2017/18 Quality Improvement Plan
"Improvement Targets and Initiatives"

Hotel Dieu Shaver HEALTH AND REHABILITATION CENTRE

Religious Hospitallers Of St. Joseph Of Hotel Dieu 541 Glenridge Avenue

AIM		Measure							Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Effective	Effective transitions	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?	% / Survey respondents	In-house survey / Jul - Sep 2016 (Q2 FY 2016/17)	790*	41.70	45.00	Given current performance, the Hospital goal is that at least 45% of patients are satisfied with information received from Hospital staff about what to do if they were worried about their condition or treatment after they left the hospital. Further, this target represents a 7% increase over last year's performance. At this point, this indicator would be comparable to data from the Canadian Patient Experience Survey (CPES), but stable data for Ontario is not yet available for benchmarking purposes.	1)A process will be introduced whereby nursing will identify when a pharmacist meeting with patient prior to discharge may be of benefit.	Nursing and pharmacy meeting for the purpose of developing a workable process.	Completion of process.	October 2017	***EXECUTIVE COMPENSATION INDICATOR.
									2)Patient handbook and binders updated to include educational information at discharge -- including exercise instruction sheets and resource contact information.	Progress co-ordinated by Manager of Patient Rehabilitation reporting to VP of Clinical Services.	Completion of updates to materials and successful distribution to patients.	Updated handbooks and educational materials available for discharged patients by late Spring 2017.	
									3)QBP Order sets to be implemented incorporating information that will be provided on discharge -- including contact and other resource information.	Manager of Pharmacy will co-ordinate the process.	Number of QBP Order sets with discharge information completed and provided.	Staff training underway with prospective implementation date of late spring 2017.	
									4)New iequip project adopted called POD (Patient Oriented Discharge)directed at reviewing current discharge summaries in order to identify improvements.	Under the leadership of the Chief of Staff, Iequip project participants to interview patients in order to collect data and input.	Completion of project and incorporation of identified improvements in discharge summaries.	End of 2017.	
		% 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 2015/16-Q2 2016/17	790*	83.68	75.00	This is the second year for this indicator and our performance well exceeds the HNHB LHIN performance for 2014/15 of 51.4 and the provincial average of 59.7. Went from 55 to 83% in first year but high concern regarding increasing complexity of patients and bed pressures. For accountability will accept 73% and higher.	1)Review and refining configuration of pods to better streamline treatment and care and facilitate reduced length of stay.	Through the Rehab Care Alliance and review of best practices, determination will be reached regarding appropriate configuration of pods.	Completion of review and determination as to whether adjustment to configuration of pods required.	Completed by December 2017.	***EXECUTIVE COMPENSATION INDICATOR.
									2)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.	
									3)Continue education to current and new staff on Stroke Length of Stay Targets.	Management team to review and update education package 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.	
									4)Monitor each patient's Length of Stay (LOS) targets.	POD clinical staff to review and monitor each patient's length of stay targets, and request that they are able to attend at Patient Flow Meeting to explain circumstances 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.	

