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.

Priority Indicator	Performance stated on previous QIP	Target on previous QIP	Current Performance	Change Ideas from Last Year QIP (2016/17)	Was change implemented Yes or No	Lessons Learned 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?	NEW Change Idea that were tested but not included in last year's QIP	Was change implemented Yes or No	Lessons Learned 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?
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)*	50.00	58.00	58.6% (Q1, Apr – Jun 2017)	**In collaboration with LAFHT, build a cross-sector discharge planning process**.	No	The medication reconciliation on discharge is communicated to LAFHT, but need to develop standard discharge instructions for patients that include appointments/ plan more clearly, what signs/symptoms to look for and when to call your doctor.	None	No	N/A
Percentage of patients identified with multiple conditions and complex needs (Health Link criteria) who are offered access to Health Links approach. *(%; Patients meeting Health Link criteria; Most recent 3 month period; Hospital collected data)*	Collecting Baseline	Collecting Baseline	36% Nov 2017-Mar-2018)	**Comparable results vs. Chatham Kent Health Alliance (CKHA).**	Yes	LAFHT Health Links Coordinator in place November 2017. Conduct process on how to refer patient to Health Links from ED/Inpatient Unit.	Establish coordinated process in which to identify patients meeting criteria for Health Links and referral.	Yes	Outline referral process from GEM nurse & ED staff on criteria for patient referral to Health Links. Develop a more stream line way in which the referral is made to the Health Links Coordinator. Educate staff on including criteria; clearly articulate key roles; map out referral process with key stakeholders.
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 recent 3 month period; Hospital collected data)*	94.00	90.00	100% (Q3, Oct – Dec 2017)	**Maintain current process and continue to include pharmacy student as admission medication reconciliation coordinator in the emergency department.**	Yes	Educate ED RNs on ways the Best Possible Med History can be obtained by ED staff when pharmacy student not working. When BPMH is obtained, fewer omissions of meds occurred.	Will continue to utilize pharmacy student in this role. Develop medication reconciliation/BPMH standard work.	Yes	Review form and process used for BPMH and revise as needed. Continual auditing.
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)*	88.00	90.00	90% (Q3, Oct – Dec 2017)	**Increase pharmacist involvement in discharge medication reconciliation in real time. Link hospital with primary care provider (LAFHT). Send discharge prescription sheet, medication teaching sheet to primary health care providers by fax.**	Yes	The BPMH Discharge is well done by the Pharmacist. Need to ensure the process can be followed for patient discharges that occur when pharmacist not able to conduct the reconciliation. Review form and process used for BPMH discharge and revise as needed. Ongoing nursing education on process for medication reconciliation at discharge. Continuous auditing.	None	No	N/A
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)*	8.25	9.48	8.45 (data is auto populated)	**Facilitate early recognition of the LAFHT patients to ER with the "Community Physician to ED Physician SBAR report sheet".**	No	Additional ED MD 4 hour coverage was added in fall 2017. This improved the ED LOS slightly.	Explore matching the ED MD additional hours of work to the times when patients are waiting in ED.	Yes	Analyze triage times /ED LOS hourly, to identify when most of the ED patients are in the department. Review the data with the ED staff and physicians on a regular basis, looking for input into process change. Continue to monitor impact of additional physician coverage on ED wait times.