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

The Network

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 about your condition or treatment after you left the hospital? TOP BOX	C	% / Survey respondents	NRC Picker / Q2 2017-18	852* (St. Michael's Site)	64.4	65.70	Current performance exceeds provincial average for like institution. This indicator was selected for aspirational target setting based on percent improvement over previous year performance. Trend analysis showed 2 per cent improvement	1)Continue rollout of Patient Oriented Discharge Summary (PODS) tool	Optimize the current PODS implementation and expand PODS initiative to additional units in the Medicine and Surgery programs at SMH (e.g. Vascular, Plastics and additional diagnosis groups in Medicine)	% of eligible patients receiving PODS.	75%	PODS initiative supports work committed to in LHIN Readmissions
										2)Optimize use of Interpreter Services to enhance patient experience across the continuum.	1)Develop standard process to complete language assessments as part of discharge planning and education 2)Implement an awareness campaign across network on use of interpreter services with a focus on discharge education	1)Standard process to complete language assessment as part of discharge planning and education developed 2)Awareness campaign across network on use of interpreter services with a focus on discharge education completed	1)Standard process to complete language assessment as part of discharge	
										3)Develop and test a method for real-time evaluation of patients who receive PODS	1)Implement a network approach to conducting discharge phone-calls with patients discharged home from units utilizing PODS 2)Develop and disseminate quarterly patient experience performance reports reflecting feedback from discharge phone calls	1)Network approach to discharge phone-calls implemented 2)Units utilizing PODS receive quarterly performance reports	1)Network approach to discharge phone-calls implemented by October 31,	
										4)Link TC LHIN Readmissions Initiatives to improvements in discharge planning at St. Joseph's Health Centre and St.	1)Implement pre-discharge screening and evaluation process for at risk populations. (CHF, COPD and CAP) 2)Implement Patient Oriented Discharge Summary process for readmission avoidance. (PODS goal above) 3)Ensure discharge summaries are available within 48	1)% of patients that fit readmission criteria screened. 2)PODS – See goal above 3)% of eligible patients that have discharge summaries available within 48 hours	1)75% of eligible CHF, COPD, CAP, and GI patients receive pre-discharge	
		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? TOP BOX	C	% / Survey respondents	Local data collection / Q2 2017-18	773* (Providence Hospital Site)	57.1	58.20	Current performance exceeds provincial average for like institution. This indicator was selected for aspirational target setting based on percent improvement over previous year	1)Continue rollout of Patient Oriented Discharge Summary (PODS) tool	Implement PODS initiative on all seven inpatient units at Providence Healthcare.	% of patients discharged home who received a PODS prior to discharge	75%	
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		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? TOP BOX	C	% / Survey respondents	NRC Picker / Q2 2017-18	898* (St. Joseph's Site)	61.7	62.90	Current performance exceeds provincial average for like institution. This indicator was selected for aspirational target setting based on percent improvement over previous year performance. Trend analysis showed 2 per cent improvement	1)Continue rollout of Patient Oriented Discharge Summary (PODS) tool	Implement PODS tool in selected areas within the Medicine and Surgery at SJHC (Including expansion beyond CHF and COPD to CAP groups in alignment with the LHINS readmissions work, oncology, hips and knees and 2L surgery).	% of eligible patients receiving PODS	75%	PODS initiative supports work committed to in LHIN Readmissions
										2)Optimize use of Interpreter Services to enhance patient experience across the continuum.	1)Develop standard process to complete language assessments as part of discharge planning and education 2)Implement an awareness campaign across network on use of interpreter services with a focus on discharge education	1)Standard process to complete language assessment as part of discharge planning and education developed 2)Awareness campaign across network on use of interpreter services with a focus on discharge education completed	1)Standard process to complete language assessment as part of discharge	
