2019-20 Quality Improvement Plan for Ontario Hospitals
Improvement Targets and Initiatives

Hamilton Health Sciences | Hamilton, ON

AIM		Measure								Change				
Issue	**Quality Dimension**	**Measure/Indicator**	**Type**	**Unit / Population**	**Source / Period**	**Baseline 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	**Timely**	Time to Physician Initial Assessment (PIA) 90th percentile: the time interval between registration/triage time in the Emergency Department (ED) to the time an ED physician assesses the patient.	Custom	Hours / ED all patients	CCO iPort / FY 2018-19	3.6 h (Dec 2017 - Nov 2018; will be updated once FY 2018-19 completed)	3.2 h by Q4	Provincial median for teaching hospitals increased to 3.35h. Continue to aim for 3.2h target set for FY18-19 by Q4.		1. Monitor variation in PIA time to identify opportunities for improvement related to advancing the ED tracker. 2. Investigate scheduling software to align demand with capacity. 3. Continue to pursue site-specific root causes to reduce PIA time.	1. PIA reports sent to individual ED physicians as part of overall practice analysis. 2. Compare patterns of times that ED patients are ready to be seen versus resources scheduled. 3. Site Innovation & Learning committees monitor work plans to address flow.	1. Percentage of reports sent quarterly. 2. Investigation into scheduling software completed.	1. 100% 2. Analysis and investigation completed by Dec 2019	
		Time to inpatient bed 90th percentile: the time interval between the disposition date/time and the date/time patient left the Emergency Department for admission to an inpatient bed or operating room.	Mandatory	Hours / All patients	CIHI NACRS / October 2018 – December 2018	26.3 h (Dec 2017 - Nov 2018; will be updated once FY 2018-19 completed)	3% relative reduction from final FY18-19 performance	A 3% improvement from full-year baseline will be a stretch target given that this is a system indicator.	This is an indicator of system performance so external collaborations with Home & Community Care and Transitional Bed providers is important to minimize ALC and ensure bed capacity exists.	1. Reduce bed empty time (time from patient leaves bed after discharge to time new admitted patient is in cleaned bed). 2. Continue to improve the triggers and responses within the overcapacity protocol.	1. Follow problem solving methodology to define the problem, collect baseline data, understand the current state, identify root causes, and determine changes that can be made that would result in improvement. 2. Internal protocol exists to identify site status related to flow. This work will continuously improve over time as triggers and responses are updated. Responding early to inpatient bed pressures helps to prevent outliers in the time to inpatient bed. This is counter-balanced by the number of patients receiving care in unconventional spaces.	1. Bed empty time 2. Number of patients receiving care in unconventional spaces	1. Baseline not yet collected; aiming for a significant reduction after process changes implemented 2. No statistically significant increase to baseline (HQO provided baseline for Oct-Dec 2018 of 113.23 patients)	HGH made significant improvement in time to inpatient bed in 2018-19; aiming to hold gains made there.
Theme II: Service Excellence	**Patient-centred**	In-house survey: % of patients rating their Overall Patient Experience at 8 or greater (on 10 point scale).	Custom	% / inpatients, outpatients and emergency	In-house survey FY 2018-19	86.3% (Apr-Dec; will be updated once FY 2018-19 completed)	86%	Continuous improvement target over time; increasing by 1% each year		1. Expand patient and family engagement efforts 2. Hear the Patient and Family Voice to inform improvements	1a. Continue to recruit patient and family advisors to support quality improvement work and committees across HHS 1b. Enhance leadership development in leading Experience Based Co-design through the Centre for People Development workshops 1c. Increase the number of hours patients and families are included in quality improvement opportunities or standing committees 2a. Continue ongoing Patient Experience survey collection across HHS with quarterly reporting to inform improvement opportunities 2b. Develop and implement storytelling process to learn from patients/families	1a. # of Patient and Family Advisors 1b. # of workshops offered in 2019/20 1c. # of hours patient and family advisors engaged in improvement opportunities 2a. # of quarterly Patient Experience Survey reports provided 2b. # of stories shared	1a. 50 1b. 2 1c. 400 hours 2a. 4 2b. 4	
Theme III: Safe and Effective Care	**Effective**	Percentage of discharged palliative care patients with an ED visit to any ED in HNHB LHIN within 30 days of acute care discharge from HHS.	Custom	% / discharged from JH, HGH or WLMH with Z51.5 as a diagnosis code.	Integrated Decision Support (IDS) database / 3.5 year baseline Apr 2015-Sep 2018	11.9%	11.3% (5% relative reduction)	Target represents a 5% relative reduction from baseline.	Work in 2019-20 will enable future collaboration with family medicine in community setting to prevent return ED visits.	1. Build capacity of staff and physicians through LEAP training (Learning Essentials Approaches to Palliative and End of Life Care). 2. Integrate indicator into CQI units	1. Conduct LEAP education sessions for staff and physicians. 2a. Stratify palliative discharges by unit and use Pareto principle to select high-discharge units. 2b. For these select units, use CQI tools such as status sheet, catch ball, and leadership teams to prioritize early palliative approaches and understand root causes to revisits to ED after discharge.	1. Number of training sessions completed. 2. Number of CQI units using CQI tools to focus on early palliative approaches.	1. 3 by March 2020 2. 4 units by March 2020, depending on results of Pareto chart.	Work in 2019-20 will enable future collaboration with family medicine in community setting to prevent return ED visits.
