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

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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)

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
Theme I: Timely and Efficient Transitions	**Efficient**	Percentage of those hospital discharges (any condition) where timely (within 48 hours)	P	% / Discharged patients	EMR/Chart Review / Last consecutive 12 month period	91397*	21	85.00	Our goal is that 80% of all discharge summaries are reviewed to		1)Following last year's process evaluation, we are implementing a modified stamp using a single form that will include basic data	Use our quality committee to evaluate modified process for post-discharge assessments as detailed below, specifically one new element ; the scanners will now be inserting a discharge f/u form into patient chart before messaging the nurses. Form process 1. scanners	# of discharge summaries that are assessed / total # of discharge summaries	1. 80% of all discharge summaries will have been assessed (either	Our goal is to have appropriate follow up for those patients deemed to be
	Timely	Percentage of patients and clients able to see a doctor or nurse practitioner on the same day or next day, when needed.	P	% / PC organization population (surveyed sample)	In-house survey / April 2019 - March 2020	91397*	50	60.00	Our current performance is adequate compared with the provincial average but we note a decrease year on year in the last few years. Thus we would like to see a an improvement over current		1)Continue to review our access and make adjustments as needed to schedules (add more designated same-day (SD)	Get clerical team involved in keeping SD data accurate: Add SD in detail of each SD appointments, regardless if being used by patient or not.	All SD appointments will include SD in the appointment details.	100% of SD appointments will include SD in the appointment details.	
											2)Same Day (SD) Appointment Data Tracking Development. Use SD appointment type to keep track of SD supply and	Practice Facilitator to review data on walk-in and same day clinic usage	# patients offered same day/next day / # patients requesting same/day next day	80% of patients requesting same/next day appointment are offered same/next	
											3)Identify high walk-in users to better understand their care needs	Approach individual providers about high walk-in users to provide context to usage	Number of providers approached about high walk-in users to provide context	All providers approached to provide context.	
		Percentage of patients discharged from hospital for which discharge summaries are	P	% / Discharged patients	Hospital collected data / Most recent 3 month period	932*	81.2	85.00	PFAC and HQO priority: 85% represents a 4.3% improvement		1)Identify barriers to completion: vacation coverage, co-signing with collaborative documentation.	Chart audit, brainstorming with medical chiefs, then department physician meetings. Reminder to pay attention to "Sign" in MEDITECH when it is red.	Complete chart audit to determine primary causes for delayed discharge summaries.	100% of discharges on the two lowest performing units will be audited to	
Theme II: Service Excellence	**Patient-centred**	Patient experience: Would you recommend this hospital to family or friends if they needed this type of care?	C	% / All inpatients	Local data collection / April 2020- March 2021	932*	84	85.00	A combined hospital programs target of 85% percent represents a continued incremental improvement in order to meet		1)Implement AIDET communication tool across the organization (incl. staff, physicians, volunteers, and students),	1) Provide blended learning approach to all staff, physicians, volunteers, and students, consisting of a short self-directed eModule and	1) Learning will track completion of eModule by Bruyère staff	1) 90% of all staff trained on AIDET using the eModule by the end of June 2020.	
