Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for the 2016/17 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 2016/17	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
1	"Would you recommend this hospital (inpatient care) to your friends and family?" Unit: % Population: All inpatients Progress Period: TBD Source: CIHI Canadian Patient Experiences Survey	CB	CB	CB	We are collecting baseline for the 2016 2017 year as a new Patient Experience survey through NRCC was provided. The survey included a number of questions specifically directed at the inpatient rehabilitation population. Diligent monitoring of results continues to ensure that our patient voice is being heard. Prior to implementation of the new survey tool and subsequently, as results have been received, we have expressed concerns with the new tool for use in a Rehab and Complex Care patient population. There are questions that refer to the patient's Emergency Department(ED) stay and transfer from, that have been answered by many of the patients. Our patients never come directly from the ED, but rather from the inpatient floor of an Acute hospital which leads us to wonder which facility the patient is actually referring to in their responses to the survey. The rehab specific questions about information sharing, discharge transition planning, respect and dignity, etc. do not contribute to the corresponding overall dimension scores again raising the question as to which facility the patient was referring to in their responses.

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Change Ideas from Last Years QIP (QIP 2016/17)	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?
Introduction of patient flow computer system (OCULYS) to assist in early transfer to appropriate service within the facility.	Yes	Work continues on the OCULYS patient flow computer system implementation. Extensive work has been done to ensure all required information is readily available, easy to access for users to assist in timely admission of patients. Diligent monitoring continues moving into the next phase of implementation which includes front line staff in admitting/bed booking. Future phases will allow "cueing" suitable patients from the acute site to optimally flow into an appropriate rehab bed. (ie # of post orthopaedic surgery or stroke). Innovation is highlighted through this joint initiative as Hotel Dieu Shaver and Niagara Health are the first two separate entity organizations in the province of Ontario that are integrated by a Patient Flow technology that allows us to progress to a “pull” referral system in comparison to a “push” referral model.
Implementation of new computerized nurse call system with ability to track number of nurse calls and associated response times.	Yes	Implementation of the computerized call system was completed and has allowed staff to respond to calls faster and more efficiently. The software affords the ability for the Managers to track the calls by unit, date, by room and by time at any point. The reports are reviewed with staff to seek opportunities for improvement in response times.
Ongoing monitoring of effectiveness of the POD model in maximizing patient outcomes and reducing length of stay.	Yes	Quarterly POD indicators are reviewed and reported though out all levels of the organization. The overall average length of stay for patients in the POD model was reduced by days, while also increasing the rehab FIM efficiency, which indicates that the patients received more effective rehab care in a shorter timeframe. The POD model is being reviewed for further roll-out throughout the hospital.
Full implementation of updated scheduling software with dual display monitors on each nursing unit and therapy area to allow at a glance awareness of next appointment and therapy location, thereby facilitating better patient flow and higher patient investment and understanding of their rehabilitation care plan.	Yes	The scheduling software was successfully updated and hardware installed on each rehab nursing unit. The information can also be viewed on hospital PC's for ease of use with the therapy staff. On admission both patients and their families are familiarized with the schedule and display monitors to have them invested in their therapy plan. The screens allow for quick reference of where the patient is to be for the present day and at what time, while maintaining patient confidentiality.
A suggestion from one of the Patient Advisors included the addition of a "schedule pocket" that could be safely applied to a patient's wheelchair making it easy to access by the patient to encourage higher patient investment and timeliness in getting to therapy appointments.	Yes	This was a very cost effective, and simple to implement solution that enhanced the participation of patients in their therapy plan. The solution allowed access to information for the patient's that were unable to reach the carrying pocket located on the backs of their wheelchairs and was very well received by patients, their families and their caregivers.

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2	% of active stroke rehab patients (RPG) where the actual active rehab length of stay matches or is less than the expected active rehab length of stay for Stroke Rehab patients as per the Quality Based Procedures Clinical Handbook for Stroke. Unit: % Population: Active Rehab Stroke Patients Progress Period: Q3 2014/15 – Q2 2015/16 Source: Hospital collected data **Tied to executive compensation*	55.00	61.00	83.68	This was the first year for this indicator so had targeted a 10% increase from our previous numbers and was able to achieve a 52% improvement. A Rehab Service Delivery Model known as the "POD Model" was implemented in 2015/16 year and was further refined in the current year which has significantly improved patient outcomes and aligns with clinical best practices and Ontario's Patients First Action Plan.

