Hotel Dieu Shaver
HEALTH AND REHABILITATION CENTRE

Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for the 2015/16 QIP

The Progress Report is a tool that will help organizations make linkages between change ideas and improvement, and gain insight into how their change ideas might be refined in the future. The new Progress Report is mostly automated, so very little data entry is required, freeing up time for reflection and quality improvement activities.

Health Quality Ontario (HQO) will use the updated Progress Reports to share effective change initiatives, spread successful change ideas, and inform robust curriculum for future educational sessions.

ID	Measure/Indicator from 2015/16	Current Performance as stated on QIP2015/16	Target as stated on QIP 2015/16	Current Performance 2016	Comments
1	From NRC Canada: "Would you recommend this hospital (inpatient care) to your friends and family?" (% of those who responded "Definitely Yes" or "Yes, definitely"). Unit: % Population: All patients Progress Period: Oct 2013- Sep 2014 Source: NRC Canada **Tied to executive compensation*	96.90	96.90	98.91	We exceeded last year's aggressive target, and have performed well beyond the provincial 90th percentile of 87% and the HQO Benchmark of 81.8%. We realize that diligent monitoring and attention to every detail is required to maintain this high performance -- with continued focus on soliciting and responding to patient concerns at the front line as quickly as possible and on ensuring that all programs and services are surveyed to ensure that all of our patients have a voice and hold us to the highest standard of care. We are also hopeful that the significant investment in an updated nurse call system has and will continue to have a positive impact on patient satisfaction rates.

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Change Ideas from Last Years QIP (QIP 2015/16)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Focus staff attention on survey results and opportunities for improvement.	Yes	We have worked with survey providers and with our own internal surveys to ensure that they are customized and closely reflect, in a practical and understandable format, the identified experiences and suggestions for improvement as received from our patients and

		caregivers. Survey results are shared with all stakeholders -- staff, physicians, and Board members -- to ensure we are aware of where we need to improve and how our efforts are meeting the needs of the patient. We know that we need to remain diligent and focused in these efforts.
Engage/consult with patients to identify improvement opportunities.	Yes	It is consistently reinforced with front line staff and managers that concerns/issues need to be addressed on the floor as quickly and expeditiously as possible. All front line patient engagement and suggestions must be taken seriously and staff are committed to do so.
Review areas of patient concern as identified in patient surveys and develop remedial action plans (i.e. number of times patients are asked to duplicate information to different members of the patient care team).	Yes	Due to outdated systems, a consistently higher than normal area of concern for patient satisfaction has been response to call bells. In response, the HDS and our Foundation have committed significant funds to the purchase of a state of the art computerized system -- allowing staff to receive calls directly, and permitting the hospital to monitor response times and areas requiring improvement.
Monitor inpatient and outpatient survey format to ensure optimal capture of patient experience and improvement suggestions.	Yes	HDS was involved in a RFP with OHA -- our new NRC Picker survey format will include a number of questions specifically directed at the inpatient rehabilitation population. Outpatient and other program surveys have been developed and results are reviewed with all stakeholders -- all staff, physicians, quality committee and board of trustees. Our goal is to ensure that all of our patients have a voice and hold us to the highest standard of care.

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2	Total Margin (consolidated): % by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expense, excluding the impact of facility amortization, in a given year. Unit: % Population: N/a Progress Period: Q3 2014/15 (cumulative from Apr 2014 to Dec 2014) Source: OHRS, MOH	0.43	0.43	-2.76	Unfortunately, and although all change ideas were implemented, the HDS was unable to meet its target. Challenges included the new funding formula and the removal of mitigation. Quality Based Procedure funding formulas that are most applicable to this facility have not been implemented -- for instance, acute care facilities are funded for QBP's related to stroke -- however, there is no QBP funding for rehabilitation of stroke patients as yet. As a result, the Hospital was not able to recover from the claw back that is associated with the new funding formula. Additionally, revenues associated with out of province and out of country patients were not at the level of previous years.

