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

Haliburton Highlands Health Services Corporation 7199 Gelert Road, P.O. Box 115

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
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)															
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	51154*	21.1	17.8	Provincial Average		1. Establish a process for early recognition of residents at risk for Emergency Department (ED) visits. 2. Establish procedures to identify and address changes in resident health status within the LTC home where appropriate, to avoid ED visits. 3. Establish a process to monitor potentially avoidable ED visits.	1. Implement discussion of at-risk residents during Resident Safety Council meetings and daily huddles. 2. Explore policies and procedures currently in use at high-performing LTC homes that are co-located with hospitals, and implement best practices as appropriate. 3. Implement a tracking form to include detailed information about ED visits including reason for transfer, outcome, who requested/initiated the transfer (e.g., family member, physician, other health team member), and whether the visit was potentially avoidable. 4. Review tracked data quarterly to identify trends and develop strategies to proactively address and prevent avoidable ED visits.	1. Number of at-risk residents discussed at Resident Safety Council and daily huddles. 2. Number of ED visits tracked.	1. 100% 2. 100%	n/a
		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	54272*	34.3	17.8	Provincial Average		1. Establish a process for early recognition of residents at risk for Emergency Department (ED) visits. 2. Establish procedures to identify and address changes in resident health status within the LTC home where appropriate, to avoid ED visits. 3. Establish a process to monitor potentially avoidable ED visits.	1. Implement discussion of at-risk residents during Resident Safety Council meetings and daily huddles. 2. Explore policies and procedures currently in use at high-performing LTC homes that are co-located with hospitals, and implement best practices as appropriate. 3. Implement a tracking form to include detailed information about ED visits including reason for transfer, outcome, who requested/initiated the transfer (e.g., family member, physician, other health team member), and whether the visit was potentially avoidable. 4. Review tracked data quarterly to identify trends and develop strategies to proactively address and prevent avoidable ED visits.	1. Number of at-risk residents discussed at Resident Safety Council and daily huddles. 2. Number of ED visits tracked.	1. 100% 2. 100%	n/a
	Efficient	Average number of inpatients receiving care in unconventional spaces or ER stretchers per day within a given time period.	P	Count / All patients in specified time period	Daily BCS / October - December 2018	938*	48	CB	New indicator; collecting baseline data	CELHIN Home and Community Care	1. Improve patient flow across organization to reduce number of patients admitted to the ED.	1. Fully implement BSO Acute Care RN role as intended, including focus on consultation with at-risk patients in the ED to help avoid hospital admission and ALC designation. 2. Complete process mapping for ED and Acute Care patient referrals to Community Programs and Home and Community Care services, and develop strategies to address identified gaps. 3. Expand daily bullet rounds to include discharge planning discussion and strategies for all patients, including new admissions; include physicians in daily bullet rounds when possible, to establish estimated discharge date as early as possible following admission to hospital.	1. Fully implement BSO Acute Care RN role as intended, including focus on consultation with at-risk patients in the ED to help avoid hospital admission. 2. Complete process mapping for ED and Acute Care patient referrals to Community Programs, and develop strategies to address identified gaps. 3. Expand daily bullet rounds to include discharge planning discussion and strategies for all patients, including new admissions; include physicians in daily bullet rounds when possible, to establish estimated discharge date as early as possible following admission to hospital.	1. >70% 2. By December 2019. 3. >75%	n/a

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		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	938*	38.5	30	Internal target, with goal of improving over previous year's performance; provincial average is 16%	CELHIN Home and Community Care	1. Reduce number of patients transitioning to ALC by developing BSO Acute Care role in both ED and Acute Care settings. 2. Improve process for referrals to Community Programs for at-risk ED and Acute Care patients. 3. Improve proactive discharge planning process for Acute Care patients. 4. Reduce risk of deconditioning of ALC patients and improve quality of life.	1. Fully implement BSO Acute Care RN role as intended, including focus on consultation with at-risk patients in the ED to help avoid hospital admission. 