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

Haliburton Highlands Health Services Corporation 7199 Gelert Road, P.O. Box 115

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	Coordinating care	Number of Coordinated Care Plans initiated or in place at HHHS	Number / Complex Care Patients	CSS and MH collected data / Most recent 3 month period	938*	CB	100.00	New indicator, collecting baseline	1)Develop infrastructure to support the coordination of care across the continuum. Increased staff awareness.	Processing mapping activity involving multiple departments and health service provider partners. Mental Health embed CPP as part of monthly clinical supervision and document.	Process map that is understood by all stakeholders providing service to clients with CCPs in place.	Process map implemented by end of Q2.	
		Percentage of clients who die at home who choose home as preferred location	% / %/ palliative clients who choose to die at home	Chart Review of Palliative Care Patients on PCCT roster / 2017	938*	CB	85.00	Consistent with 2016-17	1)Work with community partners to identify gaps in service that prevented this from occurring.	Chart review and community consultation through community palliative rounds.	PCCT client's chart reviewed	100%PCCT client charts reviewed - ongoing	
	Effective transitions	Did you receive enough information from hospital staff about what to do if you were worried	% / Survey respondents	CIHI CPES / April - June 2016 (Q1 FY 2016/17)	938*	CB	80.00	New locally established target based on overall satisfaction	1)Implement a formalized discharge process	Management will work with staff to create a formal discharge package	Tracked with the follow up phone calls	Meet target by end of 4th quarter	
		Percentage of patients discharged from hospital for which discharge summaries are	% / Discharged patients	Hospital collected data / Most recent 3 month period	938*	CB	80.00	New locally established target based on overall satisfaction	1)Improve timeliness of discharge summary preparation and delivery	1. Implement voice-recognition transcription program (in partnership with another hospital) 2. Ensure all physicians are dictating discharge summaries"	Number of discharge summaries dictated. Number of discharge summaries delivered.	End of 4th quarter	
	Effective Transitions	Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / October 2015 - September 2016	51154*	47.17	13.00	Provincial	1)1. Establish a routine process to accurately track ED visits 2. Establish a protocol for clinical feedback 3. Early	1.The home will implement a tracking form to include more detailed information including rationale i.e.: reason for transfer, admission outcome, shift trends and whether the transfer was initiated as a family directive or by health team 2. Establish an formal	Internal tracking tools will identify the number of visits to ED by residents and monitor for any trends	Prevent unnecessary use of ED. Identify the need for medical intervention early	
		Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / October 2015 - September 2016	54272*	27.78	13.00	Provincial	1)1. Establish a routine process to accurately track ED visits 2. Establish a protocol for clinical feedback 3. Early	1.The home will implement a tracking form to include more detailed information including rationale i.e.: reason for transfer, admission outcome, shift trends and whether the transfer was initiated as a family directive or by health team 2. Establish an formal	Internal tracking forms will identify the number of visits and monitor for any trends	Prevent unnecessary use of ED and identify the need for medical intervention early	
	Effective use of Community Mental Health and Addictions services	Risk-Adjusted 30-Day Mental health Readmission (repeat visit) Rate for Patients presenting in	% / All Mental Health Clients accessing ED	ADT / Most recent 3-month period	938*	11.8	16.00	HSAA target	1)Conduct monthly review of all requests for services	Identify repeat visits to ED ensure referral to Hospital to Home, develop CCP if there is not one already in place	Develop manual system to track and monitor	Limit rate of repeat visits for mental health issues to 16%	
		Risk-Adjusted 30-Day Substance Use Readmission (repeat visit) Rate for Patients presenting in	% / All Substance Use Clients accessing ED	ADT / Most recent 3-month period	938*	12	22.80	HSAA target	1)Conduct monthly review of all requests for services	Identify repeat visits to ED ensure referral to Hospital to Home, develop CCP if there is not one already in place	Develop manual system to track and monitor	Limit rate of repeat visits for substance abuse to 22.8%	