		Medication reconciliation at discharge: The total number of patients with medications reconciled at discharge (in selected units) as a proportion of the total number of patients discharged from those units. Numerator: Across all selected units, sum the number of patients with medications reconciled at discharge. Denominator: the total number of patients discharged from the units.	Priority	% / All patients in selected units	Hospital collected data / most recent quarter available	53% (Apr - Dec 2018 on selected units; will be updated once FY 2018-19 completed)	10% absolute increase over baseline by Q4	Improvement target same as in previous years.		1. Continuously improve process for medication reconciliation (Med Rec) on discharge within focus units. 2. Education for Med Rec on discharge and implementation with each focus unit. 3. Audits for Med Rec both on admission and discharge on focus units to sustain or monitor improvement.	1. Review of current processes for Med Rec on discharge, on each focus unit to determine opportunities for improvement 2. Continue implementing education plan developed for Med Rec on discharge on focus units for nursing, pharmacy and physician team members 3a. Complete new baseline audit at end of Q4 2018-19 for proportion of Med Rec on discharge across focus units 3b. Audits completed quarterly for focus units - Med Rec on discharge rate calculated for each unit 3c. Audit results reported back to Clinical Manager/Med Rec leads to work with team to improve or sustain uptake of Med Rec on discharge process	1.Percentage of focus units that have Med Rec discharge process reviewed for improvement opportunities 2. Percentage of nursing, pharmacy and physician team members new to clinical units that have received education on Med Rec on discharge 3a. Percentage of baseline audit for focus units complete by April 2019 3b. Percentage of focus units audited for Q2, Q3, and Q4 3c. Percentage of units with audit result report for Q2, Q3 and Q4	1. 50% 2. 100% 3. 100% for all	
	Safe	Overall reported incidents of workplace violence	Mandatory	Number of reported workplace violence incidents (reported by hospital workers within a 12-month period)	Internally collected data / Calendar year Total number of hospital employee full-time equivalents (FTE) at HHSC: 9,463	590 (CY 2018)	649 (CY 2019)	10% higher than 2018 baseline due to likely increase in reporting with increased awareness and availability of tools.		Patient Behaviour Safety Risk (BSR) Protocol	1a. Implementation of BSR Protocol across Children's Hospital and Ron Joyce Children's Centre 1b. Continuation of training for designated staff 1c. Ongoing evaluation of BSR protocol related to perception of safety, knowledge, and ease of use by staff to inform continuous improvement cycle and evaluate uptake and outcomes of BSR implementation	1. Percentage of units across HHS with successful roll out of BSR protocol 2. Percentage of designated employees trained/educated in BSR protocol 3. Percentage of BSR screening completed	1. 100% of EDs and identified in-patient units implement BSR protocol 2. 90% designated staff trained/ educated in BSR protocol 3. 85% of ED patients have BSR screening completed	Long-term goal for training/ educating staff as well as screening ED patients is 100%. Interim goals are stated for this year.
		Lost Time Injury Rate	Custom	The number of lost time injuries (including illnesses and exposures) per 100 insured workers	Internally collected / Apr 2018 - Mar 2019	0.89 (Apr-Dec; will be updated once FY 2018-19 completed)	5% relative reduction from final FY18-19 performance	HHS' performance is in-line with experience for Hospitals' Rate Group. A 5% reduction from final 18/19 rate strives towards a realistic improvement.		Musculoskeletal disorder prevention	1a. Continued support to high injury units in development and implementation of action plans 1b. Implementation of training for designated units 1c. Continue to promote video-based usage and participation in hands-on training in Health Professional Orientation 1d. Implement and promote new MSD prevention eLearning program	1. Number of employees participating in hands-on patient handling training for HPO 2. Number of employees receiving hands-on patient handling training for high injury units 3. Units completing action plans and implementing recommendations 4. Number of employees completing MSD prevention eLearning	1. 75% of identified roles participate 2. 90% participation 3. 100% needs assessments completed for participating high injury units 4. 70% staff completion	