2014/15 Quality Improvement Plan for Ontario Hospitals
Improvement Targets and Initiatives

AIM		Measure								Change				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performa	Target	Target justificatic	Priority level	Planned improvement initia	Methods	Process measures	Goal for change ide	Comments
Access	Reduce wait times in the ED	ED Wait times: 90th percentile ED length of stay for Admitted patients.	Hours / ED patients	CCO iPort Access / Q4 2012/13 – Q3 2013/14	900*			RHC corporate performance is below the provicial target of 8 hours.						
	Reduce unplanned ED visits	The number of repeat unplanned ED visits within 30 days for Mental Health conditions as a percent of all ED visits.	Visits / ED patients	Northwest LHIN / Q2 2013/14	900*	17.9	13.6	NW LHIN defined target from M-SAA contract schedule. 2013/14 FY	Improve	1)Develop a comprehensive protocol for individuals accessing the ED for Mental Health issues. This will ensure patients are	Meet with community partners Riverside Community Counselling, Canadian Mental Heath Association, Fort Frances Tribal Area Health Services, Gizewaadiziwin Health Access Centre, Weechi-it-te-win Family Services, Kenora-Rainy River Districts Child & Family Services to	Draft protocol developed by September 2014.	Comprehensive protocol developed.	Target for measure may change once 2014/15 contracts have
										2)ED staff to contact Crisis Response Services for any and all patients presenting to the ED/Urgent Care department with mental	Note Crisis response notified on patient chart or EHR.	Quarterly audits to ensure appropriate referrals are being made to Crisis Response Services from the ED/Urgent Care.	Create baseline.	Ongoing support and engagement with Director, Crisis Response Services for on-
										3)Ensure the most frequent users of ED services are being followed up by appropriate community resources.	Identify and develop comprehensive care plans for the top 5-10 individuals that utilize ED services for Mental Health issues.	Chart or EHR audit	100% of individuals identified have care plans noted on chart.	
										4)Staff from Community Counselling Services attend "Bullet Rounds" for inpatients at La Verendrye General Hospital site. This	Relates to change idea 1.	Relates to change idea 1.	Relates to change idea 1.	
		The number of repeat unplanned ED visits within 30 days for Substance Abuse conditions as a percent of all ED visits.	Visits / ED patients	North West LHIN / Q2 2013/14	900*	21.6	21.6	NW LHIN defined target from M-SAA contract schedule FY 2013/14. Contract extended for a three month period.	Maintain	1)Develop a comprehensive protocol for individuals accessing the ED for Substance Abuse issues. This will ensure patients are	Meet with community partners Riverside Community Counselling, Canadian Mental Heath Association, Fort Frances Tribal Area Health Services, Gizewaadiziwin Health Access Centre, Weechi-it-te-win Family Services, Kenora-Rainy River Districts Child & Family Services to	Draft protocol developed by September 2014.	Comprehensive protocol developed.	Indicator target and priority level may change once 2014/15 contracts have
										2)ED staff to contact Crisis Response Services for any and all patients presenting to the ED/Urgent Care department with addictions	Note Crisis response notified on patient chart or EHR.	Quarterly audits to ensure appropriate referrals are being made to Crisis Response Services from the ED/Urgent Care.	Create baseline.	Ongoing Support and engagement with Director, Crisis Response Services for on-
										3)Ensure the most frequent users of ED services are being followed up by appropriate community resources.	Identify and develop comprehensive care plans for the top 5-10 individuals that utilize ED services for Substance Abuse issues.	Chart or EHR audit.	100% of individuals identified have care plans noted on chart.	
										4)Staff from Community Counselling Services attends "Bullet Rounds" for inpatients at La Verendrye General Hospital site. This	Relates to change idea 1.	Relates to change idea 1.	Relates to change idea 1.	
