2020/21 Quality Improvement Plan
"Improvement Targets and Initiatives"

HÔTEL-DIEU GRACE HEALTHCARE

Hotel-Dieu Grace Healthcare 1453 Prince Road, Windsor , ON, N9C3Z4

AIM		Measure									Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	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) C = custom (add any other indicators you are working on)															
Theme I: Timely and Efficient Transitions	**Efficient**	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	P	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / Jul 2019 - Sep 2019	927*	13.5	14.00	This target is based on where we predict our ALC rate will end up for year end as Q3/Q4 is historically a high ALC rate quarter which will increase our current		1)STandardized Discharge Rounds	Continuation of the standardized complex discharge rounds (CDR) and 90 day ALC reviews as part of a robust discharge planning policy. Documentation tool has been developed to capture the finding of the CDR and ALC review	% ALC patients that have a CDR/ALC review completed	100% of patients will have a CDR review completed that are designated for ALC	Continue to maintain and stabalize CDR process
											2)Development of supporting policies and screening tools to support appropriate admissions	Review ALC admission screening tools already in use across Ontario for the purpose of adopting for HDGH. This will be built into the new Cerner HIS system for use.	If tool deemed appropriate for HDGH , 100% of all patients considered for admission would have screening tool completed	100% of ALC patients with screening tool completed by March 2021	This will be dependant on application of screening tool built in new HIS
	Timely	Percentage of patients discharged from hospital for which discharge summaries are	P	% / Discharged patients	Hospital collected data / Most recent 3 month period	927*	71.2	75.00	Limited to Rehab program . There will be a transition to new regional EMR		1)Develop best practice work plan with physicians/Medical Quality Assurance Committee to increase timeliness of	Review current state process and map out future state (included with HIS implementation planning activities) to identify gaps from physician perspective and develop work plan by Sept 2020.	Implement work plan items identified in gap analysis for 20-21	100% identified tasks for work plan completed prior by March 2021	With our HIS /Cerner transition , we will be moving to front end dictation
Theme II: Service Excellence	**Patient-centred**	Percentage of respondents who responded “completely” to the following question:	P	% / Survey respondents	CIHI CPES / Most recent 12 months	927*	52.02	57.10	Improvements in regional EMR and capability to provide real time discharge		1)Improve Information and communication to patient /families on discharge through implementation of work plan strategies.	Implementation and stabilization of Print on Discharge(POD)Information form that contains discharge instructions and follow up appointments as well as prescription generation. Includes discharge package /pamphlet and discharge survey . Continue to	Implement POD (print on discharge) package to all inpatient units (excluding deaths , AMA , discharge to acute care). Verify in documentation that patient was provided the package.	Discharge package provided to 100% of patients on discharge .	
Theme III: Safe and Effective Care	**Effective**	Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged.	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / Oct 2019–Dec 2019 (Q3 2019/20)	927*	95.2	95.00	There may be a drop in this indicator during go live (Sept 2020) and stabilization period . Our target will remain at 95% by Q3 /Q4- 2021 . We recognize there may be a drop June - Sept period as staff transition to new system and		1)1)Continued implementation of medication reconciliation work plan.	Identify new workflow changes with the implementation of Cerner documentationt standardize discharge med rec process throughout organization on the inpatient areas	Implementation completed in 100% of areas identified and revised with Cerner change management .	100% of areas identified for revised change implementation are completed by	Factors for Success : Resource allocation and program
											2)2)Review Impact of Workflow Changes with Cerner - Training and Education	Develop training strategies and roll out plans to inter-professional team based on any work flow changes required in June 2020	Education /training completed in all identified areas	100% areas identified have education and training completed by Sept 2020	Stabalize target - Sept 2020 post go live Cerner
											3)3)Software development	Complete re-evaluation of software development needs in Cerner /new HIS to support and capture reporting and data for completed discharge med recs in electronic system	Software and report requirement identified are 100% completed	Complete Needs assessment by December 2020 . Complete development of	Will need to re-implement due to HIS/Cerner transition and new reporting
		Proportion of hospitalizations where patients with a progressive, life-limiting illness, are identified to benefit from palliative care, and subsequently (within the episode of care) have their palliative care needs	P	Proportion / All patients	Local data collection / Most recent 6 month period	927*	CB	CB	We continue to collect baseline data on this indicator. We will be implementing a palliative care assessment tool with our new HIS/Cerner project in		1)Develop Palliative Care Working Group	Establish baseline through review of current state analysis . Develop Plan for non-palliative care unit trigger process /Palliative Care Documentation and chart review using the new Cerner tools .	Review documentation on all flagged palliative patients identified as at risk of dying and in need of palliative care. Cerner has built documentation into the new system	100% of palliative patients (on non palliative units) reviewed	There is small number of patients that are identified as palliative and not
											2)Review and Identify work plan to support Health Quality Ontario Palliative Care Standards.	Review HQO Palliative Care standards and identify processes and supporting documentation tools and create a best practice work plan	Palliative working group, including physicians and Intake staff , will develop process to flag and assess all patients in acute care that meet admission criteria for palliative services	100% of records reviewed to identify if contains appropriate palliative	Our goal is to have all patients assessed, by a palliative care physician, in the
	Safe	**Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.**	**MANDATORY**	**Count / Worker**	**Local data collection / Jan - Dec 2019**	**927***	**30**	**45.00**	**Our target is based on two years of data collection. We anticipate increased reporting due to education to staff combined with strategies to reduce**		**1)Continued Implementation of Workplace Violence Work Plan and 19-20 identified items.**	**1. Work with Regional HIS project to implement a chart flagging process that will alert staff to patients with high risk factors for violence as required by the OH & S Act . 2. Conduct a Violence Risk Assessment across the organization involving the Joint Health and Safety Committee, front line staff and leaders. 3. Conduct an evaluation of bringing security ni house after one year . 4. Review Violence education/training provided to staff to determine any enhancements that need to be made .**	**Completion of tasks identified in work plan for 20-21 completed**	**100% completion by March 2021.**	**We will continue to moniotr the non-mandatory indicator of # of violence incidents with injury (%) on our Executive Scorecard.**