Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2020/2021 QIP

Org ID: 736

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

Realizing that the QIP is a living document and the change ideas may fluctuate as you test and implement throughout the year, we want you to reflect on which change ideas had an impact and which ones you were able to adopt, adapt or abandon. This learning will help build capacity across the province.

Indicator	Change Idea	Method	Process measure	Target for process measure	Comments	Was this change idea implemented as intended (Y/N)	Lessons Learned
Discharge Summaries within 2 Days	Develop a physician engagement strategy, to drive improvements at provider-level.	Develop a feedback mechanism to provide data at physician-level. Understand processes and develop improvement strategies for physicians that could have the greatest positive impact on the overall performance.	Feedback mechanism rolled out and data provided at physician-level.	Feedback mechanism in place.	The engagement strategy will not only ensure physicians are aware of their timeliness of discharge summaries, but help create a catalyst for change in driving improvements. Using provider-level data, it will allow for a targeted focus where greatest improvements can be seen.	Yes	Southlake was already performing above target for this indicator, but continued to look for opportunities for improvement. Data on this indicator was provided at the the physician level. Surgery was identified as having the greatest opportunity for improvement. A Surgical physician champion was engaged, as well as a Medicine physician champion. In mid-Q4 we began a trial of a real-time notification system, where emails were sent to the physician champions when a discharge summary had not been sent by noon the day after discharge. The trial is still in process and has not been rolled out broadly yet, but we believe will be a successful change idea.

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90th Percentile ED Wait Time	Increase number of discharges on weekends	By using nurse practitioners and physician assistants in the medicine program, increase the number of patients discharged on weekends, resulting in more timely flow of patients in the Emergency Department (ED) requiring admission.	Increase weekend discharges from baseline.	20%	The largest portion of patients admitted from the ED go to the medicine program. By increasing the weekend discharges by 20% from baseline, it will mean patients will be moved to the unit sooner, spending less time in ED.	No	COVID and Leadership changes impacted the ability to implement this change idea.
	Trial of new patient flow system	Before 10am each day, select up to 5 patients waiting in the ED to be admitted to the medicine program, and move them in advance of their bed being ready.	Number of days where 0 patients are moved to the medicine unit prior in anticipation of a ready bed on the unit, prior to 10am	0	The largest portion of patients admitted from the ED go to the medicine program. Traditionally, patient flow is based on a "pull" system in the medicine unit (patients are moved only when a bed is ready). The introduction of a "push" system (where patients meeting Infection Prevention and Control (IPAC) clearance are moved to unit in anticipation of bed being ready) will improve flow by minimizing empty bed time between patients, and decrease the time these patients spend in ED.	Yes	This change idea was implemented as intended, and was showing success. Unfortunately due to COVID and subsequent infection prevention protocols, this change idea could not be sustained.
	Decrease length of stay through prevention of deconditioning	Prevent patient deconditioning by increasing the use of Physiotherapy(PT), Occupational Therapy (OT), and Physiotherapy Assitants (PTAs) outside traditional areas and hours.	Develop measure to track early mobilization strategies.	Mechanism to measure in place.	When patients are immobile, it can cause deconditioning which often results in increased length of stay. This ultimately impacts patient flow, and creates a backlog in the ED for patients needing to be admitted. By improving mobilization (trial in ED for all patients, and on weekends in medicine program), it can help decrease length of stay.	No	A team approach in helping to mobilize patients on the weekends was supported rather than a specialized group of practitioners. A trial “Up For Meals initiative” was piloted on two medicine units (Rebilitation Neuro Unit and Medicine 6) prior to COVID. Due to COVID and other prioritizes it was not considered on other units.

