# 2018/19 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 | 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 | Coordinating care | Percentage of clients who die at home who choose home as preferred location | C | % / palliative clients who choose to die at home | Chart Review of Palliative Care Patients on PCCT roster / 2018 | 938* | 81 | 85.00 | Provincial | 1)Work with community partners to identify gaps in service that prevented this from occurring. | Chart review and community consultation through community palliative rounds. Increase early identification and referral to PCCT. Increase percent of patients discharged home with support. Formal communication to referral sources (PCP, HCC, Visiting Hospice) inviting early identification. | PCCT client's chart reviewed. Clients referred to PCCT 70% or greater. Percent of patients discharged home from ED/AC with home support for palliative care 90% or greater. | 100%PCCT client charts reviewed - ongoing | |
| | Effective Transitions | Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. | P | Rate per 100 residents / LTC home residents | CIHI CCRS, CIHI NACRS / October 2016 - September 2017 | 51154* | 40.24 | 33.00 | Internal target chosen as a stretch target, realizing that process indicator improvement is needed in order to change outcome. | 1)1. Establish a routine process to accurately track ED visits 2. Establish a protocol for clinical feedback 3. Early Recognition of residents at risk for ED visits | 1. Implement a tracking form to include 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 communication process to follow between hospital and LTC for admission, follow up and any care received 3. RSC will discuss residents at risk monthly by looking into any health changes and identify any signs that warrant involvement of medical staff. 4. Discuss development and implementation of hourly rounding by PSWs. | Internal tracking tools will identify the number of visits to ED by residents and monitor for any trends. Tracking form developed, communication process implemented, monthly risk rounds conducted. | 100% residents discussed monthly with risk rounds. | |
| | Wound Care | Percentage of residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4 since their previous resident assessment | A | % / LTC home residents | CIHI CCRS / July - September 2017 | 54272* | X | 2.00 | While we are lower than the provincial target of 5.2, we seek to improve on our internal performance. | 1)Recent development of a new tool by the RSC has been implemented to improve communication between registered staff and PSWs. This tool will help to alert registered staff to a specific area of concern so that nursing interventions can be initiated and added to a residents care plan before ulcers develop or worsen | 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 specific area of concern, align work plan with Best Practice Guidelines from RNAO | # of alerts sent per month from PSW or PCP to registered staff and 100% of concerns reported forward to registered staff | 100% of concerns have an implemented action | |

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| | Timely access to care/services | % unscheduled mental health and addictions ED visits | C | % / ED MH visits/MH community clients | In house data / 2018 | 938* | CB | CB | New indicator, collecting baseline data | 1)Establish and implement an algorithm to ensure community mental health referral and follow up with patients presenting in local ED | Develop a process map and a community referral process with stakeholders across the continuum (using Lean Tools); Offer a Health Links approach to coordinated care planning for eligible patients and clients | Process map completed; community referral process developed and implemented. Establish local criteria for CCP; offer CCP; implement a trigger mechanism for patients presenting in local Eds who have CCPs for their care coordinator to be notified to follow up. | Number of referrals to community MH services increase by 10% from ED; Increase % of CCPs for community mental health clients by 20%; balancing measure: % of MH clients who respond positively to "my urgent or crisis needs were provided when needed" to target of 95% | |
| 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 | 938* | 33.58 | 28.50 | Internal target chosen as small number of in patient beds create challenges when there are 4-6 ALC patients therefore improvement based on last year's improvement | 1)Refresh the Home First Program. Improve patient flow optimization and discharge enhancements for patients. | Establish working group consisting of ED and inpatient nursing staff and physicians, Home & Community Care, CSS, and GAIN. Review Home First Map -pre-admission, daily bullet rounds, enhance & leverage social work services. Ensure Discharge Coordinator involvement and lead for discussion at weekly patient rounds. Ensure ALC patients currently in AC are offered activities and mobility to lessen any deconditioning and improve QOL. | Percent of Home First discussions taking place at daily and weekly rounds. | 100% of patients are discussed that are currently ALC. | |