2. Complete process mapping for ED and Acute Care patient referrals to Community Programs and Home and Community Care services, and develop strategies to address identified gaps. 3. Expand daily bullet rounds to include discharge planning discussion and strategies for all patients, including new admissions; include physicians in daily bullet rounds when possible, to establish estimated discharge date as early as possible following admission to hospital. 4. Refresh ALC working group consisting of ED and inpatient nursing staff and physicians, Home and Community Care, Community Programs staff, BSO Acute Care RN, physiotherapy; group to develop strategies to ensure ALC patients are offered activities and mobility.	1. Number of at-risk ED and Acute Care patients seen by BSO Acute Care RN. 2. Process map completed and strategies identified. 3. Number of patients with Estimated Date of Discharge identified, and discharge planning initiated, within 72 hours of admission. 4. Number of ALC patients offered activities and mobility.	1. >70% 2. By December 2019. 3. >75% 4. 100%	n/a
	Timely	**90th percentile Emergency Department (ED) Length of Stay for admitted patients (i.e., ED wait time for inpatient bed)**	**MANDATORY**	**Hours / patients admitted from ED**	**Q3 FY 2018/19 (October - December 2018)**	**938***	46.8	25	Internal target, with goal of improving over current performance	CELHIN Home and Community Care	1. Improve patient flow across organization to reduce number of patients admitted to the ED.	1. Fully implement BSO Acute Care RN role as intended, including focus on consultation with at-risk patients in the ED to help avoid hospital admission and ALC designation. 2. Complete process mapping for ED and Acute Care patient referrals to Community Programs and Home and Community Care services, and develop strategies to address identified gaps. 3. Expand daily bullet rounds to include discharge planning discussion and strategies for all patients, including new admissions; include physicians in daily bullet rounds when possible, to establish estimated discharge date as early as possible following admission to hospital.	1. Fully implement BSO Acute Care RN role as intended, including focus on consultation with at-risk patients in the ED to help avoid hospital admission. 2. Complete process mapping for ED and Acute Care patient referrals to Community Programs, and develop strategies to address identified gaps. 3. Expand daily bullet rounds to include discharge planning discussion and strategies for all patients, including new admissions; include physicians in daily bullet rounds when possible, to establish estimated discharge date as early as possible following admission to hospital.	1. >70% 2. By December 2019. 3. >75%	
	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	938*									Determining data collection methods and feasibility during 2019/20 year; currently not able to collect accurate data for this 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	51154*	100	100	LTCHA requirement		1. Continue to support process for residents and families to submit complaints/concerns.	1. Ensure all residents and family members receive information about the complaints/concerns process upon admission to the home. 2. Ensure all staff working in LTC receive information about the complaints/concerns process.	1. Number of newly admitted residents who receive information about complaints/concerns process. 2. Number of staff working in LTC who receive information about the complaints/concerns process	1. 100% 2. 100%	n/a
		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	54272*	100	100	LTCHA requirement		1. Continue to support process for residents and families to submit complaints/concerns.	1. Ensure all residents and family members receive information about the complaints/concerns process upon admission to the home. 2. Ensure all staff working in LTC receive information about the complaints/concerns process.	1. Number of newly admitted residents who receive information about complaints/concerns process. 2. Number of staff working in LTC who receive information about the complaints/concerns process	1. 100% 2. 100%	n/a
		Percentage of residents responding positively to: "I would recommend this site or organization to others."	P	% / LTC home residents	In house data, Resident Satisfaction Survey / April 2018 - March 2019	51154*	90.3	95	Internal target; based on improvement over current performance and previous year's target of 85%		1. Resident satisfaction surveys indicated that participation in activities is highly correlated with overall satisfaction; planned change ideas involve strategies to enhance activities for residents.	1. Improve Life Enrichment Program by adding activities through consultation with Family Council and Resident Council. 2. Ensure staff focus is on listening to residents' concerns and allowing residents to express within a climate that is free from fear.	1. Number of residents who are able to attend activities, who actually attend activities. 2. Number of new activities added to calendar.	1. 100% 2. 1 per quarter/season	n/a

