West Park HEALTHCARE CENTRE get your life back

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.

Workplace Violence

ID	Measure/Indicator from 2018/2019	Current Performance as stated on QIP18/19	Target as stated on QIP 18/19	Current Performance (CY 18)	Comments
1	Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 months period	A: 63	72	60	This is the first year for this indicator and is considered to be a developmental indicator. As such, the Centre proposed a target higher than baseline where fewer events are better yet anticipating awareness efforts to increase reporting. Also, during the year, an individual prone to responsive behaviours was discharged from the Centre resulting in current performance being less than proposed target. Lastly, innovative improvement efforts within the Centre's Acquired Brain Injury Behavioural Service (ABIBS) e.g. use of artificial intelligence to predict aggressive behaviours as well as collaboration other hospitals e.g. Hamilton Health and London Health Sciences Centres have successfully resulted in a reduction of these events. All change ideas were implemented.

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 Year's QIP (QIP 2018/19)	Was this change idea implemented as intended? (Y/N)	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?
1) With consultation with OH&S, medical staff, volunteers, and patients we will encourage reporting and work towards education and prevention of workplace violence.	Y	Incorporation of workplace violence in staff orientation was completed as well as including a focus topic at October safety fair. Work in progress to implement e-learning module by end of Q4 2018/2019.
2) The organization includes safety as a strategic priority.	Y	The idea was completed on September 2017.
3) Review best practices and external scan to select appropriate screening tool, develop processes, educate staff, and implement change ideas.	Y	Action plan was developed for highest risk area (ABIBS) was completed. Work in progress to finalize an action plan for centre wide workplace violence risk by end of Q3 2018/2019.
4) Develop a psychological health policy.	Y	The psychological health policy has been completed. Effective and comprehensive consultation is essential to success and adoption.
5) Establish a process to ensure dual reporting to OH&S and QRPS when the incident involves patient and staff.	Y	The current process involves reporting of incidents to OH&S and QRPS with separate reports. Adoption of electronic event reporting system in FY 2019-20 will be beneficial.

Ontario Telemedicine Network (OTN) Consults

ID	Measure/Indicator from 2018/2019	Current Performance as stated on QIP18/19	Target as stated on QIP 18/19	Current Performance (Q3 18/19)	Comments
1	Improve access to care by increasing number of Ontario Telemedicine (OTN) consults	Q: 20	Q: 23	Q: 42	Significant improvement and exceeded the target. Cumulative results as of Q3 are 75 compared to 54 at same period last year. Steady increase in clinical utilization of OTN service with each quarter. All change ideas completed.

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1) Conduct a review of current OTN utilization to establish baseline metrics.	Y	This change idea was been completed.
2) Identify potential for service expansion.	Y	This change idea has been completed
3) In collaboration with care teams and patients, identify 2-3 targeted OTN services within the centre by which to focus improvement initiatives.	Y	Identification completed, implementation planned

Discharge Summaries to Primary Care Provider within 2 business days

ID	Measure/Indicator from 2018/2019	Current Performance as stated on QIP18/19	Target as stated on QIP 18/19	Current Performance (Q3 18/19)	Comments
1	Percent of discharge summaries sent to primary care provider within 2 business days	91%	95%	94%	Current performance within the corridor and will continue tracking this indicator in order to sustain the success.

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1) Individual physician engagement follow-up.	In progress	This is an ongoing process.

New Stage 2-4 Pressure Ulcers in Complex Continuing Care (CCC)

ID	Measure/Indicator from 2018/2019	Current Performance as stated on QIP18/19	Target as stated on QIP 18/19	Current Performance (Q2 18/19, rolling)	Comments
1	Unadjusted percentage of patients who developed a new stage 2 to 4 pressure injuries in CCC	N/A	N/A	2.9 (unadjusted)	The Centre serves a unique patient population not well represented by the risk adjustment methodology confirmed by the Canadian Institute for Health Information (CIHI). Therefore, beginning in Q3, the Centre has transitioned to the unadjusted rate indicator. All change ideas have been completed.

