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)	736	55.00	58.00	55.00	The biggest identified theme is “getting timely access to care” and this is very difficult to change with increasing demand of long stay patients waiting to beds in the Emergency Department

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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?
Continue the real time ED feedback process	Yes	The real time feedback aligned with longitudinal survey comments and themes from the patient relations department regarding access and communication. There are multiple innovative strategies that Southlake will undertake in 2019/20 to address these challenges.

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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)	736	72.00	74.00	72.00	There are multiple variables impacting this indicator

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One of the Corporate Strategies for the upcoming years will be to focus on improving the fundamental elements of patient care: 1) Communication with patients 2) Bedside Shift reporting 3) Patient rounding	Yes	These strategies have rolled out as part of the Interprofessional Model of Care Redesign Project. However, there are no consistent mechanism of tracking and reporting on the compliance data for these practices
Revamp the real time survey plan to ensure point of care resolution is provided for patients	Yes	An evaluation of the real time survey process was conducted, and the revamped process will roll out in 2019/20

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3	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1,000 (Rate per 1,000; All inpatients; Apr-Dec 2017; Local Data Collection)	736	0.30	0.22	0.23	13% improvement from previous year's performance

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Enhanced cleaning in high priority areas	Yes	The Environmental Services team initiated quarterly "enhanced cleaning" and de-cluttering in high priority areas Additionally, they performed nocospray cleans in units with highest CDI burden in a scheduled basis. Finally, the Infection Prevention and Control Committee have continuous discussions regarding C-Diff prevention strategies and monitor process measures regarding hand hygiene, cleaning quality etc.

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4	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)	736	56.00	58.00	55.00	There are multiple variables impacting this indicator

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Initiate key improvement projects to improve discharge communication process	Yes	A comprehensive patient experience review was conducted and it was determined that discharge communication will be one of our priorities for the upcoming year. We will continue to build on our previous strategies, and build in more real time feedback opportunities to address patient and family concerns in a timelier manner.

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5	Discharge Summaries Sent within 48 hours: Discharge Summaries with a Family Provider noted on Patient Record; LOS > 2 days; Ages 65 +; includes death (%; All inpatients; Collect Baseline; Local Data Collection)	736	CB	CB	59%	This was a baseline year

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Data Evaluation	Yes	Although Surgical Services demonstrate the largest deviation from the target, there are other mechanisms for discharge follow-ups that are being used, but not captured in the data. For example, orthopaedic surgeries where primary care follow up is part of the discharge passports and/or the bundled care flow

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6	ER Wait times: 90th Percentile ER length of stay or visit for patients with complex conditions. (Hours; Patients with complex conditions; Jan-Dec 2017; CIHI NACRS, CCO)	736	14.20	12.80	14.78	Growing access and capacity challenges

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Identify improvement opportunities	Yes	The Emergency Department Leadership team initiated a “perfect week” initiative in collaboration with DI, lab etc. to identify and find solutions for ED patient flow related challenges with a goal of 90% success. The next step is to translate these solutions beyond one week and sustain them.

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7	Hand hygiene compliance before patient contact: The number of times that hand hygiene was performed before initial patient contact divided by the number of observed hand hygiene indications multiplied by 100 (%; Worker; Apr-Dec 2017; Local Data Collection)	736	91.00	91.00	88.00	A higher number of observations increases reliability of the compliance data

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Improve the communication to department leaders and staff regarding the importance of hand hygiene	Yes	A patient safety pamphlet was developed to encourage patients to voice matters with key questions to ensure best possible care was being provided. Hand Hygiene was one of the key components of this pamphlet.

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8	The number of workplace violence incidents that result in lost days is a count of the number of violent incidents in which an employee has lost more than the day of the actual incident (also known as a lost time incident). (Count; Worker; Jan-Dec 2017; Local Data Collection)	736	2.00	0.00	9.00	A target of 0 is the theoretical best

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Maintain and implement key initiatives based on the recommendations of the hospital's "Workplace Violence Prevention Committee"	Yes	All incidences of violence are immediately investigated to ensure legislative compliance and to determine root cause and steps to prevent further incidents. Immediate support is provided to employees and early and safe returns to work strategies are in place to minimize lost time. De-escalation training module is now available to all staff on SOLS to provide additional prevention tools. Despite strategies in place incidents of violence can be unpredictable. Efforts to prevent and minimize all injuries are a primary focus of the safety program. Work continues in maintaining a collaborative relationship with members of JHSC to promote our internal responsibility system.

