2019/20 Quality Improvement Plan
"Improvement Targets and Initiatives"

Hotel Dieu Shaver Health and Rehabilitation Centre 541 Glenridge Avenue

AIM		Measure									Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Theme I: Timely and Efficient Transitions	**Efficient**	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/**HNHB LHIN Required Indicator**	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July - September 2018	790*	5.45	12.00	This goal well exceeds the Q2 2018 LHIN ALC rate of 16% and the provincial rate of 15.8% and matches the LHIN target of 12%. This measure is largely outside of HDS control and is dependent upon bed pressures throughout the Region, LHIN Home and Community resources, and patient's LTC choices. For accountability purposes, we will accept values between 12% and the provincial average of 15.8%.		1)Patient Flow meetings including representation from across the interdisciplinary team occur every day at 3:00 p.m. to review patient referrals, patient discharge dates 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)Command centre teleconference meetings to take place daily including representation from senior and front line levels of staff -- from HDS, our acute care partner Niagara Health, and LHIN 4 Home and Community services -- to identify patient flow pressures and bottle necks, with the purpose of identifying immediate strategies to alleviate any barriers and facilitate expeditious patient flow on a case by case immediate basis.	Command Centre team to conduct teleconference meetings on a daily basis.	Regularity of daily teleconference meetings.	# of daily teleconference meetings conducted.	
											3)Inter-professional team charged with immediate identification and referral/escalation of complex cases.	Case managers 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 and/or timely resolution of escalated cases.	
	Timely	Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital.	Priority	% / Discharged patients	Hospital collected data / Most recent 3 month period	790*	CB	CB	As a new indicator this year, the Hospital will collect baseline on the 2nd floor of the inpatient facility where care is provided to the highest volume of patients who are more likely to be discharged to alternate settings rather than home.		1)A review and audit of discharge summaries completed to establish a baseline for ongoing audit purposes on the second floor.	Health Records will complete the review and audit.	Completion of review and audit	Review and Audit to be completed before late Spring 2019.	
											2)Ongoing audit to be completed to track completion rates.	Audit to be completed by Health Records.	Regular completion of the audit.	Audit will be completed by end of 3rd quarter.	
											3)Audit results to be monitored with interventions identified as necessary.	Health Records, Quality of Care and Risk Management Committee to review audit results and identify interventions as necessary.	Committee to review audit results on a monthly basis.	Review of statistics and identification of interventions to commence as soon as initial audit results are available.	
											4)Education to be developed for staff and physicians.	Second Floor Manager and Director of Health Data and Quality Improvement will develop and implement an education program for staff and for physicians.	Successful development and delivery of education program.	End of 3rd quarter 2019.	
		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*	5.00	5.00	Based on volumes of patients and pressures on outpatient services, we believe this is an aggressive target and exceptionally high standard to continue to aspire towards.		1)Continue to review and analyze wait time data on a regular basis to ensure interventions can be identified if there is an identified problem.	Manager of Outpatient Rehabilitation and Decision Support Analyst will continue to work together to review and analyze wait time data.	Number of reviews conducted and number of analyses completed.	At least 1 review and 1 analysis conducted monthly.	
											2)Continue to communicate wit 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	Wait times to be reported quarterly; unless there are identified anomalies, in which case reporting to other involved managers and VP Clinical should take place as soon as possible after identification of the problem.	Continued administration of current process.	
											3)Continue process to identify and implement interventions as necessary to ensure wait times stay within identified limits.	Further to discussion among the team, identify, seek approval for and implement interventions as soon as feasible.	# of identified and implemented interventions, as required and as feasible.	Continuing administration of current process.	