Efficient	Access to right level of care	Total number of alternate level of care (ALC) days contributed by ALC patients within the	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July – September 2016 (Q2 FY 2016/17 report)	938*	38.75	12.70	HSAA target	1)Refresh the Home First Program	Establish working group consisting of ED and inpatient nursing staff and physicians, CCAC, CSS, and GAIN 2. Review Home First Map -pre-admission, daily bullet rounds, enhance & leverage social work services	Number of Home First discussions taking place at daily and weekly rounds	End of Q4	

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Equitable	Access to care for persons in rural communities	Number of Telemedicine consultations / visits	Number / Patients with out of town referrals	Telemedicine database, OTN / 2017-18	938*	CB	1260.00	Locally established target, based on improvement over 2016/17	1)Increase patient consultations	1. Collaborate with OTN to develop marketing strategies to promote this service 2. Network with other hospitals to determine marketing strategies and other uses for telemedicine consultations 3. Investigate feasibility of new consultation services	Number of strategies identified and implemented	End of Q2	
Patient-centred	Palliative care	Percent of palliative care patients discharged from hospital with the discharge status	% / Palliative patients	CIHI DAD / April 2015 – March 2016	938*	66.67	85.00	CE LHIN average 83% as per OPCN statistics	1)Improve access to PCCT resources for patients upon discharge	1. Increase awareness among staff and physicians of PCCT resources available at discharge 2. Collaborate with CCAC to have PCCT information added to their discharge resources 3. Add PCCT referral check box to admission and discharge order sheet	1. Number of staff and physicians receiving communication about the availability of PCCT resources 2. Addition of PCCT referral checkbox to admission and discharge order sheets	End of Q4	
	Person experience	"Would you recommend this hospital to your friends and family?"	% / Hospital collected data	% / Survey respondents / Most recent 3 month period	938*	CB	CB	New target; collecting baseline data	1)Increased monitoring of antipsychotic usage and recommendations for change, quarterly review of non-pharmaceutical	Increased physician awareness, provide physicians with quarterly CIHI performance statistics	HC Resident Safety Committee and BSO Team will review anti psychotic medication practices monthly to help determine if current list of residents receiving antipsychotics without a diagnosis of psychosis can be managed with non-pharmaceutical behaviour	Decrease or elimination of anti psychotics for which there is not a psychosis	
		Percentage of persons responding positively to: "Overall, how would you rate the care and	% / positive responses from all emergency department patients	In-house survey / Apr 2016 - Mar 2017	938*	83	90.00	Increased target from 85% in 2016/17	1)Improve process for addressing complaints	Identify strategies for patients to provide real-time feedback, including complaints, to facilitate real-time action to address issues	Number of concerns raised in real time versus post discharge	Decrease in number of concerns raised post discharge	
		Percentage of persons responding positively to: "Overall, how would you rate the care and	% / All patients discharged from acute care	In-house survey / Apr 2016 - Mar 2017	938*	100	98.00	Striving for unmet 2016/17 target	1)Improved satisfaction with care/experience	1) Provide information on admission to HHHS that discusses the admission and discharge process 2) Call patients post discharge to seek feedback on care and identify any post-discharge concerns. 3) Identify any trends associated with concerns raised about	Number of calls made to patients post discharge, to ask about satisfaction with care/ experience	Increase number of positive responses to post-discharge follow-up calls	
	Resident experience: "Overall satisfaction"	Percentage of residents who responded positively to the question: "Would you	% / LTC home residents	In house data, InterRAI survey, NHCAHPS survey / April 2016 - March 2017	51154*	CB	80.00	New indicator, collecting baseline	1)Resident satisfaction survey's in 2016/16 indicated that participation in activities is highly correlated with overall	HC has recruited a new interim manager for the Life Enrichment Program. Our new manager is working hard to recruit and retain staff in this department and they have started to incorporate new programs into the activity calendar with feedback from resident and	Increased quality management resources, resident and family feedback, fewer complaints	Improve/ Maintain resident and family satisfaction	
