Quality Improvement Plans (QIP): Progress Report for 2017/18 QIP

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1	"Would you recommend this ***emergency department*** to your friends and family?" (%; Survey respondents; April - June 2016 (Q1 FY 2016/17); EDPEC)	954 960	45.60	50.20	49.90		Implement a framework to gather real-time feedback from patients	YES	Operationalizing reports from iPillar system for SRH-C to review with staff in ED performance huddles.
							Conduct a Kano analysis to understand patient expectations and identify factors influencing patient satisfaction and dissatisfaction	NO	Planning is underway in collaboration with Patient and Family Centred Care team. Request for timeline to be extended to winter given competing priorities (planning underway by compiling baseline feedback from existing feedback sources such as Improvement Opportunity tickets in ED and iPillar sources). Training on the Kano analysis methodology has been completed with key stakeholders. Exemplars from industry leaders such as the Mayo Clinic and the Cleveland Clinic have been incorporated into the training to support a common understanding of the process and purpose of the analysis. Next phase to coordinate staff interviews with patients and families being designed with input from PFA. Target interviews by Q1 2018/19.
							Improve clarity and frequency of wait time information in collaboration with patients/families	NO	Include new video from staff for patients explaining "what to expect in ED" – initial trial complete at SRH-G, spread to SRH-B August 2017 and pending review with IT at SRH-C. Sustainability is at risk as highly dependent on IT monitoring of the electronic display function to display wait time information at this time.
							Improve the patient experience by timely acknowledgement upon arrival to the ED	YES	Volunteer services program designed to enhance communication with patients/families around wayfinding, what to expect in the ED. Introduction of

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									new mobile app that allows patients to gain basic information on what to expect during their ED visit, standardized discharge instructions, and option to provide feedback on their ED experience. Planning phase has been initiated to design the scope and implementation as a co-design project with PFA.
2	"Would you recommend this hospital to your friends and family?" (***Inpatient care***) (%; Survey respondents; April - June 2016 (Q1 FY 2016/17); CIHI CPES)	954 960	50.70	55.70	52.2		Enhance communication with patients and families that helps them to navigate hospital processes and patient experience	YES	Developed patient communication brochures related to Medicine program that is co-designed with patient/family advisors. Develop and implement specialized discharge education packages to promote transitions in care. Plan to incorporate unit brochures with broader corporate information brochure in collaboration with corporate communications team.
							Implement communication board in all patient rooms across all 3 sites	NO	Location of beds is a limiting factor on some units in terms of visibility of board by patient. Implementation plan focused on SRH-C at this time. Will spread to other units as alternatives to white boards are investigated. Continues to be a challenge in our ward rooms.
							Develop and implement real-time patient feedback tools to enhance the patient experience.	YES	Established leadership rounding standard work to capture real time patient feedback. Pilot completed on 4D unit with spread plan underway. Expand post discharge patient feedback phone calls across all 3 sites. Feedback responses have been more positive. Discharge phone calls for orthopaedic patients started.

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3	% Hand hygiene compliance before patient contact (%; All inpatients; Oct. 2015 to Sept 2016; In house data collection)	954 960	85.00	90.00	84.70		Establish real-time hand hygiene performance reporting using a web-based hand hygiene auditing technology.	YES	Fully implemented at SRH-B and SRH-G sites. Spread to SRH-C site was delayed by 3 months due to IT issues. Full implementation on target for end of March 2018.
							Increase transparency and thus local accountability for hand hygiene performance by making unit monthly hand hygiene results visible to all staff and visitors at all sites.	YES	A Hand Hygiene accountability framework was developed and endorsed by Clinical Directors. The framework includes: public posting of results, standard work for action plan completion if target not met and checklist for leadership rounds. Leadership accountability for performance is strengthened by report outs through quality improvement huddles.
							Engage and partner with patients and families to identify strategies to improve hand hygiene and reduce hospital acquired infections.	YES	All infection control patient education material has been co-designed with input from Patient and Family Advisors. Hand hygiene education is posted on external website and available on television screens in public areas. IPAC team provides education to patients post acquisition of a new antibiotic resistant organism or CDiff. Content includes a focus on patient specific

