Let's Make Healthy Change Happen.

Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

HANOVER & DISTRICT HOSPITAL

3/29/2018

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a Quality Improvement Plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein.

Overview

Hanover and District Hospital (HDH) continues to work with our partners to provide a full range of primary acute care hospital services and selected secondary services to meet the needs of the population of Hanover and the surrounding rural townships. Our Mission is to collaborate with our partners to ensure that the residents of our region receive the highest quality accessible care possible. Our Vision is to be an "Innovative Health Care Network" living our Values: Integrity, Compassion and Collaboration. The HDH Board of Governors, staff, and physicians have maintained an unyielding focus on five pillars of strategic direction: Sustainability and Growth, People and Teams, Partnerships and Communication, Needs Based Service, and Quality and Innovation.

The Board of Governors, staff, physicians and community partners work together to accomplish seamless care that provides core rural health services close to home and formalizes clear pathways for referrals to additional services. Thus, the overall objective is to strive for integration and continuity of care across the healthcare sector. HDH partners with peer acute hospitals; community agencies, such as Home and Community Care SWLHIN (formerly CCAC); long term care homes; and social service providers to provide, or refer and connect residents of the region to ensure they receive optimal care.

We provide local residents access to the care they need through the 24/7/365 Emergency Department, Acute Care Unit (inclusive of medical surgical beds, multipurpose ICU and restorative care beds), Physiotherapy Program, Cardiac Rehabilitation Program, Surgical Services Department, Family Centered Birthing Unit, Hemodialysis Unit and Palliative Care Services. Access is provided within the organization to Community Mental Health and Addiction Services, Home and Community Support Services, Home and Community Care SWLHIN (CCAC), Victorian Order of Nurses (VON), the Hanover Family Health Team and the Hanover Medical Clinic. HDH's ambulatory clinics include: pediatrics, dermatology, urology, orthopedic, endocrinology/diabetes, surgical ophthalmology, obstetrics, PICC placement, and renal dialysis.

HDH has and will continue to maximize opportunities for service integration and coordination between acute, primary care and community care providing selected acute care, surgical and other health care services within our health care "hub". "Accredited with Exemplary Status" two consecutive surveys, reflects that our Board and staff strive to surpass the fundamental requirements of the accreditation program. Accreditation has aligned and assisted the staff of our health care organization to improve our performance, focusing on quality improvement and safety initiatives for the benefit of the patients and the services we provide.

As we planned for and developed the 2018/19 Quality Improvement Plan (QIP) we considered the six categories of quality issues with indicators as provincial priorities including: Effective, Patient Centred, Efficient, Safe, Timely, and Equitable.

The QIP continues with the direction of the Board of Governors, staff and physicians for the coming year in the quality dimensions through the 2018 initiatives. This includes an improved communication strategy and plan between staff, physicians and Board Governors, a patient centered care model with Patient and Family Advisory Committee, and increasing collaborative partnerships / integration projects to complement services both regionally and locally within the HDH Healthcare Hub. This year, the 2018/19 measurable outcomes will be achieved through Hospital peer reviews; integration; partnerships; clinical outcome review; process audits; variance analysis; patient, staff and physician satisfaction

surveys; staff education and training; and other appropriate quality improvement techniques. In doing so, the QIP will specifically focus on measurable indicators, changes and ideas under of the chosen quality dimensions:

Effective:
Effective transitions:
Patient received enough information on discharge
Patient experience: Did you receive enough information when you left the hospital? Percentage of respondents who responded positively to the following question: 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? Target will be 95%. Measuring the number of respondents who responded "Completely" (do not include non-respondents)

Discharge summaries sent within 48 hours of discharge Percent discharge summaries sent from hospital to community care provider within 48 hours of discharge will be 100%. Calculate number of discharge summaries transcribed, signed and sent within 48 hours of patient's discharge from hospital for the time period.

