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.

******* Note: These current performance are based on Q3 result (not year end results)**
CB : Collecting Baseline

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19 (previous year end result)	Target as stated on QIP 2018/19	Current Performance 2019	Comments
1	"Would you recommend this hospital to your friends and family?" (Inpatient care) (%; Survey respondents; April - June 2017 (Q1 FY 2017/18); CIHI CPES)	927	69.00	71.	**70.00 (Q3)**	Current Performance is based on April – December data. Pending Q4 results

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.

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?
Implementation of patient experience framework and supporting experience scorecards across organization.	Yes	Established framework based on NRC /Patient First structure . We have supporting scorecards developed which will roll out in April . Indicators are monitored at various committee levels and quarterly reports provided to programs and reviewed with Patient Family Advisory Committee to assist in advisement on quality improvement initiatives based on patient feedback.
Empowerment of patients and families to be involved in their health care journey	Yes	Inclusion of patient /families in setting goals. Pilot occuring on RH4 on new Care Planning Tool and tool provided to patient/families . Metrics related to questions in surveys related to inclusion in decision making and setting goals of care. Working of new CAre Plan pilot .
Identify plan for frontline care providers an customer service focus	No	Not completed - budget/capacity challenges. Looking at potential of combination of service

	excellence training and “Just culture” training as option
Real time surveying of patients/families . Patient /Family Advisory /COmmittee members conducting patient to patient surveys.	Implemented role of Quality Specialist Advocates to meet with new admissions (and conduct small survey) and meet with them just before discharge (and conduct small discharge survey) . Very positive pilot and patient's very supportive and appreciative of the personal touch of talking to someone on arrival and just before leaving.

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
2	# Of Code White (current definition used by OH & S) without injuries. Based on the % of total incidents (lost healthcare claims and lost time) (%; Employees , Code White incident; 17- 18 (up to Q3); In house data collection)	927	82.90	90.00	**80.00 (Q3)**	This indicator is different from the mandatory HQO indicator (# of Violence Incidents) and is the indicator that we have been collecting data on for several years. While we did not reach the target of 90%, we have continued our efforts to raise awareness of the issue of workplace violence in healthcare and encourage staff to report. We embarked on a communications plan in the last year that has resulted in an increase in reporting. The communications plan was two-fold: targeting the public with posters and banners advising of our zero tolerance for violence/aggression policy and secondly, targeting our staff with posters and communications encouraging them to report any incidents of violence with the slogan “It Hurts to be Quiet” and “Violence is Not Part of the Job”. We are hopeful that this will help reach our target next year. As well, we have introduced a new “Threshold Case Review” policy that allows for deep dives into root causes of any violence patterns, repeat offenders or egregious incidents by our multi-disciplinary Workplace Violence Prevention Committee (WVPC) to ensure every control measure reasonable in the circumstances is being implemented and followed by our staff and learnings, improvement and prevention initiatives are spread

throughout the organization. We are also embarking on the creation of a four-part video series aimed at staff education called "Awareness Keeps You Safe" – the first video has been completed and deals with Lockdown/Active Shooter education. The remaining videos – Patient/Family Violence, Worker to Worker Violence and Domestic Violence will follow next year. We have also added a full-time Safety Advisor position whose first piece of work was to facilitate the update of all job hazard analysis for every position at our organization and whose on-going responsibilities will include auditing our workplace violence initiatives to ensure compliance. We believe this auditing will have a significant impact on our performance. Of note is that after we trained all 1100 of our staff in mandatory 8 hour Crisis Intervention Training in 2016, all of the re-certifications have come due starting late last year. We believe that perhaps a contributing factor to not reaching our target this year was that the training we provided to all staff to help them de-escalate violent situations was needing to be refreshed. As a result, one of our learnings from this year is that we cannot let up on our efforts to keep workplace violence at the forefront of our education and awareness plans with staff – it is a constant process of learning and improving.

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.

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?
Workplace Violence Committee to establish	Y	Committee fully operational
Partner with ONA and PSHSA (Public Service Health and Safety Association) to update and introduce the PSHSA Violence Prevention Toolkit.	Y	We have actively pursued and nurtured a partnership with the Ontario Nurses Association (ONA). As a result of this partnership, we are working together to enhance our non-violent crisis intervention training and will be making site visits to other hospital's in the Province together with ONA provincial and local representatives to review best practices. In addition, we are working closely with them as we work through the establishment of a chart-flagging policy and procedure for our organization. This is a complex endeavour due to the unique nature of our inpatient and multiple outpatient and off-site programs. The partnership has been fruitful and culminated with a joint media event during which ONA's Provincial Health and Safety Specialist spoke publicly about the amazing work we have done as an organization and the value of our partnership. In terms of our work with the Public Service Health and Safety Association (PSHSA), we have also cultivated a strong relationship with that organization we well. We presented jointly with the PHSHA at the Sixth International Conference on Violence in the Health Sector in Toronto in the fall of 2018. Together, we were awarded best abstract at the conference. Using the PSHSA's guides, we have incorporated most of their tools and suggestions into our existing Workplace Violence Prevention Program. We were particularly interested in completing our updated Violence Risk Assessment for the organization using PSHSA's on-line tool. We have attended a number of sessions to learn to use the tool and we have registered as a user. However, due to the nature of the work to be done and the intensive resources required to complete this project successfully, the Executive Leadership Council has deferred this to 2020-2021 due to the fact that we have a number of significant organization wide initiatives that require focus this year (Accreditation and Health Information System Implementation).

