2017/18 Quality Improvement Plan
"Improvement Targets and Initiatives"

Sault Area Hospital 750 Great Northern Road

AIM		Measure							Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Effective	**Effective transitions**	30 Day Readmission for Mental Health and Addictions	% / Mental health patients	CIHI OMHRS / Q4	965*	24.7	17.00	Moderate improvement goal with objective of re-attaining F2014/15 performance. Q1 Target = 23%, Q2 Target = 21%, Q3 Target = 19% & Q4 Target = 17% Based on our ">=25beds" peer group in OMHRS. OMHRS reports with identifiable hospitals are only available quarterly, not YTD so a full year cannot be determined for non-SAH sites. Based on 16/17 Q2 data.	1)Ensure all patients have a Primary Care Physician. This is supported by early data for high users. In addition, individualized follow up treatment plan in place for those with frequent admissions.	High needs patient data reviewed by the Mental Health case reviewer and clerk with primary care.	Running case load data to determine who meets the need of receiving a primary care provider and contacting patients to direct how to register for Health Care Direct, as well as providing onsite support. For the high users, we are working with the family health teams, most specifically the Superior Health Team to advocate for the patients and match needs.	Quarterly metrics to be received from decision support. These reports also include any patients that currently do not have a health care provider. Those will be processed as per the plan.	
									2)In partnership with community enhance Day Program, submission and approval of new medical model for withdrawal management.	1) Community partnership for a new 13 bed new Housing Project with daily supports to address complex and difficult to serve individuals. 2. Submission and approval of Enhanced Withdrawal Management Services, Co-location of Mental Health and Addiction Services, and the development of Concurrent Day/Evening Program. 3. Withdrawal Management/EMS Diversion Project for Alcohol and Substance Use for those not requiring medical care.	1) Business Case in draft, led by CMHA, APH, DSSAB and SAH, completed in March 2017. 2. Submission of business case by SAH to the LIHN 3. Proposal submitted and approved by Ministry of Health in 2016.	1) Business case to be submitted in Q1. 2. To be submitted in Q2. To start in Q2/3.	
									3)Adjust psychiatrist inpatient model, improve communication between psychiatrists and multidisciplinary care team regarding the plan of care and discharge treatment plan.	Physician retreat was held in December 2016. An inpatient model will be developed and will impact communication, plan of care and discharge planning.	Psychiatrist group to develop an inpatient model to improve communication and discharge planning. New model of multi-disciplinary rounds have been implemented and efficiency of plans are being monitored and adjusted to help streamline patient flow.	Model discussion planning to occur in Q1 with implementation in Q2.	
									4)Expansion of CCRT (Community Crisis Response Team) program with Sault Ste. Marie police services. Additional funding would allow for two crisis workers and two police officers to respond proactively to community crises. A coordinated effort would allow for the formulation of a plan, utilization of police in potentially unsafe situations and ensure multi service providers are aware of a plan which would reduce duplication of service referrals and improve continuity of care.	Business case submitted to the NELHIN in March 2017.	1) Expand CCRT to do more follow up/coordination of care for recently discharged patients. 2) CCRT will utilize outpatient service providers for intervention rather than ED. 3. CCRT will improve utilization of case management services.	Hospital readmissions within 30 days will be reduced.	

