2019/20 Quality Improvement Plan
"Improvement Targets and Initiatives"

Haldimand War Memorial Hospital & Edgewater Gardens 400 Broad St. W. Dunnville, ON N1A 2P7

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

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Theme I: Timely and Efficient Transitions	**Efficient**	Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	P	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / October 2017 – September 2018	54626*	20.29	20.00	Edgewater's ED visit rate is lower than the provincial average. Edgewater has had a significant number of newer staff which has the potential for avoidable ED visits. Will try to maintain current performance.		1)Provide education to Registered Staff on COPD which is a diagnosis listed as avoidable for an ED visit	Education session will be set up on COPD including early intervention	Reduce ED visits related to COPD	Goal for the year is less than 20 avoidable ED visits.	
											2)Provide education to Registered Staff on septicemia which is a diagnosis listed as avoidable for an ED visit	Education session will be set up on septicemia including early intervention	Reduce ED visits related to Septicemia	Goal for the year is less than 20 avoidable ED visits	
											3)Provide education to Registered Staff on congestive heart failure which is a diagnosis listed as avoidable for an ED visit	Education session will be set up on congestive heart failure including early interventions	Reduce ED visits related to congestive heart failure	Goal for the year is less than 20 avoidable ED visits	
	Efficient	Average number of inpatients receiving care in unconventional spaces or ER stretchers per day within a given time period.	P	Count / All patients	Daily BCS / October - December 2018	648*	0.43		HWMH is not monitoring this indicator.						
		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 data	P	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July - September 2018	648*	32.92	12.00	HWMH strives for the LHIN target of 12%		1)Ensure all inpatients participate in the 48 hour conversation to identify potential barriers to discharge as early as possible.	The charge nurse on the inpatient unit will conduct and record this meeting.	Number of patients who are admitted per quarter with a completed 48 hour conversation on record.	Audits will be completed. Target is 90% of patients having a completed 48 hour conversation.	
											2)Host weekly discharge rounds with all physicians.	Update the white board as necessary to ensure clear communication around discharge plans.	Whiteboard updated weekly during physician rounds. Identify barriers to discharge and document plans to address these barriers on the whiteboard.	Achieve the 12% ALC rate.	
	Timely	Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital.	P	% / Discharged patients	Hospital collected data / Most recent 3 month period	648*									

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		The time interval between the Disposition Date/Time (as determined by the main service provider) and the Date/Time Patient Left Emergency Department (ED) for admission to an inpatient bed or operating room.	**MANDATORY**	**Hours / All patients**	**CIHI NACRS / October 2018 – December 2018**	**648***	**CB**		**This is a new mandatory indicator and previous data is not available. CB stands for Collecting Baseline. Once we have some baseline data a target will be set.**	**Niagara Health System**	**1)This indicator is new for 19/20. Once baseline data has been established, HWMH will set a target goal.**	**Work with clinical records to ensure data available for tracking. Some collaboration with Niagara Health as they compile some of our mandatory CIHI reports.**	**Determine current state and set up a reasonable plan for improvement. Monitor new emergency department flow.**	**To be determined once baseline data has been established.**	**Historically, the wait time to inpatient bed data comes from the LHIN. This indicator uses CIHI/NACRS data so a new process will be set to ensure this data reflects the goal of this mandatory indicator.**
Theme II: Service Excellence	**Patient-centred**	Percentage of complaints received by a LTCH that were acknowledged to the individual who made a complaint within 10 business days.	P	% / LTC home residents	Local data collection / Most recent 12-month period	54626*		100.00	Edgewater Gardens will ensure that all complaints are followed up with family within 10 business days.		1)Edgewater Gardens has a complaint policy that all staff are educated on. Continue to follow the policy in dealing with complaints.	All complaints are tracked including follow up with the individual making the complaint along with dates.	Percentage of complaints followed up within 10 business days.	100% of individuals making a complaint will be followed up with within 10 business days.	
		Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"	P	% / LTC home residents	In house data, NHCAHPS survey / April 2018 - March 2019	54626*	87	90.00	Edgewater Gardens will continue to stress the importance of active listening and applying skills of reflection and validation.		1)EW will continue utilizing volunteers to help complete surveys with the residents who are able. This method of survey completion proved to be effective in 2018 so will be utilized again in hopes of increasing numbers.	EW will provide a list to the volunteers of residents who are either capable of completing the survey on their own or who could complete the survey but need help documenting on the form.	Satisfaction in this category will be complied by adding up the number of residents responding with an 8, 9, or 10 and dividing by the total number of respondents.	The goal for this satisfaction question is 80%.	
		Percentage of residents who responded positively to the question: "Would you recommend this nursing home to others?" (NHCAHPS)	P	% / LTC home residents	In house data, NHCAHPS survey / April 2018 - March 2019	54626*	94.74	95.00	Edgewater Gardens will strive to maintain the level of quality which will result in residents choosing to recommend our nursing home.		1)EW will continue utilizing volunteers to help complete surveys with the residents who are able. This method of survey completion proved to be effective in 2018 so will be utilized again in hopes of increasing numbers.	EW will provide a list to the volunteers of residents who are either capable of completing the survey on their own or who could complete the survey but need help documenting on the form.	Edgewater will compile the results from the satisfaction surveys. This question requires residents to answer a "4-definitely yes" to be included in the results.	Goal will be to maintain overall satisfaction above 95%. This question is used for EG to represent overall satisfaction.	
		Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	P	% / LTC home residents	In house data, interRAI survey / April 2018 - March 2019	54626*	97.37	100.00	Edgewater Gardens will strive to ensure that all residents feel comfortable in being able to express their feelings, and will encourage feedback.		1)#1) EW will continue utilizing volunteers to help complete surveys with the residents who are able. This method of survey completion proved to be effective in 2018 so will be utilized again in hopes of increasing numbers.	EW will provide a list to the volunteers of residents who are either capable of completing the survey on their own or who could complete the survey but need help documenting on the form.	The total percentage will be obtained by totalling up the number of residents who answered "3" most of the time and "4" always. This will be divided by the total number of residents who answered the question.	EW was able to attain 100% in 2018. Goal will be to maintain this number in 2019	