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		Percentage of residents responding positively to: "I would recommend this site or organization to others."	P	% / LTC home residents	In house data, Resident Satisfaction Survey / April 2018 - March 2019	54272*	100	95	Internal target; based on improvement over previous year's target of 85%		1. Resident satisfaction surveys indicated that participation in activities is highly correlated with overall satisfaction; planned change ideas involve strategies to enhance activities for residents.	1. Improve Life Enrichment Program by adding activities through consultation with Family Council and Resident Council. 2. Ensure staff focus is on listening to residents' concerns and allowing residents to express within a climate that is free from fear.	1. Number of residents who are able to attend activities, who actually attend activities. 2. Number of new activities added to calendar.	1. 100% 2. 1 per quarter/season	n/a
		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, survey / April 2018 - March 2019	51154*	n/a	CB	New indicator; collecting baseline data		1. Implement new Resident Satisfaction Survey to monitor this indicator.	1. Review existing surveys identified by Accreditation Canada; select two potential surveys. 2. Seek feedback from Resident Council and Family Council on selected surveys, and make final selection based on feedback.	1. Resident Satisfaction survey identified and implemented.	1. By December 2019.	n/a
		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, survey / April 2018 - March 2019	54272*	n/a	CB	New indicator; collecting baseline data		1. Implement new Resident Satisfaction Survey to monitor this indicator.	1. Review existing surveys identified by Accreditation Canada; select two potential surveys. 2. Seek feedback from Resident Council and Family Council on selected surveys, and make final selection based on feedback.	1. Resident Satisfaction survey identified and implemented.	1. By December 2019.	n/a
		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	51154*									Being captured through indicator "I would recommend this site or organization to others"
		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	54272*									Being captured through indicator "I would recommend this site or organization to others"
		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, survey / April 2018 - March 2019	51154*	n/a	CB	New indicator; collecting baseline data		1. Implement new Resident Satisfaction Survey to monitor this indicator.	1. Review existing surveys identified by Accreditation Canada; select two potential surveys. 2. Seek feedback from Resident Council and Family Council on selected surveys, and make final selection based on feedback.	1. Resident Satisfaction Survey identified and implemented.	1. By December 2019.	n/a
		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, survey / April 2018 - March 2019	54272*	n/a	CB	New indicator; collecting baseline data		1. Implement new Resident Satisfaction Survey to monitor this indicator.	1. Review existing surveys identified by Accreditation Canada; select two potential surveys. 2. Seek feedback from Resident Council and Family Council on selected surveys, and make final selection based on feedback.	1. Resident Satisfaction Survey identified and implemented.	1. By December 2019.	n/a
		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	938*	n/a	CB	New indicator; collecting baseline data		1. Improve process for tracking complaints as well as monitoring and addressing trends.	1. Develop database to track complaints (and compliments), and provide information/education to hospital leaders on how to use database. 2. Develop and implement process to inform hospital leaders of complaints received, and reminder of required acknowledgement within 5 days. 3. Conduct quarterly review of complaints and compliments received, to identify trends and develop strategies to address common issues as well as celebrate successes.	1. Database and related processes developed and implemented. 2. Number of complaints and compliments received entered into database. 3. Number of complaints acknowledged within 5 business days. 4. Implementation of quarterly review process.	1. By December 2019. 2. 100% 3. 95% 4. By December 2019.	n/a
		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	938*	n/a	85	New indicator; collecting baseline data		1. Implement new Patient Satisfaction Survey to monitor this indicator.	1. Review existing surveys identified by Accreditation Canada; select two potential surveys. 2. Seek feedback from Community Advisory Committee on selected surveys, and make final selection based on feedback. 3. Establish process for distribution of survey, collection of data, and data analysis.	1. Patient Satisfaction Survey identified and implemented. 2. Process for survey distribution, data collection, and analysis established and implemented.	1. By December 2019. 2. By December 2019.	n/a