											2)Implement AIDET communication tool across the organization (incl. staff, physicians, volunteers, and students)	2) a facilitated group practice on the units/depts. as appropriate	2) Learning will track the number of staff attending the facilitated group practice (LMS).	2) Learning will track the number of staff attending the facilitated group practices by	
		Percentage of residents responding positively to: "Staff ask how to meet my needs." (InterRAI QoL)	C	% / LTC home residents	In house data, interRAI survey / April 2020- March 2021	51651*	40	50.00	Did not meet in 19-20 - working to better understand responses	SQLI Quality of Life Working Group	1)Ongoing implementation of focused rounding	1) Rounding champions, education	1) staff complete online module	1) 100% regular staff	
											2)Ongoing roll-out of "All About" project	2) Visuals completed and posted in resident rooms	2) visuals in long-stay rooms	2) 75% of rooms	
											3)Incorporate Always Practices into Orientation	3) Standardized Orientation	3) roll out of new standardized orientation by summer 2020	3) complete roll out of new standardized orientation by summer 2020	
											4)Enhance shift reports	4) Standardized shift report	4) engagement of staff in standard shift report model	4) staff retreat complete, model drafted	
											5)Begin roll-out of AIDET in LTC	5) Online education module	5) staff complete online module	5) 80% regular staff complete the online module	
		Percentage of residents responding positively to: "Staff ask how to meet my needs." (InterRAI QoL)	C	% / LTC home residents	In house data, interRAI survey / April 2020- March 2021	53536*	40	50.00	Did not meet in 19-20 - working to better understand responses	SQLI Quality of Life Working Group	1)Ongoing implementation of focused rounding	1) Rounding champions, education	1) staff complete online module	1) 100% regular staff	
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											5)Begin roll-out of AIDET in LTC	5) Online education module	5) staff complete online module	5) 80% regular staff	
Theme III: Safe and Effective Care	**Effective**	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	P	Proportion / All patients	Local data collection / Most recent 6 month period	932*	CB	CB	As there is currently no formal indicator in place, we are collecting baseline data for this year.		1)Use the RESPECT tool with our CCC MDS data to identify patients who will benefit from Advanced Care Planning and Serious Illness	Bruyere Information Systems and researchers from the Bruyère Research Institute collaborated to create a report using the RESPECT algorithm on MDS data. In the coming year, the report will be given to CCC physicians who will be trained regarding use of the	1) Validation of the RESPECT tool.	Initial report generated.	We will be working to establish a common understanding
											2)Provide physicians in the Complex Continuing Care program training on the use of the Serious Illness Conversation Guide	Conduct facilitated training/education sessions with CCC physicians.	Percent of physicians who have completed Serious Illness Conversation Training	72% of CCC physicians will have completed the training.	
		Proportion of patients with a progressive, life-limiting illness who were identified to	P	Proportion / All patients	Local data collection / Most recent 6 month period	91397*	CB	CB	New effort so we do not have baseline measure. However we feel	eHealth Center of Excellence	1)Screen patients identified as palliative using the criteria below. Refine algorithm based on provider feedback. Develop	Identify palliative patients: EMR Search (Search on K Code, "pallia" term & keyword pallcarexqbrc). Screen: Provider meeting discussion to review the list of identified patients. PDSA: One provider to use the palliative toolbar and complete the documented	Number of patients identified as "palliative." %patients (identified as palliative) with the palliative toolbar for the single provider with completed documented assessment	20% increase over baseline	Gathering baseline data
		The proportion of residents with a progressive, life-limiting illness, that are identified to benefit from palliative care, who subsequently have their palliative care needs assessed using a comprehensive and holistic assessment.	P	Proportion / LTC home residents	Local data collection / Most recent 6 month period	51651*	CB	CB	There is currently no data available		1)Serious Illness Conversation education	Plan and conduct education	Percentage of physicians and Nurse Practitioners who have completed the education session	60% of physicians/NP	
											2)Enhanced scheduling of care conferences.	Work with clerks to enhance scheduling and track performance	Percentage of admission care conferences within 6 weeks	80% of admission care conferences held within 6 weeks	
											3)Standardize content of care conferences to include goals of care	Engage staff and physicians to standardize care conference content and update assessment tool	Update assessment tool	Assessment tool update completed	
