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

Royal Ottawa Health Care Group 1145 Carling 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)															
Theme I: Timely and Efficient Transitions	**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	651*	CB	CB	This indicator is new and the target will be set based on results of baseline review.		1)1) Engage programs and departments to set baseline measurements for discharge reports 2) Collaborate with Clinical Records on an approach to meet targets 3) Investigate new E.H.R. tools	Quarterly reporting of discharge plans and those sent to the community physician	# of discharges and % of plans available within 48 hours	The target for process measures will be determined as part of the review.	This is a new indicator and the process is under review. A target will be set based on the outcome of the review.
		Reduce Wait Times in Mood and Anxiety Outpatient Services	C	Days / Mental health patients	In house data collection / FY2018-2019	651*	223	90.00	Realign wait time targets with entire service functioning as a whole.		1)1) Realigning the MAP vision to focus on the needs of clients and families and to address identified gaps in mood and anxiety services within the Champlain LHIN 2) Implement recommendations from the MAP Program developement project (AFP) 3)Leverage partnerships to create a stepped care model based on the needs of clients and families as well as align with other provincial resources	Develop a workplan and engage the teams as part of the initiatives listed above.	Process measures will be develop out of the above work.	Targets will also be set with the ambitious goal of decreasing wait time to 90 days.	
Theme II: Service Excellence	**Patient-centred**	Resident Experience "Overall Satisfaction"	C	% / Residents	In house data collection / 2018-2919	54482*	54	70.00	Based on the results from last calendar year 54% of residents completed the		1)1) Improve response rate by moving the survey to June and increasing education on the importance of the survey	Work with the resident council and volunteers to promote the new time of year for the survey.	# of surveys provided and the # of surveys returned	Ensure that 100% of residents that are able have an opportunity to complete the survey	
		Resident Experience "Overall Satisfaction"	C	% / Residents	In house data collection / 2018-2019	54482*	91.7	92.00	Maintain the overall positive nature of the responses, but also review the %		1)1) Maintain overall satisfaction but improve the % of good to % of very good 2) Shorten survey and create a 1 question follow-up study	1) Focus group with resident council and review specific questions on the survey 2) Implement the new Feedback system from Datix and continue to track issues, and positive feedback	# of surveys provided and # of surveys returned, # of good and # of very good responses	Ensure that 100% of residents that are able have an opportunity to complete the survey	
	Patient-centred	Percentage of complaints acknowledged to the individual who made a complaint within five	P	% / All patients	Local data collection / Most recent 12 month period	651*	CB	CB	We will be collecting baseline data to begin. The expectation is that all		1)1)Learning session for leaders 2) Update of feedback system to Datix software	1) Quarterly feedback on % resolved within target 2)Customer Service connections with new Communication team connections	1) % Managers & Directors completed learning session 2) Increase number of programs at 80% within 6 months	The target for the process measures will by 100% of Managers and Directors	In alignment with Accreditation priorities
		Satisfaction with Services: Ontario Perception of Care Survey response to Q31: "I think the services provided here are of high quality"	C	% / Mental health patients	OPOC-MHA Question 31 / May, November 2019	651*	83	87.00	Return to a level of 87% combining inpatient and outpatient survey results		1)1) Work across teams to improve customer service and bring forward change ideas 2) Engage clients and families to further enhance services	1) OPOC - 31, May and November results 2) Investigate the implementation of the Family focused OPOC in May 2019	Continue to track Q31, and connect with our peers that are reviewing this question	Connect with peers through the MHAQI group to better understand and streamline process measure	
Theme III: Safe and Effective Care	**Effective**	Percentage of residents with worsening bladder control during a 90 day period	C	% / Residents	CIHI CCRS / 2018-2019	54482*	13	9.00	Continue with multi-year approach bringing ROP-LTC closer to target Improvement based on average from last year		1)1) Continue to identify our residents with recurring urinary tract infections and implement interventions 2) Nursing is utilizing the bladder scanner more frequently to determine need for in/out catheterization 3) Resident specific toileting plans and interventions discussed at huddles	Increase understanding of current coding practices regarding worsening bladder control & provide timely feedback to the front line staff.	# patients that are amenable to a having toileting plan that actually have a plan/#worsening bladder control patients.	Goal is 100% of patients	A good number of our patients, due to their illnesses, may experience worsening continence.