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									moments for hand hygiene.
4	% Hospital acquired inpatient pressure injuries (≥ Stage 2) (%; All inpatients; Oct. 2015 to Sept 2016; TBD)	954 960	0.38	0.37	0.13		Create a corporate Scarborough and Rouge Hospital (SRH) Pressure Injury Prevention (PIP) Committee	YES	The establishment of a harmonized committee has allowed the team to come together to look at practices across the sites. The main key learning includes having a Patient Family Advisor (PFA) as part of the team as a member on the committee. The PFA provides a very valuable perspective on decisions and ideas for moving forward with pressure injury prevention in the organization.
							Standardized Review Process for Pressure Injuries Prevention	YES	This change idea is continuous and remains in progress. Sustainability requires continuous effort due to the high number competing priorities of both staff and leadership. A standardize metric, and prevalence tool will allow the sites to measure the prevalence and incidence in the same way that will allow evaluation of prevention strategies.
							Establish Pressure Injury Prevention Champions to support implementation and adherence to	YES	This change idea is continuous and also remains in progress. Efforts have been placed on high incidence units. Lessons learned – Building of prevention

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							best practices for pressure injury prevention.		champions takes time to establish, including time and funds for training, management support and mentoring and practice for knowledge transfer.
5	Clostridium difficile infection rate per 1,000 patient days (Rate per 1,000; All inpatients; Oct. 2015 to Sept. 2016; In house data collection)	954 960	0.32	0.30	0.23		Standardize the use of Ultraviolet (UV) Light no-touch technology where indicated across all three SRH sites to enhance environmental disinfection.	NO	Newly published report suggests evidence is not strong supporting UV light no-touch technology. More success eliminating CDiff spores from the environment is seen with adherence to cleaning protocols. Focus of change plan shifted to prioritize standardization of cleaning products that are effective and facilitate adherence to cleaning protocols (see change idea below)
							Explore and standardize sporicidal cleaning agents for everyday use across SRH.	YES	Worked collaboratively with Environmental Services and other stakeholders to review cleaning products for everyday use with a less than 10 minute contact time to eliminate CDiff spores. Analysis and recommendation for standardized sporicidal cleaning agents complete and trial currently underway. Full implementation of standardized cleaning processes on track for completion by March 2018.
							Raise physician awareness and understanding of C. difficile risk factors through implementation of an online IPAC module for new physicians.	NO	Delays in launch of on line learning platform have been a barrier to full implementation. Presentation is currently available through the physician orientation webpage. Next steps will be to transfer content to format supported by new on line system.

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							Engage physicians in current IPAC matters of interest relevant to their programs during departmental meetings	YES	Focus of content is on raising physician awareness and understanding of CDiff risk factors and infection control knowledge. Infection Control physicians have attended Medicine department meetings and presented at Medical Rounds.
6	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)	954 960	48.50	53.30	44.90		Enhance communication with patients and families that helps navigate hospital processes and patient experience.	YES	Patient Handbook standardized across all 3 sites and is now almost complete. Corporate communications is developing broader communication brochure.
							Ensure timely and complete communication to primary care providers and LTC Homes of their patients' discharge information.	NO	Primary care providers listed on patient charts will receive discharge information within one week of patient discharge (80%). Patients discharged back to LTCH with standardized discharge package (100%).

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							Implement real time patient feedback process across all sites.	YES	Discharge telephone calls across three sites are made within 48 hours of discharge (Medicine - focus on COPD patients) (70%).
7	Ideas Implemented per Full Time Equivalent (FTE) (Ratio (No unit); N/a; Oct. 2015 to Sept 2016; In house data collection)	954 960	1.00	1.00	0.45	• SRH challenged in attaining target idea generation goal • Underestimation of degree of change within organization this year; including staff requested to provide additional input and ideas for other requirements (i.e. strategic planning, integration, Corporate Staff engagement survey) • Changing program portfolios and leadership structure created some delay in initiation and	Increase visibility/awareness of idea generation as innovation opportunities; Focus staff ideas on improved patient experience and staff satisfaction.	YES	Improvement Idea recognition program was launched in Q3. Key learnings related to the need to align the program to other corporate celebration programs - creating some implementation delay. This change idea positively affected staff and leaderships' understanding of the impact of small changes towards improvement that could significantly improve patient experience. As an example, the first celebration highlighted process changes enacted to reduce falls.
							Create opportunities for patients and families to provide feedback re improvement opportunities or ideas and a portal to share their feedback with members of the SRH workforce.	YES	Mobile/web based Improvement Idea platform was launched in Q3 following a federally funded co-design initiative with Centennial College. (http://everydayimprovement.ca) Key learning related to the different project challenges encountered in collaboration with academic institutions (i.e. unplanned labour disruption). SRH staff are seeing the impact of a streamlined process to document ideas. There is potential for further development of a platform to incorporate patient feedback.