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		Employee engagement	% / Survey respondents	NRC Picker / February 2018	965*	61	66.00	Achievement of the current all hospital 75th percentile by F2020/21. It is important to note that this multi-year plan will require annual review based on actual results and current state. These proposed improvements will require a significant and sustained change in our performance related to execution, as well as consistent focus.	1)Sustainment of actions to achieve appropriate staffing. Transition to use of workforce analytics data, operational planning and elevated practice related to recruitment to ensure appropriate actions and planning for ongoing workforce requirements.	A) Implementation of Workforce Analytics Module B) Expanded Leadership presence C) Documentation of a Nursing recruitment strategy D) Standardized practice regarding panel interviewing and other proactive hiring tactics	Overtime Costs	Achievement of budgeted overtime costs	
									2)Continued improvement and sustainment of Patient Flow Redesign initiatives and reducing variation in care planning and delivery.	See plan regarding ED Wait Times for Admitted Patients (90% Percentile)	See plan regarding ED Wait Times for Admitted Patients (90% Percentile)	See plan regarding ED Wait Times for Admitted Patients (90% Percentile)	
									3) Focus on retaining and developing the right leaders to ensure sustainment of must haves of the iCcare Way and demonstrated consistency related to leader standard work.	Best Leadership Program strategy and tactics	1) Overall Retention of Leaders 2) Achievement of expected rounding with staff	1) No turnover of High/Middle performing Leaders 2) 90% or greater adherence to staff rounding by Leaders	
		Patient Satisfaction % Excellent	% / Survey respondents	NRC Picker / Q2 of F2018/19	965*	CB	CB	The multi-year targets will be set in Q2 of 17/18 and represent sustained focus and incremental improvement to achieve the top quartile by 2020/21. It is important to note that this multi-year plan will require annual review based on actual results and current state. F16/17 is a baseline year due to the change in NRC survey instruments.	1)Hardwire the key strategies through goal setting and 90 day plans for Clinical Directors and appropriate clinical leaders. (AIDET, Patient rounding and whiteboard utilization)	Performance targets set with each leader to target compliance of AIDET use, patient rounding and whiteboard utilization.	Leaders will meet compliance targets on a monthly basis.	Compliance reporting logs are reviewed monthly.	
									2)Implement real time survey options in 2017/18 for better service delivery and recovery	Pilot real time surveying option on the rehabilitation unit 2B. Pilot email survey sampling for Maternity.	Real time surveying will be successfully implemented. Email survey sampling will be successfully implemented for Maternity.	In Progress.	
									3)Patient Centred Flow Redesign is a key element to improving value in the system for patients and will help drive patient satisfaction improvement.	Patient Centred Flow plan has been implemented and ongoing monitoring of process will occur.	Admitted patients will flow to right bed within 24 hours.	Sustainability of plan in progress.	

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		Physician Engagement	% / Survey respondents	NRC Picker / Q2 F2018-2019	965*	60	64.00	NRC Median Score - All Hospitals is 70.8%. The most recent benchmarking information from NRC indicates that the 75th percentile has only changed slightly (73.9%). Consistent with employee engagement, NRC recommends improvement targets between 2-4 percentage points assuming an organizational commitment, significant focus and attention towards achieving improvement and sufficient time to see the results of those actions and improvements, and it is noted that annual surveying and goal setting is not typical. Achievement of the current all hospital 75th percentile by F2020/21.	1)Chiefs of Departments and Medical Directors will be rounded on with purpose on a monthly basis; undertake regular physician service rounding.	Beginning September 2016, Vice President Medical Affairs and Manager Medical Affairs round jointly with all Medical Directors and Chiefs of Departments (whose Department is not aligned with a Program) following the Monthly Meeting Model and standard service rounding approach.	Continued participation in monthly rounding by all Medical Directors tracked via rounding log	Ongoing.	
