Hotel Dieu Shaver
HEALTH AND REHABILITATION CENTRE

Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for the 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	% of Stroke Rehab patients (RPG) where the actual active rehab length of stay matches or is less than the expected active rehab length of stay for Stroke Rehab patients as per the Quality Based Procedures Clinical Handbook for Stroke (%; Active Stroke Rehab patients; Q3 2016/17-Q2 2017/18; Hospital collected data)	790	84.85	80.00	87.88	

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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 designated Inpatient Stroke POD (clustered active stroke patients being designated to a dedicated stroke rehabilitation team, located in a designated unit).	Yes	A dedicated stroke POD was implemented with input from front line staff, management, physicians and external partners. Work is currently being done to enhance the referral form from our external partners to ensure appropriate and timely access to the Stroke POD beds.
Review and analyze stroke length of stay data to monitor performance.	Yes	Ongoing review and analysis of the quarterly Ontario Stroke Network data is completed. Information is presented throughout the organization on a quarterly basis, which includes all staff and the senior team.

Patient Flow Team to monitor each stroke rehab patient's length of stay (LOS) as related to organizational target and initiate interventions as required.	Yes	The daily Patient Flow meeting assists in reviewing upcoming admissions to the Stroke POD in order to enhance timely access to Rehab post acute care. Even with a dedicated Stroke POD, there are challenges due to the lack of private beds needed to accommodate for gender, and ARO's. The Patient Flow Team has a process in place which requires a report from the interdiscplinary team when a stroke rehab patient's length of stay is likely going to vary (shorter or longer)from the target LOS. Each case is reviewed individually and the Patient Flow Team in conjunction with the interdisciplinary team adjusts the length of stay accordingly to ensure the best possible outcome can be achieved by the patient.
Continue education to current and new staff on stroke length of stay best practices and targets.	Yes	The interdisciplinary team and Patient Flow team are provided with regular feedback from our provincial and HNHB LHIN comparators. There continued to be an increase in Rehab Intensity along with the decrease in length of stay. In keeping with best practice it is recognized that not all patients will meet their expected length of stay.
Process developed to notify Managers and interdisciplinary team of incomplete admission FIM's in order to encourage timely completion	Yes	A process for flagging incomplete admission FIM's was developed and reviewed with the interdisciplinary team to help them to understand the importance and impact that this can have on the LOS and appropriate RPG assignment.

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2	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; July - September 2017 (Q2 FY 2017/18); In-house survey)	790	99.19	90.00	100.00	

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Survey to be conducted with patient three or fewer days before anticipated discharge date.	Yes	The Patient Advisors have been instrumental in conducting the Patient Experience surveys from three or fewer days prior to discharge. To date we have not had a patient decline participation in the interview. The goal is to interview all patients (excluding program transfers, discharges to acute care) or their family member if the patient isn't capable to participate.
Process identified whereby Patient Delegate to be notified by Patient Advisors or other staff if patient/family identifies need for further information prior to discharge.	Yes	The Patient Advisor reports each day's results to the Patient Relations Process Delegate, including comments and in any case where more information was wanted, the Patient Relation Process Delegate notifies the appropriate clinical, therapy, or LHIN staff to meet with the patient or family to ensure information is provided.
Expand availability and accessibility of service and vendor brochures and other educational materials which may be of value to patients and care givers after discharge.	Yes	Brochure display stands were installed on each inpatient floor. Any brochure included must be reviewed with the CNO to ensure appropriate and correct information is available. The display stands are reviewed on a regular basis for content.
Stage discussions between disciplines and over a few days before discharge to reduce volume of information that patient and caregivers receive all at once.		Interdisciplinary staff have a team conference prior to discharge to ensure appropriate information is provided to patient/families. When required for complicated discharge plans, a patient/family meeting is arranged that includes the entire interdisciplinary team to ensure all areas of care are understood.

Meet and Greet with each new patient, performed by the Patient Advisors.	Yes	The Patient Advisors perform a Meet and Greet with new patients/family members to review information in the Patient and Family Handbook. The Advisor that completes the meet and greet will check back in with the patient throughout their stay (if wanted) to ensure that there is a clear line of communication for any questions that may arise.
Meet and Greet with each new patient, performed by the Patient Advisors.	Yes	The Patient Advisors perform a Meet and Greet with new patients/family members to review information in the Patient and Family Handbook. The Advisor that completes the meet and greet will check back in with the patient throughout their stay (if wanted) to ensure that there is a clear line of communication for any questions that may arise.