											4)Explore the integration of the RESPECT tool within the PCC EPR	Explore with the research team and seek funding	Work with research team to identify steps and funding	Plan created and funding secured	
		The proportion of residents with a progressive, life-limiting illness, that are identified to benefit from palliative care, who subsequently have their palliative care needs assessed using a comprehensive and holistic assessment.	P	Proportion / LTC home residents	Local data collection / Most recent 6 month period	53536*	CB	CB	There is currently no data available		1)Serious Illness Conversation education	1) Plan and conduct education	1) Education conducted	1) 60% of physicians/NP	
											2)Enhanced scheduling of care conferences.	2) Work with clerks to enhance scheduling and track performance	2) Percentage of admission care conferences within 6 weeks	2) 80% of admission care conferences held within 6 weeks	
											3)Standardize content of care conferences to include goals of care	3) Engage staff and physicians to standardize care conference content and update assessment tool	3) engagement of staff and physicians in care conference content	3)Assessment tool update completed	
											4)Explore the integration of the RESPECT tool within the PCC EPR"	4) Explore with the research team and seek funding	4) Work with research team to identify steps and funding	3) Plan created and funding secured	
		Percent of patients with social determinants of health (SDH) included in the EMR	C	% / Patients	in specific cohorts at the clinic / April 2020-March 2021	91397*	1	40.00	Identifying SDH has been identified as important in alignment with clinic strategic plan but implementation of change effort has been slow		1)Increase use of SDH stamp and add Myanmar refugee cohort to denominator.	Choosing patients who have been referred FHT Social Workers, as well as selecting patients in the cohort of St. Mary's, Bethany Hope and Cornerstone Housing and Myanmar refugee (denominator).	% of patients in the the cohort of St. Mary's, Bethany Hope, Cornerstone Housing and Myanmar refugee; or referred to the Social Workers with SDH information in the chart	40% % of patients in the the cohort of St. Mary's, Bethany Hope, Cornerstone	There has been an increase on #patients with SDH stamp since implementation
											2)Continue to track usage, identify if providers are noting SDH challenges in their patients.	Approach individual MRP and have our community liaison clerk complete the SDH stamp for the identified patient cohort.	Track the number where the Social Determinants of Health stamp has been completed and documented in the chart.	40% of the identified cohort with an SDH stamp completed and documented on	
		Percentage of residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4 since their previous resident assessment	C	% / LTC home residents	CIHI CCRS / July-September 2020	51651*	3.5	3.50	Met 4% target in 19-20 Gradual improvement approach (3% for 21-22)	RNAO	1)Ongoing implementation and sustainability of focused rounding	1) Rounding champions, education	1) staff complete online module	1) 100% regular staff	
											2)Sustain implementation of S&W program including risk-based huddles for new or worsening wounds - Ongoing audits on	2) Monthly audits and spreadsheet updated	2) monthly audit and spreadsheet done	2) 12 monthly audits and spreadsheet 2) Risk huddle held for 90% of	
											3)Launch revised online module	3) Launch new online module	3) Module completed by staff	3) 100% regular staff	
											4)Explore mechanism for imaging of wounds and uploading to PCC	4) Explore possibilities for uploading images of wounds to PCC	4) Exploration complete and plan created	4) complete exploring mechanisms for imaging of wounds and uploading to	

	Percentage of residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4 since their previous resident assessment	C	% / LTC home residents	CIHI CCRS / July-September 2020	53536*	4.3	3.50	Did not meet target in 19-20 but improved Gradual improvement approach (3% for 20-21)	RNAO	1)Ongoing implementation and sustainability of focused rounding	1) Rounding champions, education	1) staff complete online module	1) 100% regular staff	
										2)Sustain implementation of S&W program including risk-based huddles for new or worsening wounds, Ongoing audits on	2) Monthly audits and spreadsheet updated	2) monthly audit and spreadsheet done	2) 12 monthly audits and spreadsheet 2) Risk huddle held for 90% of	
										3)Launch revised online module	3) Launch new online module	3) Module completed by staff	3) 100% regular staff	