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Review and Analyze Stroke Length of Stay Data on a regular basis, with interventions initiated as necessary.	Yes	Regular review and extensive analysis of the results from the Ontario Stroke Network are ongoing each quarter. The information is presented throughout the organization including the senior team and all staff. The analysis of information includes the Rehab Intensity which has improved from 0.9 to 1.25 while reducing the average length of stay by 10 days.
Provide staff education on Stroke Length of Stay Targets.	Yes	Promotion of the importance of timely completion of the admission FIM is ongoing and ongoing education on the LOS assignment per RPG was provided prior to implementation.
Monitor each patient's LOS targets.	Yes	Prior to admission referrals are reviewed to ensure that a patient is suitable for active rehab. Within 72 hours of admission the FIM scoring must be completed for active rehab patients in order to apply the appropriate RPG and resulting length of stay. Weekly multi-disciplinary team conferences are held to review and update as required the therapy plans for each patient to achieve their optimal length of stay.
Review and benchmark internal LOS results with comparator organizations.	Yes	Quarterly reporting to the Ontario Stroke Network report card is reviewed for like facilities in both our LHIN and the Waterloo-Wellington LHIN.

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3	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI during the reporting period, divided by the number of patient days in the reporting period, multiplied by 1,000. Unit: Rate per 1,000 patient days Population: All patients Progress Period: Jan 2015 - Dec 2015 Source: Publicly Reported, MOH	X	0.08	0.08	We had again identified the goal of meeting .08 recognizing the challenges that our environment presents (few private rooms). One case can dramatically affect the result due to our small size. With the reinforcement to staff of PIDAC guidelines and heightened surveillance for early identification, we have been able to meet the aggressive target of .08

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Increase awareness and accountability for CDI rates to the public and all levels of staff.	Yes	Regular and consistent posting of results to all levels of staff and the public on the Patient Safety Board and on each unit. (quarterly)posting of the room cleaning sign-off sheet continued to increase awareness. The staff was encouraged to continuously review the policy and informal education occurs on an ongoing basis. Mandatory reporting to the Ministry and on our hospital website occurs monthly.
Enhanced awareness campaign to better educate staff and physicians on CDI prevalence for the unit and the Hospital, and where to find this information.	Yes	The enhanced PIDAC guidelines continued to be reinforced with staff and physicians, promoting earlier identification. When a case is identified, Pharmacy is made aware to enable medication review, the daily bed meeting and Patient flow teams are notified, a FACT sheet on CDI is provided to the patient and family, Housekeeping is notified to update the room cleaning to twice daily.
Monitor staff and physician awareness of CDI rates and their knowledge of where to find associated information.	Yes	While performing hand hygiene audits, the auditor also asks questions of staff regarding their awareness of current CDI rates and where CDI information is posted at the same time as the hand hygiene audits are performed.
Update policies to better reflect adapted best practices associated with isolation requirements and room exiting for therapy attendance by CDI patients.	Yes	Policies reflect the most current PIDAC guidelines and education was provided to the staff to increase awareness of the importance of attending therapy. Each patient is reviewed on a case by case basis in our patient centred care model.

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4	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: Rate per total number of admitted patients Population: Hospital admitted patients Progress Period: Most recent quarter available Source: Hospital collected data **Tied to executive compensation*	100.00	100.00	100.00	Continued diligence in the medication reconciliation process implemented has resulted in HDS maintaining the 100% completion target.

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Perform audits, analyze data, and initiate interventions as necessary.	Yes	Audits are completed monthly and data is analyzed. As a result of data analysis and most efficient use of our limited resources, the process was streamlined to have the Pharmacist's roll enhanced in the medication reconciliation process.
Continue meetings of Nursing Pharmacy Council as part of the Hospital's Quality Improvement and Patient Safety programs.	Yes	The monthly council meetings continue with inter-professional review of the current auditing process, to problem solve and to enhance the medication reconciliation process. The council also promotes adherence to the current policy to enhance the quality of the med rec process.

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5	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 1, 2015 - Dec 31, 2015 Source: Hospital collected data	10.88	10.88	8.92	Regular review of wait time data is used to support the analysis of inpatient volumes that experience uncontrollable fluctuations. This process assisted the Hospital in exceeding the target for this indicator. Challenges continue with the indicator as the length of stay for inpatient rehabilitation decreases. The optimum target for wait time from inpatient to outpatient services can vary dramatically amongst individual patients. The clinical team works with each patient and family to take into consideration the adjustments and arrangements that need to occur before moving into the outpatient phase of their treatment.