		Percentage of residents who responded positively to the question: "Would you	% / LTC home residents	In house data, InterRAI survey, NHCAHPS survey / April 2016 - March 2017	54272*	CB	80.00	New indicator, collecting baseline	1)Resident satisfaction survey's in 2016/16 indicated that participation in activities is highly correlated with overall	HW has recruited a new interim manager for the Life Enrichment Program. Our new manager is working hard to recruit and retain staff in this department and they have started to incorporate new programs into the activity calendar with feedback from resident and	Increased quality management resources, resident and family feedback, fewer complaints	Improve/ Maintain resident and family satisfaction	
		"Would you recommend this hospital to your friends and family?"	% / Survey respondents	Hospital collected data / Most recent 3 month period	54272*	CB	CB	Hospital collected data / Most recent 3 month period	1)Improved satisfaction with care/experience	"1) Provide information on admission to HHHS that discusses the admission and discharge process 2) Call patients post discharge to seek feedback on care and identify any post-discharge concerns. 3) Identify any trends associated with concerns raised about	Number of calls made to patients post discharge, to ask about satisfaction with care/ experience	Increase number of positive responses to post-discharge follow-up calls	
	Palliative care	Percentage of residents whose mood from symptoms of depression worsened	% / LTC home residents	CIHI CCRS / July - September 2016	51154*	CB	23.80	Provincial	1)Significantly increase our current performance. Goal is to meet the provincial average by the end of the 4th quarter in 2017/18	Staff and Management are working together with the resident safety committee to identify root cause of why the indicators are so high and identifying where this indicator is derived from within the home assessments	Quarterly assessment indicators on mood and behaviours	To improve mood/ depression in our residents	
		Percentage of residents whose mood from symptoms of depression worsened	% / LTC home residents	CIHI CCRS / July - September 2016	54272*	CB	23.80	Provincial	1)Significantly increase our current performance. Goal is to meet the provincial average by the end of the 4th quarter in 2017/18	Staff and Management are working together with the resident safety committee to identify root cause of why the indicators are so high and identifying where this indicator is derived from within the home assessments.	Quarterly assessment indicators on mood and behaviours	To improve mood/ depression in our residents	
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	Person experience	"Would you recommend this hospital to your friends and family?"	% / Hospital collected data	% / Survey respondents / Most recent 3 month period	938*	CB	CB	New target; collecting baseline data	1)Increased monitoring of antipsychotic usage and recommendations for change, quarterly review of non-pharmaceutical	Increased physician awareness, provide physicians with quarterly CIHI performance statistics	HC Resident Safety Committee and BSO Team will review anti psychotic medication practices monthly to help determine if current list of residents receiving antipsychotics without a diagnosis of psychosis can be managed with non-pharmaceutical behaviour	Decrease or elimination of anti psychotics for which there is not a psychosis	

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		Percentage of persons responding positively to: "Overall, how would you rate the care and	% / All patients discharged from acute care	In-house survey / Apr 2016 - Mar 2017	938*	100	98.00	Striving for unmet 2016/17 target	1)Improved satisfaction with care/experience	1) Provide information on admission to HHHS that discusses the admission and discharge process 2) Call patients post discharge to seek feedback on care and identify any post-discharge concerns. 3) Identify any trends associated with concerns raised about	Number of calls made to patients post discharge, to ask about satisfaction with care/ experience	Increase number of positive responses to post-discharge follow-up calls	
	Resident experience: "Overall satisfaction"	Percentage of residents who responded positively to the question: "Would you	% / LTC home residents	In house data, InterRAI survey, NHCAHPS survey / April 2016 - March 2017	51154*	CB	80.00	New indicator, collecting baseline	1)Resident satisfaction survey's in 2016/16 indicated that participation in activities is highly correlated with overall	HC has recruited a new interim manager for the Life Enrichment Program. Our new manager is working hard to recruit and retain staff in this department and they have started to incorporate new programs into the activity calendar with feedback from resident and	Increased quality management resources, resident and family feedback, fewer complaints	Improve/ Maintain resident and family satisfaction	
