2015/16 Quality Improvement Plan for Ontario Hospitals
"Improvement Targets and Initiatives"

Hotel-Dieu Grace Healthcare 1543 Prince Road

AIM		Measure							Change				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
Access	**Improve access to outpatient rehabilitation services**	Wait time for Outpatient Rehab Services - Referral to Initial Outpatient admission- % meeting target (discharge to initial OP initial appointment)	% / Rehab	Hospital collected data / monthly	927*	0	30	Based on the target groups and anticipated improvement by Q3 15-16	1)Review process for OP therapy booking , including process for multiple bookings for therapy	Create a team to review OP booking requirements , processes and map out department booking flow	% of appts booked prior to discharge	30% appt booked prior to discharge	
									2)Monitor wait time data by three areas (Speech, Occupational Therapy & Physiotherapy	Monitor wait time data monthly through the OP unit based Quality team, including avg wait time and % meeting targets	1. Avg wait time & % meeting target for OP therapy (three OP disciplines and also specific case mix groupings : i.e. neuro, stroke , # hip) 2. % stroke patients booked within 72 hours of discharge (QBP best practice	1)Improve avg wait time by Q3(establish baseline and target) 2) Track data related	
									3)Review programming requirements and OP flow initiatives to support access to outpatient therapy and provide recommendations	Patient Flow will be mapped out by the team and gap analysis completed	Mapping completed by July 2015	Work plan to be completed by end of Q2.	
Effectiveness	**Improve organizational financial health**	Total Margin (consolidated): % by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expense, excluding	% / N/a	OHRS, MOH / Q3 FY 2014/15 (cumulative from April 1, 2014 to December 31, 2014)	927*	-2.5	0	The target is YTD budget. the % will be reported for purposes of QIp - the dollar amount will be provided monthly to support understanding	1)Measure & Monitor costs & clinical indicators	Continue to monitor departmental budgets monthly at on-off budget meetings or through processes established with budget reps/department managers and establish process for monthly which continues to include variance reporting by managers/directors 2)	1) 100% variance reports submitted by due date for financial on/off budget meeting reviews 2) Monitor Core savings	1)100% of change idea processes in place by September 2015 2) Core Savings Goal -	
									2)Sharing and education to programs of financial and clinical data that supports costs and funding to organization	3) Establish a data quality framework that is integrated with the program based unit councils and program structure	1. LOS information shared at 100% of quarterly Utilization /Quality /Physician Advisory Committee meetings 32. Share 1HSFR information and education at various meetings for adequate dissemination to leadership and staff 3. Share data quality information	100% of education processes in place by September 2015	
		FIM efficiency Indicator : Discharge FIM - Admission FIM / LOS	Ratio (No unit) / Rehab	NRS-CIHI / YTD 14-15	927*	0.94	1.1	Target is based on peer comparison	1)Improve FIM efficiency scores and ensure timely and accurate capture of admission and discharge FIM	1) Review and implement improvement process for timely capture of Admission FIM score. 2) Review RPG's & RCG's & target high volume case mix groups where there is greatest efficiency opportunity. 3) Ensure that staff that are responsible for FIM scoring	1) % of Admission FIM's completed in 72 hours - as well review 48-72 hour compliance(currently - 70%- February . 2) % designated FIM scoring staff have received annual certification and education	1. 100%completed within 72 hours by March 2016 2.100% eligible staff have	
Integrated	**Reduce wait times and faciliate early access for admission to post acute rehabilitation**	% of Rehab patients transferred within two days	% / Rehab	Hospital collected data / Q3	927*	42	60	Continued improvement of transition time once patients are read to be	1)Improve timely access to inpatient rehabilitation services through partnership with acute care site.	1) Implement 9am discharge time on unit to increase admission flow: Currently 7.1% of patients are discharged by 9am. 2)Monitor discharge and admission flow : Monitor monthly # admissions, discharges , patient days . Avg LOS and BTR (bed turnover rate) .	1) Overall discharge time compliance by 9am : % discharged by 9am & 11am 2) Monitor Avg Wait time for transfers from acute (currently 4.8 days)	1)To improve discharge by 9am compliance to 25% discharged and 100% prior to	
Patient-centred	**Improve patient satisfaction**	Overall, How would you rate the care and services you received at the hospital (Complex Continuing	% / Complex continuing care residents	Internal Survey / Q3 - 14/15	927*	97.1	95	Continue to strive for very high satisfaction results .	1)Improve engagement of patients to design and deliver healthcare and create partnerships in the hospital setting	1) Establish a Patient Centered Care Advisory Committee by June 2015 2) Review CCC results bi-annually and establish a Patient Experience working plan that focuses on creating partnerships with patients (i.e. communication , participation in	1) % of identified HDGH committees that have a patient/family representative 2) % of executive walkabout 's completed to plan	1) 100% of committees (identified by Patient Care Advisory Council)	
		Overall, How would you rate the care and services you received at the hospital(NRC - Rehab)	% / Rehab	NRC Picker / YTD	927*	89.3	95	Continue to Strive for a very high rating of care and services	1)Improve engagement of patients to design and deliver healthcare and create partnerships in the hospital setting	1) Establish a Patient Centered Care Advisory Committee by June 2015 2) Review CCC results bi-annually and establish a Patient Experience working plan that focuses on creating partnerships with patients (i.e. communication , participation in	1) % of identified HDGH committees that have a patient/family representative 2) % of executive walkabout 's completed to plan	1) 100% of committees (identified by Patient Care Advisory Council)	
Safety	**Increase proportion of patients receiving medication reconciliation upon admission**	Medication reconciliation at admission: The total number of patients with medications	% / All patients	Hospital collected data / most recent quarter available	927*	23	40	Accreditation Canada requires implementation across all programs by	1)Embed medication reconciliation into the normal processes of patient care	1) Form a multidisciplinary team to coordinate a work plan and the implementation of medication reconciliation across organization and smaller teams at the patient care unit level to conduct tests of change	Implement test of change in Rehab by Q3 and Complex Continuing Care by Q4	Test changes completed in Rehab and CCC by March 31, 2016	Note: The current % completed may be higher due to nursing

