What Matters to You?

How to design and deliver a Quality Improvement Program

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Canberra Hospital

HealthCARE Improvement Division

Vision:

‘To promote & facilitate a culture of excellence, innovation, education & research in healthcare improvement through a framework designed for the delivery of a safe & reliable healthcare system’

[ACT Health, 2015]

What Matters to You?

Purpose:

- Allow staff to improve the care they deliver, giving them greater ownership and empowerment through transparency and accountability of quality measures
- To increase knowledge of staff about the quality of patient care through the collection of quality measures, reflecting and learning from them

Quality Improvement Program

- Based on Transparency & Accountability
- Accessible to and informed by all staff
- Informed by information and measurement
- Complemented by education

Quality Improvement Program

Components:

- E- Improvement Register
- Mortality & Morbidity Library
- Measuring Patient Care Program
- Quality Plan Platform
- Quality Improvement Boards

Quality Improvement Library

Welcome to the Improvement Library

Contact Shayne.Brown@act.gov.au - 6244 3138 or Natalie.Zuber@act.gov.au - 6244 3465

The purpose of the Improvement Library is to inform quality improvement by bringing together the organisation's information about safety and quality. Read More

Scroll down to access information and view data.

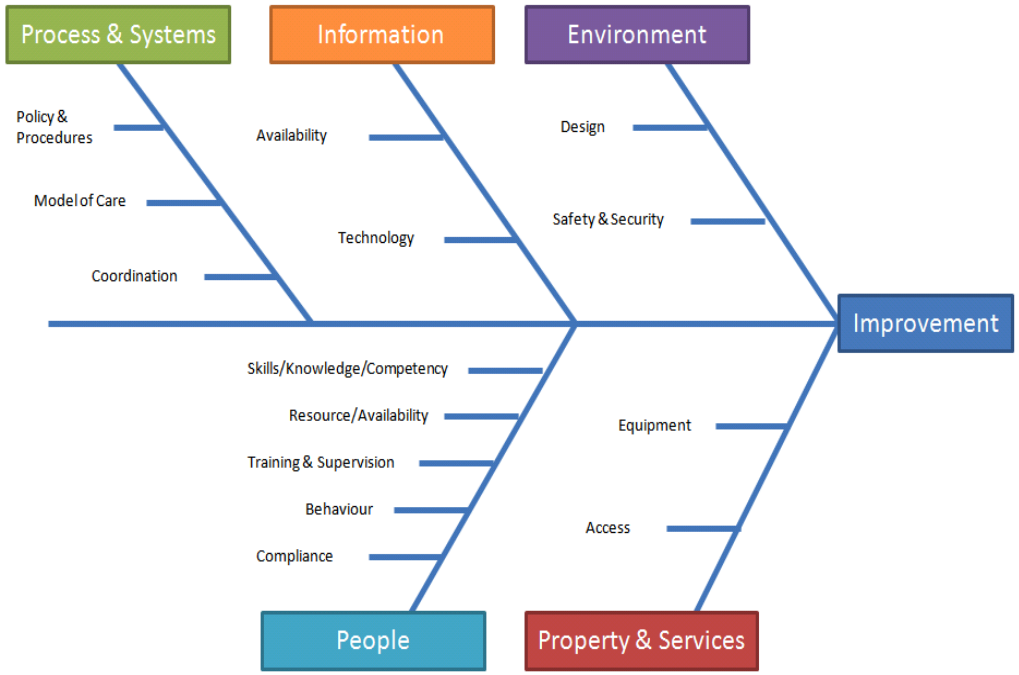
Features

Improvement Register - a dynamic record of issues and solutions across Canberra Hospital and Health Services.

Measuring Patient Care – clinical audit results.

M&M Library – a library of lessons learned in Morbidity and Mortality meetings.

Quality Plans - outline work required to achieve goals to improve the quality of care.



Links to other safety and quality info

Accreditation & the 10 NSQHS Standards
Clinical Governance Forums
Clinical Indicators (coming soon)
Incident Reports
Patient Safety Conversations
Quality Improvement Activities - How To
Quality Improvement Activity Register

Divisional Improvement Libraries (in development)

Cancer, Ambulatory and Community Health Support
Critical Care
Medicine
Mental Health, Justice Health & Alcohol and Drug Services
Rehabilitation, Aged and Community Care
Surgery, Oral Health & Medical Imaging
Women, Youth & Children

ACT Government Health

NSQHS STANDARDS

Measuring Patient Care Program

- Continuous Improvement vs Compliance
- Collaborative design to Improve Patient Care
- Tools designed for front line staff
- Aligned to National Standards
- 1 Patient per ward per day 5 days a week.

