2016/17 Quality Improvement Plan
"Improvement Targets and Initiatives"

Hotel Dieu Shaver
HEALTH AND REHABILITATION CENTRE

Hotel Dieu Shaver Health and Rehabilitation Centre 541 Glenridge Avenue

AIM		Measure							Change				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
Effective	**Reduce length of stay in rehabilitation for stroke inpatients**	% 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.	% / Active Stroke Rehab Patients	Hospital collected data / Q3 2014/15 - Q2 2015/16	790*	55.00	61.00	This is the first year for this indicator and our performance currently exceeds the HNHB LHIN performance for 2013/14 of 45.50 and the provincial average of 53.20. As a result, we have targeted a 10% improvement in our first year, but for accountability purposes, we will accept values between 55-61%.	1)Review and Analyze Stroke Length of Stay Data on a regular basis, with interventions initiated as necessary.	Manager of Inpatient Rehab, Director of Rehab and VP of Clinical Services to review and analyze data, and identify interventions as necessary.	# of reviews and analyses conducted and/or interventions initiated.	Minimum of 1 review and analysis per quarter.	*Executive Compensation.
									2)Provide staff education on Stroke Length of Stay Targets.	Management team to develop and conduct staff education sessions based on most current information regarding Stroke LOS targets.	# of education sessions conducted.	Minimum of one education session per year.	
									3)Monitor each patient's LOS targets.	POD clinical staff to review and monitor each patient's length of stay targets, and request attendance at Patient Flow Meeting if it appears that the target may not be met.	# of patient flow meeting interventions requested.	Reduction in number of patient flow meeting interventions requested.	
									4)Review and benchmark internal LOS results with comparator organizations.	Clinical management to conduct regular reviews of internal LOS data as compared to results obtained by external comparators.	# of reviews conducted.	One review per quarter.	
Efficient	**Reduce unnecessary time spent in complex care**	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. Hospital collected data Q2 2015/16	% / All inpatients (Rehab and CCC)	Hospital collected data / Q2 2015/16	790*	6.40	6.00	Goal well exceeds the September 2015 LHIN average of 13.49 and provincial average of 13.8, as well as the provincial and LHIN identified target of 12.7. Given our unusually high performance, and the high reliance on external factors for success (CCAC resources; patients' LTC selection), for accountability purposes, we will accept values between 6 to 10.	1)Communicate discharge planning statistics for patients with more complex discharge needs.	Decision Support and Social Work/Case management to produce and communicate ALC statistics and discharge planning results to applicable Senior Team members, Quality Committee and Board of Trustees.	# of reports to applicable Senior Team members, Quality Committee, and Board of Trustees.	1 report weekly to applicable Senior Team members and 1 report quarterly to Quality Committee and Board of Trustees	
									2)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.	Establishment of process and education of interprofessional team to assist them in focusing on the value of safe and timely discharge and how they are vital in that process.	Number of interprofessional team requests for attendance at patient flow meetings for the purpose of presenting their recommendations.	Minimum of once per week request from interprofessional team.	
									3)Continued application of process for escalation of complex cases.	Case management and clinical managers to ensure process of escalation is followed as necessary and in a timely manner.	# of cases referred for escalation or resolved without escalation.	Decreased number of escalated cases per month.	
									4)Participation in LHIN-wide Patient Flow teleconferences along with CCAC and other LHIN Hospitals to identify and resolve barriers to early discharge.	Vice President of Clinical Services and/or Director of Nursing or designate to participate in teleconferences.	# of teleconferences participated in.	Participation in at least 1 teleconference every second week.	

