Excellent Care for All

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.

ID	Measure/Indicator from 2017/18	Past Performance listed in QIP2017/18	Target from QIP 2017/18	Current Performance	Comments
1	"Would you recommend this emergency department to your friends and family?" (% of all ED respondents who chose the most positive response “Yes, definitely”)	66.00 (Apr-Jun 2016)	66.00	63.00 (Apr-Jun 2017)	The slight decrease in how often patients would recommend our emergency department was most likely due to the fact that planned interventions were not in place until July 2017. The impact of those interventions was measurable only as of September 2017.

Change Ideas for Patient Satisfaction in the ED from QIP 2017/18	Was this change idea implemented as intended?	Lessons Learned:
Completion of new Emergency Department space by September 2017	Yes	Since the new space for assessment of non-acute, non-admitted patients was opened in October 2017, there has been insufficient time to assess its impact on freeing up space to treat the acutely ill. However, in its first 2 months, time waiting for assessment by a physician, for patients with less serious conditions, decreased by approximately 45 minutes.
Ensure all patients are screened with the ISAR tool to improve identification of those who require admission to ACE.	Yes	Compliance for completion of the ISAR has not been as high as desired. We will continue to pursue 100% completion for each patient requiring admission to the Acute Care of the Elderly (ACE) unit.
Increase number of staff members trained in the Geriatric Emergency Nursing Education (GENE) Course	Yes	94% of nurses who were eligible to received extended training in Geriatric Emergency Nursing completed the training by December 31, 2017.
Provide Geriatric-specific training to Emergency Department physicians	Yes	79% of eligible Emergency Room physicians received extended training specific to working with Geriatric patients.

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2	"Would you recommend this hospital to your friends and family?" (Inpatient care) (% of all inpatient respondents who chose the most positive response "Yes, definitely")	65.00 (Apr-Jun 2016)	65.00	74.00 (Apr-Jun 2017)	74% of patient survey respondents would recommend this hospital to friends and family up from 65% in the previous year

Change Ideas for Inpatient Satisfaction from QIP 2017/18	Was this change idea implemented as intended?	Lessons Learned:
Develop more robust information for transfer of care at care transitions	Yes	This initiative is a large-scale plan for the organization and the various transitions that a patient experiences while in the hospital (e.g. from the ED to the in-patient unit; from the inpatient unit to a testing area such as diagnostic imaging; between units; between shifts; etc). We will be continuing work on this into the next year.
Roll out ICARE standards in a pilot project	No	It was decided that a full and complete corporate wide roll out of these updated standards would be the best approach and therefore the already existing standards will remain in place until the timing is right for a full scale enterprise roll out.

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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? (% of all respondents who chose the most positive response "Yes, definitely")	63.00 (Apr-Jun 2016)	64.00	55.00 (Apr-Jun 2017)	Several initiatives were developed and trialed on a single unit. The intention is to expand the roll out of successful initiatives to all inpatient units. The impact will be measurable once implemented more widely.

Change Ideas for Information on discharge QIP 2017/18	Was this change idea implemented as intended?	Lessons Learned:
On Rehabilitation/THP Unit: Provide non-pharmacist medication education (using nursing staff)	Yes	A flagging system has been developed: a yellow ticket, placed on the patient's white board 5-7 days prior to discharge, cues the nurse to educate the patient about their medications as part of discharge planning. Currently there is good compliance.
On C3 Medical/Surgical Unit establish a shift to shift communication tool that incorporates discharge planning	Yes	A communication tool has been implemented successfully on one unit, and is now being rolled out to other units in the hospital to ensure that the planning for discharge is initiated as early as possible.
On Acute Care of the Elderly (ACE) Unit: Ensure follow up appointments are made with family physician while patient still in hospital	Yes	100% of patients discharged from the ACE unit had follow up appointments with their family physician documented on their chart as of October 2017. This initiative is now being spread to other Medicine units.
On A3 (Medicine): Implement a revised generic medicine GAP (Guidelines Applied in Practice) discharge education tool.	Yes	92% of A3 patients received their discharge education using the GAP tool, prior to discharge. This initiative is now fully implemented on A3.

ID	Measure/Indicator from 2017/18	Past Performance from QIP2017/18	Target from QIP 2017/18	Current Performance 2018	Comments
4	HSMR: Number of observed deaths/number of expected deaths x 100 (HSMR is a measurement tool that compares a hospital's mortality rate with the overall average rate reported in Canada)	88.00 (FY 15-16)	88.00	85.00 (FY 16-17)	Our HSMR has remained lower than expected, which is a positive indicator of care provided at QCH.

