Let's Make Healthy Change Happen.

Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

St. Joseph's Continuing Care CCC 2019-2020

CENTRE DE SOINS PROLONGÉS
ST. JOSEPH'S
CONTINUING CARE CENTRE

3/29/2019

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a Quality Improvement Plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein.

Ontario

Overview

Our organization will focus its efforts in the dimensions of Efficiency, Effectiveness, Timeliness, and Safety.

Our focus in the dimension of Safety will be the monitoring of Workplace Violence and although we are a sub-acute facility, and the incidents are few, we as an organization need to be aware of the growing number of incidents in the health sector.

We will continue our focus in the Efficiency dimension, namely to increase our patients' access to the right level of care. Our ability to maintain our ALC numbers under control directly affects our ability to support our community by improving patient flow.

We have added two new dimensions in this year's QIP submission including Timeliness whereby Expected Date of Discharges are measured and the dimension of Effectiveness whereby medication reconciliations at discharge are measured.

Describe your organization's greatest QI achievement from the past year

Our greatest achievement from the past year revolves around our ALC population. Last year we were averaging a rate of 21% when measuring our ALC days to total inpatient days. We not only surpassed our target of 19% we are currently measuring 13.8%. The strengthening of our admission process and criteria was a huge contributing factor to this success along with a pilot program which saw an Outreach Team identify opportunities and "out of the box thinking" for patient transitions.

Patient/client/resident partnering and relations

We feel that the surveys are a great tool in capturing the patients voice. More specifically we currently use a post-discharge survey which asks the patient "Please share any challenges/difficulties you may have encountered in the few weeks after leaving our hospital". The survey which is completed by phone includes plenty of opportunity to have the patient share more than the standard responses. We follow up by understanding how we could have addressed the situation better or differently. This feedback is brought forward for review and discussions in an effort to improve our services.

Our intentions are to increase the patient's perspective by identifying committees where a patient's view would be crucial. This will be developed in the coming year.

Workplace Violence Prevention

Workplace violence prevention is monitored and presented by the Joint Health and Safety Committee. A Workplace Violence Prevention Programme is in place defining behaviour that constitutes workplace violence and defining procedures for reporting and resolving incidents of workplace violence.

Executive Compensation

The hospital has only one executive position; namely the Executive Director (ED). The ED is the chief administrator of both the hospital operation and the long-term care operation. For the fiscal year 2019-2020 a percentage of the annual base of the ED (3%) as determined by the Board of Directors, will be linked to the achievement of targets set out in the QIP.

Contact Information

Gizanne Lafrance-Allaire
Executive Director
613-933-6040 ext 21189

Sign-off

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan

Board Chair _____ (signature)
Board Quality Committee Chair _____ (signature)
Chief Executive Officer _____ (signature)
Other leadership as appropriate _____ (signature)

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

Hotel Dieu Hospital - Cornwall 840 McConnell Avenue

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)															
		Total number of alternate level of care (ALC) days contributed by ALC patients within the	P	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July - September 2018	644*	13.8	11.00	Continue with a strong referral on-site patient assessment.		1)Outreach team initiative was very successful but funding ended March 31, 2019. We need to continue some form of Team to help	The Outreach Team identifies early in the process challenging discharges. Working with the family / care giver early in the process ensures a discharge location has been identified.	Weekly review of discharge plans for the challenging discharges identified.	11.0 percent is the rate of inpatient days over all inpatient days.	A significant improvement has been made over the year.
		The rate at which the patients achieve their Expected Date of Discharge (EDD).	C	% / Discharged patients	In house data collection / 2019	644*	90	92.00	We are in the early stages of measuring this metric.		1)The involvement of the multi-disciplinary team in the management of patient EDD goals.	Multi-disciplinary team reviewing on a weekly basis the probability of achieving the EDD goal and intervening when EDD is in jeopardy.	% of patients achieving established EDD.	92% of patients to achieve their established EDD.	In a sub-acute environment the EDD metric drives operational
Theme III: Safe and Effective Care	Effective	Medication reconciliation at discharge: Total number of discharged patients	P	Rate per total number of discharged patients / Discharged	Hospital collected data / October - December 2018	644*	CB	95.00	Being a sub-acute hospital discharge process allows for proper		1)To maintain current process but focus on quality of information.	Tracking to be done through discharge checklist.	# of patients discharged with medication discharge plan/total # of patients discharged.	95% of all discharged patients are discharged with a medication plan	Maintaining the current rate will be key.
	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	644*	X	5.00	Sustaining our current level of success.		1)Continued emphasis on Gentle Persuasive Approach (GPA) training and include a full review of all incidents by the Leadership Team.	Continue with the yearly education days to targeting GPA training. Review of all incidents a the bi-monthly Leadership meetings.	# of workplace violence incidents per year.	A maximum of 5 workplace violence incidents in the fiscal year.	FTE=40