Local data collection in SURGE learning system 24/25	AGH NA FVM NA CPDMH NA	Target: 75% of all full time/part time staff at all levels	Improve awareness of issues which will translate into a more inclusive care and work place					1. Identify key learning modules available in the SURGE learning program and elsewhere that will assist staff to understand cultural diversity and inclusion issues. Then enable their access in SURGE for all staff; indicating mandatory for completion. 2. Analyze the recent employee engagement survey results and comments to identify themes that may need to be addressed. 3. Discuss with DEIB committee priorities that should be identified. 4. Launch this initiative to all staff through email, newsletters, huddles, staff meetings, posters, etc.	Communication and connecting the "why" with staff will be a key to success. Helping them understand how this education translates into better outcomes for employees and patients in our care	1. Provide monthly reports to each manager on progress of their team. 2. Identify on Manager's LEM for inclusion in tracking success. 3. Remind staff during performance reviews and huddles about the expectations for completion of mandatory training	1. Target is completion by 75% of full time and part time employees across all 4 entities of MRHA.
re	Patient/	7. Reduce number of inpatient falls per 1000 patient days	AGH MS & CPDMH MS (falls per 1000 patient days rate	Local data collection 23/24	AGH MS: 6.5 CPDMH MS: 7.2	AGH 5.3 CPDMH 6.0	Falls cannot be prevented but					1. Review and revise fall prevention policy and provide education to frontline staff. 2. Ensure individualized fall prevention strategies implemented for each patient/resident identified at high risk of falls	1. Ensure falls risk assessment completed on admission, quarterly, post fall and with a condition change. 2. Refer to allied health, pharmacy or NP for further assessment if needed. 3. Provide annual training to	1. Total number of patient and resident falls. 2. New reporting of falls with moderate to severe injury according to standard definitions in the PRIMS system.	1. Monthly review with managers as PRIMS are closed. 2. Quarterly data reporting to quality committees.

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Ca	Resident Falls	Reduce number of resident falls in the last 30 days Report falls rate with moderate to severe injury.	4.8 - 8.4 as of Q3 23/24) FVM Residents (falls per 30 days)	MDS-RAI	FVM: 16.8	FVM 16.8	injury from falls can be.					risk of falls. 3. Integrate call bells into nurse phones for alertness of care need. 4. Falls rate with moderate to severe injury is new data to report	3. Provide annual training to staff on safe lifts and transfers. 4. Continue to evaluate the impact of the walking program in falls reduction.		