Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2016/17 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 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
1	30-day All Cause Readmission rate for Patients with COPD (QBP cohort) (%; COPD QBP Cohort; 2 year baseline - FY 2012-2014; CIHI DAD)	674	21.00	19.00	30.40	The COPD readmission rate continues to be a challenge for us. Patients who are enrolled in the ICC program do have a lower readmission rate that is below target; however the challenge is that we don't yet have funding for all COPD patients to be included. When it was clear that we were not going to meet this target, the entire multidisciplinary team gathered in January of 2017 with the purpose of re-evaluating the current project plan, and establishing a number of PDSA improvement cycles in order meet the target.

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Change Ideas from Last Years QIP (QIP 2016/17)	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?
Continued work with patients enrolled in the Integrated Comprehensive Care Program (ICC)	No	The Integrated Comprehensive Care Program is an innovative program that provides comprehensive follow-up in the community. Enrollment in the program didn't increase as expected.
Reinforce teach-back	Yes	Education to the staff was refreshed on the

education methodology.		teach-back method. The educational package was redeveloped for COPD patients with input from staff and patient advisors.
Ensure all eligible and interested patients are enrolled in Caring for my COPD -a community based program.	Yes	Staff identify patients who are interested and who qualify for this program.

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2	Enhance appropriate antibiotic usage and timely cessation of antibiotics in the General Internal Medicine program. (Number; All acute medical patients; March 2017; Hospital collected data)	674	CB	75.00	64.00	Current performance is 64%, however target is expected to be achieved. •The pharmacists and medical teams have been committed to reviewing antibiotics. •Formally documenting the reviews has taken some time to become more firmly established in the team workflows.

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Enhance appropriate antibiotic usage and timely cessation of antibiotics.	Yes	Impact of the change: •Reinforcing the documented outcomes from antibiotic reviews provides clinical information that is useful for the care team when making treatment decisions. •Tracking clinical outcomes, such as duration of therapy reductions and/or overall usage data is still being compiled, so it is difficult to know the magnitude of impact from this perspective. Advice for others: •Continued follow-up with the team regarding the results that are compiled from the monthly auditing; to celebrate accomplishments and also discuss potential barriers and strategies to overcome.

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3	Percent of patients seen within 60 days of referral. (Days; Mental health patients; March 2017; Hospital collected data)	674	48.60	61.00	95.00	This indicator was directly related to our ability to service patients in a timely manner. For some time we were concerned about wait time for our service and had made some minor changes, but were not able to sustain any real improvements. Our change idea has made a significant impact on the time patients are waiting to see us for the first time. That said- there are still other waits associated with care in our program and now we will need to address these this year.

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Improvements in intake process as well as clinic structure.	Yes	One primary learning was the support and timely response that we needed to report data for this initiative. Registration of patients in our registration system and interface with the scheduling system had not been validated for some time and it was not clear who should have the responsibility for this action. Early on in our QIP it was evident that the data was not matching up and that there had been some knowledge of this by persons working outside of our program, but did not bring it to my attention. These then had to rectify quickly to ensure that reporting for QIP was accurate. Advice to others is to ensure that you determine a realistic QIP based on accurate data- and review and rectify any outstanding data issues that exist.

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4	Percent of patients that have a conversation with their healthcare provider within 48 hours of admission on their plan of care. (%; All acute patients; March 2017; Hospital collected data)	674	50.00	80.00	83.00	The practise of reviewing the plan of care with patients was not new to our practitioners, however, the standardization of documenting these conversations was a challenge. With our current paper-based systems, this was an added piece of work as was auditing our progress. As with any change, engaging stakeholders and allowing them to direct the change ideas led to the success of this initiative.

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Continued roll-out of the 48-hour conversation	Yes	The 48-hour conversation (which we later changed to "Plan of Care" as part of the Home First Refresh in the HNHB LHIN was rolled out and we achieved our goal of increasing to 80% of our patients. Initially we had asked clinicians to document in the chart which was difficult to achieve consistency on. The team then worked together to document during patient care rounds which was a much more consistent approach.
Reviewing content and perceptions with patients of the Plan of Care.	Yes	We are still implementing and collecting information, but the next phase of this initiative is to interview patients and families to assess the comprehension, feeling of collaboration and satisfaction with their participation in the plan of care.

