Hotel Dieu Shaver
HEALTH AND REHABILITATION CENTRE

Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for the 2019/20 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	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; Q2 2018/19 (Jul - Sep 2018); In-house survey)	790	100.00	98.00	96.81	

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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?
Continuation of surveys to be conducted with patient three or fewer days before anticipated discharge date.	Yes	The Patient Advisors have been very successful in interviewing the patients 2 to 3 days prior to the patient's discharge date. The goal is to interview all patients discharged, or their family member if the patient isn't capable to participate (excluding program transfers, discharges to acute care).
Continued communication between patient advisors and clinical managers to ensure that any concerns identified are flagged and, if possible, addressed prior to discharge.	Yes	The Patient Advisors communicate on a regular basis with the Charge Nurses to seek out information that the patient is requiring. The Patient Advisor reports each day's results to the Patient Relations Process Delegate, who in turn communicates with the appropriate staff to ensure all questions are answered.

Trial of adopting pharmacist on the inpatient floor model.	Yes	Pharmacist presence was implemented on the first floor units which proved to be very successful. Many of the concerns about having enough information for discharge are centred around the medications. The plan moving forward into 2020/2021 is to include pharmacists on all units.
Institution of initial meet and greet process by patient advisors to help familiarize patients with what they can expect from their inpatient and discharge journey, including review of patient handbook.	Yes	There is a daily presence of the Patient Advisors, including weekends. They meet with patients and their families to familiarize them with all aspects of their hospital visit. Feedback from the visits provides us with changes for each 6 month print of the Patient and Family Handbook to ensure it is a resourceful tool for the users.
Institution of group sessions for "Meet and Greet" to help caregivers and family members understand what to expect from the inpatient experience and discharge journey.	No	The group sessions are still being considered. We have been fortunate in acquiring additional patient advisors, (currently 12 with 2 more that are onboarding) enabling meetings with all patients that want one.
It was recognized that there needs to be a review by the Patient Relations Process Delegate (PRPD) of each patient experience survey. During the course of this year a delegate was assigned to take over in the absence of the PRPD to ensure review of all surveys at least one full day before discharge.	Yes	The addition of a delegate has assisted in getting questions answered for our patients and their families when the PRPD is not on site.

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2	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 2018; Hospital collected data)	790	98.68	80.00	99.16	

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Expansion of pilot through all floors of the Hospital.	Yes	This has successfully been implemented and all floors are doing very well. The barcoding of medications in the Acudose machines has been completed and will continue to be done for any new medications so that we are ready for future steps towards a fully electronic system.
Education of nursing staff and physicians working on the 2nd floor.	Yes	The process that was implemented on the first floor was expanded to the second floor and has been successful. The updated BPMR (Best Possible Medication Record) was reviewed with the 2nd floor units and education provided to the staff/physicians early in 2019.
Physicians to be contacted a few days before anticipated discharge to remind of upcoming discharges to facilitate completion of medication reconciliation.	Yes	This has proven to be helpful in getting the physicians on board. Some of our attending physicians are not always on site as they have their own office practices.

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3	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	5.00	5.00	6.00	

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Continue to review and analyze wait time data on a regular basis to ensure interventions can be identified if there is an identified problem.	Yes	Tracking on an excel spreadsheet continues and findings are reported to Senior Team. Historically, there has been a two week outpatient shutdown over Christmas which results in an increase in wait times for the following quarter. This has recently been reviewed and will be changed to a one week shutdown next year in hopes of preventing the backlog from occurring to the same degree.
Continue to communicate wait time status to all relevant parties on a regular basis.	Yes	One area of concern in our area is lack of availability of public transportation often making it difficult for some patients to get to the out patient program until they can secure rides with family/friends.
Continue process to identify and implement interventions as necessary to ensure wait times stay within identified limits.	Yes	Inpatient stays are becoming shorter for stroke patients as well as many are discharged directly from Acute care to the community. These community patients also require timely intervention in an outpatient program. Both impact the in-to-out referral. A 7-day wait is considered to be acceptable, but we will continue to aim to reduce that as resources allow.

