Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2014/15 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 2014/2015	Current Performance as stated on QIP14/15	Target as stated on QIP 14/15	Current Performance 2015	Comments
1	ED Wait times: 90th percentile ED length of stay for Admitted patients. Hours ED patients Q4 2012/13 – Q3 2013/14 CCO iPort Access	27.95	25.00	26.42	This is not an indicator we focused on for our 2014/15 QIP.

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Change Ideas from Last Years QIP (QIP 2014/15)	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?
	No Comment.	

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2	Total Margin (consolidated): % by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expense, excluding the impact of facility amortization, in a given year. % N/a Q3 2013/14 OHRS, MOH	0.49	0.00	0.54	This is not an indicator we focused on for our 2014/15 QIP.

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3	HSMR: Number of observed deaths/number of expected deaths x 100. Ratio (No unit) All patients 2012/13 DAD, CIHI	93.00	93.00	NA	This is not an indicator we focused on for our 2014/15 QIP.

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4	Percentage ALC days: Total number of acute inpatient days designated as ALC, divided by the total number of acute inpatient days. % All acute patients Q3 2012/13 – Q2 2013/14 Ministry of Health Portal	14.87	11.00	17.54	This is not an indicator we focused on for our 2014/15 QIP.

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5	Percentage of acute hospital inpatients discharged with selected Case Mix Groups (CMGs) that are readmitted to any acute inpatient hospital for non-elective patient care within 30 days of the discharge for index admission. % All acute patients Q2 2012/13-Q1 2013/14 DAD, CIHI	19.22	15.00	20.49	This is not an indicator we focused on for our 2014/15 QIP.

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6	In-house survey (if available): provide the % response to a summary question such as the "Willingness of patients to recommend the hospital to friends or family" (Please list the question and the range of possible responses when you return the QIP). % Other Other In-house survey	93.00	85.00	NA	This is not an indicator we focused on for our 2014/15 QIP.

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7	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 Most recent quarter available (e.g. Q2 2013/14, Q3 2013/14 etc) Hospital collected data	67.00	100.00	100.00	This indicator was focused on the following: 1. Implementation of Med Rec Plan for Rehabilitation Services. 2. Completion rate of > 100% for patients admitted to Rehab Services in February/ March 2015.

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Medication will be reconciled for 100% of patients admitted to Rehabilitation Services.	Yes	Key Success Factors: - Identify leadership and scope for the initiative, specifically roles, responsibilities and accountabilities when there is a corporate priority being implemented within a program// Involve staff, physicians and patients throughout the initiative//Understand the medication reconciliation process on each unit/program that refers to Rehabilitation Program and within the Rehabilitation Program, identify gaps and develop strategies to address such (consider completing a Value Stream Mapping Exercise) //Implement process changes for each step consecutively // Maximize utilization of information technology//Complete regular audits of completion rates and share results with team members to reinforce, acknowledge and celebrate progress.

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8	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 - Average for Jan-Dec. 2013, consistent with publicly reportable patient safety data. Rate per 1,000 patient days All patients 2013 Publicly Reported, MOH	0.59	0.39	0.42	The focus of this project was to reduce catheter use in the operating room, and specifically for patients having orthopedic surgery and colorectal surgery. The focus on this project has resulted in a reduction of catheter use in the operating room in general - the concept has spread to other disciplines.

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Introduce best practices that reduce the need for antibiotics Our goal is to introduce best practices that reduce the need for antibiotics during hospital care. The use of antibiotics is a major risk factor for CDI. For 2014/15 our focus will be on a reduction in the use of urinary catheters because they increase the risk of urinary tract infections that require antibiotics used to treat them.	Yes	Key Learnings: Our work at Quality Council where we focused on nurse sensitive indicator results really meant something to staff- they were upset that we didn't look great in comparison to some peer hospitals and there was enthusiasm to fix it. - Nurses specifically are now paying closer attention to the sterile technique used by everyone - at the Quality Council developed evidence based rational for catheter insertion and made them simple (this led to new policy) - some procedures such as many gyne cases need a catheter so that the full bladder doesn't get accidentally nicked during the case; other cases like total joints were looked at and it was clear that the anxiety around getting patients up within hours of their surgery was the driver vs. sound clinical

rationale. - with the new guidelines, nurses began to look critically at catheter use and this led to changing ingrained habits - We also took catheters off the case carts for certain procedures where a catheter was not routinely required so that the staff had to go look for a catheter if they needed one vs. routinely having one at hand.