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		"Would you recommend this hospital to your friends and family?"	% / Survey respondents	Hospital collected data / Most recent 3 month period	54272*	CB	CB	Hospital collected data / Most recent 3 month period	1)Improved satisfaction with care/experience	"1) Provide information on admission to HHHS that discusses the admission and discharge process 2) Call patients post discharge to seek feedback on care and identify any post-discharge concerns. 3) Identify any trends associated with concerns raised about	Number of calls made to patients post discharge, to ask about satisfaction with care/ experience	Increase number of positive responses to post-discharge follow-up calls	
	Palliative care	Percentage of residents whose mood from symptoms of depression worsened	% / LTC home residents	CIHI CCRS / July - September 2016	51154*	CB	23.80	Provincial	1)Significantly increase our current performance. Goal is to meet the provincial average by the end of the 4th quarter in 2017/18	Staff and Management are working together with the resident safety committee to identify root cause of why the indicators are so high and identifying where this indicator is derived from within the home assessments	Quarterly assessment indicators on mood and behaviours	To improve mood/ depression in our residents	
		Percentage of residents whose mood from symptoms of depression worsened	% / LTC home residents	CIHI CCRS / July - September 2016	54272*	CB	23.80	Provincial	1)Significantly increase our current performance. Goal is to meet the provincial average by the end of the 4th quarter in 2017/18	Staff and Management are working together with the resident safety committee to identify root cause of why the indicators are so high and identifying where this indicator is derived from within the home assessments.	Quarterly assessment indicators on mood and behaviours	To improve mood/ depression in our residents	
Safe	**Medication safety**	Percentage of residents who were given antipsychotic medication without psychosis in the 7	% / LTC home residents	CIHI CCRS / July - September 2016	51154*	16.92	21.30	The 2017-18 target was set on performance in 2016-17 Q1 and Q2. The Current	1)Increased monitoring of antipsychotic usage and recommendations for change, quarterly review of non-pharmaceutical	Increased physician awareness, provide physicians with quarterly CIHI performance statistics	HC Resident Safety Committee and BSO Team will review anti psychotic medication practices monthly to help determine if current list of residents receiving antipsychotics without a diagnosis of psychosis can be managed with non-pharmaceutical behaviour	Decrease or elimination of anti psychotics for which there is not a psychosis	
		Percentage of residents who were given antipsychotic medication without psychosis in the 7	% / LTC home residents	CIHI CCRS / July - September 2016	54272*	19.23	21.30	The 2017-18 target was set on performance in 2016-17 Q1 and Q2. The Current	1)Increased monitoring of antipsychotic usage and recommendations for change, quarterly review of non-pharmaceutical	Increased physician awareness, provide physicians with quarterly CIHI performance statistics	HW Resident Safety Committee and BSO Team will review anti psychotic medication practices monthly to help determine if current list of residents receiving antipsychotics without a diagnosis of psychosis can be managed with non-pharmaceutical behaviour	Decrease or elimination of anti psychotics for which there is not a psychosis	
	Medication safety	Medication reconciliation at admission: The total number of patients with medications	Rate per total number of admitted patients / Hospital	Hospital collected data / Most recent 3 month period	938*	84	90.00	Increased target from 87% in 2016/17	1)Identify a strategy to ensure all patients have BPMH completed upon admission	Develop and implement admission order set that includes BPMH	Health Records department to track med rec completion at time of coding.	Increase percentage by end of 2nd quarter	
		Medication reconciliation at discharge: Total number of discharged patients	Rate per total number of discharged patients / Discharged	Hospital collected data / Most recent quarter available	938*	54	75.00	Striving for unmet 2016/17 target	1)Identify a strategy to ensure all patients have BPMH completed upon admission	Develop and implement admission order set that includes BPMH	Health Records department to track med rec completion at time of coding.	Increase percentage by end of 2nd quarter	