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Review financial reports on a regular basis, analyze data and initiate interventions as necessary.	Yes	The processes were of value in ensuring that all stakeholders possess current information with respect to financial status and attention is paid to possible intervention strategies. Unfortunately, due to funding considerations, the change idea was not entirely successful and would not have been without a reduction in services.
Maximize LHIN-wide and/or partnered RFP opportunities to reduce buying costs.	Yes	This change idea was maintained from previous years. The LHIN 4 hospitals are currently involved in a back office process involving accounts payable work. It is hoped that this experience will establish the model for further back office integration, at which time savings may be experienced.
Reduce supply costs.	Yes	Consistent and regular attention is paid to potential savings in the bulk buying area. Alternate vendors are canvassed on a regular basis, through informal or formal procurement processes.
Research government payment opportunities such as energy reduction rebates and incentives.	Yes	Ongoing attention is paid to potential rebate opportunities -- in 2015, Finance was successful in securing rebates for our boiler replacement and lights in the outpatient rehabilitation facility. At time of writing, the organization is engaged in a further rebate incentive involving lighting in the inpatient areas.

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3	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1,000. Unit: Rate per 1,000 patient days Population: All patients Progress Period: Jan 2014 - Dec 2014 Source: Publicly Reported, MOH	0.08	0.08	0.09	Although all change ideas were implemented, the HDS marginally failed to meet our target. As noted in our target justification last year, when we identified an acceptable performance corridor of 0.5% or lower, the small size of this facility can result in 1 or 2 CDI cases significantly skewing performance result. Although CDI cases in calendar year 2015 totalled less than five, this resulted in a higher than hoped CDI rate. We continue to aspire to this very aggressive target which well exceeds the 90th percentile for CC/Rehab facilities of .22%.

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Increase awareness and accountability for CDI rates by communicating current rates to the public and all levels of staff.	Yes	Results were posted and otherwise communicated on a regular basis and it was felt that this enhanced reporting assisted in raising staff awareness. Lessons learned would include the possibility of developing a questionnaire, perhaps by unit, to measure staff awareness of their unit rate, as well as the overall hospital rate.
Intensify regular hand hygiene audit and personal protective equipment audit efforts.	Yes	Hand hygiene audits were carefully monitored and completed, as evidenced in last year's enhanced performance of 92.26%
Ensure cleaning practices reflect most current PIDAC guidelines.	Yes	Enhanced PIDAC guidelines were adopted and again, we believe that this measure also contributed to the relatively small number of CDI cases experienced at HDS.
Enhance transparency and accountability for room cleaning.	Yes	The enhanced measures involving publically posting the room cleaning sign-off sheet was adopted and we will continue with this initiative in future.
Monitoring of high risk antibiotics.	Yes	As one of their initiatives, the Antimicrobial Stewardship Committee has monitored high risk antibiotics and is moving towards a process whereby appropriate antibiotic usage will be monitored by the Committee on a regular basis.

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4	Current Ratio: Measure of short term liquidity risk, it is intended to indicated the ability of an organization to meet its current obligations. Higher values indicate greater liquidity and lower values indicate lesser. Unit: % Population: N/a Progress Period: Q3 2014/15 Source: Hospital collected data **Tied to executive compensation*	1.01	1.01	0.87	Although falling somewhat short of the absolute target of 1.01%, the Hospital did end the 3rd quarter within the identified acceptable corridor of between 0.0 and 1.01%. This result was accomplished as a result of careful financial pre-planning over the past number of years.

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Review financial reports on a regular basis, analyze data, and initiate interventions as necessary.	Yes	Financial reports were generated and reviewed by applicable and committees, including the Audit Committee and the Board of Trustees on a monthly basis. The processes were of value in ensuring that all stakeholders were in possession of the most current information and did afford the organization opportunity to attempt to address potential financial issues at early stages.
Maximize LHIN-wide and/or partnered RFP opportunities to reduce buying costs.	Yes	Participation in LHIN-wide RFP processes did allow the organization to canvas a broader base of potential vendors and did result in maximized group purchase savings. As a small organization, the ability to participate in a large scale purchasing base allowed the organization access to vendors who might not have otherwise responded to our request, and at a price that we would not otherwise have been able to obtain.
Reduce supply costs.	Yes	This change idea was adopted, even to the extent that purchases were made at the local dollar store and other cost reduced retail outlets for non patient care supplies.
Research government payment opportunities such as energy reduction rebates and incentives.	Yes	As noted under Total Margin, potential government and other rebate opportunities were carefully canvassed and researched, resulting in successful implementation of a number of rebate initiatives.