| Equitable | Access to care for persons in rural communities | "Percent of consultations requesting telemedicine that have a telemedicine consultation done" | C | % / Percent / Patients with referrals | Telemedicine database, OTN / 2017-18 / 2017-18 | 938* | CB | 95.00 | Locally established target | 1)Increase patient consultations and audit consultations that do not happen. Improve equity understanding among staff. | 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 by engaging more regional consultation services. Investigate MOH's Health Equity Impact Assessment Tool and Measuring Health Equity: Demographic Data Collection in Health Care and Ontario Health Profiles to ensure we are capturing community needs. Offer online training on Ontario Indigenous Cultural Safety Program. | Number of strategies identified and implemented. % of staff trained among those identified for initial phase of training. | 100% of staff trained that are identified to be trained. | |

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| Patient-centred | Person experience | Would you recommend this hospital to your friends and family? | C | % / Hospital collected data | Survey respondents / Most recent 3 month period | 938* | 96 | 98.00 | Average for comparator hospitals | 1)Improved satisfaction with care/experience Improve process for addressing complaints | Provide information on admission to HHHS that discusses the admission and discharge process Call patients post discharge to seek feedback on care and identify any post-discharge concerns. Identify any trends associated with concerns raised about experience/care, and develop action plans to address. Identify strategies for patients to provide real-time feedback, including complaints, to facilitate real-time action to address issues | Number of calls made to patients post discharge, to ask about satisfaction with care/ experience Number of concerns raised in real time versus post discharge Percentage of persons responding positively to: Overall, how would you rate the care and services you received at the ED? | Increase number of positive responses to post-discharge follow-up calls TBD Decrease in number of concerns raised post discharge by 50% by year end | |
| | Resident experience | Percentage of residents who responded positively to the question: "Would you recommend this nursing home to others?" | C | % / LTC home residents | In house data, InterRAI survey / April 2018 - March 2019 | 51154* | 81 | 85.00 | New indicator, aligned with HQO | 1)Resident satisfaction survey's in 2016/17 indicated that participation in activities is highly correlated with overall satisfaction in our LTC home. HW's planned change ideas involve strategies to enhance activities for residents. | Improve Life Enrichment Program by adding activities through consultation with Friends and Family Council. Ensure staff focus is on listening to residents' concerns and allowing residents to express within a climate that is free from fear. | Percent of residents who attend activities; number of new activities added to calendar; satisfaction by FFC. | 100% of residents able to attend activities on a daily basis attend activities | |
| | | Percentage of residents who responded positively to the question: "Would you recommend this nursing home to others?" | C | % / LTC home residents | In house data, InterRAI survey / April 2018 - March 2019 | 54272* | 80 | 85.00 | New indicator, aligned with HQO | 1)Resident satisfaction survey's in 2016/17 indicated that participation in activities is highly correlated with overall satisfaction in our LTC home. HW's planned change ideas involve strategies to enhance activities for residents. | Improve Life Enrichment Program by adding activities through consultation with Friends and Family Council. Ensure staff focus is on listening to residents' concerns and allowing residents to express within a climate that is free from fear. | Percent of residents who attend activities; number of new activities added to calendar; satisfaction by FFC. | 100% of residents able to attend activities on a daily basis attend activities | |
| Safe | Safe care | Percentage of residents who fell during the 30 days preceding their resident assessment | A | % / LTC home residents | CIHI CCRS / July - September 2017 | 51154* | 19.3 | 19.00 | Worsening of indicator was seen last year, therefore focus is on process indicator improvement. | 1)To focus on reduction of falls sustained by new resident admissions, our improvement initiatives involve documentation and education of a falls prevention strategy within 24 hours of admission for new residents 2. Continue work on GAP analysis with RNAO to identify areas for improvement in our falls prevention program | 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 | |

