Hotel Dieu Shaver
HEALTH AND REHABILITATION CENTRE

Excellent Care for All
Quality Improvement Plans (QIP): Progress Report for the 2017/18 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 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
1	"Would you recommend this hospital to your friends and family?" (Inpatient care; in-house survey) Unit: % Population: Survey respondents Progress Period: Jul - Sep 2016 (Q2 FY 2016/17) Source: In-house survey	790	CB	CB	99.19	The Hotel Dieu Shaver implemented a new "in-house" patient satisfaction survey tool in June 2017. The survey includes a number of questions specifically directed at our rehabilitation and complex care patient population. We have attained a greater than 60% response rate, ensuring that our patient voice is being heard. The Patient Advisors meet with the patients 1 to 2 days before discharge and have been very well received by our patients.

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Change Ideas from Last Years QIP (QIP 2017/18)	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?
Generate, review and post tracking matrix of number of nurse calls and associated response times.	Yes	The tracking and reporting of response times is completed and reported monthly to staff and quarterly to the Quality Committee of the board. A question on the Patient Satisfaction survey addresses response time to call bells and the data from the tracking system has identified interventions to adopt.
Continued implementation of patient flow computer system (OCULYS) to assist in early transfer to appropriate service within the facility.	Yes	Implementation is ongoing. Hotel Dieu Shaver information is populated in live time. The plan is to be able to identify prospective patients that are currently in acute care beds in order to optimize the admission date for their post acute care.

Ongoing monitoring of effectiveness of the POD model in maximizing patient outcomes and reducing length of stay.	Yes	Regular review of patient outcomes with the inter-disciplinary team ensures maximization of patient outcomes and a length of stay in keeping with RPG best practice.
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 fully implemented which provides both patients and their families and the staff ease in determining the next appointment and therapy location. This has facilitated timely attendance at appointments and provides patients with the power to better invest in their rehabilitation plan.
Consideration is being given to implement a "Meet and Greet" to new patients with a Patient Advisor to review our Patient and Family Handbook to ensure awareness of all services available.	Yes	Feedback from Patient Advisors indicates that many of the "extra" services offered are often not known to new patients until well into their stay (i.e. laundry facility) even though the information is included in the Patient and Family Handbook. The Patient Advisor would welcome each patient and review the Handbook with the patient.

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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 Stroke Rehab patients Progress Period: Q3 2015/16-Q2 2016/17 Source: Hospital collected data **Tied to executive compensation*	790	83.68	75.00	84.85	The Rehab Service Delivery Model known as the "POD Model" continues to enable HDS to improve patient outcomes and aligns with clinical best practices and Ontario's Patients First Action Plan. The median Rehab Intensity continues to show improvement from 93.43 for 2016/17 to 96.46 current year to date while also achieving timely and safe discharges for our patients.

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Review and refining configuration of pods to better streamline treatment and care and facilitate reduced length of stay.	Yes	Feedback is continually received and used accordingly from the daily Patient Flow meetings, Daily bed meetings, and the weekly interdisciplinary patient conferences, to ensure optimum patient rehab with a team that is consistent.
Review and analyze stroke length of stay data on a regular basis, with interventions initiated as necessary.	Yes	Ongoing review and analysis of the Ontario Stroke Network data is completed. Information is presented throughout the organization on a quarterly basis, which includes all staff and the senior team. Feedback on the increased Rehab Intensity along with the decrease in length of stay was important to provide to staff to show that a longer stay does not necessarily mean a better outcome.
Continue education to current and new staff on Stroke Length of Stay Targets.	Yes	All members of the interdisciplinary team are provided with regular and ongoing feedback from our provincial and HNHB LHIN comparators. Timely completion of the admission FIM is promoted and education around the impact that this has on the LOS and assignment to RPG is ongoing.
Monitor each patient's Length of Stay (LOS) targets.	Yes	All referrals are reviewed prior to admission to ensure that each patient is suitable for the active rehab program. The admission FIM must be completed within 72 hours of admission for appropriate RGG assignment and the resulting length of staff in order to assist the inter-disciplinary team to create an appropriate care plan.

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3	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? (in-house survey) Unit: % Population: Survey respondents Progress Period: Jul - Sep 2016 (Q2 FY 2016/17) Source: In-house survey **Tied to executive compensation*	790	41.70	45.00	99.19	Implementation of an "in-house" survey has assisted in ensuring patients are receiving all information to support them following their discharge. A staged approach from therapy, nursing and Case Managers is used to provide information over the few days preceding discharge so as not to overwhelm the patient. If the response to this survey question is not YES, then the Patient Relations Process Delegate meets with the patient and family to determine where more information is required and connects with the appropriate staff to ensure additional or clarification of information is given.

