Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2018/19 QIP

The Progress Report is a tool that will help organizations make linkages between change ideas and improvement, and gain insight into how their change ideas might be refined in the future. The new Progress Report is mostly automated, so very little data entry is required, freeing up time for reflection and quality improvement activities.

Health Quality Ontario (HQO) will use the updated Progress Reports to share effective change initiatives, spread successful change ideas, and inform robust curriculum for future educational sessions.

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
1	"Would you recommend this emergency department to your friends and family?" (%; Survey respondents; April - June 2017 (Q1 FY 2017/18); EDPEC)	964	50.00	90.00	38.00	Low volume of surveys completed

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Change Ideas from Last Years QIP (QIP 2018/19)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Increase number of surveys completed for ED patients by improving access to surveys.	Yes	Installation of survey kiosk, in the ER department. Reduction in number of survey questions.

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2	"Would you recommend this hospital to your friends and family?" (Inpatient care) (%; Survey respondents; April - June 2017 (Q1 FY 2017/18); CIHI CPES)	964	76.31	90.00	58.00	Low volume of surveys completed

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Increase number of surveys completed for inpatients by improving access to surveys.	No	Still struggling with survey completion rates. Strategies have begun in the outpatient areas and will focus on inpatient in new fiscal.
Implementation of Leader Rounding on Patients	No	Still in the implementation process of rounding on patients

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3	Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital? (%; Survey respondents; April - June 2017(Q1 FY 2017/18); CIHI CPES)	964	64.00	75.00	57.14	Complete PDSA cycles for updated discharge careplan to ensure all necessary elements are captured. As well ensure that careplan is sent to the nursing stations.

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Provision of post discharge follow-up call that will include the question "Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital". (Medical/Surgical Unit)	No	Unable to fill the position of second discharge planner therefore workload did not permit to continue with this initiative.
Creation of a standardized discharge careplan that will include key information about how to access services upon discharge.	Yes	Development of careplan completed with input from stakeholders.

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4	ED length of stay for admitted patients.(*ED Length of Stay defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ED) (%; ED patients; April 2017-December 2017; CIHI DAD)	964	85.00	100.00	84.00	84% of admitted patients left the ED within 8 hours

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Implement standardized response for management of surge in the ED. Improve patient flow by creating overflow bed availability and by increase in staffing to allow for flexing over capacity	Yes	Positive impact to the ER department to overflow in times of surg but nursing shortage impacts the patient care load on the medical/surgical unit.

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5	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; October – December (Q3) 2017; Hospital collected data)	964	100.00	100.00	NA	Initiatives around improving the admission medication reconciliation is under process

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Continue implementation of real time audits to increase opportunities for teaching.		
Continue to include medication reconciliation information to staff at orientation.	Yes	

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6	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 ; October – December (Q3) 2017; Hospital collected data)	964	CB	CB	CB	Ongoing process under review

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7	Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (Rate per 100 residents; LTC home residents; October 2016 - September 2017; CIHI CCRS, CIHI NACRS)	53643	X	20.00	X	Exceeded the target

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Consult home physician regarding patients identified for potential ED visits.	Yes	

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8	Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period. (Count; Worker; January - December 2017; Local data collection)	964	X	0.00	38.00	Investment in a communication device for staff to ensure timely access to assistance during moments where potential for situation to escalate to violence

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All clinical staff will complete e-learning focused on the prevention and response to patient violence and aggression.	No	Instead of an e-learning module we conducted a train-the-trainer for Healthcare Aggression Response Training, Code White, and Pinel Restraint Certification through the M.D. Burgess And Associates Inc.
All staff will attend the Non-Violent Crisis Intervention (NVCI) training	Yes	Mandatory education for staff
Implementation of screening tool to identify patients with behavioral or physical risk tendancies.	No	Will be working on this screening tool in next fiscal
N/A		

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9	Percentage of complaints acknowledged to the individual who made a complaint within three to five business days. (%; All patients; Most recent 12 month period; Local data collection)	964	CB	CB	100.00	100% of the Patient complaints were acknowledged within 3-5 business days

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Initial patient contact by the patient safety lead regarding the complaint will occur within two business day	Yes	

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10	Percentage of complaints received by a long-term care home that were acknowledged to the individual who made a complaint (%; LTC home residents; Most recent 12 month period; Local data collection)	53643	CB	CB	NA	No complaints received from long-term care patients for this Year.

