2016/17 Quality Improvement Plan for Ontario Hospitals
"Improvement Targets and Initiatives"

		Measure									
	Objective	Measure/Indicator	Unit / Population	Source / Period	Current performance	Target	Target justification	Action Plans	Action Plan - Process Measures	Indicator Lead	Executive Sponsor
	Reduce ALC	ALC Rate - % of patients who are ALC	All IP beds (CCC,MH, Rehab)	IPORT	26.4% YTD (Q3)	19.90%	Based on current status , provincial and LHIN targets and taking into consideration post acute factors	As part of the ALC avoidance principles, EDD (Estimated Date of Discharge) will be entered on every patient	% completed EDD and entered into Medworxx within 72 hours of admission for Rehab (50%)	Shelley Toth	Ester Lipnicki
								As part of the 14 hospital best practices : Implementation of Blaylock Screening Tool to identify patients that are higher risk of becoming ALC, as part of Intake process	% blaylock screening tool received with intake referral. (90%)		
								Support discharge home prior to moving forward with eligibility assessment for LTC . An ALC-LTC designation will be considered a last resort .	% patients brought to CDR with CCAC prior to ALC-LTC designation (90%)		
	Improve patient satisfaction	Overall, how would you rate the care and services you received at the hospital	CCC/Rehab	NRC/Internal	95.0%	97%	25th percentile - 96.6%	1. Implement core modules of new Patient Satisfaction Survey contract 2. Monitor patient satisfaction scores and themes , with development of Action Plans to address common themes . 3.. Implement all ECFAA required metrics related to Patient Relations with focus on turnaround time for responses and resolution.	1. 100% implementation in 16-17 of core modules (CMC, Rehab) 2. Patient Satisfaction metrics on all program scorecards with unit level results for core programs . 3. % concerns acknowledged within 72 hours (target: 100%)	Marg Campigotto/Kathy Quinlan/Joanne Desjardins	Ester Lipnicki
	Improve patient satisfaction	Would you recommend this hospital to your friends	Rehab , CCC	Internal survey	94.30%	97%	We are currently at top 10 percentile	1. Implement core modules of new Patient Satisfaction Survey contract 2. Monitor patient satisfaction scores and themes , with development of Action Plans to address common themes . 3. Implement all ECFAA required metrics related to Patient Relations with focus on turnaround time for responses and	1. 100% implementation in 16-17 of core modules (CMC,Rehab) 2. Patient Satisfaction metrics on all program scorecards with unit level results for core programs . 3. % concerns acknowledged within 72 hours target: 100%)		

								resolution.			
	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**	**46% (Q3)**	**75%**	**Accreditation Canada requires implementation across all programs by 2018. We are required to report ALL patients for QIP . Based on Q3 - Currently, SMH is at 100% , Rehab is at 19% and Complex is at 9% . Our target is based on 100% completed on**	1. Embed medication reconciliation into normal process of patient care with support of full staff model. 2. Work plan and model of process/best practice being developed by multi-disciplinary team to increase medication reconciliation at admission and discharge. Includes Pharmacy scheduling plans/process, Transfer Medication Reconciliation process and Discharge reconciliation process	1. Continue tests in TNI and implement to Rehab & CMC programs 2. 100% of identified staff in place	Susan Bastable/John Norton	Sonja Grbevski
	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. 2014, consistent with HQO's Patient Safety public reporting web**	**All**		**0.06**	**0.05**	**.14 was target for 15-16 (this is 3 cases per quarter) .Quality committee /ELT - 25th percentile**	1. Utilization of the nocospry disinfection system for post terminal clean of all c-diff rooms 2. Implementation of a trial for distribution of alcohol hand wipes for every patient prior to every meal to reduce transmission of infections 3. Monthly ATP testing post terminal cleans as part of quality assurance to ensure rooms are properly cleaned 4. Reduce risk of c-diff from inappropriate use of antibiotics for those patients that are high risk 5. Continue with "anonymous" audit approach so results are accurate and real results	1. % target of nocospray utilization post terminal clean of all c-diff rooms (100% target) 2. % target of patients given opportunity to clean hands before meals 3. % of rooms that pass ATP testing 4. % target of patients identified at risk with Pharmacy reviews	Marg Campigotto	Ester Lipnicki