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		Number of customer service discussions held with front line staff.	C	Number / Health providers in the entire facility	In-home audit / April 2019-January 2020	54626*	X	20.00	The goal of customer service education will be to discuss common customer service issues and complaints that occur in the health care setting. The target of 20 sessions is an in house goal.		1)EW will strive to ensure that all residents, coworkers, volunteers and any other individual entering the home are treated with respect, dignity and a pleasant manner.	Provide regular huddles and workshops for our employees. If negative trends are seen in the way people are being treated, these will be addressed in the workshops. Role-playing situations will be provided where people can act out scenarios to learn more about how to better treat our residents.	Number of sessions provided by month to the staff.	Edgewater will have 20 sessions completed before the end of December 31, 2019.	
											2)Removing "I don't know" from normal vocabulary	During the monthly customer service sessions, a focus will be on never using the phrase "I don't know". This leaves the customer feeling unimportant and should never be the response.	All incidents from customers where staff responded with "I don't know" will be tracked and discussed with the staff.	The instances of this phrase being used will be decreased and eliminated before December 31, 2019	
	Patient-centred	Percentage of complaints acknowledged to the individual who made a complaint within five business days	P	% / All patients	Local data collection / Most recent 12 month period	648*		100.00	Response to complaints is very important to the organization. Aim to reach 100% for this indicator.		1)Tracking of all complaints in a shared database will allow better tracking of this indicator.	Complaints can be logged into a shared database by multiple staff members to ensure tracking is accurate. Identify key personnel to monitor response times.	Audit of the database quarterly to review timeframe for initial response to the complaint.	Aim for 100% response rate within 5 business days.	
		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?	P	% / Survey respondents	CIHI CPES / Most recent consecutive 12-month period	648*	CB		Currently this indicator is around 47%. Aim to make improvements to reach 58%.		1)Data is captured on the patient survey however the wording will be updated to reflect this indicator's wording exactly.	Results will be calculated quarterly by the volunteers.	Once accurate data is obtained a reasonable target for improvement will be set. Currently a high number of survey respondents do not answer this question.	Question responses will be changed to align with this indicator. Answers will be a choice of 1) completely, 2)quite a bit, 3)partly, 4) not at all. This will allow better comparison with other hospitals' data.	
Theme III: Safe and Effective Care	**Effective**	Proportion of long-term care home residents with a progressive, life-threatening illness who have had their palliative care needs identified early through a comprehensive and holistic assessment.	P	Proportion / at-risk cohort	Local data collection / Most recent 6-month period	54626*			N/A Will not be participating in this indicator						