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
3	Average Latency - Ministry of Child /Youth Services Indictor - P11a. Regional Children's Centre. ** Average Time from initial contact to wait list. (Days; Children's Mental Health; 17-18; MCYS Indicator - P11a)	927	CB	CB	CB	The definition for this indicator was never defined through MCYS, most likely due to changes occurring at that level. Comments are related to general work that was completed around assessing and improving wait times in the program.

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.

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?
Conduct a Current State Mapping Session to establish Improvement Plan for 18-19	Yes	Current state mapping related to access and flow of patients was completed. This is very helpful in identifying where gaps are occurring and initiatives established around various factors that impact wait time.

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
4	Did you receive enough information during the admission process (%; Survey respondents; Q3 - YTD 17-18; NRC Picker)	927	18.00	23.00	**24.6 (Q3)**	Welcome Package implemented in Jan 2019 – additional questions on real time survey to assess welcome package information. Real time results for this indicator are : 63% with >20% increase over past year –asked at discharge and does not have influence of acute care experience in results

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.

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?
In partnership with Intake team and acute care, review data collected during the Quality Improvement Advocate Pilot position and develop a work plan based on Patient feedback and Patient Family Engagement Council.	Yes	This was critical - using real time survey results from actual conversations with patients about what information did they require that did not get during admission process. Also identified key challenges from patient perspective on transition from acute care - their experience in acute was also very much influencing this indicator. Real time survey's has allowed us to create a new Welcome Package based on their feedback which was implemented in January 2019
Transition patient greeting activities from pilot position to unit managers by end of 18-19.	No	We have identified need for Quality (non unit staff) Advocate positions to continue in a more permanent role as part of learnings from our pilot. We will extend pilot most likely at least 6-12 more months and review at that time if this is appropriate to move to unit managers. Other priorities are also influencing this.

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
5	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)	927	31.00	38.00	**35.6 (Q3)**	Overall YTD improvement of 4.6% which is considered significant by NRC. Real time results : 57%

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.

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?
Through partnership with social work, patients/families , LHIN Community Homecare (CCAC) and program /unit based councils, create a work plan	Yes	Working collaboratively with partners to communicate experience feedback from patients. Have developed work plan for 19-20 with 4 key initiatives
Empowerment of patients and families to be involved in their health care journey	Yes	
Identify plan for frontline care providers and customer service focus	No	Small workgroup formed to review this initiative and “just culture” education . Resource /capacity constraints –will occur in 19-20

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
6	Medication reconciliation at admission. The total number of patients with medications reconciled as a proportion of the total number of patients to the hospital. (%; All inpatients; 17-18; Hospital collected data)	927	47.00	100.00	**94.50 (Q3)**	Consistently over 95% for past six months...

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.

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?
In collaboration with Quality/PMO team , develop a detailed action plan to ensure compliance by Q4, 18-19	Yes	To improve medication reconciliation process we were able to secure commitment from senior leadership in having an organizational-wide focus on medication reconciliation by securing additional pharmacy resources to ensure compliance. Having an organizational focus and resources on medication reconciliation proved invaluable in our ability to make tremendous progress on the admission med rec process. Our starting performance was ranging from 30-40%, with target set for 95% and we are proud to report that we have consistently sustained 100% compliance. By incorporating pharmacy techs and pharmacists, related to collection of the Best Possible Medication History (BPMH), who are important collaborative partners in healthcare team, improved the accuracy and completion of the medication reconciliation process.

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
7	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)	927	CB	100.00	CB	Pilot completed and final implementation and education plan in progress. Working with IT provider on required reporting and required system changes to support. Current performance is not validated (approx. 30%)

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.

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?
In collaboration with Quality and PMO team, develop a detailed action plan to ensure 100% of applicable discharges compliant by Q4.	Yes	The next segment of the med rec process, the transfer/discharge med and the med rec process in our 16 outpatient clinic areas. We have employed value stream mapping to identify current state, identified gaps and ideal state. We developed a Standard Operating Procedure (SOP) to establish key role expectations, timelines, and standardize the work and templates to improve consistency of practice and improve quality off the information. A learning package has been established with plans for training and roll out will be progress

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
9	Rate of psychiatric (mental health and addiction) discharges that are followed within 30 days by another mental health and addiction admission (Rate per 100 discharges; Discharged patients with mental health & addiction; January - December 2016; CIHI DAD,CIHI OHMRS,MOHTLC RPDB)	927	9.26	6.00	**3.00 (q2**)	This represents 2 cases. Only 2 quarters reported by CIHI

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.

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?
Complete deep dives on each re-admission within 30 days to identify potential preventative measures and opportunities for improvement	Yes	Proven to be very manual process. Completed on every re-admission. Very low volumes.
Ensure proper information and communication is available to patients/family at discharge.	Yes	Completed – package developed and implemented. Based on feedback from patients /families

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
10	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 - September 2017; WTIS, CCO, BCS, MOHLTC)	927	15.43	16.50	11.7 * (Q3)	Still require Q4 results which will be higher- YE will be approximately 13-14%.

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.

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?
Provide all patients/SDMs with Estimated Date of discharge (EDD) in writing shortly following admission and also documented on chart (Leading Practice #2)(2-7 days of admission	Yes	In process of implementation (March 2019). Challenges with physicians setting EDD on admission.
The roles/responsibilities and expectation s of SDM are clearly explained in writing on admission (leading practice #9)	Yes	Still to be implemented is “Partners in Care “letter for patients and families on admission that will introduce the concept of collaborative relationship, roles, responsibilities. To go to PFAC March /April 2019.
Develop a standardized Complex Discharge Rounds (CDR and ALC Deep dive process within IP Mental Health	Yes	Collaboration with social work group and MH managers as cases occur.