2014/15 Quality Improvement Plan for Ontario Hospitals
"Improvement Targets and Initiatives"

HOTEL-DIEU GRACE HOSPITAL 1453
Prince Road | Windsor, Ontario

AIM		Measure					
Quality dimension	**Objective**	**Measure/Indicator**	**Unit / Population**	**Source / Period**	**Organization Id**	**Current performa**	**Target**
Access	**Improve access to high intensity rehab for stroke patients**	Average adjusted Length of Stay (LOS) for Moderate Stroke Patients (RPG - 1120	Days / Rehab	IntelliHealth, MOH / 12-13 YTD used for baseline	927*	33.9	28

Effectiveness	**Improve organizational financial health**	Total Margin (consolidated): % by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expense, excluding the impact of facility amortization, in a given year.	% / N/a	OHRS, MOH / Q3 2013/14	927*		0
Integrated	**Reduce unnecessary hospital readmission**	% mental health patients readmitted to same facility within 30 days (OMHRS)Q1	% / Mental health/addiction patients	OMHRS, CIHI / Q1 - 13-14 used as baseline	927*	31	20
Patient-centred	**Improve patient satisfaction**	From NRC Picker "Overall, how would you rate the care and services you received at the hospital (add together percent of those who responded "excellent, very good and good " . (Rehab)	% / Rehab	NRC Picker / Q2 - 13/14	927*	81.9	95

		Internal Survey : "Overall, how would you rate the care and services you received at the hospital" (add together Excellent, Very good and Good) Complex Continuing Care	% / Complex continuing care residents	In-house survey / bi-yearly survey	927*	96	95
Safety	**Increase proportion of patients receiving medication reconciliation upon admission**	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.	% / All patients	Hospital collected data / Most recent quarter available (e.g. Q2 2013/14, Q3 2013/14 etc.)	927*	44	100
	Reduce hospital acquired infection rates	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1,000 - Average for Jan-Dec. 2013, consistent with publicly reportable patient safety data.	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / 2013	927*	0	0.14

		Hand hygiene compliance before patient contact: The number of times that hand hygiene was performed before initial patient contact divided by the number of observed hand hygiene indications for before initial patient contact multiplied by 100 - consistent with publicly reportable patient safety data.	% / Health providers in the entire facility	Publicly Reported, MOH / 2013	927*	CB	95
	Avoid Patient falls	Total Falls rate with harm (Category E and above) per 1000 patient days (all in-patients)	Rate per 1,000 patient days / All patients	Hospital collected data / Q3 - HDGH -baseline	927*	0.83	0.9

		Change				
Target justificatio	**Priority leve**	**Planned improvement initiat**	Methods	Process measures	Goal for change ide	Comments
The 12-13 YTD baseline/current performance is based on previous 12-13 WRH data. Due to realignment activities and the need to discharge and readmit all patients during the transition, we are not able to utilize Q2 or Q3 13-14 data for baseline or comparison. We would like to move towards the Ontario Stroke Network recommended LOS (length of stay) for 1120 of 25.8 days.	Improve	1)In consultation with our partners, review role and standard work processes of the Intake Nurse within the program. In doing so, identification of potential candidates for IP Rehab can occur earlier in their acute care stay. This will identify barriers to admission to the program. It will also assist the program in determining when these candidates are both appropriate and ready to participate in the program, so to achieve the most gains in functional status within the projected LOS.	1) Implementation of standard order set by June 2014. 2)Review LOS monthly with Quality Team , Program and Staff Review RPG 1120 cases (chart review, service interruptions and contributing factors and data quality)	1)100% of RPG 1120 cases reviewed 2)Implementation of Order set by June 2014.	100% of RPG 1120 cases reviewed to	Meeting target is dependent on adequate post - rehab services being available

We have set this at 0 , however, due to realignment of hospitals in Windsor , there will be a reconciliation	Maintain	1)Measure & Monitor costs & clinical indicators	1)Review departmental budgets monthly at on-off budget meetings and establish process for monthly variance reporting by managers/directors 2)Review LOS vs ELOS information at Quarterly Utilization /Physician Advisory Committee meetings	1)100% variance reports submitted by due date for financial on/off budget meeting reviews 2)LOS information shared at 100% of quarterly Utilization /Quality /Physician Advisory Committee meetings Share HSFR at various meetings for adequate dissemination to leadership and staff	1)100% of change idea processes in place by June 2014	
Improvement towards like peer group. We have used Q1 13-14 as baseline due to data quality challenges in 12/13.	Improve	1)Monitor and review all readmission to Specialized Mental Health	1) Engage Hospitalist team and GEM nurse with readmission review process and perform root cause analysis of all readmit cases from acute care. 2) data will be tracked and cases reviewed by the care team monthly to identify common challenges and/or barriers	100% of readmission cases reviewed by Readmission Review Team. (RRT)	100% compliance with review of readmission cases by June 2014.	Most of readmissions are patients that are over 65 years of age with medical conditions and transfers to acute. Goal of readmission reviews to identify any contributing factors and improvements related complex medical conditions of patients
We have based the target on our global target for overall rating of care for all services which is	Improve	1)Establish a Patient Centered Care Advisory Committee	Establish a Patient Centered Care Advisory Committee and review quarterly Rehab Satisfaction results . 2) Establish a Patient Experience working plan through review of the results	100% review of quarterly satisfaction reports at Patient Centered Care Advisory Committee	Advisory Committee established by April 2014.	

