2018/19 Quality Improvement Plan
"Improvement Targets and Initiatives"

Holland Bloorview Kids Rehab Hospital 150 Kilgour Road

AIM		Measure						Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Effective	**Effective transitions**	% of families and clients reporting they felt they were adequately supported in preparing for discharge	% / Pediatric Patients	Hospital collected data / 2017/18	90.30%	90.00%	We only have 3 quarters of data for this indicator and will therefore be continuing with the target from 2017/18. A target of 90% is both aggressive and consistent with our other patient experience targets as well as reflective of the volume of work underway in the hospital to support families through the transition to home process. The target includes Top Box responses only. Data source is our 72 hour follow up phone call.	1)**Education and Training:** Update Client and Family Discharge Support (Transition Passport) Materials	a. Conduct jurisdictional scan b. Obtain feedback from clients and families c. Update transition passport materials d. Disseminate updated passport	% of inpatient families who receive a discharge follow up phone call 72 hours post discharge # new/updated materials % clients discharged with a completed PODS (patient orientated discharge summary) % families feeling they received enough information from hospital staff around what to do if they were worried about their child's condition after leaving the hospital % families feeling prepared to manage their child's condition upon discharge % families feeling ready for discharge % kids who know what to do to get ready to go home	90% of inpatient families who receive a discharge follow up phone call 72 hours post discharge # new/updated materials 100% clients discharged with a completed PODS (patient orientated discharge summary) 90% families feeling they received enough information from hospital staff around what to do if they were worried about their child's condition after leaving the hospital 90% families feeling prepared to manage their child's condition upon discharge 90% families feeling ready for discharge 75% kids who know what to do to get ready to go home	This work is closely aligned with the new organizational strategy priorities - Personalized Pathways and Connect the System.
Patient-centred	**Person experience**	% 'excellent' rating by clients and/or families to the question: Overall how would you rate Holland Bloorview	% / Pediatric Patients	NRC Picker / 2017/18	59.30%	60.00%	We are evolving this metric to focus on 'top box' or excellent responses only. Historical performance is variable and ranges from the low fifty's to very low sixty's percent range and achieving the OHA benchmark of 60 per cent would be an improvement over baseline. Given the variation in our historical values, this would still be significant improvement over baseline, as well with the new implementation of our strategic plan that will shift the way in which care is delivered, we anticipate our improvement will be slow in the first year.	1)**Measurement and Feedback**: Continue pilot of kids feedback process	a. Conclude interviews b. Conduct data analysis c. Identify and implement improvement initiatives in partnership with children and youth d. Develop sustainability plan	# clients interviewed % clients feeling safe when visiting Holland Bloorview % clients understanding communication with health care provider % clients satisfied with access to service % clients who know how to continue their rehab therapy at home % clients who feel that their care is helping them reach their goals	100 clients interviewed 95% clients feeling safe when visiting Holland Bloorview 75% clients understanding communication with health care provider 75% clients satisfied with access to service 75% clients who know how to continue their rehab therapy at home 75% clients who feel that their care is helping them reach their goals	We hosted an inaugural kids feedback month for our inpatient clients in the summer of 2016 and this past fiscal year the initiative expanded to include both inpatient and outpatient clients. With the interviews concluding at the end of the 2017/18 fiscal year the work in 2018/19 will be to analyze the feedback data and identify targeted improvement initiatives. The feedback questions were developed in partnership with client and family integrated care and quality, safety, performance. The interviews were facilitated by a former client who was hired into the children's feedback specialist role.
								2)**Measurement and Feedback**: Explore additional real time client and family experience feedback methodologies	a. Trial different methodologies(e.g. Youth Feedback Video Booth and Real-Time Surveying with Youth Interns) b. Create robust mechanisms to incorporate feedback data into quality/safety boards and huddles	# respondents # quality improvement initiatives	Youth feedback booth initiative completed in Q1 Real time surveying with youth leaders piloted in Fall 2018	Having introduced a new longitudinal client and family experience survey in October of 2015 we are now looking to supplement this data with additional real time information.