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Patient-centred	**Person experience**	Complaints received that were acknowledged to the individual who made the complaint within 5 business days	C	% / LTC home residents	In house data collection / Q2-Q3 2018-19	51357* (Houses of Providence - LTC)	CB	80.00	By regulation, LTCHs are required to have complaints acknowledged within 6-10 business days. On the hospital side, complaints must be acknowledged within 5 days. To make this a standard goal across the	1)Develop a process to acknowledge concerns and complaints expeditiously	Create and implement a process for documenting resident and family feedback including complaints electronically to ensure accurate and timely reporting	Electronic documentation system for resident and family feedback including complaints implemented in Houses	Implementation of documentation system completed by June 30, 2018 (Q1)	
										2)Calculate baseline for Days to Acknowledgement indicator	Create report in electronic system to calculate baseline for time to acknowledgement using Q2 to Q3 2018-19 data	Baseline report generated for time to acknowledgement indicator	Baseline report generated by December 31, 2018 (Q3)	
										3)Share monthly data for Days to Acknowledgement indicator with the Houses Management team to understand current	Generate and distribute monthly reports on days to acknowledgement performance	Monthly reports generated and distributed to Houses management team	Monthly reports generated and distributed to Houses management by	Targeting implementation of electronic system by September 30,
	Person experience	Committees/activities/ initiatives patient/caregiver/ community advisors are involved in across the Network	C	Number / Patients, Caregivers and Community	Local data collection / 2017	9999999* (Network)	55	77.00	This target represents a 40% increase in the number of activities patient/caregiver / community advisors are involved in across the Network.	1)Continue to expand Patient, Caregiver and Community Advisory Program	1)Create partnerships with local community agencies to engage with our diverse populations. (MH & Addictions, Aboriginal, Under-housed) 2)Partner patient/caregiver/ community advisors with additional activities across the network 3)Increase number of patient/caregiver/	1)Number of community agencies each site has engaged with 2)Number of activities patient/caregiver/ community advisors across the network are involved in 3)% increase of patient/caregiver/ community advisors	1)Each site to engage with one community agency by March 31, 2019 (Q4) 2)Increase	
										2)Develop an evaluation tool for Advisor Engagement Satisfaction	1)Perform environmental scan to determine available tools 2)Develop network tool to evaluate Advisor engagement satisfaction 3)Pilot tool for baseline data collection	1)Environmental scan completion 2)Network evaluation tool development 3)Baseline data collection completed	1)Environmental scan completed by May 2018 2)Network evaluation tool	
										3)Develop a process to integrate the lived experience of patients into clinical education programs through Advisors.	1)Perform environmental scan on best practices related to integrating the lived patient experience into clinical education programs through Advisors. 2)Integrate Advisors into clinical education programs to share the lived patient experience	1)Completion of environment scan 2)Number of advisors integrated into a clinical education program to share their lived experience.	1)Environmental scan completed by June 2018 2)Three Advisors integrated into one clinical	
										4)Develop network based Patient Declaration of Values in keeping with the Excellent Care for All Act	1)Undertake broad stakeholder engagement to inform a network Patient Declaration of Values 2)Develop a network based Patient Declaration of Values	1)Stakeholder engagement completion 2)Network Patient Declaration development	1) Broad stakeholder engagement completed by September 2018 2)	
Safe	**Safe care**	Residents who develop a stage 2-4 pressure injury	C	% / LTC home residents	In house data collection / Q3 2016/17 - Q2 2017/18	51357* (Houses of Providence - LTC)	3.78	3.10	Represents achievement of provincial average	1)Review all Residents with a Pressure Ulcer Risk Scale (PURS) score of 4 or greater at weekly High Risk Rounds to revise/implement new	1)Informatics Specialist to pull PURS scores from Resident Assessment Instrument-Minimum Data Set (RAI-MDS) 2)Conduct walk rounds (as part of high risk rounds) on a weekly basis 3)Assess all Residents with a PURS score of 4 or greater to ensure that all elements	% of residents with PURS score of 4 or greater will be included in weekly high risk rounds	80% of residents with PURS score of 4 or greater will be included in weekly high risk rounds by	
										2)Educate staff and MDs on the new Medical Directives for pressure injuries	1)Wound Care specialist to present to MDs at The Quality and Safety Committee meeting 2)Wound Care specialist to present in-service to registered staff.	% of FT and PT registered staff and MDs trained	85% of registered staff and MDs trained by end of Q3 2018-19	