Change Ideas for HSMR from QIP 2017/18	Was this change idea implemented as intended?	Lessons Learned:
Develop Medical Directive for use of Regional Nerve block for pain control in Emergency Department for eligible patients presenting with fractured hip	Yes	The implementation of regional nerve block to treat pain related to hip fractures has resulted in increased comfort for affected patients.
Decreased Length of Stay for patients with Fractured hip in the Emergency Department	No	Unfortunately, we have not realized a decrease in length of stay of patients with fractured hips in the Emergency Department primarily due to the overall increase in numbers of patients being admitted to hospital from the ED reducing availability of beds. Significant attention is being paid to address this problem of supply and demand.
Compliance with "HIP QBP Clinical Handbook"	Yes	Over 90% of the QBP best practices have been instituted and those remaining, which require substantial investment of resources to realize, are being considered or are in process.

ID	Measure/Indicator from 2017/18	Past Performance from QIP2017/18	Target from QIP 2017/18	Current Performance 2018	Comments
5	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)	48.00 (Oct-Dec 2016)	50.00	78.00 (Oct-Dec 2017)	The Medication Reconciliation process has been successfully expanded to include Mental Health patients after several reviews and process changes. Medication Reconciliation is not completed for the Mother/Baby population, (a high volume, short stay population).

Change Ideas for Medication Reconciliation at admission from QIP 2017/18	Was this change idea implemented as intended?	Lessons Learned:
Sustain current BPMH compliance during expansion of program	Yes	Completion of the Best Possible Medication History (BPMH) on admission was sustained at 90% for patients in Medicine and Surgery during the expansion of the program to other units.
Expand Medication Reconciliation program to include patients admitted under Mental Health Services.	Yes	Mental Health Crisis nurse involvement in Medication Reconciliation for Mental Health patients has improved the rate of reconciliation on admission to 90-100%. The process for recording the reconciliation in patients' medical records was adjusted to facilitate completing audits accurately.
Expand medication Reconciliation program to include patients admitted to Rehabilitation Services	No	Because all patients admitted to the Rehabilitation Service are transferred from other units within the hospital, the discharge medication reconciliation process overlaps the subsequent admission Medication Reconciliation process; further review will be needed to accurately measure the success of the Medication Reconciliation program for patients admitted to rehabilitation.

ID	Measure/Indicator from 2017/18	Past Performance from QIP2017/18	Target from QIP 2017/18	Current Performance 2018	Comments
6	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)	Collecting Baseline (CB)	CB	65.00 (Oct-Dec 2017)	We continue to explore ways to ensure all patients successfully transition back into the community with a clear understanding of their medication plan prior to discharge.

Change Ideas for Medication Reconciliation at Discharge from QIP 2017/18	Was this change idea implemented as intended?	Lessons Learned:
Evaluate readmission rate of patients who received medication discharge counselling	Yes	Patients who received follow-up medication counselling after discharge were 6% less likely to be readmitted to our hospital within 30 days of discharge.
Provide targeted discharge counselling with Medication Reconciliation and follow up for high risk COPD and CHF patients (for patients identified with high risk of readmission or LACE scores).	Yes	44.7% of patients received discharge counselling regarding their medications when 50% of a pharmacist's time was dedicated to this initiative. A pharmacist will now be 100% dedicated to this initiative.
Post discharge calls to patients for whom "Best Possible Medication Discharge Plan (BPMDP) has been performed to confirm that the current approach is effectively meeting their needs.	Yes	Post discharge follow-up calls made to patients with a LACE score of 11 or greater to determine if pre-discharge medication counselling has been successful. We have found that many patients express understanding of their medications.

ID	Measure/Indicator from 2017/18	Past Performance listed in QIP2017/18	Target from QIP 2017/18	Current Performance	Comments
7	Percent of palliative care patients discharged from hospital with the discharge status "Home with Support".	93.55 (FY 15-16)	93.55	92.05 (FY 16-17)	Over 90% of palliative patients are discharged "Home with Support"; we will continue to follow the processes established..

Change Ideas for Supported Discharge for Palliative Patients from QIP 2017/18	Was this change idea implemented as intended?	Lessons Learned:
We are focusing our improvement efforts in other areas of this quality plan.	Yes	We expect that continuing the processes we've established will continue to ensure more than 90% of palliative patients are discharged "Home with Support".

ID	Measure/Indicator from 2017/18	Past Performance listed in QIP2017/18	Target from QIP 2017/18	Current Performance	Comments
9	Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort) (Risk Adjusted)	18.68 (Jan-Dec 2015)	19.00	18.33 (Jan-Dec 2016)	Tracking of information for referrals to QCH and outside resources has proved to be a difficult undertaking. However, we believe that these clinics provide the best support for our patients with COPD, and we will continue to make efforts to ensure the resources are provided appropriately.