Patient Centered:
Palliative Care: Home support for discharged palliative patients. Percent of palliative care patients discharged home from hospital with the discharge status "Home with Support" This will include any diagnosis code with a palliative care indication: ICD 10 Code Z51.5 or ICD 9 Code V66.7 or Main patient service of palliative care (PATSERV = 058). Discharge destination is home (Discharge disposition = 4 (home with support) or 5 (home without support). This does not include Same Day Surgery patients. 2017/18 established a baseline for % of home support for discharge palliative patients; Percent of palliative care patients discharged home from the hospital with the discharge status "Home with Support" for 2018/19 will be set for 85%.

Person experience: Patient experience: Would you recommend inpatient care? Percentage of respondents who responded positively to the following question: "Would you recommend this hospital to your friends and family?" A 95% satisfaction rating overall. Counting number of survey respondents (exclude non-respondents)

Person experience: Would you recommend emergency department? Percentage of respondents who responded positively to the following question "Would you recommend this emergency department to your friends and family?" A 95% satisfaction rating overall is the target. Counting number of survey respondents (exclude non-respondents)

Person experience: Percentage of complaints acknowledged to the individual who made a complaint within three to five business days. This indicator measures the percentage of complaints received by hospitals that were acknowledged to the individual who made a complaint within the period of 3 to 5 business days, will be 95%. This indicator is calculated on the number of complaints received in the reporting period that have been acknowledged to the complainant within the 3 to 5 business days of submitting a complaint.

Safe Care:
Workplace Violence: Number of workplace violence incidents (overall) measuring the number of reported workplace violence incidents by hospital workers (as defined by OHSA) within a 12-month period including physicians and those who are contracted by other employers (e.g., food services, security, etc.) as defined by the Occupational Health and Safety Act. 2018/19 will establish a baseline for data.

Safe Care: Medication safety: Medication Reconciliation at discharge. Total number of discharged patients for whom a Best Possible Medication Discharge Plan (BPMDP) was created as a proportion of the total number of patients discharged.

Medication safety: Medication reconciliation at admission. Total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital.
Increase proportion of patients receiving medication reconciliation on Admission and at Discharge will be measured at 100%.

Timely:
Timely access to care/services: 90th percentile emergency department length of stay for complex patients. ED Length of Stay defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ED will be within the 90th percentile. Inclusions: Admitted patients – Disposition Codes 06 and 07

Equitable: Throughout all chosen indicators we will be engaging community members/patients through surveys and Patient and Family Advisory Committee (PFAC), for purposes of improving quality; integration and coordination, to ensure the delivery of appropriate, high quality co-ordinated care. Lastly, Quality and Funding, as a small facility we continue to monitor the Quality Based Procedures (QBPs) following their processes and aligning our services to meet the best practices established. The QIP is aligned with our strategic plan, operational plan, service accountability agreements and hospital goals and objectives as well as the provincial priorities and LHIN initiatives through being innovative, collaborative and accountable.

The suggested indicators that HDH chose not to include as priority indicators in the QIP as they are either not within our realm of control, not applicable to our organization or are not stretch targets include;
•Risk Adjusted 30 day all-cause readmission rate for patients with congestive heart failure (A QBP Cohort – HDH does not have enough volume);
•Risk Adjusted 30 day all-cause readmission rate for patients with chronic obstructive pulmonary disease (A QBP Cohort – HDH does not have enough volume);
•Risk Adjusted 30 day all-cause readmission rate for patients with stroke (A QBP Cohort – HDH is not a stoke centre);
•90th Percentile Emergency Department length of stay for complex patients (Not a stretch target) for discharged patients;
•Alternate level of care rate. The indicator is beyond our control and measures within the HSAA.
•Percentage of patients identified as meeting Health Link criteria who are offered access to Health Links approach
•Pressure ulcers for complex continuing care patients (HDH does not have CCC beds);
•Readmission within 30 days for selected Health Based Allocation Model Inpatient Grouper (HDH is not part of HBAM);
•Hospital readmission rates for a mental illness or an addition (HDH does not have mental health beds);
•Physical restraints in mental health (HDH does not have mental health beds);
•ICU antimicrobial utilization – Antimicrobial-free days (AFD) LOS and volumes is too low

Describe your organization's greatest QI achievements from the past year

Last year's QIP was instrumental in achieving stretch targets to enhance care provisions for the patients and educating the staff with regard to using data to drive improvement with the exception of ALC inpatient days.

