2018/19 Quality Improvement Plan
"Improvement Targets and Initiatives"

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

AIM		Measure								Change				
Quality dimension	Issue	Measure/Indicator	Type	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	% of 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. ***Executive Compensation**	Custom	% / Active Stroke Rehab patients	Hospital collected data / Q3 2016/17-Q2 2017/18	790*	84.85	80.00	This is the third year for this indicator and our performance continues to well exceed the 3 year average of the HNHB LHIN, being 63.7%. Stroke rehab best practices are currently under review due to several factors including co-morbidity. It is anticipated that the new best practice recommended target may fall between 70-75%. As a result, for accountability purposes, the HDS will accept results between 70 and 80%.	1)Implement designated Inpatient Stroke POD (clustered active stroke patients being designated to a dedicated stroke rehabilitation team, located in a designated unit).	A stroke pod committee has been constituted, including front line staff, management, physicians and external partners to develop and implement a new model of care.	Design and implementation of new model of care.	Late spring 2018.	
										2)Review and analyze stroke length of stay data to monitor performance.	Vice President of Clinical Operations, Chief Nursing Officer, Manager of Inpatient Rehabilitation, Director of Health Data and Quality and Decision Support Analyst to meet, review, and analyze data quarterly.	Quarterly meetings and analyses.	Ist Quarter, 2018.	
										3)Patient Flow Team to monitor each stroke rehab patient's length of stay (LOS) as related to organizational target and initiate interventions as required.	Daily Patient Flow Meeting and Team to monitor each patient admitted under the diagnosis of stroke.	# of daily flow meetings used as a forum to review daily admissions under diagnosis of stroke.	1st quarter 2018	
										4)Continue education to current and new staff on stroke length of stay best practices and targets.	Management team to review and update education package and conduct staff education sessions based on most current information on stroke length of stay practices and targets.	# of education sessions conducted.	Minimum of 1 education session twice per year.	
		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? ***Executive Compensation**	Custom/**HNHB LHIN Required Indicator**	% / Survey respondents	In-house survey / July - September 2017 (Q2 FY 2017/18)	790*	99.19	90.00	The target is very high based on last year's very high performance. Stable data for Ontario is not yet available for benchmarking purposes. Given limited ability to increase performance, the Hospital will accept 85% or higher.	1)Survey to be conducted with patient three or fewer days before anticipated discharge date.	Patient Advisors to be provided with a list of patients with imminent discharge dates and will attend at bedside with survey materials.	Successful completion of in-house surveys prior to discharge.	100% of patients with pre-scheduled discharge dates to be surveyed.	
										2)Process identified whereby Patient Delegate to be notified by Patient Advisors or other staff if patient/family identifies need for further information prior to discharge.	Patient Delegate to provide education to patient advisors and front line staff as to process to follow if further information required by patient or family.	Completion of initial education of patient advisors by patient delegate and updates as new patient advisors are tasked with the survey function.	Immediate with ongoing education as required.	
										3) Expand availability and accessibility of service and vendor brochures and other educational materials which may be of value to patients and care givers after discharge.	Director of Nursing to work with clinical management and vendors to ensure expanded capacity has been instituted and educational materials are identified and available.	Installation of brochure and educational material displays on the inpatient floors.	Completed by March 2019.	
										4)Stage discussions between disciplines and over a few days before discharge to reduce volume of information that patient and caregivers receive all at once.	Interprofessional team to stage discharge discussions beginning a few days before discharge.	Number of discharge discussions that are staged.	Late spring 2018	
	Wound Care	Percent of complex continuing care (CCC) patients with a new pressure ulcer in the last 3 months (Stage 2 or higher).	Custom/**HNHB LHIN Required Indicator**	% / Complex continuing care patients	CIHI eReporting Tool / Q2 2017/18 rolling 4 quarter average (Oct. 2016 to Sep. 2017)	790*	5.50	5.40	This target is very aggressive and difficult to maintain given our small patient pool and the nature of our referral sources; one or two cases can significantly skew results. For accountability purposes, therefore, we will accept values between 5.4 and 10%. Valid external comparators are not currently available.	1)Implementation of a Wound Consultation Team. This team engages with patients on weekly rounds to assess the wounds and develop treatment plans to achieve optimal recovery.	Under the management of the Wound and Skin Committee, our Nurse Practitioner and our Advanced Practice Nurse, weekly rounds to be conducted.	Number of rounds and treatment plans completed.	Fully implemented by spring 2018.	
										2)Development and implementation of a documentation tool that facilitates assessment, planning and implementation of care plan for the wound following best practice guidelines.	Members of the Wound and Skin Committee are working to refine the documentation tool, which is currently in trial stage.	Successful refinement of the document and full implementation.	Trial to be completed by the end of calendar year 2018.	