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		Percentage of clients who responded positively to the question: "Would you recommend Community Support Services programs to someone else?	P	% / All Community Support Services clients	In house data / Most recent 6 month period	938*	100	100	New indicator; collecting baseline data; focusing on maintaining current performance		1. Improve system navigation.	1. Implement centralized intake program.	1. New referrals to CSS programs will receive a full-intake. 2. Existing clients requesting a new service will receive a full-reassessment of their service needs. 3. Clients will receive relevant referrals for programs/services in addition to the initial request. 4. Referrals resulting in uptake/use of services.	1) 100% 2) 100% 3) 62% (10% higher than existing performance) 4) 75%	n/a
Theme III: Safe and Effective care	**Safe**	Percentage of residents who were physically restrained every day during the 7 days preceding their resident assessment	A	% / LTC home residents	CIHI CCRS / April 2018 - September 2018	51154*	12.1	5.5	Provincial average		1. Implement strategy to reduce restraint use, in alignment with organization's least restraint policy.	1. Review RNAO Best Practice Guidelines for restraint use in LTC; identify gaps, and implement recommended practices to address gaps. 2. Conduct regular review of restraint use during monthly Resident Safety Committee meetings and daily huddles.	1. Review of BPG and gap analysis completed. 2. Number of residents for whom restraints were used that were reviewed during Resident Safety Committee meetings and daily huddles.	1. By December 2019. 2. 100%	n/a
		Percentage of residents who were physically restrained every day during the 7 days preceding their resident assessment	A	% / LTC home residents	CIHI CCRS / April 2018 - September 2018	54272*	7.9	5.5	Provincial average		1. Implement strategy to reduce restraint use, in alignment with organization's least restraint policy.	1. Review RNAO Best Practice Guidelines for restraint use in LTC; identify gaps, and implement recommended practices to address gaps. 2. Conduct regular review of restraint use during monthly Resident Safety Committee meetings and daily huddles.	1. Review of BPG and gap analysis completed. 2. Number of residents for whom restraints were used that were reviewed during Resident Safety Committee meetings and daily huddles.	1. By December 2019. 2. 100%	n/a
		Percentage of residents who were given antipsychotic medication without psychosis in the 7 days preceding their resident assessment.	A	% / LTC home residents	CIHI CCRS / April 2018 - September 2018	51154*	30.5	21.3	Provincial average		1. Conduct review of antipsychotic use and explore potential alternatives to reduce incidence.	1. In collaboration with interprofessional team, review best practices for antipsychotic use in LTC; identify gaps, and implement recommended practices to address gaps. 2. Collaborate with LTC BSO nurse to identify and implement alternative strategies for addressing responsive behaviours	1. Review of best practices and gap analysis completed. 2. Number of residents for whom an alternative plan of care is established in place of antipsychotic use.	1. By December 2019. 2. 50% of applicable residents.	n/a
		Percentage of residents who were given antipsychotic medication without psychosis in the 7 days preceding their resident assessment.	A	% / LTC home residents	CIHI CCRS / April 2018 - September 2018	54272*	12	21.3	Provincial average		1. Conduct review of antipsychotic use and explore potential alternatives to reduce incidence.	1. In collaboration with interprofessional team, review best practices for antipsychotic use in LTC; identify gaps, and implement recommended practices to address gaps. 2. Collaborate with LTC BSO nurse to identify and	1. Review of best practices and gap analysis completed. 2. Number of residents for whom an alternative plan of care is established in place of antipsychotic use.	1. By December 2019. 2. 50% of applicable residents.	n/a
		Percentage of staff who provide positive responses to Pulse survey by rating excellent, very good, good to the question: "Overall, how would you rate the organization as a place to work?"	A	% / All Staff	Pulse survey / 2018	938*	69.4	75	Internal target, with goal of improving current performance		1. Increase staff engagement. 2. Identify strategies to improve morale.	1. Engage and support staff at department level to identify challenges and strategies to improve the work environment in their areas. 2. Develop action plans at the departmental level to improve employee satisfaction, based on top 3 prioritized departmental survey results. 3. Continue supporting organization's Healthy Workplace Workgroup to identify and implement healthy work environment strategies and morale boosters across the organization.	1. Number of departments with action plans developed. 2. Number of action plan items implemented. 3. Number of staff participating in healthy work environment initiatives.	1. 100% 2. 70% 3. 70%	n/a