								3) **Measurement and Feedback**: Implement NRC Health client experience phone survey in top 5 Non-English languages	a. In order to hear back from more of our families who do not speak English we are working with NRC Health to pilot the client experience survey via telephone to a sample of families who communicate in one of our top 5 languages b. Compare telephone (non-English) results to English-languague paper survey results c. Implement targeted quality improvements as required	# non English phone surveys completed	150 non English surveys completed	At Holland Bloorview our 5 most common languages other than English are Mandarin, Arabic, Cantonese, Tamil and Spanish. There 5 languagues account for 80% of our requests for interpreter services. As this is a new product for NRC Health Canada it will likely involve a year of planning prior to implementation in year 2.

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								4)**Client and Family Experience**: Explore translation of key educational materials into top 5 non-English languages (80% of interpreter service requests)	a. Identify materials for translation in partnership with clients and families b. Translate materials c. Incorporate into hospital communication/ dissemination channels d. Obtain feedback from families	# resources translated % families stating their care was negatively impacted by language	collecting baseline- % families stating their care was negatively impacted by language	This initiative, led by our Client and Family Integrated Care team, is looking to translate a number of key educational documents into our top 5 languages. Based on family input the translation initiatives will focus on materials related to safety, consent/usage agreement, and family education.
								5) **Client and Family Experience**: Advance the organizations mental health strategy for clients, staff, and caregivers	a. Awareness: Create a culture inclusive of mental health b. Education: Identify screening tools and pathways to address mental health c. Education: Increase capacity and knowledge of staff regarding mental health and resilience of children, youth and families d. Resources: Create a core team of experts in mental health e. Partnerships: Establish strong community partnerships and pathways for child/youth mental health(Leadership Collective accountability)	Address mental health status as it pertains to the child and youth and accordingly the family Advance the capacity of staff to recognize, respond and manage child and youth mental health Enhance the potential for Holland Bloorview to be a leader in advocating for services for child and youth mental health as it pertains to disability	This is a long term project, with a target of 2-5 years for full implementation.	Over the last few years management and clinicians alike have seen a trend in the increase of mental health needs within the client population. Children and youth are coming to Holland Bloorview for rehabilitation but the provision of care is becoming more complex due to underlying pediatric mental health needs. While provincial initiatives such as Moving on Mental Health (MOMH) are addressing this need in the general population there is a paucity of expertise and service for children with disabilities. To date, partnerships have been forged with the Healthcare Partnership Table (Toronto arm of MOMH) and with CAPHC Child and Youth Mental Health Community of Practice (CoP). It is anticipated that the Leadership Collective at Holland Bloorview will further partnerships and linkages as determined through the fifth key enabler.
								6)**Client and Family Experience**: Investigate possible solutions to improve parent/caregiver sleep quality on the inpatient units	a. Explore options in partnership with families b. Pilot potential solutions and evaluate inpatient family experience c. Implement selected improved throughout units d. Monitor impact	# solutions tested # families/caregivers engaged	Solution identified by Q4 2018/19	As part of our QIP development process we conducted semi structured interviews with families from all 3 of our inpatient units. We learned that improving the quality of the parent/caregiver sleep is a key area for improvement which will have impact on the overall care experience. This work will be a collective initiative across the Client and Family Integrated Care, Rehab and Complex Continuing Care, and Quality Safety and Performance teams.
		Distribution of Client and Family Relations (CFR) experience survey within 7 calendar days following completion of complaint process	% / All patients	Hospital collected data / 2018/19	Collecting baseline (CB)	100.00%	We have advanced our moderate complaint resolution time indicator to focus on the timely distribution of a newly developed CFR experience survey. While we do not have historical data, we are confident in our planned process to distribute the survey to all clients and families who file complaints so long as they are identifiable, can be contacted, agree to be contacted, and agree to complete the survey.	1)**Measurement and Feedback**: Understand our new client and family relations experience data.	a. Implement new Client and Family Relations (CFR) experience survey b. Reporting of survey results on a biannual basis to Quality Committee of the Board and other internal reporting channels. c. Modify survey tool if/as appropriate at the end of year 1	Survey response rate % clients/families satisfied with the outcome/result % clients/families indicating process was fair % clients/families indicating they were treated with respect throughout the complaint resolution process	25% response rate Collecting baseline: clients/families satisfied with the outcome/result Collecting baseline: clients/families indicating process was fair Collecting baseline: clients/families indicating they were treated with respect throughout the complaint resolution process	The measure selected for the current fiscal year is a process metric; following one year of data collection we will consider developing a QIP metric and target based on the experience data in the survey.