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Include consideration of potential impact on in to outpatient waiting times when considering any organizational initiative affecting the outpatient programs, including staffing assignments and re-alignments.	Yes	Challenges that impact this indicator include staffing and associated funding issues. The potential for surge is always present due to the fluctuating volumes and the compressed length of stay for inpatients. A surge plan to support a significant increase in wait times was developed in the event it had to be implemented.
Review and analyze wait time data on a regular basis.	Yes	At minimum there is a monthly review of wait times for the In to Outpatient referrals, as well as ongoing monitoring of the Inpatient numbers to be prepared for surges that will impact the outpatient referrals.
Communicate wait time status to all relevant parties on a regular basis.	Yes	A monthly report continues to be forwarded to the Director of Finance and CEO/CFO and quarterly report is provided to managerial and quality committees, including the Board of Trustees.
Identify and implement interventions as necessary to ensure wait times stay within identified limits.	Yes	Regular analysis of the wait time data, in-patient volumes, impact of seasonal program shut-downs allows for timely intervention to avoid negative impacts on the wait time. A model for a finite period of time to add a session to address fluctuations has been developed.

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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 1, 2015 - Dec 31, 2015 Source: Hospital collected data	7.70	7.70	6.65	Regular review of wait time data is used to support the analysis of inpatient volumes that experience uncontrollable fluctuations. This process assisted the Hospital in exceeding the target for this indicator. Challenges continue with the indicator as the length of stay for inpatient rehabilitation decreases. The optimum target for wait time from inpatient to outpatient services can vary dramatically amongst individual patients. The clinical team works with each patient and family to take into consideration the adjustments and arrangements that need to occur before moving into the outpatient phase of their treatment.

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7	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 2015 – Dec 2015 Source: Publicly Reported, MOH	92.26	92.30	94.78	A stretch target to improve our already high performance was set. We were able to achieve and exceed the target with the completion of regular hand hygiene and personal protective equipment audits. A main focus this year was to educate the patients and families and promote their role in hand hygiene in the reduction and prevention of transmission of infection.

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Adopt patient awareness campaign whereby patients are encouraged to ask their healthcare provider if they have washed their hands before patient contact.	Yes	In May a campaign was rolled out to patients and families that was well received and continues. By encouraging patients and families to ask their healthcare providers if they washed their hands also stressed the importance of regular and diligent hand hygiene for themselves as they moved throughout the facility. The Patient and Family Handbook was also updated to include best practices guidelines.
Enhanced awareness campaign to better educate staff and physicians on hand hygiene compliance within their occupational group and the Hospital as a whole, and where to find this information.	Yes	All results are posted on the patient safety board in bar graph format providing an easy visual to both staff and public. The Manager of Infection Control monitors results and provides enhanced education to any groups as necessary. The information is also posted on each nursing unit.
Increase knowledge of hand hygiene compliance rates throughout the Hospital.	Yes	Trending by healthcare provider is conducted and results are clearly posted on the patient safety board. The "clean your hands" and "Did you Know" campaigns are promoted facility-wide to all staff. During the monthly departmental safety inspection staff are asked to identify one moment of hand hygiene from the four they are educated on.

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8	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, 2015/16 Source: CIHI CCRS	15.40	14.70	14.70	The team was challenged with a target that reflected a 5% improvement over the previous year which they were able to achieve. The successful implementation of additional change ideas to the previous year's education and awareness has helped to meet the target again this year. There were a number of initiatives that were finalized including a "Catheterization monitoring form" that is nurse driven. This determines the appropriateness for the catheter and a process for catheter removal, when appropriate upon physician order, or to monitor daily and obtain an order when appropriate to remove. There is a clinical/treatment algorithm for UTI's to support clinical decision making. The ongoing practice is in keeping with the Antimicrobial Stewardship Program.

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Reduce the number of unnecessary urine samples sent.	Yes	A poster was developed and continuing education to staff has further decreased the number of unnecessary urine samples proven by regular audits. A series of FACTS and FAQ's on antimicrobial stewardship and "Asymptomatic bacteremia - Why don't you treat?" has been presented to staff throughout the facility with regular reminders monthly.
Reduce misdiagnosis and treatment of asymptomatic bacteriuria (ABU) as a UTI and subsequent overuse of antibiotics.	Yes	RN's and RPN's have been educated on providing the physician with the clinical presentation of a patient, including the Culture & Sensitivity results. Physicians have reviewed changes in antibiotic use with regular audits on the review of antimicrobials for UTI.
Treat UTI appropriately according to best practice.	Yes	Treatment follows best practice. The use of antibiotics has been reduced and ongoing auditing occurs. The UTI clinical pathway /treatment was developed and education to staff is ongoing. A self-learning package was developed and available for staff on best practice for catheter care, including catheter monitoring and early removal.