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Average ALC days for Southlake@home patients	Implement strategy to ensure rehab equipment in the home is fully utilized by patients.	In partnership with patients, families and rehab professionals (hospital and community based) co-design a most required list of rehab equipment for discharge.	For each patient discharged with rehab equipment, the number of pieces of equipment used by the patient /number of pieces of equipment ordered.	80%	In 2019/2020 it was identified by the community rehabilitation professionals that many pieces of rehab equipment recommended by the hospital rehab professionals were unused by the patients. In addition, the community rehab professionals identified that much of the equipment recommended was not required to meet the patient's goals. Further, in bundled care programs, efficiency and effectiveness of services and equipment is a responsibility shared by all partners. Thus it is in the best interest of the program to develop tools to ensure all pieces of rehab equipment provided by the program are fully utilized.	Yes	Worked with the Champion group to ensure appropriate equipment was ordered, focusing on minimum required at discharge. Rehabilitation provider in community would order additional equipment, when required. A mechanism was in place to measure utilization and monitor process.
	Understand root causes of ALC days to home, and develop strategies to address common issues identified in 2020/2021.	Synthesis of root cause analyses will be provided to Champions Group and where appropriate Hospital Leadership tables to co-develop plans to address underlying issues.	Percentage of patients discharged through Southlake@home with ALC days > 0, that are investigated and assigned a primary root cause.	100%	Southlake@home is an integrated, bundled care program for patients with frailty, social and medical complexity. Thus addressing the root-causes of ALC days associated with these patients is multi-factorial. It is important to determine the root causes associated with ALC for the Southlake@home population and theming these causes. This work will inform both the future opportunities for the program and enhance the overall local knowledge of ALC prevention and management with the hospital. In addition, emerging new barriers should be more readily identified and addressed.	Yes	All patients with Southlake@Home days >0 were reviewed to determine and address root cause. After the Southlake@home program 43% of patients were discharged to self care. It was identified that system issues such as not having enough social housing, lack of system wide resources and/or patients with responsive behavours related to advance dementia were root causes or contributing factors for patients who were not able to transition to home. In addition, there were also delays relating to access to Restorative Care Unit due to COVID outbreaks.

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Information on Discharge	Corporate roll out of PODS (Patient Oriented Discharge Summary). PODS is a paper-based communication mechanism to provide patients with a summary of the information they need post-discharge.	By the end of 2020/21, PODS will be rolled out on all inpatient units in the hospital.	Percentage of inpatient units where PODS is rolled out on.	100%	PODS was developed with input of Patient and Family Advisors (PFACs). After 6 months of use, an evaluation will take place to determine if changes are required in the tool.	Yes	Roll-out began corporately in February 2020. Evaluation in September 2020 revealed sustainability was an issue on some units. Re-education occurred and further rollout was to resume. Due to COVID related activities, re-evaluation has not yet occurred. Electronic options are currently being explored.

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Workplace Violence	Investigate special cause variation of workplace incidents.	Use the last 2 years of baseline data to understand normal variation of reported workplace violence, and determine an upper tolerance level. Any month where reported incidents are above the tolerance level, complete a full investigation to understand root cause(s).	Determine upper tolerance level for monthly workplace violence incident.	Tolerance level established	Collect monthly statistics on reported workplace violence, and share with JHSC and WPV Prevention Committee, showing comparison to tolerance level. Frequency and Severity rates reported quarterly as a cumulative number, to collect baseline data at this level of detail.	No	We continue to work with Meditech to pull the worked hours report to be able to determine frequency and severity. We hope to have this in place for the new fiscal 2021/22
			Number of investigations completed, divided by the number of months where reported incidents were above tolerance level.	100%	JHSC and WPV Prevention Committee will be involved in investigations and the follow-up of corrective actions.		
	Expand WPV Prevention training to other high risk groups based on a risk assessment.	Have all departments complete a risk assessment, to identify gap in education needs	Number of departments completing risk assessment by June 30 2020, divided by the number of departments.	100%	To understand and address gaps in education relating to workplace violence	Yes	Many risk assessments have been completed: EMHAU, ED, CAN, MACU. The rest of Medicine is booked to be completed by the end of April. The MH program will follow. Due to COVID activities, the WPVP education was put on hold from April to September 2020. We did complete a train-the-trainer program in August and October, and commenced training, encompassing all the high risk areas. Unfortunately, again due to COVID-related limitations, class sizes have not been optimized. Since January 2021, limitation on room capacity have only 9 attendees have been allowed per class.
		Optimize class enrollment in WPV training sessions	Number of people participating in the classes divided by the number of spots available.	90%	For those requiring additional education, ensure class enrollment is optimized		