								2)**Measurement and Feedback**: Continue to monitor resolution times for our client and family complaints	a. Client and Family Relations Facilitator will continue to track and report CFR indicators through various internal reporting channels	# complaints # compliments % operations leaders receiving monthly CFR reports	100% operations leaders receiving monthly CFR reports (where complaint related to their department was filed with CFR)	Tracking client and family complaints and compliments is a tremendous source of information for the hospital. Our Client and Family Integrated Care (CFIC) team has a well established process for handling and resolving complaints, led by our Client and Family Relations Facilitator. Monthly thematic analysis of the complaints will continue to be reported internally.

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Safe	**Safe care/ Medication safety**	Understanding Medication: % of families rating that health care providers gave an understandable explanation of medicines	% / All inpatients	Hospital collected data / 2017/18	96.80%	95.00%	Based on our historical performance we are advancing our target from 90 to 95 percent. With a sample size of approximately 45 respondents per quarter 95 percent achievement is our maximum target.	1)**Education and Training**: Provide refresher education for clinical staff around available medication resources	a. Design education with external partner b. Conduct education sessions c. Obtain staff feedback	Staff satisfaction with education	90% staff satisfaction	We plan to reach out to external provider Lexicomp to deliver the education.
								2)**Access to Information**: Leverage connect2care as a source of medication information for discharged clients and families.	a. Engage with Collaborative Practice and Health Science Library to understand functionality and build requirements b. Co-develop medication resource tool in partnership with clients and families c. Implement medication resource tool d. Evaluate usage	# clients/families accessing new medication resources % families indicating they understand their home medications (from the NRC Client experience survey; second data collection time point) % families indicating that staff explained medication side effects to watch for	Resource implemented 90% families indicating they understand their home medications (from the NRC Client experience survey; second data collection point) 70% families indicating that staff explained medication side effects to watch for	Connect2care is a consumer health portal through which clients and families can view their clinical documentation, view appointment schedule and engage in secure two way messaging with clinicians. We are interested in exploring the possibility of including a searchable source of medication information available to users.
								3)**Process Improvement Initiative**: Incorporate ISMP 5 Questions To Ask About Your Medications poster into Patient Oriented Discharge Summary (PODS) package.	a. Provide staff education b. Incorporate into PODS package (in family's preferred language) c. Evaluate and sustain usage	# handouts distributed # non-English handouts distributed	Implementation to occur in Q1.	The ISMP poster "5 questions to ask about your medications" is an educational poster targeted at clients and families. Last year the tool was posted in all of our outpatient clinic rooms, the outpatient orientation package as well as within inpatient transition passport. The plan for this year is to disseminate the poster together with the PODS (patient oriented discharge summary). As the poster is now available in 22 different languages, the handout will be specific to the client/family's native language.
	Workplace Violence	Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period (Mandatory).	Count / Worker	Local data collection / January - December 2017	Collecting baseline (CB)	CB	Our goal for this fiscal year will be to better understand our data. We will be establishing a target for the 2019/2020 fiscal year.	1) **Process Improvement Initiative:** Complete the community safety program and implementation of recommendations	a. Create organizational community safety policy b. Implement a community risk hierarchy with associated controls which will ground the community safety policy c. Identify and standardize access to existing controls and strategies based on risk hierarchy d. Evaluate effectiveness	# staff incidents from 'high risk' areas Confirm risk hierarchy taxonomy with staff Staff and manager feedback (once implemented) on available controls/ strategies Staff patient safety culture survey	# staff incidents (note: we expect this number to increase in the first year of this work, then plateau, and then decrease in year 2) Taxonomy identified	The hierarchy identifies which departments are at higher risk based on the existing controls. This is also an Accreditation Canada requirement.