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4	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)	790	109.00	110.00	43.00	

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Continue meetings of the violence in the workplace working group to identify and develop recommended interventions to assist in the reduction of workplace violence and facilitate increased protection of staff, patients and visitors.	Yes	The meetings are ongoing with changes being implemented including: daily reporting of any patients that have had a history of violence to the interdisciplinary team and to determine if care plans put into place have been effective. Ongoing education is conducted to encourage the reporting of workplace violence. Findings indicate that incidents of violence are being reported immediately, a care plan is implemented, and the number of repeat instances of violence with a given patient has significantly decreased.
Continue to monitor and refine application of recently updated version of RL Solutions (Hospital incident reporting system) which has recently added capacity to report and monitor all staff incidents, as well as current capacity to report patient incidents.	Yes	The violence reporting has its own section in the upgraded RL6 incident reporting tool. It also allows for cross-referencing of cases that has proven to be useful in developing appropriate care plans for patients when required.
Continue work on activation of a 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	The screen for electronic flagging has been developed in the test environment of Meditech and review is being done by all disciplines prior to moving to the live environment. This will be beneficial both internally for our Inpatient to Outpatient visits and for patient transfers between our partner facilities.

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5	Patient experience: Would you recommend inpatient care? (%; Survey respondents; Q2 2018/19 (Jul -Sep 2018); In-house survey)	790	100.00	95.00	99.47	

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Increase number of patient advisors to assist with sharing of patient experiences.	Yes	We have increased the Patient Advisors to 12 with 2 more that are currently onboarding. One of the Advisors receives the list of discharges for the following week and arranges for the surveys to be completed on the appropriate day.
Patient Advisors to provide feedback to staff regarding results of patient experience survey and possible areas for improvement.	Yes	This process is currently being worked on in conjunction with the Clinical Quality Council. The data is reported by unit which includes a summary of comments.
Approach to Nursing Professional Practice Council to be reviewed to better address issues on the floor and measures to assist with patient satisfaction.	Yes	Unit Councils are meeting monthly and each has Patient Advisor representation to address the results of the survey questions.

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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 2018/19 rolling 4 quarter average (Oct. 2017 to Sep. 2018); CIHI eReporting Tool)	790	1.80	5.40	0.00	

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Continuation of process to procure internal surfaces as opposed to rentals, to both ensure that the appropriate surface is available in a more timely manner and to reduce cost associated with rentals.	Yes	The process of purchasing appropriate surfaces is completed on an annual basis. This helps to ensure that an appropriate surface is available at the earliest stage of a pressure injury, rather than waiting for a rental to be ordered and received.
Refine documentation tool that facilitates assessment, planning and implementation of care plan for the wound following best practice guidelines.	Yes	The training and education of staff is completed at orientation and on an ongoing basis. Wound identification in the very early stages, with the implementation of appropriate care plan is done "as an automatic process" now. Best practise guidelines have been put into place and are being followed as the norm.
Utilize I-Equip Students from Brock University to develop a quick reference pocket guide to assist with dressing choices for dressing wounds.	Yes	The I-Equip students referenced best practice guidelines for dressing choices and the quick reference pocket guide has been very well received by staff.

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 complaints acknowledged to the individual who made a complaint within five business days. (%; All patients; Most recent 12 month period; Local data collection)	790	100.00	95.00	100.00	

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Enhanced publication of the contact information for the Patient Relations Process Delegate.	Yes	A flow chart was developed to assist patients and family members in determining who they contact if they have a concern that is not being addressed. The information is posted on each inpatient unit and is also included in the Patient and Family Handbook, which every patient receives.
Identify appropriate backup for acknowledgement of documented patient complaints in the absence of the Patient Relations Process Delegate.	Yes	Arrangements were put into place to ensure there are two staff that can act as backup to the Patient Relations Process Delegate to ensure timely response to our patients and/or family occurs.
Formal tracking of all formally documented complaints including time lines for first acknowledgement, substance of complaint, nature of resolution and resolution timelines.	Yes	An excel spreadsheet is maintained for all formal complaints that are reported to the Patient Relations Process Delegate (PRPD). A complaint reporting form is used that tracks the date of the complaint, the date of first contact with the PRPD, the nature of the complaint, the contact information for the patient and the person presenting the complaint, the departments that were involved in the concern, the staff assigned to follow-up, follow-up details, and results provided to the person making the complaint. As per the Excellent Care for All Act (ECFAA) this information is summarized (no identifying information) and reported to the Quality Committee of the Board on a quarterly basis.

