Excellent Care for All

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.

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 hospital to your friends and family?" (Inpatient and Outpatients) (%; Survey respondents; January - December 2017; In-house survey)	650	87.00	90.00	92.00	The experience survey for 2018 had 530 responses. For this question from those who either agree or disagree, 92% would recommend this hospital to their friends and family.

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?
Provide patient experience survey in paper format via direct mail out as well as through a promotional blitz from January - March 2018 and continue to promote access on line to complete the survey	Yes	This continues to be an effective strategy to get patients to complete surveys
Present patient experience survey results to the Patient and Family Advisory Committee (PFAC) to identify strategies to address key areas for improvement.	Yes	Yes, this was presented to PFAC. Received good feedback however this is a new committee and we continue to grown the experience of the members

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
2	Did you feel you received all of the information you needed about your condition and treatments in order to take care of yourself at home? (%; All patients discharged home from the Medical Surgical Unit; April - December 2017; In house data collection).	650	92.00	94.00	93.00	When completing the telephone follow up calls, patient feedback was very positive and they appreciated the contact to inquire on how they were doing and assist with any questions they may of had.

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?
Conduct an assessment by gathering data regarding patients experience and satisfaction with the quality of information they receive on discharge.	Yes	The process we originally developed to have Charge Nurses call to do the follow up calls was impacted when their regular staff was not present. Lesson learned would be to have a more focus follow up to decrease the resistance in work load
Explore the use of bedside patient communication boards to increase the transmission of information to and from patients/ families and health care providers	No	This continues to be a project we are working on. Due to workload issues we have no completed this task

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
3	Hand hygiene compliance before patient contact - The number of times staff perform hand hygiene before initial patient contact divided by the number of observed hand hygiene indications for before initial patient contact multiplied by 100 - April 2018 to December 2018 (%; Health providers in the entire facility; April - December 2017; In-home audit)	650	65.00	75.00	77.00	This was a very focused effort on education and auditing for hand hygiene which was very successful in increasing compliance with staff and physicians. The public education was new for the organization and we will continue to refine this education.

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?
Education to Managers on how to complete Hand Hygiene Audits	Yes	Offering education was valuable but a lesson learned was to continue with group follow up with managers.
Complete education on Hand Hygiene for physicians and staff which provides an in depth understanding of the importance of hand hygiene and the 4 Moments	Yes	Completed 1 session, lesson learned when educating physicians ensure that there is focus maintained on the hand hygiene education. Providing education to physicians was valuable for our organization to ensure all were aware of importance and include the points that they are leaders in our institution and that staff look up to them and they have the ability to reinforce EBP for HH.
Implement a 'WASH & GLOW' hand hygiene Checkpoint, to enable staff to test their own hand washing technique	Yes	This was a very engaging strategy for education for staff and physicians and allowed staff to receive immediate feedback on how good their technique was. Completed 10 sessions with staff & physicians. This was also offered during 3 general orientation sessions to get new staff and volunteers off on the right foot.
Implement a "wash & Glow" hand hygiene check point for patients waiting in the ER waiting room to educate and test hand washing technique	Yes	Completed 3 engagement sessions, lesson learned was this this was not as engaging for patients who were waiting to go into the ER. Lesson learned was that this was not as successful as we thought with visitors or patients waiting in the ER waiting room.

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
4	Medication reconciliation for discharge home from Medical Surgical Unit: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged (excluding those who passed/ left without medical advice). (Percentage of total number of discharged patients; Discharged patients from the Medical Surgical Unit; April - December 2017; Hospital collected data)	650	77.00	80.00	97.00	Medication reconciliation on discharge continue to be an essential part of discharge planning. We will continue to implement improvements based on feedback from patients, such as creating a separate medication reconciliation form for admission and discharge.

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?
Auditing medication reconciliation to ensure that there is more that 1 source & the pt/caregiver is one of the sources; each medication listed with name, dose, strength, route & frequency; assessments of lovenox is completed; and the 2 QA signatures are documented	Yes	This was a very effective assessment tool to evaluate the correct implementation of the med reconciliation form. This continues to to be a work in progress to continue to increase the percentage of completed medication reconciliation
Educate nursing staff on how to pull and reconcile the discharge medication reconciliation from Meditech and document that the reconciliation was completed in Meditech	Yes	Education was completed as planned

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
5	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)	650	CB	CB	X	The percentage workplace violence incidents reported in 2017 was statistically insignificant at less that 1 % (2 Incidents/204 FTE's)

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?
Create and implement New Code White/ Workplace Violence Prevention training	No	Unfortunately due to staff loss this work did not get completed as planned
Continue to provide education on work place violence	Yes	Completed one Lateral Violence workshop. This continues to be a priority for the organization
Conduct an organizational risk assessment and update Workplace Violence Polices and Checklists.	Yes	Completed updating policies were: - Workplace violence, Harassment, Abuse and Bullying - Code White security Alert at switchboard

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
6	Percent of palliative care patients discharged from hospital with the discharge status "Home with Support". (%; Discharged patients ; April - December 2016; In house data collection)	650	80.00	90.00	75.00	The challenge with performance is due to the small number of palliative patients who are discharged home. The percentage of palliative patients discharged home with support is significantly impacted by 1 patient declining support (ie: 3/4 from April 1 - Sept 30/18).

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?
Annual review of the palliative care order set to ensure it is current with best practice	Yes	This continues to be valuable work to ensure the order set is current and aligns with best practice
Work with physicians, nursing and discharge planning team to identify patients with plan/Dx of palliative care to ensure referral is made	Yes	The nurses continue to promote the use of the order set with physicians to ensure consistent care for patients.

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
7	Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort) (Rate; COPD QBP Cohort; January - December 2016; CIHI DAD)	650	24.41	23.50	26.00	Considering the demographics of the community it is an ongoing challenge to make reductions in the readmission rate for COPD when patients have much comorbidities which impact the disease process.

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?
Annual review of COPD order set to ensure we are current with best practice	Yes	This continues to be valuable work through the P&T committee to ensure that the order set is up to date and reflects best practice.
Monitor the utilization of the COPD order set	No	Usage of order sets continues to be physician choice, therefore we have no ability to make physician use the best practice order sets. For April 1 to Nov 30/18 the usage of the COPD order set was only 25% for eligible patients.

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
8	Total number of alternative level of care (ALC) days contributed by ALC patients within the reporting period using bed census data (%; ALC patients; April - December 2017; In house data collection)	650	30.00	30.00	46.00	This continues to be a system issue not only one for SJGH.

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?
Hospital to approach the NELHIN for Crisis 1A status when bed census data reached 40-45% ALC status	Yes	This process is in place and is executed when required. Lesson learned is that when we have majority of the ALC patients requiring basic accommodation the LHIN will deny 1A status due to the likely hood of no movement in patients
Continue to work in partnership with Red Cross PATH program to increase referrals to the PATH program	Yes	This partnership continues to support patients being discharged home. We are working on a pilot project to assess if it is viable to have PATH 7 days a week