2020/21 Quality Improvement Plan
"Improvement Targets and Initiatives"

Hotel Dieu Shaver Health and Rehabilitation Centre 541 Glenridge Avenue, St. Catharines, ON, L2T4C2

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 / Jul 2019 - Sep 2019	790*	4.38	12.00	This goal well exceeds the LHIN and provincial ALC rates and aligns with the LHIN target of 12%. This measure is largely 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 15.4%.	Niagara Health System; , LHIN Home and Community, Long Term Care Homes, Niagara Ontario Health Team - Equipe Sante Ontario Niagara (NOHT-ESON), Retirement homes, Patients' families and caregivers	1)Increase bi-weekly meetings with LHIN Home and Community to every week.	Arrange weekly meetings with LHIN Home and Community.	Number of weekly meetings held.	Regular weekly meetings.	
											2)Initiate dual process whereby applications are made to both transitional and LTC beds at the same time thereby increasing the patient's likelihood of receiving a bed offer in a timely manner.	Director of Quality will ensure dual process is in place.	Number of patients for whom dual process is initiated.	Maximum number of patients benefit from dual application process.	
											3)Continue Pilot of HIROS programme to maximize appropriate referrals to HDS from Niagara Health in a timely fashion	Vice President of Clinical Operations and Rehab Managers to ensure that pilot is operational and staffed appropriately	Number of referrals arising out of HIROS pilot	Documented number of referrals arising out of HIROS pilot.	
											4)Participate and implement Team Fit initiatives in concert with Niagara Health.	Inter-professional team to complete Team Fit education regarding program streaming and what HDS requires as a fulsome referral.	Completion of training	Team Fit education and initiatives to be implemented by end of calendar year 2020	
		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 2019	790*	6.00	6.00	Based on volumes of patients and pressures on outpatient services, we believe this is an aggressive target and exceptionally high standard to aspire towards. The stroke outpatient program currently operates two days per week. Therefore, we will accept 6-9 days for accountability purposes.	Rehab Care Alliance, Ontario Stroke Network, Niagara Health System, Patients' families and caregivers	1)Reduce Christmas closure of outpatient services from current two weeks to one week to increase patient access to services.	Rehabilitation management to work with Human Resources to communicate and implement the reduction in the closure period.	Successful communication and implementation of reduction in the closure period from the current two weeks to one week.	Christmas 2020.	
											2)Development of process to ensure communication with front line staff regarding status of inpatient to outpatient data on a regular basis.	Rehabilitation management to set up process to ensure regular communication with front-line staff takes place.	Adoption of process to ensure regular communication to front line staff.	Summer 2020.	
											3)Development of process to ensure broader access to the data result spreadsheet is provided to all discharge planners so that issues may be identified and addressed.	Rehabilitation managers and Director of Health Data to develop process for implementation with the discharge planners.	Successful adoption of a process to ensure that discharge planners receive timely access to in to out data statistics.	Summer 2020	
	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*	65.79	68.00	Last year was the first year that this indicator was tracked for the full facility and information supports that the current result is high. As a result, target for next year is set at 3.5% higher and HDS will accept results between 60 and 68% for accountability purposes.	Doctor's offices, College of Physicians and Surgeons , Family Health Teams	1)Implementation of a sustainability plan in excel spreadsheet to track discharge summary completion rates and timing of completion completion rates on both inpatient floors on both patient floors.	Director of Health Data and Chief Nursing Officer will implement sustainability plan for completion of discharge summaries on both patient floors.	Implementation and use of sustainability plan for completion of discharge summaries for both patient floors.	End of 3rd quarter 2020.	
											2)Sustainability Plan results will be circulated at SMC, MAC, Health Records and Quality Improvement of the Board committees.	Director of Health Data will ensure data is available for circulation at meetings.	Plan reviewed by Committees on a regular basis.	End of 3rd quarter 2020.	