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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)	790	CB	CB	65.79	

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A review and audit of discharge summaries completed to establish a baseline for ongoing audit purposes on the second floor.	Yes	The process that was implemented last year was expanded to include the second floor units. This consists of maintenance of an Excel spreadsheet that tracks where a patient was discharged to and, when required, that a summary was provided to the Primary Care physician within the 48 hour window. The Most Responsible Practitioner is notified 2 days prior to discharge so they can be prepared to have the summary completed.
Ongoing audit to be completed to track completion rates.	Yes	The spreadsheet is maintained daily so early identification occurs when the distribution of a discharge summary is in question.
Audit results to be monitored with interventions identified as necessary.	Yes	It was noted that one of the common causes of a discharge summary not being sent to the Primary Care Physician was when relief staff were covering for the Ward Clerk. Continuing education is provided to the staff and with the daily monitoring we can often "catch" the missed summary within the 48 hour window.
Education to be developed for staff and physicians.	Yes	The Medical Staff chart completion policy was revised to include the new College of Physicians and Surgeons (CPSO) policy and procedure guidelines for completion of discharge summaries in a timely manner.
An audit process has been implemented to not only determine that a discharge summary was completed but also reviews the quality of the	Yes	The facility has continued work to ensure the discharge summaries are being completed and sent within 48 hours of discharge and are also striving to ensure that the information contained within is of high quality.

information contained in the report and feedback is provided to the Health Records Quality Council Risk Management committee and then up to the Medical Advisory Committee.

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
9	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 2018; WTIS, CCO, BCS, MOHLTC)	790	5.45	12.00	4.38	

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Patient Flow meetings including representation from across the interdisciplinary team occur every day at 3:00 p.m. to review patient referrals, patient discharge dates and identify recommended interventions that may assist in facilitating safe and timely discharge.	Yes	The Patient Flow team reviews all referrals to determine which patients are most suitable for admission to the available beds/programs. Immediately following the meeting, if there are patients that we can admit, the sending facility is notified in hopes of receiving the patient the next day. The team also reviews upcoming discharges so that arrangements can be made to admit patients in a timely fashion, for example monitoring total knee and total hip surgery patients to avoid delaying the start of their rehab.
Command centre teleconference meetings to take place daily including representation from senior and front line levels of staff -- from HDS, our acute care partner Niagara Health, and LHIN 4 Home and Community services -- to identify patient flow pressures and bottle necks, with	Yes	There is a meeting held each weekday morning that our patient flow coordinator participates in. This assists in determining patients for admission, if there are any isolation patients that will require matching with another, and provides us with the state of patient flow at the acute sites. When the situation becomes critical we have flex beds that can be opened quickly based on need. The VP of Clinical Operations attends a meeting each weekday afternoon that includes VP's and leads from the other sites to review patient flow pressures and attempt to develop a plan to alleviate the pressures as effectively as possible.

the purpose of identifying immediate strategies to alleviate any barriers and facilitate expeditious patient flow on a case by case immediate basis.		
Inter-professional team charged with immediate identification and referral/escalation of complex cases.	Yes	Interdisciplinary team conferences occur weekly. When a complex case is identified, a representative reports to Patient Flow if a change in programs is required. There is also a weekly ALC review meeting with the LHIN Home and Community staff to review complex cases to start the transition process to a setting that will best suit the patient's care needs.
As a result of the weekly ALC review meetings with the LHIN Home and Community a dual process was implemented whereby an application for a Transitional Care Bed (TCB)and a Long Term Care (LTC)bed was done simultaneously.	Yes	To date we have processed 5 such cases and 3 successfully received a LTC bed of their choice before a TCB became available. This prevented the patient from making two moves, therefore was both beneficial to patient flow, and much more patient centred.