									2)Develop and disseminate a physician / Sault Area Hospital relationship framework.	Physician / Sault Area Hospital relationship framework developed, consulted upon, and awaiting final approval by Senior Management Team. Once approved, framework will be shared broadly amongst physicians	Evaluation plan to measure impact of relationship framework	Rolling out April 2017 and framework in place by March 2018	
									3)Develop and trial effective mechanism to 'close the loop' with physicians (informed by a Survey Monkey survey to solicit preferred communication mode) and for soliciting feedback and ideas for improving processes / ease of practice.	•Piloting mechanism in the Electronic Occurrence Reporting System (eORS) with Chief of Anaesthesia Department to notify Chief when any physicians in the Department report an occurrence. Commitment from Chief to follow up with physicians who report. •Create and share monthly 'Stop Light' Reports at Medical Staff Association and post on Pillar Boards in Medical Affairs and Physician Lounge. •Create and disseminate a quarterly physician-specific newsletter	Survey physicians by December 2017 to evaluate effectiveness of mechanisms to close the loop	December 2017	
Efficient	**Access to right level of care**	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	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July – September 2016 (Q2 FY 2016/17 report)	965*	25.21	16.00	16% = Annual Target. ALC continues to be an area of focus in healthcare and achieving efficiencies in caring for these patients is essential for optimal patient outcomes and patient flow through the system. It is recommended that this remain a monitoring goal in 17/18. Benchmarking and Other Targets F2016/17 Hospital Services Accountability Agreement (HSAA) Target: 16.0% * 2015-2018 Ministry LHIN Accountability Agreement (MLAA) Target: 12.7% Provincial Target: 12.7% * LHIN was asked to amend this to 23% to align to SAH's revised target of 23%. Target Recommendation and Justification: The F2017/18 and multi-year targets are set in order for SAH to achieve the provincial target by F 2018/19. The achievement of the provincial target is contingent upon sustainable plans for Key Actions.	1)All acute in-patients will have discharge risk plans documented in their plan of care. All medicine in-patients will be assessed for restorative potential and transition to an appropriate Rehab Bedded Level of	• Adopt Bedded Levels of Care models to maximize patients restorative potential and mitigate ALC designation. •Physician re-engagement in "Home First" admission/discharge principles. • ALC Avoidance Framework priority/action/sustainability plan.	1) ALC rate < = 16% 2) All patients ALC for LTC have been appropriately escalated.	1) Target Q1 for 2017/18 2) 100% by September 30, 2017.	
									2)Evolving opportunity at SAH to develop a coordinated admission process for bedded rehabilitative care (2nd floor) that aligns to Rehabilitative Care Alliance deliverables: to be implemented by May 1st, 2017.	• Develop admission criteria for each bedded level of rehabilitative care unit. • Develop and provide organization-wide education regarding admission criteria, restorative potential, referral process. • Established standard process for determining EDD. • Identify standard approach to communicate with patient/family/SDM. • Define standard work to support early discharge planning.	1) Criteria used for all patient referrals to internal bedded rehab care (2nd floor; 2) All patients on 2nd floor have an EDD, and; 3)Patients and their families are aware of EDD and plan of care to meet that discharge data.	1) 100% by June 30, 2017. 2) 100% by June 30, 2017.	
									3)100% ED patients being considered for admission will be assessed by the Admission Avoidance Team (pilot underway). Implement an Assess and Restore (A&R) care path (screening, assessment and early access to rehabilitative care) to reduce risk of admission to hospital and/or LTC by June 30, 2017.	Patients, 65 years of age or older, presenting to the ED with complaints of failure-to-cope, functional decline-type complaints and dementia-type patients will be referred by the ED physician directly to the Admission Avoidance Team prior to EDMC referral.	1) PDSA criteria for Admission Avoidance Team referral. 2) Implement risk screening tool (AUA)at triage to optimize resources. 3) Define approach to identification of individual patient need; 4) Identify what service/care is required to meet patient needs 5) Determine most appropriate care setting (i.e. Can needs be met in the community?) 6) Standard "report out"/collaboration with physician with plan.	1) First day of each month. 2) June 30, 2017 3) to 6) May 1, 2017	
