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

West Park Healthcare Centre 82 Buttonwood Avenue

AIM		Measure						Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) A= Additional (do not select from drop down menu if you are not working on this indicator) C = custom (add any other indicators you are working on)												
Effective	**Length of stay efficiency**	Improve length of Stay (LOS) efficiency-Stroke	Patient with stroke admitted to High Intensity Rehabilitation	CIHI- National Rehabilitation Reporting System (NRS) / Q1 &Q2 2017/18	0.9	1.00 (0.95)	Targeting LOS efficiency in- line with GTA average. (0.95-1.0)	1)Review current coding and documentation practices.	Conduct audit on FIM completion. This will involve forming a working group from interdisciplinary care team.	1. Completed LEAN process map of FIM assessments. 2. Completed process to identify change ideas.	1. Number of change Ideas identified 2. Number of change ideas implemented	
								2)Improve FIM coding and data driven decision making.	1. Staff education on ideal process for FIM assessment. 2. Number of education sessions about FIM process and scoring. 3. Collaborate with physicians to promote timely conversion of patients to Low Tolerance Long Duration (LTLD) Rehabilitation program as applicable and appropriate.	1. Completed process review for FIM assessment. 2. Number of patients converted to LTLD (baseline and criteria to be established).	Number of change ideas implemented	
								3)Enhance the discharge process.	1. Provide patients/families with a memo on admission that includes the expected discharge day. 2. On admission, review with patients/families expected discharge date and patient oriented discharge plan for a safe and supported discharge. 3. Explore strategies to decrease LOS	1. Percent of patients received the memo on admission. 2. Number of change ideas identified.	1. 90%-95% 2. Number of change ideas implemented	
		Improve length of stay efficiency - Hip Fracture	Patient with Hip Fracture admitted to High intensity Rehabilitation	CIHI- National Rehabilitation Reporting System (NRS) / Q1 &Q2 2017/18	1.31	1.41 (1.35)	The aim is to sustain improvement achieved in 2017-18 QIP and continue to improve LOS in-line with GTA rehab average within high intensity rehab program. (1.35-1.41)	1)Improve FIM coding and data driven decision making.	1. Use LEAN methods to optimize FIM coding and ensure RPG is shared with clinicians and LOS target established for MSK population (hip fracture). 2. Explore the feasibility of expedited referral and admission process for appropriate complex hip fracture patients from acute care centres to rehab. 3. Perform daily FIM assessment for the first 72 hours.	1. Completed LEAN process map for FIM assessments. 2. Completed process redesign identified through LEAN review. 3. Number of education sessions about FIM process and scoring. 4. Percentage of patient who had daily FIM assessment for the first 72 hours	1. Number of change ideas identified 2. Number of change ideas implemented 3. Number of education session 4. 72 hours FIM assessment completed	
								2)On admission, review with patients/families expected discharge date and plan for supported discharge.	1. Provide patients/families with a discharge memo on admission that includes the expected discharge day. 2. Provide patients and families with education on discharge process	Percent of patients receiving memo on admission	90-95%	
Efficient	**Access to care**	Improve access to care by increasing number of Ontario Telemedicine (OTN) consults	Count / All patients	In house data collection / 2017	20	23.00 (22)	This is a new QIP indicator for the centre. We will aim to increase awareness, utilization and access to specialized services via OTN.(22-23 econsults)	1)Conduct a review of current OTN utilization to establish baseline metrics.	Collaborate with OTN to collect and analyze current utilization baseline data.	Number of OTN consults	Increase by 10%-15% (2-3 consultations)	
								2)Identify potential for service expansion.	Review new Patient First Digital Health Strategy and explore ways in which to support service delivery models.	Number of OTN consults	Increase by 10%-15% (2-3 consultations)	