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A process will be introduced whereby nursing will identify when a pharmacist meeting with patient prior to discharge may be of benefit.	Yes	The physician completes the medication reconciliation on discharge. The nursing review with the patient includes information about the discharge medications. For patients that are high risk or are not fully understanding the medication information arrangements are made for the Pharmacy staff to speak with the patient.
Patient handbook and binders updated to include educational information at discharge -- including exercise instruction sheets and resource contact information.	Yes	The Patient and Family Handbook is provided upon admission and is now collated by an external company. this has allowed for updates to be completed twice a year to ensure information remains relevant. The discharge portion of the information was relocated within the Handbook to an area that is easier for patients and their families to find. We can also provide hard copy and soft copy versions of the handbook and it is posted on the hospital website so is always available.
QBP Order sets to be implemented incorporating information that will be provided on discharge -- including contact and other resource information.	Yes	The QBP order sets for all Quality Based Procedures have been developed during this year. Physician and nursing champions will be working towards full implementation and adoption of the process.
New iequip project adopted called POD (Patient Oriented Discharge) directed at reviewing current discharge summaries in order to identify improvements.	Yes	Under the leadership of the Chief of Staff, I-Equip projects are continuing with a collaboration from our partners at Niagara Health, McMaster University medical students, and Brock University community Health Sciences students. Related to best practice for discharge planning and information the projects include: Secondary stroke follow-up and the Stroke Patient Discharge Checklist.

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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 3 month period Source: Hospital collected data **Tied to executive compensation*	790	100.00	100.00	100.00	Performance continues to be maintained resulting in meeting the 100% completion rate. Measurement is based on med reconciliation being completed within 72 hours of admission.

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Perform audits, analyze data, and initiate interventions as necessary.	Yes	Monthly audits on admission and transfers are completed and information analyzed to most efficiently use the limited resources. The Pharmacist's roll was enhanced in the medication reconciliation process.
Continue meetings of Nursing-Pharmacy Council and associated accreditation team as part of the Hospital's Quality Improvement and Patient Safety programs.	Yes	There are monthly Nursing/Pharmacy council meetings with an inter-professional review of the current auditing process and results. As required problem solving and enhancement of the process is done by the council, while also promotion of adherence to the current policy to enhance the quality of the med rec process.
Review of software options for medication reconciliation to achieve maximum efficiencies, quality and patient safety.	Yes	Currently a paper based method is in place which would be greatly enhanced via use of an electronic software program. Review of software programs continue to determine the system that best meets our Rehab/Complex Care requirements.

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5	Meet optimal wait times for internal inpatient to outpatient services based on neurology wait times Unit: Days Population: Inpatients waiting for internal outpatient neurology services Progress Period: January 1, 2016 - December 31, 2016 Source: Hospital collected data	790	8.92	8.90	12.38	Regular review of wait time data is used to support the analysis of inpatient volumes that experience uncontrollable fluctuations. Although we did not meet the target of 8.90 we were well within the accountability corridor of 16 days or less. Unforeseen staffing loss (temporary) of therapy staff in combination with surges in many of the months created significant challenges.

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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.	Yes	Challenges that impact this indicator include staffing and associated funding issues. The potential for surge is always present due to the uncontrollable fluctuating volumes in combination with the compressed length of inpatient stay. Budget constraints restrict surge plans when there are significant increases in patient volumes.
Review and analyze wait time data on a regular basis.	Yes	There is, at minimum, 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 is forwarded to the Director of Finance and CEO/CFO and a 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, inpatient volumes, impact of seasonal program shut-downs allow for timely intervention to avoid negative impacts on the wait time. An area being more thoroughly reviewed is the patient preference for appointment times in this particular patient population (preference for afternoon or morning appointments)

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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: January 1, 2016 - December 31, 2016 Source: Hospital collected data	790	6.65	6.50	8.85	This was an aggressive hospital target, dependent on staffing, volume of orthopedic events, decreased in-patient length of stay that results in dramatically increased pressures on outpatient access. During the course of this year there was loss of physiotherapy hours, which were not replaced in order to address budget constraints. The accountability corridor was set at 14 days or less and we did manage to achieve significantly lower results.

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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.	Yes	Challenges that impact this indicator include staffing and associated funding issues. The potential for surge is always present due to fluctuation volumes and the compressed length of stay for inpatients.
Review and analyze wait time data on a regular basis.	Yes	Regular review of data is used to support the analysis of inpatient volumes as well as the challenges with the decreasing length of stay for inpatient rehabilitation.
Communicate wait time status to all relevant parties on a regular basis.	Yes	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 impact the outpatient referrals. Of note, this current fiscal year, as of December 31, the number of total joint inpatient admission had already exceeded the volumes for the entire previous fiscal year, which directly impacts the outpatient wait times.

Identify and implement interventions as necessary to ensure wait times stay within identified limits.	Yes	Regular analysis of wait times data, inpatient volumes, and impact of seasonal shut-downs allows for timely intervention. However, there were unanticipated losses in therapy staff, with a decision made not to replace in order to address budgetary constraints.

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7	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 2016/2017 rolling 4 quarter average (Oct. 2015 to Sept. 2016) Source: CIHI eReporting Tool	790	6.60	6.00	5.50	With ongoing education and implementation of new processes we were able to achieve and exceed our target. However, this target can be difficult to maintain given our small patient population and extended length of stay for End of Life patients or patients with complex discharge plans received from acute care.