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Hotel Dieu Shaver
HEALTH AND REHABILITATION CENTRE

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

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Quality dimension	Issue	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
										3)Initiate nurse led wound care protocols, which will include all types of wounds, including pressure ulcers.	Under the leadership of the Wound and Skincare Committee, protocols are being developed to complement the assessment documentation tool referenced in Change Idea #2.	Complete implementation of the wound care protocols.	End of calendar year 2018.	
										4)Utilize I-Equip Students from Brock University to conduct a gap analysis of wound management practices and knowledge transfer.	Under the leadership of the Wound and Skin Committee, and our Nurse Practitioner, the students will complete the analysis so that recommendations can be developed and implemented.	Completion of analysis, and development and implementation of recommendations.	End of calendar year 2018.	
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	Priority	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July - September 2017	790*	5.47	12.00	Goal well exceeds the Q2 2017 LHIN and provincial targets of 12.7. Effective November 2017, the provincial average had risen to 17.2, the HNHB average was 21.4 and the HDS average had risen to 7.8%, reflective of an increasing ALC rate province wide. Effective February 2018, HDS performance was tracking at 12.7%. This indicator is largely outside of HDS control and is dependent upon bed pressures throughout the Region, CCAC resources and patient's LTC selections. For accountability purposes, we will accept values between 12% and the provincial average of 17.2%.	1)Conduct in-house patient flow meetings on a daily basis with representation from across the inter-professional team to assess patient status and identify recommended interventions that may assist in facilitating safe and timely discharge.	Inter-professional team to meet on a daily basis.	Regularity of patient flow meetings.	Daily meetings to take place.	
										2)Monthly meeting with LHIN Home and Community (CCAC) and HDS management to conduct monthly case review of all ALC patients.	Clinical and patient flow managers to ensure that data is co-ordinated and meetings conducted.	# of monthly meetings conducted.	Immediate implementation.	
										3)Participation in LHIN wide Patient Flow meetings with CCAC and other LHIN facilities to discuss strategies and share successes and ideas.	Vice President of Clinical to attend meetings on a monthly basis.	Number of meetings attended.	Immediate and ongoing implementation.	
										4)Interprofessional team to refer/escalate 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.	Reduction in number of escalated cases.	
Patient-centred	Person experience	Would you recommend this hospital to your friends and family? (Inpatient Care)	Custom	% / Survey respondents	In-house survey / July -September 2017 (Q2 FY 2017/18)	790*	99.19	90.00	The target is very high as a result of our internal high results and is significantly higher than the Health Quality of Ontario reported provincial average of 81.8%. Given the very high results obtained, and narrow room for improvement, the Hospital will accept results between the provincial average of 81.8 and 100%.	1)Expand membership on Patient Advisory Council.	Patient Relations Delegate to identify prospective advisors through patient satisfaction survey group, recommendations from clinical managers, former patients, etc.	Number of new patient advisors recruited.	Increase in number of active patient advisors.	
										2)Expand committees where patient advisors are in attendance.	Patient relations designate to review committee representation with HDS management lead for the purpose of identifying suitability/value for expanded representation.	Increased number of committees with patient advisor assignments.	Expanded number of committees with patient advisor representation by end of fiscal year.	
										3)Expand functionality of OCULYS - computerized patient flow computer system to assist in early transfer to appropriate service within the facility.	Appropriate clinical managers working to expand functionality.	Degree of expansion completed.	Completion of expansion by end of fiscal year.	
										4)Refine, analyze, post and distribute data on number of nurse calls and associated response times.	Chief Nursing Officer to refine analysis and post and distribute data, identifying interventions as necessary.	# of analyses and postings/distributions completed.	Summer 2018	