Change Ideas for Readmission of COPD patients from QIP 2017/18	Was this change idea implemented as intended?	Lessons Learned:
Ensure COPD patients are referred to COPD clinic at QCH	Yes	We exceeded our target for referral of patients to the QCH COPD clinic. However, we found that the referral data has been very difficult to obtain.
Continue to expand medication discharge counselling for COPD patients	Yes	44.7% of patients received discharge counselling regarding their medications when 50% of a pharmacist's time was dedicated to this initiative. A full time pharmacist will now be dedicated to this initiative
Ensure appropriate patients are referred to community COPD rehab programs	Yes	We have found it difficult to track these numbers, but indications are that we are reaching the goal set for referral to COPD Rehab Programs.

ID	Measure/Indicator from 2017/18	Past Performance from QIP2017/18	Target from QIP 2017/18	Current Performance	Comments
11	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)	9.17 (Jan-Dec 2015)	9.80	9.72 (Jan-Dec 2016)	Planned ED interventions were not in place until July 2017. The impact of those interventions was measurable only as of September 2017. We anticipate that 2018 results will demonstrate a reduction in time spent in the ED for complex patients.

Change Ideas for ED Length of Stay from QIP 2017/18	Was this change idea implemented as intended?	Lessons Learned:
Complete renovations and utilize new space for CTAS 4 & 5 patients in Emergency Department.	Yes	In the short time since the additional ED space was opened indications are that the number of people waiting in Observation and Cubicles overall has decreased allowing staff to focus on the most acutely ill. A surge of high volumes and an early influenza season made it difficult to accurately measure the impact of the new space. We will continue to monitor to determine if this initiative has decreased the Length of Stay for ED patients not requiring admission.
Redevelop the Geriatric Assessment flowsheet	Yes	Time from arrival in ED until a decision is made to consult for potential admission has decreased to 3.7 hours (well below the target of 4.5 hours) following the redevelopment of the Geriatric Assessment flow sheet.
Decreased length of stay in the Emergency Department for patients with fractured hip.	Yes	The following interventions: pre-printed orders for patients with fractured hip, automatic admission with phone consult and a system to isolate urgent from non-urgent medical consults, were implemented to reduce LOS in ED for patients with hip fractures. LOS in ED did not decrease as expected; all interventions will be analysed and monitored further to assess why.

ID	Measure/Indicator from 2017/18	Past Performance from QIP2017/18	Target from QIP 2017/18	Current Performance	Comments
12	Total Margin (consolidated): % by which total corporate (consolidated) revenues exceed or fall short of total corporate expenses (The impact of building amortization in a given year is excluded).	1.39	0.00	2.80 (Apr-Dec 2017)	The Queensway Carleton Hospital's benchmark is to be within the 25th percentile of the lowest level of spending while maintaining quality service. As of December 2017, revenues continue to exceed expenditures

Change Ideas for Financial Indicators from QIP 2017/18	Was this change idea implemented as intended?	Lessons Learned:
Renew review process and development of plans to maintain efforts to realize financial expenditures at the 25th percentile level compared to peers.	Yes	All departments are reviewing the 25th percentile level of financial expenditures of peer hospitals to determine if any other interventions might further reduce costs.

ID	Measure/Indicator from 2017/18	Past Performance from QIP2017/18	Target from QIP 2017/18	Current Performance	Comments
13	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) Patients who no longer require the acute care services of the hospital but who cannot return home are considered as needing an “alternate level of care”.	13.39 (Jun-Aug 2016)	16.00	15.13 (Jun-Aug 2017)	Every opportunity is explored to ensure patients no longer requiring acute care, but unable to return home, are placed in the most appropriate setting. An increasingly aged patient population and lack of available community resources make it difficult to reduce total days of ALC required for these patients.

Change Ideas for ALC Days from QIP 2017/18	Was this change idea implemented as intended?	Lessons Learned:
Develop and implement functional assessment tool for geriatric patients on the Acute Care of the Elderly (ACE) Unit.	No	An October 2017 audit identified 33% of patients admitted to the ACE unit have a documented daily functional assessment. This may be an under representation due to auditing problems; we will continue to monitor.
Trial and evaluate NUDESC (Nursing Delirium Screening Scale) for delirium patients on the Acute Care of the Elderly (ACE) Unit	No	Our current electronic documentation system includes the CAM scale, an older delirium assessment tool. The NUDESC will be a component of the new electronic health record planned for 2019.