Measuring Patient Care: Organisational Summary Sheet

Measuring Patient Care Data Summary Report

Organisation Level

Divisions who submitted data in last reporting period: **30 March-12 April 2015**

CACHS----------(N=10-*--50 on some)	✓	RACC-----(N=20)	✓
Critical Care-----(N=45)	✓	SOH------(N=80)	✓
Medicine--------(N=50)	✓	WYC------(N=80)	✓
MHJHADS--------(N=30)	✓		

Standard	Number of Audits Conducted	Required Number of Audits	Care Bundle Score	Summary of Findings for Reporting Period:	Actions	Risk Rating
	213	355	91%	**Partnering with Consumers** • **71% reported receiving information on Patients' Rights compared to 65% last reporting period** • The CARE program had been explained by staff 86% of the time, compared with 81% last reporting period. • 98% of patients reported that they understood plans for their care • 92% indicated that they were given an opportunity to ask questions of the staff with 97% noting that staff introduced themselves. •		
	117	Not Denominator	89%	**Hand Hygiene Snapshot** • Hand Hygiene before donning gloves and after removal of gloves was inconsistent across the all moments of hand hygiene observed: • **Before Procedure** Pre Gloves—100% / Post Gloves 82% • **Body Fluid exposure** Pre Gloves—100% / Post Gloves 80% • Hands being washed or cleaned at the hand hygiene moment was variable between the healthcare workers with 98% (80/82) for nurses, 83% (5/6) for midwives, 90% (9/10) for medical officers and 100% (7/7) for allied health professionals		
	218	355	95%	**Medication Administration** • **Labelling of Injectables left unattended or administered by others was 51% (29/57) compared with 53% last reporting period** • **Use of the oral syringe dispenser when required was 83% compared with 81% last reporting period** • Explanation of the medication purpose to the patient was 92% • The core elements of medication administration are well managed with the checking of patients name, medication strength, dose, route and expiry date reported at or above 95% • Use of ID band to compare the 3 core Identifiers was 97% and use with the medication chart with the core identifiers was 96%		
	269	355	76%	**Medication Chart** • **54% of medication charts reviewed had the patients weight recorded.** • **Management of Warfarin prescriptions were low 44% having an indication for Warfarin recorded (compared with 61% last reporting period) and 67% (10/15) had a target INR noted.** • **Evidence of pharmacy review was low across all divisions with an overall score of 45%. Completion of Medication Reconciliation forms was also low at 46%.** • **Evidence of VTE prophylaxis management was low across the Divisions with 36% being signed and dated and 21% having a contraindication ticked.** • **Paediatric dose calculations were documented 80% of times and were double signed 84%** • **Of the ceased medications 21% had the date recorded when the medication was ceased and 35% were initialled.** • 83% had their current ward/unit recorded on the chart. • The core elements of medication prescription, route, dose, frequency, times of administration and signed were above 95% • Names of prescribers were present in 90% of cases o 78% were printed (81% last reporting period) o 76% were legible (80% last reporting period)		

Ward/Unit level Summary Sheet

Measuring Patient Care Data Summary Report

Ward/Unit: 7A

Ward/Unit submitted data in last reporting period: **30 March -12 April 2015**

DoM Ward Level 7A (N=10)

Standard	Number of Audits Conducted	Required Number of Audits	Care Bundle Score	Summary of Findings for Reporting Period:	Actions