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Safe	Safe care/Medication safety	Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged.	Priority	Rate per total number of discharged patients / Discharged patients	Hospital collected data / October – December (Q3) 2017	790*	CB	CB	This is a new indicator that will require development and introduction of processes as well as education of staff and physicians. The Hospital will be collecting baseline for this indicator in 2018-19 and will begin with the 1st floor for data purposes.	1)Review and revise current forms to ensure that appropriate information is captured and communicated.	Director of Health Data, Manager of Pharmacy and Director of Nursing to review and update forms and identify process to be followed.	Successful updating and distribution of forms and development/ communication of process.	Summer 2018.	
										2)Involve physicians in discussions regarding appropriate workflow processes.	Discussions at MAC and MSA regarding indicator, forms, and work processes to seek input from physicians.	# of discussions that take place.	Summer 2018	
										3)Involve patient and caregiver in medication reconciliation on discharge.	Immediately prior to discharge, interactive discussion with patient and/or caregiver to ensure that parties clearly understand medication reconciliation requirements for the patient.	Number of interactive discussions conducted.	Spring 2018	
										4)Exploration of the availability and feasibility of an electronic medication reconciliation process.	Manager of Pharmacy and Director of Health Data to stay current and advise Hospital as to any new developments that may support this initiative.	Information provided by Manager of Pharmacy and Director of Health Data.	Fiscal year 2018.	
		Percent of patients with urinary tract infection: Number of patients with UTI on their target assessment divided by the number of patients with valid assessments, excluding end-of-life patients.	Custom	% / Complex continuing care patients	CIHI eReporting Tool / Q2 2017/18 rolling 4 quarter average (Oct. 2016 to Sep. 2017)	790*	5.00	5.00	This indicator is three years old and has been reduced by in excess of 10% during that period. The target identified is very aggressive and may not be realistic given the nature and size of the patient population. Given the aggressive nature of the target and very small patient pool, the Hospital will accept results of 5 to 10% for accountability purposes.	1)Re-institution of the Antibiotic Stewardship Team.	The Manager of Infection Prevention and Control will be charged with re-instituting the committee.	Re-institution of the committee.	Late Spring 2018.	
										2)Monthly audit of CCRS Data to ensure accurate capture of UTI data.	Manager of Infection Prevention and Control and Decision Support Analyst to collect and review data on a monthly basis.	# of monthly reviews completed.	Spring 2018	
										3)Ongoing education of staff assigned to input initial data into system.	Director of Health Data and Quality to regularly review educational needs and develop action plan.	Completion of regular reviews and action plan development.	Ongoing over fiscal year.	
										4)Issue new template to staff with education materials from Dr. Steward Ship.	Antibiotic Stewardship Team, under direction of Chief Nursing Officer, to issue materials.	Successful launch of new education materials.	November 2018	
	Workplace Violence	Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period. ***Executive Compensation**	**MANDATORY**	Count / Worker	Local data collection / January - December 2017	790*	**42.00**	**55.00**	Although progress has been made in reinforcing the need to report violent incidents, the HDS is still moving towards a culture where staff recognize workplace violence for what it is and the requirement to report workplace violence. Success with this indicator is premised on INCREASING the number of violent incidents reported. Given the continued staff learning curve associated with this indicator, we will accept results between 45 and 55 for accountability purposes.	1)Working Group/sub-committee on violence in the workplace including front line and union representation, as well as patient advisors, to be struck and meet on regular basis to identify initiatives which may assist in staff and patient safety.	Working group to be struck under the leadership of Manager of Human Resources and Co-ordinator of Safety and Disability Management.	Establishment of committee and terms of reference.	Committee to be fully operational by late spring 2018.	**FTE=400**
										2)Update of all workplace violence and harassment policies.	Manager of Human Resources, Safety and Disability Co-ordinator and Joint Occupational Health and Safety Committee to take the lead in reviewing and updating all workplace violence and harassment policies.	# of policies reviewed and updated.	All policies to be reviewed and updated by September 2018.	
										3)Update RL Solutions (Hospital incident reporting system) to Version 6.0 which will allow inclusion of all staff incidents, as well as current capacity to report patient incidents.	Director of Health Data and Quality Improvement will oversee implementation and rollout of updated Version.	Completion of update.	End of calendar year 2018.	

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										4)Activate screen in Meditech system to allow staff registering patients to be aware of those who were flagged as behavioral while inpatients at the HDS or at the Niagara Health System.	Director of Health Records and Quality Improvement to oversee implementation while working with Information Systems and Workplace Violence sub-committee.	Successful activation of screen.	End of calendar year 2018.	

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Timely	Timely access to care/services	Meet optimal wait times for internal inpatient to outpatient services based on stroke wait times.	Custom	Days / Inpatients waiting for internal outpatient stroke services	Hospital collected data / January - December 2018	790*	CB	CB	The Hospital will be collecting baseline data for this indicator during the calendar year 2018. Data will be based on number of days before first offer of outpatient services made after date of discharge.	1)As a priority consideration, factor potential impact on stroke wait times when considering any initiatives that may have an impact - including service closures, cost savings, staffing assignments and re-alignments and satellite programs.	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 re-organizations.	Number of decision reviews that formally incorporate consideration of impact on in to out patient wait times for stroke.	100% of organizational decisions that have the potential of impacting wait times be considered in that context.	
										2)Review and analyze wait time data on a regular basis.	Manager of Outpatient Rehabilitation and Decision Support Analyst 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 steams, 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 attempt to ensure that referrals are received within best practice number of days.	Vice President of Clinical Operations and Chief Nursing Officer will continue to monitor referrals and work with all partners to ensure timely transitions.	# of stroke referrals monitored.	Referrals monitored on a regular basis as soon as possible.	
										5)Implementation of a digital tracking tool to ensure accuracy and timeliness to assist with identification of any irregularity regarding stroke wait time.	Manager of Rehabilitation and Decision Support Analyst to develop and implement digital tracking tool.	Development and roll out of digital tracking tool.	Late spring 2018.	