									4)Key elements of Senior Friendly Hospital (SFH) strategies in acute medicine are implemented by September 30, 2017: Reduce functional decline amongst seniors in hospital; and Reduce rates of and/or duration of delirium episodes amongst seniors in hospital.	1) Develop/Implement mandatory education (clinical Staff): a) geriatric syndromes; b) frailty and delirium; and c) evidence-based approaches to hospital care. 2) Ensure key best practices recommendations identifying interventions for various geriatric syndromes are included in the patients care plan: • daily mobility • least restraint • optimize nutrition and hydration • initiate early discharge planning with patient and family.	1) Percent hospitalized patients (aged 65 and older) receiving assessment of ADL function at admission and discharge to 2nd floor. 2) Percent patients (aged 65 and older) with no decline in ADL function from hospital admission to hospital discharge as measured by a validated tool. 3) Percent of patients (65 and older) receiving delirium screening using CAM tool on admission to hospital. 4) Incidence of delirium in patients (aged 65 and older) acquired and documented over the course of hospital admission.	1) September 30, 2017 2) Q3 2017/18 3) September 30, 2017 4) Q3 2017/18	

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Safe	**Medication safety**	Medication reconciliation at admission: The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital	Rate per total number of admitted patients / Hospital admitted patients	Hospital collected data / Most recent 3 month period	965*	85.8	90.00	Recommended Target: 90% This aligns to the target on the F2015/16 QIP. At present, SAH has come close to achieving this target, but has not sustained it on annual basis. This would represent a 5% improvement from current state (non-validated). HQO does not provide a recommended target, however it suggests an increase as the direction of improvement.	1)Education, training, and communication of current or new processes to multi-disciplinary staff.	1) Review Current Process 2. Identify gaps requiring training 3. Develop new process and education	New process will be developed and implemented. Education will be developed and utilized for multi-disciplinary staff.	Process will be implemented.	
									2)Creation of quarterly working group meetings to review audit results and develop improvement strategies. Communicate audit results on the respective units.	1) Initiate a multidisciplinary Medication Reconciliation Working Group 2. Audit med rec at admission within 24 hours of admission 3. Provide monthly audit results to units	1) Develop a process to identify patients to be audited within the timeframe 2. Audit the charts using the audit tool 3. Provide audit results to the Working Group for review and input 4. Display audit results on each unit and provide to physicians	Process implemented and results displayed on the units and to physicians.	
									3)Share physician compliance results with Operational Leadership.	1) Monitor physician compliance during audit procedure 2) Develop and offer physicians education on the med rec process required at SAH	1. Include physician compliance as part of audit process 2) Identify education required to facilitate physician engagement	Process will be implemented and compliance achieved.	
		Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged.	Rate per total number of discharged patients / Discharged patients	Hospital collected data / Most recent quarter available	965*	55.6	75.00	Q4 target set at 75%. F18/19 target set at 90%. Target recommendation and justification: HQO does not provide a recommended target, however it suggests an increase as the direction of improvement.	1)Education, training, and communication of new processes to multi-disciplinary staff. Formalize and test process improvements.	1. Review Current Process 2. Identify gaps requiring training 3. Develop new process and education	New process will be developed and implemented. Education will be developed and utilized for multi-disciplinary staff.	Process will be implemented.	
									2)Work with community pharmacies to improve the discharge medication reconciliation report in its readability and usability.	1) Review the current process and identify gaps in communication 2) Develop new processes to increase med rec with community partners	New process will be developed and implemented. Facilitate community involvment and audit reporting.	Process will be implemented and community partners involved.	
									3)Confirm the role of the discharge medication reconciliation report to mitigate ambiguity regarding MRP for home medications when the hospital physician is not the patients primary care provider.	1) Develop a process to clarify the patient's list of medications upon discharge	Work with physicians to implement a discharge medication form for the patient upon discharge.	A discharge medication form will be utilized.	
