Quality Improvement Plans (QIP): Progress Report for 2016/17 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 Perform	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?
"Overall, how would you rate the care and services you received at the ED?", add the number of respondents who responded "Excellent", "Very good" and "Good" and divide by number of respondents who registered any response to this question (%; ED patients; October 2014 - September 2015; NRC Picker)	84.50	85.00	89.5 *(Oct/15 - Mar/16)*	**Increase satisfaction by implementing "Hourly Comfort Rounds" concept.**	Yes. 89.5% indicates an improvement from previous QIP and above target.	Dependant on staffing and acuity needs in the department.	Engage nursing staff to consistently utilize existing white boards to keep patients up to date on their Emergency Department visit.	Yes	Staff are not engaged in this process during high volume and high acuity in the department. Patient experience was more favourable when the nursing staff utilized this process.
"Overall, how would you rate the care and services you received at the hospital?" (inpatient), add the number of respondents who responded "Excellent", "Very good" and "Good" and divide by number of respondents who registered any response to this question (%; All patients; October 2014 – September 2015; NRC Picker)	93.10	91.00	92.0 *(Oct/15 - Mar/16)*	**Increase satisfaction by implementing "Hourly Comfort Rounds" concept.**	Yes	Rounding has always been part of staff's work. Plan is to focus on 4 P's. Advice: audit and continue to improve processes, change takes time.	Developing a new bedside white board to assist patients to follow plan of care, and capture comfort rounds	No	White board developed. Will be implementing this year.
"Would you recommend this ED to your friends and family?" add the number of respondents who responded "Yes, definitely" (for NRC Canada) or "Definitely yes" (for HCAHPS) and divide by number of respondents who registered any response to this question (%; ED patients; October 2014 – September 2015.; NRC Picker)	55.60	58.00	55.2 *(Oct/15 - Mar/16)*	**Increase satisfaction by implementing "Hourly Comfort Rounds" concept.**	Yes	Scores are consistent as compared to previous QIP. Opportunity to continue to improve by fostering a positive culture of respect and values.	New Emergency Department Director to engage Nan Brooks to implement strategic change recommendations.	No	Emergency Department Redesign Committee meetings to restart this year.
"Would you recommend this hospital (inpatient care) to your friends and family?" add the number of respondents who responded "Yes, definitely" (for NRC Canada) or "Definitely yes" (for HCAHPS) and divide by number of respondents who registered any response to this question (%; All patients; October 2014 – September 2015; NRC Picker)	65.10	66.50	77.2 *(Oct/15 - Mar/16)*	**Increase satisfaction by implementing "Hourly Comfort Rounds" concept.**	Yes	Rounding has always been part of staff's work. Plan is to focus on 4 P's. Advice: audit and continue to improve processes. It works – increased satisfaction of 12.1	Developing a new bedside white board to assist patients to follow plan of care, and capture comfort rounds	No	White board developed. Will be implementing this year.
CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI during the reporting period, divided by the number of patient days in the reporting period, multiplied by 1,000. (Rate per 1,000 patient days; All patients; January 2015 – December 2015; Publicly Reported, MOH)	0.48	0.46	0.22	**Using Plan of Care for Patient Isolation on Admission. Continue with Antibiotic Stewardship initiative. Staff training. Ensure best practices for environmental cleaning. Increase in private rooms**	Yes No increase in private rooms in the process	Better compliance with isolation from family & visitors due to the explanation on admission for isolation through care plan. Will continue to audit documentation	E-learning available for staff training for routine practices, PPE and hand hygiene To decrease number of bed moves by maintaining private isolation in semi-private (as a private room)	Yes	Continue to monitor

Priority Indicator	Current Performance stated on QIP 2016/17	Target as stated on QIP 2016/17	Current Performance 2016	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?
ED Wait times: 90th percentile ED length of stay for Admitted patients. (Hours; ED patients; January 2015 - December 2015; CCO iPort Access)	11.50	10.90	13.88	**Utilize staff, patient and community input to investigate opportunities for improvement in wait times.**	Yes. # 1 in LHIN 1 in this metric.	Continue to engage physicians ensuring admissions are not batched to maintain efficiency in this metric.	N/A	N/A	N/A
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 quarter available; Hospital collected data)	94.0	95.0	94.0	**Education of staff**	Yes	With staff changeover there is always a "learning curve". Staff are followed up with on an individual basis when it is identified that medication reconciliation was not completed	Continue to provide information about med incidents related to admission medication reconciliation to front line staff. Investigate sample assignment for data collection.	N/A	N/A
Percentage of acute hospital inpatients discharged with selected HBAM Inpatient Grouper (HIG) that are readmitted to any acute inpatient hospital for non-elective patient care within 30 days of the discharge for index admission. (%; Discharged patients with selected HIG conditions; July/14 – June/15 ; CIHI DAD)	14.58	14.50	15.11	**Updating patient information on discharge as it relates to Quality Based Procedures (QBP) being monitored.**	yes	Updating information alone does not decrease readmits. Must also incorporate community resources, ccac follow up and patient education.	N/A	N/A	N/A
Risk-adjusted 30-day all-cause readmission rate for patients with CHF (QBP cohort) (Rate; CHF QBP Cohort; January 2014 – December 2014; CIHI DAD)	15.47	14.70	19.76	**Enhance education provided to patients starting on admission through discharge (both written and visual education materials.**	Yes	Pamphlets developed to give to patients. Need to include community resources for patients and referral to CCAC	Every patient receives a referral for CCAC		Need to place the CCAC referral form on every chart at the time of admission. Although it's on the admission order set for CCAC, it does not always happen. Need the actual referral form
Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort) (Rate; COPD QBP Cohort; January 2014 – December 2014; CIHI DAD)	19.89	19.20	20.97	**Enhance education provided to patients starting on admission through discharge (both written and visual education materials.**	Yes	Pamphlets developed to give to patients. Need to include community resources for patients and referral to CCAC	Every patient receives a referral for CCAC		Need to place the CCAC referral form on every chart at the time of admission. Although It's on the admission order set for CCAC, it does not always happen. Need the actual referral form
Risk-adjusted 30-day all-cause readmission rate for patients with stroke (QBP cohort) (Rate; Stroke QBP Cohort; January 2014 – December 2014; CIHI DAD)	10.00	9.50	X	**Enhance education provided to patients starting on admission through discharge (both written and visual education materials.**	No	Most acute strokes are sent to WRH. Need to develop education for those admitted to or returning to LDMH	N/A	N/A	N/A
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 2015 – September 2015; WTIS, CCO, BCS, MOHLTC)	26.50	20.00	22.09	**Have one dedicated Director lead utilization to monitor and guide flow. Recreate the hospital discharge policy**	Yes Discharge policy still being created.	It is effective to have one person oversee utilization and guide flow. Allows for person to follow the barriers to patient discharge and seek out the resources for patient to be discharge safely.	Bullet rounds are now captured on an electronic flow board. Easier to visualize barriers. Medworxx completed on night shift, for better compliance.	Yes	Medworxx on nights has lead to increased compliance which has enhanced flow on dayshift.