## Appendix One

# Quality Action Plan FY2013-2014

| Aim | Action | KPI Owner* | Measures | | Responsible Committee/ Group/Person* | Timeline |
|---|---|---|---|---|---|---|
| Enhance Patient Safety | **Reduce Infections** by:<br>• Compliance with good hand hygiene (HH) practice<br>• Reduce Central Line Associated Bacteraemia (CLAB)<br>• Reduce Catheter Associated Urinary Tract Infections (CAUTI)<br>• Reduce Surgical Site Infections (SSI) | | • >75% HH compliance across DHB by June 2014 | N | • Infection and Prevention Control Executive<br>• Associate Director of Nursing<br>• Chief Medical Officer<br>• Quality Team | June 2014 |
| | | | • Rate of healthcare associated Staphlococcus bacteraemia <0.25 per 1,000 bed days | W | | |
| | | | • >90% compliance with central venous line insertion and maintenance bundles | N | | |
| | | | • <1 CLAB per 1,000 line days | N | | |
| | | | • <15 CAUTI per 1000 catheter days across all inpatient wards | W | | |
| | | | • Establish baseline rate of SSI for hip and knee joint replacements | N | | |
| | **Reduce Injuries by:**<br>• Reduce harm from falls<br>• Prevent pressure injuries<br>• Reduce harm from delirium | | • >90% patients 75 years and over (Maori and Pacific Islanders 55 and over) are given a falls risk assessment | N | • Director and Associate Director of Nursing and Midwifery<br>• Clinical Charge Nurses<br>• Chief Medical Officer<br>• Quality Team | June 2014 |
| | | | • 100% of patients have an individualised care plan in place where falls risk assessment took place and the patient was judged to be at sufficient risk to require a care plan | W | | |
| | | | • Rate of Falls with Harm < 0.4 per 1000 bed days | W | | |
| | | | • Rate of Falls with Major Harm < 0.1 per 1000 bed days | W | | |
| | | | • 30% reduction in Total Number of-hospital Falls Resulting in Fractured Neck of Femur | W | | |
| | | | • Establish baseline rate of in-hospital falls resulting in fractured neck of femur | W | | |
| | | | • <4 patients with pressure injuries per 100 patients | W | | |

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| | | | • <0 Grade 3 and 4 pressure injuries | R | | |
| | | | • >90% of patients assessed for risk of pressure injury within specified timeframe | W | | |
| | | | • >90% patients receiving appropriate bundle of pressure injury care per risk score | W | | |
| | | | • >90% patients with the correct pressure injury care plans implemented | W | | |
| | | | • 30% reduction in prevalence of delirium for patients >65 years (Maori and Pacific Island patients >55 years) | W | | |
| | **Reduce Peri-Operative Harm by:**<br>• Compliance with the surgical safety checklist<br>• Prevention of post-operative venous thromboembolism (VTE)/pulmonary embolism (PE) | | • >90% of operations where all three parts of the surgical safety checklist were used | N | • General Manager Surgical & Ambulatory Services<br>• Charge Nurse Manager Operating Theatres<br>• Chief Medical Officer<br>• Quality Team | June 2014 |
| | | | • >90% of operations where VTE was considered as part of the surgical checklist | N | | |
| | | | • Establish baseline rate of post-operative deep vein thrombosis (DVT)/PE for hip and knee replacement surgery | W | | |
| | **Improve Medication Safety by:**<br>• Continue implementation of the Medication Safety Strategic Action Plan including:<br>- Continued roll out of electronic medicine reconciliation (e-MR) and electronic prescribing and administration (ePA) to inpatient units<br>- Continued roll-out of e-MR on admission and discharge<br>- Install Pyxis Medstations in all new and outstanding inpatient areas | | • 100% medicine reconciliation on admission | W | • Chief Pharmacist<br>• Medication Safety Group<br>• Chief Medical Officer<br>• Quality Team | June 2014 |
| | | | • 100% of medication charts have allergies/adverse drug reactions completed | W | | |
| | | | • ePA used in Medical Wards at NSH or WTH | W | | |
| | | | • eMR used for 90% of high risk patients in Medical Wards in NSH and WTH | W | | |
| | | | • All clinical areas using medicines use Pyxis Medstations for storage of medicines | W | | |
| | | | • Pyxis overrides <15% of all transactions on ePA wards | W | | |