										3)Residents with PURS score of 4 or above will have an individualized Pressure Ulcer Care plan recommendation in their	Wound Care specialist to develop treatment plan template that RNs can include on resident care plans based on wound specific care protocol	% of residents with PURS score of 4 or greater that have individualized care plan recommendations listed on their care plans	80% of residents with PURS score of 4 or greater that have individualized care plan	
										4)Learn from and share best practices in pressure injury prevention and management across the Network	Share and identify best practices in pressure injury prevention and management used in the Network suitable for LTC	# sharing sessions held	1 by end of Q2	
		Residents who fell during past 30 days	C	% / LTC home residents	In house data collection / Q3 2016/17 - Q2 2017/18	51357* (Houses of Providence - LTC)	14.93	13.43	Represents a 10% improvement from current performance	1)Implement High Risk Rounds for Residents who are at risk for falls or fell in the previous week	1)Conduct walk about rounds on a weekly basis (interprofessional team) to ensure the Resident is on the Falling Star program and that all elements of the program are in place. 2)Re-assess for any additional supports needed. 3)Nominate Falls Change Champion	1)# of units completing weekly rounds 2)# of change champions in place 3)# of checklists developed and in use	1)8 units completed weekly rounds by end of Q4 2018-19 2)1 by end Q1 2018-19	
										2)Implement Rounding Project for preventative measures	Roll out Rounding Project to all clinical staff.	% rounding forms completed	80% residents round on by end of Q3 2018-19	
										3)Explore and test a new Falls Risk Assessment Tool that is appropriately sensitive for the Long Term Care population	1)Perform environmental scan 2)Review available Falls Risk Screening Tools 3)Select Tool most appropriate for LTC 4)Pilot and implement tool	# tools reviewed and tested on all residents who have had falls or are identified as at risk for falls	1 tool implemented by end of Q3 2018-19	

										4)Learn from and share best practices in fall prevention across the Network	Share and identify best practices in falls prevention used in the Network suitable for LTC	# sharing sessions held	1 by end of Q2	
Safe care/Medication safety	Serious safety event recommendations that are completed within committed timeframe. (Events occurring after April 1, 2018)	C	% / All patients	In house data collection / Q4 2017-18	9999999* (Network)	CB	CB	When a serious event occurs, patient and families expect that it will not happen again. To ensure that we meet this commitment, recommendations need to be implanted in a timely manner while being centrally tracked and reported to the Board.	1)Develop and implement a consistent approach to reporting serious safety events across the Network.	1)Develop a single corporate safety event reporting policy. 2)Harmonize safety event taxonomy across Network sites. 3)Provide education and on-site support across sites on new safety event policy.	1) Completion of Safety Event Reporting Policy by end of Q2 2018-19. (Includes harmonized event taxonomy) 2) Percentage of units/departments that receive safety event reporting education by end of Q4 2018-19.	1)Yes 2)70%	
									2)Develop and implement a consistent approach to review and analyze serious safety events across the Network	1)Map current state 2)Gather insights from stakeholders (including patient and family members) on current processes and what they would like to see in future site 3)Develop corporate safety event process and corresponding accountabilities and support	Percentage of clinical directors and managers educated on new review process by end of Q4 2018-19.	100%	
									3)Develop and implement a consistent approach to share learnings and recommendations from serious safety events across	1)Gather insights from stakeholders on current state of knowledge sharing about safety events. 2)Implement a communications plan to share knowledge related to safety events.	Completed implementation of communications plan by Q4 2018-19. Yes/No metric	Yes	
									4)Develop and implement a consistent approach to implement recommendations from safety events across the	1)Understand current state of recommendation implementation. 2)Develop corporate support structure for the implementation of event review recommendations. 3)Build capacity for recommendation implementation at clinical program	Percentage of serious safety event recommendations that are completed within committed timeframe. (Events occurring after April 1, 2018)	75%	
