### 2015/16 Quality Improvement Plan for Ontario Hospitals

**"Improvement Targets and Initiatives"**

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<tr>
<th>Area</th>
<th>Objective</th>
<th>Measure</th>
<th>Unit / Population</th>
<th>Source / Period</th>
<th>Organization Id</th>
<th>Current performance</th>
<th>Target</th>
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<th>Planned improvement initiatives (Change Ideas)</th>
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<tr>
<td><strong>Access</strong></td>
<td>Reduce wait times in the ED</td>
<td>90th percentile ED length of stay for Admitted patients.</td>
<td>Hours / ED patients</td>
<td>OECD QIPI report Jan 1, 2014 - Dec 31, 2014</td>
<td>37.95</td>
<td>15.73</td>
<td>64 hours FY2014_15</td>
<td>December YTD performance is 13.8 hours. Provincial performance is 13.5 hours. HSAA target 8 hours. Stretch target 8 hours.</td>
<td>1. Reinforce and sustain processes to &quot;pull&quot; patients admitted from the emergency department. Clinical programs to monitor and report against scorecard indicators to senior quality team. Clinical program leadership to attend daily bed rounds. Clinical programs to monitor compliance to overcapacity policy and protocol by unit.</td>
<td>60th percentile time to inpatient bed (hours) from decision to admit when an inpatient bed is available. 90th percentile time to inpatient bed (hours) from decision to admit when an inpatient bed is not available.</td>
<td>Time from discharge to patient assigned to registered practice nurse caseload. Time to transfer from patient bed to discharge lounge. Percent of discharges achieved before 11:00 AM.</td>
<td>1 hour</td>
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<tr>
<td><strong>Effectiveness</strong></td>
<td>Improve organizational financial health</td>
<td>Total Margin (consolidated): % by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expenses, excluding the impact of facility amortization, in a given year.</td>
<td>% / N/A</td>
<td>OHRS, MOH / Q4 FY 2014/15 (cumulative from April 1, 2014 to December 31, 2014)</td>
<td>930%</td>
<td>0.11</td>
<td>26% Consistent with HSAA</td>
<td>Implement case costing. Achieve Ministry of Health and Long-Term Care case costing status.</td>
<td>2. Improve the ability to obtain consolidated information in a more timely manner to inform decision making. Continue the development of the data warehouse by further integrating laboratory, complex continuing care, mental health and addictions sources systems and data mart integration.</td>
<td>Percent integration complete.</td>
<td></td>
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<td>This initiative aligns with a FY2015-16 operational priority milestone.</td>
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<td>2) Improve patient flow in the medicine program.</td>
<td>Time from discharge to patient assigned to registered practice nurse caseload. Time to transfer from patient bed to discharge lounge. Percent of discharges achieved before 11:00 AM. Time to inpatient bed from decision to admit in emergency when an inpatient bed is available in medicine 90th percentile.</td>
<td>Case costing status achieved Q1.</td>
<td>This initiative aligns with P4R funding.</td>
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<td>4) Improve evidence-informed practices aligned with FY2015_16 planned quality based procedures.</td>
<td>Develop and implement practices as defined by Clinical Handbooks for cancer surgery - colorectal and knee arthroscopy.</td>
<td>Pathways implemented. Indicators and targets to be developed.</td>
<td>Q4.</td>
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### Table: Measure Measures

