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

Haliburton Highlands Health Services Corporation 7199 Gelert Road, P.O. Box 115, Haliburton , ON, K0M1S0

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**	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 / Jul 2019 - Sep 2019	938*	37.33	37.33	Maintain; current performance is lower than previous years, and it is not yet known whether this can be sustained	CELHIN Home and Community Care	1)Improve discharge planning processes to decrease potential for ALC designation.	1)Initiate discharge planning within 48 hours of admission 2) Involve family and patient as well as Home and Community Care Coordinator in weekly ALC review (TRAC) 3) Implement discharge rounding initiative 4) Explore opportunities to leverage HHHS Community Programs to help support patients to return home to await LTC placement, when able	1)Discharge planning initiated within 48 hours of admission for all patients by January 2021 2) ALC reviews occurring weekly by Dec 2020 3) Discharge rounding 3 times per week for 100% of patients by December 2020 4) Hospital leadership team to meet with Community Programs leadership to identify strategies for linking potential ALC patients with Community Programs	1)100% by January 2021 2) 100% of ALC patients being reviewed weekly by December 2020 3) 100% of patients being reviewed on discharge rounds 3 times per week by December 2020 4) Leadership teams to hold initial discussions by November 2020, and identify at least one strategy by January 2021	
Theme II: Service Excellence	**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	938*	CB	100.00	All complaints received by the hospital within the reporting period Current Performance= 100% Maintain; current performance is based on complaints in central repository only; it is not yet known whether complaints that haven't been		1)Ensure all patient / client complaints are captured within a central repository to enable analysis, trending, and tracking of complaints	1) Improve complaint documentation form by including sign-off sections for all management levels 2) Provide training to management team on documentation process for complaints	1) Form to be revised by September 2020 2) All managers in clinical / client-facing areas to receive training on process for addressing and documenting complaints	1) Complete by September 2020 2) 100%, by December 2020	LTC homes will be excluded from this initiative, as a separate process is used as per the LTCHA; based on past and current performance, both LTC homes are performing well in terms of following up on complaints.
		Percentage of residents responding positively to: "What	P	% / LTC home residents	In house data, NHCAHPS survey / April 2019 –	51154*	CB				1)				Not submitting this indicator.
		Percentage of residents responding positively to: "What	P	% / LTC home residents	In house data, NHCAHPS survey / April 2019 –	54272*	CB				1)				Not submitting this indicator.
		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 2019 - March 2020	51154*	CB	85.00	Current Performance is 79% Source also includes Government of Saskatchewan/ April 2029-20 Current Performance= 79% (%/LTC Home Residents) Improve current performance.		1)Improve resident and family engagement to help build trust by creating opportunities for partnership and collaboration within the LTC home	Regular leadership participation in Family Council meetings, including opportunities to identify improvement ideas, establish plans for change, and evaluate change (request same approach at Resident Council meetings)	1) % Family Council meetings attended by leadership 2) % Resident Council meetings attended by leadership 3) Participation of residents and families in at least one change imitative	1) 100% 2) 80% 3) One initiative by March 2021	1) The action plan created following the Highland Wood roof incident to be used as a starting point for improvement ideas 2) Opportunities for engagement of residents and families are somewhat limited (although still possible) due to the COVID-19 pandemic

		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 2019 - March 2020	54272*	CB	85.00	Current Performance=83 % Improve current performance		1)Improve resident and family engagement to help build trust by creating opportunities for partnership and collaboration within the LTC home	Regular leadership participation in Family Council meetings, including opportunities to identify improvement ideas, establish plans for change, and evaluate change (request same approach at Resident Council meetings)	1) % Family Council meetings attended by leadership 2) % Resident Council meetings attended by leadership 3) Participation of residents and families in at least one change imitative	1) 100% 2) 80% 3) One initiative by March 2021	1) The action plan created following the Highland Wood roof incident to be used as a starting point for improvement ideas 2) Opportunities for engagement of residents and families are somewhat limited (although still possible) due to the COVID-19 pandemic
		Percentage of respondents who responded "completely" 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 12 months	938*	CB	66.00	In house data - Accreditation Canada Client Experience Survey - Inpatient-Outpatient / Jan 2019 - Dec 2019 Current Performance 64% Improve current performance	Haliburton Highlands Community Programs, Central East Local Health Integration Network, Haliburton Highlands FHT	1)Select new survey tool and revise survey methodology	Acute care team to review survey for content, and revise methodology	1) New survey selected; survey methodology revised and implemented 2) New survey methodology implemented: Patients to be contacted post discharge and offered opportunity to complete patient satisfaction survey (to be sent via email or post)	1) New survey tool identified and implemented by January 2021 2) 80% of patients contacted after discharge by March 2021"	Note: review of survey will consist of reviewing relevance of current survey and other available surveys, and replacing current survey with a more relevant tool (a valid and reliable tool approved by Accreditation Canada)
Theme III: Safe and Effective Care	**Effective**	Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / Oct 2019– Dec 2019 (Q3 2019/20)	938*	CB	75.00	Current Performance= 64% (Rate per total number of discharged patients/discharged Patients) In house collected data / Jan 2019 -		1)Improve medication reconciliation process at discharge by ensuring all patients have a Best Possible Medication Discharge Plan (BPMDP) completed prior to discharge	1) When discharge date is known, nurse assigned to patient completes BPMDP with physician input 2) Nurse assigned to patient on day of discharge to ensure a copy of the BPMDP is made for the patient record	1) All patients have a BPMDP on their patient record at time of discharge 2) Chart audits to be completed weekly by Discharge Coordinator to track completion of BPMDP	1) 100% 2) 100% of charts of discharged patients reviewed weekly	
		Percent of unscheduled repeat emergency visits within 30 days following an emergency visit for a mental health condition (HALIBURTON)	C	% / All Mental Health Clients accessing ED	NACRS, CIHI, Health Analytics Branch, MOH / Apr 2019 - Jun 2019	938*	10	10.00	HSAA target is 16.3%	RAAM Clinic, Point in Time, Haliburton Highlands FHT	1)Increase knowledge and support for ED staff regarding care of persons with mental health conditions, and improve referral process to Community Mental Health program.	1) Provide training for Acute Care BSO Nurse to be able to complete mental health intake assessments in the ED, to facilitate access to community mental health services for follow up 2) Develop and implement an education binder for staff, that also contains all the necessary mental health forms and processes for staff to easily access	1) Three day training of BSO Nurse to be completed by January 2021 2) Binder to be developed and implemented by March 2021	1) Training complete by January 2021 2) Binder implemented by March 2021	Note: Increasing referrals from ED to the HHHS Community Mental Health Program is also a priority however we are currently exploring ways to efficiently track this process; if an efficient method can be identified, this will be added as a change initiative for 2021/22