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Theme II: Service Excellence	**Patient-centred**	Percentage of complaints acknowledged to the individual who made a complaint within five business days ***Executive Compensation**	Priority	% / All patients	Local data collection / Most recent 12 month period	790*	100.00	95.00	This is an exceptionally high target with additional challenges -- being the lean staffing at the facility and potential difficulty in staff backfill in the event of absence. However, the Hospital is committed to responding to all documented complaints as quickly as possible.		1)Enhanced publication of the contact information for the Patient Relations Process Delegate.	Ensuring notices are developed, and distributed to key points throughout the Hospital and included in the patient relations handbook.	Completion of notice and number of notices that are distributed.	Notices placed at all elevators, Nursing stations, scheduling offices and in the patient relations handbook by end of 3rd quarter.	
											2)Identify appropriate backup for acknowledgement of documented patient complaints in the absence of the Patient Relations Process Delegate.	Formal identification and communication to appropriate staff of back-up contacts for formal complaints in the event that the Patient Relations Delegate is unavailable.	Completion of identification and communication.	Completion by Spring 2019	
											3)Formal tracking of all formally documented complaints including time lines for first acknowledgement, substance of complaint, nature of resolution and resolution timelines.	Patient Relations Process Delegate to document all formal complaints with chronology for time of first response, substance of complaint, nature of resolution and resolution timelines.	Completion and maintenance of tracking document on a quarterly basis.	Development and implementation by Spring 2019	
		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**	**HNHB LHIN Required Indicator**	% / Survey respondents	In-house survey / Q2 2018/19 (Jul - Sep 2018)	790*	100.00	98.00	This target is very high based on last year's high performance. Stable data for Ontario is not yet available for benchmarking purposes. Given limited ability to increase performance, and small volumes of patients, the Hospital will accept 85% or higher for accountability purposes.		1)Continuation of surveys to be conducted with patient three or fewer days before anticipated discharge date.	Patient Advisors continue 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)Continued communication between patient advisors and clinical managers to ensure that any concerns identified are flagged and, if possible, addressed prior to discharge.	Patient Delegate Advisor to ensure that all patient advisors are aware of process to follow with clinical manager in the event that items of concern are flagged by patients or care givers prior to discharge.	Number of patient advisors advised of process to follow with clinical manager.	All patient advisors who administer the survey provided orientation on process to follow with clinical manager.	
											3)Trial of adopting pharmacist on the inpatient floor model.	The model of a pharmacist assigned to an inpatient unit will be adopted to assist in the event of questions or the requirement for more information regarding medications from patients or caregivers immediately prior to discharge.	Implementation of the model.	Recruitment and assignment hoped to be complete by summer 2019.	
											4)Institution of initial meet and greet process by patient advisors to help familiarize patients with what they can expect from their inpatient and discharge journey, including review of patient handbook.	Director of Health Data and Quality Improvement to co-ordinate meet and greet schedule with patient advisors.	Number of meet and greet sessions successfully co-ordinated.	Planning and trial to be finalized by April 2019.	
											5)Institution of group sessions for "Meet and Greet" to help caregivers and family members understand what to expect from the inpatient experience and discharge journey.	Director of Health Data and Quality Improvement and Manager of Inpatient Rehabilitation to develop schedule for group Meet and Greets.	Successful completion of schedule and implementation of group Meet and Greets.	Late Spring 2019.	
		Patient experience: Would you recommend inpatient care? ***Executive Compensation**	**HNHB LHIN Required Indicator**	% / Survey respondents	In-house survey / Q2 2018/19 (Jul - Sep 2018)	790*	100.00	95.00	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 no measurable room for improvement, the hospital will accept results between 81.8 and 100% for accountability purposes.		1)Increase number of patient advisors to assist with sharing of patient experiences.	Patient Relations Process 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)Patient Advisors to provide feedback to staff regarding results of patient experience survey and possible areas for improvement.	Clinical Manager will familiarize staff with questions on patient experience survey and patient advisors will then follow up with staff with results.	Sessions with patient advisors and staff to be conducted monthly if possible.	12 sessions held between staff and patient advisors per year.	
											3)Approach to Nursing Professional Practice Council to be reviewed to better address issues on the floor and measures to assist with patient satisfaction.	Terms of reference or approach guidelines to be modified at NPPC.	Completion of modification to terms of reference or approach guidelines.	Completion by Fall 2019.	

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Theme III: Safe and Effective Care	**Effective**	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 2018	790*	98.68	80.00	Baseline was collected on one floor. We are now expanding to the full hospital. Therefore, we are adopting a target of 80% which we believe to be a stretch target in the circumstances. For accountability purposes we will accept results between 70-100%.		1)Expansion of pilot through all floors of the Hospital.	Development of new process to be distributed to second floor staff and physicians.	Nursing Manager to complete new process.	Process to be complete by mid Summer 2019.	
											2)Education of nursing staff and physicians working on the 2nd floor.	Nurse Manager, Chief of Staff, Pharmacy manager and pharmacists to complete the education with staff and physicians.	Completion of education for all affected staff and physicians.	End of 3rd quarter 2019.	
											3)Physicians to be contacted a few days before anticipated discharge to remind of upcoming discharges to facilitate completion of medication reconciliation.	Health Records staff to contact Most Responsible Practitioner to advise of pending discharge and requirement for completion of medication reconciliation.	Number of calls completed by Health Records.	End of 3rd quarter 2019.	
		Percent of complex continuing care (CCC) patients with a new pressure ulcer in the last 3 months (Stage 2 or higher).	**HNHB LHIN Required Indicator**	% / Complex continuing care patients	CIHI eReporting Tool / Q2 2018/19 rolling 4 quarter average (Oct. 2017 to Sep. 2018)	790*	1.80	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 8%.		1)Continuation of 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.	Manager of Infection Control to work with Purchasing to ensure process is established and followed.	Completion of process and procurement of products.	By end of fiscal year 2019-20.	
											2)Refine documentation tool that facilitates assessment, planning and implementation of care plan for the wound following best practice guidelines.	Wound Consultation Team will continue to work to refine the tool with staff input.	Completion of refined assessment tool.	By the fall of 2019.	
											3)Utilize I-Equip Students from Brock University to develop a quick reference pocket guide to assist with dressing choices for dressing wounds.	Brock University I-Equip students to complete guide in conjunction with staff and Wound Management team.	Completion of guide.	Early fall 2019 for completion	
	Safe	Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.	**MANDATORY**	Count / Worker	Local data collection / January - December 2018	790*	109.00	110.00	We believe that staff have largely adopted a culture of reporting with workplace violence. However, we do feel that continuing education is essential and we do not want to discourage staff from reporting by setting a lower target. In the circumstances, for accountability purposes we will accept results between 90-and above.		1)Continue meetings of the violence in the workplace working group to identify and develop recommended interventions to assist in the reduction of workplace violence and facilitate increased protection of staff, patients and visitors.	Human Resources to continue meetings of the committee made up of representation from various employee groups as well as a patient advisor, to meet on a regular basis.	Continued meetings of the committee and development of action initiatives.	Regular meetings to be held throughout 2019.	FTE=310
											2)Continue to monitor and refine application of recently updated version of RL Solutions (Hospital incident reporting system) which has recently added capacity to report and monitor all staff incidents, as well as current capacity to report patient incidents.	Director of Health Data and Quality Improvement will continue to oversee application and identified areas of improvement for updated Version.	Continuous monitoring and implementation of modifications or improvement s to the system as required.	Throughout 2019-20.	
											3)Continue work on activation of a 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 Data and Quality Improvement to continue working with Information Systems, the NHS, and Workplace Violence Committee to complete work in this area.	Successful activation and staff education on the screen.	End of 2019-20 QIP year.	