2024/25 Quality Improvement Plan
"Improvement Targets and Initiatives"

Hotel Dieu Shaver Health and Rehabilitation Centre 541 Glenridge Avenue, St. Catharines , ON, L2T4C2

AIM		Measure									Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Access and Flow	Efficient	Alternate level of care (ALC) throughput ratio	Optional	Ratio (No unit) / ALC patients	WTIS / July 1 2023 - September 30, 2023 (Q2)	790*	1.07	1.07	This is a very aggressive goal, is largely outside of HDS control and is dependent upon bed pressures throughout the Region, pressures on Home and Community Support Services, and patient's LTC choices. We are above the provincial average of .97%. For accountability purposes, we will accept values between .5 and 1.07%.	HNHBB Home and Community, Niagara Health System, Ontario Health West	1)ALC Rounds meeting with Home and Community Care Support Services (HCCSS)to review all cases likely destined for LTC.	Weekly meetings with Management and staff representation from both the HCCSS and HDS to exhaust all possible avenues before approving to wait for LTC from the hospital.	Regularity of ALC Rounds meetings.	Weekly meetings to take place.	
											2)Patient Flow meetings including representation from across the interdisciplinary team occur every day at 3:00 p.m. to review patient referrals, patient discharge dates and identify recommended interventions that may assist in facilitating safe and timely discharges.	Interdisciplinary team to meet on a daily basis.	Regularity of daily teleconference meetings.	# of daily teleconference meetings conducted.	
											3)Command Centre teleconference meetings to take place daily including representation from senior and front line levels of staff - from HDS, our acute care partner, Niagara Health, and Home and Community Care Support Services - to identify patient flow pressures and bottle necks, with the purpose of identifying immediate strategies to alleviate any barriers and facilitate expeditious patient flow on a case by case immediate basis.	Command centre team to conduct teleconference meetings on a daily basis.	Regularity of daily teleconference meetings.	# of daily teleconference meetings conducted.	
		Meet optimal wait times for internal inpatient to outpatient services based on stroke wait times.	Custom	Days / Stroke inpatients referred to outpatient stroke services	In house data collection / January - December 2023	790*	31.00	28.00	Based on volumes of patients and pressures on outpatient service taking into account Health Human Resource challenges and Christmas shutdowns due to funding restrictions we believe this is an aggressive target and exceptionally high standard to continue to aspire towards.	Rehab Care Alliance, Ontario Stroke Network, Niagara Health System, Patients families and caregivers	1)Continue to review and analyze wait time data on a regular basis to ensure interventions can be flagged if there is an identified problem.	Manager of Outpatient Rehabilitation and Specialty Clinics and Decision Support Analyst will continue to work together to review and analyze wait time data.	Number of reviews conducted and number of analyses completed.	At least one (1) review and one (1) analysis conducted monthly.	
											2)Continue to communicate wait time status to all relevant parties on a regular basis.	Wait time status to be communicated by Rehab leadership to staff teams, Executive VP of Operations and other managers, Finance, Senior Team, Quality Committee of the Board of Trustees.	Wait times to be reported quarterly, unless there are identified anomalies, in which case reporting to other involved managers, and Executive VP of Operations should take place as soon as possible after identification of the problem.	Continued administration of current process.	
											3)Continue process to identify and implement interventions as necessary to ensure wait times stay within identified limits.	Further to discussion among the team, identify, seek approval for and implement interventions as soon as feasible.	Number of identified and implemented interventions as required and as feasible.	Continuing administration of current process.	

Equity	Equitable	Development of training materials and completion of training in DEI Essentials for Managers, Human Resources and DEI Committee members.	Custom	% / Staff	In house data collection / April 1 2024 - March 31 2025	790*	CB	CB	The training package will take time to develop and implement. Therefore, we believe that 75% completion of training is an aggressive target for our baseline.		1)Research and development of DEI Essentials Training.	Director of Human Resources will research training packages and approaches available.	Completion of package for HDS.	Completion by mid 2024.	