	Safe care	Clostridium difficile (CDI)	Rate per 1,000 patient days / All inpatients	HQO public reporting website / April 1, 2017 to March 31, 2018	965*	0.25	0.16	Multi-year targets reflect stepped improvement each year to achieve 'best' result of 0.00. YTD F16/17 rate is 0.08 higher than the same period last year. For the 2016 / 2017 fiscal year, the target of 0.18 calendarized evenly is usually breached in any month where there is more than 1 CDI case. Alignment to Health Quality Ontario Recommendations: CDI is not a Health Quality Ontario recommended indicator (retired 2017/18). We have chosen to include it in our 2017 / 2018 QIP as we did not meet our target last year and are off-track to meeting our target this year. Our goal is to achieve 'best' result of 0 by F2021/22. Target Recommendation and Justification Recommended Target: 0.16 SAH typically experiences approximately 80,000 inpatient days on medical units (include emergency). A rate of 0.18 would equate to 13 cases in a year. Of the 9 months for which we have data, 6 of those months have been below the target of 0.18. Spikes above target were seen in April, May and July.	1)Reducing the use of antimicrobials known to be high-risk (in particular, identifying and engaging physician champions to reduce post-operative antimicrobial use).	Implement strategic work plan. Build and strengthen ASP team members. Identify a physician champion for ASP. Develop a plan for sharing information with the community.	Development of strategic work plan will include: bringing to the physicians to determine focus for their departments, and bring the draft work plan to surgical and medical business rounds to get feedback and recruit champions.	A draft plan will be developed and tested in selected units.	
									2) Campaign to improve hand hygiene (in particular, greater visibility of hand hygiene reminders in hospital).	IPAC will continue to develop awareness campaigns highlighting Hand Hygiene across the organization. These include: additional signage upon entering in-patient units, floor decals in strategic areas and elevator wraps in employee and patient areas.	Hand hygiene compliance will continue to be audited and monitored on a monthly basis with the aim to increase hand hygiene compliance across the board.	Increased hand hygiene practice will be demonstrated across the organization.	
									3)Environmental decontamination (in particular, implement a two week, twice daily sporicidal clean of all high-touch surfaces in the hospital).	Once the hospital reaches a threshold of 4 newly identified patients with CDI in a month, environmental decontamination will be initiated.	IPAC will conduct ongoing monitoring of acquired CDI cases on a monthly basis as part of standard care.	Environmental decontamination will be instigated when it is determined that it is required to decrease the burden of C-diff within the organization in a select period of time.	

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									4)Rapid screening for C-difficile will be initiated by April 1, 2017.	Pilot project for screening C-difficile will begin April 1, 2017.	1) Tracking of reporting times will be made during the pilot phase. 2) IPAC data collection will identify those cases that are removed to determine efficiency of on-demand testing.	1) Turn around time for screening will be improved from ~48 hours to 2 hours during regular working hours and greatly decreased during evenings and nights. 2) Decrease in the number of isolations and length of isolation beginning immediately upon implementation of on-demand testing.	
		Falls per 1,000 Patient Days	Rate per 1,000 patient days / All inpatients	Hospital collected data / April 1, 2017 to March 31, 2018	965*	6.3	5.60	RNAO definition of a fall is: An event that results in a person coming to rest inadvertently on the ground or floor or other lower level. Missed falls, where a fall by definition has not occurred, will not be included. F2017-18 target is equal to the F2016-17 target as there is still opportunity for improvement in falls prevention.	1)All patients will have a fall risk assessment on admission to hospital. Falls prevention strategies will be implemented on all identified high risk patients.	1. Review of risk assessment process and develop education/re-education via LMS modules. 2. Incorporate additional modified risk assessment at the beginning of each shift.	Chart review of risk assessment compliance will be reviewed and disseminated to the staff on all the inpatient units. Roll out of LMS modules designed to highlight falls prevention strategies will be developed and staff registered.	Decrease falls for the year to meet the target and specifically focus on decreasing the moderate to severe falls.	
									2)Clinical Education focusing on falls prevention education (based on RNAO Best Practice Guidelines) will be aligned to the patient's pre-hospital functional ability and their rehabilitative potential.	Develop a consistent onboarding package for new nurses, LMS education modules and on-unit in-services focusing on best practice guidelines. Education will provide education on activities that align with the college's expectations.	Different initiatives will be implemented highlighting specific efforts to decrease falls.	Professional development plans will be implemented allowing for staff to be accountable for the evaluation of their clinical skills including falls prevention.	
