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.

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
1	"Would you recommend this hospital to your friends and family?" (Inpatient care) (%; Survey respondents; April - June 2017 (Q1 FY 2017/18); CIHI CPES)	932	66.90	70.00	67.90	Current performance data is April 1, 2108 to February 28, 2019, weighted by beds for hospital programs.

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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?
Implement the newly revised always practices bundle developed in collaboration with the Patient and Family Advisory Committee.		
Ensure that always practices are being sustained across hospital programs		
Provide education to staff and patients on the expectations related to always practices.		

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2	% of observations of Moment 1 hand hygiene out of all observations. (%; Staff observed during usual care; January-December 2017; 2017; Hospital collected data)	932	86.60	90.00	86.80	Current performance data is calendar year 2018.

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Continue to conduct regular monthly audits on hospital units.	No	Due to long-term position vacancies on the IPAC team, it was not possible to conduct 12 monthly audits for each site. However, we were able to conduct 9 monthly audits at ÉBH and 10 monthly audits at SVH. Except for the occasional month that only had 9 moment 1 observations, the remainder had 10 or more. Currently there is only one auditor who covers all 12 units (4 at ÉBH and 8 at SVH). Now that the IPAC team is fully staffed, plans are in place to train at least one more auditor to share the workload.
New hand hygiene eLearning module.	No	Currently, there are 5 IPAC eLearning modules. The initial plan was to update the hand hygiene module. However, the decision was made to update all of the modules and to condense the material into two modules. As such, the hand hygiene module will be combined with material re: routine practices. Due to long-term position vacancies on the IPAC team, the module is still in build mode, with an intended launch date of spring 2019. However, due to the impending launch of the Meditech upgrade and its associated education requirements for the majority of staff, the launch of the IPAC module (and all other education initiatives) has been pushed to early summer 2019.

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	% of patients with social determinants of health included in the EMR (%; Rostered patients; 2017; EMR/Chart Review)	91397	CB	80.00	20.00	

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Stamp developed last year. This year, we want to track usage. Are providers noting Social Determinants of Health (SDH) challenges in their patients, using the tracking stamp	Yes	Due to administrative burden and other issues the north clinic pilot did not continue beyond summer 2018. 20% of patients who were seen in clinic the by north and/or FHT social workers have had their social determinants of health assessed using the SDH stamp. Education sessions were provided to all staff and residents on identifying social determinants of health and the tool as part of the change implementation plan. 2019/2020 - we will continue to encourage the use of the SDH tool with not only social worker and providers but also with our nurses, clinic navigators, and clerks. There is also a SDH stamp pathway that has been developed to help users understand the process better.

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4	Falls per 1000 patient days for hospital programs. (%; All inpatients; April 2017-January 2018; Hospital collected data)	932	3.60	3.40	3.81	Current performance data is April 1 2018 to January 2019 to match previous year.

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Develop a frequent falls protocol for use across hospital programs (including internal evidence based definition of frequent faller).		
Develop a process to include Nursing Professional Practice (NPP) in falls analysis.		
Update the overall fall prevention program for inpatient units.		

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5	Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period. (Count; Worker; January - December 2017; Local data collection)	932	30.00	30.00	30.00	

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Roll out of the new on-line incident reporting system		Met with all managers and supervisors in clinical and operations departments, as well as corporate directors during strategy and operations team meeting to provide training. Remaining management staff were reached through information posted on InfoNet. Introduction of new system has resulted in employee incident reports being received by employee manager and occupational health immediately via e-mail when submitted by employee, providing immediate knowledge of incident and increasing response to employee needs and corrective actions. Quality and quantity of information provided by the employee has increased. Incident investigations by supervisors are required to be completed within 6 days of incident or it will be escalated to the next higher level of management. To date, all investigations have been completed in less than 6 days.

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	Percentage of complex patients who were reviewed for case management (%; internally identified complex patients; 2017; EMR/Chart Review)	91397	CB	80.00	7.00	

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Process for identifying high user patients has been implemented. Now we wish to track the number reviewed with the provider and identified as requiring a case management approach	No	7% of our identified high users have care plans in their charts Due to staffing challenges and turnover we were not able to review our high users with the providers and identify those who required case management. We do have a way of identifying high users which could be beneficial for providers to review charts but having one-on-one sessions between designated clerk and each provider proved difficult to resource and schedule. In the future we may look at having nurses more involved in reviewing these lists and identifying a few patients per-provider to review for case management, for the time-being we have suggested the use of care plans for more complex patients; this has resulted in the above 7% of identified high users having care plans in their charts.
Care plan prepared for all identified case management patients	No	7% of our identified high users have care plans in their charts.
Advance care planning (ACP) used with all patients over 55 years	No	2% of patients over 55yrs have the ACP stamp in their charts. We continue to suggest the use of this tool for patients over 55 and we have created an easy to access button on our provider toolbar in the EMR to encourage use.
Advance care planning (ACP) used with all patients over 55 years	No	We held one workshop that was well attended by patients.