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Patient-centred	**Improve patient satisfaction**	"Would you recommend this hospital (inpatient care) to your friends and family?"	% / All inpatients	CIHI Canadian Patient Experiences Survey / TBD	790*	CB	CB		1)Introduction of patient flow computer system (OCULYS) to assist in early transfer to appropriate service within the facility.	Stage 1 introduced. Stage 2 to be implemented.	Implementation of Stage 2 (allowing HDSHRC to identify prospective patients currently admitted at acute facilities well in advance), thereby allowing maximization of care plan preparation.	Implementation of Stage 2.	The Hotel Dieu Shaver is moving towards use of a new patient satisfaction survey tool and will be collecting baseline data during the 2016/2017 year.
									2)Implementation of new computerized nurse call system with ability to track number of nurse calls and associated response times.	Director of Nursing and Chief Nursing Officer to track data; post data monthly; and identify interventions as necessary.	# of calls and response times tracked and posted; as well as interventions adopted.	Tracking completed monthly with interventions adopted as necessary.	
									3)Ongoing monitoring of effectiveness of the POD model in maximizing patient outcomes and reducing length of stay.	Vice President of Clinical Services and Director of Rehab to review and analyze data on a regular basis with respect to outcomes and length of stay data.	# of reviews and analyses completed.	One (1) review and analysis per quarter.	
									4)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.	Review and tracking of implementation process and monitors and interventions as necessary.	Complete implementation of software and monitors; # of necessary and successful interventions.	100% successful implementation of software and monitors.	
Safe	**Increase proportion of patients receiving medication reconciliation upon admission**	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	% / All patients	Hospital collected data / most recent quarter available	790*	100.00	100.00	Current performance is as high as possible. Measurement is based on med reconciliation being completed within 72 hours of admission. Maintenance at this level can be difficult given variables that are not necessarily within Hospital control -- i.e. unexpected staffing absences. Resultantly, for accountability purposes, we will accept values between 95-100% (theoretical best).	1)Perform audits, analyze data, and initiate interventions as necessary.	Manager of Pharmacy to continue to perform audits and communicate results to his Director, Department Managers, Nursing Pharmacy Council, pharmacy staff, Senior Team, MAC, Quality Committee and Board of Trustees.	# of audits performed; # of reports to Department Managers, Nursing Pharmacy Council, pharmacy staff, Senior Team, MAC, Quality Committee and Board of Trustees.	1 audit performed monthly; 1 report monthly to Nursing Pharmacy Council and pharmacy staff; 1 report quarterly to Department Managers, Senior Team, MAC, Quality Committee and Board of Trustees.	*Executive Compensation.
									2)Continue meetings of Nursing Pharmacy Council as part of the Hospital's Quality Improvement and Patient Safety programs.	Interprofessional team of Pharmacy Manager, VP Clinical, Rehab and Nursing leadership, nurse practitioners, front line pharmacy and nursing staff to meet to collect and review information to identify success and issues related to quality and efficiency of medication practices, develop and evaluate effectiveness of improvement strategies, and recommend/implement interventions as necessary.	# of meetings and evaluations or interventions conducted.	Targeted minimum of one meeting per month.	

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	Reduce hospital acquired infection rates	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.	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / January 2015 – December 2015	790*	0.09	0.08	We have again identified the goal of meeting .08 in the hope that we will be able to achieve that result this year. This is a very aggressive target given our current environment (older building with few private rooms) and our size -- as noted, and as occurred, one case can dramatically affect result. This target is well below the 90th percentile of 0.22 for CC and Rehab facilities. Therefore, for accountability purposes we will accept a value of 0.3% or lower, plus or minus random variation.	1)Increase awareness and accountability for CDI rates to the public and all levels of staff.	Manager of Infection Control to continue to post CDI rates on patient safety boards and website and report results to hospital committees. Additionally, the Manager will display unit specific rates on the unit, so that staff will clearly understand the number of cases, if any, that are occurring in their specific unit, in addition to being made aware of the overall Hospital experience.	# of postings of CDI rates on patient safety boards, within the nursing stations, including postings of breakdowns by individual units. # of reports on results to Infection Prevention Committee, Senior Team, MAC, Quality Committee, and Board of Trustees.	1 posting quarterly on the safety boards and within the units; 1 report to Infection Prevention Committee every 2 months; 1 report to Senior Team, MAC, Quality Committee, and Board of Trustees quarterly.	
									2)Enhanced awareness campaign to better educate staff and physicians on CDI prevalence for the unit and the Hospital, and where to find this information.	Use of "Did you know" staff information emails to provide rates based on hospital and unit averages, as well as where information is regularly posted.	# of Did you Know emails circulated.	Once per quarter; once updated data is available.	
									3)Monitor staff and physician awareness of CDI rates and their knowledge of where to find associated information.	Questions will be asked of staff and physicians during hand hygiene audits, rounds and education sessions.	Percentage of staff and physicians canvassed who are aware of CDI rates and/or location of where to find the information.	A minimum of 50% of staff and physicians who are able to successfully identify current rates and/or location of information.	
									4)Update policies to better reflect adapted best practices associated with isolation requirements and room exiting for therapy attendance by CDI patients.	Policy will be modified to reflect best practice accordingly; guideline sheet with checklist to be developed to assist staff and patients in safe exiting processes, and associated education and evaluation follow up to take place.	Completion of modified policy; development of guideline sheet and checklist; number of staff educated and number of staff with whom follow up evaluation process takes place.	The policy will be updated; checklist developed; all nursing and inter-professional staff to be educated before the end of the fiscal year.	
		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.	% / Health providers in the entire facility	Publicly Reported, MOH / Jan 2015 - Dec 2015	790*	92.26	92.30	Stretch target to improve on our high performance, which already well exceeds the provincial average of 87.51 (HQO, Apr 2014-March 2015). At this high end of the spectrum, any further percentage increase is very difficult to obtain. For accountability purposes, we will accept a value of 87.5 to 100%.	1)Adopt patient awareness campaign whereby patients are encouraged to ask their healthcare provider if they have washed their hands before patient contact.	Engage in information sessions with all healthcare provider groups and identify a process for canvassing of healthcare providers by patients, formally through committees and staff meetings, and informally through education materials.	Completion of information sessions and distribution of education materials to all affected health care provider groups.	To further raise awareness of the importance of hand hygiene for patient and staff safety; and to raise accountability.	*Executive Compensation.
									2)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.	Questions will be asked of staff and physicians during hand hygiene audits, rounds and education sessions.	Percentage of staff and physicians canvassed who are aware of hand hygiene compliance rates within their occupational group and the Hospital, and/or where to locate this information.	A minimum of 50% of staff and physicians who are able to successfully identify current compliance rates and/or location of relevant information.	
									3)Increase knowledge of hand hygiene compliance rates throughout the Hospital.	Expand posting of information relevant to occupational group and hospital hand hygiene compliance rates to ensure maximum number of staff and physicians are aware.	Number of additional areas where postings are introduced -- i.e. physicians' lounge, environmental services laundry room, therapy rooms, etc.	Meet with managers and expand number of posting areas beyond current locations.	