								2) **Process Improvement Initiative**: Complete a workplace violence risk assessment	a. Create working group b. Complete workplace violence risk assessment tool by department in consultation with Joint Health and Safety Committee (JHSC) c. Document existing safety controls d. Identify gaps e. Create additional controls as necessary	% departments completing tool	100% of departments completing risk assessment tool Additional controls identified as needed	Completion of this risk assessment is mandated by the Occupational Health and Safety Act (OHSA). Tools provided by the Public Services Health and Safety Association (PSHSA) will be leveraged to ensure successful completion. Operations leadership engagement is critical to the success of this initiative. Senior management support is critical for implementation of identified additional safety controls.
								3) **Measurement and Feedback**: Harmonize the incident reporting system to accurately capture the number of employee incidents secondary to unintentional/ intentional aggression/ violence	a. Upgrade existing employee incident reporting system to enable more accurate and specific data capture to ensure alignment with Occupational Health and Safety Act b. QM/RM training refresh for staff and managers	% compliance with including appropriate behavior information in patient safety tool % incidents with manager follow up	100% compliance 75% incidents with manager follow up	In instances of violence not related to client behavoiur, delineate the antecedent of violence. We plan to include client name in the incident report to track and monitor behaviour patterns related to employee incidents. Contributing factors to the behaviour will also be included in the incident description. We will also introduce a reminder notice to encourage staff to update the patient safety tool in the electronic medical record.

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								4) **Strategy Development**: Develop organizational approach (partnered with clients and families) to minimize safety events secondary to client behaviour	a. Environmental scan of best practices b. Co-design, with staff and family leaders, a strategy to streamline communication of safety information in line with best practices c. Conduct necessary education	# client and family behaviour incidents Feedback from staff regarding ease of locating relevant information	We do not have a target for client and family behaviour incidents as we expect this number increase due to enhanced awareness. Target will be established in year 2 based on year 1 data	This is a continuation of a preliminary consultation with our Family Advisory Council.
								5) **Education & Training:** Develop and implement education across the organization on workplace violence	a. Continue with organization-wide eWISE module for all staff b. Enhance emergency preparedness orientation module to include more information about workplace violence c. Explore need for additional manager support related to incident follow-up	% staff completed eWISE (annually)	80% eWISE completion	Additional organization activities include de-escalation training and non violent crisis intervention (mandatory for clinical staff).
Timely	**Timely access to care/ services**	% clients seen within target wait time (137 days) for Autism Diagnostic Services	% / Pediatric Patients	Hospital collected data / 2017/18	40.30%	55.00%	This is a new metric for our Autism Diagnostic Services (ASD) wait times. Feedback from our clients, families, and clinicians indicated that this is a more meaningful metric than the 80th percentile wait time in days. We have a plan to evolve the target on an annual basis.	1) Build Community Capacity through ECHO (Extensions for Community Healthcare Outcomes-ECHO) Ontario funding: Link our internal expert inter-professional teams with primary care providers in our community to increase knowledge and skills for autism diagnoses and on-going medical management.	a. Formalize partnerships in the community b. Develop capacity building module and materials using ECHO Ontario format c. Evaluate with partner and family input d. Create sustainability plan	# referrals Improved access: % of clients seen within target # of clients on wait list Satisfaction of community providers as part of formal ECHO Ontario evaluation process	Decrease in referral volumes Reduction in # of clients waiting by 5% Obtain baseline satisfaction	This is an initiative through project ECHO to build community capacity for autism diagnostic assessments and medical management. This new community capacity will ensure that more complex children are referred to Holland Bloorview where the expertise of a developmental paediatrician will be leveraged and assist families in assessing further services based on their diagnosis.