											3)Health records staff to contact physicians with a reminder of an upcoming discharge and the need to complete the discharge summary.	Director of Health Data to ensure health records staff are aware of process and place calls.	Regular contact of physicians prior to patient discharge.	End of 3rd quarter 2020.	

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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 hospital 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. For accountability purposes, the Hospital will accept results between 90 and 100%.	Ombudsmans Office, Patient Families and Caregivers	1)Identification and communication of two back-up complaint responders in the event of absence of the Patient Relations Process Delegate (Health Records Co-ordinator and Chief Nursing Officer).	Formal identification and communication of two backup delegates for receipt and response to patient complaints.	Identification of backup delegates completed and communication to necessary stakeholders completed.	End of 1st quarter 2020.	
											2)Broaden distribution of data and results with more in-house committees and staff.	Patient Relations Process Delegate and Chief Nursing officer to ensure that data is distributed to more in-house committees and staff.	Distribution of data to more in-house committees and staff.	End of 2nd quarter 2020.	
											3)Patient Handbook to be updated to ensure information regarding Patient Relations Process Delegate and alternates are identified.	Director of Communication to circulate handbook to appropriate parties for updating.	Handbook successfully updated, published and distributed so all affected stakeholders will be in receipt of updated information in a timely manner.	By end of 2nd quarter 2020.	
		Patient experience: Would you recommend inpatient care to your friends and family? ***Executive Compensation**	**HNHB LHIN Required Indicator**	% / Survey respondents	In-house survey / Q2 2019/20 (Jul-Sep 2019)	790*	99.47	95.00	This is a very aggressive target and is significantly higher than the provincial average of 62.00%. Given the very high results we have obtained, and no measurable room for improvement, the Hospital will accept results between 85 and 100% for accountability purposes.	Comparator Hospitals, Patients' Families and Caregivers, Niagara Ontario Health Team - Equipe Sante Ontario Niagara	1)Initiate the availability of face-timing so that a patient may face-time family and friends with the assistance of a Patient Advisor.	Director of Health Data and Quality Improvement to work with IT representatives and patient Advisors to facilitate implementation of ability to face time.	Implementation of a process whereby Patient Advisors have ability to assist patients in face timing their friends and family members.	End of year 2020 or earlier	
											2)Increase number and availability of Patient Advisors so that they are able to attend on weekends and Holidays.	Director of Health Data and Quality Improvement to work with Human Resources staff to ensure appropriate and ongoing recruitment of Patient Advisors.	Increase of complement and availability of Patient Advisors so that patients have access to the Advisors on weekends and Holidays.	End of year 2020 or earlier.	
											3)Development and promotion of a process to educate staff on patient satisfaction results and details -- including sharing the positives.	Director of Health Data and Quality Improvement to work with Nursing and Rehabilitation Managers to develop a process whereby staff are informed of patient satisfaction results in a timely manner.	Implementation of a process whereby staff are educated on patient satisfaction results in a timely manner.	End of 2020 or earlier.	
