Excellent Care for All

Quality Improvement Plan (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.

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
1	"Would you recommend this emergency department to your friends and family?" (%; Survey respondents; April - June 2017 (Q1 FY 2017/18); EDPEC)	596	56.50	65.00	49.10 (Q3 2018/19) (Direction of Improvement: Increase/ higher)	While we were unable to meet our target, significant change, providing improved patient safety, patient access, and standardization have been our priority this year.

Realizing that the QIP is a living document and the change ideas may fluctuate as you test and implement throughout the year, we want you to reflect on which change ideas had an impact and which ones you were able to adopt, adapt or abandon. This learning will help build capacity across the province.

Change Ideas from Last Years 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?
Evaluate ED patient experience feedback results. Improve transparency of sharing patient experience data and embed in the unit based Transforming Care Quality Improvement Huddles	Yes	We were successful in sharing patient experience data on our unit communication boards while the manager regularly reviewed patient experience data and themes sharing both success stories and points of improvement when appropriate.
2)We will build upon the improvement strategies identified in our mapping process and continue to track system flow through the use of our daily monitoring tool (DART), in unit-level performance huddles, Discharge	Yes	Robust data review has been completed despite struggles to obtain data post Meditech implementation December of 2018 through the DART (daily statistical report), board and leadership scorecards. Unit huddles, discharge

Rounds and Daily Bed Meetings. By engaging frontline staff and leaders, we are better able to identify challenges and barriers. We will increase data review at program and leadership level.		rounds and daily bed meetings have been used regularly to identify struggles, what's going well, and where attention is required. The voice of the frontline staff and all levels of leadership have effectively come together to identify challenges and barriers on all levels of the organization.
ED program will develop and implement action plans to create improvement aligned to two key driver associated with the overall rating of care.	Yes	Successful implementation of both the Meditech health information system in December of 2018 along with a new patient flow that allows patients to be assessed and care initiated in a more timely fashion have been the focus. These initiatives have resulted in improved patient flow and further standardization of care.

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2	"Would you recommend this hospital to your friends and family?" (Inpatient care) (%; Survey respondents; April - June 2017 (Q1 FY 2017/18); CIHI CPES)	596	45.10	52.00	48.00 (Q3 2018/19) (Direction of Improvement: Increase/ higher)	Though we did not reach our goal of 52% we are pleased to report an improvement. Our performance represents our commitment to setting a new standard for community hospital care.

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Evaluate Medicine Unit patient experience. Improve transparency of sharing patient experience data and embed in the unit based Transforming Care Quality Improvement Huddles	Yes	We were successful in sharing patient experience data on our unit communication boards while the manager regularly reviewed patient experience data and themes sharing both success stories and points of improvement when appropriate.
Real Time in patient experience survey. Leverage PFAC members across every committee and within every quality improvement process to ensure patients add their lens and guide decisions.	Yes	These surveys were completed regularly for half of the year at which time the PFAC decided to improve on the survey to prompt a more meaningful conversation while speaking to the patient. The PFAC members reported that the survey was helpful, and patients felt free to talk about their experience but they wanted to leverage them to gather more meaningful information.
The Inpatient program will develop and implement action plans to create improvement aligned to two key driver associated with the overall rating of care.	Yes	Successful implementation of Meditech brought with it many changes that allowed us to align the nursing process with effective use of Meditech. Prior to Meditech, a downtime process was created which involved creating a downtime chart and adjusting the nursing process to allow for more presence and charting at the bedside. Bedside reporting and communication boards continue to be

	supported and audited as we focus on our patients and their safety.

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3	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 2017(Q1 FY 2017/18); CIHI CPES)	596	47.90	50.30	61.50 (Q3 2018/19) (Direction of improvement: Increase/ higher)	Though we have moved forward positively, we continue to improve on timely follow-up post discharge with follow-up phone calls and plan to ensure standardized discharge practices are implemented throughout the organization as the previous focus has been on the medical unit.

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Implement Discharge follow-up phone calls to reinforce discharge instructions and address opportunities for improvement by the Admission Discharge Transfer nurse and/or modified staff.	Yes	Though discharge phone calls were not implemented, a standard operating procedure was created. We struggled with resources to start the discharge follow-up phone calls. Through collaboration with the Quality, Risk and Patient Experience department, the Admission Discharge Transfer Nurse and Occupational Health Nurse there is a plan in place to move this change idea forward in the next fiscal year.
Enhance communication with patients and families that helps navigate hospital discharge and patient experience.	Yes	Through standardization of the discharge process and communication methods we have positively impacted patient experience. Medication reconciliation at discharge with pharmacy collaboration has improved medication knowledge allowing patients to go home and manage their situation with confidence. Communication has been more

transparent with the use of bedside communication boards and bedside reporting keeping the patient and family more informed.

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4	ED Wait times: 90th percentile ED length of stay for Admitted patients (90th percentile; ED patients; Q3 2017/18; CCO iPort)	596	15.40	12.00	14.50 (Q3 2018/19) (Direction of improvement: Reduce/ lower)	Significant work has been completed on an initiative labelled 'First In, First Seen' that focuses on bringing patients into our department in order of arrival, when possible, with the combined efforts of all physicians and front-line staff. Front-line staff have worked tirelessly to improve the flow of patients through the department and though the presented time does not fully reflect this improvement, the implementation of an electronic medical record has caused a momentary interruption in our improved patient flow. Our organization also supports extensive efforts of our Admission Discharge Transfer Nurse who has been, and continues to standardize the process and educate staff accordingly to make the process of admission flow as smoothly as possible for our patients.