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3	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)	790	CB	CB	98.68	

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Review and revise current forms to ensure that appropriate information is captured and communicated.	Yes	Update of BPMR (Best Possible Medication Reconciliation) on Discharge form was updated and staff/physicians educated in late spring 2018 for the first floor. Second floor roll-out with staff/physician education scheduled for early 2019.
Involve patient and caregiver in medication reconciliation on discharge.	Yes	The nursing staff have an interactive discussion with the patient/family/caregiver to ensure all medication reconciliation requirements are understood. When required, a Pharmacist will be involved if further explanation is required.
Involve physicians in discussions regarding appropriate workflow processes.	Yes	A multidisciplinary team including nursing staff, physicians, Pharmacy staff and Manager, Director of Nursing, Director Health Data and Quality Improvement reviewed the form and workflow that would be most appropriate to successfully complete the task at our facility.
Exploration of the availability and feasibility of an electronic medication reconciliation process.	Yes	Manager of Pharmacy has reviewed various options available to our facility. The IT support is provided by our acute care external partner and must be able to be supported by them. Barcoding of medications will be the first step towards the electronic process.

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4	Meet optimal wait times for internal inpatient to outpatient services based on stroke wait times. (Days; Inpatients waiting for internal outpatient stroke services; January - December 2018; Hospital collected data)	790	CB	CB	5.00	

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As a priority consideration, factor potential impact on stroke wait times when considering any initiatives that may have an impact - including service closures, cost savings, staffing assignments and re-alignments and satellite programs.	Yes	The outpatient program consists of 3 PODS (groups) of 6 stroke patients in each group that run for 7 weeks. This helps to accommodate patients over the Christmas closure by ensuring no treatment time is lost. The POD model provides more treatment time than best practice.
Review and analyze wait time data on a regular basis.	Yes	Regular review completed by the Manager of Outpatient Rehabilitation to adjust resources as required (i.e. Outpatient shut down over Christmas holidays) to ensure compliance with Best Practice.
Communicate wait time status to all relevant parties on a regular basis.	Yes	The wait time results are provided quarterly to: the staff, the Senior Team, the Health Records, Quality of Care, Risk Management Committee, and the Quality Improvement Committee of the Board.
Identify and implement interventions as necessary to attempt to ensure that referrals are received within best practice number of days.	Yes	Work is underway with our Acute care partners to redesign the referral form to enhance ease in referrals. The shared Oculys bed board helps both the Acute care facility and HDS monitor status of patients to ensure that referrals occur within the best practice number of days. Order sets for Stroke patients were worked on by both partners to ensure effective transition of stroke patients from acute to post acute setting.

Implementation of a digital tracking tool to ensure accuracy and timeliness to assist with identification of any irregularity regarding stroke wait time.	Yes	An internal excel tracking tool was developed by the decision support analyst in conjunction with the Manager of Outpatient Rehab. Education was provided to the users and it has been successfully implemented. It is used by the schedulers to track the wait times and reasons for delay (i.e. patient not able to come in for 2 weeks) to ensure accuracy in numbers.

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5	Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period. (Count; Worker; January - December 2017; Local data collection)	790	42.00	55.00	109.00	

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Working Group/sub-committee on violence in the workplace including front line and union representation, as well as patient advisors, to be struck and meet on regular basis to identify initiatives which may assist in staff and patient safety.	Yes	Committee has been struck and work is ongoing. To date all policies have been reviewed, the language in the Patient's Rights and Responsibilities is undergoing change to enhance the messaging regarding behavior expectations at the facility. A poster is also being developed with similar messaging. The student and staff orientation packages have been updated to reflect current policies, expectations in reporting, etc.
Update of all workplace violence and harassment policies.	Yes	All relevant policies were reviewed and updated in August 2018. As policies were updated ongoing education was provided to all staff, physicians, students, and Patient Advisors, and volunteers.
Update RL Solutions (Hospital incident reporting system) to Version 6.0 which will allow inclusion of all staff incidents, as well as current capacity to report patient incidents.	Yes	Upgrade was completed in late 2018 that includes a specific incident type for violence to ensure required information is collected and then appropriate follow-up occurs.
Activate screen in Meditech system to allow staff registering patients to be aware of those who were flagged as behavioral while inpatients at the HDS or at the Niagara Health System.	Yes	A process for electronic flagging of patients involved in violent interactions is being developed to ensure awareness by all staff/physicians as the patient moves through the care system (i.e. inpatient to outpatient). We are on a shared Patient Database with our acute care partner. The flagging is being aligned with their process to enable awareness of potential violent situations when patients are transferred between care types.

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6	Percent of complex continuing care (CCC) patients with a new pressure ulcer in the last 3 months (Stage 2 or higher). (%; Complex continuing care patients; Q2 2017/18 rolling 4 quarter average (Oct. 2016 to Sep. 2017); CIHI eReporting Tool)	790	5.50	5.40	1.80	

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Implementation of a Wound Consultation Team. This team engages with patients on weekly rounds to assess the wounds and develop treatment plans to achieve optimal recovery.	Yes	The team has been struck and meets on a regular basis. Weekly rounds are done and appropriate treatment plans developed.
Development and implementation of a documentation tool that facilitates assessment, planning and implementation of care plan for the wound following best practice guidelines.	Yes	A wound assessment tool was developed and trialed which did not have the expected results, therefore a Nurse led Medical directive is being developed.
Initiate nurse led wound care protocols, which will include all types of wounds, including pressure ulcers.	Yes	A nurse led would care protocol for all types of wounds including pressure ulcers is in the development stage with anticipated completion by late spring 2019.
Utilize I-Equip Students from Brock University to conduct a gap analysis of wound management practices and knowledge transfer.	Yes	The I-Equip project is to develop a pocket guide quick reference that will assist with dressing choices for treating pressure ulcers.
A review of all ulcers captured in CCRS is done to ensure accurate assignment of the type of wound.	Yes	If changes are required, the correction is made prior to submission of the clinical database quarter to CIHI.