								2)Process Improvement Initiative: Develop the preferred future state for an integrated, coordinated Ambulatory services model to improve access for clients and families	a. Implement key improvement initiatives that will contribute to new service delivery models, including 1. Implement enhanced hours of service for therapy and medical clinics. 2. Redesign electronic referral/intake form and processes. 3. Enhance alignment and consistency in orientation and transition between Inpatient and Outpatient services.	New referral form launched # of redirected/cancelled referrals % of clients seen within 137 days for autism services	New referral form in place in Q1 Decrease # of redirected/cancelled referrals Wait time: 137 days for ASD assessment appointment	Our overall goal for the ambulatory care program is to develop and implement an integrated, coordinated care model in ambulatory care. This work will support the achievement of our No Boundaries strategic plan, specifically the personalized pathways impact area. This work will be advanced in full partnership with hospital leadership, staff, clients and families.
								3) Process Improvement Initiative: Create capacity in the physician schedule to see more clients	a. Build ADOS (Autism diagnostic observation schedule) appointments into SLP schedules b. Monitor progress c. Develop sustainability plan	Improved access and > % of clients seen within target # ADOS completed # patients seen by SLP rather than MD	Wait time: 137 days for ASD assessment appointment Increase number of Autism Diagnostic Observation Schedule (ADOS) assessments completed by SLP instead of MD	As the number of ADOS completed by the SLP increases, it creates additional appointment slots in the MD schedule for new clients

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		% of clients seen within 91 days for first therapy service (Occupational & Physical Therapy) with the Neuromotor service	% / Pediatric Patients	Hospital collected data / 2017/18	24.20%	40.00%	This is a new metric for our Neuromotor Services. Feedback from our clients, families, and clinicians indicated that this is a more meaningful metric than the 80th percentile wait time in days. We have a plan to evolve the target on an annual basis; aiming for a 15.8% percent improvement in the first year.	1)Process Improvement Initiative: Streamline referral process for Neuromotor Services	a. Explore a dual referral methodology whereby clients with confirmed diagnoses are not required to be screened by a developmental pediatrician to access therapy services b. Test new screening appointment process c. Evaluate based on client, family and staff feedback	# referrals % of clients seen within target % families indicating they were able to get a therapy appointment within an appropriate timeframe(NRC)	40% of clients seen within 90 days of receipt of referral	As part of the larger ambulatory care-wide initiative to develop and implement an integrated coordinated care model, this work is specifically exploring the possibility of not requiring physician referral to access therapy services for clients with a confirmed diagnosis. The referral process for clients with a query diagnosis will remain the same. As part of this work we will also be exploring how multiple referrals can be happening concurrently, in a coordinated way.
								2) Offer assessment/ consultation clinics after triage on a consistent and timely basis to improve access	a. Currently half day clinics are offered on a quarterly basis for each discipline. We will explore the impact of offering clinics more frequently, and/or for longer duration, on timely access to service.	# referrals % of clients seen within target % families indicating they were able to get a therapy appointment within an appropriate timeframe (NRC)	Increase percentage of families indicating they were able to get a therapy appointment within an appropriate timeframe	Client referrals are triaged off of waitlist and identified as appropriate for an assessment, consultation for a specific issue that is easily addressed within one session, and/or are the clients that would likely benefit from a short block with PTA/OTA. The clinic format helps to meet client needs and optimizes scope of practice for clinicians. Reminder calls for clinics are offered.
								3) Offer reminder calls for OT/PT new appointments as well as enhanced hours to improve attendance and reduce no show rate	a. Reminder calls two weeks prior to appointment b. Monitor impact to no show rate	No show rate for first appointments	Reduce no show rate for first appointments	A short term trial of reminder calls demonstrated an increase in attendance.
								4) Streamline and standardize reason for referral for OT/PT, and redirect back to referring physician if more appropriate services are available in the community and continue to build capacity and relationships with our community partners.	a. Identify criteria for clients that require/ benefit from OT /PT services here and share with physicians and referring sources	# of appropriate referrals # redirects to referring physician	Increase proportion of appropriate referrals	A system to triage referrals and leverage technology for quicker and more meaningful access will be trialed.