									5)Perform a current state assessment of our safety culture as a foundation to build a quality and safety strategy	1)Administer a validated patient safety culture survey across the network. 2)Conduct focus groups at each site to better understand results. 3)Develop a corporate communication plan to share results and engage people in culture change.	1)Survey response rate. 2)Percentage of clinical programs at each site that had at least one focus group.	1)40% 2)100%	
									6)Perform an environmental scan of support models for staff members and healthcare workers who have witnessed traumatic	1)Assess current state of support across the three sites in the Network 2)Perform an environmental scan of support models that currently exist	1)Current State Assessment completed 2)Environmental scan completed	1)Yes 2)Yes	
									7)Implement the Escalation of Care Policy to ensure prompt escalation and response to clinical concerns.	1)Implement policy and associated education plan at St. Michael's 2)Review and revise escalation policy at St. Joseph's and Providence as required	1) Policy implemented 2) Education plan at St. Michael's implemented 3) Policy approved at St. Joseph's and Providence	1) Yes 2) Yes 3) Yes	
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**	**773* (Providence)**	**68**	**71.00**	**This is a new indicator and there are no historical data to base any benchmarks on. Given the definition of workers includes learners and**	**1)See Network Workplan**	**See Network Workplan**	**See Network Workplan**	**See Network Workplan**	**FTE=750**
	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**	**852* (St. Michael's Site)**	**374**	**393.00**	**This is a new indicator and there are no historical data to base any benchmarks on. Given the definition of workers includes learners and**	**1)See Network Workplan**	**See Network Workplan**	**See Network Workplan**	**See Network Workplan**	**FTE=6265**

		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**	**898* (St. Joseph's Site)**	**176**	**185.00**	**This is a new indicator and there are no historical data to base any benchmarks on. Given the definition of workers includes learners and**	**1)See Network Workplan**	**See Network Workplan**	**See Network Workplan**	**See Network Workplan**	**FTE=2015**
		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**	**9999999* (Network)**	**619**	**649.00**	**This is a new indicator and there are no historical data to base any benchmarks on. Given the definition of workers includes learners and physicians and our focus on increasing awareness and improving the reporting culture for workplace violence, we are targeting a 5% increase for 2018-19.**	**1)Raise awareness about workplace violence**	**Develop and implement an education strategy, including a visual awareness campaign, to increase the understanding and identification of workplace violence and appropriate responses to it.**	**1)Per cent of targeted areas that have visual materials displayed 2)Per cent of targeted areas that receive education**	**1)90 per cent 2)90 per cent**	**FTE=9030**
										2)Develop a workplace violence prevention multi-year plan for the Network inclusive of physical and psychological harm	1)Form a Task Force Steering Committee , co-lead by Corporate Health & Safety and Clinical Operations. 2)Perform a current state analysis at each site to inform multi-year plan; to include focus groups, deep dive data analysis, risk assessment and current interventions in	1)Task Force Committee formation 2)Number of focus groups held 3)Per cent targeted areas having a deep dive data analysis and/or risk assessment 4)Number of high risk areas identified • Network Spread Playbook developed with specific initiatives identified for	1)Task Force formed and active 2)At least one focus group completed per site	High risk areas for the SMH site: - ED - GIM - MH departments, including
										3)Complete an inventory of risk identification and care planning approaches across the Network and develop a standard approach	1)Adopt early identification and communication of patients who pose a risk of violence/aggressive behavior 2)Develop a toolkit of possible approaches to care planning for patients at risk for violence/aggressive behaviour.	1)Implement a policy that promotes the early identification and management of patients at risk for violence/aggressive behaviour. 2)Develop communication plan 3)Roll out staff education in high risk areas	1)Yes/No 2)Yes/No 3)100 percent	
										4)Harmonize site policies to a Network Workplace Violence Prevention Policy	1)Review current site workplace violence policies 2)Harmonize site policies and include recommendations to inform a Network policy 3)Provide education and on-site support at targeted areas at each site across the Network on Policy	1)Per cent site policies reviewed 2)Completion of Network Policy 3)Percentage of targeted areas that received policy education	1)100 per cent 2)Completed 3)90 per cent	