Efficient: We reduced unnecessary time spent in acute care by reducing the total number of ALC inpatient days within the specific reporting period. ALC rate is difficult as it is changeable with the small number of inpatient days and inpatient population for the hospital; This is not solely a hospital issue/metric, this makes this a variable metric. However, staff and Physicians worked closely with the Home and Community Care (SWLHIN) staff as this ALC metric is a system wide issue; HDH plays a role, but cannot control this metric solely. Staff continue to work with Home and Community Care SWLHIN daily to discuss discharge plans and promoting home first with families.

Patient Centered: Improve patient satisfaction by Positive Patient Experience through ER and in-patients services. Our performance for Q1-Q3 is 92% overall (In-patient Unit 87%, Emergency Department 98%, Family Centered Birthing Unit 92%). A number of organizational wide initiatives have been put in place to increase this metric. We continue to implement the "Achieving Excellence" modules; reinforcing the code of conduct (COC), staff has been impressed with the consistency of how the leaders have enforced the COC. The patient rights and responsibilities document has been widely distributed, and there is an increased involvement of the Patient & Family Advisory Committee via committee work and organization wide decisions involvement in projects. Furthermore the staff and physicians have been provided education of what discourteousness is. Many Patient stories are shared with the Board Governors.

The community, patients, and family members have been involved in sharing their experiences, opinions, and ideas about the health care services we provide and how we can improve the services to them through meetings, presentations, surveys and satisfaction data. We actively sought out the perceptions, understanding and advice of our stakeholders through public engagement sessions, as well as through our Network/healthcare partners for the hospital services, to or not to provide Medical Assistance in Dying as well as adding a CT scanner as a service to HDH. Through engagement sessions and patient feedback we continue to learn and improve how we deliver care over the years. With their feedback, we identify gaps and issues that are important to them and work collaboratively to address issues and develop programs and services within our catchment area. The feedback we receive helps us identify and work on issues to improve the health of our communities as well as shape and develop the content of our QIP.

Safety: Increase proportion of patients receiving medication reconciliation upon admission and discharge was achieved in all areas measured. Although this is not a stretch target we as an organization will continue to track this very important indicator.

Safety Increase: Hand Hygiene Compliance Before Patient Contact. The number of times that hand hygiene is performed before initial patient contact during the reporting period has been a resounding success. Volunteers are actively helping with audits and educating visitors as they filter through the facility.

Resident, Patient, Client Engagement and relations

HDH is always cognisant of striving for the vision of a patient centered model: a system centered on the needs of the demographics, the people's needs and preferences. Knowledgeable and involved patients, informed and investing in their own health care will reflect in the overall improvement of the broader health care system. Patients bring their unique and important perspective about the care and services provided. They know firsthand about the experience they receive at HDH and in other organizations, and on the coordination and cooperation among healthcare partners involved in their care. At HDH we strive to involve patients, their

families and other caregivers, and the public in meaningfully engaged care or as partners in its improvement.

Recognizing the importance to focus on the patient, a learning health care facility like HDH is one in which patients and their families are key drivers of the design and operation of the learning process. The Patient and Family Advisory Committee is utilized 100% for important feedback. This committee involves patients, families, other caregivers, and the public, who are full, active participants in care and engaged with the organizational decisions, the overall health experience of care, and the improvement of economic outcomes.

This is important as the ripple effect of discharge planning is placing an increasing burden of care on the family caregiver. Discharge planning is significant for the growing numbers of the older population where inadequate practices can be linked to adverse outcomes. There is an increased risk for readmission. The role of discharge planning is important and plays a role in bridging the gap between the care provided in hospital and the care needed in the community. The need for a coordinated discharge approach includes clear communication, distribution of information, and active support linking to community services. It is our goal that including the informed, involved patient and family with the discharge process will entail positive outcomes, allowing nurses and others involved with the discharge process to better reconcile the family caregivers' needs and expectations.

