Scarborough Health Network

Quality Improvement Plans (QIP): Progress Report for 2018/19 QIP

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP 2018/19	Target as stated on QIP 2018/19	Current Performance 2018	Comments	Change Ideas from Last Year's 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?
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?	979	46	53.3	48.9	Internally monitoring all positive responses (Top 2 boxes – 'Completely' and 'Quite a bit'). Current YTD performance with all positive responses is 74.3.	1)Communication Theme Point of Contact: Access/Entry Discharge/Transfer Spread the utilization of a unit specific information brochure for all medicine units at SRH	YES	-developed with variety of feedback from our patients and families including post discharge follow-up phone calls, real time feedback during hospitalization, and patient and family advisors. -the broader SHN information brochure was developed in tandem to the unit specific information sheet to increase the potential impact that enables the interprofessional team to utilize the tool to enhance communication.
							2)Communication Theme Point of Contact: Discharge/Transfer Standardize and spread COPD education on self-management and resources	YES	-standardize education materials to align with information in follow-up clinics to reinforce learnings
							3)Communication Theme Point of Contact: Discharge/Transfer Develop and implement a standardized Patient Discharge Summary for patients and families	NO YES	Project continues to be underway. Led under Chief of Staff office to include opportunities to populate electronically and include discharge medication lists. Pilot project with long term care partners on new standardized discharge information sheet complete and moving into spread planning
							4)Communication Theme Point of Contact: Access/Entry Treatment Discharge/Transfer Enhance communication with patients and families to help navigate hospital processes, address patient expectations and improve patient experience	NO	Standardization of processes across hospital site is a critical success factor in creating consistent patient and family experience. Building positive patient/family expectations are grounded within uniformity of practices that promotes patient/family abilities to seamlessly navigate through their hospital journey.

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2	Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort)	979	18.2	15.9	16.3		1)Communication Theme Point of Contact: Discharge/Transfer Revise and spread standardized COPD education on self-management and resources	YES	-standardize education materials to align with information in follow-up clinics to reinforce learnings
							2)Communication Theme Point of Contact: Discharge/Transfer Standardize and spread post discharge follow-up for COPD patients	YES	-Post discharge calls include COPD patients across Medicine at all 3 sites - COPD patients are included in referrals to post discharge clinic. Transition plan underway to specialize the follow-up in the discharge clinic for COPD patients to reinforce teaching and community based follow up. -Further development to tracking all COPD patients for post discharge clinic follow-up is underway
							3)Integrate the COPD discharge order set into the discharge planning process on the inpatient units	YES	-integrated a prompt in discharge bullet rounds to complete the order set upon discharge -low uptake on digital order set and further root cause analysis may be helpful
3	Inpatient Mental Health readmission back to same institution within 30 days of initial discharge	979	10	10.0	8.2	The 30-day readmission rate has remained below the set target all year, noting that the lower the performance the better.	1)Retrospective readmission trend analysis	YES	Chart audits were conducted across both Birchmount and Centenary. A post discharge follow up phone call script and implementation plan was developed following this audit.
							2)Communication Theme Point of Contact: Discharge/Transfer Improve availability of resources post-discharge for mental health patients	YES	Implementation of HQO Quality Standards is supporting improved follow up and resources post discharge for patients with major depressive disorder, schizophrenia and dementia. Patients presenting with substance use disorders also have opportunity to be connected with addiction counsellors and Rapid Access Addiction Medicine (RAAM) treatment clinic.
							3)Develop an automatic flag to identify to staff when a mental health patient has been readmitted for a mental health-related condition	NO	This proved more challenging and required significant resources from our IT department. Unfortunately competing priorities would not allow for this to be complete; however, through daily bullet rounds, patients are being identified as having been re-admitted within the 30 days. The interdisciplinary team is very involved in assessing whether additional supports or resources are required at discharge.

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							4)Communication Theme Point of Contact: Discharge/Transfer Implementation of post-discharge follow-up phone calls for mental health patients at-risk of readmission	YES	Resources were identified across both in-patient units to have nurses begin making these calls. There is not a uniform way to track these follow up calls given the different medical records.
4	"Would you recommend this emergency department to your friends and family?"	979	48.8	50.2	49.5	Internally monitoring all positive responses (Top 2 boxes – 'Definitely yes' and 'Probably yes'). Current YTD performance with all positive responses is 85.0.	1)Communication Theme Point of Contact: Access/Entry Treatment Discharge/Transfer Standardize and spread a framework to gather real-time feedback from patients	YES	-iPillar real time patient feedback system spread across all 3 sites in ED with the use of tablet located in key volume areas in the department -redesign required to facilitate ease in reviewing results
							2)Communication Theme Point of Contact: Access/Entry Treatment Discharge/Transfer Continue Kano analysis to understand patient expectations and identify factors influencing patient satisfaction and dissatisfaction	NO	-training on the Kano analysis methodology was completed with key stakeholders -extensive data collection process has required more time than anticipated but is essential to a comprehensive review
							3)Communication Theme Point of Contact: Access/Entry Improve the availability of ED wait time information with patients/families	YES	-helpful to broaden sources of information to support access to patients and families including mobile app available, ED pamphlet during triage, communication by volunteer in waiting room and on screens in waiting room
							4)Communication Theme Point of Contact: Access/Entry Improve the patient experience by timely acknowledgement upon arrival to the ED	YES	-volunteer availability may fluctuate at different periods of the year so it was helpful to prioritize activities for any volunteers in the ED to support the waiting room