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5	Percent of planned discharges that receive all components of the "Keys to Discharge" program. (%; Mental health patients; Fiscal; Hospital collected data)	674	0.00	100.00	100.00	The Key Steps to Discharge initiative is a comprehensive discharge planning process that involves the multidisciplinary team to begin to prepare patients for discharge from the time they arrive. This initiatives was implemented on the Schizophrenia and Community Integration unit (HN2). In addition to a discharge planning meeting during the last week of hospitalization, the other five steps include: •Key Steps to Discharge Form – completed at admission •Groups: 1) Goal Setting Group and 2) Peer Support led Group •Patient Communication Whiteboards – in every patient room •Patient Resource Binder •Unit Poster

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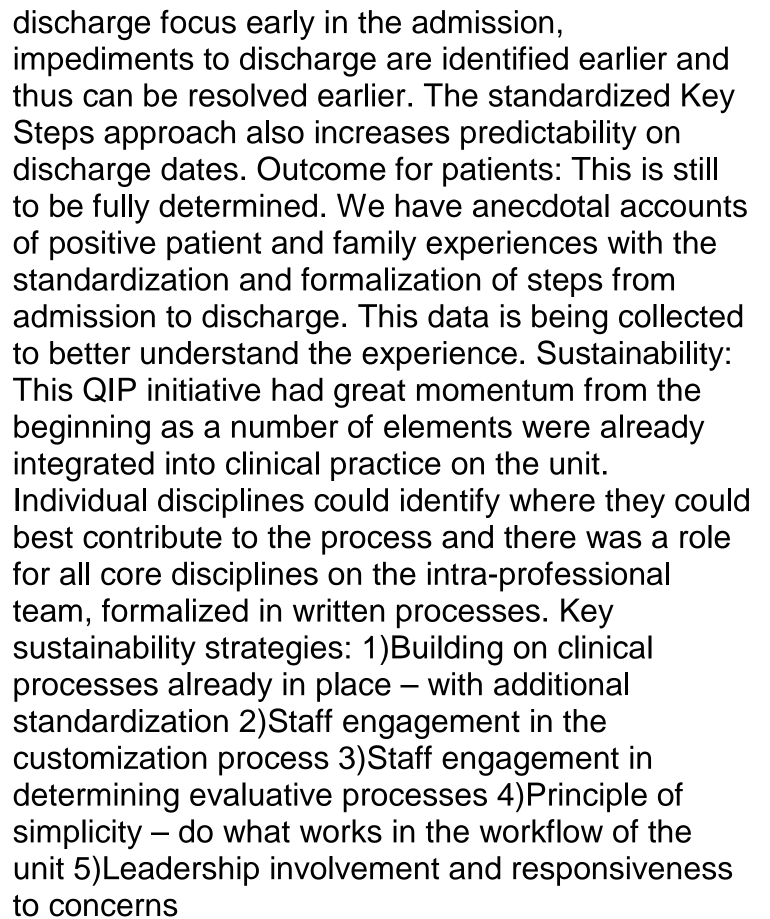
Implement the "Keys to Discharge" program in the Schizophrenia Community Integration Services on Harbour North 2.	Yes	Leadership Involvement: From the beginning there were regular QIP Project meetings chaired by the SCIS Director and often attended at by the Head of Service. Membership includes team members from all 3 units along with the managers. The commitment, support and endorsement of the service leadership in the development, implementation and evaluation of the project has helped to make this QIP an ongoing success. Identification of challenges, barriers and learnings are welcomed yielding good solution finding discussions. Benefit to Patient Flow: With a



discharge focus early in the admission, impediments to discharge are identified earlier and thus can be resolved earlier. The standardized Key Steps approach also increases predictability on discharge dates. Outcome for patients: This is still to be fully determined. We have anecdotal accounts of positive patient and family experiences with the standardization and formalization of steps from admission to discharge. This data is being collected to better understand the experience. Sustainability: This QIP initiative had great momentum from the beginning as a number of elements were already integrated into clinical practice on the unit. Individual disciplines could identify where they could best contribute to the process and there was a role for all core disciplines on the intra-professional team, formalized in written processes. Key sustainability strategies: 1)Building on clinical processes already in place – with additional standardization 2)Staff engagement in the customization process 3)Staff engagement in determining evaluative processes 4)Principle of simplicity – do what works in the workflow of the unit 5)Leadership involvement and responsiveness to concerns