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Efficient	Access to right level of care	Total number of alternate level of care (ALC) days contributed by ALC patients within the specific reporting month/quarter using near-real time acute and post-acute ALC information and monthly bed census data	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July – September 2016 (Q2 FY 2016/17 report)	790*	5.82	6.00	Goal well exceeds the Q2 2016 LHIN and provincial targets of 12.7 and the HNHB LHIN average of 13.8%. Our Q3 performance reflected an increase to YTD average of 8.64%, reflective of an increasing provincial ALC rate. 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 and 12.	1)Communicate discharge planning statistics for patients with more complex discharge needs.	Decision Support and Case Managers 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)Maintenance and refinement of process where length of stay is longer than anticipated, representatives from the inter-professional team request to attend patient flow meetings to present their recommended interventions that may assist in facilitating safe and timely discharge.	Maintenance of process and education of inter-professional team members to assist them in focusing on the value of safe and timely discharge and how they are vital in the process.	Number of inter-professional team requests for attendance at patient flow meetings for the purpose of presenting their recommendations.	Minimum of once per week request from inter-professional 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 one teleconference every second week.	
Patient-centred	Person experience	"Would you recommend this hospital to your friends and family?" (Inpatient care)	% / Survey respondents	In-house survey / Jul - Sep 2016 (Q2 FY 2016/17)	790*	CB	CB	The Hotel Dieu Shaver is moving towards use of a new patient satisfaction survey tool and will be collecting baseline data during the 2017/2018 year.	1)Generate, review and post tracking matrix of number of nurse calls and associated response times.	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 number of interventions adopted.	Tracking completed monthly with interventions adopted as necessary.	The Hospital is moving towards implementation of a customized in-house survey tool and is therefore collecting baseline for 2017-2018
									2)Continued implementation of patient flow computer system (OCULYS) to assist in early transfer to appropriate service within the facility.	Stage 1 implemented. Continued work to implement Stage 2.	Implementation of Stage 2 (allowing HDSHRC to identify prospective patients currently admitted at acute facilities well in advance), thereby allowing maximization of care plan implementation.	Implementation of Stage 2 by late summer 2017.	
									3)Ongoing monitoring of effectiveness of the POD model in maximizing patient outcomes and reducing length of stay.	Inter-disciplinary team to hold POD review meetings on a regular basis. 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 POD review meetings; # of data reviews and analyses completed.	POD review meetings bi-weekly and data review quarterly.	
									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.	Software implemented on 1st floor; still to implement on 2nd floor.	Complete implementation of software and monitors.	100% successful implementation of software and monitors.	

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Safe	Medication safety	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	Rate per total number of admitted patients / Hospital admitted patients	Hospital collected data / Most recent 3 month period	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 Committees and Board of Trustees.	# of audits performed; # of reports to Department Managers, Nursing-Pharmacy Council, pharmacy staff, Senior Team, MAC, Quality Committees 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 Committees and Board of Trustees.	***EXECUTIVE COMPENSATION INDICATOR
									2)Continue meetings of Nursing-Pharmacy Council and associated accreditation team as part of the Hospital's Quality Improvement and Patient Safety programs.	Inter-professional team of Pharmacy Manager, VP Clinical, Rehab and Nursing leadership, advanced practice nursing, pharmacy staff 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.	Target to meet weekly with minimum of once per month.	
									3)Review of software options for medication reconciliation to achieve maximum efficiencies, quality and patient safety.	Manager of Pharmacy, clinical managers, CNO and VP Clinical involved in review of software options.	Review completed.	End of 2017.	
	Safe care	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	CIHI eReporting Tool / Q2 2016/2017 rolling 4 quarter average (Oct. 2015 to Sept. 2016)	790*	6.60	6.00	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, therefore, we will accept values between 6 to 10%.	1)Establishment of a Wound Management Team to take charge and act as consultants on pressure ulcer and wound care best practices and education/treatment at the bedside.	Chief Nursing Officer and Infection Prevention Control Practitioner to compile team; 1 champion from each unit, drawing from staff who have received education and/or expressed an interest in the role.	Compilation of the team and implementation of role.	End of 2017.	
									2)Expand on process to 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.	Infection Control Practitioner to ensure research completed and procurement approval is obtained through the appropriate channels.	Approval of the internal approval process and receipt of the surfaces.	Maximum # of surfaces purchased as opposed to rented.	
									3)Enhance staff confidence and comfort level with identification and calibration of various therapeutic surfaces.	Provide comprehensive training, including creation of a video by Occupational Therapy staff on how to monitor and maintain ROHO surfaces.	Completion of training development and rollout.	Education uploaded and rolled out by end of summer 2017.	
									4)Integration of Braden Scale and Wound Management Best Practices (heel protection and surfaces) being integrated into digital Order Sets.	Manager of Professional Practice and Infection Control and CNO will take the lead with this initiative in concert with software vendor.	Successful Integration of Braden Scale and Best Practices into Digital Order Sets.	Completion by late Spring 2017	
		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	CIHI eReporting Tool / Q2 2016/17 rolling 4 quarter average (Oct. 2015 to Sep. 2016)	790*	14.70	14.00	This is only the third year for this indicator. Current performance of 14.7 represents a 5% decrease from last year, and a 17% decrease over the past 2 years, which is very significant. This year's target reflects the goal of a further 5% reduction.	1)Reduce the number of unnecessary urine samples sent.	Infection Control Practitioner and Extended Class RN will take the lead to continue to monitor and refine "Only Send If" campaign to audit compliance and determine if further and/or different education is required.	# of audits; # of revisions	End of 2017.	
									2)Pharmacy to conduct reviews of number and appropriateness of antibiotics used and work with Niagara Health to obtain an antibiogram.	Manager of Pharmacy to oversee process which will allow provision of monthly report on number of urine specimens sent and the problems that are being identified.	Development of antibiogram; monthly reports received.	End of 2017	
									3)Continued education along with development of new poster logo -- Dr. Steward Ship.	CNO, Infection Control Practitioner and Extended Class RN to continue to develop and distribute educational materials.	# of educational materials developed and distributed.	Ongoing to end of 2017.	

