Theme I: Timely and Efficient Transitions | Efficient | Priority Indicator

Indicator #9

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. (Queensway Carleton Hospital)

Last Year		This Year	
16.51	**16.51**	**20.10**	**20.10**
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

Partner with external facilities to re-house ALC patients, allowing the freeing of beds to admit acute care patients.

Target for process measure

- 5 patients per month

Lessons Learned

Whenever possible, we re-house ALC patients in safe external facilities, in most cases closer to their home. In each case, this has allowed us to admit patients needing acute care. While this initiative has not decreased the number of ALC patients, it has very slightly increased acute care bed availability.

Change Idea #2

Prevent ALC designation by transitioning patients who meet specific criteria to the SAFE (Sub acute for Frail Elderly) unit at Perley/Rideau Veteran's Health Centre.

Target for process measure

- 12 patients to be transferred to the SAFE unit.

Lessons Learned

3 patients were successfully transferred to the SAFE unit to prevent ALC designation. QCH is working with the Perley to pursue admission avoidance to identify patients whose care needs could be met at the SAFE Unit rather than in acute care.
Using Geriatric Emergency Medicine (GEM) resources, we will endeavour to move patients directly from the QCH ED to the SAFE unit as of February 1, 2020

Indicator #10

Unconventional spaces (Queensway Carleton Hospital)

Last Year		This Year	
9.43	**9.43**	**CB**	**CB**
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

Improve the availability of inpatient medicine beds by facilitating the movement of ACE-appropriate patients to the ACE unit as soon as possible.

Target for process measure

- 70% of ACE-appropriate patients will be moved to an ACE bed during their admission.

Lessons Learned

This was not feasible as the use of isolation spaces on the ACE unit were needed for patients who did not meet ACE criteria, but who could not be isolated elsewhere in the facility due to a lack of private rooms. Rather than moving patients to and from ACE to try to realign the population on the unit, an initiative has been underway to move the ACE principles to other medicine units (e.g. up for meals, multi-purpose room)

Change Idea #2

Measure and improve the time from notification of an inpatient bed being available to the time that the patient leaves the ED through process review and standardization of practices.

Target for process measure

- 60 minutes by November 2019.

Lessons Learned

This wait time is being examined in detail by a dedicated group. A value stream mapping exercise has been completed to identify the myriad steps required to move patients from the Emergency Department to inpatient beds. Changes are now being implemented to decrease the number of steps involved.

Theme I: Timely and Efficient Transitions | Timely | Priority Indicator

Indicator #4

Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital. (Queensway Carleton Hospital)

Last Year		This Year	
75	**76**	**84.20**	**90**
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

Implement front-end self-editing dictation within the scope of Connected Care physician documentation project (PDoc)

Target for process measure

- 25% of all patient discharges will have discharge summaries completed in the electronic record immediately after launch

Lessons Learned

We exceeded our expectations in this area, with over 99% of discharge summaries being present in the system after the launch of electronic physician documentation in November. While it is too soon to measure, we anticipate that this improved compliance with information entry will improve communication, particularly for patients who must be seen in a short period of time after discharge.

Change Idea #2

The Physician Documentation (PDoc) Implementation team will develop standardized discharge summary templates to improve timely completion of the discharge summary

Target for process measure

- 75% utilization rate of discharge summary template

Lessons Learned

Standardized discharge summary templates have been substantially completed. The success of this measure can be attributed to the fact that templates were developed by the Physicians Working Group themselves within the scope of Connected Care, and this high level of involvement in template creation drove high buy-in and motivation for physicians to use the correct template. Training and go-live support was also very thorough, which would have helped physicians understand how to use the new technology correctly.

Theme I: Timely and Efficient Transitions | Timely | Mandatory Indicator

Indicator #8

The time interval between the Disposition Date/Time (as determined by the main service provider) and the Date/Time Patient Left Emergency Department (ED) for admission to an inpatient bed or operating room. (Queensway Carleton Hospital)

Last Year		This Year	
27.10	**27.10**	**30.98**	**27.10**
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

Improve compliance with a 1-hour turnaround time for transfer of patients between acute and sub-acute units through improving communication, building accountability for the Care Facilitators, and reporting compliance to stakeholders.

Target for process measure

- 70% of patients moving from an acute to a non-acute unit will be transferred within one hour of the bed becoming available.

Lessons Learned

Work on this indicator began in earnest in January 2020 with a team gathered to identify the factors that impact this important transition period.

Change Idea #2

Measure and improve the time from notification of an inpatient bed being available to the time that the patient leaves the ED through process review and standardization of practices.

Target for process measure

- 60 minutes average time for ED admission to leave the ED by November 2019.

Lessons Learned

As noted above. The preliminary work on this indicator has begun.

Theme II: Service Excellence | Patient-centred | Priority Indicator

Indicator #5

Percentage of respondents who responded “completely” to the following question: 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? (Queensway Carleton Hospital)

Last Year		This Year	
66.49	**70**	**61.89**	**66.50**
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

Continue to expand reach to ensure follow up appointments are made with the family physician while the patient is still in hospital.

Target for process measure

- 80 percent of all inpatients will have a follow-up appointment with the family physician documented in their inpatient chart

Lessons Learned

From October to December, 75% of patients across all Medicine units had follow up appointments booked with their family physician prior to discharge

Change Idea #2

Fully distribute the revised generic medicine GAP (Guidelines Applied in Practice) discharge tool.

Target for process measure

- 75% positive response in the "top box"

Lessons Learned

Over the 12 month period from Sept 2018 to Sept 2019, 70% of patient satisfaction survey respondents chose the highest level of satisfaction in response to the question "Do you know what to do is you are worried about your condition or treatment?". Since July 2019, a new Patient Education Discharge booklet, developed with patient/family involvement, has been provided to all patients discharged from medicine units. This is part of the GAP discharge tool.

