Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2019/2020 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 2019/20	Org Id	Current Performance as stated on QIP2019/20	Target as stated on QIP 2019/20	Current Performance 2020	Comments
1	"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?" Percent positive score. (question from CPES) Current Performance FY18/19 Nov (%; All inpatients; April 2018 - November 2018; CIHI CPES)	736	55.00	58.00	56.6	This indicator was one of the five corporate Patient Safety priorities for Southlake in 2019/20. The corporate focus increased awareness of performance and expectation, and units began making individual commitments to help reach the corporate goal. During 2019/2020, we began to post unit level performance for these five indicators on huddle boards throughout the hospital. This further increased awareness as daily huddles occurred on all inpatient units. “Current Performance 2020” based on timeframe specified in HQO Tech Specs (most recent 12 consecutive months): Aug. 2018 - Nov. 2018, Apr. 2019 - Nov. 2019

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Change Ideas from Last Years QIP (QIP 2019/20)	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?
Initiate key improvement projects to improve	Yes	A working group was established to look at standardizing the approach/tool, to provide patients with information at discharge. With input from Patient and Family Advisors (PFACs), a Patient Oriented

discharge communication process	Discharge Summary (PODS) was developed. PODS was piloted on a few units, to allow for a trial period before full rollout. This pilot has already helped inform the process regarding when to provide this information to the patient. Additional feedback from the pilot will be reviewed in 6 months to determine if revisions to the tool and process are required, after which it will be rolled out to all appropriate inpatient units in 2020/2021.

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2	Alternate Level of Care (ALC) Days for Placement to Home with Services: Total number of inpatient days designated as ALC (Acute) for patients with a placement to home with services as a proportion to the number of patient encounters in a given period Current Performance FY 2018/19 YTD Q3 (Days; All acute ALC patients with a placement to home with services designation; 2018/19 YTD Q3; In house data collection)	736	13.10	1.00	1.4	This indicator definition was refined during the year, in order to align with our corporate Balanced Scorecard indicator related to ALC. The revised definition is for Southlake@home patients only (excluding patients from our two off-site Restorative Care Centre locations). As this was a new program, a defined comparable "current performance"/baseline was not available, however the target was set at theoretical best, 0 days. Some of the challenges faced that hindered our ability to meet the target were Personal Support Providers and rehabilitation equipment shortages in the community. These led to some delays in discharges, resulting in additional ALC days for this patient population. “Current Performance 2020” based on Apr. 1 – Dec. 31 2019.

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Implement "Southlake at Home" Program	Yes	This change idea worked as designed in reducing ALC days for a specific patient population. Southlake@home launched in Aurora, Newmarket and Keswick. Positive feedback was received from patients, families, and caregivers on the overall experience and quality of care. After eight months of progressive success, the program was expanded into additional areas within the geographical region. This program required significant collaboration with home and community partners, in effort to place ALC patients in appropriate destinations. In addition to the Southlake@home program, Southlake continued with ALC avoidance leading practices and improvement strategies, to decrease the broader ALC rate.

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3	Discharge Summaries Sent within 2 days: Discharge Summaries with a Family Provider noted on Patient Record; LOS > 2 days; Ages 65 +; includes death Current Performance FY 2018/19 YTD Q3 (%; PC organization population aged 65 and older; October 2018 - December 2019; Hospital collected data)	736	59.00	59.00	72	Southlake has been surpassing the current target since November 2018. For our 2020/2021 QIP, we have increased our target to maintain current performance. “Current Performance 2020” based on Apr. 1 – Dec. 31 2019.

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Process Evaluation	No	Our performance continued to surpass the target every month, so resources were not used to complete a process evaluation as a change idea. That said, as we continue to collaborate with our OHT partners, this evaluation will occur as part of the process. For our 2020/2021 QIP, we have increased our target to maintain our current performance, and developed a new change idea.