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	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	61.60	67.80	72.10	Current performance = Last 3 months, December 2018 to February 2019.

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Review current state of discharge summaries being sent to primary care providers.	Yes	Department meetings. Use of Meditech template or dictation. Audit of all discharge summaries in January that did not get completed in 48 hrs.
Partner with the primary care providers to develop a discharge summary template that meets the needs of primary care providers.	Yes	Already developed. Together with the medical chiefs, we will determine barriers to timely completion and develop clear and achievable actions to remove those barriers.
Develop a standardized process for discharge summaries.		This was done with input from primary care providers incorporated into the template that was developed in Meditech. Will use our family medicine department to review and update.

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
8	Percentage of patients with diabetes, age 18 or over, who have had a diabetic foot ulcer risk assessment using a standard, validated tool within the past 12 months (%; patients with diabetes, aged 18 or older; Last consecutive 12 month period; EMR/Chart Review)	91397	CB	100.00	54.00	

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This has never been tracked although the tool is available in the chart. We will track the numbers completed and take further action if there appears to be a deficit	No	Not tracked quarterly. Searches were run at the end of the “reporting period”. 54% of patients seen within the last year with an hba1c >8 have had a foot assessment.

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	Percentage of residents responding positively to: "I would recommend this site or organization to others." (InterRAI QoL) (%; LTC home residents; April 2017 - March 2018; In house data, interRAI survey)	53536	71.11	76.50	81.16	

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Culture change journey.	Yes	On-track to accomplish workplan.
Enhance laundry and lost items process.	Yes	Process for lost items launched and formalized.
Enhance activities and opportunity for mobility and social interaction.	Yes	Java program implemented and evaluated – positive outcomes
Environmental enhancements.		

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10	Percentage of residents responding positively to: "I would recommend this site or organization to others." (InterRAI QoL) (%; LTC home residents; April 2017 - March 2018; In house data, interRAI survey)	51651	71.11	76.50	81.16	

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Culture change journey.	Yes	On-track to accomplish workplan.
Enhance laundry and lost items process.	Yes	Process for lost items launched and formalized.
Enhance activities and opportunity for mobility and social interaction,	Yes	Java program implemented and evaluated – positive outcomes.
Environmental enhancements.	Yes	Enhancements to tub rooms to be finalized in Q4 – received an eldercare grant to help fund needed equipment.

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
11	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 (%; LTC home residents; July - September 2017; CIHI CCRS)	53536	6.05	3.00	5.90	Current performance = Unadjusted for QIP; Q2 2018-19 from dashboard.

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Enhanced use or data and reporting to ensure follow-up and just in time education (ex: on asseessments, management, etc).	Yes	Reports developed monthly. Due to delay in PSN role, audits formally starting in January.
Case Reviews.	No	Committee decided to focus on higher level policy and program (as it meets only quarterly and generally reviews are needed asap), case reviews at the unit level. Occasional cases discussed for information.
Education to staff.	Yes	100% (through Excellence In Resident Centered Care Education – PSWs, and inservices – registered staff).
Education to residents and families.	Yes	Brochure developed and launched.
Education to staff.	No	Review of online module delayed to next fiscal year due to learning department priorities.

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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 (%; LTC home residents; July - September 2017; CIHI CCRS)	51651	3.74	3.00	5.90	Current performance = Unadjusted for QIP; Q2 2018-19 from dashboard.

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Enhanced use or data and reporting to ensure follow-up and just in time education (ex: on asseessments, management, etc).	Yes	Reports developed monthly. Due to delay in PSN role, audits formally started in February.
Case Reviews	No	Committee decided to focus on higher level policy and program (as it meets only quarterly and generally reviews are needed asap), case reviews at the unit level. Occasional cases discussed for information.
Education to staff.	Yes	100% (during education days).
Education to residents and families.	Yes	Brochure developed and launched, presented to family council.
Education to staff.	No	Review of online module delayed to next fiscal year due to learning department priorities.

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
13	Percentage of residents who fell during the 30 days preceding their resident assessment (%; LTC home residents; July - September 2017; CIHI CCRS)	53536	10.63	14.00	21.20	Current performance = Unadjusted for QIP; Q2 2018-19 from dashboard.

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Promote existing and new fall interventions.	Yes	Care plan reviews conducted regularly.
Environmental assessments.	No	Process developed but not formally launched. Being done ad hoc and will be linked to purposeful rounding implementation in 2019.
Education to staff.	Yes	100% staff trained, focus on safety during lifts and transfers to prevent falls or injury.
Education to residents and families.	Yes	Brochure developed and launched.
Case reviews.		
Review online module on Falls.	Yes	Ongoing – to be finalized by end of fiscal year

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
14	Percentage of residents who fell during the 30 days preceding their resident assessment (%; LTC home residents; July - September 2017; CIHI CCRS)	51651	16.49	14.00	18.40	Current performance = Unadjusted for QIP; Q2 2018-19 from dashboard.