								3)In collaboration with care teams and patients, identify 2-3 targeted OTN services within the centre by which to focus improvement initiatives.	1. Align targeted OTN services communication between inpatient ambulatory care providers and primary referral sources. 2. In collaboration with patients and care providers, develop communication material regarding OTN services at the centre.	Develop communication materials	1-2 Communication Material	
Patient-centred	**Person experience**	Percentage of patients rating 'staff' dimension positively.	% / Complex continuing care patients	NRC Picker / 2017/18	50	55%	Increase positive response rate (52%-55%)	1)1. Increase survey (Staff dimension) frequency to twice per year rather than annually 2. Engage patients and families to identify	Review and adjust the current process to identify patients, administer surveys, analyze, share and better utilize the data throughout the year.	1. Complete LEAN project (Q3). 2. Administer of surveys on a regular basis.	1. Survey "staff dimension" by August 31st. 2. Number of change idea identified	
								2)Communicate results and engage frontline staff in change actions	1. Enhance communication of improvement activities and survey results within CCC. 2. Develop and deliver education on Person centred care to interprofessional team.	1. Results discussed at staff meetings and number of change ideas identified. 2. Number of education sessions.	1. Number of change ideas implemented 2. Number of education sessions	
								3)Communicate results and engage patients and families to have in-depth insight into improvement opportunities.	1. Update visitor policy to incorporate principles of family presence. 2. Using a model of engagement, partner with the PFAC to identify key improvement. 3. Engage with patients through regularly conducted focus groups to explore 'their story' and care experience at the centre. 4. Reinforce "Always events" by service managers.	1. Policy update completed. 2. Number of change ideas identified by the PFAC as priorities for 2018-19. 3. Number of focus groups conducted. 4. Survey patients to evaluate patient experience with always event.	1. Policy completed 2. Number of ideas 3. 2 focus groups by March 31, 2019. 4. Survey completed	
Safe	**Safe care/Medication safety**	Adjusted percentage of patients who were given antipsychotic medication without diagnosis of psychosis	Complex continuing care patients	CIHI CCRS, CIHI NACRS / Q2 2017/18	36	27% (30%)	Decrease percentage to be in benchmark corridor of comparable centres (27%-30%)	1)List of patients triggering indicator sent to pharmacists for confirmation, verified list will be sent to QI team for review.	In collaboration with physicians, pharmacists and clinical team, continue to review current practices to identify additional opportunities for improvement.	Practice reviewed and process established with collaboration of key stakeholder.	Number of change ideas identified and implemented	
								2)MDS assessors to use a list of CIHI antipsychotic drugs for cross-referencing.				
								3)Automated data mining being developed (Chopin project).	Data mining process	Process developed	Completed	
								4)Perform further review to identify improvement opportunities to enhance care and management of patients with responsive	Explore opportunity to develop behavioural management program to enhance non-pharmacological approaches to management of escalating behaviour.	Number of non-pharmacological (i.e behaviour management) approaches identified and implemented.	Number of change ideas identified and implemented	
								5)Educate and support physicians and interprofessional care team	Education provided.	Number of employees and physicians educated	Targeting education of 80-90% prescribers within the centre.	
								6)Case review to identify patients where de-prescribing is a possibility - care plan created.	Case reviews of patients on anti-psychotics	1. Number of case reviews completed. 2. Number of patients with whom antipsychotic medications were decreased. 3. Number of patients with whom antipsychotic medications were stopped.		
	Workplace Violence	Number of workplace violence incidents reported by hospital workers	Count / Worker	Local data collection / January - December 2017	114 FTE: 740	129.00 (124)	Increase reports by 10%- 15% (10-15 reports)	1)With consultation with OH&S, medical staff, volunteers, and patients we will encourage	OH&S and QRPS will collaborate to establish a consistent reporting / monitoring process involving workers and patients/families.	Number reported incidents	Increase by 10%-15%	

		(as by defined by OHSA) within a 12 month period.						2)The organization includes safety as a strategic priority.	Develop and implement education related to workers safety.	Number of education sessions staff attended.	50-60% staff attend training by March 31, 2019	
								3)Review best practices and external scan to select appropriate screening tool, develop processes, educate staff, and implement change ideas	1. Select evidence-based screening tool and establish process by which patients admitted in high-risk units are screened and assessed as soon as possible on admission or when triggered by behaviour change or other identified 2. Establishes screening and assessment processes and education relevant to other departments within the centre 3. The organization develops and delivers education regarding work place safety and/or accountability to the code of conduct.	1. Tool selected 2. Processes developed 3. Number of education sessions	Completed	
								4)Develop a Psychological Health policy.	In collaboration with relevant stakeholders evidence and best practices are analysed and discussed to identify opportunities for improvement.	1. Policy developed 2. Number of change ideas identified	Policy completed	
								5)Establish a process to ensure dual reporting to OH&S and QRPS when the incident involves patient and staff.	QRPS and OH&S to developed a shared tracking sheet to ensure all incidents involving staff and patients are reported to both departments	Percent of incidents involving staff and patient reported to both departments	Process established	
	Safe Care	Adjusted percentage of patients who developed a new stage 2 to 4 pressure injuries	Complex continuing care patients	CIHI CCRS, CIHI NACRS / Q2 2017/18	3.6	2.50 (3.0%)	Decrease percentage to be in benchmark corridor of comparable centres (2.5-3.0%)	1)Perform Root Cause Analysis new stage 2 and 4 Pressure ulcer to inform process/practice improvement	Conduct an interprofessional RCA	Number of stage 2 to 4 pressure injury RCA completed	2 cases	
								2)Education and support to nurses on wound assessment and treatment.	1. Education curriculum and practical component (registered staff). 2. Link and align education to RNAO best practice guidelines.	1. Education curriculum developed. 2. Number of nurses educated.	1. Completed 2. 50-60% of RNs/RPNs attend education. (Year 1)	
								3)Refresh education to CCAs on skin checks and reporting.	Education curriculum CCAs.	Number of CCAs educated.	40-50% of CCAs educated	
								4)Promote compliance to the use of pressure injury risk assessment tool.	Review process for skin assessments, risk assessments and ongoing interventions.	Number pressure injury risk assessments completed on admission.	90-100%	
Timely	**Improve access to clinical information**	Percent of discharge summaries sent to primary care provider within 2 business days	Rehab	In house data collection / 2017/18	91	95.00 (91%)	Maintain 91-95% with implementation of electronic discharge system	1)Individual physician engagement follow-up.	1. The Chief of Staff will meet with physicians to promote improvement. 2. Report results at the service level by physician and enhance reporting processes. 3. Explore ways in which to further expedite discharge summary completion (=2 business days) in identified units. 4. With input from patients and the interprofessional care team identify the opportunity for a patient oriented discharge summary. 5. With input from patients and families, identify ways in which to further promote continuity of care, safe transitions in care as part of the discharge process.	1.Percent of those not achieving target who met with Chief of Staff. 2. With support from QI facilitate discussion exploring supported opportunities for improvement.	1. 91-95% 2. Number of change ideas	