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Patient Identification	Continue with audit and feedback mechanism developed in 2019/20.	Complete random audits on compliance to Two Patient Identification Policy, and report data back at both corporate level and unit level.	Percentage of audited units provided with unit-specific data on a quarterly basis for posting on quality and patient safety huddle boards.	100% of audited units provided with quarterly data for posting on huddle board.	Patient Identification has been identified as one of the top 5 Patient Safety priorities for the organization. Through a marketing campaign and the enhancement of communication relating to audit performance, we have already seen improvements. By continuing with visual management at the unit level, we expect to continue to see performance by driving awareness.	Yes	Between Q1-Q3, 845 audits were completed. Audit results at the unit level were shared quarterly for posting on huddle boards. In Q3, the organization participated in a competition related to patient identification. For two weeks, audit results for each unit were shared daily with the organization. This not only increased awareness of practice expectations, but also drove improvements in the measure. Providing unit level data did make an impact. In Q4, the method to audit was modified to be more sustainable, by leveraging existing real-time surveys, and engaging patients in helping evaluate our performance on this indicator.
	Identify and share learnings relating to incidents resulting from patient identification errors.	Standardize the mechanism to identify and share learnings relating to incidents resulting from patient identification errors.	Mechanism in place and followed.	Yes	By identifying and sharing learnings from incidents relating to errors in patient identification, it will help put into context the importance of the process, and communicate the negative impact that can result if not properly done.	No	Due to the limitations of the existing incident management reporting system, this change idea was not feasible. It was not easy to identify and trend incidents relating to patient identification errors. As we designed our new incident reporting system that will be rolled out in 2021/22, this was kept in mind. With advanced administrative rights with the new system, we will be able to identify a standard mechanism for identifying incidents relating to this, and can appropriately share learnings.

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Pressure Injuries	Improve system to monitor location of therapeutic surfaces (beds)	Use the Versus monitoring system to track therapeutic surfaces in the hospital. At all times, the location of these surfaces should be known. Develop mechanism to ensure assets do not lose visibility at 30-day.	Percentage of times that all beds can be located through versus system, when audited.	100%	Therapeutic surfaces (beds) help maintain skin integrity for those at risk for pressure injuries, through pressure relief. At times, there is a delay in acquiring the appropriate beds for those at risk, due to inaccurate asset tracking. If a bed has not moved for 30+ days, there is no longer visibility of the asset, which makes them more difficult to locate. This change idea will help improve monitoring of asset locations.	No	Recently, the Versus system underwent an upgrade and unfortunately, the ability to find the specialty surfaces was lost. Work is underway to fix this issue prior to the start of 2021/22.
	Enhance data sharing of reported Pressure Injuries	Using data from our Incident Management software, provide unit level data, to increase awareness of trends, and drive commitments and improvements at the unit level.	Data used to inform unit commitments relating to decreasing pressure injuries	Yes	In addition to the Prevalence and Incidence study data which feeds the QIP indicator, unit level data from our incident management software will be used to increase awareness about emerging trends. Units can use this information to help inform their unit/program commitments, to be discussed at daily huddles.	No	Data from our current incident reporting system was provided at the program level, but not at the unit level. Data from our quarterly prevalence and incidence study was provided to each unit. Many strategies were used to address issues relating to pressure injuries, including a briefing note to senior team, investigations presented at QCC (Quality of Care Committee) resulting in recommendations, engagement with MAC (Medical Advisory Committee) as well as information to front line through the Southlake newsletter.
	Complete a pressure injury process map and identify strategies for improvement.	Identify primary contributing factors leading to pressure injuries and strategies to mitigate.	Process map completed	Yes	A process map will help inform where gaps exist, and identify areas of further opportunities in prevention of pressure injuries	Yes	The Quality and Risk team, in collaboration with the Professional Practice team, mapped out the process for identifying and addressing pressure injuries. This exercise identified several opportunities in the existing process, including accountabilities, duplication of documentation, as well as gaps. One of the outcomes to the process mapping was the future design of the follow up for pressure injury documentation from management. Currently we have a manual pull process where the quality team asks for confirmation of staging and interventions in place once a pressure injury is identified. This manual process will be automated with the new incident reporting system coming in 2021/2022.

