2023/24 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 period, divided by the total number of inpatient days (midnight census) in the same period.	Custom	Rate per 100 inpatient days / All inpatients	Hospital collected data / Jul-Sep 2022 (Q2 2022/23)	790*	9.47	13.00	This goal exceeds the Q2 Hamilton Niagara Haldimand Brant (HNHB) Sub-region ALC rate for post acute care of 16.5% and the provincial rate of Post Acute care of 13.1%. This measure is largely outside of HDS control and is dependent upon bed pressures throughout the Region, the pressures on Home and Community Care Support Services, and patient's/family's LTC choices. For accountability purposes, we will accept values between 13% and the HNHB 16.5%	Niagara Health System; Home and Community Care Support Services, Long Term Care Homes, Niagara Ontario Health Team – Équipe Santé Ontario Niagara (NOHT-ÉSON), Retirement homes, Patients' families and caregivers	1)ALC Rounds meeting with Home and Community Care Support Services (HCCSS)to review all cases likely destined for LTC	Weekly meetings with Management and staff representation from both the HCCSS and HDS to exhaust all possible avenues before approving to wait for LTC from the hospital.	Regularity of ALC Rounds meetings	Weekly meetings to take place	
											2)Patient Flow meetings including representation from across the interdisciplinary team occur every day a 3:00 p.m. to review patient referrals, patient discharge dates and identify recommended interventions that may assist in facilitating safe and timely discharges.	Interdisciplinary team to meet on a daily basis.	Regularity of Patient Flow meetings	Daily meetings to take place	
											3)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 Home and Community Care Support 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.	
											4)Interdisciplinary 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.	
		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 / Jan-Dec 2022	790*	22.00	25.00	Based on volumes of patients and pressures on outpatient service, which include inability to hold group sessions due to COVID restrictions, virtual visits, summer and Christmas shut-downs due to funding restrictions, and Health Human Resource limitations. We believe this is an aggressive target and exceptionally high standard to continue to aspire towards.	Rehab Care Alliance, Ontario Stroke Network, Niagara Health System, Patients' families and caregivers	1)Continue to review and analyze wait time data on a regular basis to ensure interventions can be flagged if there is an identified problem.	Manager of Outpatient Rehabilitation and Specialty Clinics 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 one (1) review and one (1) analysis conducted monthly.	
											2)Continue to communicate wait time status to all relevant parties on a regular basis.	Wait time status to be communicated by Rehab leadership to staff teams, Executive VP of Operations and other managers, Finance, Senior Team, Quality Committee of the Board of Trustees.	Wait times to be reported quarterly, unless there are identified anomalies, in which case reporting to other involved managers, and Executive VP of Operations 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.	Number of identified and implemented interventions as required and as feasible.	Continuing administration of current process.	

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	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.	Custom	% / Discharged patients	Hospital collected data / Oct-Dec 2022 (Q3 2022/23)	790*	84.70	85.00	We believe staff/MRP's have adopted a culture and recognize the importance of discharge information and have a process in place to ensure this information is delivered in a timely manner.	Doctor's offices, College of Physicians and Surgeons , Family Health Teams	1)Review and audit completed discharge summaries that are delivered to primary care physicians within 48 hours of discharge and report findings to HRQCRM Committee, MAC, Senior Team and Quality Improvement Committee of the Board.	The discharge summaries are sent via FAX to the primary care physician's office by the Ward Clerk and the original report and confirmation of FAX is kept in the health record. Health Records staff review, and report on every discharged patient, which includes date and time sent to calculate turn around time of delivery of information.	Completion of review of number of discharge summaries that are sent to primary care physicians within the 48 hour time frame.	Continued review and reporting for all discharged patients.	
											2)Review of process and training as required for new MRP'S completing the summary, and ward clerks that FAX the reports.	Written process being developed to support accurate completion of discharge summary in a timely manner and subsequent delivery to the primary care physician.	Successful development and delivery of education and training program.	Ongoing review, analysis and reporting monthly.	
											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 continue.	
Theme II: Service Excellence	Patient-centred	Percentage of complaints acknowledged to the individual who made a complaint within five (5) business days	Custom	% / All patients	In house data collection / Jan-Dec 2022	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.	Ombudsmans Office, Patients' Families and Caregivers	1)Enhanced publication of the contact information for the Patient Relations Process Delegate.	Ensuring notices are developed, and distributed to key areas throughout the Hospital and included in the Patient and Family Handbook.	Completion of notice and number of notices that are distributed.	Notices placed at all elevators, Nursing stations, scheduling offices and in the Patient and Family Handbook.	
											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 the patient Relations Delegate is unavailable.	Completion of identification and communication.	Ongoing communication.	
											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 the first response, substance of complaint, nature of resolution and resolution timelines.	Completion and maintenance of tracking document on a quartely basis with reporting to Quality Improvement Committee of the Board.	Ongoing to include quarterly reporting.	
		Patient experience: Would you recommend inpatient care to your friends and family?	Custom	% / Survey respondents	In-house survey / Jul-Sep 2022 (Q2 2022/23)	790*	100.00	95.00	The target is very high as a result of our internal high results and is significantly higher than the CIHI YHS (Your Health System) Overall Hospital Experience HNHB results of 58%. Given the very high results obtained, and no real measurable room for improvement, the hospital will accept results between 90 and 100% for accountability purposes.	Comparator Hospitals, Patients' Families and Caregivers, Niagara Ontario Health Team – Équipe Santé Ontario Niagara (NOHT-ÉSON)	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 and current patients.	Number of new Patient Advisors recruited.	Increase in number of active patient advisors.	
											2)Patient Advisors to provide feedback to staff regarding the positive results of patient experience surveys and opportunities for improvement.	Clinical Manager will familiarize staff with questions on patient experience surveys and Patient Advisors will then follow-up with staff with results.	Sessions with Patient Advisors and staff to be conducted monthly, if possible.	Twelve (12) sessions held between staff and Patient Advisors per year.	
											3)Results of patient experience surveys to be presented at the newly formed Clinical Quality Council that consists of frontline staff, management, physicians and Patient Advisors to better address successes on the nursing units and identify areas of opportunity to assist with patient satisfaction.	Terms of reference guidelines established and this is a standing item on the Clinical Quality Council agenda.	Present at least one scenario at each quarterly Clinical Quality Council.	Minimum of four (4) reviews annually.	