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| | | Percentage of residents who fell during the 30 days preceding their resident assessment | A | % / LTC home residents | CIHI CCRS / July - September 2017 | 54272* | 22.86 | 22.00 | Worsening of indicator was seen last year, therefore focus is on process indicator improvement. | 1)To focus on reduction of falls sustained by new resident admissions, our improvement initiatives involve documentation and education of a falls prevention strategy within 24 hours of admission for new residents 2. Continue work on GAP analysis with RNAO to identify areas for improvement in our falls prevention program | 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 | |
| Safe care | | Percentage of residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4 since their previous resident assessment | C | % / LTC home residents | CIHI CCRS / July - September 2017 | 51154* | 2.63 | 2.00 | While we are lower than the provincial target of 5.2, we seek to improve on our internal performance. | 1)Recent development of a new tool by the RSC has been implemented to improve communication between registered staff and PSWs. This tool will help to alert registered staff to a specific area of concern so that nursing interventions can be initiated and added to a residents care plan before ulcers develop or worsen | 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 specific area of concern, align work plan with Best Practice Guidelines from RNAO | # of alerts sent per month from PSW or PCP to registered staff and 100% of concerns reported forward to registered staff | 100% of concerns have an implemented action | |
| Safe care/Medication safety | | Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication | P | Rate per total number of discharged patients / Discharged patients | Hospital collected data / October – December (Q3) 2017 | 938* | 24.69 | 75.00 | Aligned with Accreditation Canada ROPs; we will seek a 59% improvement quarter to | 1)1)Identify a strategy to ensure all patients have BPMH completed upon discharge; use learnings from successful med recon at admission | Develop and implement discharge order set that includes BPMH | Health Records department to track med rec completion at time of coding. | Increase percentage by 50% by end of 2nd quarter | |
| **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** | **938*** | **CB** | **5.00** | **Based on best practice** | **1)Create a workplace violence risk assessment tool 2) Increase staff's ability to de-escalate and manage potentially violent patients, by implementing mandatory training, based on available funding. 3) Improve the 'Flagging"" program and ensure alignment with CELHIN.** | **1) Review and update the risk assessment tool, based on best practice. 2) Investigate and offer training options for staff. 3) Working with the CE LHIN partner Hospitals, review and implement a standardized flag/symbol for consistency.** | **1) Risk assessment tool completed 2) Percent staff trained based on those who were identified for training 3) Number of instances a flag/symbol was utilized** | **% use of Risk Assessment Tool TBD; 100% staff attending mandatory training by Q4; Baseline number of Flags identified** | **HHHS Full Time Employees as of March 26, 2018 = 300 FTE** |

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| | **Health Work Environment** | Percentage of staff who provide positive responses to Pulse survey by rating excellent, very good, good to the question: "Overall, how would you rate the organization as a place to work?" | C | % / All Staff | Pulse Survey / December 2017 | 938* | 72.3 | 75.00 | Internal target | 1)Improve employee satisfaction by engaging staff with identifying and addressing barriers and challenges. | Engage and support staff in working groups and in implementing suggestions for work life improvement. Develop action plans at the departmental level to improve employee satisfaction, based on top 3 prioritized departmental survey results. | # of department working groups; % of action plans developed | 100% of all departments have a working group; 100% of departments have an action plan | |
| | **Safe Care** | Number of falls in hospital per 1000 patient days | C | Rate per 1,000 / DAD / DAD | Hospital data; DAD / April 1, 2016 - March 31, 2017 | 938* | 8 | 15.00 | Provincial; RNAO BPGs | 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 | 80% of staff to complete falls education by 2nd quarter | |
| **Timely** | **Timely access to care/services** | 90th percentile Emergency Department (ED) length of stay for complex patients | C | Hours / Patient / Patients with complex conditions | CIHI NACRS / January 2017 – December 2018 | 938* | 5 | 8.00 | HSAA target; although we would strive to continue to improve our performance | 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 monitor through monthly DART report | 1. Number of times discharge planning orders are checked off on admission order sheet 2. Number of days bullet rounds take place | 100% | |