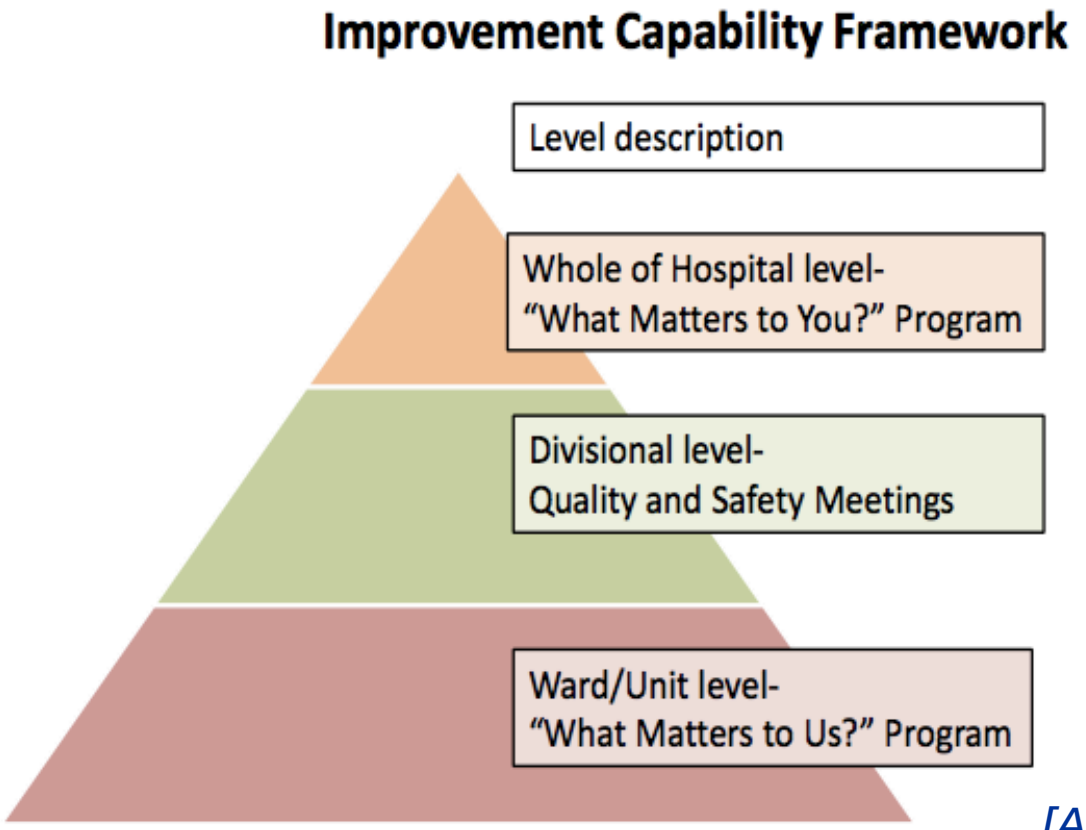
	10	10	98%	**Partnering with Consumers**
				• 90% of patients were given the opportunity to ask questions to staff with regards to their care.
				• 100% was attained for the core elements of Partnering with consumers which include:
				  ◦ Understand care
				  ◦ Staff introducing themselves
				  ◦ Information on patients rights and religious and cultural needs met
				  ◦ Care program	

	N/A	N/A	N/A	**Hand Hygiene Snapshot** • Hand Hygiene Australia Audit – Results not available with MPC Data summary	
	10	10	96%	**Medication Administration** • **Checking of allergy prior to administration of medication on reconciliation form at 33% (3 out of 9)** The core elements of medication administration are managed well on the ward with checking of patient's name, DOB, medication strength, Route, dose and expiry date consistently at 100%.	

	12	10	75 %	**Medication Chart**
				• **67% Nil Known Allergy documented and signed**
				• **86% Allergies recorded**
				• **57% explanation of reactions of allergies recorded.**
				• **75% of patients weight documented on medication charts**
				• **VTE Risk – 27% had signature, 25% was dated and 17% had the contraindicated boxes ticked.**
				• **The ore elements of 60% prescribers name present. Of these:**
				  ◦ **70% legible**
				  ◦ **60% printed**
				  ◦ **90% signed**
				• **Only 20% had indications for medications documented.**
				• **Prescriptions for ceased medications had 10% of date recorded and only 10% initials were recorded.**
				• **90% completed Medication Reconciliation forms in patient medication.**
				• **Evidence of pharmacy review at 90%**	

	9	No Denominator	89%	**Schedule 8 Drug Register** • **100% attained for all core elements except name of prescribing medical officer legible only at 60%.**	
	1	10	100%	**Medication Reconciliation Schedule 4/8 Register** • Reconciliation of medication chart and register of patients names at 80% • Dates and times reconciliation at 40% • Names of prescribing Officer documentation and alignment with chart and register at 40% • None of the staff were identifiable with their signatures (0%)	