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Promote existing and new fall interventions.	Yes	Care plan reviews conducted regularly.
Environmental assessments.	No	Process developed but not formally launched. Being done ad hoc and will be linked to purposeful rounding implementation in 2019.
Education to staff.	Yes	100% staff trained, focus on prevention of falls by proactively meeting the needs of residents.
Education to residents and families.	Yes	Brochure developed and launched, and presentation given to family council.
Enhance communications with physicians and team.	No	This project is on hold (secure conversations) due to additional planning required for information tech and privacy, and other commitments.
Review on-line module on Falls.	Yes	Ongoing – to be finalized by end of fiscal year.

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
15	Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (%; LTC home residents; April 2017 - March 2018; In house data, interRAI survey)	53536	77.00	80.00	68.66	

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Opportunities for feedback through surveys, resident council, informally.	Yes	Highest number of surveys (69 total) ever achieve in summer, surveys ongoing for Q4.
Opportunities for feedback through surveys, resident council, informally.	Yes	All meetings had over 10 residents (average of approximately 12). Meetings are held on the unit, in the dining rooms which promotes easy participation for residents.
Code of conduct (including retaliation).	Yes	Always practices developed and all stakeholders engaged. Formal launch in March 2019.

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
16	Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (%; LTC home residents; April 2017 - March 2018; In house data, interRAI survey)	51651	77.00	80.00	47.76	

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Opportunities for feedback through surveys, resident council, informally.	Yes	Highest number of surveys (69 total) ever achieve in summer, surveys ongoing for Q4.
Opportunities for feedback through surveys, resident council, informally.	Yes	In 2018 4 of 9 meetings had over 10 residents (average of 9). Starting in March 2019, meetings will be held on the units to ensure enhanced participation.
Code of conduct (including retaliation).	Yes	Always practices developed and all stakeholders engaged. Formal launch in March 2019.

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
17	Percentage of residents who were given antipsychotic medication without psychosis in the 7 days preceding their resident assessment (%; LTC home residents; July - September 2017; CIHI CCRS)	53536	21.49	21.00	21.20	Current performance = Unadjusted for QIP; Q2 2018-19 from dashboard.

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Participation in CFHI Collaborative.		Review of all residents on antipsychotic. Few were candidates to deprescribe. Full review will be done again in Q4. Ongoing learning from our other site.
Care reviews.		

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18	Percentage of residents who were given antipsychotic medication without psychosis in the 7 days preceding their resident assessment (%; LTC home residents; July - September 2017; CIHI CCRS)	51651	23.37	21.00	21.10	Current performance = Unadjusted for QIP; Q2 2018-19 from dashboard.

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Participation in CFHI Collaborative.	Yes	Ongoing participation. Cohort of 17 residents. So far, 2 deceased, 11 deprescribed or decreased, 1 increased, 4 not changed yet.
Case reviews and progressive deprescribing (reductions and discontinue).	Yes	See above. Lessons learned include; -involvement of the pharmacist is key -protected time for RN lead to connect with stakeholders essential -coding of diagnosis and review of coding errors had big impact - most cases deprescribed without changes in behaviour -sustaining is key as many residents admitted on anti-psychotics

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19	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	CB	100.00	29.00	

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Stamp developed last year to track followup. This year, we want to track usage of the stamp tool. Is follow-up being done withing the 7 day time frame for every (identified diagnosis) discharge and by what staff designation?	No	Post-hosp. discharge encounter completed for ~29% of all discharge summaries received. The tool is primarily being used by nurses. 57% of patients (who had the post-hospital encounter completed) were booked (in-person) with MRP team within 7 days *Discharge summary categories **Data pulled from post-hospital encounters completed Acute Myocardial Infarction AMI (age 45+) – 2.3% Cardiac conditions (excluding AMI and CHF) (age 40+) – 9.7% Congestive heart failure CHF (age 45+) – 7.5% Chronic obstructive pulmonary disease COPD (age 45+) – 12% Pneumonia – 13.2% Diabetes – 6.32% Stroke (age 45+) – 2.3% Gastrointestinal disease- 4%
Hospital readmission within 30 days of discharge: This year we will implement a process to better understand why patients are re-admitted post discharge within 30 days and what additional changes we could implement	No	No reliable process was implemented to track 30 day readmission. Future focus on increasing uptake of the post-hospital discharge encounter to be able to more readily pull information on specifics. New for 2019/2020-added a section to the post-hospitalization encounter assistant to track if patient was admitted within 30 days of a previous discharge to simplify data collection.