2018/19 Quality Improvement Plan
"Improvement Targets and Initiatives"

HÔTEL-DIEU GRACE HEALTHCARE

Hôtel-Dieu Grace Healthcare 1453 Prince Road

AIM		Measure								Change				
Quality dimension	Issue	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments

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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?	P	% / Survey respondents	CIHI CPES / April - June 2017(Q1 FY 2017/18)	927*	31	38.00	Targeting 5% improvement over previous year.	1)Through partnership with social work, patients/families , LHIN Community Homecare (CCAC) and program /unit	tilize 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 . A work plan will be created for 18-19 from feedback from	Sharing of patient experience real time information (monthly) and NRC feedback quarterly with discussion of improvement opportunities at program , Unit based council and PFEC levels	Information is shared at three key levels quarterly at minimum (Program	
										2)Empowerment of patients and families to be involved in their health care journey	Implementation of consistent rounds process across the organization which empowers patients /families engagement. Increase the number of patient /family reps on various committees and within the accreditation teams accross the organization .	Increase the number of patient reps on committees and accreditation teams over the next year - identify which committees and teams and track compliance to plan.	Track the number of patient /family reps on identified committees /accreditation	
										3)Identify plan for frontline care providers and customer service focus	Identify customer service standards strategy for frontline staff	Track the completed items on customer service strategy plan .	100% of strategies identified for 18-19 completed	
		Rate of psychiatric (mental health and addiction) discharges that are followed within 30 days by another mental health and addiction admission	P	Rate per 100 discharges / Discharged patients with mental health & addiction	CIHI DAD,CIHI OHMRS,MOHTLC RPDB / January - December 2016	927*	9.26	6.00	Aiming for performance better than direct peer group . Currently better than Provincial and ESCLHIN rates .	1)Complete deep dives on each re-admission within 30 days to identify potential preventative measures and opporunities for	Develop a standardized tool to perform and monitor deep dives and identify any themes .	Establish a flagging process to identify when patients are re-admitted so deep dive can be completed .	Complete deep dive on 100% of patients .	
										2)Ensure proper informaiton and communication is available to patients/family at discharge .	Revise the current discharge checklist to align with evidence -informed best practice	Discharge checklist revised and implemented into practice	use of revised dicharge checklist for 100% of patient discharges (Audit processes to be	
		Did you receive enough information during the admission process	C	% / Survey respondents	NRC Picker / Q3 - YTD 17-18	927*	18	23.00	Based on a 5% improvement which is considered a stretch target by NRC. This indicator is highly influenced currently by acute care	1)In partnership with Intake team and acute care , review data collected during the Quality Improvement Advocate Pilot position and	Develop a work plan that will be monitored through QIP monitoring through Director's Council/Senior Management over site. Review partnership opportunities with Acute Care to improve information provided to HDGH patients at acute care and prior to	Completion of work plan items identified for 18-19 .	100% completed strategies identified for 18-19 work plan completion.	
										2)transition patient greeting activities from pilot position to unit managers by end of 18-19.	Transition admission interview within 72 hours to front line leadership and checkin's within 7-10 days for follow up by frontline leadership	Transition completed prior to end of fiscal year (and upon completion of pilot position)	Transition completed and occurring on 80% of eligible admissions (within	This change idea and timing will be based on planning around Quality Advocate
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	P	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July - September 2017	927*	15.43	16.50	previous target 19.9 . Year End results are expected to be approx. 16-17% . Target is based on maintaining current rates and current ALC rates for post acute care.	1)Provide all patients/SDMs with Estimnated Date of discharge (EDD) in writing shortly following admission and also doucmented on	Draft a sample letter ensuring standarized way of establishing EDD is use, and process/responsibilities are clear and established for completing and distributing letter	% of EDD given to SDM/Patient and recorded in chart/total admissions (Rehab and Comlex)	100% EDD provided (intake office to audit)	
										2)The roles/responsibilites and expectation s of SDM are clearly explained in writing on admission (leading practice #9)	A SDM is confirmed within 48 hours of admission for all patients, includes obtaining and documenting accurate contract details. Create a document that will be provided within the first 48 hours of admission and outlines : roles and responsiblities of the patient, the	% SDM/POA identified and recorded in chart % pamphlet given to patient/family and recorded in chart to be reported quarterly	100% SDM/POA identified 100% pamphlet provided to patient/family and recorded in	
										3)Develop a standardized Complex Discharge Rounds (CDR and ALC Deep dive process within IP Mental Health	Utilize existing work done in CMC/Rehab and apply to MH population	Weekly CDR's and monthly ALC deep dives on all patients that are currently designated ALC, or anticipated/at risk to become ALC	100% weekly CDR and 100% monthly ALC deep dives completed - monitored	
Patient-centred	**Person experience**	"Would you recommend this hospital to your friends and family?" (Inpatient care)	P	% / Survey respondents	CIHI CPES / April - June 2017 (Q1 FY 2017/18)	927*	69	71.30	Target above Ontario Average of 70.4% and LHIN average of 58.8%.	1)Implementation of patient experience framework and supporting experience scorecards across organization.	Sharing of patient experience data throughout the organization on a monthly and quarterly basis with discussion of improvement strategies .	Sharing of patient experience real time information (monthly) and NRC feedback quarterly with discussion of improvement opportunities at program , Unit based council and PFEC levels.	information is shared at three key levels quarterly at minimum (Program	