		Survey question: 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 2019/20 (Jul-Sep 2019)	790*	96.81	97.00	This target is very high based on last year's high performance. Stable data for Ontario is not yet available for benchmarking purpose. Given limited ability to increase performance, and relatively small volumes of patients, the Hospital will accept results of 85% or higher for accountability purposes.	Patients' Families and Caregivers, Niagara Health Information Technology Systems Department	1)Develop a schedule for patient advisors to complete surveys at least 2 days prior to discharge date	Director of Health Records and Quality Improvement to work with staff and patient advisors to devise and implement schedule.	Process for development of schedule has been successfully developed and rolled out to Patient Advisors.	End of calendar year 2020	
											2)Process developed whereby Health Records Co-ordinator and Director of Health Data and Quality Improvement review survey results as soon as possible after completion in order to determine if follow up is required before discharge.	Health Records Co-ordinator and Director of Health Data and Quality Improvement to develop and implement process to ensure timely review of completed surveys.	Development and implementation of process to ensure timely review of surveys as soon as possible after completion in order to identify potential gaps and follow up requirements.	Summer 2020	
											3)Implement trial of assigning pharmacist on the inpatient floors in order to facilitate timely and comprehensive information to patients and their caregivers before discharge from the hospital.	Vice President of Clinical Operations and Manager of Pharmacy will work with Chief Nursing Officer to ensure implementation of trial programme.	Successful implementation of pharmacist to be assigned to the inpatient floors.	Fall 2020	

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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 / Oct 2019– Dec 2019 (Q3 2019/20)	790*	99.16	85.00	Last year was the first year that we expanded this initiative to the whole hospital and we are still working with partners to familiarize them with the process. As a result, for accountability purposes we will accept results between 80-100%.	Accreditation Canada, Community Pharmacists, Niagara Health System, Patients' families and caregivers	1)Pilot initiative whereby Pharmacy staff are assigned to the patient floors and can assist with the medication reconciliation at discharge process.	Chief Nursing Officer and Manager of Pharmacy to work together with Human Resources to implement this initiative.	Successful adoption of pharmacy staff on the inpatient floors to assist with, among other things, the medication reconciliation at discharge process.	End of year 2020.	
											2)Review and complete modifications to the Best Possible Medication History Form (BPMH) to ensure that it is easy to follow and complete by physicians.	Manager of Pharmacy will work with Chief Nursing Officer to ensure that review and modifications are completed, approved, and implemented.	Successful completion of review, approval process through various committees including Health Records and Medical Advisory Committee, and implementation.	End of year 2020 or earlier.	
											3)Adoption of Digital Hospital Drug Repository (DHDR) which will allow physicians and pharmacists to view a more comprehensive drug history of patients in one place.	Director of Health Data and Quality Improvement to work with Chief Nursing Officer to ensure implementation and training have taken place.	Successful implementation and training on the DHDR has been completed with applicable parties.	By end of year 2020 or earlier.	
		Percent of complex care 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 2019/20 rolling 4 quarter average (Oct. 2018 to Sep. 2019)	790*	0.00	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. The target of 5.4% effectively represents 3 cases. For accountability purpose, therefore, we will accept values between 5.4 and 8%.	Brock University I-Equip Students, Canadian Institute of Hospital Information - Comparator Hospitals	1)Conduct quality review of data being entered into CCRS to ensure accuracy.	Chief Nursing Officer to conduct quality audits.	Regular completion of audit.	End of 3rd quarter 2020.	
											2)Expansion of Wound Care Team to include more front line staff in addition to the Charge Nurse and Nurse Practitioner leads.	Chief Nursing officer to ensure that team is expanded.	Successful implementation of expanded Wound Care Team.	End of 3rd quarter 2020.	
											3)Continue to streamline dressing therapies and associated education sessions.	Chief Nursing Officer and team will continue to work on this initiative.	Evidence of ongoing streamlining of dressing therapies and associated education sessions.	End of 3rd quarter 2020.	
	Safe	Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.	**MANDATORY**	Count / Worker	Local data collection / Jan - Dec 2019	790*	43.00	50.00	The Hospital's interest is in promoting a culture of reporting. As a result, our target in this year's QIP is again premised on increasing, and not reducing, the number of reported incidents.	Ministry of Health, Ministry of Labour, Patients' families and caregivers	1)Complete ongoing training for staff on recognition of workplace violence.	Health and safety Co-ordinator to continue with staff training.	Completion of staff training.	End of calendar year 2020.	FTE=311
											2)Continue timely flagging of patient for implementation of violence care plan.	Nursing managers to continue to identify patients flagged as violent who may benefit from violence care plan.	Implementation of violence care plans for applicable patients.	Current and ongoing.	
											3)Continue to work to modify Meditech so that patient is flagged in the system and the information is printed on the Meditech face sheet.	Violence Prevention Committee is continuing to work on this modification.	Completion of implementation of modification to Meditech.	End of calendar year 2020.	