QI Educational Program



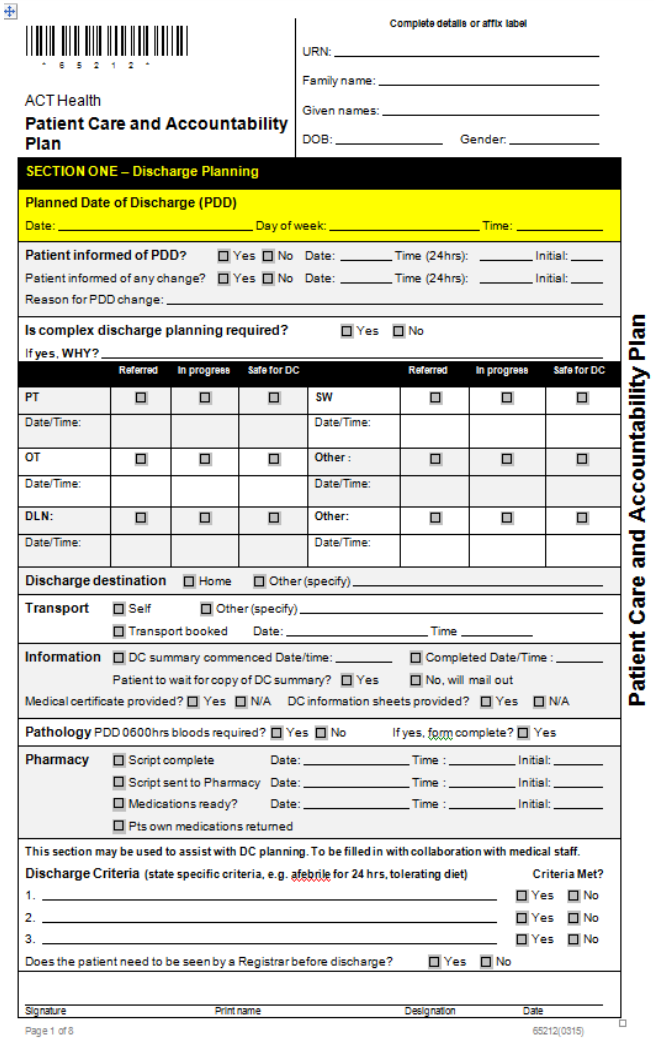
[ACT Health, 2015]

Quality Improvement Education

What Matters to You Program:

- Uses Improvement Science methodology
- Incorporating Measuring Patient Care Program
- Sharing of results and challenges key to success
- Multidisciplinary teams
- Coaching of teams essential

Patient Care & Accountability Plan



ACT Health

Patient Care and Accountability Plan

Complete details or affix label

URN: _____

Family name: _____

Given names: _____

DOB: _____ Gender: _____

SECTION ONE – Discharge Planning

Planned Date of Discharge (PDD)

Date: _____ Day of week: _____ Time: _____

Patient informed of PDD? ☐ Yes ☐ No Date: _____ Time (24hrs): _____ Initial: ____

Patient informed of any change? ☐ Yes ☐ No Date: _____ Time (24hrs): _____ Initial: ____

Reason for PDD change: _____

Is complex discharge planning required? ☐ Yes ☐ No

If yes, **WHY?** _____

	Referred	In progress	Safe for DC		Referred	In progress	Safe for DC
PT	☐	☐	☐	SW	☐	☐	☐
Date/Time:				Date/Time:			
OT	☐	☐	☐	Other :	☐	☐	☐
Date/Time:				Date/Time:			
DLN:	☐	☐	☐	Other:	☐	☐	☐
Date/Time:				Date/Time:			

Discharge destination ☐ Home ☐ Other (specify) _____

Transport ☐ Self ☐ Other (specify) _____

☐ Transport booked Date: _____ Time _____

Information ☐ DC summary commenced Date/time: _____ ☐ Completed Date/Time : _____

Patient to wait for copy of DC summary? ☐ Yes ☐ No, will mail out

Medical certificate provided? ☐ Yes ☐ N/A DC information sheets provided? ☐ Yes ☐ N/A

Pathology PDD 0600hrs bloods required? ☐ Yes ☐ No If yes, form complete? ☐ Yes

Pharmacy ☐ Script complete Date: _____ Time : _____ Initial: _____

☐ Script sent to Pharmacy Date: _____ Time : _____ Initial: _____

☐ Medications ready? Date: _____ Time : _____ Initial: _____

☐ Pts own medications returned

This section may be used to assist with DC planning. To be filled in with collaboration with medical staff.

Discharge Criteria (state specific criteria, e.g. afebrile for 24 hrs, tolerating diet) **Criteria Met?**

1. _____ ☐ Yes ☐ No
2. _____ ☐ Yes ☐ No
3. _____ ☐ Yes ☐ No

Does the patient need to be seen by a Registrar before discharge? ☐ Yes ☐ No

Signature Print name Designation Date

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Patient Care and Accountability Plan

ACT Government Health

NSQHS STANDARDS

Quality Improvement Program

Results

- Operational use of analysed Measuring Patient Care data
- Use of data to drive system level improvements and microsystem (ward) level improvements e.g. medication labelling, VTE risk assessment, clinical handover.

Quality Improvement Program

Conclusions/Lessons

- Operational use of continuous improvement data from ward to board
- Alignment of strategic planning with quality agenda
- Educational platform for all staff members
- Cultural improvement

"Every piece of data is a patient and every patient has a story "