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5	% of complaints closed within 60 days	979	94	98.0	99.1		1)Educate team and stakeholders on harmonized patient relations policy	YES	
							2)Patient relations representative to offer local/program level support based on identified complaint trends	YES	Program specific action plans continue to be generated based on any trends of increased negative patient/family experience (complaints). Patient relations team will continue to provide education to all new managers, directors and physician chiefs on the harmonized patient relations process. Focused education will be provided to program managers at the manager forum meetings.
6	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.	979	85	90.0	77.3		1)Communication Theme Point of Contact: Discharge/Transfer Refresh medication reconciliation communication and education for physicians, staff, and patients	YES	Education has been provided to the Centenary physicians/NPs to support the roll out of the computer generated prescription tool. The introduction of the new audit process at the Birchmount and General sites has provided another opportunity to highlight the importance of the medication reconciliation process at the local level.
							2)Standardize discharge prescription form across all sites	YES	The computer generated prescription tool available from the patient's current medication list has now been rolled out to the Centenary site. This prescription form was modified slightly based on input from the Centenary physicians/NPs. When the modifications were introduced to the General physicians, there was no interest in adopted the slight change. Lesson Learned: It is difficult to modify forms/processes unless there are significant benefits to the stakeholder group (i.e. physicians)
							3)Communication Theme Point of Contact: Discharge/Transfer Roll out audit process for medication reconciliation at discharge across all sites	YES	Yes, the audit process for the Admission and Discharge Medication Reconciliation which was introduced at the Centenary site has now been rolled out at the Birchmount and General sites. <u>Lessons Learned</u> The process was trialed on several units at the General and Birchmount sites first. This enabled the team to make modifications to the process and understand challenges in

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									workflow impacted by the change. Prior to the final rollout, education and awareness of the new process was facilitated through several workshops held at the Birchmount and General sites. These were excellent opportunities to obtain feedback and questions from the Managers and Unit Clerks. In order to standardize our approach and answers to the questions, the Steering Committee met several times to review and standardize our responses. After the process was implemented, there continued to be questions from the units. Subsequently, we have held small meetings with Managers from specific patient care areas such as Critical Care, Mental Health. Due to the differences patient populations (mental health vs pediatric patients), there is often a need to modify the process to best meet the local need. The new tool has only been in place for one month and will require ongoing support at the local level to improve the audit results.
7	% Hand hygiene compliance before patient contact	979	89	90.0	93.0		1)Strengthen use of the Hand Hygiene Accountability Framework to increase transparency and accountability for hand hygiene performance at all levels of the organization	YES	Hand hygiene performance data posted in all inpatient units across 3 sites. Performance discussed at director's huddles. Action plans developed when unit level performance falls below target and/or required number of audits not completed.
							2)Communication Theme Point of Contact: Treatment Continue development of awareness campaign for patients and families about the importance of hand hygiene	YES	Ongoing patient hand hygiene awareness campaign across 4 units. Patient Family Advisory Council (PFAC) was consulted in the development and implementation of the awareness campaign.

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8	Inpatient falls rate per 1,000 patient days (moderate/severe harm)	979	0.16	0.14	0.15		1)Raise awareness of staff on SRH falls prevention policy including focus on reducing use of restraints, post fall monitoring and conducting a debrief after all falls	YES	Implemented Purposeful Rounding (PR) as a corporate clinical practice standard on all inpatient units to focus nurses' attention on patient safety and comfort. Education on bedrails as a restraint (4 bedrails versus 2) was rolled out and appropriate use of bedrails embedded as a component of PR. Practice is strengthened by audits and coaching from leadership. We are in the early stages of implementing Purposeful Rounding for leaders which will support sustainability of practice change and enhance patient experience.
							2)Spread and strengthen implementation of unit specific falls prevention and injury reduction strategies	YES	Rapid Improvement Events within the Medicine program enabled root cause analysis and team engagement to determine sustainable unit specific strategies focused on prevention and injury mitigation. Fortunate to have a Patient and Family Advisor participate in co-design of new processes with the clinical team.
9	Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.	979	CB	CB	7		1)Establish a Corporate Workplace Violence Prevention Committee	YES	This change idea requires commitment from senior leaders and managers. A value stream analysis was completed and five working groups have since been created that report into the Committee. These working groups include: • Integrated Incident Management • Policies, Programs, Measures, Procedures • Training • Response Team • Physical Plan and Structural
							2)Develop a process for assessing patients for acting out/violent behaviours and a methodology for identifying risk to the care team and others	NO	This change idea is in progress and taking longer than expected to standardize a tool across the organization. This work will continue into the QIP for 2019/20. This change idea requires documentation, policy, practice change, and education development.

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							3)Improve processes for reporting violent incidents	YES	This work will continue into the QIP for 2019/20. A rapid improvement was held and further changes ideas were identified to improve the processes. As a newly merged organization, terminology was standardized within the incident management system. A stand-alone icon for Workplace Violence is now being added to make it easier for staff to report. All incidents are now being reviewed daily through the Occupational Health and Safety Team
							4)Assess the level of risk for workplace violence across the organization	YES	Environmental risk assessments for high-risk clinical areas have been completed. Resources and time commitment is required for this change idea. The remaining areas of the hospital will be completed in the 2019/20 fiscal year.
10	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	979	10.7	9.7	10.2		1)Implement a Virtual Medical Short Stay Unit (MSSU) in order to reduce Length of Stay (LOS)	YES	Continues to be available at Centenary site based on patient need and is tightly aligned to follow-up supports such as procedures. Continuous review to expedite any follow-up actions is underway to allow shorter stay in MSSU.
							2)Standardization of corporate overcapacity protocols for admitted patients waiting in ED	YES	New flow reports, threshold triggers and actions such as scheduled admissions. Spread into a harmonized policy is still underway.
							3)Reduce wait time for diagnostic test(s)	YES	ED/DI quarterly working group supports opportunity to review performance and engage in a collaborative solution based process