Collaboration and Integration

HDH Board of Governors, physicians, leaders and frontline staff believe the focus should be on patient-specific continuums of care. As an organization we have and will continue to focus on enhance diagnosis, treatment and follow-up practises. Timely assessments are important for the safety and recovery of our patients. HDH continues to have a long history of collaborating with other health and social service organizations to partner and thus deliver the necessary services our residents require.

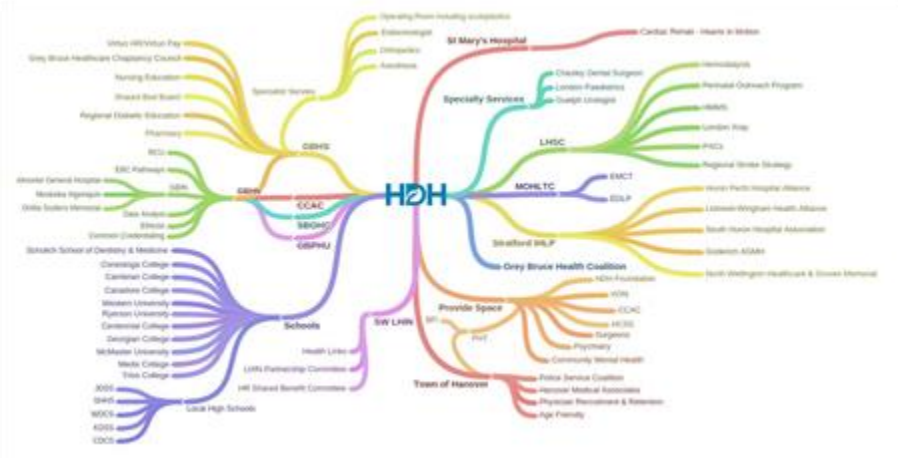
As a small hospital faced with the reality of public sector funding we have adapted and found new ways to remain viable. Working in collaboration with our partners; neighbouring hospitals, Home and Community Care SWLHIN, Family Health Team, Mental Health and Addictions Services and so forth to address the gaps in the services of our communities, planning for the future, and helping to support the navigation of our clients through the health care system, we will communicate frequently and clearly to seek input.

The QIP helps us find ways to continually improve the depth, quality, and access to the services our residents require and allows for a systematic, coordinated, and continuous approach to improving performance in a coordinated and collaborative effort with external partners to facilitate continuity of care for the patients we serve. The approach to improving our performance involves multiple departments and key external partners and disciplines, i.e. the Home and Community Care SWLHIN, Family Health Team, primary care providers, Public Health, and neighbouring hospitals.

The quality dimensions focus on patient centered care and the integration of services across all areas of the patient journey ensuring the patient receives high quality, accessible and coordinated care. This past year a strong focus of integration and partnership occurred with the Patients, Physicians, Family Health Team and the community with the decision to offer Medical Assistance in Dying (MAiD) and apply for a CT scanner. While establishing the plan, processes, and mechanisms that comprise performance improvement activities for Effective, Patient

Centred, Efficient, Safe, Timely, and Equitable care indicators. A key component to the success of all quality dimensions will include well informed staff and ongoing communication with our health care partners. This will be critical for transparency and success to ensure our efforts are successful.

A strong focus this year will be on mental health and addiction issues. Mental illness affects people of all ages, education, income levels, and cultures and is notably growing, impacting all healthcare facilities. Collaboration with our partners is a necessity for finding solutions to this growing concern. This focus too will reduce an increasing number of code whites of aggressive and angry mental health and addictions form one patients as well as reported workplace violence incidents by hospital workers. As hospitals are moving toward electronic charts, sharing information and adapting so that functional areas do not operate in isolation. Collaboration and integration is important. Technology enables collaboration and integration of patient flow in assisting resolution of getting patients to the right care in a timely matter.



Engagement of Clinicians, Leadership & Staff

The development of the QIP represents the collective work of the Board of Governors of HDH and includes input received from our physicians, staff and stakeholders. The 2018/19 QIP reaffirms the hospital's longstanding commitment to continuous quality improvement through accessible quality patient care, partnering with integration projects and being patient focused. The selected QIP quality dimensions and objectives were chosen with Physician input during Medical Advisory Committee meeting (MAC) and through Achieving Excellence meeting with Managers, Team Leads and Charge persons. The chosen indicators are then incorporated in the five strategic plan pillars used as a living document and a significant lever for driving change within HDH with the goal of improving system quality and performance. Furthermore, the QIP document will outline the quality dimensions and objectives and the proposed measurement outcomes in the Hospital scorecard that will demonstrate the monitoring of progress.