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						standardization of Improvement huddles			
							Implement routine evening/night/weekend shift idea board huddles in departments/units that have 24/7 shifts.	NO	While select departments and units were able to complete evening/weekend improvement idea huddles, this was not successfully spread across SRH. Key learning was the challenge in influencing a successful change outcome without a strong process to monitor. Some managers felt that the quality of evening/weekend improvement idea huddles would be low without their direct onsite support. The commitment to taking a 24/7 approach to engaging our frontline staff was tested with the use of Strategy 'Wallpaper' to collect staff ideas and input as part of our strategic planning process. Wallpaper was posted and left on units/departments 24/7 over a 3 week period so that staff on all shifts could contribute input. This was well-received by our staff however, a noteworthy finding was that more comments were collected through manager-led team huddles than through independent contributions by frontline staff. We will continue to assess and test innovative approaches to 24/7 frontline staff engagement.
8	Inpatient falls rate per 1,000 patient days (moderate/severe harm) (Rate per 1,000; All inpatients; Oct. 2015 to Sept 2016; In house data collection)	954 960	0.15	0.14	0.11		Harmonize to a corporate Scarborough and Rouge Hospital (SRH) Falls Committee	YES	SRH Falls Prevention Committee has been formed and has been successful in recruiting a Patient and Family Advisor as a member. Successful in adopting standardized reporting methodology to falls/1,000 patient days to facilitate trending and comparison across 3 sites and to external benchmarks. SRH Falls Prevention Committee continues to oversee and monitor implementation of recommendations from falls analysis completed in April 2017.

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							Standardized Review Process for Patient Falls	YES	Pilot units with high incidents of falls have implemented the post fall debrief tool. Standard work developed for leadership follow-up post fall to ensure comprehensive review of contributing factors and plan of care has been updated to include additional precautions appropriate to ensure patient safety. In addition, email trigger for leadership to complete post fall debrief tool.
							Develop and implement unit specific falls prevention and injury reduction strategies	YES	Leadership from two pilot units, with support from Innovation and Performance Improvement team are utilizing Lean methodology to implement unit specific falls prevention and injury reduction strategies, with a focus on implementing purposeful rounding for clinicians and leadership. Corporate inventory of falls prevention interventions completed and will be updated on a quarterly basis.
9	Medication reconciliation at admission: The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital (Rate per total number of admitted patients; Hospital admitted patients; Most	954 960	85.00	89.00	79.40		Establish oversight committee (i.e. SRH Safe Medication Practice Committee) - Corporate wide - Physician rep from each site - Exec sponsorship - Reporting to the Quality of Care Committee	YES	SRH Safe Medication Practice Committee (SMPC) was formed. Regular updates on the progress of the change ideas to SMPC provides support to sustain the change plans.

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	recent 3 month period; Hospital collected data)								
							Standardize auditing process of Medication Reconciliation at Admission within Medicine units across all 3 sites	YES	Trial of new audit tool at SRH-C on Cardiology unit. Rollout to all the units at the C site has been completed. Roll out to other sites will occur after the Meditech upgrade (April 2018). Reporting the current performance by program and site to the Clinical Directors supports the change process.
							Standardize Medication Reconciliation process at admission across 3 sites, for Medicine patients admitted through the Emergency Department.	NO	Value stream map developed for all sites was initiated. In progress: 50% prospective MedRec completed (in ED, before admission). 75% patients within Medicine who were asked by a staff member for a medication history (part of "Best Possible Medication History"). 50% of Medication Reconciliation amended by Pharmacy staff when initially performed by physician/nurse
10	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.	954 960	75.00	79.00	83.85		Establish oversight committee (i.e. SRH Safe Medication Practice Committee) - Corporate wide - Physician rep from each site - Exec sponsorship - Reporting to the Quality of Care Committee	YES	SRH Safe Medication Practice Committee was formed. Regular updates on the progress of change ideas to SMPC provides support to sustain the change plans.