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5	Medication reconciliation at admission: The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital. Unit: % Population: All patients Progress Period: Most recent quarter available (Q3 2014/15) Source: Hospital collected data **Tied to executive compensation*	98.72	98.72	100.00	As a result of implementation of all change ideas, and diligent application of the principle of ensuring that med reconciliation is completed within 72 hours of admission, the HDS was able to meet and exceed its target of 98.72.

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Perform audits, analyze data, and initiate interventions as necessary.	Yes	This change idea has been implemented. Very careful consideration is given to data and performance results on a regular basis, with interventions adopted as necessary (i.e. staff education).
Form interprofessional team of pharmacists, nursing staff and physicians to monitor medication reconciliation status.	Yes	The Nursing Pharmacy Council has been formed with representation from Nurse Practitioners, Pharmacy Manager, Nursing leadership and Clinical Educators. This Committee reports to the Pharmacy and Therapeutics Committee, consisting of representation from physicians, nursing and pharmacy. As a result, much attention is given to ensuring the principles of medication reconciliation are followed.

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6	Meet optimal wait times for internal inpatient to outpatient services based on orthopedic wait times. Unit: Days Population: Inpatients waiting for internal outpatient orthopedic services Progress Period: Jan 2014 - Dec 2014 Source: Hospital collected data	7.66	7.50	7.70	The Hospital was effectively successful in meeting the absolute target of 7.5 and the acceptable corridor of 16 days or less. This target is very much dependent on staffing changes and our inability to cover for instance for vacation and sick leave due to funding restrictions. Additionally, other initiatives, such as successful decrease in the in-patient rehab length of stay, results in additional pressure to expedite patient access in the outpatient programs. Our out-patient programs are basically built on a 6 week model. With shorter length of stay on the in-patient side, which we are proud of, the rate at which the patients are being referred exceeds our capacity in out-patient services.

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Review and analyze wait time data on a regular basis.	Yes	All components of the change idea were implemented including a monthly review and analysis by the Manager of Outpatient Rehabilitation and his staff.
Communicate wait time status to all relevant parties on a regular basis.	Yes	A monthly report is forwarded to the Director of Finance and CEO/CFO and a quarterly analysis is forwarded through the various managerial and quality committees, including the Board of Trustees.
Identify and implement interventions as necessary to ensure wait times stay within identified limits.	Yes	This change idea was also implemented. On a monthly basis, access numbers are carefully reviewed and if necessary, interventions are adopted as a result of discussions with the VP of Clinical and other members of the senior team.

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7	Meet optimal wait times for internal to outpatient services based on neurology wait times. Unit: Days Population: Inpatients waiting for internal outpatient neurology services Progress Period: Jan 2014 - Dec 2014 Source: Hospital collected data **Tied to executive compensation*	10.25	10.00	10.88	Although marginally higher than our absolute target of 10.00, the Hospital successfully fell within the acceptable corridor of 16 days or less. Challenges associated with this indicator include staffing and associated funding issues (i.e. no replacement for short term staff absences), an increasingly compressed length of stay in inpatient rehabilitation, which places higher pressure on freeing up outpatient spots as quickly as possible, as well as the variation in total number of patients requiring inpatient and then outpatient neuro services. Our outpatient programs are basically built on a 6 week model. With shorter length of stay on the in-patient side, which we are proud of, the rate at which the patients are being referred can exceed our capacity in out-patient services. The Hospital will continue to monitor this indicator very closely to ensure maximum access to outpatient services.

