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	Falls (per 1000 patient days). (%; All inpatients; April 1 to Jan 31; RIMS and Meditech)	932	3.81	3.40	3.47	

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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?
Establish a corporate Fall Risk Reduction Committee.	Yes	•Information sharing of fall risk improvement strategies •Still early days only have had 3 meetings to date •Ability to prioritize Fall Risk Reduction Interventions and Projects
Pilot Nurse Practice Leader (NPL) fall incident review process	Yes	•Pilot on-going •Need to clarify outcome goals of this project: 1.Assist CMs with workload – then on-going NPL fall review 2.Identify falls learning needs – do not need on-going RIMs review. This can be done with 10 chart audit
Review and revise Fall Risk Reduction program to improve patient rates of falls.	Yes	1.Key need identified in review was Pt and Family Education ¬Tips to Avoid Falls Posters Created / Implemented ¬Next Step: Personalized handout / Education Material 2.Falls Policy to be updated to align with MediTech – on-going 3.Post Falls Huddles – Level 4 (EBH) QI project. In initial phase 4.Falls MediTech / Documentation Audit: completed

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2	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)	932	30.00	33.00	38.00	

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December 2018 implemented on-line incident reporting & investigation system to make it easier for staff to report all incidents including violence. System includes violence specific investigation tool for managers. Monitoring, coaching and training will continue throughout 2019.	Yes	Using total number of reported violence incidents as an indicator requires some discussion as generally it is perceived that a reduction in number of reported incidents is the goal whereas what we really want to see is an increase in staff reporting. The on-line incident reporting system has made it easier for staff to report all types of incidents that occur in the workplace and as such we have seen an increase in reporting. This is a benefit as greater reporting leads to improved resolution of staff safety concerns.

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3	Patient experience: Would you recommend this hospital to family or friends if they needed this type of care? (%; All inpatients; 2019-20; Modified CIHI CPES)	932	81.10	82.50	83.40	

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Ensure that always practices are being sustained across hospital programs.	No	Decision to move away from quarterly audits. At least one audit conducted on every unit in 2019/2020. Focused on unit teaching in areas with demonstrated issues related to aspects of always practices. Moved away from practice of using peers as auditors because audits with specific, in-the-moment feedback from a formal leader have been found to be more effective. Update of Always Practices policy currently underway to include information about unit-to-unit transfers. Focus groups held with clinical nurses on bedside shift report and hourly rounding. A meeting was held with the Studer coach to discuss additional strategies especially for the transitional care patient population.
Ensure that always practices are being sustained across hospital programs	No	Decision to move away from quarterly audits. At least one audit conducted on every unit in 2019/2020. Focused on unit teaching in areas with demonstrated issues related to aspects of always practices. Moved away from practice of using peers as auditors because audits with specific, in-the-moment feedback from a formal leader have been found to be more effective. Update of Always Practices policy currently underway to include information about unit-to-unit transfers. Focus groups held with clinical nurses on bedside shift report and hourly rounding. A meeting was held with the Studer coach to discuss additional strategies especially for the transitional care patient population.

Implement the discharge checklist – Overview of roles and responsibilities for all staff following a transfer/discharge.	No	The PCS optimization in Meditech introduced 2 new modules on discharge including a discharge planning intervention and a discharge summary intervention. These interventions provided similar reminders to staff as a discharge checklist. The interhospital transfer protocol was revised and added to Meditech and tip sheets were created for staff.

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4	Percent of patients who stated that when they see the doctor or nurse practitioner, they or someone else in the office (always/often) involve them as much as they want to be in decisions about their care and treatment (%; PC organization population (surveyed sample); April 2018 - March 2019; In-house survey)	91397	90.04	90.00		This was not selected as an indicator to work on as we have been currently doing well.

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5	Percent of patients with social determinants of health (SDH) included in the EMR. (%; Patients in the the cohort of St. Mary's, Bethany Hope and Cornerstone or referred to the Social Workers with SDH information in the chart.; Quarterly; EMR/Chart Review)	91397	20.00	40.00	3.82	The current performance is, as of Jan 1, 2020, the % of patients in the cohort of St-Mary's Bethany Hope and Cornerstone with SDH info in the chart

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Increase use of SDH stamp developed last year. This year, we want to track usage, identify if providers are noting SDH challenges in their patients, and identify if providers are noting challenges with use of stamp.	Yes	Although use of SDH numbers have increased in the clinic; it has not in the specific cohorts identified in the workplan. The complexity and urgency of the work in the cohorts have resulted in forgetfulness to complete the SDH stamps with patients. One learning is that it is helpful to have an identified support to providers for completion of these stamps with the patients in these cohorts. Next year we have identified a community liaison clerk already working closely with the patients in this cohort to assist; and by providing her with a toolbar as a reminder.