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	(Rate per total number of discharged patients; Discharged patients ; Most recent quarter available; Hospital collected data)								
							Standardize auditing process of Medication Reconciliation at Admission within Medicine units across all 3 sites	YES	Trial of new audit tool at SRH-C on Cardiology unit. Rollout to all the units at the C site has been completed. Roll out to other sites will occur after the Meditech upgrade (April 2018). Reporting the current performance by program and site to the Clinical Directors supports the change process.
							Standardize Medication Reconciliation process at discharge across 3 sites, for Medicine patients admitted through the Emergency Department.	NO	Value stream map developed for all sites was initiated. Electronic discharge tool used at SRH-B/G, developed for SRH-C to be tested on the Cardiology unit prior to March 2018. Based on physician input, the SRH-C discharge tool has incorporated improvements from the SRH-B/G tool. If successful, the revised discharge tool can later be made available to the SRH-B/G sites.
11	Net Margin (Ratio (No unit); N/a; Oct. 2015 to Sept 2016; Hospital collected data)	954 960	0.00	0.00	3.16		Volume Management (ongoing monitoring & oversight of volume performance that are incrementally funded)	YES	
							Improve documentation and	Y ES	

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							coding to maximize Resource Intensity Weighting (RIW) and Expected LOS		
12	Percent of palliative care patients discharged from hospital with the discharge status "Home with Support". (%; Discharged patients ; April 2015 – March 2016; CIHI DAD)	954 960	93.40	95.00	96.2	The majority of patients identified as palliative are discharged home with supports. The challenge remains to increase this number of palliative patients who can be supported at home to die at home, if that is their choice of place of death. Additional work is required here to ensure the appropriate resources are in place	Standardize referral criteria and process for patients referred to the Palliative Care Team.	YES	Palliative care referral criteria standardized across all three sites.
							Discussion in daily bullet rounds across all units where patients can be identified as benefiting from palliative supports to safely transition home.	YES	Standard work established to identify patients that would benefit from a referral to the SRH Palliative Care Team. When patients are being discharged home for palliative care, nearly 100% of patients receive support in the home.
							Enhance staff awareness of palliative care.	YES	Online palliative care education module rolled out. A needs assessment was completed during the month of October 2017. Responses received from front line staff provided the team with some areas to prioritize regarding education.
							Define a Multidisciplinary Palliative Care Team approach to support the palliative care assessment, consultation and treatment planning across all sites.	YES	Multidisciplinary Palliative Care Team approach established for each SRH site.
13	Risk-adjusted 30-day all-cause readmission rate for patients with CHF (QBP cohort) (Rate; CHF QBP Cohort; January 2015 - December 2015; CIHI DAD)	954 960	16.80	16.50	15.50		Standardized care pathway for CHF patients across all sites at Scarborough and Rouge Hospital.	NO	• We are still working on the process to harmonize across all three sites. • Our experience with the indicator is that efficiencies could have been realized had the care pathways been included when the order sets were being standardized.

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									• Order sets are standardized across 3 sites however pathways differ between Gen/Birch (i.e. use of HF clinic) and Centenary i.e. use of Cardiovascular Rehabilitation and Secondary Prevention (CRSP).

							Implement and increase utilization of CHF order sets (including medication reconciliation)	YES	• All cardiologists are using HF order sets (paper based and digitized), however digitized order set utilization is at 30%, with the remainder completed manually.
									• Greater compliance will be achieved through existing cardiology committee work and as an addition to the CRSP annual operating plan for 2017-18.
									• The change idea can have greater impact through:
									  ○ Active promotion of the usage of digitised order sets; and
									  ○ Monthly report of digitised order set usage by cardiologists.
									• Reporting on order set usage will provide:
									  ○ Information on a regular basis to the team;
									  ○ timely update and information to management; and
									  ○ Support ongoing decision making process for the management of HF.

							Provide physicians with their CHF readmission rate	YES	• Our experience with the indicator is that the data needs to be more readily available to the physicians as well as management in order to plan for contingencies and analyse trends. • The report is being worked on and will be available on a quarterly basis from Decision Support.

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									• Physician readmission rates will be provided by Decision Support to the program backdated to Q2 2017. The readmit data comes from the Discharge Abstract Database (DAD) which has a two quarter lag.