		Percent of unscheduled repeat emergency visits within 30 days following an emergency visit for a mental health condition (MINDEN)	C	% / All Mental Health Clients accessing ED	NACRS, CIHI, Health Analytics Branch, MOH / Apr 2019 - Jun 2019	938*	8.7	10.00	HSAA target is 16.3%	Haliburton Highlands FHT, RAMM Clinic, Point In Time	1)Increase knowledge and support for ED staff regarding care of persons with mental health conditions, and improve referral process to Community Mental Health program.	1) Provide training for Acute Care BSO Nurse to be able to complete mental health intake assessments in the ED, to facilitate access to community mental health services for follow up 2) Develop and implement an education binder for staff, that also contains all the necessary mental health forms and processes for staff to easily access	1) Three day training of BSO Nurse to be completed by January 2021 2) Binder to be developed and implemented by March 2021	1) Training complete by January 2021 2) Binder implemented by March 2021	Note: Increasing referrals from ED to the HHHS Community Mental Health Program is also a priority however we are currently exploring ways to efficiently track this process; if an efficient method can be identified, this will be added as a change initiative for 2021/22
	Safe	**Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.**	**M A N D A T O R Y**	**Count / Worker**	**Local data collection / Jan - Dec 2019**	**938***	**1**	**15.00**	**Current performance raises concerns of under-reporting; increased target is an estimate, based on anticipated increase in reporting following staff education and other interventions**		**1)Ensure a clear reporting method exists for WPV and staff are aware and find value to reporting / culture 2) Create methods for sharing data and action plans to address reported incidents 3) Explore possible solutions for providing security on site after hours**	**1) Review and improve reporting tools/ methods and provide training for staff 2) Include this report in management/ staff meetings 3) Survey regional and small hospitals to determine possible security solutions / practices**	**1) Reporting process reviewed and process modified if needed 2) Staff education completed 3) Management team and staff meetings / huddles include WPV reporting 4) Survey of security services at regional and small hospitals completed**	**1) Review and revisions completed by January 2021 2) 80% of staff will receive report training by March 2021 3) WPV reporting added to management team agenda by December 2020; WPV reporting reminders and discussion added to staff huddles by January 2021 4) Security services survey completed by November 2020**	**HHHS will also track number of WPV incident reports from all HHHS staff**
		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?"	C	% / All Staff	Work Life Pulse Survey / Apr 2018 - Mar 2019	938*	69.4	72.00	Maintain / improve current performance; national average is 66%		1)Obtain up-to-date staff satisfaction data (last survey completed in 2018)	1) Obtain up-to-date staff satisfaction data 2) Identify strategies for engaging staff in pandemic response and other improvement initiatives 3) Identify and implement at 'pandemic friendly' staff recognition initiatives	1) Complete Work Life Pulse Survey by December 2020 2) Staff from each program area engaged in at least one group or activity to provide input to pandemic response 3) At least two initiatives implemented across all areas of HHHS	1) Survey completed by end of December 2020 2) All programs to have engagement activity in place by September 2020 3) Two initiatives implemented by September 2020	Include some psychological safety and communication questions in Work Life Pulse survey
Equity	**Equitable**	Number of telemedicine visits for persons requiring	C	Count per Quarter / Persons	In House Data Collection / Jul 2019- Sep 2019	938*					1)				Not submitting this indicator.
		Percentage of clients who respond positively to the question, "I was told about other programs and services at CSS that might meet my	C	Count per quarter / Clients access to community services	In house data collection / 2020-21	938*	49	75.00	Improve		1)Ensure all clients receive a comprehensive intake, assessment, and service plan discussion within 2 weeks of initial service connection.	1) Review central intake and assessment process 2) Embed valid and reliable assessment tools (i.e., interRAI screener) in new community programs Information system	1) All new referrals to CSS will receive a full intake and assessment 2) Existing clients receive an annual review and reassessment	1) 100% 2) 100%	