Effectiveness	Improve organizational financial health	Total Margin (consolidated): % by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expense, excluding the impact of facility amortization, in a given year.	% / N/a	OHRS, MOH / Q3 2013/14	900*	-0.87	0	Balanced Budget	Improve	1)Austerity & Revenue Generation measures will be implemented in early 2014-15 to achieve a balanced budget position.	TBD	TBD	Balanced budget	
		Current Ratio: The ratio of current assets divided by current liabilities.	Ratio (No unit) / N/a	OHRS, MOH / Q3 2013/14	900*	1.19	1.2	Balanced budget	Improve	1)Austerity & Revenue Generation measures will be implemented in early 2014-15 to achieve a balanced budget position.	TBD	TBD	Balanced Budget	
Integrated	Reduce unnecessary time spent in acute care	Percentage ALC days: Total number of acute inpatient days designated as ALC, divided by the total number of acute inpatient days.	% / All acute patients	Ministry of Health Portal / Q3 2012/13 – Q2 2013/14	2148	24.51	12.1	NW LHIN defined target from H-SAA contract schedule	Improve	2)Continued regular and ongoing collaboration/communicatio n with the NW CCAC to ensure timely transitioning	Regular meetings held with the NW CCAC to discuss issues/concerns and to identify opportunities on an ongoing basis.	Regular meetings scheduled with NW CCAC.	Minimum of eight meetings held to discuss discharge and transition issues.	Following a lengthy interim period, we have filled the full time position of

							2013/14 FY.							
	Percentage ALC days: Total number of acute inpatient days designated as ALC, divided by the total number of acute inpatient days.	% / All acute patients	Ministry of Health Portal / Q3 2012/13 – Q2 2013/14	2150	18.63	12.1	NW LHIN defined target from H-SAA contract schedule 2013/14 FY.	Improve	1)Continued regular and ongoing collaboration/communication with the NW CCAC to ensure timely transitioning	Representative from NW CCAC to attend daily bullet rounds at LVGH.	Attendance at bullet rounds by NW CCAC representative.	75% of bullet rounds are attended by NW CCAC representative.	
									2)Continued regular and ongoing collaboration/communication with the Rapid Response Nurse Program (RRNP). The	Regular meetings held with the NW CCAC to discuss issues/concerns and to identify opportunities on an ongoing basis as they relate to care across the continuum.	Meetings scheduled with NW CCAC on a regular basis.	Minimum of eight meetings held to discuss discharge and transition issues.	Following a lengthy interim period, we have filled the full time position of
	Percentage ALC days: Total number of acute inpatient days designated as ALC, divided by the total number of acute inpatient days.	% / All acute patients	Ministry of Health Portal / Q3 2012/13 – Q2 2013/14	2153	19.82	12.1	NW LHIN defined target from H-SAA contract schedule 2013/14 FY.	Improve	1)Continued regular and ongoing collaboration/communication with the NW CCAC to ensure timely transitioning	Regular meetings held with the NW CCAC to discuss issues/concerns and to identify opportunities on an ongoing basis.	Regular meetings scheduled with NW CCAC.	Minimum of eight meetings held to discuss discharge and transition issues.	Following a lengthy interim period, we have filled the full time position of
Reduce unnecessary hospital readmission	Readmission to any facility within 30 days for selected CMGs for any cause: The rate of non-elective readmissions to any facility within 30 days of discharge following an admission for select CMGs.	% / All acute patients	DAD, CIHI / Q2 2012/13-Q1 2013/14	900*	18.68	17.74	The group of small rural hospitals in the NW LHIN will monitor readmission rates with the hope that improvements in discharge transitions (listed below) may help reduce readmissions at a regional level. However, given the limited sample size, it will be difficult to see a change	Improve	1)Change ideas to address this indicator are all related to discharge planning and proposed activities (see below).	See discharge plan change ideas.	See discharge plan change ideas.	Explore initial results to determine feasible and appropriate targets for QIP	
									2)Continue to conduct post discharge follow-up phone calls to all in-patients within 48 hours of discharge.	Track phone calls for responses and identify areas for improvement.	Phone record audit.	100% of inpatients are phoned post discharge.	Follow up phone calls from the manager of the in-patient units conducted for
									3)Post-discharge questionnaire reviewed/revised to better reflect relevant indicators and to address areas for	See change idea 2.	See change idea 2.	See change idea 2.	