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Communicate wait time status to all relevant parties on a regular basis.	Yes	A monthly report is forwarded to the Director of Finance and CEO/CFO and a quarterly analysis is forwarded through the various managerial and quality committees, including the Board of Trustees.
Identify and implement interventions as necessary to ensure wait times stay within identified limits.	Yes	Wait time data is analyzed regularly, and at least quarterly, to identify status and any possible issues, allowing for timely intervention as necessary.

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8	Hand hygiene compliance before patient contact: Number of times that hand hygiene was performed before initial patient contact during the reporting period, divided by the number of observed hand hygiene opportunities before initial patient contact per reporting period, multiplied by 100. Unit: % Population: Health providers in the entire facility Progress Period: Jan 2014 – Dec 2014 Source: Publicly Reported, MOH	89.33	90.00	92.26	All change ideas were implemented and last year's very high target and performance results were exceeded. There is a clear indication that staff and patients have an enhanced awareness of the importance of hand hygiene and the best practice measures associated with hand hygiene, resulting in our continuing to improve our results and consistently exceed the HQO benchmark of 87.5%.

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Intensify regular hand hygiene audit and personal protective equipment audit efforts.	Yes	Audits have generally been increased to almost daily with monthly reports. Challenges involve availability of managerial staff given limited number of managerial resources.
Ensure hand hygiene information in patient information booklet reflects best practice guidelines and reinforces staff commitment to cleaning hands before patient care.	Yes	Updated and increased information on hand hygiene best practices have been incorporated into the most recent version of the patient information handbook. It would appear that hand hygiene knowledge and awareness has increased with the patient population.
Provide targeted hand hygiene education to staff.	Yes	Trending by healthcare provider is being conducted and reported quarterly. The results are posted on the patient safety board and all units as well as shared with all committees. The bar graph reports clearly indicate how each occupational group has performed and how they align with organizational targets. Groups that are seen to be lagging are provided with enhanced education by the Manager of Infection Control.
Remove impediments to staff and patient use of hand sanitizer.	Yes	All identified point of care areas have been provided with installed or table top hand sanitizer dispensers. Continued monitoring will take place with renovations etc.

Engage all staff in hand hygiene awareness activities to sustain a unified culture of infection prevention and control.	Yes	Various activities were adopted -- such as a quiz on hand hygiene best practices, a "Did you Know" email on the four moments for hand hygiene, sharing of links for external hand hygiene fun videos and during our safety inspections, we ask staff members to identify one moment for hand hygiene.

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9	Percent of complex continuing care (CCC) residents with a new pressure ulcer in the last three months (stage 2 or higher). Unit: % Population: Complex continuing care residents Progress Period: Q2, 2014/15 (cumulative from Oct 2013 – Sep 2014) Source: CCRS, CIHI (eReports)	3.10	3.00	2.00	Increased audits and education regarding algorithm revision have contributed to a continued decrease in our pressure ulcer numbers, representing a final result of one full percentage point below last year's target. It is clear that the understanding and awareness associated with pressure ulcers -- their prevention, early identification, and treatment-- has increased significantly within the staff and physician population. It is anticipated that even further focus on front line education next year, and our potential ability to purchase our own surfaces, will assist in continuing our successful trend.

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Enhance knowledge uptake and transfer for front-line staff about pressure ulcer performance.	Yes	Audits were conducted with associated postings and communications to committees.
Increase efficiency and utilization of internal therapeutic surfaces.	Yes	Algorithm was revised with education and now incorporates the type of suggested surface. Education was provided to staff along with a trial to ensure that the algorithm was user friendly and the staff were comfortable with the process. We enhanced the chart that outlines our in-house surfaces, including pictures, with a description as to which frame they are compatible with, which had been identified as a challenge for staff.
Improve availability and utilization of therapeutic surfaces.	Yes	Successful trial of alternate surface was conducted and a proposal has been drafted recommending procurement options.
Support early and accurate identification of pressure ulcer risk.	Yes	Discussions and pre-planning did take place during the course of the algorithm revision and input has been sought from the charge nurses. A launch of the education on the completion of the Braden Scale by nursing staff will be completed in 2016.
Enhance staff confidence and comfort-level with identification and calibration of various therapeutic surfaces.	Yes	Investigation of appropriate education materials has been underway. It is intended that a finalized approach to the education process will be completed in 2016.