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Initial resident contact by the patient safety lead regarding the complaint will occur within six to 10 business day		

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11	Percentage of patients responding "The hospital staff took my cultural values and those of my family or caregiver into account." (%; All inpatients; Quarter 1 -Quarter 3 2018; In-house survey)	964	82.60	90.00	42.00	Re-working of the question, as it has been identified that it does not convey the same meaning to various cultures and age groups, to be more meaningful.

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Ensure 24 hour access to interpreter services	Yes	Some shifts were not able to be filled due to staffing shortage
Ensure all staff have attended Anishinabe Cultural Training	Yes	

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12	Percentage of residents responding positively to: "I would recommend this site or organization to others." (InterRAI QoL) (%; LTC home residents; April 2017 - March 2018; In house data, interRAI survey)	53643	50.00	75.00	100.00	Exceeded the target

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Implement regular rounding on residents in the home by the Director of Patient Care (all residents rounded on monthly)	Yes	

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13	Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (%; LTC home residents; April 2017-March 2018; In house data, NHCAHPS survey)	53643	50.00	80.00	85.71	Exceeded the target

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14	Percentage of residents responding to "The staff take my cultural values and those of my family or caregiver into account. (%; LTC home residents; Quarter 1 -Quarter 3 2018; In-house survey)	53643	60.00	80.00	84.62	Exceeded the target

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Cultural discussions to take palace at all case conferences	Yes	

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15	Percentage of residents who fell during the 30 days preceding their resident assessment (%; LTC home residents; July - September 2017; CIHI CCRS)	53643	12.68	0.00	17.00	

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Continue to implement falls huddle in the home with rehab staff in attendance to promote reduction in injury resulting from falls.		
Continue to implement falls risk assessment for all residents to identify those at risk for fall.		
Ensure all residents identified with high falls risk scores are placed in a bed with an alarm.		
Continue to implement regular toileting rounds.		

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16	Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (%; LTC home residents; April 2017 - March 2018; In house data, interRAI survey)	53643	50.00	75.00	100.00	Exceeded the target

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Continue to engage residents and their family members in established Advisory Council. (Meeting schedule quarterly bais)	Yes	
Continue to engage residents and their family members in established Advisory Council.(Meeting schedule quarterly basis)		

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
17	Percentage of residents who were given antipsychotic medication without psychosis in the 7 days preceding their resident assessment (%; LTC home residents; July - September 2017; CIHI CCRS)	53643	32.76	20.00	41.00	With adequate assessment, residents will receive appropriate care

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Continue work with physician to increase screening of all residents requiring antipsychotics to determine if they have a diagnosis of psychosis.		

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18	Risk-adjusted 30-day all-cause readmission rate for patients with CHF (QBP cohort) (Rate; CHF QBP Cohort; January - December 2016; CIHI DAD)	964	17.52	10.00	6.00	Achieved target

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Ensure the utilization of standardized CHF order sets to ensure appropriate care and treatment.	No	Difficulty with physician buy-in to use the digital order sets

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19	Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort) (Rate; COPD QBP Cohort; January - December 2016; CIHI DAD)	964	X	5.00	9.00	Re-work the existing order sets to reduce the number of pages within each set and move to a paper based order set rather than digital (to encourage increased usage)

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Ensure the utilization of standardized COPD order sets to ensure appropriate care and treatment.	No	Difficulty with physician buy-in to use the digital order sets

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20	Staff and Physicians will comply with all moments of hand hygiene (%; Health providers in the entire facility; January - December 2018; Local data collection)	964	CB	100.00	74.50	Annual target goal for compliance for next 3 years is on the current strategic plan and is assigned a champion with oversight.

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Increase Hand Hygiene Audits	Yes	

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21	Total ED length of stay (defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ED) where 9 out of 10 complex patients completed their visits (Hours; Patients with complex conditions; January - December 2017; CIHI NACRS)	964	100.00	100.00	100.00	100% complex patients completed their visits within 7 hours

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Increase access to mental health and addictions outpatient, withdrawal services to reduce the number of mental health patients seen in ED.	Yes	Implementation of a crisis response counselor in the ER department 7 days a week
Increase access to mental health beds.	No	

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22	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; July - September 2017; WTIS, CCO, BCS, MOHLTC)	964	31.42	15.55	34.16	Any patient with a L.A.C.E score of 12 or greater will have a complex discharge careplan initiated.

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Any patient with a L.A.C.E score of 12 or greater will have a complex discharge careplan initiated.	No	Not consistent with implementation. Will continue to work on this next fiscal