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4	Inpatient Falls Resulting in Harm: The number of reported falls (mild, moderate, severe and death) resulting in harm in inpatient areas as a proportion of 1000 patient days Current Performance: 2018/19 YTD Q3 (Rate; All inpatients; October 2018 - December 2018; In house data collection)	736	0.56	0.34	1.33	The target for this indicator was updated to 1.25 within 2019/2020. Unfortunately, the original target was set based on an incomplete data set (a result of our HIS implementation). Updated data indicated that current performance was 1.4 (2019/20 Q1). We set a goal of 10% improvement from the revised current performance. This indicator was one of the five corporate Patient Safety priorities for Southlake in 2019/20. The corporate focus increased awareness of performance and expectation, and units began making individual commitments to help reach the corporate goal. During 2019/2020, we began to post unit level performance for these five indicators on huddle boards throughout the hospital. This further increased awareness as daily huddles occurred on all inpatient units. Patients at risk for falls were discussed during huddles. In 2019/2020, we continued to monitor our compliance to falls risk assessment completion within 24 hours of admission, as well as completion rates of the CAM (delirium) on a monthly basis. We also were involved with the new Senior strategy working group to align initiatives related to our elder population. In Q4, we conducted sample audits on the use of falls risk identifiers for patients at risk for falls such as yellow wrists bands, falls signage and yellow non-slip socks. During the audits, we recognized that there was inconsistent signage being used throughout the organization. To address this, units were provided

					with standard, yellow, falls risk signage. The audits also helped us better understand our current state regarding individualized care plans for those identified as high risk. "Current Performance 2020" based on Apr. 1 – Dec. 31 2019.

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Implement Falls Prevention Best Practice Guidelines from Registered Nurses' Association of Ontario	Yes	Through the year, we reviewed our inpatient falls resulting in harm prevention strategies at BPSO Champions meeting. The key areas of focus in 2019/2020 were the patient pamphlet, and updating of the Standards of Care (SOCs) and the Early Mobilization Algorithm. Three of the SOCs updated related to falls were: Fall Risk Reduction-Adult Inpatient, Fall Risk Reduction-Outpatients, and Falls-Inpatients-Follow Up Assessment. Patient education included the roll out of new inpatient "Reducing the Risk of Falls in Hospital" brochure across the organization; developed with input from PFAs (Patient and Family Advisors). Additionally, we promoted the viewing of the Patient Safety Video on patient IBTs as well as Southlake website.
Falls monitoring strategies	Yes	The goal of this change idea was to identify opportunities to improve our falls monitoring of high-risk patients, establish a business case for an optimal solution, and implement in high risk areas. We initiated this change idea and identified an opportunity, which was to use a remote video monitoring system with two-way communication. We then developed the business case. Unfortunately, due to the cost of the strategy, it was not approved for implementation, however other strategies were put in place through the 5 patient safety priorities and huddle boards including an depth analysis for high risk falls.

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5	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 2018; Hospital collected data)	736	61.85	100.00	55.5	We have continued to refine our data extraction methods throughout the year, as we adapt to our new Health Information System (HIS). Process mapping efforts have assisted with standardizing the method for documenting, which support more reliable data and easier data extraction. This indicator was one of the five corporate Patient Safety priorities for Southlake in 2019/20. The corporate focus increased awareness of performance and expectation, and units began making individual commitments to help reach the corporate goal. During 2019/2020, we began to post unit level performance for these five indicators on huddle boards throughout the hospital. This further increased awareness as daily huddles occurred on all inpatient units. "Current Performance 2020" based on Apr. 1 – Dec. 31 2019.

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Continuing the implementation plan across the organization	Yes	Throughout 2019/2020, implementation continued across the hospital. This indicator measured only units where implementation was complete. As of October 2019 onward, the denominator included all inpatient units. We also further refined the indicator to include only patients where LOS > 24 hours, as these were the most appropriate patients for a Med Rec at discharge.

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6	Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period. (Count; Worker; January - December 2018; Local data collection)	736	121.00	121.00	314	A decision was made to modify the source of data for this indicator from our incident reporting software to our Occupational Health system as it was a more reliable data source. With this, we removed our target of 121 and considered the year a baseline year. There was an increase in reporting. “Current Performance 2020” based on timeframe specified in HQO Tech Specs: Jan. 1 – Dec. 31, 2019

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Monitor trends and follow up in a timely manner	Yes	All incidents were followed up on in a timely manner. In addition, we started to review trends to further understand issues and develop mitigation strategies. Some of the changes driven by the information included updating our versus system, and Violence Assessment Tool

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7	Patient Identification: Percentage of times Two Client Identifiers are used before medication administration, treatments, tests and procedures Current Performance: 2018/19 Q2 Snapshot Audit (%; All patients; Q2 Snapshot Audit; In house data collection)	736	48.00	100.00	69	This indicator was one of the five corporate Patient Safety priorities for Southlake in 2019/20. The corporate focus increased awareness of performance and expectation, and units began making individual commitments to help reach the corporate goal. During 2019/2020, we began to post unit level performance for these five indicators on huddle boards throughout the hospital. This further increased awareness as daily huddles occurred on all inpatient units. Additionally, launched during Patient Safety Week, a significant effort went into promoting 2 Patient Identification. Posters and signage were developed and placed in various areas of the hospital. This not only increased visibility to staff, but to patients/families/caregivers as well. "Current Performance 2020" based on Apr. 1 – Dec. 31 2019.