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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.	Yes	A wound care consultant team has been developed to assess pressure ulcers weekly and develop a treatment plan and implement changes when required. Development of a wound assessment tool is being trialed that includes assessment, planning, implementation and evaluation with the goal to build knowledge capacity within our nursing staff. Additionally, nurse led pressure ulcer protocols are being developed to ensure prompt treatment of pressure ulcers.
Expand on process to procure internal surfaces as opposed to rentals, to both ensure that the appropriate surface is available in a timelier manner and to reduce cost associated with rentals.	Yes	Purchase of four (4) pressure relief mattresses has occurred. A new therapeutic surface algorithm has been developed and implemented that directs staff to utilize internal surfaces first, with rentals available as a last resort. Also, a mattress and bed frame fact sheet has been developed and implemented outlining the benefits of each mattress and which bedframe best suits the mattress chosen. Education has been provided by the vendor There is education also including a ROHO video on calibration. Monthly tracking of rental surfaces is maintained and reported to the senior team.

Enhance staff confidence and comfort level with identification and calibration of various therapeutic surfaces.	Yes	A video was developed by HDS staff that outlines the steps required to calibrate a ROHO surface. This video is available on-line for ongoing education. We are also including this in the annual educational Passport days for pressure ulcer prevention.
Integration of Braden Scale and Wound Management Best Practices (heel protection and surfaces) being integrated into digital Order Sets.	Yes	The Braden Scale is conducted on all patients admitted to HDS and weekly thereafter. Pressure ulcer prevention and management is being incorporated into our digital order sets to ensure best practices are followed from admission to discharge.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
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 patients Progress Period: Q2 2016/17 rolling 4 quarter average (Oct. 2015 to Sep. 2016) Source: CIHI eReporting Tool	790	14.70	14.00	5.00	Ongoing education re: sending of urine samples for testing, and review of appropriateness of antibiotics has assisted in meeting and exceeding the target. Data quality in the CCRS database was also reviewed with a process recommended for moving into the 2018 2019 fiscal year.

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Reduce the number of unnecessary urine samples sent.	Yes	Education is ongoing under the leadership of the Antimicrobial Stewardship Committee for the "Only send if" campaign. Monitoring is done on a regular basis via an audit process to assist in determining if further or different education is required.

Pharmacy to conduct reviews of number and appropriateness of antibiotics used and work with Niagara Health to obtain an antibiogram.	Yes	The Manager of Pharmacy oversees a process which allows for the provision of monthly reports on the number of antibiotics and class used for treatment of UTI's. Any areas for improvement are identified and reported to Pharmacy and Therapeutics Committee. The development of a scorecard is being investigated to determine the current successes of the UTI program, and will identify any changes/improvements required. A "Dr. Steward Ship" program and template is in the development stage to encourage teach back of "Asymptomatic bacteremia - Why don't you treat?" and also for RN's and RPN's for provision of information of C & S results, as well as clinical presentation to the physician.
Continued education along with development of new poster logo -- Dr. Steward Ship.	Yes	As noted above all education and information sharing about antimicrobial stewardship and treatment of asymptomatic bacterium, etc. will be via the "Dr. Steward Ship" character and logo to make it interesting and easily identifiable. Utilization of the Antibiotic Awareness campaign will be offered at HDS annually.
Identification of requirement for an audit of CCRS data supported a monthly quality review by IP&C to be implemented to ensure the indicator was being captured accurately.	Yes	CCRS data for UTI's will be reviewed monthly for accuracy. Education will be provided to the clinicians that input data into CCRS about when it is appropriate to capture a UTI in the infection section of the abstract.

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9	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 Unit: Rate per 100 inpatient days Population: All inpatients Progress Period: July – September 2016 (Q2 FY 2016/17 report) Source: WTIS, CCO, BCS, MOHLTC	790	5.82	6.00	5.47	We were able to exceed the aggressive target as this indicator can vary significantly and can be reflective of issues beyond our control, such as the impact of the influenza season on acute care. Often the patients that are suitable for care are those that have complex discharge plans. Diligent attention is given from the time of admission to develop a plan for safe discharge for each patient. It has been very beneficial to schedule regular meetings with our LHIN Community Service partners to review our patient population to develop the discharge plans.

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Communicate discharge planning statistics for patients with more complex discharge needs.	Yes	Decision support and the case managers produce Weekly reports which are provided to the Senior Team and the HNHB LHIN, as well as quarterly reports that are provided to the Quality Committee and Board of Trustees.
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.	Yes	The inter-disciplinary teams review all patients and present recommendations at the daily Patient Flow meeting. Managers from HDS and the HNHB LHIN Community services work together to review the very complex discharges.
Continued application of process for escalation of complex cases.	Yes	Bi-monthly meetings with our LHIN home care partners to review all cases in the facility has assisted in identifying those patients that are expected to require a more complex discharge plan. This assists in having all relevant parties involved in the discharge plan to be aware as soon as possible to collectively develop the safest and most timely transition 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 VP of Clinical Operations and/or the Director of Nursing participate in the bi-weekly teleconferences with all of our HNHB LHIN partners. The Admissions Nurse participates in daily LHIN teleconference bed meetings to review possible patient admissions from the acute sites.