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										3)Identify plan for frontline care providers an customer service focu	Identify customer service standards strategy for frontline staff	% of staff educated on customer service standards strategies	Two year target : 100% . year 1 - 50%	
Safe	**Safe care/Medication safety**	Medication reconciliation at discharge: Total number of discharged patients	P	Rate per total number of discharged patients / Discharged	Hospital collected data / October – December (Q3) 2017	927*	CB	100.00	Our long term target is 100% completed on all inpatient discharges.	1)In collaboration with Quality and PMO team , develop a detailed action plan to ensure 100% of applicable discharges	Recruitment of appropriate supporting resources to meet work plan Establish small working group with key stakeholders. Develop and standardize process for completion of discharge medication forms Establish process for capture of data of completed metrics	% of work plan items completed Patient Experience Indicator - were you clear on medications before you left ? (NRC results - quarterly	100% of identified work plan for 18-19 completed (monitored quarterly by Senior	
		Medication reconciliation at admission. The total number of patients with medications	C	% / All inpatients	Hospital collected data / 17-18	927*	47	100.00	Based on appropriate inpatient admission target to all programs.	1)In collaboration with Quality/PMO team , develop a detailed action plan to ensure compliance by Q4, 18-19	Recruitment of resources allocated Create working group to develop standardized processes Establish key roles and responsibilities , Embed process and roles into policy and educate all team members Establish working group	% of work plan items completed	100% of all strategies outlined on 18-19 work plan	
	Workplace Violence	**Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.**	**MANDATORY**	**Count / Worker**	**Local data collection / January - December 2017**	**927***	**CB**	**CB**	**Collecting baseline data in accordance with definition**	**1)Collection of baseline data and establishment of reporting processes.**	**Refine and introduce new reporting methods to be able to collect data as required by this indicator. Currently the data is reported in RL6 and cross checked with Safe Workplace Advocate data repository - refine collection and reporting of data in accordance with OH & S definitions and be sure we are collecting accurate baseline data.**	**Complete Collection of Baseline data and data collection process by June 2018**	**June 2018 - identify data collection processes and establish baseline.**	
										2)Establish and implement communication plan	A broad communication plan has been established that will include on-line and poster publications to educate our staff, patients and public that we have zero tolerance for violence, aggression or disrespect of health care works and encouragement of employees to	Completion of Communication Plan by end of Q1	Communication Plan completed by Q1 . Implementation of communications	
		# of Code White (current definition used by OH & S) without injuries. Based on the % of total incidents (lost healthcare claims and lost time)	C	% / Employees , Code White incident	In house data collection / 17-18 (up to Q3)	927*	82.9	90.00	Maintain current high level target . There has been decreasing number of overall incidents over past four quarters.	1)Workplace Violence Committee to establish	Establish and monitor metrics on a monthly basis so that trends can be identified and corrective actions put in place.	Set metrics and monitor monthly	Once metrics established , ensure 100% monthly monitoring and	
										2)Partner with ONA and PSHSA (Public Service Health and Safety Association) to update and introduce the PSHSA	Implement the PSHSA tools into our workplace including client risk assessment and chart flagging process and tools Conduct a refreshed violence risk assessment for the organization this year using the PSHSA online tool	Implementation of Chart Flagging Tool and risk assessment tool Complete violence risk assessment using online tool	Implement Chart Flagging Tool and risk assessment tool by Q2 Conduct violence risk	
Timely	**Timely access to care/services**	Average Latency - Ministry of Child /Youth Services Indictor - P11a. Regional Children's	C	Days / Children's Mental Health	In house data collection / 17-18	927*	CB	CB	Collecting Baseline due to changes with definition. Once definition is	1)Conduct a Current State Mapping Session to establish Improvement Plan for 18-19	Conduct ideal Client Journey mapping session Identify Areas of process gaps and opportunities for improvements . Develop and Implement Streamlined patient processes identified in current state /future state gap analysis.	Complete mapping session by end of Q1 Develop areas of opportunity by end of Q3 . Implement process revisions by Q4	Mapping Session (current state) completed - Q1 Mapping Session to identify future	This represents the first step in wait time for RCC services. The next step is wait from