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Develop an audit and feedback mechanism	Yes	The 2 Client ID audit tool was enhanced to capture more information during audits (i.e. specifics on who was being audited, where the audits occurred, and during what process, such as medication administration). This allowed us to provide more feedback and information to the units. In Q3, we also held a contest to give out a "Patient Safety Champion" award to the unit who has the best audit results on this indicator, in effort to further increase awareness and engage staff in this important safety practice.

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8	Percent of patients with new pressure injury (stage 2 or higher). Current Performance FY 17/19 Q3 YTD Q3 Include adult acute care, complex care and rehab patients. (%; adult acute care, complex care and rehab patients; October 2018-December 2018; In house data collection)	736	1.40	1.40	2.3	This indicator was one of the five corporate Patient Safety priorities for Southlake in 2019/20. The corporate focus increased awareness of performance and expectation, and units began making individual commitments to help reach the corporate goal. During 2019/2020, we began to post unit level performance for these five indicators on huddle boards throughout the hospital. This further increased awareness as daily huddles occurred on all inpatient units. "Current Performance 2020" based on Apr. 1 – Dec. 31 2019.

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Appropriate staff education	Yes	Continued staging certification as a mandatory component for clinical staff upon initial orientation to the organization, and tracked the percentage of staff completing mandatory components. Quarterly Pressure Injury Education days (8 hours) were held. The surface selection tool was updated in the pressure injury toolkit as a staff resource. With input from Patient and Family Advisors (PFACs), an information pamphlet specific to pressure injuries was developed and deployed on inpatient units. This was a tool that staff had access to provide patients and families with, in effort to increase awareness to prevention.
Sustain innovative strategies from previous year	Yes	Throughout 2019/2020, we continued to use the trigger tool that had previously been developed and implemented. This tool created accountabilities among the inter-professional team, and helped ensure organizational compliance with pressure injury management best practices. We also continued the process to create daily situational awareness of patient safety concerns, by using quality and safety huddle boards.

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9	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 Adult, LOS>3 days; October 2018 - December 2018; Hospital collected data)	736	9.70	10.80	9.5	We have seen increasing volumes in our outpatient areas particularly in Q3 – which is also supported by our decreased readmission rate for Q3. These outpatient areas are those listed – RAAM Program (Rapid Access Addiction Medicine, run by Addiction Services of York Region but located in Southlake on West 4, Community Treatment Order Program and Schizophrenia clinic). Additionally the post-discharge clinic saw large volumes through Q3 to support patients who had been discharged. South Simcoe Assertive Community Treatment Team (ACTT) has been taking on additional patients to support patients staying home and in their community. The program continues with daily quality huddles and has also begun a Mental Health Quality Committee. "Current Performance 2020" based on timeframe specified in HQO Tech Specs: Oct. 1 – Dec. 31, 2019

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Sustain discharge and education strategies from previous year	Yes	The discharge and education strategies were sustained. However, challenges arose from having "new" patients (complex cases) move into our area, and no longer having their psychiatrist follow up and then relapsing, requiring a readmission. Another challenge is housing and group home availability in our region. In the last quarter, we have seen several pts discharged to shelters and not being able to spend extended time at those, this circumstance being a trigger for patients, having involvement of police and apprehension leading to hospital readmission. The lack of adequate housing leads to patients not having routines and not taking medications on regular basis, which result in relapse and readmission.

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10	The time interval between the Disposition Date/Time (as determined by the main service provider) and the Date/Time Patient Left Emergency Department (ED) for admission to an inpatient bed or operating room. (Hours; All patients; October 2018 – December 2018; CIHI NACRS, CCO)	736	32.47	32.47	32.50	Investigation of different strategies to improve performance of this indicator were discussed throughout the year. Change ideas are set in place for implementation for 2020/21. “Current Performance 2020” pre-populated by HQO, and based on timeframe specified in HQO Tech Specs: Oct. 1 – Dec. 31, 2019.

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Bed Optimization Project	N	This change idea was started, but not completed. The project plan was developed, and staffing levels were determined through model of care (but not implemented). This project required significant resources from IT, but due to the recent implementation of a new Health Information System, competing priorities for IT meant that this project had to be put on hold. Smaller scale change ideas have been developed and tested in 2020/2021, in effort to help drive improvements on this indicator.