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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**	**932***	**38**	**36.00**	**Workplace violence reporting increased in 2019-20 and we are hoping to continue to improve reporting across hospital programs as**		**1)Continue monitoring, coaching and training of the online incident reporting and investigation system. We will also expand the flagging system used to identify patients and visitors who pose a risk of violence to staff to in our Long-Term Care**	**In person training onthe on-line incident reporting & investigation system is provided to all Directors, managers and supervisors in clinical and operations departments. Remaining management and front-line staff reached via corporate e-mail announcement and Intranet. OHSS reviews violence incidents reports and investigations to ensure all necessary information provided and corrective measures implemented.**	**Percentage of new managers and directors trained on the reporting system.**	**100% of new managers/directors trained.**	**Introduction of on-line system resulted in improved reporting and investigation time, quality, and quantity of information.**
	Percentage of non-palliative patients newly dispensed an opioid prescribed by any provider in the	P	% / Patients	CAPE, CIHI, OHIP, RPDB, NMS / 6 month period ending Mar 31, 2019	91397*	3.5	5.80	Maintain performance which is already 15% below provincial	HQO My Practice Reports	1)Reduce number of patients on over 90meq of morphine.	1. Increase the number of MDs using mypractice reports 2. Build registry of patients on high dose morphine; pharmacist and Chronic Disease Management Nurse will review this list and then collaborate with providers on a strategy to reduce use	1. % of doctors signed up for mypractice reports. 2. Denominator: #patients on over 90meq of morphine, Numerator: #patients offered support by pharmacist and CDMN to reduce opioids. 3. # patients on 90 meq or more of morphine. 4. Resident project - %patients	1.75% physicians signed up. 2. 100% over 90meq had their charts reviewed and the	
	Falls (per 1000 patient days).	C	% / All inpatients	RIMS/Meditech / April 2020-March 2021	932*	3.43	3.40	Maintain the 3.4 target is a stretch goal given the increase in Restorative beds in CCC.	Champlain LHIN Regional Falls Committee	1)A corporate Fall Risk Reduction Committee was established. A gap analysis will be conducted using the RAC. Preliminary review	Yearly review of committee strategic priorities and workplan. To maintain organizational linkages and literature revirew for best practice in falls reduction and injury prevention.	Yearly review of workplan to ensure that goals are met. In addition, regular reporting to senior quality team as well as Meditech audits.	1) Once implemented in September 2020, 100% of debriefs to occur post-fall.	
										2)Repeat falls post-fall huddles	Yearly review of committee strategic priorities and workplan. To maintain organizational linkages and literature revirew for best practice in falls reduction and injury prevention.	Yearly review of workplan to ensure that goals are met. In addition, regular reporting to senior quality team as well as Meditech audits.	2) The post-fall huddle is a standalone project and it will be pilotted on one	
										3)Post-fall care algorithm.	Yearly review of committee strategic priorities and workplan. To maintain organizational linkages and literature revirew for best practice in falls reduction and injury prevention.	Yearly review of workplan to ensure that goals are met. In addition, regular reporting to senior quality team as well as Meditech audits.	3) Once implemented in September 2020, 100% of the post-fall algorithms to	This to be completed in conjuction with patients and families. Falls
	Percentage of residents who fell during the 30 days preceding their resident assessment	C	% / LTC home residents	CIHI CCRS / July - Sept 2020	51651*	19	15.00	Maintain 19-20 target (REB almost meeting)	RNAO	1)Ongoing implementation and sustainability of focused rounding	Rounding champions, education	Staff complete online module	100% regular staff	
										2)Teams to identify and implement prevention solutions - formalize risk-based huddles for frequent fallers (at least monthly on	Risk based huddles monthly for residents with 2+ falls	Risk based huddles held and documented	90% of all residents monthly who fell 2+ times had risk huddles	
										3)Enhance shift reports	Standardized shift report	Engagement of staff in standard shift report model	Staff retreat complete, model drafted	
										4)Post-Fall Huddle to include a section on actions done to prevent future falls	Update assessment tool	Assessment tool updated and implemented	This is complete	
										5)Create a continence assessment tool and bowel protocol.	Create continence assessment tool and bowel protocol	Assessment tool and bowel protocol created and implemented	This has been completed.	
	Percentage of residents who fell during the 30 days preceding their resident assessment	C	% / LTC home residents	CIHI CCRS / July - Sept 2020	53536*	15.8	15.00	Maintain 19-20 target (REB almost meeting)	RNAO	1)Ongoing implementation and sustainability of focused rounding	Rounding champions, education	Staff complete online module	100% regular staff	
										2)Teams to identify and implement prevention solutions - formalize risk-based huddles for frequent fallers (at least monthly on	Risk based huddles monthly for residents with 2+ falls	Risk based huddles held and documented	90% of all residents monthly who fell 2+ times had risk huddles	
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