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9	The number of seclusions in 3 phase one clinical units as measured in Quarter 4 of the fiscal year. Seclusions are measured by clinical staff who use hand held electronic tablets to conduct assessments and to monitor the health and well-being of patients at regular intervals. Counts Mental Health Patients in Three Clinical Units Q3 See definition above.	167.00	125.25	NA	Q4 data is not yet available for this indicator, as of Q2, we had achieved a 39% reduction in seclusions on phase 1 clinical units. The four levels of debriefing: • Post-Acute Debriefing, facilitated by the Unit manager/Supervisor, and engages as many of the staff directly involved as possible, conducted before end of shift. • Peer Debriefing conducted by a Peer Support provider, with the individual who was secluded/restrained to gain an insight into the individual's perception of the experience, and how they can be supported in future. • Family Debriefing, conducted by assigned Nurse or Social Worker, to notify the family and get their perspective and to gain insights to the individual allowing us to be more proactive in our interventions. • Formal Debrief, facilitated by the program Director and Head of Service, the manager and charge nurse summarize the findings from all three debriefs and provide context. This group identifies themes, organizational factors, and recommendations etc. that can improve patient experience and help with reduction in seclusion/restraint use.

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Our goal is to reduce Seclusion Incidents in Mental Health by	Yes	Key Success Factors: The Seclusion/Restraint Debrief protocol is part of a larger Restraint Reduction Strategy, which is based on six core strategies

debriefing with the clinical teams involved after every seclusion.

that the Mental Health and Addiction Program at St. Joseph's Healthcare Hamilton has adopted. Over the past few years, the five strategies, namely, Senior Leadership, Data/Evaluation, Peer Support, Workforce Development, and Prevention had been established.// Debriefing has been successfully rolled out on all the Inpatient Units at the West 5th campus, the Acute Units and Psychiatric Emergency Services at Charlton Campus are starting during April 2015. // The main reason for the successful implementation is the senior leadership commitment and the non-punitive nature of the discussions at the debriefing meetings. There are four levels of debriefing that aim to cover all aspects of patient experience and what led up to the event and how we can better support the patient and staff to reduce the occurrence and length of seclusion/restraint events. Immediate follow-up on lessons learned and process changes, stemming from the debriefing discussions have encouraged staff to continue to participate in the process. // Lessons learned: End user engagement in planning phase// Visibility of senior leadership commitment and participation// Incorporating end-user feedback in a timely manner, both in the process and any required practice changes that support the initiative and improve patient care. // For example, clear definitions and procedure provided for Use of Chemical Restraint in the policy. Plan of care for individuals secluded off unit clearly defined. //

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10	Completion of a Patient Shadowing Project. The project will be co-designed by hospital staff and members of our Patient and Family Advisory Council. Project Completion All patients Q4 Project Report Out	0.00	1.00	1.00	Staff partnered with Patient and Family Advisors and piloted "patient shadowing". We used a train the trainer model and have been able to spread the concept of patient shadowing to multiple ares within the hospital. This is an excellent method of gaining an understanding of the patient's experience and can be used in conjunction with other information the unit/program area has already collected relating to quality. This initiative has led to our involvement in a CFHI collaborative: patients partnering with staff to develop education related to the discharge process on a specific unit.

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Introduce patient shadowing using a pilot project. Patient shadowing will provide a mechanism to identify improvement opportunities from the bedside perspective of our patients and their families. The direct involvement of our Patient and Family Advisory Council as co-designers brings a powerful added dimension and face validity to the project.	Yes	Key Success Factors: - already established Patient Family Advisory Council; our patient advisors were eager to participate - communication to all physicians and staff in the area that is shadowing patients; everyone needs to be aware of the rationale of this undertaking - established quality councils that can take this information and link it with already known quality metrics to paint a complete picture - leadership support - organizational goals and desire to improve the patient experience