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10	Percent of residents with urinary tract infection: Number of residents with UTI on their target assessment divided by the number of residents with valid assessments, excluding end-of-life residents. Unit: % Population: Complex continuing care residents Progress Period: Q2, 2014/15 (cumulative from Oct 2013 – Sep 2014) Source: CCRS, CIHI (eReports)	17.60	16.72	15.40	Under the governance and direction of the Antimicrobial Stewardship Committee, and the successful implementation of a number of change ideas involving enhanced education and awareness of the implications of antibiotic and/or catheter use, the UTI incidence within our patient population has been reduced by 12%. There are a number of excellent additional change ideas which will be implemented in 2016 in our efforts to further provide the safest patient care possible.

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Reduce the number of unnecessary urine samples sent.	Yes	A poster has been developed and distributed on the Signs and Symptoms of UTI/Definition of UTI in furtherance of efforts to decrease the number of inappropriate urine samples.
Reduce misdiagnosis and treatment of asymptomatic bacteriuria (ABU) as an UTI and subsequent overuse of antibiotics.	Yes	Discussion has taken place regarding audit and review processes relevant to antibiotic usage on the units. Potential communication to the physicians relating to suggested changes in antibiotic use are also being investigated.
Treat UTI appropriately according to best practice.	Yes	Further work is being conducted on development of a clinical pathway/treatment algorithm with follow up education and evaluation.
Increase awareness and accountability for UTI rates by building Antimicrobial Stewardship Program capacity in day to day practice.	Yes	Antimicrobial Stewardship Program capacity has been built into day to day practice, with an introduction of regular interprofessional team review of patients with potential UTI symptoms, starting with the first floor.
Collaborate in the development of a patient care team driven early catheter removal process.	Yes	The admission form was modified to include information regarding whether the patient is being admitted with a catheter; which now prompts the Catheterization Monitoring Form. The form facilitates a daily assessment of appropriateness of the

catheter and whether it can be removed or not at the earliest opportunity. The form also incorporates best practice guidelines for reduction of trauma and UTI.

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11	Percentage ALC days: Total number of complex care inpatient days designated as ALC, divided by the total number of complex care inpatient days. Unit: % Population: Complex continuing care residents Progress Period: Q3 2013/14 - Q2 2014/15 Source: Hospital collected data	11.28	11.00	10.77	Despite challenges associated with this indicator, specific to availability of CCAC resources and waiting periods for patients' LTC selections, the HDS successfully met and exceeded our target of 11 percent. Significant time and diligent attention is given to monitoring the ALC status and pursuing interventions (within the scope of our control) as necessary.

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Communicate discharge planning statistics for patients with more complex discharge needs.	Yes	This change idea was implemented. A weekly report, as per LHIN protocol, is generated and communicated to senior team members and the LHIN. A quarterly report is generated and shared with the senior team, MAC, quality committee of the board and the Board of Trustees.
Continued application of process for escalation of complex cases.	Yes	The process of escalation is followed on a regular basis in a timely manner, ensuring that complex discharge cases are addressed as quickly as possible.
Participation in LHIN-wide Patient Flow Teleconferences along with CCAC and other LHIN Hospitals to identify and resolve barriers to early discharge.	Yes	The HDS Assessment nurse participates in daily regional patient flow teleconferences; the Chief Nursing Officer participates in the monthly patient flow meetings with the HNHB LHIN and the monthly Home First Refresh Advisory Committee teleconferences. There are also weekly team meetings within the HDS, the interprofessional team discusses discharge dates with the patient within 48 hours of admission, and a daily interprofessional patient flow meeting takes place.
Review discharge planning model every day to identify special patient needs and address issues associated with timely discharge.	Yes	In the context of the several patient flow meetings that are conducted, as well as the day to day work of the discharge planners, the discharge planning model is continuously reviewed.