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| | - Reduce the rate of Pyxis overrides<br>- Extend use of Global Trigger Tool to adverse drug event (ADE) tool to measure harms caused by medications and use this to further inform quality improvement<br>- Improve compliance with completion of allergy/adverse drug reaction section on medication charts<br>- Continue development of medication safety E-Learning modules | | • 100% of medication charts have allergies/adverse drug reaction boxes completed | W | | |
| Improve Systems and Processes | • Increase patient responsiveness by timely, responsive, transparent complaints and reportable event management processes including:<br>- Resolve complaints promptly and effectively, and using the lessons from complaints to improve the quality of care and communication for future patients<br>- Undertake an annual survey of a random sample of complainants after their complaint is closed off, and of staff, about the complaint process – to further improve the way complaints are handled<br>- Report back to complainants in appropriate cases, on action taken in response to their complaint | | • <15 days average time to respond to complaints | W | • General Managers and Heads of Divisions<br>• Serious and Sentinel Event Committee<br>• Chief Medical Officer<br>• Quality Team | June 2014 |
| | | | • 100% all serious (SAC 1 & 2) reportable events investigated and responded to within 70 working days | N | | |
| | | | • 6S sustainably implemented in all hospital wards by June 2014 | W | | |
| | | | • Quality Boards published all inpatient wards and outpatient areas | W | | |
| | | | • Findings and recommendations of SAC1&2 events reported in public section of the board report each month | W | | |
| | | | • Safety themes and learnings reported in the monthly quality report to HAC and CGB, and in the Division's monthly service review quality reports | W | | |
| | | | • Documented quality improvement initiatives undertaken in response to complaints and reportable events | W | | |

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| | - Develop a system for documenting and tracking implementation of corrective actions from complaints and reportable events, and capturing and sharing generalisable lessons from complaints, reportable events and quality initiatives<br>- Report all findings and recommendations from completed serious (SAC 1&2) reportable event investigations in the public section of the board report<br>- Determine, for each service group, the most effective means for feedback of quality and safety themes and learnings from serious reportable event reviews. These feedback mechanisms should be documented in each of the Division quality plans and reviewed annually<br>- Ensure safety themes and learnings from serious reportable event reviews become a standard part of the reportable information available across the organisation and are reported to the Board, the Health Quality and Safety Commission and the public<br>• Continue to develop Global Trigger Tool analysis and reporting, including implementation of the Adverse Drug Event tool and use this to further inform quality improvement<br>• Increase Visual Quality Management | | • Continue roll out of Kanban and VQM in ARDS and Child Women and Family Services | W | | |

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| Best clinical practice & clinical leadership | • Enhance systems for continuous clinical practice improvement including:<br>- Development of quality plans by each hospital Division and by Clinical Directors for each service which align with the DHB's quality strategy and plan and include:<br>o key quality indicators and how these will be measured<br>o how patient feedback on quality of care and communication will be obtained<br>o the clinical governance system in place (including morbidity and mortality meetings; audit; arrangements for discussion of major quality issues from complaints, incidents, feedback and data monitoring)<br>o the quality improvements that have been made in the past year and will be made in the following year<br>- Ongoing development of medical credentialing processes<br>• Implement robust performance and skills management processes to ensure the workforce has the right qualifications and skills to provide safe, high quality care<br>• Continue to support the healthy workforce initiatives<br>• Continue to development and monitoring of quality of care indicators based on clinical outcome, safety and patient experience at service, division, | | • Documented quality plans by each Division and by Clinical Directors for each service by June 2014 | W | • General Managers and Heads of Divisions<br>• Clinical Directors<br>• Chief Medical Officer<br>• Quality Team<br>• Chief Executive<br>• Richard Bohmer | June 2014 |
| | | | • Quality indicator scorecards for HAC, CGB, Divisions and Clinical Directors by June 2014 | W | | |
| | | | • Revised Morbidity and Mortality Review Processes by June 2014 | W | | |

