2017/18 Quality Improvement Plan
"Improvement Targets and Initiatives"

Hôtel-Dieu Grace Healthcare

Hotel-Dieu Grace Healthcare 1453 Prince Road

CHANGING LIVES TOGETHER

AIM		Measure							Change				
Quality dimension	Issue	Measure/Indicator	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	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?	% / Survey respondents	CIHI CPES / April - June 2016 (Q1 FY 2016/17)	927*	25.5	38.00	Targeting TOP Box results - Movement towards Ontario Average	1)Improve Scores through partnership with social work , patient /families and program /unit based councils to improve discharge information .	Utilize patient experience /patient /family consultation to identify required information and develop strategy that would support excellent experience In this Key Experience question related to discharge process .	Identify Key Strategic priorities to support this indicator	100% of strategies implemented that are identified as priority for 17-18 .	
	FIM Efficiency	Total Function Score Change divided by LOS for each client, averaged over the number of clients. Service interruptions excluded	Rate / Rehab	CIHI NRS / April , 2016- December 2016	927*	1.1	1.30	Target for 15-16 was 1.1 . This indicator has been increasing with the action plans in place - Q1- .83 , Q2 - .95 and Q3 - 1.26 In comparing to peers , we feel this is a reasonble target considering the FIM data quality work that still needs to occur	1)Develop an interdisciplinary team to Implement Best Practice data collection for FIM	Develop and Implement a best practice worksheet to improve FIM accuracy and improve inter professional team relationships	% of worksheets completed	100% of worksheets completed month	
									2)Implement Education Program for completing FIM's	Complete Education of FIM /NRS with Managers/CPM and Charge Nurse Roles . Complete Education with all Front Line Staff on completion of FIM's	% of staff completed education	100% of staff that completed education by year end	

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	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July – September 2016 (Q2 FY 2016/17 report)	927*	15.91	19.90	Current Performance is 24.2% . The 15.91 was only for Q1-Q2 . LHIN targets and current community and acute care challenges has been taken into consideration is setting our overall target. Focus will be on Complex Continuing Care program where we are focusing on Restorative Care Model . Rehab rates are 13.2% and MH is 3.2% YTD. Complex is 35% YTD and this is the are we will be targeting improvements that support moving to a Restorative model of Care in CMC .	1)Interdisciplinary Focus on CMC ALC rate to facilaite discharge and remove barriers with goal of creating capacity .	1. Monthly "deep dive" ALC reviews with CCAC and ALSO partners . 2. Continue with twice weekly CDR's. 3. Implement weekly ALC bed reviews on units to facilitate discharge and remove barriers 4. ALC rates on Program scorecards .	1. % of Montly Deep Dive reviews with CCAC /ALSO 2. % CDR's completed /occurring 3. Monitor Throughput ratio : CMC 4. Monitor ALC rates on CMC /Rehab and MH scorecards with associated Action Planning with Program & Manager, Flow .	1. 100% of Weekly Deep Dive ALC reviews 2. 100% of CDR's occurring 3. Goal : Throughput Ratio : >1	
		Total number of ALC days contributed by ALC patients within the specific reporting quarter using near real time post acute ALC information and monthly bed census data .	Rate per 100 inpatient days / Complex continuing care patients	WTIS, CCO, BCS, MOHLTC / April - December - Q3	927*	35	19.90	HDGH will be focusing on CMC /ALC rates . Our current rates reflect impacts from acute care /community ALC pressures . Our program focus is on a Restorative Care Model .	1)Interdisciplinary Focus on CMC ALC rate to facilitate discharge and remove barriers with goal of creating capacity .	1. Monthly "deep dive" ALC reviews with CCAC and ALSO partners . 2. Continue with twice weekly CDR's. 3. Implement weekly ALC reviews on units to facilitate discharge and remove barriers 4. Imbed ALC rates on Program scorecards .	% of Montly Deep Dive reviews with CCAC /ALSO 2. % CDR's occuring 3. Monitor Throughput ratio : CMC 4. Monitor ALC rates on CMC /Rehab and MH scorecards with associated Action Planning with Program & Manager, Flow .	1. 100% of Weekly Deep Dive ALC reviews 2. 100% of CDR's occuring 3. Goal : Throughput Ratio : >1	
Patient-centred	**Person experience**	"Would you recommend this hospital to your friends and family?" (Inpatient care)	% / Survey respondents	CIHI CPES / April - June 2016 (Q1 FY 2016/17)	927*	58.3	70.00	We will be using the "TOP BOX" methodology . Our target is based on the current Ontario average and is a stretch target. Responses include "excellent" responses of " Definitely Yes " only . We	1)Develop a formal patient experience framework and identify key improvement initiatives with Patient /Family , Staff and Leadership .	1. Develop best practice patient experience framework based on NRC and HQO/Patient First Guidelines. 2. Identify Key Improvement Strategies by July 2017 for implementation in 17-18 fiscal .	Complete Framework and Identify Key Improvement Strategies by July 2017	Implementation of Key identified strategies - 100%	