	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**	**938***	**6**	**5**	**Based on best practice**		1. Implement a workplace violence risk assessment tool 2. Increase staff's ability to de-escalate and manage potentially violent patients.	1. Review and update the risk assessment tool, based on best practice, and provide training/education for all staff on how to use the tool. 2. Investigate and offer training options for staff with focus on de-escalation strategies. 3. Fully implement BSO nurse role across all program areas in the organization to help reduce incidence of responsive behaviours and provide ongoing support for patients and staff.	1. Risk assessment tool review and updates completed. 2. Percent staff trained based on those who were identified for training. 3. BSO nurse role fully implemented where available.	1. By December 2019. 2. 100% identified staff attending training by Q4. 3. By April 2019.	n/a
	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	51154*									Determining data collection methods and feasibility during 2019/20 year

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		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	54272*									Determining data collection methods and feasibility during 2019/20 year
		Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan (BPMDP) was created as a proportion the total number of	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / October - December 2018	938*	51	75	Previous year's target was not met; goal is to achieve target set in previous year.		1. Identify a strategy to ensure all patients have completed BPMDP upon discharge.	1. Develop and implement discharge order set that includes BPMDP. 2. Collaborate with Discharge Coordinator and Acute Care Team Leader to develop and implement process to ensure copy of BPMDP is left on patient chart following discharge.	1. Number of patients with discharge order set used. 2. Process implemented for ensuring copy of BPMDP remains on patient chart following discharge.	1. >75% 2. By April 2019.	n/a
		Proportion of hospitalizations where patients with a progressive, life-threatening illness have 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	938*									Determining data collection methods and feasibility during 2019/20 year
		Rate of mental health or addiction episodes of care that are followed within 30 days by another mental health and addiction admission.	P	Rate per 100 discharges / Discharged patients with mental health & addiction	CIHI DAD,CIHI OHMRS,MOHTLC RPDB / January - December 2017	938*									Not applicable; no inpatient mental health & addiction services
		Percentage of clients who die at home who choose home as a preferred location	A	Rate per total number of palliative clients who choose home as a preferred location	Local data collection / Most recent 6 month period	938*	79	85	Provincial	CELHIN Home and Community Care	1. Work with community partners to identify gaps in service that prevented this from occurring.	1. Chart review and community consultation through community palliative rounds. 2. Increase early identification and referral to PCCT. 3. Increase percent of patients discharged home with support. 4. Formal communication to referral sources (PCP, HCC, Visiting Hospice) inviting early identification.	1. Number of PCCT client charts reviewed. 2. Number of palliative clients referred to PCCT. 3. Number of patients discharged home from ED or Acute Care with home support for palliative care.	1. 100% 2. >70% 3. >90%	n/a
		Percentage of unscheduled ED visits for mental health and/or addictions	A	Rate per total number of Community Mental Health program clients	Local data collection / Most recent 6 month period	938*	8.2	5	Internal target; second year of tracking this indicator; goal is improvement over current performance	Haliburton Highlands Family Health Team	1. Develop a strategy to improve referrals to and follow up by Community Mental Health program to help avert potentially avoidable ED visits.	1. Implement a Health Links approach to coordinated care planning for eligible patients and clients. 2. Implement a common referral form and process for health service providers in the community.	1. Number of Coordinated Care Plans for Community Mental Health clients. 2. Number of referrals received that result in follow-up and Coordinated Care Plan.	1. >75% 2. >75%	n/a
Equity	Equitable	Number of telemedicine visits for persons requiring out-of-town consultations	A	Count per quarter / persons requiring out-of-town consultations	Local data collection / October - December 2018	938*	375	400	Internal target, with goal of increasing visits over previous year and improving current performance	Haliburton Highlands Family Health Team	1. Develop strategies for increasing referrals to telemedicine service.	1. Collaborate with Ontario Telemedicine Network to explore feasible areas for expansion of this service in Haliburton County, including the possibility of provision of virtual services in areas such as the ED. 2. Consolidate telemedicine consultations at Haliburton Highlands Family Health Team (FHT) with HHHS. 3. Develop patient story related to telemedicine use, to use as part of communication strategy and community education about the service.	1. Number of additional consultation types our sources added. 2. Number of FHT telemedicine visits consolidated with HHHS. 3. Patient story developed and published.	1. 5 2. >50% 3. By December 2019.	n/a