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Inpatient Falls with Harm	Continue feedback mechanism developed in 2019/20.	Report falls data at both corporate level and unit level on a quarterly basis.	Percentage of inpatient units provided with unit-specific data on a quarterly basis for posting on quality and patient safety huddle boards.	100% of inpatient units provided with quarterly data for posting on huddle board.	Falls reduction has been identified as one of the top 5 Patient Safety priorities for the organization. Data will be provided on a quarterly basis to units for posting on quality huddle boards. By continuing with visual management at the unit level, it will increase awareness and encourage conversations at daily huddles.	Yes	As one of our Five Patient Safety Priorities, all inpatient huddle boards have designated areas for data on these indicators. The falls data was provided to all inpatient units each quarter for posting on these boards.
	Monitor compliance of falls risk identification.	Develop a mechanism to audit whether appropriate falls risk identifiers are in place for patients at highest risk for falls.	Mechanism in place and used to audit.	Yes	In addition to falls prevention strategies such as individualized care plans for patients at risk of falls, Southlake uses visual falls risk identifiers to increase staff awareness of these patients, which help keep them safe. Examples include a yellow sign above their bed, a yellow patient armband, non-slip socks (where appropriate), and falls risk being flagged on huddle board/MPV board.	Yes	An audit tool and process was developed in 2020/2021, and used as planned. Through auditing, gaps were identified and addressed to ensure consistency and standardization across the hospital. For example, it was identified that non-laminated sheets of different color were being used for falls signs. Through investigation, we learned that our environmental services team had been throwing out the signs intended to be used, instead of cleaning them after patient discharge. This was leading to a shortage of posters. We worked with professional practice to resolve the communication issues to inform the processes to key stakeholders.

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Medication Reconciliation at Discharge	Continue to improve and refine processes and measures that were introduced in 2019/20.	Complete a deeper dive into areas where there is a suspected gap between what the data shows and what is believed to be occurring. In areas where improvements are required, use a physician champion to support process improvement.	Engage a physician champion to help develop improvement strategies for other physicians that could have the greatest positive impact on the overall performance.	Physician champion in place.	There are some areas where it is believed that Medication Reconciliation at Discharge is occurring 100% of the time, but the data is not reflecting that. In these areas, the data will help identify where improvements in the measure may be required. A physician champion will help support a targeted focus where greatest improvements can be seen.	Yes	Throughout the year, we continued to refine the measure to ensure data was being captured on the various forms being used for Med Rec on Discharge. We worked with physician champions to identify gaps and forms not being captured. Maternal Child continues to be an area of focus, and ensuring documentation is completed in the health information system that can be captured in the measure. This work is expected to continue in 2021/22.

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Patient Satisfaction	Corporate roll out of patient-ambassador volunteer program.	By the end of 2020/21, patient-ambassador volunteer program will be rolled out on all inpatient units in the hospital.	Percentage of inpatient units where patient-ambassador volunteer program is rolled out on.	100%	The goal of patient-ambassador volunteers is to enhance the experience of patients and their families/caregivers while in hospital. Patient-ambassadors provide information about parking, food services, ensure patients know how to access the patient handbook (which includes information on safety) and welcome video, as well as provide support in using the "smart tv". Limitations include patients on precautions and those where volunteer safety is at risk.	Yes	The on-site Volunteer program was paused on March 16, 2020 due to COVID. The duties of the patient-ambassador volunteer were incorporated into Patient Family Liaison (PFL) pandemic position supported by redeployed staff. Pandemic visitor restrictions increased the importance of the PFL as it facilitated communication between patients, families and the healthcare team. This positon was well received by patients, families and staff. Key Learnings: • Taking time to provide information to patients and families improves the patient experience; • The positive impact of technology, regardless of a pandemic; • The benefits of video chat technology for patients isolated due to precautions and/or with loved ones that cannot travel; • How we could benefit from an in house chat feature platform to support group sessions for patients that cannot leave their rooms. Impact: • Have received very positive feedback from patients and their families; • The team was awarded the 2020 Champions award for the Courage to Think Differently. Advice: The PFL team shared their process, learnings and technology with other healthcare organization in Canada and the USA.