								consider this part of our Strategic Priority related to Identity . Our Fiscal YTD (April - December is 64.2%)	2)Improve transparency of sharing patient experience data and embed in the unit based & program scorecards	1. Imbed patient experience scores into unit /program scorecards . 2. create a Patient Experience Intranet Page so all staff can review patient experience results and comments 3. Post QIP quarterly on HDGH public website 4. Work with Communications team to highlight success stories .	1. Add patient experience results to unit/program scorecards where applicable by May 2017 . 2. Create Intranet page by June 2017 3. Start to post quarterly QIP results beginning in Q1 - 17-18 .	1. 100% of applicable scorecards with experience data added . 2. Posting of Patient Experience results by June 2017 for staff . 3. Post QIP quarterly - 100% 4 Track the # of success stories shared .	
		Did you receive enough information on admission (TOP BOX Score - Definitely "YES" only) .	Rate / Survey respondents	NRC Picker / YTD - April - December	927*	28.6	39.00	Goal is to improve the TOP BOX responses by 10%.	1)Improve Scores through partnership with intake , patient/families and community partners and standardized admission information	Create a standardized Patient/Caregiver letter for Restorative care patients : What to expect at post acute care .	% of patients provided with standardized information	100% receive standardized information	
Safe	**Medication safety**	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	Rate per total number of admitted patients / Hospital admitted patients	Hospital collected data / Most recent 3 month period	927*	62	100.00	Accreditation Canada requires implementation across all programs by our next accreditation (June 2019). We have improved over the past year by 13% with plans impacted by the increase in patient flow and increase of admissions. We have set an aggressive target of 100% by Q4 - 2018 and will be focusing on the admission	1)1. Redesign of current Medication Reconciliation admission process with the goal of increasing the number of medication reconciliations completed on admission. and improved use of available resources	1. Review of Pharmacy department by external consultants and to identify a gap analysis. 2 Create a working group with key stakeholder . 3. Complete review of literature and best practice 4. Evaluate current process of collecting BPMH, and identify areas/gaps in the process that can be enhanced to increase number of BPMH's through process mapping .	1. Complete mapping and gap analysis by July 2017 . 2. Identify model and recruit staff as required	1. Post metrics on 100% of safety boards . 2. Complete Education and training with staff by September 2016 .	
									2)To move from a one unit based pharmacy led BPMH process to an organizational wide plan.	1. Optimize collection process to maximize the total number of BMPMH's completed 2. Focus on quality of BPMH through education of all end users . 3. Provide monthly data for posting on metric boards and for discussion at safety huddles.	1. Identify model and recruit staff as required 2 Decrease transcription errors . 3. Post metrics and integrate discussion with safety huddles by Q2 . 5. Complete Education with Staff .	1. Post metrics on 100% of safety boards . 2. Complete Education and training with staff by September 2016 .	

								reconciliation processes .	3)Explore, implement and evaluate other models beside pharmacy led med rec (BPMH) process such as Pharmacy Techs, Nursing, Nurse Practitioner models.	1. Review of Pharmacy department by external consultants and to identify a gap analysis. 2 Create a working group with key stakeholder . 3. Complete review of literature and best practice	Recruit potential pharmacy techs, nursing and NP's to support collection of BPMH	1. Complete mapping and gap analysis by July 2017 . 2. Identify model and recruit staff as required	
	Safe care	% of physical restraint usage	Rate per total number of discharged patients / Mental Health inpatients	CIHI DAD,CIHI OHMRS,MOHTLC RPDB / YTD April - December 2016	927*	2.9	1.00	Based on review of current performance rates , along with Peer (.7%) and Province (.6%) , along with specific comparator organizations.	1)Education to staff regarding restraint definition and policy	Enhance Knowledge of restraint use and policy	% staff who received education	100% of staff completed education review by December 2017	
									2)Review all restraint usage in real time within 24 hours	1. Explore alternatives to physical restraint use within 24 hours . 2. Staff re-assess every 24 hours	% cases reviewed in real time	100% reviewed within 24 hours .	
									3)Monitor impacts on other restraints such as chemical and seclusion rates .	Monitor other seclusion rates and monitor on MH Program scorecards .	% cases reviewed by staff every 24 hours	100% of cases re-assessed every 24 hours .	
	Employee Safety	# of Code Whites without injury (healthcare & lost time) as a % of total incidents.	% / employee incidents	Hospital collected data / YTD - April - December 2016	927*	97	100.00	Our goal is set and supported by our senior leadership team . Our goal is for NO INJURIES from code white incidents .	1)Education refresh for prevention of Workplace Violence Policy and Code of Conduct Policy	Mandatory E-learn module for all staff	100% - mandatory e-learn completed by deadline	100% e-learn module completed by all staff	
									2)Correction Action Forms Reviewed on all incidents.	Review of all Corrective Action forms submitted by Managers	Completion of Forms	100% of forms reviewed	
									3)RL Solution Implementation for Electronic reporting of staff injuries	Training of all staff on new reporting process	% staff trained on RL Solutions	3. 100% trained by Dec 2017.	

Timely	**Timely access to care/services**	Days between date ready and admission date - % transferred from Acute care meeting targets : Rehab/Complex (Restorative Program) - 2 days target : TNI (MH) : 14 day target	% / All inpatients	Hospital collected data / Q3	927*	72.1	85.00	Current status is : Rehab : 85% YTD meeting target , CMC - 77% and MH - 60% . A stretch target of 85% may be impacted by ALC factors as this moves us away from Restorative Care and impacts our patient flow into our Restorative Care Programs. Our target is to reach 85% which allows for other factors that would impact ability to transition but sets forth an aggressive target as making sure our patients are in the right bed at the right time is priority for HDGH .	1)Implement Standardized Application Processes that support provincial referral standards and improve flow .	1. Implement Standardized Application Form complying with provincial referral standards (PRS) . 2. Separate out application for IP programs vs consult requests for physiatry and geriatricians to improve referral process 3. Complete Education session on Eligibility Criteria with Acute Care Partners	% Referral Form Completed on CMC/Rehab admissions 2. Maintain consult to intake assessment at 2 days 3. Complete Education Sessions with acute care partners by Q2	1. 100% 2. 100% at 2 days	