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		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**	Priority	% / Survey respondents	In-house survey / Jul-Sep 2022 (Q2 2022/23)	790*	100.00	95.00	The target is very high based on last year's high results and is significantly higher than the CIHI YHS (Your Health System) reported results for "Information and Understanding When Leaving the Hospital" (2020-2021) HNHB average of 60%. Given limited ability to increase performance, and small volumes of patients, the Hospital will accept 90% or better for accountability purposes.	Patients' Families and Caregivers, Niagara Health Information Technology Systems Department	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 upcoming discharge dates and will attend at the 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 Relations Process Delegate 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/families prior to discharge.	Number of patient advisors instructed on process to follow with clinical manager.	All patient advisors who administer the survey provided orientation on process to follow with clinical manager.	
											3)"Meet and greet" process by patient advisors to help familiarize patients/families with what they can expect from their inpatient stay and discharge journey, which includes review of the Patient and Family 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.	Gradual re-implementation post-COVID during periods when we are clear of outbreaks.	
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. ***Executive Compensation**	Priority	Rate per total number of discharged patients / Discharged patients	Hospital collected data / Oct–Dec 2022 (Q3 2022/23)	790*	99.48	90.00	The target is very high as a result of out internal high results. For accountability purposes we will accept results between 90 and 100%.	Accreditation Canada, Community Pharmacists, Niagara Health System, Patients' families and caregivers	1)Expansion of medication reconciliation to all floors	New process developed to be distributed to second floor staff and physicians.	Nursing Manager to complete new process and information for MRP's also.	Completed during COVID pandemic with continued education ongoing	
											2)Continuing education of nursing staff and physicians working on any unit in the hospital.	Nurse manager, Chief of Staff, Pharmacy Manager and pharmacists to complete the education with the staff and physicians.	Continuing education for all affected staff and physicians.	Ongoing as new staff and physicians are onboarded.	
											3)Physicians to be contacted a few days before anticipated discharge to be reminded of upcoming discharges to facilitate completion of medication reconciliation.	Health Records staff to contact MRP to advise of pending discharge and requirement for completion of medication reconciliation.	Number of calls completed by Health Records.	Ongoing process reviewed a few days prior to discharge to allow time to contact MRP.	
		Percent of complex care patients with a new pressure ulcer in the last 3 months (Stage 2 or higher).	Custom	% / Complex continuing care patients	CIHI eReporting Tool / Q2 2022/23 rolling 4 quarter average	790*	0.00	3.00	This target is very aggressive and can be 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 3.0 and 8%.	Brock University I-Equip Students, Canadian Institute of Hospital Information - Comparator Hospitals	1)Implementation of a Nurse-lead wound care team on 2nd floor (Complex Care, Rehab Lo and EOL) now in place on all units that has refined a documentation tool that facilitates assessment, planning and implementation of care plan for following wound best practice guidelines.	Wound Consultation Team will continue to work to refine the tool with staff input and ongoing education for staff.	Completion of education material re: the wound care tool and tracking of education.	Through 2023 2024.	
											2)Continue process to procure internal surfaces, rather than 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 Prevention and Control to continue work with Purchasing to ensure process of replacing surfaces as required.	Ongoing procurement of appropriate surfaces.	Through 2023 2024.	
											3)Quality Improvement project/HFMEA on wound incidents are tracked for low intensity rehab patients as well as Complex Care and EOL patients through CCRS reporting.	Nursing and Wound Care Team capture data in the CCRS regarding wounds on admission and then quarterly thereafter.	Monitoring quarterly to ensure interventions/processes are effective.	Ongoing as required by CCRS clinical data capture for quarterly reviews.	

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	Safe	Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period. ***Executive Compensation**	Priority	Count / Worker	Local data collection / Jan 2022-Dec 2022	790*	92.00	60.00	We believe that staff have largely adopted a culture of reporting with workplace violence. 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 60 and above.	Ministry of Health, Ministry of Labour, Patients' families and caregivers	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 for the development of action initiatives.	Regular meetings to be held.	FTE=308
											2)Continue to monitor RLsolutions incident reporting system that includes the capacity to report violence/harassment in a customized set of appropriate fields in the reporting structure.	Senior Coordinator of Safety and Disability and Health Data Coordinator will oversee application and identify areas for improvement in the reporting structure.	Continuous monitoring and implementation of modifications or improvements to the system as required.	Through 2023 2024.	
											3)Go-live for the activation of a screen in Meditech (HIS system) to allow staff registering patients to be aware of those who were flagged as behavioural/aggressive while inpatients at the HDS or at the Niagara Health system.	Development of field has been completed and currently Director of Health Data and Quality Improvement is working with Information Systems to push it to the "live" environment in Meditech.	Staff education has taken place and now waiting on successful activation in Meditech.	Early March 2023	
											4)Back loading of patients flagged with behaviours/aggression from April 2022 to present into the Meditech environment so staff can review care plans in advance of receiving patient to protect staff, other patients and visitors.	List created from RLSolution electronic incident reporting system with any previously flagged patients as above and these will be entered into Meditech, with a new face sheet printed for the patient record.	Completion of list form April 2022 to present.	Early March 2023	