Quality Improvement Plans (QIP): Progress Report for 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.

Measure/Indicator from 2018/19	Current Performance stated on QIP 2018/19	Target as stated on QIP 2018/19	Current Perform 2019	Change Ideas from Last Years QIP (2018/19)	Was change implemented as intended 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 as intended 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?
"Would you recommend this emergency department to your friends and family?" (%; Survey respondents; April - June 2017 (Q1 FY 2017/18); EDPEC)	39.30	43.30	50 (Q1 18/19)	Develop an educational module to improve communication techniques with patients. Improve patient flow through the emergency department.	Yes	AIDET training for all staff. Coaching in real time for communication issues. Feedback regarding poor communication from patients and families shared with staff during staff meetings. Implemented AIDET training for all staff. This training provided staff with the necessary tools to improve communication with patients and families. Impact: improvement seen with keeping patients and family informed about plan of care. Improvement seen with the acknowledgement of patient feelings/ concerns/ frustration. Improved feedback from patients and families during leadership rounding.	Real-time surveys.	Yes	The Patient Advocate in collaboration with trained volunteers implemented a daily survey of patients and families in the ED and IP units. This allowed the organization to quickly bring back concerns to be addressed, trends and accolades to frontline staff for feedback.
"Would you recommend this hospital to your friends and family?" (Inpatient care) (%; Survey respondents; April - June 2017 (Q1 FY 2017/18); CIHI CPES)	58.70	64.60	73.9 (Q1 18/19)	Develop an educational module to improve communication techniques with patients.	Yes	Feedback regarding poor communication from patients and families shared with staff during staff meetings. Implemented AIDET training for all staff. This training provided staff with the necessary tools to improve communication with patients and families. Impact: improvement seen with keeping patients and family informed about plan of care. Improvement seen with the acknowledgement of patient feelings/ concerns/ frustration. Improved feedback from patients and families during leadership rounding.	Real-time surveys.	Yes	The Patient Advocate in collaboration with trained volunteers implemented a daily survey of patients and families in the ED and IP units. This allowed the organization to quickly bring back concerns to be addressed, trends and accolades to frontline staff for feedback.
				Use white boards in patient rooms to increase communication of the plan of care/goals for discharge - to be started on admission and updated daily.	Yes	Current patient white boards were removed and replaced with new boards that were more conducive to communicating plan/goals. New boards are focused more on what is important to the patient. Compliance with usage of the boards requires consistent auditing.	NA		
				Comfort rounding on all inpatient units.	Yes	Comfort rounding implemented in July. This tool requires auditing for completion. Comfort round compliance was discussed during staff meetings. Discussion regarding the rationale of intentional rounding is necessary with the staff. Impact: when completed appropriately -- intentional rounding met patient's basic care needs, decreased number of call bells. Compliance with rounding requires consistent auditing required.	NA		
				Implement Oculys StayTrak program by July 1, 2018.	Yes	Roll out of StayTrak was delayed until August, 2018 due to several technical complications from Oculys. Feedback provided to Oculys – rolled out again in October. Recommend a longer trial period to ensure program is ready. Impact: all members of the healthcare team can quickly be informed of patient status and discharge plan. The next step is ensuring this information is then consistently communicated to patient via patient white board.	NA		