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		Falls	C	% / LTC home residents	CIHI CCRS / July-September 2018	54626*	21.3	15.00	Edgewater Gardens previous target was 15% which we were unable to achieve. Edgewater will continue to strive to reach the 15% target for the 2019-2020 QIP.		1)EW will institute guidelines for preventing falls with regards to the physical space.	All front line staff will be reminded to ensure that areas are clean of clutter, well lit and surfaces are smooth and dry.	Falls rate will be tracked quarterly	Edgewater will strive to achieve a falls rate of 15% or below by December 31, 2019	
											2)EW will review medications with a focus on medications known to trigger falls	Medications will be changed to ensure appropriate levels of Vitamin D, and wherever possible decrease those that cause syncope or other visual or coordination abilities.	All falls will be reviewed by the nursing team at weekly report.	Edgewater will strive to achieve a falls rate of 15% or below by December 31, 2019	
											3)EW will strive to increase staff's ability to anticipate resident needs that when gone unmet may lead to falls.	Staff huddles and training will teach how to recognize resident's needs such as being pain free, having possessions within reach and that they are in a comfortable position.	Residents will not fall because their needs are not being met.	Edgewater will strive to achieve a falls rate of 15% or below by December 31, 2019	
											4)EW will conduct regular reviews of resident's sensory devices.	Regular checks to ensure that devices such as glasses and hearing aids are appropriate for the residents and in good working order.	Residents will not fall due to inability to see well or hear.	Edgewater will strive to achieve a falls rate of 15% or below by December 31, 2019	
											5)EW will strive to ensure timely toileting and quality continence assessments.	Assess and create appropriate toileting routines for the residents based upon their needs and timing that works for them	If a resident falls, the goal is that it is not triggered by a need for toileting	Edgewater will strive to achieve a falls rate of 15% or below by December 31, 2019	
		Percentage of long-term care home residents in daily physical restraints over the last 7 days	C	% / LTC home residents	CIHI CCRS / July-September 2018	54626*	12.5	10.00	Edgewater's target for the 2018-2019 QIP was 10%. This was a significant reduction from the previous year's result of 23.56%. Edgewater was able to reduce the % of resident's requiring a restraint to 12.5%. The goal of achieving 10% or below remains.		1)Discussion is always held with families requesting restraints. Alternatives of least restraint are proposed including interventions such as nurse alerts, lowering the bed, etc.	All restraints and PASDs are tracked. Each resident who has a restraint will have the restraint discussed at their annual care conference with family. Restraints are also reviewed quarterly by the Administrator/Director of Care and if there are changes in the resident's condition or behavior, it can be reassessed at any time.	Restraints will be tracked on a quarterly basis, reported to the board quarterly and yearly as well as family council.	Edgewater will strive to reduce the number of restraints down to 10% for the 2019 year.	
		Percentage of long-term care home residents without psychosis on antipsychotics in the last 7 days	C	% / LTC home residents	CIHI CCRS / July-September 2018	54626*	14.8	15.00	Edgewater will continue to strive for the 15% goal which is below benchmark. This target is difficult to maintain and therefore remaining with a target of 15% is manageable.		1)Weekly physician/NP follow up regarding residents who are newly prescribed antipsychotic medications to ensure the medication is needed.	Antipsychotic usage will be discussed at all relevant meetings including weekly multidisciplinary report, physician rounds, nurse practitioner rounds, medication reviews, care conferences and any other avenue deemed appropriate.	EG tracks antipsychotic usage quarterly with the score card reviewed by the board and also discusses quarterly at Medication Management meetings.	Target will be to achieve 15%. This is well below benchmark and is a goal that will take significant monitoring to achieve.	

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	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 / October - December 2018	648*	81.51	83.00	This indicator's result was low at the start of 18/19. Slight increase in target for 19/20 to help ensure processes are well defined and sustainable. Medication reconciliation was identified by the quality survey to be a top priority for our patients.		1)Ensure processes are well defined for sustainability into the future.	The number of patients discharged with a clear record of medication reconciliation on discharge.	Audit the number of patients with a discharge reconciliation on file every quarter.	Aim for a 2% improvement in this indicator.	
		Medication reconciliation at admission	C	% / All inpatients	In house data collection / 2019-20	648*	78	80.00	Medication reconciliation was identified by the quality survey to be a top priority for our patients. This indicator has a target of 80 which is 2% higher than current performance.		1)Confirm reconciliation on admission completed within 24 hours of admission to the inpatient unit.	Enforce process with all nurses and include pharmacy technicians in this double check to help improve outcomes.	Number of admitted patients with medication reconciliation completed on admission over total number of admitted patients.	Improve this indicator by 2%	
	Safe	**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 2018**	**648***	**1**	**0.00**	**Aim for zero incidents.**		**1)Policies related to violence will be reviewed annually.**	**The Occupational Health and Safety Committee will review the policies related to violence annually and share updates with the hospital staff.**	**All full and part time staff working in clinical areas will review and sign off on any policy updates annually.**	**Policies will be approved by the Occupational Health and Safety Committee annually.**	**FTE=126**
											2)Mock drills will be held to review policies and procedures for various violent scenarios.	Occupational Health and Safety Committee will plan mock drills annually.	Two mock drills will be held in 2019/20.	Two mock drills will be held and a debrief on each scenario will be shared with the Occupational Health and Safety Committee and staff members.	
											3)Two staff members will maintain trainers' certification in Non-Violent Crisis Intervention so that new staff can receive training on site as soon as possible.	The hospital will assist with ongoing certification and education for two in house instructors.	All new full and part time Emergency Department staff hired in 2019/20 will be trained in Non-Violent Crisis Intervention.	Training for new staff will be completed within 6 months of hire.	