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6	Proportion of patients receiving medication reconciliation upon admission into the ICU, medical step down (MSDU) and nephrology inpatient units (%; ICU, MSDU, nephrology; April 2016-March 2017; Hospital collected data)	674	CB	90.00	100.00	Medication reconciliation is a key patient safety initiative. For the 2016-17 QIP, our goal to achieve admission Med Rec for 90% of patients admitted to Critical Care and Nephrology with an anticipated length of stay greater than 48 hours for 3 consecutive months was successfully achieved in June 2016, and has been maintained since; with several months achieving 100% completion rates.

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Expand medication reconciliation into our Critical Care areas (ICU, MSDU) as well as nephrology inpatient unit.	•Pre-existing Med Rec processes in the target areas provided a strong foundation upon which to build the QIP work. •Pharmacists are completing admission Med Recs within 48 hours of patient admission for majority of the patients. However, there is always a role for other health care professionals to contribute to the process and with the implementation of our new IT system; some of the workflow will change. •Nurses and prescribers are aware of the process and have been appreciative of the Pharmacists' effort as indicated at various orientation sessions held for new residents in the past few months. Impact: • We have been able to raise awareness about Med Rec process and its significance	

at orientation sessions held for the new residents every month starting in December 2016. •The completion rates for admission med rec for patients with length of stay greater than 48 hours have surpassed our initial expectation. •The success of this QIP indicator has been recognized by the Senior Leadership and Joint Board of Governors. •The completion rates for transfer and discharge med recs are being monitored as well and we are pleased to note full implementation of Med Rec at each transition of care as per our plan for spread across the organization. Advice for others: •It’s important to understand existing workflows in all areas before implementing the change. •Including front line staff as part of the working group is helpful for the successful implementation. •Regular feedback and monitoring helps to track progress and make changes in the initial plan. •Sharing success helps to positively reinforce the change and improve quality.

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7	To implement an early warning score as part of the vital signs reporting tool for nursing. (Number; Acute nephrology, medical patients; Fiscal; Hospital collected data)	674	0.00	3.00	5.00	This initiative was a "spread" initiative based on the success of the Early Warning Score implementation in the surgical program in the previous fiscal year. The Early Warning Score is now applied to all Acute medical surgical patients in ward beds. The project team exceeded the target of implementing on 3 inpatient units and were successful at implementing on 5 as well as including admitted patients in the emergency department as well as patients who are leaving the surgical recovery area.

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Implement Early Warning System on nephrology inpatient unit as well as 2 General Internal Medicine units.	Yes	This project followed the same implementation structure was used in the year prior for the surgical program. A few small changes were made to the scoring system: 1) a system developed for patients with COPD 2) system developed for patients with chronically low blood pressure to be used where appropriate with the nephrology population. Clinicians choose appropriately when to use which scoring system. The fear was that the new system would trigger many calls to the medical team but only approximately 5% of all EWS scores led to a call to the team and all were deemed appropriate.

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8	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 2015 – September 2015; WTIS, CCO, BCS, MOHLTC)	674	14.00	9.47	13.48	ALC Reduction has been a focus within our organization for several years. During the past year, we have undertaken a multipronged approach with two specific foci of Admission Avoidance in the ED and ALC Reduction throughout the organization.

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Avoid admission of patients in the Emergency Department who could be cared for in the community.	Yes	This has been fully implemented Monday-Friday, and is currently expanding to include the weekend. This is an inter-disciplinary approach where the team meets and reviews potential admissions avoidance daily. Interestingly, this complement of staff has always been available in the ED, it just took a shared vision with key stakeholders to make it possible.
Fully implement home first philosophy.	Yes	We are working towards full implementation; the next element includes spread into the Mental Health program - one portion of which is on the QIP for 2017/18.