As an organization, the Hospital staff, physicians and Board Governors strive to improve its horizontal integrated systems of care with the delivery of a 'seamless service' through coordination of accessible health care, education of staff and patients, and the sharing of information about the programs and services offered at HDH.

Population Health and Equity Considerations

Hanover and District Hospital continues to provide a full range of primary acute care hospital services and selected secondary care services to meet the needs of the population of Hanover and the surrounding rural townships. According to Grey Bruce Public Health 18% of the population in the Grey Bruce region is over 65 years

of age, 2% higher than the provincial average. In addition, cohorts between 45 and 54 years of age, and 55 to 64 years of age have also demonstrated growth in the last decade (Public Health, 2011). This means Grey and Bruce counties populations are made up of older people than the provincial average and it can be expected that they will require an increased access to healthcare close to home, including diagnostic technologies and services.

The major ailments that residents of Grey-Bruce counties experience that are associated with death are attributed to a wide-range of cardiovascular disease, various forms of cancers, diabetes mellitus, pneumonia, influenza, Alzheimer's disease, injury and poisoning (Based on Public Health data and Top case mix groups (CMG) admitted to HDH). In addition to these disease processes, patrons of HDH experience a higher rate of obesity than the rest of Canada, as well as higher smoking and drinking rates in relation to other parts of Ontario and Canada (Public Health, 2011). The most frequent admission diagnoses that presented at HDH over the last few years continue to be: congestive heart failure, chronic obstructive pulmonary disease, uncontrolled diabetes mellitus, angina, falls and failure to cope. This data is reflected in the number of people aged 65 and older (the aging baby boomers) presenting to the emergency department requiring more complex emergency care. These silver tsunamis are expected to more than double over the next 25 years.

HDH has the busiest Emergency Room (ER) in South Grey Bruce counties and is the only Emergency Department that provides a physician on-site 24/7. This requires a higher level of acuity to complete complex assessments and treatment modalities. Serving the population we also provide a robust Surgical Services program in South Grey Bruce counties housing two full-time general surgeons that provide 24/7 on-call surgical coverage, as well as a number of visiting surgeons. The increased volume of the Emergency Department paired with an increase of volume and complexity in Surgical Services have led to increased utilization of the Intensive Care Unit and increased volume and complexity in the acute care medical surgical unit. More recently Mental Health and Addictions has been an increasing concern and top CMG in the emergency department volumes. Unfortunately violence in the workplace too increases with the form one mental health and addictions patients.

Mental health and Addictions is highly prevalent and causes considerable concern and suffering in the Grey Bruce area. Mental health and addictions is at a crisis. HDH does not have Mental Health and Addiction beds. HDH is NOT a form one facility. The Emergency Department is faced with the ongoing challenges with the growing numbers of mental health and addiction patients, young and old, unable to find mental health and addiction services and or beds for Form 1 patients, and are seriously concerned of no services for those under the age of 18. Many phone calls and letters are written to the SWLHIN and Ministry on the patient safety perspective, and providing the right care in a timely fashion. This is a common frustration and time consuming for physicians and staff to get the mental health and addiction patient the help they require. This continues to place stress on the department and causes safety concerns for staff, family and patients. To compound this problem, many individuals with psychiatric illnesses remain untreated. The treatment gap for mental disorders is collectively huge. Recently, HDH has partnered with Grey Bruce Health Services to create a collaborative approach in finding the bed for admitted mental health and addiction patients across the SWLHIN and beyond.

HDH is willing to partner with necessary stakeholders in order to ensure the residents of our region receive the necessary care.