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Timely	Timely access to care/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 / January 1, 2016 - December 31, 2016	790*	8.92	8.90	This is an aggressive Hospital target to at least maintain exceptional wait times but is dependent on staffing, volume of neurological events, decreased in-patient length of stay with resultant dramatic pressures on outpatient services. Therefore for accountability purposes, we will accept values of 16 days or less.	1)As a priority consideration, factor potential impact on neuro wait times when considering any initiatives that may have an impact - including service closures, cost savings, satellite services, staffing assignments and re-alignments.	Regular reminders to all areas, including clinical, human resources and finance -- to be cognizant of need for attention to impact on wait times when considering new initiatives or routine re-assignments.	# of decision reviews that formally incorporate consideration of impact on in to out patient wait times.	100% of organizational decisions that have the potential of impacting wait times be considered in that context.	This is the third year for this indicator and the organization continues to show improvement in terms of keeping in the forefront the need to consider potential impact on wait times when adopting/implementing any initiative, whether new or routine.
									2)Review and analyze wait time data on a regular basis.	Director of Rehabilitation to review and analyze wait time data.	# of reviews conducted; # of analyses completed.	At least 1 review and 1 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 managers, Finance, Senior Team, Quality Committees, Patient Advisory Council and Board of Trustees.	# of status reports provided.	At least one status report to be communicated to internal team and managers monthly or more often if irregularities identified and to Senior Team, Quality Committees 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.	Developed alternatives to assist in reducing wait times if the need arises.	
		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, 2016 - December 31, 2016	790*	6.65	6.50	This is an aggressive Hospital target to at least maintain the current level of access, dependent on staffing, volume of orthopedic events, decreased in-patient length of stay resulting in dramatically increased pressures on outpatient access. Therefore, for accountability purposes, we will accept values of 14 days or less.	1)As a priority consideration, factor potential impact on ortho wait times when considering any initiatives that may have an impact -- including service closures, cost savings, satellite services, staffing assignments and re-alignments.	Regular reminders to all areas, including clinical, human resources and finance -- to be cognizant of need for attention to impact on wait times when considering new initiatives or routine re-assignments.	# of decision reviews that formally incorporate consideration of impact on in to out patient wait times.	100% of organizational decisions that have the potential of impacting wait times be considered in that context.	This is the third year for this indicator and the organization continues to show improvement;keeping in the forefront the need to consider potential impact on wait times when adopting any initiative, whether new or routine.
									2)Review and analyze wait time data on a regular basis.	Director of Rehabilitation to review and analyze wait time data.	# of reviews conducted; # of analyses completed.	At least 1 review and 1 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 managers, Finance, Senior Team, Quality Committees, and Board of Trustees	# of status reports provided.	At least one status report to be communicated to internal team and managers monthly or more often if irregularities identified and 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.	Developed alternatives to assist in reducing wait times if the need arises.	