	Safe care	Percentage of residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer	% / LTC home residents	CIHI CCRS / July - September 2016	51154*	X	2.80	Provincial	1)Recent development of a new tool by the RSC has been implemented to improve communication between registered staff	When PSWs or PCP recognize resident verbalizations and behaviours indicative of skin discomfort or when abnormal or unusual skin conditions such as red or open areas, blisters, bruises, tears, or scratches they will use this new tool to alert registered staff to the	# of alerts sent per month from PSW or PCP to registered staff	For PSWs to identify early stages of skin concerns and registered staff to	

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		Percentage of residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer	% / LTC home residents	CIHI CCRS / July - September 2016	54272*	4.55	2.80	Provincial	1)Recent development of a new tool by the RSC has been implemented to improve communication between registered staff	When PSWs or PCP recognize resident verbalizations and behaviours indicative of skin discomfort or when abnormal or unusual skin conditions such as red or open areas, blisters, bruises, tears, or scratches they will use this new tool to alert registered staff to the	# of alerts sent per month from PSW or PCP to registered staff	For PSWs to identify early stages of skin concerns and registered staff to	
		Percentage of residents who fell during the 30 days preceding their resident assessment	% / LTC home residents	CIHI CCRS / July - September 2016	51154*	17.67	15.60	Provincial	1)1. To focus on reduction of falls sustained by new resident admissions, our improvement initiatives involve documentation and	1. Admission RN/RPN to initiate resident fall risk assessment and start interventions on the care plan on the day of admission 2. Work with RNAO on strategies to improve	Reconcile date of fall intervention care plan against date of admission	100% of care plans of new admissions should have a fall intervention noted on their care plan	
		Percentage of residents who fell during the 30 days preceding their resident assessment	% / LTC home residents	CIHI CCRS / July - September 2016	54272*	17.54	15.60	Provincial	1)1. To focus on reduction of falls sustained by new resident admissions, our improvement initiatives involve documentation and	1. Admission RN/RPN to initiate resident fall risk assessment and start interventions on the care plan on the day of admission 2. Work with RNAO on strategies to improve	Reconcile date of fall intervention care plan against date of admission	100% of care plans of new admissions should have a fall intervention noted on their care plan	
		Percentage of residents who were physically restrained every day during the 7 days preceding	% / LTC home residents	CIHI CCRS / July - September 2016	51154*	6.05	5.50	Provincial	1)Improve the accuracy of documented restraint use including staff education as to the legislated definition of restraint devices verses	RSC will complete a team review of staff education provided on surge learning. RSC will provide an educational pamphlet for staff annually	Management to monitor completion of surge learning modules	To prevent a reoccurrence of defining PASDs as restraints in error	
		Percentage of residents who were physically restrained every day during the 7 days preceding	% / LTC home residents	CIHI CCRS / July - September 2016	54272*	X	5.50	Provincial	1)Improve the accuracy of documented restraint use including staff education as to the legislated definition of restraint devices verses	RSC will complete a team review of staff education provided on surge learning. RSC will provide an educational pamphlet for staff annually	Management to monitor completion of surge learning modules	To prevent a reoccurrence of defining PASDs as restraints in error	
		Incidence of hand hygiene performance prior to initial person contact	% / Health providers in the entire facility	Hand hygiene performance MOH compliance / April 1, 2016 - March 31, 2017	51154*	CB	80.50	Provincial average	1)Increase hand hygiene compliance	1. Increase hand hygiene audits to monthly. Have audits more visible. 2. Hand hygiene education to all departments with a glo germ roadshow.	Audit for compliance	82.5% compliance rate of the first moment of hand hygiene	
		Incidence of hand hygiene performance prior to initial person contact	% / Health providers in the entire facility	Hand hygiene performance MOH compliance / April 1, 2016 - March 31, 2017	54272*	CB	80.50	Provincial average	1)Increase hand hygiene compliance	1. Increase hand hygiene audits to monthly. Have audits more visible. 2. Hand hygiene education to all departments with a glo germ roadshow.	Audit for compliance	82.5% compliance rate of the first moment of hand hygiene	