		Pressure Ulcers in Complex Continuing Care	% / Complex continuing care patients	CIHI CCRS / Q3 and Q4	965*	CB	3.80	Pressure Ulcer results are based on CIHI CCRS reporting. 2016/17 results are not confirmed. F2016/17 Hospital Services Accountability Agreement (HSAA) Target: 0.00 2015-2018 Ministry LHIN Accountability Agreement (MLAA) Target: n/a Provincial Target: 0.00 Best Hospital Result: 0%Year:Q2 F2016/17 75th Percentile: 7.6% Peer Group: Hospital Based Sector Median:3.8% 25th Percentile: 0% Recommended Target: 3.8% (Q3 & Q4) Reach median performance by Q3 and maintain for Q4.	1) Confirm data/assessment results.	Create a review process and review cases where a pressure ulcer has been identified.	Chart review and process review leading up to pressure ulcer identification or progression will be conducted.	We will not have any cases of pressure ulcers stage 2 or higher identified.	
									2)Determine clinical practice evaluation and root cause of pressure ulcer incidence.	Conduct a review of current practice and policies.	Update practice and policy information where necessary. Using chart reviews being conducted, identify root causes for pressure ulcer development.	Root causes will be identified per reported case and efforts made to implement prevention strategies.	
									3) Identify key opportunities using the RNAO Best Practice Guidelines Risk Assessment and Prevention Pressure Ulcers.	Assessment of current pressure ulcer cases using RNAO Best Practice Guidelines to determine gaps in care and prevention.	Identify gaps and develop education designed to eliminate these gaps and improve standard practice.	Gaps will be identified and addressed appropriately.	
									4) Engage Allied Health in assessment, intervention, and treatment planning.	Develop a pressure ulcer working group consisting of a multidisciplinary team to evaluate the process around prevention, follow-up, and treatment planning.	To be determined.	Planning will be developed by June 30, 2017	

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Timely	**Timely access to care/services**	ED Wait Times for Admitted Patients (90% Percentile)	Hours / ED patients	CCO iPort Access / April 1, 2017 to March 31, 2018	965*	64.9	24.00	Multi-year targets have been set to allow SAH to be a "top 5" hospital by F2020/2021. It is important to note that this multi-year plan will require annual review based on actual results and current state.	1)Recruitment and staffing to appropriately care for the patients and allow for surge and overcapacity processes to be implemented. Resources to support Flow improvement and sustainability.	See plan regarding Employee Engagement - Sustainment of actions to achieve appropriate staffing.	See plan regarding Employee Engagement - Sustainment of actions to achieve appropriate staffing.	See plan regarding Employee Engagement - Sustainment of actions to achieve appropriate staffing.	
									2)ALC education, awareness and analysis to clearly understand current state and to implement short and longer term improvements.	Robust admission policies and procedures are in place to support ALC avoidance and management particularly escalation policy and processes.	ALC decision making processes including escalation developed jointly by CCAC and SAH.	June 30, 2017	
									3)Bedded Level of Care and Access and Restore Collaborative partnership and aligned process implementation.	Robust admission policies and procedures are in place to support ALC avoidance and management.	1) Evolving opportunity at SAH to develop a coordinated admission process for bedded rehabilitative care (2nd floor) that aligns to Rehabilitative Care Alliance deliverables. 2)Rehabilitative care nursing education program implemented by Late Career Initiative RN. by March 31, 2017.	1) May 1, 2017 2) March 31, 2017	
									4)Flow governance and control process over patient moves, transfers and bed assignments implemented.	Oculys performance to "see" bed availability, governing policies and processes, bed matrix to flow patient to right bed, standard work for bedboard and Flow office, Weekend Flow support processes	Linked to ALC decision making escalation processes (above; Admission rates, Discharge rates, Length of Stay, PIA, Time to Bed	Less than 24 hour LOS for Admitted Patients. June 30, 2017.	
									5)Ensure standardized approach to evidence based practice e.g. plan of care with estimated date of discharge and Leader Standard work.	•Leader standard work has already been developed and rolled out •Plan of care and EDD work will begin in April	EDD documented on all patient charts in acute medicine.	100% by Q3.	