Change Idea #3

Patient education booklet with a discharge action plan to be finalized and a process established for distribution of the booklet and education of all patients.

Target for process measure

- 80% on all medical units

Lessons Learned

77% responded at the highest level to the question "Did you receive information in writing about what surgical or health problems to look for after you left hospital". The patient education booklet described above helped to address gaps previously identified in this area.

Indicator #3

Percentage of complaints acknowledged to the individual who made a complaint within five business days. (Queensway Carleton Hospital)

Last Year		This Year	
98.79	**98.79**	**97.71**	**98**
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

Target for process measure

No target entered

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Lessons Learned

No lessons learned entered

Theme III: Safe and Effective Care | Safe | Mandatory Indicator

Indicator #2

Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period. (Queensway Carleton Hospital)

Last Year		This Year	
235	**223**	**193**	**183**
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

Education of staff in electronic platform for Client Violence Risk Assessment.

Target for process measure

- 75% of those eligible to be trained in PCS education.

Lessons Learned

100% complete. Staff are very pleased with the new software that is being used to report these and other incidents.

Change Idea #2

Increase reach of Violence Prevention Training based on risk assessments to include 100% of staff employed in highest risk areas (ED, MH, ALC).

Target for process measure

- 90% of all staff in high risk areas will completed NVCI training by December 2019

Lessons Learned

Because we increased the frequency of training from every 3 years to every 2 years, we did not meet our original target of 90%. However, within the past 3 years (original frequency), 89% were trained. Of the 11%(52 staff) that have never received training 42%(22)are registered for upcoming courses before the end of March.

Change Idea #3

Continue to improve percent of Code White events that are followed with a formal debrief to help learn from each incident.

Target for process measure

- 100% of Code White debrief forms completed from June to December 2019

Lessons Learned

100% of Code White events were followed by a formal debrief. To accomplish this, we have included some of the debrief questions (i.e. contributing factors and immediate actions)in our electronic incident reporting system.

Theme III: Safe and Effective Care | Effective | Priority Indicator

Indicator #6

Proportion of hospitalizations where patients with a progressive, life-limiting illness, are identified to benefit from palliative care, and subsequently (within the episode of care) have their palliative care needs assessed using a comprehensive and holistic assessment. (Queensway Carleton Hospital)

Last Year		This Year	
CB	CB	CB	CB
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

Build a new report to identify Health Links patients for Social Work team to consult palliative care.

Target for process measure

- 100% of Health Links patients will be given a palliative consult.

Lessons Learned

A specific report to identify Health Links patients was not produced once it was identified that this information is available in the electronic medical record.

Change Idea #2

Secure increased resources for physician coverage for continuity of palliative care by September 2019

Target for process measure

- 1 FTE palliative physician

Lessons Learned

A palliative care physician is available Monday to Friday, through a shared partnership model with Bruyere Continuing Care/Palliative Care.

Indicator #7

Rate of mental health or addiction episodes of care that are followed within 30 days by another mental health and addiction admission. (Queensway Carleton Hospital)

Last Year		This Year	
9.89	**9.40**	**7.10**	**--**
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

Develop and begin to distribute Mental Health discharge tool

Target for process measure

- 100% of patients who are discharged home will receive a discharge tool

Lessons Learned

A discharge tool was not developed this year due to the large scale changes that were being made to the entire medical record. Ongoing work towards development of a universal discharge tool will be reviewed to determine whether it meets the needs of mental health.

Change Idea #2

Develop a "Working with Emotions" outpatient group to assist patients identified with personality disorders

Target for process measure

- Collecting Baseline rate. Expect a 10% improvement from baseline in this fiscal year.

Lessons Learned

The Working with Emotions group began in mid- February. We have determined that from April to Sept 2019, there was a 5.1% 30 day readmission rate for patients with personality disorder. This will form the baseline from which we will compare future readmission rates to determine whether this new group is having the expected positive impact.

Change Idea #3

Increase number of psychologist-led psychotherapy groups to address long wait times.

Target for process measure

- Collecting baseline. Increase the number by 50% from October to December 2018 versus October to December 2019.

Lessons Learned

A psychologist-led out-patient psychotherapy group started morning sessions in July 2018. From Jan to Dec 2019, 44 sessions were held.

Indicator #1

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. (Queensway Carleton Hospital)

Last Year		This Year	
77.78	**82**	**87.59**	**88**
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

Conduct a survey of physicians to understand the current use of Meditech's discharge prescription.

Target for process measure

- 50% of privileged physicians will complete and return the survey

Lessons Learned

Surveys completed: 81/276 (29%). Only privileged physicians were surveyed (i.e. those who have gone through the process to be allowed to regularly admit and treat patients to hospital). Courtesy physicians (those whose practice is for a shorter period or is less regular) were not included.

Change Idea #2

Develop a video-taped interim learning package for physicians concerning the discharge medication prescription.

Target for process measure

- 50% of privileged physicians will view the video learning from June to December 2019

Lessons Learned

It was decided that it would not be appropriate at this time to develop and deliver video training to physicians due to new, developing discharge routines and increased workload related to extensive computerization training for documenting orders and patients care.

Change Idea #3

Develop and/or review standard work for Administrative Control Clerk (ACC) to ensure that a signed discharge prescription is reaching both the patient and the chart.

Target for process measure

- 9 inpatient units will have ACC clerks applying standard work to the distribution of the discharge prescription.

Lessons Learned

A review tool was developed, however it was not completed because of priorities that arose from the electronic documentation projects. As well, the implementation of changes to the discharge routine means that the clerical roles in discharge prescriptions is unclear at this time, and this must be defined.