Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2017/18 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 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
1	"Would you recommend this emergency department to your friends and family?" (%; Survey respondents; April - June 2016 (Q1 FY 2016/17); EDPEC)	596	59.10	65.10	56.50	While we were unable to meet target for Q1, we continue to address our feedback identified through our surveys and internal processes.

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 2017/18)	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 operational review to assess resources for Emergency Nursing and so we increase ED nursing touch time	Yes	We successfully completed our operational review and determined additional nursing hours would support improved patient experience and address increased volumes in the Emergency Department

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2	"Would you recommend this hospital to your friends and family?" (Inpatient care) (%; Survey respondents; April - June 2016 (Q1 FY 2016/17); CIHI CPES)	596	40.40	45.00	45.10	We are pleased with our performance in meeting our goal with an 11% improvement in our patients' experience. Our performance is representative of our commitment to transforming the care we provide.

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We will implement Intentional Rounding for all patients on Medicine	Yes	Visiting patients at regular time intervals using structured interaction and clear documentation to address patient needs will improve communication and engage patients and families in their care plan. This has also provided an opportunity to establish improved communication techniques including the use of Acknowledge, Introduce, Duration, Explanation (AIDET)
We will implement two way communication boards within each patient room	Yes	The implementation of our communication boards was endorsed by our patients and Patient Family Advisory Council, and has demonstrated the need to communicate using various techniques in order to partner with our patients and families.

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3	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 2016 (Q1 FY 2016/17); CIHI CPES)	596	40.80	45.00	47.90	We are pleased with our performance demonstrating a 17% improvement in this indicator. Improving communication at discharge represents our commitment to safe quality care.

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Implement Discharge Phone Calls to Patients within 48 hours of discharge	No	We were unable to implement discharge phone calls due to resource challenges, however we demonstrated improvements from in our mailed surveys in related questions such as getting enough information about condition and treatment and improved understanding about condition. With a robust discharge process including our discharge information sheet, discharge medication reconciliation, booking follow-up family physician appointments and faxing discharge information to family physicians, we feel we have been able to mitigate this strategy.
We will develop a standardized Discharge information sheet for all patients that are leaving Stevenson Memorial to go home	Yes	We were successful in implementing standardized information sheet for our patients, and feel that the use of an Admission, Discharge and Transfer Nurse (ADT) during peak discharge hours has contributed to our overall improvement in our discharge process.

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4	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 ; Most recent quarter available; Hospital collected data)	596	CB	CB	66.27	Our performance demonstrates our commitment to safe quality care for our patients as we strive to provide clear and comprehensive information for our patients and other care providers.

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We will continue to improve upon the Medication Discharge Planning and teaching for our patients	Yes	Although we were unable to implement our discharge phone call process, we were able to evaluate the process through our mailed patient surveys where patients identified they had a clear understanding about their medications. We will continue on our path to implement discharge phone calls to increase our feedback opportunities.

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5	Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort) (Rate; COPD QBP Cohort; January 2015 – December 2015; CIHI DAD)	596	16.97	15.20	21.82	Although we did not meet our target for this measurement time in 2016, we have seen a demonstrated improvement as we measure our performance on a quarterly basis.

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We will increase the use of COPD clinical and patient pathways to improve the transition of care for these patients in the community	Yes	Staff and Physicians were trained on the use of the clinical pathway. We have seen a 90% utilization compliance of the pathway upon random audit over three months and have identified the opportunity to refresh education related to staff and physician transitions.
We will increase the number of patients referred to Telehomecare for follow-up	Yes	A telehomecare referral was added to the standardized order set for COPD patients. In addition Telehomecare education has supported a successful strategy.

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6	Total ED length of stay (defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ED) where 9 out of 10 complex patients completed their visits (Hours; Patients with complex conditions; January 2016 – December 2016; CIHI NACRS)	596	6.22	5.90	6.37	With the implementation of additional resources and scheduling changes in the ED, data sharing, and daily quality improvement huddles, we continue on our journey to ensure our complex patients are treated within a timely manner. In addition we have conducted lean improvement strategies including a value stream mapping session and workplace organization initiative to highlight additional process improvements which forms the work ahead.

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We will be implementing Transforming Care Performance Boards to begin to track Length of stay from Decision to Admit to transfer to inpatient bed time	Yes	We have successfully implemented the Transforming Care Quality Improvement huddles. These huddles have provided the opportunity to engage with staff and physicians and share data to highlight opportunities for improvement.

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7	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 2016 (Q2 FY 2016/17 report); WTIS, CCO, BCS, MOHLTC)	596	17.31	17.13	13.18	Our collaborative work with our internal and community partners is representative of our ability to reach our goal during Q2, however we continue to see fluctuations as a result of a number of challenges beyond the control of the organization. This performance represents the degree of hospital-community integration as we strive to improve safe, equitable access in appropriate care settings.

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We will introduce Restorative Care Program including Malnutrition Screening by Sept. 1, 2017	Yes	The Malnutrition screening was introduced and those patients identified as high risk and treated accordingly.
Implement two way communication boards so that patients and families are included in their plan of care	Yes	We have successfully developed and implemented our two way communication based on feedback from our patients, PFAC, and staff to improve communication as we partner with our patients.