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<td>Effectiveness Reduce unnecessary deaths in hospitals</td>
<td>HSMR: Number of observed deaths/number of expected deaths x 100.</td>
<td>Ratio (No units)</td>
<td>DAD, CIHI / April 1, 2013 to March 31, 2014</td>
<td>s58</td>
<td>FY2013-14 = 82</td>
<td>≤83</td>
<td>This target represents better than the 25th percentile performance of CIHI peer group for 2012-13 as the baseline year.</td>
<td>Improve early identification and management of sepsis in the emergency department.</td>
<td>Conduct chart review. Revise and implement emergency department admission sepsis order set. Develop and implement monitoring process for uptake of sepsis order set.</td>
<td>Results of chart review presented to Emergency Department and Quality Council. Order set implemented. Monitoring process implemented.</td>
<td>Q1 Q2 Q3</td>
<td></td>
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<td>Integrated Reduce unnecessary time spent in acute care</td>
<td>Alternate Level of Care Days - Percentage of inpatient days where a physicians has indicated that a patient occupying an acute care hospital bed does not require the intensity of resources/service provided in this care setting.</td>
<td>N / All acute patients</td>
<td>COC (Port Akways / FY2014_15 December YTD</td>
<td>s30</td>
<td>20-44</td>
<td>≤12%</td>
<td>Target takes into consideration access to community based service may be constrained in the current environment.</td>
<td>Improve data quality for submission of wait time day.</td>
<td>Standardize workflows. Educate staff on information management principles and importance of correct data entry. Track volume and work effort for manual wait time information system corrections.</td>
<td>ACI Forms and Assessment Module for Wait Time Information System implemented. Deliver staff education sessions. Reduce in number of data entry errors. Reduce waste (re-work) for data entry corrections.</td>
<td>Q1 100% staff receive education Baseline being collected for data entry errors and re-work. Target to be determined.</td>
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</tr>
<tr>
<td>Reduce unnecessary hospital readmission</td>
<td>Redimissions to Grand River Hospital within 30 days for selected case mix groups</td>
<td>N / All acute patients</td>
<td>DAD, CIHI / FY2014_15 November YTD</td>
<td>s30</td>
<td>12.8</td>
<td>≤12%</td>
<td>Based on historical trend.</td>
<td>Investigate variables and gaps associated with readmissions.</td>
<td>Conduct in-depth data analysis and health record review of readmissions.</td>
<td>Analysis completed. Gaps identified. Priorities established. Current and future state mapping conducted. Improvement opportunities initiated.</td>
<td>Analysis completed and priorities established Q2 Improvement opportunities initiated Q3</td>
<td></td>
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**Comments:**

- The target represents better than the 25th percentile performance of CIHI peer group for 2012-13 as the baseline year.
- The target is set to align with RMCHN initiative.
- The initiative aligns with FY2015-16 operating plan priority.
- The target is set to align with provincial strategies.
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<td>1</td>
<td>Improve patient satisfaction</td>
<td>% / All patients</td>
<td>NRC Picker / October 2013 - September 2014</td>
<td>930*</td>
<td>92</td>
<td>≥93%</td>
<td>Improvement of current performance.</td>
<td>1) Measure the patient experience as a means of identifying quality improvement initiatives.</td>
<td>Sustain current practices for longitudinal surveys using telephone mode for the emergency department and face-to-face mode for the medicine, surgery, intensive care, childbirth, children's, stroke and cancer programs. Expand longitudinal survey to mental health and addictions program.</td>
<td>Surveys conducted. Quality improvement initiatives initiated based on results. Annual report developed for Quality and Patient Safety Committee of the Board.</td>
<td>Quarterly results published. Report delivered Q1 of FY2016_17.</td>
<td>This initiative aligns with both our draft 2015-17 strategic and 2015-16 operating plan priorities.</td>
</tr>
<tr>
<td>2</td>
<td>Increase proportion of patients receiving medication reconciliation upon admission</td>
<td>% / All patients</td>
<td>In-house survey / Jan 2014_15 Q3</td>
<td>930*</td>
<td>96</td>
<td>≥95%</td>
<td>Indicator refreshed from previous year, limited amount of data. Need to ensure data validity.</td>
<td>1) Improve completeness and accuracy of best possible medication history.</td>
<td>Auditing process in place for medicine program, adult mental health in patient unit and surgical pre-admit clinic. Expand audit process pending approval of resources.</td>
<td>% of patients with best possible medication histories reviewed by patient. % of best possible medication histories with significant errors.</td>
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<td>3</td>
<td>Reduce hospital-acquired infection rates</td>
<td>Rate per 1,000 patient days</td>
<td>Publicly reported, MOH / Dec 1, 2014</td>
<td>930*</td>
<td>0.14</td>
<td>≤0.20</td>
<td>Clinical opinion is that Clostridium difficile activity in FY2014-15 year is unusual provincially. The target represents a 25% reduction from the previous year of 0.26.</td>
<td>1) Sustain gains made in hand hygiene practices. 2) Expand patient hand hygiene program.</td>
<td>Hand hygiene audits conducted in clinical programs with just in time feedback. Publication of internal results quarterly in hospital newsletter. Internal monitoring of clinical programs using scorecards and quarterly report on performance.</td>
<td>Hand hygiene before patient contact.</td>
<td>95%</td>
<td></td>
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**Quality dimension**
- Patients' centred
- Safety
- Efficiency