	Percentage of patients for whom discharge plan is completed and sent to receiving Primary Care Provider at time of discharge on chart or EHR audit.	% / All acute patients	Hospital collected data / Q1-Q3 2014/15	900*	CB	80	We aim to adopt this new tool for the large majority of patients in the first year of implementation and in subsequent years, aim for 100%	Improve	2)Conduct risk assessment for readmission.	Complete an audit of patient chart or EHR.	Percentage of patients for whom a risk assessment is completed on chart or EHR.	80%	Participate in Collaborative activities across small and rural hospitals in NW
									3)Provide written discharge instructions to patient and note on chart or EHR.	Chart or EHR audit	Percentage of patients for whom written discharge instructions are completed and provided to patient, as noted on chart or EHR audit.	80%	See above
									4)Ensure timely follow-up with primary care provider.	Chart or EHR audit.	Percentage of high risk discharge patients who have follow-up with primary care provider scheduled within 7 days, as noted on chart or EHR.	80%	See above
									5)Ensure timely follow-up with homecare.	Chart or EHR audit	Percentage of high risk patients who have confirmed follow-up with homecare within 1 day, as noted on chart or EHR.	80%	See above
									6)Ensure clinical best practices for common conditions followed at time of discharge.	Chart or EHR audit.	Percentage of patients with CHF, COPD, CAD or DM, for whom the appropriate clinical best practices checklist has been completed on chart or EHR.	80%	See above
Patient-centred	**Improve patient satisfaction**	From NRC Picker: "Would you recommend this hospital (inpatient care) to your friends and family?" (add together % of those who responded "Definitely Yes" or "Yes, definitely").	% / All patients	NRC Picker / Oct 2012- Sept 2013	900*	71.7	81.8	Benchmark target provided by Health Quality Ontario	Improve	1)All of the change ideas related to discharge planning, communication, discharge transitions will contribute to improvements	See discharge transitions/communications.	See discharge transitions/communications.	See discharge transitions/communications.	Riverside may be moving toward an in-house satisfaction survey in

		From NRC Picker: "Overall, how would you rate the care and services you received at the hospital (inpatient care)?" (add together % of those who responded "Excellent, Very Good and Good").	% / All patients	NRC Picker / Oct 2012- Sept 2013	900*	94.55	96.4	Benchmark target provided by Health Quality Ontario	Improve	1)See discharge planning change ideas.	See discharge transitions/communications.	See discharge transitions/communications.	See discharge transitions/communications.	Riverside may be moving toward an in-house survey in 2014/15 but will
	Improve patient experience (communication)	Percentage of patients who reported during their stay, doctors and nurses explained things in a way they could understand.	% / All acute patients	NRC Picker / Q3 2013/14	900*	81.95	87	Aligned with 90th percentile.	Improve	1)Adopt Teachback as a consistent approach to patient discharge discussions and planning.	Chart or EHR audit	Percentage of patients for whom Teachback template is completed on chart or EHR.	80%	Written discharge instructions described elsewhere in this
	Improve patient experience (discharge transitions)	Percentage of patients for whom they got adequate information on ALL of the following: *danger signs to watch for *purpose of medication *how to take medication *side effects to watch for *when to resume usual activity *who to call for help	% / All acute patients	NRC Picker / Q 3 2013/14	900*	70.9	78	Aim to increase patient understanding of discharge care by 10%	Improve	1)Adopt discharge and written discharge instructions as described above.	Chart or EHR audit	Percentage of patients who received adequate information on danger signs to watch for as noted on chart.	80%	These questions will be incorporated into RHC's post discharge follow-
										2)Adopt Teachback and written discharge instructions as described above.	Chart or EHR audit	Percentage of patients who received adequate information on the purpose of their medication as noted on chart.	90%	
										3)Adopt Teachback and written discharge instructions as described above.	Chart or EHR audit	Percentage of patients who received adequate information on how to take their medication as noted on chart.	80%	
										4)Adopt Teachback and written discharcge instructions as described above.	Chart or EHR audit	Percentage of patients who received adequate information on side effects to watch for as noted on chart.	80%	
										5)Adopt Teachback and written discharge instructions as described above.	Chart or EHR audit	Percentage of patients who received adequate information on when to reusme usual activity as noted on chart or EHR.	80%	
										6)Adopt Teachback and written discharge instructions as described above.	Audit of chart or EHR.	Percentage of patients who received adequate information on who to call for help as noted on chart or EHR.	80%	