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6	Percentage of non-palliative patients newly dispensed an opioid prescribed by any provider in the health care system within a 6-month reporting period. (%; Patients; Six months reporting period ending at the most recent data point; CAPE, CIHI, OHIP, RPDB, NMS)	91397	5.80	5.80	3.50	The data for current performance is, as of March 31, 2019, data from HQO my practice report for FHT

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Reduce number of patients on over 90meq of morphine.	Yes	We continued with the method of use of registry of patients on high dose morphine; pharmacist and Chronic Disease Management Nurse does review this list and then collaborate with providers on a strategy to reduce use. Continued push for MDs to sign up for mypractice reports to have data on their patient roster. With increased awareness and structured approach we continue to make improvements on an already excellent performance.

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
7	Percentage of patients and clients able to see a doctor or nurse practitioner on the same day or next day, when needed. (%; PC organization population (surveyed sample); April 2019 - March 2020; In-house survey)	91397	50.00	60.00	50.00	Comments as of final survey 2018/2019 no results for 2019/20 as of yet

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1. Explore why we have seen a decrease in this access measure year on year, while maintaining high access in other measures (ie: % receiving an appointment when they needed it) 2. Continue to review our access and make adjustments as needed to schedules (add more designated same-day appointment slots at high times, i.e., after holidays/extended closed periods). 3. Create a walk-in protocol. 4. Assess our same day clinic useage; we have been piloting a Monday afternoon same day clinic to address high demand on Mondays for appointments.	Yes	Monday same day clinic has been very effective to meet demand during that time. Due to staffing shortages we have not been able to yet complete the walk in protocol which will be a priority for the coming year. We also realized we need more data on supply and demand for our same days for specific times during the day, so we are assessing this in the coming year.

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
8	Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital. (%; Discharged patients ; Most recent 3 month period; Hospital collected data)	932	72.10	75.00	81.20	

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Identify barriers to completion: vacation coverage, co-signing with collaborative documentation.	Yes	Reminders to eSign documentation that has essentially been completed did improve rates of completion. In addition, increasing use of collaborative documentation so the attending physician can largely complete the discharge summary prior to vacation, leaving minimal work for the covering physician to complete and eSign.
Provide reminders to the physicians in the two lowest performing departments to prioritize completion and signing.	Yes	100% of discharges on the two lowest performing units have been audited to identify reasons for not meeting the 48 hour timeline. PCU audit revealed that discharge summaries had been completed and signed within 48 hours. Addendums added and signed later made it appear that they were delayed. In CCC the physician model of care and vacation coverage were identified as primary factors for delay. With recent changes in physician staffing, it is anticipated this will improve in the next quarter.

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9	Percentage of patients who have had a 7-day post hospital discharge follow up, by a community care provider for selected conditions- CHCs. (%; Discharged patients ; Last consecutive 12-month period.; See Tech Specs)	91397	CB	CB	21.60	Not clear what % of all hospital discharges required follow-up. Focus of initiatives were to identify highest risk patients for follow-up.

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Continue promoting use of the post-hospitalization follow up tool in the EMR (Primarily for the Nursing team). Add to the discharge summary encounter assistant a re-admission risk screening tool.	Yes	Unclear of actual impact and there appears to be inconsistency with the implementation of the post discharge process we had outlined. Our current workflow in EMR makes it difficult to link the associate discharge summary review to its proper discharge summary report. We are working on improving stamp and process.

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10	Percentage of residents responding positively to: "Staff ask how to meet my needs." (%; Residents; April 1 to Jan 31; In house data, InterRAI survey, NHCAHPS survey)	53536	49.00	52.00	40.00	We are working to better understand resident perceptions of this question and what impacts their answers.

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Implement focused rounding. Continue to implement Always Practices.	Yes	Peer to peer education and influence is very powerful Recognition is very powerful in changing practice Through the implementation of focused rounding, the expectations of residents changes which can impact their answers.

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
11	Percentage of residents responding positively to: "Staff ask how to meet my needs." (%; Residents; April 1 to Jan 31; In house data, InterRAI survey, NHCAHPS survey)	51651	49.00	52.00	40.00	We are working to better understand resident perceptions of this question and what impacts their answers.

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Implement focused rounding. Continue to implement Always Practices.	Yes	Peer to peer education and influence is very powerful Recognition is very powerful in changing practice Through the implementation of focused rounding, the expectations of residents changes which can impact their answers.

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
12	Percentage of residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4 since their previous resident assessment. (%; Residents; Q3 2019-20 (Jul-Sept 2019); CIHI CCRS)	53536	4.60	4.00	3.50	Data on current performance is from Q2

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Implementation of focused rounding. Enhanced use of data and reporting to ensure follow-up and just in time education (ex: on assessments, management, etc). Education.	Yes	Regular audits and follow-up are essential to ensure sustained progress following education Re-education is necessary in some cases.