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| | management and board level<br>• Support implementation of the Enhanced Care Management and Clinical Leadership models including the clinical leadership and outcomes-based organisational design and management model. | | | | | |
| Increase quality and safety capability | • Continue to implement and promote the Patient Smart quality improvement methodologies (STEPS, Blitz, FAST, Rigour)<br>• Develop quality improvement specialist role to accelerate quality improvement training across the DHB<br>• Continue to develop and promote the clinical leadership programme<br>• Continue to implement the Advanced Care Planning training programme | | • An additional 40 staff complete Advance Care Planning training by June 2014 | R | • Quality Team<br>• Chief Medical Officer | June 2014 |
| Patient & family centred care | • **Strengthen patient, family & community engagement by:**<br>- Develop and implement a Patient and Family Centred Care programme for 2013 -2015 including:<br>○ Appointing a steering group including Health Links representatives, consumer advisors, senior clinical staff, a board member, and a senior manager;<br>○ Development of a work plan and timetable for the achievement of change in each of the New South | | • Documented terms of reference for Patient and Family Centred Care Steering Group | W | • Consumer Engagement Coordinator<br>• Associate Director of Nursing<br>• Quality Team | June 2014 |
| | | | • Documented work plan for Patient and Family Centred Care Programme | W | | |
| | | | • Publication of FY2012-13 Quality Account by December 2014 | N | | |
| | | | • Complaint responsiveness - <15 working days average time to respond to complaints | W | | |
| | | | • Surveys of overall complainant satisfaction with handling of complaint | W | | |
| | | | • Evidence of quality improvement initiatives undertaken in response to complaints | W | | |

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| | Wales Clinical Excellence Commission's 'Patient Based Care Challenge' challenge areas<br>o Implementing Ron Paterson's 2012 Quality Review recommendations<br>o Pilot of AI2DET training<br>o Promoting patient co-design, including highlighting the DHB's 'Health Service Co-design' guide & toolkit<br>o Implementation of a patient experience survey system including the Friends & Family Test<br>o continuing the telling patient stories at Board meetings<br>o Appointing a consumer member to the Clinical Governance Board<br>- Supporting and promoting the work of the Health Links groups including:<br>o Training and up-skilling consumers<br>o Community engagement in locality planning<br>o Health literacy<br>o Health Links sourced consumer involvement in DHB activities<br>• **Optimise the patient's experience by:**<br>o Resolving complaints promptly and effectively, and using the lessons from complaints to improve the quality of care and communication for future patients<br>o Implementing the Friends and Family | | • Establish baseline Net Promoter Score for Friends and Family Test by June 2014 | W | | |
| | | | • >15% response rate for Friends and Family Test by June 2014 | W | | |
| | | | • Improvement in patient experience survey results over time | W | | |
| | | | • Evidence of quality improvement initiatives undertaken in response to feedback | W | | |
| | | | • Evidence of quality improvement initiatives undertaken in response to patient experience feedback | W | | |
| | | | • New End of Life/Bereavement processes in place by June 2014 | W | | |
| | | | • Ongoing staff training in End of Life/Bereavement care | W | | |

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| | Test and a customised patient experience survey tool across the DHB and survey patients about their experience and using the feedback to improve the quality of care and communication for future patients<br>○ Ensuring all Waitemata DHB services undertake a survey of patient experience (at least annually), using a customised survey tool, and report the results and improvement actions to the Clinical Governance Board<br>○ Monitoring patient experience results and publicly reporting (via the DHB website and annual report) improvements in the experience of patients.<br>○ Continuing to implement the End of Life/Bereavement project<br>○ Developing and implementing an annual communication training programme for Senior Medical Officers<br>○ Improving the transition of information for aged residential care patients when admitted and discharged from hospital by implementing the 'yellow envelope' | | | | | |

| * | To be further developed |
|---|---|
| N | National |
| R | Regional |
| W | Waitemata DHB |