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9	Percentage of patients receiving complex continuing care with a newly occurring Stage 2 or higher pressure ulcer in the last three months. Unit: % Population: Complex continuing care patients Progress Period: July – Sept 2015 (Q2 FY 2015/16 report) Source: CIHI CCRS	X	1.95	X	The target of 1.95% exceeded the provincial average of 2.2% This target is difficult to maintain given our small patient population. One or two cases that are outliers in the length of stay for our facility that are included in the rolling four quarters can significantly impact results, as evidenced this year current year.

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Continue with process to potentially procure internal surfaces as opposed to rentals, to both ensure that the appropriate surface is available in a more timely manner and to reduce cost associated with rentals.	Yes	Pressure reduction surfaces have been purchased to provide timely availability for patients identified as being at high risk for pressure ulcer development. Rental costs have been reduced significantly with this initiative.
Support early and accurate identification of pressure ulcer risk.	Yes	Completion of the Braden Scale is done for every patient admitted. Ongoing education on the completion of the Braden Scale is provided to all nursing staff and compliance audits are completed bi-annually showing positive results.
Enhance staff confidence and comfort level with identification and calibration of various therapeutic surfaces.	Yes	A chart was developed that has actual pictures of both owned and rental surfaces. They identify purpose, and the most suitable mattress for each type of bed frame.
Assist staff in their identification of pressure ulcer and skin tear identification for quick intervention, accurate documentation, and appropriate treatment.	Yes	Resourcing of appropriate education materials is ongoing to support the education process. An audit of Complex Care Reporting system data captured for cases with recorded ulcers helped to identify areas to incorporate into the education, including pressure versus stasis ulcers. A chart was developed for the pressure ulcers and skin tears including how to treat the pressure ulcer (quick reference material) with education provided.

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10	Total number of ALC inpatient days contributed by ALC patients within the specific reporting period (open, discharged and discontinued cases), divided by the total number of patient days for open, discharged and discontinued cases (Bed Census Summary) in the same period. Unit: % Population: All inpatients (Rehab and CCC) Progress Period: Q2 2015/16 Source: Hospital collected data	6.40	6.00	5.82	We were able to exceed the aggressive target of 6.00, however this indicator is very dependent on the availability of CCAC resources and the bed pressures of our partner acute care hospitals, as well as the availability of suitable discharge destinations for an ever increasing complex patient population. Diligent attention is given during the course of a patient's stay from time of admission to develop a workable discharge plan with increasing challenges to find destinations that are able to accommodate our patient's physical limitations in a setting that they can afford.

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Communicate discharge planning statistics for patients with more complex discharge needs.	Yes	This change was implemented in the previous year and continues with a weekly report, as per LHIN protocol. The information is also communicated to the senior team and a quarterly report is shared with the senior team, MAC, quality committee of the board and the Board of Trustees.
Establishment of a process for challenging discharges. Where length of stay may be longer than anticipated, representatives from the interprofessional clinical team request to attend patient flow meetings to present their recommended interventions that may assist in facilitating safe and timely discharge.	Yes	A process that includes notification and subsequent presentation to the daily Patient Flow Team has increased the accountability of the entire team from the inter-professional clinical team up to the VP level to ensure every opportunity is reviewed in the facilitation of safe discharge to the most appropriate setting.
Continued application of process for escalation of complex cases.	Yes	Work was done in partnership with CCAC to enhance the Home First process through the use of Transitional Beds, whenever possible. When this is not possible, a timely process to approve "Crisis status" from hospital has

		been used. The wait time for Behavioural Beds presents the greatest challenge, closely followed by the availability of affordable beds for patients with limited physical mobility.
Participation in LHIN-wide Patient Flow teleconferences along with CCAC and other LHIN Hospitals to identify and resolve barriers to early discharge.	Yes	Participation in daily regional patient flow teleconferences and monthly HNHB LHIN patient flow meetings and Home First Refresh Advisory Committee teleconferences has assisted in identifying the various challenges faced by the partner hospitals in our LHIN. Discrepancies in availability of services from one region to another have been identified.
A joint review process between the hospital and CCAC.	Yes	Bi-monthly meetings were set up to review all patients on the medically complex units to get early discharge plans in place for the cases that are recognized as having a challenging discharge plan. The early recognition of these patients provides opportunity to begin early work in the hopes of meeting their targeted discharge date.