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
13	Percentage of residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4 since their previous resident assessment. (%; Residents; Q3 2019-20 (Jul-Sept 2019); CIHI CCRS)	51651	5.50	4.00	4.30	Data on current performance is from Q2.

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Implementation of focused rounding. Enhanced use or data and reporting to ensure follow-up and just in time education (ex: on assessments, management, etc). Education.	Yes	Regular audits and follow-up are essential to ensure sustained progress following education. Re-education is necessary in some cases.

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
14	Percentage of residents who fell during the 30 days preceding their resident assessment. (%; Residents; Q3 2019-20 (July-Sept 2019); CIHI CCRS)	53536	20.80	15.00	19.00	Data on current performance is from Q2

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Implement focused rounding.	Yes	We have had an ongoing challenge with fall rates. We will be working to make the front line teams further accountable to identify and implement fall prevention solutions in the coming year. Several falls have been prevented through focused rounding and staff are noticing the benefits.

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15	Percentage of residents who fell during the 30 days preceding their resident assessment. (%; Residents; Q3 2019-20 (July-Sept 2019); CIHI CCRS)	51651	17.80	15.00	15.80	Data on current performance is from Q2.

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Implement focused rounding.	Yes	We have had an ongoing challenge with fall rates. We will be working to make the front line teams further accountable to identify and implement fall prevention solutions in the coming year.

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
16	Percentage of residents who were given antipsychotic medication without psychosis in the 7 days preceding their resident assessment. (%; Residents; Q3 2019-20 (Jul-Sept 2019); CIHI CCRS)	53536	21.80	20.00	16.10	Data on current performance from Q2.

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Ongoing deprescribing initiatives.	Yes	A regular (monthly) process is required to continue tracking residents who are candidates for deprescribing. Many residents are admitted on antipsychotics with no diagnosis.

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17	Percentage of residents who were given antipsychotic medication without psychosis in the 7 days preceding their resident assessment. (%; Residents; Q3 2019-20 (Jul-Sept 2019); CIHI CCRS)	51651	19.50	20.00	24.60	Data on current performance is from Q2.

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Ongoing deprescribing initiatives.	Yes	A regular (monthly) process is required to continue tracking residents who are candidates for deprescribing. Many residents are admitted on antipsychotics with no diagnosis. It is essential to review coding of diagnosis and to regularly identify residents who are candidates for deprescribing.

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18	Percentage of those hospital discharges (any condition) where timely (within 48 hours) notification was received, for which follow-up was done (by any mode, any clinician) within 7 days of discharge. (%; Discharged patients ; Last consecutive 12-month period.; EMR/Chart Review)	91397	29.00	80.00	21.00	

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We will formalize the process we use for post-discharge assessment. Our change idea will involve working with our RNs, MDs, and pharmacist to gather input on how to improve the tool and improve the process.	Yes	Unclear of actual impact and there appears to be inconsistency with the implementation of the post discharge process we had outlined. Our current workflow in EMR makes it difficult to link the associate discharge summary review to its proper discharge summary report. We are working on improving stamp and process.

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19	Proportion of hospitalizations where patients with a progressive, life-limiting illness, are identified to benefit from palliative care, and subsequently (within the episode of care) have their palliative care needs assessed using a comprehensive and holistic assessment. (Proportion; All patients; Most recent 6 month period; Local data collection)	932	CB	CB	CB	

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Integrate the RESPECT tool within the Electronic Patient Record (EPR).	No	There are several key learnings. In addition to addressing change management with the physicians involved, we need to ensure correct procedures are followed to integrate new software with our EPR.
Screen patients with the RESPECT tool.	No	There are several key learnings. In addition to addressing change management with the physicians involved, we need to ensure correct procedures are followed to integrate new software with our EPR.

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20	Proportion of patients with a progressive, life-limiting illness who were identified to benefit from palliative care who subsequently have their palliative care needs assessed using a comprehensive and holistic assessment. (Proportion; All patients; Most recent 6 month period; Local data collection)	91397	CB	CB	CB	Current performance had not been measured

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Gather baseline data: patients who have palliative care stamps/advanced care planning in their charts, dates of stamps and date deceased Explore tools to be used in the EMR(palliative toolbar) Involving nursing team in identifying patients in need of palliative care assessment.	Yes	We learned that it there is lack of clarity and agreement with the team on when one might identify someone as palliative, and needing early assessment; nor could we come to agreement on the tool. We are now developing a more robust method of screening and identifying palliative patients who would benefit from early assessment.