Access to the Right Level of Care - Addressing ALC

We strive to provide and ensure safe quality care and ensure the patients' needs are met through providing the right care, at the right place, and at the right time through the right service in our acute care setting and Health Care Hub. HDH supports and are actively involved with integration projects, with a strong focus on collaboration, evidence and quality-based framework and investigating opportunities for process improvements and clinical redesign. The end goal is to minimize inappropriate readmissions; provide smooth transition transfers of ALC patients; improved patient outcomes; enhanced patient experience; and potential resource/cost savings. The ALC metric is a system wide issue; HDH plays a role, but cannot control this metric solely. Staff continue to work closely with Home and Community Care SWLHIN daily to discuss discharge plans and promote home first with families.

Opioid Prescribing for the Treatment of Pain and Opioid Use Disorder

Opioids are recognized as an all too frequently prescribed means for the treatment of acute and chronic pain. HDH leaders and Board Governors will work with the Physicians to review policies to prescribe only enough to last for the expected duration of severe pain (generally 3–5 days) using the lowest effective dose of immediate-release formulation. The policy will be developed with discussions regarding contraindications to prescribing opioid treatment, such as mild to acute pain (e.g., low back pain, dental pain, muscle strains) and if the patient is an active substance user. We will continue the practice of being a non-narcotic emergency department. Further, a standardized pain assessment tool has been developed and adopted by HDH, providing a consistent approach to assessing patient's pain status across the organization. Annual education regarding opioid use and its risks is also a patient education priority.

Workplace Violence Prevention

Patient and staff safety are of paramount concern. Workplace violence prevention is a strategic priority for our organization with the growing number of mental health patients being police escorted to the emergency department and an increase in overall Acute incidents. Concerns about frequency and severity of workplace violence incidents with Code White alerts are a growing concern of the leadership team, staff, physicians and governors. Leaders realize the importance of identifying tangible steps toward changing attitudes, teaching defensive skills, and providing support for prevention and escalation of violence and harm. As an organization we are focused in making our health care environment safer and being more responsive to occurrences of violence.

The Code White policy is regularly reviewed to ensure optimal patient and staff safety. Proper restraints for code white patients have been purchased, and key staff and security have all been trained. A quasi designated "mental health safe" room within the emergency department was established that has minimal equipment in it for code white patients. Staff receives regular code white training from two in house Crisis Prevention Intervention (CPI) Train the Trainers. With two trained educators, we are able to provide increased training for staff and physicians. Education on how to handle and diffuse a potentially aggressive situation and apply restraints, are very important for the safety of everyone and has been incorporated into our CPI in house training program.

All staff are encouraged to practice personal safety measures when entering or leaving the building after hours; park in the designated staff on call parking spots across from the emergency department doctor's entrance (close to the building) and to use a buddy system when leaving the building after hours. Staff working alone or few in number are provided personal safety alarms. Late fall 2017, HDH hired a security firm to assist staff with building security, code white scenarios and guarding violent patients. The security team was provided all the training that our hospital staff receive, which includes CPI in-house training.

HDH has a monthly workplace inspection program where all hospital departments are inspected for violence and safety concerns. We annually administer a workplace violence survey to gain feedback and insight from our staff and volunteers. A mandatory annual education fair is held to ensure that all staff, physician and volunteers receive necessary safety education (some of the many elements covered during this fair include; violence and respect in the workplace, organization policies and procedures pertaining to code of conduct, personal alarm use, code white training and response). As an organization we have implemented enhanced communication strategies pertaining to violent or potentially violent patients which include; 'Blue Stop Sign' posted on the patient doorways for aggressive or potentially aggressive patients, 'System Alerts' that identify patients that have a history of aggressive behaviour, "Dealing with Difficult Patients and Families" reference list that clearly outlines that resources for staff to utilize and a "Zero Tolerance" policy and posters, which are displayed throughout the organization. We continue to work closely with Public Services Health and Safety Association (PSHSA) to review our program and utilize existing toolkits and resources made available to the Acute Care sector.

The Joint Health and Safety Committee (JHSC) in conjunction with the Code White team ensure that annual mock training is provided in order to ensure that staff is well educated and trained to respond to emergency situations.