Safety	**Increase proportion of patients receiving medication reconciliation upon admission**	Medication reconciliation at admission: The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital.	% / All patients	Hospital collected data / Most recent quarter available (e.g. Q2 2013/14,	900*	96.73	100	Theoretical Best	Improve					
	Reduce hospital acquired infection rates	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1,000 - Average for Jan-Dec. 2013, consistent with publicly reportable patient safety data.	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / 2013	2148	0	0		Maintain					
		CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1,000 - Average for Jan-Dec. 2013, consistent with publicly reportable patient safety data.	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / 2013	2150		0		Maintain					
		CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1,000 - Average for Jan-Dec. 2013, consistent with publicly reportable patient safety data.	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / 2013	2153	0	0		Maintain					
		Hand hygiene compliance before patient contact: The number of times that hand hygiene was performed before initial patient contact divided by the number of observed hand hygiene indications for before initial patient contact multiplied by 100 - consistent with publicly reportable patient safety data.	% / Health providers in the entire facility	Publicly Reported, MOH / 2013	900*	85.45	89.72	Improve current performance by 5%	Improve	1)All staff to participate in annual on-line Hand Hygiene module.	Compliance reports.	Percentage of staff completing the OHA Discovery Campus on-line Hand Hygiene module.	100% of all staff participate in Hand Hygiene education.	

										2)Participate in the national STOP! Clean Your Hands Day on May 5, 2014.	Track newsletter submission and distribution of promotional material to all sites.	Newsletter submission for first week of May to entire corporation. Promotional materials distributed.	All sites to have promotional material in place for the event.	
										3)Ensure process in place for refilling Hand Sanitizer stations.	Conduct random audits of Hand Santizer stations.	All Hand Sanitizer stations are kept filled.	100% of Hand Sanitizer stations filled.	
										4)Hand Hygiene Committee established creating more Hand Hygiene awareness for RHC employees.	Monthly newsletter submissions and activities for employee hand hygiene awareness.	Quality reports to be submitted to reflect employees participation.	Hand Hygiene committee reports to Quality Committe quarterly.	
Reduce rates of deaths and complications associated with surgical care	Surgical Safety Checklist: number of times all three phases of the surgical safety checklist was performed (briefing, time out and debriefing) divided by the total number of surgeries performed, multiplied by 100 - consistent with publicly reportable patient safety data.	% / All surgical procedures	Publicly Reported, MOH / 2013	2150	99.93	100	Theoretical best	Improve					
Increase proportion of patients receiving medication reconciliation upon discharge	Percentage of patients with medication reconciliation completed and sent to receiving primary care provider at the time of discharge.	% / All acute patients	Hospital collected data / Q1 - Q3 2014/15	900*	CB	80	Ensure continuity of care.	Improve	1)Verify a standard process for obtaining BPMH at time of admission is being followed.	Audit of random sample of patients.	Patient chart or EHR audit.	100%	In order to obtain "Best Possible Medication History", it's important for
									2)Implement a revised medication reconciliation form documenting medication changes, reasons for changes and	Audit of patient chart or EHR	Percentage of patients for whom the revised medication reconciliation form was completed.	80%	Revised medication reconciliation form with this information could
Reduce harm from falls	Falls Reduction: Reduce the number of level 3 & 4 falls for the organization, Acute & LTC combined.	Falls / All patients	Hospital collected data / Q4 2012/13 - Q3 FY 2013/14	900*	25	23	No industry standard for falls reduction target for Acute and LTC populations combined. Rate proposed is 8% reduction from current performance.	Improve	1)Increase use of whiteboards as a communication tool (Acute care) to alert falls risk.	Whiteboard audit.	Where falls risk is present as noted on patient chart or EHR, risk identified on bedside whiteboard.	100%	
									2)Increase staff awareness of falls risks and interventions through multiple channels of education and information.	Staff participation in awareness and education activities.	Percentage of staff that participate in awareness and education activities.	80% of direct care staff.	
									3)Increase patient/resident participation in physiotherapy related services and activities.	Encourage and monitor patient/resident participation in physiotherapy activites.	Physiotherapy participation reports.	Create a baseline.	