											2)Training package will be vetted and approved by DEI Committee.	Director of Human Resources will share DEI training package with the DEI committee for input and approvals.	Completion of vetting and review process with the DEI Committee.	Vetting and approvals completed by Mid 2024.	
											3)Launch and completion of training for managers, Human Resources staff and DEI Committee members.	Human Resources will track training completion by whom and numbers.	Number of representative staff members who have successfully completed the training.	75% completion of training by the end of the 4th quarter 2024-2025.	
Experience	**Patient-centred**	Percentage of complaints acknowledged to the individual who made a complaint within 3 to 5 business days ***Executive Compensation**	Custom	% / People	In house data collection / January - December 2023	790*	100.00	95.00	This is an aggressive target with additional challenges -- being the very lean staffing at the hospital and potential difficulty in staff backfill in the event of absence. However, the hospital is committed to responding to all documented complaints as quickly as possible.	Ombudsmans Office, Politicians constituency offices, Patients and caregivers	1)Retain and train additional senior staff member on complaint response processes and requirements.	Progress in terms of completion of recruitment and training exercise.	Completion of retention and training.	Recruitment and training to be complete in 2024.	
											2)Enhanced publication of the contact information for the Patient Relations Process Delegate.	Ensuring notices are developed, and distributed to key areas throughout the Hospital and included in the Patient and Family Handbook.	Completion of notice and number of notices that are distributed.	Notices placed at all elevators, Nursing stations, scheduling offices and in the Patient and Family Handbook.	
											3)Formal tracking of all formally documented complaints including time lines for first acknowledgement, substance of complaint, nature of resolution and resolution timelines.	Patient Relations Process Delegate to document all formal complaints with chronology for time of the first response, substance of complaint, nature of resolution and resolution timelines.	Completion and maintenance of tracking document on a quarterly basis with reporting to Quality Improvement Committee of the Board.	Ongoing to include quarterly reporting.	
		Survey question: 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? ***Executive Compensation**	Custom	% / Survey respondents	In-house survey / January - December 2023	790*	99.71	95.00	This is an aggressive target particularly in light of the provincial average of 59% and the HNHBB average of 59%, and continuing stresses associated with viral outbreaks and HHR pressures. Therefore, for accountability purposes, we will accept results between 85-100%.		1)Continuation of surveys to be conducted with patient three or fewer days before anticipated discharge date.	Patient Advisors continue to be provided with a list of patients with upcoming discharge dates and will attend at the bedside with survey materials.	Successful completion of in-house surveys prior to discharge.	100% of patients with pre-scheduled discharge dates to be surveyed.	
											2)Continued communication between patient advisors and clinical managers to ensure that any concerns identified are flagged and, if possible, addressed prior to discharge.	Patient Relations Process Delegate to ensure that all patient advisors are aware of process to follow with clinical manager in the event that items of concern are flagged by patients/families prior to discharge.	Number of patient advisors instructed on process to follow with clinical manager.	All patient advisors who administer the survey provided orientation on process to follow with clinical manager.	
											3)Meet and greet process by patient advisors to help familiarize patients/families with what they can expect from their inpatient stay and discharge journey, which includes review of the Patient and Family Handbook.	Director of Health Data and Quality Improvement to co-ordinate meet and greet schedule with patient advisors.	Number of Meet and Greet sessions successfully co-ordinated.	Complete implementation subject to inability to attend units in outbreak.	

		Would you recommend inpatient care to your friends and family?	Custom	% / Survey respondents	In-house survey / January - December 2023	790*	100.00	95.00	This is an aggressive target particularly in light of our high current performance, the HNHBB rate of 56% and the Ontario rate of 63% and the current climate of continuing outbreaks and HHR pressures. As a result, we will accept performance between 85-95%.		1)Continue to increase and replace Patient Advisors to assist with sharing of patient experiences.	Patient Relations Process Delegate to identify prospective advisors through patient satisfaction survey group, recommendations from clinical managers, former and current patients.	Number of new and replacement Patient Advisors recruited.	Maintain or increase number of active patient advisors.	