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Continue to implement Transforming care Quality Improvement Huddles across the organization to discuss opportunities for improvement	Yes	Part of our struggle with huddles is obtaining the data that helps guide our discussions along with the resources to facilitate huddles as we have had significant turnover of key positions in our organization and have implemented electronic documentation transforming our organization from a paper-based facility to fully electronic. Meditech optimization continues and with this we are continuing to see more available data to support our huddles with key opportunities for improvement identified.
Examine opportunities to expand the role of volunteer supports to improve patient flow in the ED	Yes	A wheelchair portering program has been developed by our physiotherapist, and focuses on utilization of our volunteer population for transferring stable patients between units via wheelchair. Constraints on this initiative are the age of our volunteer population along with our inpatient population. The Hospital Elder Life Program (HELP) has also been explored and initial planning is underway as we look at our capacity and what we are able to implement within our organization moving forward in the new fiscal year. Daily visitors, therapeutic activities, and feeding assistance are likely to be our focus within the HELP program.

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5	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 ; October – December (Q3) 2017; Hospital collected data)	596	66.27	72.00	66.26 (Q2 2018/19) (Direction of improvement: Increase/ higher)	We are committed to quality improvement that gives our patients a clear and comprehensive understanding of their individual care plans. Though we have improved throughout the year, we recognize that there are still areas requiring further improvement.

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We are expanding to include patients on our medicine short stay unit and surgical patients	Yes	This process has commenced but was not completed in its entirety. Standardization throughout our organization will continue and has been indicated on our new work plan.

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6	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)	596	CB	CB	10 (Calendar year total) (Direction of improvement: Increase/ higher)	Though we were collecting baseline data, a great deal of work has been completed on behalf of patients and staff in order to maintain a safe environment for healing and working. We are committed to continued improvement and are dedicated to improving the safety for all in the coming year as work on violence prevention carries on. This includes increased incident report submissions to support action plans focused on safety.

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1)Develop and implement Violence risk screening questionnaire at triage to identify patients that can be aggressive/violent towards staff	Yes	Stevenson has implemented a screen called 'Alert for Behavioral Care (ABC)' that is completed at triage on all patients entering the facility. Further work will continue to guarantee that alerts for aggressive/violent patients remain on patient charts and are not lost between visits both for the safety of the patient themselves and staff.
2)Reduce Workplace violent incidents by developing and implementing a standardized approach to conducting post Code White evaluations (violent patient incident) to share lessons	Yes	A debriefing form has been completed and is being circulated. Recommendations are being compiled and managed through the Emergency Planning Committee. This form

learned, identify root causes and trends to reduce future incidents.		has been implemented for both mock codes and actual codes alike.
Reduce number of workplace violence incidents by providing mandatory violence prevention and response training to identified staff.	Yes	80% of the emergency staff have received 'Non-violent Crisis Intervention Training' through in-house crisis intervention trainers. Likewise, 80% of medicine staff have received 'Gentle Persuasion' training through in-house personnel trained in this specialty.
Provide opportunities for interprofessional learning by simulating a violent patient incident (mock code white)in an environment that closely resembles real clinical situations.	Yes	A near real simulation was completed in the emergency department. A volunteer acting as the violent patient demanding medication for pain had the staff engaged and working through the appropriate steps to de-escalate the situation in the most appropriate manner. In the moment feedback was obtained through our debriefing process.
Assessment and flagging patients identified in workplace violence incidents will provide the staff caring for these patients with information that could prevent further incidents.	Yes	In our move to electronic documentation patients are flagged accordingly based on the 'Alert for Behavioral Care (ABC)' intervention. Further work is being carried out to maintain that status from visit to visit until designation is assessed as no longer appropriate and removed by a designated lead.

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7	Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort) (Rate; COPD QBP Cohort; January - December 2016; CIHI DAD)	596	21.82	15.20	6.30 (Q2 2018/19) (Direction of improvement: Decrease/ lower)	Though we have met our target with most recent available data, we did see fluctuations that were out of the organization's control. Though we strive to set every patient up with appropriate resources both in the hospital and community, individuals choosing to be non-compliant continue to cause fluctuations in our data.

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Provide Chronic Obstructive Pulmonary Disease (COPD) Pathway education to staff including early initiation in Emergency Department (ED)	Yes	The pathway for COPD continues to be put in place through the COPD order set commenced on designated COPD patients in the emergency department. New staff continue to be educated on this process.

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8	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 - September 2017; WTIS, CCO, BCS, MOHLTC)	596	13.18	15.10	18.28 (Q2 2018/19) (Direction of improvement: Decrease/ lower)	We continue to work collaboratively with our community partners, Home and Community Care, Matthew's House, and Helping Hands in an effort to get our patients the right care at the right time. Due to constraints in the community outside of the control of the organization, the ALC rates continue to fluctuate in various degrees around our current target.

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Develop ALC specific surge practices and increase organizational awareness of ALC pressures.	Yes	Stevenson has been able to collaborate with a government funded program called 'Helping Hands.' This program offers transitional beds to ALC patients with a mandatory end destination among other criteria.
Continue to collaborate with our community partners at weekly Complex Care rounds to enhance early identification and monitoring of our patients requiring discharge to alternate levels of care	Yes	ALC patient situations are discussed at various levels of the health care system including ALC rounds in collaboration with Matthew's House and Home and Community Care. Rehab applications are submitted by our physiotherapist as soon as possible.
Implement Discharge Pathway with escalation framework to enhance patient flow		This pathway is in place and includes a letter to the patients that indicates what is required and walks patients through the process of utilizing hospital care until an

appropriate care location becomes available. This is set up in a pay for service format.