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1) Perform Root Cause Analysis on new stage 2 - 4 pressure ulcers to inform process/practice improvement	Y	Key learnings for optimal impact include engaging front line staff in RCA and sharing a summary of themes emerging from analyses with front line staff and unit leaders to inform process and practice improvements
2) Education and support to nurses on wound assessment and treatment.	Y	Key learnings: Ensure daily rounding liked to a focus on wound and skin health; rounding linked to real time education and implementation of best practice guidelines for pressure injury prevention, wound assessment and treatment best practices
3) Refresh education to CCAs on skin checks and reporting.	Y	Key learnings: Ensure CCA role clarity for skin checks linked to importance of reporting to supervising nurse; daily rounding by y unit leadership will ensure CCA and assigned RN, RPN engaged and working in partnership for patient safety.
4) Promote compliance to the use of pressure injury risk assessment tool.	Y	Key learnings: Ensuring daily head-to-toe assessment has a focus on skin integrity, completion of pressure injury risk assessment tool and implementation of aligned interventions. Daily rounding provides space for needed education and coaching of staff.

Antipsychotic medication usage without diagnosis of psychosis in CCC

ID	Measure/Indicator from 2018/2019	Current Performance as stated on QIP18/19	Target as stated on QIP 18/19	Current Performance (Q2 18/19)	Comments
1	Adjusted percentage of CCC patients who were given antipsychotic medication without diagnosis of psychosis	36%	27%	16%	Current performance represents Q2 2018/19. Target has been met and considerable effort has been expended to achieve these results. The Centre achieved significant improvement, exceeded its target and is proud of its performance in this area. All change ideas completed.

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1) List of patients triggering indicator sent to pharmacists for confirmation, verified list will be sent to QI team for review.	Y	This change idea was completed.
2) MDS assessors to use a list of CIHI antipsychotic drugs for cross- referencing.	Y	This change idea was completed.
3) Automated data mining being developed (Chopin project).	Y	This change idea was completed.
4) Perform further review to identify improvement opportunities to enhance care and management of patients with responsive.	Y	This change idea was completed.
5) Educate and support physicians and interprofessional care team.	Y	This change idea was completed.
6) Case review to identify patients where deprescribing is a possibility -care plan created.	Y	This change idea was completed.

Length of stay efficiency - Hip Fractures

ID	Measure/Indicator from 2018/2019	Current Performance as stated on QIP18/19	Target as stated on QIP 18/19	Current Performance (Q2)	Comments
1	Improve length of stay efficiency - Hip Fracture	1.31	1.41	1.54	Significant improvement and target surpassed. Both change ideas implemented.

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1) Improve FIM coding and data driven decision making.	Y	This idea was completed.
2) On admission, review with patients/families expected discharge date and plan for supported discharge.	Y	This idea was completed.

Length of stay efficiency - Stroke

ID	Measure/Indicator from 2018/2019	Current Performance as stated on QIP18/19	Target as stated on QIP 18/19	Current Performance (Q2)	Comments
1	Improve length of stay (LOS) efficiency- Stroke	0.9	1.0	1.24	Significant improvement and target surpassed. Team and physician engagement and on-going review and discussion have been success factors in implementing and sustaining improvements

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1) Review current coding and documentation practices.	Y	This idea was completed. Audits completed; process implemented for team huddle following admission to discuss FIM
2) Improve FIM coding and data driven decision making.	Y	This idea was completed. Staff training & recertification in place; earlier identification and conversion of patients to LTLD
3) Enhance the discharge process.	Y	This idea was completed. Process in place to provide discharge letter and discussion to patient on admission; on-going discussion throughout

Patient Experience in CCC – staff dimension

ID	Measure/Indicator from 2018/2019	Current Performance as stated on QIP18/19	Target as stated on QIP 18/19	Current Performance	Comments
1	Percentage of patients rating 'staff' dimension positively.	50%	55%	54%	Survey of this patient population completed in February, 2019. This year's performance has improved and is within corridor.

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1) a) Increase survey (Staff dimension) frequency to twice per year rather than annually b) Engage patients and families to identify to identify opportunities for improvement.	Y	The timing of the survey has been linked to measuring the impact of the changed ideas that are generated.
2) Communicate results and engage frontline staff in change actions	Y	The results of the survey were communicated to staff for 2016/17; 2017/18 and September 2018. The next step is to implement person-centred education (e-learning video, communication strategy). Staff change ideas will be informed by sharing feedback and improvement ideas gleaned from December patient/family forum sessions. A call bell data analysis will also occur.
3) Communicate results and engage patients and families to have in-depth insight into improvement opportunities.	Y	Results shared at CCC/CAVC patient/family forums; included inquiry-based engagement sessions to uncover patient perspectives on actions and behaviours underpinning staff dimension questions. Visitor policy will be finalized; ready for implementation. Forums results indicate value of focused work on staff communication i.e. NOD (Name, Occupation, Duty). Regular engagement and follow up on progress at patient family forums.