											2)Patient Advisors to provide feedback to staff regarding the positive results of patient experience surveys and opportunities for improvement.	Clinical Manager will familiarize staff with questions on patient experience surveys and Patient Advisors will then follow-up with staff with results.	Sessions with Patient Advisors and staff to be conducted monthly, if possible.	Twelve (12) sessions held between staff and Patient Advisors per year.	
											3)Results of patient experience surveys to be presented at the Clinical Quality Council that consists of frontline staff, management, physicians and Patient Advisors to better address successes on the nursing units and identify areas of opportunity to assist with patient satisfaction.	Continue as a standing item on the Clinical Quality Council agenda.	Present at least one scenario at each quarterly Clinical Quality Council.	Minimum of four (4) reviews annually.	
Safety	**Effective**	Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged.	Optional	% / Discharged patients	Local data collection / Most recent consecutive 12-month period	790*	89.92	90.00	This target is very high as a result of internal high results. Further, a new HIS system will be launched in 2024 which may negatively impact results until users have developed a stronger familiarity with the system. For accountability purposes we will accept results between 80-90%.	Niagara Health System, Accreditation Canada, Community Pharmacists, Patients families and caregivers	1)Implementation of new orientation package for all prescribers.	Orientation package to be developed and delivered to all prescribers.	Package to be delivered at orientation and included in continuing education.	Ongoing as new staff and physicians are onboarded.	The numerator and denominator for the medication reconciliation indicator exclude discharges that occur due to transfers between rehab and complex care bed types during the same stay, AWOL (absent without leave), and AMA (against medical advice).
											2)Continuing education of nursing staff and physicians working on any unit in the hospital.	Nurse manager, Chief of Staff, Pharmacy Manager and pharmacists to complete the education with the staff and physicians.	Continuing education for all affected staff and physicians.	Ongoing as new staff and physicians are onboarded.	
											3)Physicians to be contacted a few days before anticipated discharge to be reminded of upcoming discharges to facilitate completion of medication reconciliation.	Health Records staff to contact MRP to advise of pending discharge and requirement for completion of medication reconciliation.	Number of calls completed by Health Records.	Ongoing process reviewed a few days prior to discharge to allow time to contact MRP.	
		Number of workplace violence incidents (Overall) ***Executive Compensation**	Custom	Count / Staff	In house data collection / January - December 2023	790*	101.00	90.00	We do see an improvement in the reporting culture of the hospital. This indicator assists in continuing to encourage staff to report all incidents of violence and do not want to discourage staff from reporting by setting a low target. As a result, for accountability purposes we will accept results from 60 and above.	Ministry of Labour, Ministry of Health, patients families and caregivers	1)Continue to monitor RL Solutions incident reporting system that includes the capacity to report violence/harassment in a customized set of appropriate fields in the reporting structure.	Coordinator of Safety and Disability and Director of Health Data will oversee application and identify areas for improvement in the reporting process.	Continuous monitoring and implementation of modifications or improvements to the system as required.	Through 2024-2025.	
											2)Monitor the activation of a screen in Meditech (HIS system) to allow staff registering patients to be aware of those who were flagged as behavioural/aggressive while inpatients at the HDS or at the Niagara Health system.	Review/audit outpatients who should be flagged as behavioural as a result of their inpatient stay to ensure that identification in the system has been completed.	Regular audits completed to identify effectiveness of the process.	Audit results consistently indicating that all relevant patients are correctly flagged in the system.	
											3)Increased reporting of violent patients.	Regular follow up/education with staff to ensure that incidents that have come to the attention of the hospital have been appropriately documented in the IRS.	Audit completed by Safety Coordinator in consultation with clinical management.	All identified violent incidents are appropriately recorded in the IRS.	