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		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.	% / Complex continuing care residents	CCRS, CIHI (eReports) / Q2 2015/16	790*	15.40	14.70	This is only the second year for this indicator. Current performance of 15.4 represents a 12% decrease from the year prior, being a very significant decline. This year's aggressive target of 14.7 further challenges the clinical team to improve performance by an additional 5%.	1)Reduce the number of unnecessary urine samples sent.	Engage in further enhancement and implementation of the "Only Send If" campaign by developing a decision tree form and engage in both formal and informal staff education.	Development of the form and implementation of education.	100% of nursing staff to receive the decision tree form and associated education.	
									2)Reduce misdiagnosis and treatment of asymptomatic bacteriuria (ABU)as a UTI and subsequent overuse of antibiotics.	Develop and implement use of standard UTI vs ABU diagnostic criteria, educate staff, and develop and trial a prospective audit and review process.	Diagnostic criteria implemented and in use; % of staff who have completed education; prospective audit and review process in place.	Diagnostic criteria implemented and in use by the end of December 2016; and 100% of affected staff and physicians educated.	
									3)Treat UTI appropriately according to best practice.	Create a clinical pathway/treatment algorithm to be incorporated into a decision tree form with staff education on its use.	Clinical pathway/treatment algorithm incorporated into decision tree form; % of staff who have completed education.	Clinical pathway/treating algorithm incorporated into decision tree form by the end of 2016. 100% of staff educated on decision tree form.	
	Reduce incidence of new pressure ulcers	Percent of complex continuing care (CCC) residents with a new pressure ulcer in the last three months (stage 2 or higher).	% / Complex continuing care residents	CCRS, CIHI (eReports) / July – Sept 2015 (Q2 FY 2015/16 report)	790*	2.00	1.95	Goal exceeds provincial average of 2.2%. This target is difficult to maintain given our small patient pool and our referral sources; one or two cases can significantly skew results. For accountability purposes, we will accept values between 0-5%.	1)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.	Finalize proposal approval through the appropriate channels.	Approval of the internal procurement process and receipt of the surfaces.	To facilitate timely availability of appropriate surfaces for our patients and cost reductions.	
									2)Support early and accurate identification of pressure ulcer risk.	Finalize targeted re-education package and conduct training on Braden Scale Score calculation, starting with 2 West nursing staff.	% of nursing staff on 2 West who have completed the education.	100% of nursing staff on 2 West complete the education by the end of 2016.	
									3)Enhance staff confidence and comfort level with identification and calibration of various therapeutic surfaces.	Provide comprehensive training to nursing staff on set up and calibration of ROHO sections, including an online video for ongoing review.	% of nursing staff who have completed education.	100% of nursing staff completed education by the end of December 2016.	
									4)Assist staff in their identification of pressure ulcer and skin tear identification for quick intervention, accurate documentation, and appropriate treatment.	Develop quick reference sheets on pressure ulcer staging and the treatment of specific types of pressure ulcers; with the same exercise to be completed on skin tears.	# of reference sheets developed and distributed to each unit; # of staff educated on the reference sheets; # of follow up meetings conducted for evaluation purposes.	100% of nursing staff to be exposed to reference sheets to assist them in early and accurate identification and documentation of pressure ulcer staging.	