	Reduce hospital acquired infection rates	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / Jan 1, 2014 - Dec 31, 2014	927*	0.17	0.14	The provincial average is .30 . A target of .14 would equal one less case per	1)Improve education and training for all staff , patient's and families.	1)We will be continuing to offer the “Just Clean Your Hands” education to all staff as an education opportunity which gives a more in depth understanding of the importance of HH and the 4 Moments 2) We continue to release the HH E-Learn	"1) 100% annually eLearning compliance 2) 100% compliance on discussion at QIT and unit level safety huddles of Hand Hygiene data 3) complete hand hygiene audits : -Each unit – 25 audits per week - Dietary and ES – 25 per week -ICP’s to perform 25	1) 100% eLearning compliance 2) HH Data discussed at 100% Quality Improvement	
		% Hand Hygiene Compliance Before Patient Contact (all patients)	% / All patients	internal audit tool /Mariner / YTD 14-15	927*	52	95	Continue to strive for high compliance . New audit process and tool	1)Improve education and training for all staff , patient's and families.	1)We will be continuing to offer the “Just Clean Your Hands” education to all staff as an education opportunity which gives a more in depth understanding of the importance of HH and the 4 Moments 2) We continue to release the HH E-Learn	"1) 100% annually eLearning compliance 2) 100% compliance on discussion at QIT and unit level safety huddles of Hand Hygiene data 3) complete hand hygiene audits : -Each unit – 25 audits per week - Dietary and ES – 25 per week -ICP’s to perform 25	1) 100% eLearning compliance 2) HH Data discussed at 100% Quality Improvement	