Performance Based Compensation

The Effective Care for All Act (ECFAA) requires that the compensation of the CEO and other executives be linked to the achievement of the performance improvement targets laid out in the QIP. The purpose of performance-based compensation related to ECFAA is to drive accountability for the delivery of QIPs. The Board agrees the following executives will be linked to the organization's achievement of the targets set out in the annual QIPs:

- President CEO (Administrator)
- Chief of Staff
- Senior Management reporting directly to the President CEO

Each year, QIP targets will be reviewed with the Board Directors indicating the degree to which the targets have been met. As indicated in the Hospital Board Policy and QIP, 5% of the President/CEO annual base salary (step increase) is considered to be 'at risk' and is linked to achieving 100% of the targets set out in the QIP. Achievement of all targets would result in 100% payout; partial achievement of targets will result in partial payout, as determined by the Board of Governors.

Summary: Performance based compensation accounts for 5% of each executive's annual compensation.

Other

Overall, the goal of the QIP is to provide safe quality care and ensure the patients' needs are met through providing the right care, at the right place, and at the right time through the right service in our acute care setting and Health Care Hub. The plan reflects integration projects with a strong focus on collaboration, evidence and quality-based framework and investigating opportunities for process improvements and clinical redesign to minimize inappropriate readmissions; provide smooth transition transfers of ALC patients when possible; improved patient outcomes; enhanced patient experience; and potential cost savings.

Furthermore, the actions and care provided by HDH are enhanced with recommended evidence-based best practices developed by clinical consensus of the Grey Bruce Health Care Network Partners Evidenced Based Care program.

Sign-off

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan

Board Chair Dave Cardwell
Quality Committee Chair Brandon Koebel
Chief Executive Officer Katrina Wilson