90 Percentile ED LOS for Non-Admitted Minor Patients (CTAS 4-5) Defined as the time from registration date/ time or triage date/time (whichever is earlier and valid) to the date/time the patient left ED (90th percentile; (hours); October - December 2017; CCO iPort)	4.78	4.00	4.42 (Q3 18/19)	Increase # of patient assessments /treatment by ED NP to 15/shift.	Yes	RAZ initiated to pull vertical patients out of the acute care stretchers. Correct triage is essential to optimize this quick flow by not bottlenecking the area with patients that need a stretcher for long periods of time. This initiative has been valuable to the flow and P4R outcomes with realized improvements.	NA		
90th Percentile ED LOS for Complex Patients (Admitted and Non-Admitted) (CTAS 1-3) Defined as the time from registration date/time or triage date/time (whichever is earlier and valid) to the date/time the patient left ED (90th percentile; (hours); October - December 2017; CCO iPort Access)	7.13	6.42	8.43 (Q3 18/19)	Identify opportunities for safe reduction of diagnostic testing when unnecessary testing contributes to longer ED LOS.	No		Chart board redesign mimicking the patients' journey at specific time points to pinpoint gaps and opportunities for improved and timely flow.	Yes	Good visual of where the flow is challenged. Both MD and RN are responsible for bottlenecks that occur in order to resolve. Yes, made an impact – charge nurse can assist to resolve.
							Visual management for order time for lab and DI.	Yes	Great visual for when order was initiated and completed, especially for the charge nurse. Yes, makes an impact, more staff aware of delays.
90th Percentile LOS for Admitted Patients Defined as the time from registration date/time or triage date/time (whichever is earlier and valid) to the date/time the patient left ED (Admitted patients only) (90th percentile; (hours); October - December 2017; CCO iPort Access)	16.35	14.70	15.42 (Q3 18/19)	Review present transporter role.	Yes	Role reviewed and new transporter role being developed to assist with optimal flow.	Follow-up with IP Side 1.Surge beds opened 2.Isolation protocols revised with education 3.Focus on bed allocation	Yes	More global awareness of the need and benefits to the patient when transitioned quickly to the inpatient bed. Change management essential.
				Develop standard work to include transport of patient in ED to DI and inpatient units.	No	Standard work for the role in progress.	NA		
				Follow-up with inpatient programs. Charge nurse to be hired with main duties to include patient flow.	Yes	CRN implemented with obvious positive change in patient management / flow within the ED department. Good support and direction to nurses, EMS, physicians, allied health. Essential for CRN to know ED waiting room patients as well as the patients in the department. Has resulted in improved ED flow and P4R outcomes/ranking.	NA		
90th Percentile Time to Physician Initial Assessment (Hours) Defined as the time from registration date/time or triage date/time (whichever is earlier and valid) to the physician initial assessment date/time (90th percentile; (hours); October - December 2017; CCO iPort Access)	4.00	3.60	3.98 (Q3 18/19)	Implement Clinical Resource Nurse in ED daily 9-5 pm - role to increase patient flow through ED.	Yes	CRN implemented with obvious positive change in patient management / flow within the ED department. Good support and direction to nurses, EMS, physicians, allied health. Essential for CRN to know ED waiting room patients as well as the patients in the department. Has resulted in improved ED flow and P4R outcomes/ranking.	NA		
				Implement Oculys prEDict tool by July 1, 2018.	Yes				
Medication Reconciliation at Discharge (Current monthly audit is based on a sample of 50 discharged patient charts from various units/ services at ESHC excluding Obstetrics, newborns and deaths.; Discharged patients ; October - December 2017 (Q3); Hospital collected data)	90.00	90.00	99 (Q3 18/19)	Review discharge medication reconciliation process and redesign standard tool used. Develop standard work regarding medication reconciliation on discharge. Going forward, we will be reporting on the total number of 8discharged patients for whom a Best Possible Medication Discharge Plan (BPMDP) was created as a proportion of the total number of patients discharged, excluding discharge that is death, OB patients, newborn or stillborn.	Yes	One on one nursing education was complete, and incorporated with nursing orientation for new hires. A laminated standard reference sheet / checklist was created and placed in all nursing med books for reference. A blank medication teaching card was developed and available in all nursing units (encouraged to print electronic discharge med card). Nursing is very appreciative of service when pharmacy available. Continue to strive for interdisciplinary rounding with prescribers and pharmacy to streamline discharge process with time for advanced planning and preparation. Investigate opportunity for pharmacy collaboration with discharge nurse.			

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)	13.00	26.00	41 (Jan – Dec 2018)	Increase the awareness of the importance to report workplace violence incidents.	Yes	Reporting has increased significantly. Having an electronic reporting system with a separate ICON for Workplace violence and harassment was very helpful and instrumental in increasing reporting.	E-learning for all employees. Employee code white training. Policy revision that includes deadlines for leadership investigation of incidents.	Yes	This is a valuable indicator for improving staff to staff relations. There were no physician to staff incidents reported which may indicate staff reluctance to report this type of incident.
				All patients - admitted patients and those triaged in ED will have a Violence Assessment Tool completed as part of their documentation.	No	NA	NA		
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)	36.00	100.00	88 (Q3 18/19)	Develop coordinated care plans across ESHC, LAFHT and other primary care providers.	Yes	This indicator only reports the number of referrals sent; it does not capture how many people are then followed up with by a Health Links coordinator and how many of the initially referred patients are then offered the coordinated care plan approach. It is easier to follow up with those patients connected with the LAFHT than it is for the patents with other primary care providers – this is because LAFHT has a dedicated LHIN coordinator for the Health Links approach. A more expansive outreach would be beneficial.	Na		
				Track readmit rates for Health Link participants and Health Link eligible participants.	Yes	Indicator doesn't truly capture the effectiveness of the coordinated care plan, rather captures the number of people who are deemed eligible and then offered access. It has helped to know if there are patients who are being missed – why was the patient determined eligible but not offered the approach. If we are able to identify those reasons, then we are able to problem solve as to how best to address the concern and ensure that 100% of the patients who are eligible for health links approach are given access to it.	NA		
Reduce unscheduled Emergency visits within 30 days for Mental Health conditions (%; ED patients; October - December 2017; IDS BI Portal Health Information Insights)	18.10	16.00	19.5 (Q3 18/19)	Improve coordination and safety of care transitions from Emergency Department to Community through links to Community resources and effective referrals.	Yes	A specialized mental health nurse provides an assessment to the Emergency Departments (ED) and any inpatient unit 8 hours per day/7 days per week. Our PAN partners with many other community agencies with the goal of creating a treatment plan that allows the client to return to the community with a coordinated treatment plan in place.	NA		