Previous performance in Q4 12-13 was 92%. We have based the target justification on our global goal of >95% satisfaction in rating of care and services.	Improve	1)Establish a Patient Centered Care Advisory Committee	1) Establish a Patient Centered Care Advisory Committee . 2) Review CCC results bi-annually and establish a Patient Experience working plan. 3) Review survey questions and survey process Review survey questions and survey process	1) Establish a Patient Centered Care Advisory Committee 2) Review bi-annual results with team and 100% completion of survey questions and process	Establish a Patient Centered Care Advisory Committee by April 2014.	
We have set a target of 100% for our Rehab population only, Current performance for Complex Continuing Care is currently 44% and MH is 100%.	Improve	1)Implement ISMP standards for medication reconciliation	1) 100% of all Rehab admissions are to be flagged through a notification process and have medication reconciliation completed by a pharmacist within 48 hours of admission. 2) Engagement of Physicians for discharge component is required and will be coordinated through Vice President of Medical Affairs.	1)100% of Rehab admissions flagged through a notification process to Pharmacist at time of admission 2) 100% compliance - monitored at weekly/bi-weekly team huddle meetings.	Implement Flagging/Notification Process by April 2014 and ensure compliance with ISMP standards.	Evaluate current tools and clearly define the medication reconciliation process as well in CCC area .
Our current performance is .17 (Q3) and .25 for the previous period for the Tayfour campus which is now part of HDGH. This would be below the provincial average of .3	Improve	1)Establish a Process Improvement Team to review Infection Control Procedures and Develop a Process Improvement work plan.	1) Increase hand hygiene compliance through education and training. 2) Ensure patients are moved to private room and/or cohorted with like organisms as soon as identified. 3) Use of disposable slings or single patient sling. 4)Eliminate storage of supplies in patient rooms. 5)Cleaning routines for equipment such as wheelchairs, infection control carts, etc.	1) >95% hand hygiene compliance 2) 100% compliance with cohort initiative 3)Develop work plan through Process Improvement Team "	Implementation of Process Improvement Team in April 2014 and establishment of work plan by May 2014.	

This target is based on alignment with our regional targets . Due to realignment of our organization, we are currently re-establishing our infection control audit processes and data collection process within our new organization. Previous	Maintain	1)Review Audit Tools and Audit Process and Enhance Education and Training Campaign	1)Review audit tools to ensure use of MOHLTC audit tool. 2)Auditors to attend formal hand hygiene auditor training for standardization. Provide real time feedback on education on the 4 moments of hand hygiene. 3)Increase educational campaign on 4 moments of hand hygiene targeting nurses, physicians, support groups and public. 4)Review all alcohol hand washing stations in all programs to ensure within appropriate location. 5)Increase staff awareness of compliance by posting results per clinical area. 6)Consider using incentives to reward compliance (i.e. coffee vouchers).	1) Increase hand hygiene compliance before patient / environment contact and after patient / environment contact. Target - 95% 2) Monthly Review of data with Improvement Team, Quality Teams , Leadership and Staff Meetings. 3) 100% of auditors complete formal auditor training	1)Complete Audit Tool & Audit Process Review by April 2014. 2)Develop Education & Training Campaign by May 2014.	
Due to realignment in October 1st, 2013, we have one quarter of data which represents our baseline. This is consistent with historical performance prior to Oct 1, 2013	Maintain	1)Maintenance (or improvement of) current fall reduction strategies. Look at fall prevention rather than fall reduction.	1) Review contributing factors for 100% of falls looking for trends. 2) Continue to follow IHI tool kit and fall screening tool, ensuring interventions are in place.	1) Review of monthly falls data and contributing factors information with Quality Team and Quality Committee 2) Review of falls data and information with staff through staff meetings and huddles	Identification of Fall Prevention Strategy by May 2014 by Process Improvement Team.	As part of a falls prevention strategy , we will be examining restraint use, improving mobility, delirium screening and medical causes for further prevention strategies