	Reduce hospital acquired infection rates	**% Hand Hygiene Compliance Before Patient Contact (includes CCC, Rehab and SMH)**	**All Programs**	**Hospital collected - Mariner system**	**83.0%**	**95%**	**15-16 target was 95%**	1. Roll out of mandatory HH refresher training on the nursing units per e-learn module 2. Posting of weekly metrics and include discussion of monthly corrective actions required by each area/department to meet or exceed target when running below target 3. Engage patients/family on HH & proper use of PPE's 4. Recognition of units/departments achieving HH compliance & modeling best practices through showcasing areas in the weekly Need to Know newsletter . 5. Continue with "anonymous" audit approach so results are accurate and real results	1. % target completion of e-learn (- target : 90%) 2. % monthly metric results posted with action items 3. % target of ICP's meeting with each new patient /family admission to review proper HH & use of PPE's - need target) 4. % of unis raising profile of HH compliance as a means to increase the culture of safety (need target)	Marg Campigotto	Ester Lipnicki
	Reduce employee related workplace violence incidents & injuries	**# of Code Whites without Injury (healthcare & lost time) as % of total incidents**		**Hospital collected - OH & S office**	**85%**	**90%**		1. Improvement of the % staff trained in non-violent crisis intervention 2. Implementation of Chart-Flagging Policy 3. Risk Identification and Review process	1. 100% of risk assessment tools reviewed after every violent incident 2. 100% of staff eligible for training have received training	Sheri McGeen	Mary Benson-Albers
	Improve hospital identity and partnerships	**% target met on student & academic placements**			**62.0%**	**100%**	**Target for 16-17 is 588. Target in 15-16 was 523 and currently meeting 62% of target**	1. Discussion with the Directors/Managers about student placements and what they can offer here 2. Discussion with schools about school placements and working with areas that we can place students 3. Increase on # of school placements	1. Conduct meetings with 100% of departments (Director/Manager reps to discuss placements (need target of # of depts.) 2. # of discussions with schools (need target)	Paulette Jagatic	Bill Marra
	Fim Efficiency Improvement	**Total Function Score Change divided by LOS for each client, averaged over the number of clients**		**NRS - CIHI**	**0.96**	**1.1**	**Target for 15-16 is 1.1 . This indicator has been increasing with the action**	1. Continue to Review and improve process for timely capture of Admission FIM score . 2. Review and set RPG/RCG's and co-hort ELOS using peer and provincial comparisons	1. % of admission FIMS completed within 48 hours . (Target: 75% completed) 2. % of dishcarge FIM completed prior to or on day of discharge (Target: 80%) 3. LOS vs ELOS for cohort groups and specific	John Norton	Sonja Grbevski

		number of clients. Service interruptions excluded .					**with the action plans in place - Q1- .83 , Q2 - .95 and Q3 - 1.1**		3. LOS vs ELOS for cohort groups and specific QBP groupings (stroke/hips)		
	Reduce wait time for for Rehab Admissions to post acute care	**Days between date ready and admission date-% transferred from Acute Care within 2 days**	**Rehab**	**Internal**	**41.0%**	**65%**	**Continued improvement in transitions from ready to transfer - Opening of new Rehab unit & cohorting patient populations should improve LOS**	1. Cohorting of patients within the Rehab program to better utilize human resources, align treatment plans/resources to specific goals of patients to better met targeted LOS	1. Monthly monitoring of LOS & wait time turnaround times. Including wait time ready to IP bed for QBP populations (stroke & hip #) as well as overall wait time /avg wait time by cohort	Shelley Toth	Ester Lipnicki
								2. Implementation of two additional Patient Intake Nurses and standard assessment tolls that assess risk for complex discharges, and/or risk of patient becoming ALC/LTC & engagement of earlier CCAC resources.	2. Monthly reporting of Admission/Discharges per program.		
								3. Biweekly flow meetings with community partners to discuss ALC, wait times and patient flow .	% of bi-weekly meetings held with community partners (target 85%)		