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7	Percent of patients with urinary tract infection: Number of patients with UTI on their target assessment divided by the number of patients with valid assessments, excluding end-of-life patients. (%; Complex continuing care patients; Q2 2017/18 rolling 4 quarter average (Oct. 2016 to Sep. 2017); CIHI eReporting Tool)	790	5.00	5.00	3.10	

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Re-institution of the Antibiotic Stewardship Team.	Yes	The Antibiotic stewardship team was re-instituted in the fall of 2018. Monthly meetings are scheduled.
Monthly audit of CCRS Data to ensure accurate capture of UTI data.	Yes	The audit has been very successful in correcting inaccurate information regarding UTI's. Prior to the quarterly submission the decision support analyst runs a list of all of the patients for the quarter that were flagged in CCRS as having a UTI. The list is reviewed by the Manager of Infection Prevention and Control to determine if a C&S was sent and then an antibiotic was ordered.
Ongoing education of staff assigned to input initial data into system.	Yes	Ongoing education is done and follow-up with staff occurs after each audit has been completed.
Issue new template to staff with education materials from Dr. Steward Ship.	Yes	This was completed and very well received by staff during the summer of 2018.

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8	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)	790	5.47	12.00	5.45	

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Conduct in-house patient flow meetings on a daily basis with representation from across the inter-professional team to assess patient status and identify recommended interventions that may assist in facilitating safe and timely discharge.	Yes	There is an inter-professional daily patient flow meeting at 1500 hours that assess the status of current patients that are nearing the completion of their inpatient stay so that appropriate discharge planning is occurring. This also provides a review of patients earlier on in their stay that are likely going to require a program change to best suit their current therapy capacity.
Monthly meeting with LHIN Home and Community (CCAC) and HDS management to conduct monthly case review of all ALC patients.	Yes	A monthly meeting occurs with the Case Managers from the hospital and the LHIN staff to review the patients that likely have a complex discharge plan. All avenues for discharge are explored well in advance of discharge to arrange the most appropriate discharge destination.
Participation in LHIN wide Patient Flow meetings with CCAC and other LHIN facilities to discuss strategies and share successes and ideas.	Yes	A daily meeting at 1300 hours takes place with all of our LHIN hospital partners to review appropriate bed type assignment for patients ready to be transferred.
Interprofessional team to refer/escalate complex cases.	Yes	When an extremely difficult case arises, the LHIN approaches their management and the Case Managers approach the hospital senior management and once it has been determined that no other option for discharge exists, the patient is given approval to wait in hospital for a LTC bed.

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9	Would you recommend this hospital to your friends and family? (Inpatient Care) (%; Survey respondents; July - September 2017 (Q2 FY 2017/18); In-house survey)	790	99.19	90.00	100.00	

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Expand membership on Patient Advisory Council.	Yes	The fiscal year began with six Patient Advisors (5 former patients and 1 caregiver of a former patient). The caregiver had to resign due to personal commitments. We currently have eleven Patient Advisors (10 former patients and 1 caregiver of a former patient).
Expand committees where patient advisors are in attendance.	Yes	There is at least one Patient Advisor on all of the Standing Committees of the hospital, as well as our Accreditation Teams. We also have a Patient Advisor on our Projects/Infrastructure committee that reviews all building/repair projects. As adhoc committees arise, any related to patients/family are provided with a Patient Advisor for the duration of the committee.
Expand functionality of OCULYS - computerized patient flow computer system to assist in early transfer to appropriate service within the facility.	Yes	Work continues with our Acute Care partner to enhance use of the Oculys Patient Flow board. Work with the Acute care partner and the orthopods is being done to enhance the flow of total joint replacement patients to the appropriate post Acute care of either Inpatient Rehabilitation or Outpatient Therapy.
Refine, analyze, post and distribute data on number of nurse calls and associated response times.	Yes	Implementation of the digital call bell system has enhanced the tracking and reporting of response times. The information is posted on the nursing units and is presented quarterly to the Quality Improvement Committee of the Board. The question on our Patient Experience survey "When you used your call bell was the time you waited usually reasonable?" has a positive response rate of 92.11%. Any time there is a negative response, it is brought to the attention of the Clinical Manager who then reviews the concern.