	Effective	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 OMHRS,,MOHTLC RPDB / January - December 2017	651*	9.91	10.00	There has been a slight increase in this indicator over the last few months and our goal is to keep it under 10. This value also aligns with our strategic plan.		1) Review Data from CIHI that should be available in February 2) Engage with community partners to determine improvement ideas 3) Discharge planning improvements and reporting 4) We will investigate discharge plans that result in readmission and follow-up with the programs.	Quarterly reporting of discharge plans and tracking of care transitions	# of discharge plans and readmission rates	We will investigate discharge plans that result in readmission and follow-up with the programs.	Review the RNAO Best Practice to ensure alignment.
	Safe	Hand Hygiene including Residents	C	% / Residents	In house data collection / 2019-2020	54482*	CB	CB	New indicator which we will establish in Q1. Baseline testing quarterly audits		1)1) Improve resident engagement with staff training and resident education 2) Involve Infection Control Nurse to train on proper hand hygiene	Education and resident engagement to improve overall hand hygiene in the facility, reduce potential outbreaks	Quarterly audits on the 3rd floor, number of outbreaks	Targets will be established following initial audits, expectation of 0 outbreaks	
		Prevalence of falls in the quarter as a percentage of residents	C	% / Residents	CIHI CCRS / 2018-2019	54482*	13	12.00	Based on average of last 6 quarters, 1% decrease		1)Continue with the Falls Prevention Project	1) Team audits post fall assessments and trains staff as required. 2) Interventions are reviewed and modified if required. 3) Post fall huddles are done and documented with team and resident after fall on unit. 4) QI Team and PT continue to review at resident use of PASD (weighted	Resident Falls reported in Continuing Care Reporting System (CCRS) and The Royal's Incident Management System (CSIP)	All incidents to be reported	
	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**	**651***	**772**	**772.00**	**The current performance is based on a forecast as we wait for final review of Q4 numbers. We want to increase reporting, but**		**1) Increase Near Miss Reporting 2) Ensure staff are using the new Client Staff Incident & Feedback (CSIF) system 3) Continue to work with staff and clients to reduce critical events**	**Continue working with Workplace Violence committee (WPV), engage staff in initiatives to increase near miss reporting**	**% of Threat, Assault, Agression Incident reports (broken down by actual and near miss reporting)**	**100% of all units have education session and poster for promotion**	**FTE=1111 Continue to work on the reporting culture while focusing on decreasing the number of critical incidents. We expect this**
		Medication reconciliation at admission (Outpatient): # of Med Rec completed / total number of patients where med rec is	C	% / Mental health patients	In house data collection / June 2019 - March 2020	651*	CB	CB	New E.H.R. system will update how we complete, track and calculate the # of Med Rec completed. Med		1)1)Work with physicians in clinics without regulated health professionals assigned to patients. 2) Develop processes in each clinic	MAC through the Pharmacy & Therapeutics to commission small work group	% patients who meet definition receive med rec in the out patient population	TBD based on baseline data	Project to follow the E.H.R. implementation and improve from the calculated baseline
		Number of lost time claims related to workplace violence events	C	Rate per 100 / Worker	In house data collection / FY2018/19	651*	0.17	0.17	Sustain for current year and compare with peers in 2019-20		1) Engage clients, JOHSC, WPV committees for ideas	Using principles of co-design, work with clients/families to plan and implement improvement strategies	% of Threat, Assault, Aggression reports (broken down by actual and near miss reporting)	100% of all units have education session and poster for promotion	
		Restraint Use - The number of hospital patients who were physically restrained at least once in the 3 days prior to a full admission assessment, divided by all patients	C	% / Mental health patients	CIHI OMHRS / 2018-2019	651*	4.1	3.00	Target aligned to that of the Royal's strategic plan at 3%.		1)1) Create connections between old intervention and new workflows in the new E.H.R. 2) Determine new workflows to capture data that leverages the new E.H.R. release in June 2019	1) Create work-group to consider at one program level: Is client assessment / potential for restraint and triggers documented on the crisis prevention plan comfort care plan 2) Create a work-group at one program level to assess: Was debrief post untoward event - was comfort care plan followed? - need update	1) Determine appropriate process measures using the new Meditech System. 2) Look at potentially updating targets with data directly from EMR interventions	Expect to have process measures available by Q2	
		WSIB days lost related to workplace violence events	C	Rate per 100 / Health providers in the entire facility	In house data collection / Q4 2018/19	651*	6.1	0.25	The goal is to return to target once the time lost due to a specific incident is past.		1)1) Understand the issues related to specific events that can effect this indicator 2) Investigate a simulation exercise to enhance safety practices	Workplace violence simulation exercise, working with the workplace violence committee. Note: target will be affected by past incidents	Using principles of co-design, work with clients/families to plan and implement a simulation	Goal will be to have at least 1 simulation event and involve CAC/FAC in the design of other initiatives.	