							Develop an integrated and coordinated plan of care for patients upon discharge.	YES	• This indicator allowed us to continue or start to build our partnerships with relevant community resources name:
									  ○ Health Links;
									  ○ Telehomecare - HF module;
									  ○ Central East LHIN enhanced regional cardiovascular rehabilitation for HF support;
									  ○ HF Clinic; and
									  ○ MD (either primary care or cardiologist) office).
									• Working group established to identify HF model and opportunities for services utilizing existing resources within the 3 sites. Always remembering that we are one organisation across 3 sites when planning for further growth and appropriate resource utilization is a common theme we are using when planning our cardiac services.
									
									As part of the discharge process, High risk HF cases are identified and seen prior to discharge by the HF RN/NP (Centenary site). As a result, 100% of high risk HF patients (end stage) are discharged with appropriate follow up or support (palliative/home care).

14	Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort) (Rate; COPD QBP Cohort;	954 960	14.60	15.90	20.30		Develop a standardized care pathway for COPD patients across all sites	YES	Integrate admission order set best practices into patient care plan. Integrate discharge order set into interprofessional discharge planning process and bullet rounds. Discharge order set updated to reflect new

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	January 2015 – December 2015; CIHI DAD)								ideal state post discharge services.
							Develop an integrated and coordinated plan of care for patients upon discharge.	YES	COPD RIE outcome include all QBP Best Practice recommendations: The introduction of standardized post discharge COPD clinic follow-up for medical review and education follow-up, pulmonary rehab program services through CATCH program and community based program at Carefirst, and enhanced access to Rapid Response Nurse home visit post discharge and opportunity to participate in Telehomecare program for home based management.
							Provide physicians with their COPD readmission rate.	NO	Work in progress for a Physician Scorecard.
							Implement and increase utilization of COPD order sets and care pathways (including medication reconciliation)	YES	Expand COPD performance and operations committee across all 3 sites to review performance associated with QBP best practice guidelines.
15	Total ED length of stay (defined as the time from triage or registration,	954 960	9.90	9.00	10.20		Implement a virtual short stay unit in order to reduce Length of Stay(LOS)	YES	Pilot for Medicine short stay unit at SRH-C site designed to expedite access to tests required that could facilitate short admission in virtual medicine satellite beds.

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	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)								Medical Short Stay Unit (MSSU) has gone live to now capture the short stay patients that have streamlined access to test and follow-up.
							Fast track registration process to decrease length of wait	YES	Change idea updated to: Streamline patient flow processes for Ambulatory Care Areas to decrease length of wait. Spread HUB design at SRH-B to other sites to promote earliest possible point of assessment and intervention for patients and rapid release for patients that do not require more intensive treatment/observation/investigations. Explore opportunities to fast track registration for lower acuity patients to expedite care delivery.
							Reduce Wait time for diagnostic imaging test(s)	YES	SRH-G and SRH-B have recently extended ultrasound after-hours access and continued access to CT scan after hours.
							Expand geriatric management care for higher needs frail seniors in the ED	YES	Rapid Improvement Event to enhance geriatric care management for patients requiring intensive functional and cognitive supports. Action plans include a) explore model of care PSW integration, b) implement identified senior friendly strategies including delirium order set by c) optimize stretcher capacity and realign EMS offload directly into ED stretchers in Acute.
16	Total number of alternate level of care (ALC) days	954 960	18.80	21.20			Complete and spread the ED Non-Acute Admission Diversion project	YES	

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	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)						recommendations to all three Emergency departments		
							Ensure best practices to divert ALC are optimized and sustained across inpatient units at all sites	YES	The ALC Avoidance self-assessment tool was initiated. This identified gaps and variation in processes across the organization - specifically around early identification for at risk complex discharges, discharge support meetings, and how the ALC designation is applied. A Rapid Improvement Event was held with multidisciplinary team members, leaders and patient/family advisors who together identified improvement opportunities that included an immediate refresh of standard work and expectations at the local unit level, revised policy supporting escalation and standards regarding communication to patients and families.
						We continue this work re: implementation. This work is in progress.	Develop and implement patient and family education about discharge planning expectations	YES	Through the ALC RIE, patient/family advisors are working with the team, to co-develop the communication - both in how we verbally communicate also what would be required in terms of written goals of care.
							Develop and reinforce an escalation process to ensure all steps have been taken to divert ALC and determine ALC designation	YES	Working collaboratively with the Patient Flow Steering committee with a target to address and harmonize escalation policy. This is work being addressed in the RIE - to be completed by December 2017 for final approval.