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9	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. (%; All patients; Apr-Dec 2017; Local Data Collection)	736	86.70	90.00	90.00	Target achieved

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Continue collaborative efforts to further improve the Medication Reconciliation process in the Mental Health Department	Yes	Mental Health improved their Med Rec on Compliance by more than 10% over the year
Data Evaluation	Yes	Audits of the quality of the Med Rec is based on reviewing the incidents related to Med Rec, and manual audits of the Med Rec process

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10	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)	736	57.80	70.00	61.8	The performance is calculated in implemented areas only

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Continuing our implementation plan across the organization	No	There has been a delay in the project plan due to the Health Integration System project. The goal is to get back on track for 2019/20
Pilot a workflow based redesign to improve the documentation	Yes	This has been a very manual and labour intensive process, as it was dependent on availability of Pharmacy resources

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11	Non Risk-Adjusted 30-Day All-Cause Readmission Rate (Southlake only) for CHF (Rate; All inpatients; Jan-Dec 2017; CIHI DAD)	736	14.80	13.20	16.20	Includes all cause readmission

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Implement improvement strategies	Yes	The multiple improvement strategies along with previously established strategies have demonstrated a 42% improvement in same cause readmissions. Learnings from these strategies will continue to roll into the following year
Continue previously established strategies	Yes	See above

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12	Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period. (Count; Worker; January - December 2017; Local data collection)	736	CB	CB	121	The purpose of this indicator is not to increase or decrease in performance, but to monitor the types of reported incidents and implement concrete mitigation strategies

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Data monitoring and quarterly evaluation	Yes	All incidences of violence are immediately investigated to ensure legislative compliance and to determine root cause and steps to prevent further incidents.

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13	Percent ALC days: Total number of acute inpatient days designated as ALC in acute care beds due to "Hospital Reasons" divided by the total number of inpatient days. (Days; All inpatients; Jan-Dec 2017; Local Data Collection)	736	0.00	0.00	0.50	An outlier in performance in 2018/19 Q3

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Data monitoring	Yes	Majority of the days due to hospital reason are from two patients that initially refused possible placement options. The learnings from these incidents will be incorporated in future discharge planning discussions

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14	Percent of palliative care patients discharged from hospital with the discharge status "Home with Support". (%; Discharged patients ; April 2016 - March 2017; CIHI DAD)	736	89.79	93.00	88.70	The success of this indicator is based on a strong partnership with C-LHIN's Home and Community

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Data Evaluation	Yes	A working group has met several times to investigate different areas and identify opportunities. The team identified documentation, community involvement in case rounds and an IT solution to alert palliative care outreach when a patient presents to the emergency department as improvement strategies. The process requires ongoing collaboration from the listed stakeholders to ensure data quality is consistently accurate.

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15	Percent of patients with new pressure injury (stage 2 or higher). Include adult acute care, complex care and rehab patients. (%; All inpatients; Apr-Dec 2017; Local Data Collection)	736	4.10	2.80	1.40	66% improvement from previous year's performance

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Appropriate staff education	Yes	Ongoing exploration for education funding and mandatory staging certification for all clinical staff are required
Implement Joint Centres Pressure Injuries Working Group strategies	Yes	In 2018/19, we optimized our efforts to be able to proactively monitor and act on the always events to eliminate preventable pressure injuries. We developed processes to create daily situational awareness of patient safety concerns and ensure organizational compliance with pressure injury management best practices by using a trigger tool to create accountabilities among the interprofessional team. The goal for the upcoming year is to sustain these strategies and maintain a very low rate

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16	Rate of psychiatric (mental health and addiction) discharges (LOS > 3 days; Ages 18+) that are followed within 30 days by another mental health and addiction admission (Southlake Only) (Rate; Mental health patients; Jan-Dec 2017; CIHI OMHRS)	736	12.10	12.10	9.70	This is a 20% improvement from previous year's performance

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Sustainability of previous strategies	Yes	There was great success in sustaining the previous strategies, and discussing the progress of this indicator on a quarterly basis
Alignment with corporate initiatives	Yes	Mental Health program is one of the leaders in driving the corporate initiatives related to interprofessional rounding and discharge communication