Board Chair, Dave Cardwell

President & CEO, Katrina Wilson

Quality Governance & Risk Management Chair, Brandon Koebel

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

Hanover And District Hospital 90-7th Avenue

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
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	Effective transitions	Did you receive enough information from hospital staff about what to do if you were worried	P	% / Survey respondents	CIHI CPES / April - June 2017(Q1 FY 2017/18)	676*	CB	95.00	Monitor the number of patients sent home with enough	1)Continue to hand-out prepared packages on commonly admitted conditions: COPD, DM , HTN, Angina, Arrhythmia,	•Handout prepared folders to patients •Orientate nurses to Lexicom annually •Discuss patient education at rounds •Work with Family Health Team to ensure that patients rostered receive information about community based patient education programs •Review	•# of information folders handed out quarterly •# of referrals that FHT receives from Acute Care and ER •Audit the education section of CareNet on patient e-chart	To ensure that patient education is viewed as an integral part of providing sound	Survey responses: •Completely •Quite a bit •Partly •Not at
		Percentage of patients discharged from hospital for which discharge summaries are	A	% / Discharged patients	Hospital collected data / most recent 3 month period	676*	CB	100.00	PHA Ensure continuum of information on transfer of care	1)Audit patient charts for completed discharge summaries transcribed, signed and sent within 48 hours	Calculate number of discharge summaries transcribed, signed and sent within 48 hours of patient's discharge from hospital for the time period.	Exclusions: • Discharges of inpatients who do not have a documented primary care provider. • Discharges from outside the LHIN. • Emergency Department patients. • Newborns, deaths, and delivery summaries.	To ensure continuation of information to healthcare partners	
Patient-centred	Palliative care	Percent of palliative care patients discharged from hospital with the discharge status	P	% / Discharged patients	CIHI DAD / April 2016 - March 2017	676*	55.56	85.00	•Monitor the number of palliative patients that are discharged with	1)Continue to work with the Palliative Care Outreach team via CCAC to ensure that patients are linked and supported about discharge.	•Monitor the number of discharges home that indicate the patient is receiving palliative care	% Inpatient discharged with a palliative diagnosis	Track the % of palliative care patients discharged home from hospital with	
	Person experience	"Would you recommend this emergency department to your friends and family?"	P	% / Survey respondents	EDPEC / April - June 2017 (Q1 FY 2017/18)	676*	CB	95.00	Ensure quality services by monitoring patient satisfaction and	1)Continue to implement the "Achieving Excellence" modules. •Reinforce the code of conduct •Distribute the revised patient rights	•AIDET •Critical conversations •Code of conduct education •Incorporate in to rounding conversations. •Videos demonstrating courteous behaviour •Inclusion of patients on the Patient and Family Advisory committee and other committees to provide insight.	•% registration from home. •% utilizing kiosk for outpatient clinics. •Overall patient satisfaction score	Provide staff the tools and education to understand what is courteous	Definitely no Probably no Probably yes Definitely yes
		"Would you recommend this hospital to your friends and family?" (Inpatient care)	P	% / Survey respondents	CIHI CPES / April - June 2017 (Q1 FY 2017/18)	676*	CB	95.00	Monitor patient satisfaction and referral. Patients bring their unique and	1)Continue to implement the "Achieving Excellence" philosophies. •Reinforce the code of conduct •Distribute the revised	•AIDET, Critical Conversations Training; on-going education on customer service techniques. •Code of conduct education and awareness •Incorporate in to rounding conversations (perhaps add the following question to rounding logs "How have you improved the	•LDI delivered •Managers provide documentation on critical conversations. •Attendance at AIDET training or other educational workshops •Senior Team completes 1 patient rounding per week. •Number of patient complaints Patients in the right room	•Provide staff the tools and education to understand what is courteous	Definitely no Probably no Probably yes Definitely yes
		Percentage of complaints acknowledged to the individual who made a complaint within	A	% / All patients	Local data collection / Most recent 12 month period	676*	CB	95.00	Collecting Baseline	1)Trend quarterly •Policy Patient Complaint Follow-Up ADM 1-70	•Quarterly reports of complaints tallied. •Revise policy to reflect response time.	•Indicator is calculated on the number of complaints received in the reporting period	Respond to complaints, within three (3) to five (5) business days	
Safe	Safe care/Medication safety	Medication reconciliation at admission: The total number of patients with medications	A	Rate per total number of admitted patients / Hospital	Hospital collected data / October – December (Q3) 2017	676*	99	100.00	•Based on current performance •Important to emphasize the	1)Renewed emphasis on completing medication reconciliation at admission	•Education on importance and proper completion of medication reconciliation •Education for nurses and Physicians •Continue to audit charts to determine compliance	•Education sessions to all staff •Audit medication reconciliation quarterly	•Increase Medication Reconciliation at admission to 100%	
		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	676*	99	100.00	Based on current performance •Important to emphasize the importance of	1)Renewed emphasis on completing medication reconciliation at discharge	•Education on importance and proper completion of medication reconciliation •Education for nurses and Physicians •Continue to audit charts to determine compliance	•Education sessions to all staff •Audit medication reconciliation quarterly	•Increase Medication Reconciliation at Discharge to 100%	

	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**	**676***	**CB**	**CB**	**Continue to track and monitor, and report to the Board quarterly.**	**1)identify causes, challenges, gaps and develop education/safety networks for staff**	**•Use the RL6 in-house hospital incident and patient safety reporting systems for determining the number of reported workplace violent incidents •Provide education to staff defining the terminology with respect violence and harassment •September is Violence in the Workplace Awareness Month •Mandatory CPI training for Acute Care and Emergency •Staff to complete annual survey regarding violence in the workplace. •LDI to review Violence in the workplace legislation and policies at HDH**	**•Collect data on the number of violent incidents reported by workers, including physicians and those who are contracted by other employers (e.g., food services, security, etc.) as defined by the Occupational Health and Safety Act. •Monitor the number of staff with CPI training against those who still need training •Review survey results**	**Develop education, awareness and strategies for a safe work environment.**	**FTE is 122.6**
Timely	**Timely access to care/services**	Total ED length of stay (defined as the time from triage or registration, whichever comes	A	Hours / Patients with complex conditions	CIHI NACRS / January - December 2017	676*	6.15	6.15	90th Percentile-based on current performance	1)Review with staff imp •MAC review of this metric •Provide staff and physicians feedback when this metric does not meet	•Monthly review of performance rolled up	•Daily reminders of patients that need have not met this target	Timely access to care/services	