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Timely	**Meet optimal wait times based on offered access for internal inpatient to outpatient neurology services**	Meet optimal wait times for internal inpatient to outpatient services based on neurology wait times	Days / Inpatients waiting for internal outpatient neurology services	Hospital collected data / Jan 1, 2015 - Dec 31, 2015	790*	10.88	10.88	This is an aggressive Hospital target to at least maintain the current level of access, dependent on: staffing, volume of neurological events, decreased length of stay in in-patient services resulting in dramatically increased pressures on outpatient access, and, in future, volume of acute care inpatients waiting for our outpatient rehab services. For accountability purposes, we will accept values of 16 days or less.	1)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.	Ensure that special and appropriate consideration is given to impact on outpatient wait times -- including financial and human resource decisions that require input from clinical staff as to potential impact on wait times.	# of decision reviews that formally incorporate consideration of impact on in to outpatient wait times.	100% of organizational decisions that have the potential of impacting in to outpatient wait times to be considered in that context	
									2)Review and analyze wait time data on a regular basis.	Director of Rehabilitation to review and analyze data.	# of reviews conducted; # of analyses completed.	At least 1 review and analysis conducted monthly.	
									3)Communicate wait time status to all relevant parties on a regular basis.	Wait time status to be communicated by Rehab leadership to staff teams, VP of Clinical Services and other clinical managers, Senior Team, Quality Committee and Board of Trustees.	# of status reports provided.	At least 1 status report to be communicated to staff teams, VP of Clinical Services, and other clinical managers monthly or more often if irregularities identified; to Senior Team, Quality Committee and Board of Trustees quarterly.	
									4)Identify and implement interventions as necessary to ensure wait times stay within identified limits.	Further to discussions amongst the team, identify, seek approval for, and implement interventions.	# of identified and implemented interventions, as required and as feasible.	# of assessments as to whether an identified need exists and implementation of interventions monthly.	
	Meet optimal wait times based on offered access for internal inpatient to outpatient orthopedic services	Meet optimal wait times for internal inpatient to outpatient services based on orthopedic wait times	Days / Inpatients waiting for internal outpatient orthopedic services	Hospital collected data / January 1, 2015 - December 31, 2015	790*	7.70	7.70	This is an aggressive Hospital target to at least maintain the current level of access, dependent on: staffing, volume of neurological events, decreased length of stay in in-patient services resulting in dramatically increased pressures on outpatient access, and, in future, volume of acute care inpatients waiting for our outpatient rehab services. Therefore, for accountability purposes, we will accept values of 14 days or less.	1)Include consideration of potential impact on in to outpatient wait times when considering any organizational initiative affecting the outpatient programs, including staffing assignments and re-alignments.	Ensure that special and appropriate conside4ration is given to impact on outpatient wait times- including when dealing with financial and human resource decision that may require input from clinical staff as to potential impact on wait times.	# of decision reviews that formally incorporate consideration of impact on in to outpatient wait times as a criterion.	100% of organizational decisions that have the potential of impacting in to outpatient wait times to be considered in that context.	
									2)Review and analyze wait time data on a regular basis.	Rehabilitation management to review and analyze data.	# of reviews conducted; # of analyses completed.	At least 1 review and analysis conducted monthly.	
									3)Communicate wait time status to all relevant parties on a regular basis.	Wait time status to be communicated by Rehab leadership to staff teams, VP of Clinical Services, and other clinical managers, Senior Team, Quality Committee and Board of Trustees.	# of status reports provided.	At least 1 status report to be communicated to staff teams, VP of Clinical Services, and other clinical managers monthly or more often if irregularities identified. To Senior Team, Quality Committee and Board of Trustees quarterly.	
									4)Identify and implement interventions as necessary to ensure wait times stay within identified limits.	Further to discussions amongst the team, identify, seek approval for, and implement interventions.	# of identified and implemented interventions, as required and as feasible.	# of assessments as to whether an identified need exists and implementation of interventions monthly.	