**Objective**
- Improve patient satisfaction
- Increase proportion of patients receiving medication reconciliation upon admission
- Reduce hospital-acquired infection rates

**Measure**
- % / All patients
- Rate per 1,000 patient days / All patients

**Unit / Population**
- NRC Picker / October 2013 - September 2014
- In-house survey / Jan 2014_15 Q3
- Publicly reported, MOH / Dec 1, 2014

**Source / Period**
- October 2013 - September 2014
- Jan 2014_15 Q3
- Dec 1, 2014

**Organization**
- NRC Picker
- In-house survey
- Publicly reported, MOH

**Current performance**
- 92
- 96
- 0.14

**Target**
- ≥93%
- ≥95%
- ≤0.20

**Target justification**
- Improvement of current performance.
- Indicator refreshed from previous year, limited amount of data. Need to ensure data validity.
- Clinical opinion is that Clostridium difficile activity in FY2014-15 year is unusual provincially. The target represents a 25% reduction from the previous year of 0.26.

**Planned improvement initiatives (Change ideas)**
- Measure the patient experience as a means of identifying quality improvement initiatives.
- Sustain current practices for longitudinal surveys using telephone mode for the emergency department and face-to-face mode for the medicine, surgery, intensive care, childbirth, children's, stroke and cancer programs. Expand longitudinal survey to mental health and addictions program.
- Auditing process in place for medicine program, adult mental health in patient unit and surgical pre-admit clinic. Expand audit process pending approval of resources.

**Methods**
- Sustain current practices for longitudinal surveys using telephone mode for the emergency department and face-to-face mode for the medicine, surgery, intensive care, childbirth, children's, stroke and cancer programs. Expand longitudinal survey to mental health and addictions program.

**Process measures**
- Surveys conducted. Quality improvement initiatives initiated based on results. Annual report developed for Quality and Patient Safety Committee of the Board.

**Goal for change ideas**

**Comments**
- This initiative aligns with both our draft 2015-17 strategic and 2015-16 operating plan priorities.
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<td>1) Develop infrastructure to support falls risk assessment and prevention.&lt;br&gt;Leadership to establish Falls Steering Committee with defined role accountability. Leadership to develop driver diagram of primary and secondary drivers. Leadership and staff to identify improvement opportunities to reduce falls with harm.</td>
<td>Leadership to establish Falls Steering Committee with defined role accountability. Leadership to develop driver diagram of primary and secondary drivers. Leadership and staff to identify improvement opportunities to reduce falls with harm.</td>
<td>Number of falls with harm.</td>
<td>Steering Committee established and operational Q1. Reduction in falls with harm.</td>
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<td>2) Improve patient/family communication to anticipate care needs and reduce patient safety risk.</td>
<td>Implement intentional rounding.</td>
<td>Staff compliance to conduct intentional rounding. Daily monitoring of falls.</td>
<td>Q1 implementation with hourly intentional rounding maintained by staff for all patients.</td>
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<td>3) Improve patient/family understanding of risks for falls and methods of prevention.</td>
<td>Develop patient/family education tools.</td>
<td>Educational tools developed.</td>
<td>Q2</td>
<td></td>
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