	Safe care	Hospital-acquired C-Difficile infection (CDI) rate per 1,000 patient days	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / Jan 1, 2015 - Dec 31, 2015	938*	0.09	0.20	Target performance for Small Ontario Community Hospitals 0-100	1)Maintain target less than performance of small Ontario Community Hospitals	1) Continue to monitor patients and follow IPAC standards 2) Continue with sporicidal cleaning and best practice for environmental cleaning 3) Continue linkages with RMH for antimicrobial stewardship.	Audit quarterly via IPAC data. Report to MOH monthly	Decrease c.diff nosocomial rate	
		Incidence of hand hygiene performance prior to initial person contact	% / Health providers in the entire facility	Hand hygiene performance MOH compliance / April 1, 2016 - March 31, 2017	938*	100	80.50	Provincial average	1)Increase hand hygiene compliance	1. Increase hand hygiene audits to monthly. Have audits more visible. 2. Hand hygiene education to all departments with a glo germ roadshow.	Audit for compliance	82.5% compliance rate of the first moment of hand hygiene	
		Number of falls per 1000 patient days	Rate per 1,000 / DAD	Hospital data; DAD / April 1, 2016 - March 31, 2017	938*	14.7	8.00	Improvement over current average performance of 14	1)Refresh the fall prevention strategy and program for acute care	1. Conduct hourly safety rounds on all patients 2. Continue working with the designated "Falls Prevention Champion" 3. Provide staff education 4. Analyze falls incident reports to look for trends	Number of safety issues and/or near misses identified and addressed during hourly safety rounds; number of staff who have completed fall prevention education	Improvement by end of 4th quarter	
		Percentage of patients with completed skin risk assessment within 3 days of admission	Rate per total number of admitted patients / Admitted	Hospital collected data / 2016	938*	CB	90.00	New locally established target	1)Identify and implement strategies to ensure skin risk assessment is completed for all patients upon admission	1. Identify skin/wound nurse champion 2. Develop working group to identify strategies for completion of skin risk assessment 3. Provide ongoing education for staff	Percentage of patients with completed skin assessment on chart	Improvement each quarter	
		Percentage of staff and volunteers at HHHS who receive the Flu Shot (excludes medically	% / HHHS staff and volunteers	Hospital collected data / October 2017 - December 31 2017	938*	80.5	78.00	Increase past target by 3%	1)Increase compliance of staff obtaining flu vaccine.	1. Continue to offer the flu shot in house. 2. Continue providing education on the flu and the flu shot.	Compliance report for percentage of staff who have received vaccine.	78% by Dec 31, 2017.	The Flu Campaign runs until December 15th so we are continuing to

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		Percentage of staff who provide positive responses to Pulse survey by rating excellent, very good,	% / All Staff	Pulse survey / 2016-17	938*	71	75.00	Increase to current performance by 5%	1)1. Improve employee satisfaction by engaging staff with identifying and addressing barriers and challenges.	1. Continue to engage staff in working groups and in decision making. 2. Develop action plans at the departmental level to improve employee satisfaction, based on departmental survey results.	Percentage of positive responses to the Pulse Survey.	Improve employee engagement to increase satisfaction.	
		Sick time rate	Paid sick days / Full time HHHS employees	Payroll/HR reports / April 2016-March 2017	938*	3.5	12.20	CE LHIN 2015/16 Hospital Average for sick days/full time employee	1)1. Support the ASP to enable 100% compliance with the program. 2. Implement a Healthy Workplace Strategy.	1. Track and follow ASP program on a quarterly basis. 2. Continue to engage staff with the Healthy Workplace working group, with a focus on proactive health and wellness.	# of Sick days/ full-time employee. Participation of staff in the health and wellness initiatives. "	Decrease sick time of employees.	
Timely	**Timely access to care/services**	90th percentile Emergency Department (ED) length of stay for complex patients	Hours / Patients with complex conditions / Patients with complex	CIHI NACRS / January 2016 – December 2016	938*	78.3	8.00	HSAA target	1)Improve patient flow from ED to acute care	1. Add discharge planning options to admission order sheet to ensure proactive approach to discharge planning 2. Follow SURGE policy when required 3. Identify and address barriers to discharge during daily bullet rounds and weekly medical rounds 4. Continue to	1. Number of times discharge planning orders are checked off on admission order sheet 2. Number of days bullet rounds take place	End of Q4	100 compliance of bullet rounds, use of SURGE policy