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	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
1	"Would you recommend this emergency department to your friends and family?" (%; Survey respondents; April - June 2016 (Q1 FY 2016/17); EDPEC)	745	55.60	58.00	56.00	In 17-18 our improvements focused on increasing patient involvement in the co-ordination of their care. Following an ED patient visit a sampling of our patients receive a post ED visit survey questionnaire. On the survey questions related to how well Emergency Dept. doctors and nurses communicated with their patients our response scores were higher than the national average (NRC ED patient survey). However in June 2017 the 90th percentile wait time for admission through the Emergency Department was the highest in nine years. One of the key drivers of our current performance on the post ED visit survey question “would you recommend this ED to your family and friends” was the question regarding getting timely care. In 2017-18 our response score to this question was statistically significantly less than the NRC survey benchmark. As part of the patient engagement strategy for this initiative, follow up phone calls to all patients who left the emergency department without being seen were initiated. The goal was to understand why patients left the ED prior to being assessed by the physician.

Change Ideas from Last Years QIP (QIP 2017/18)	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?
Improving the quality of professional transfer of accountability will increase patient safety and patient involvement in the coordination of care plans.	Yes	We are trending towards target and predict that we will reach our goal for this change initiative. This initiative will lead to measureable improvement. Success factors include: the engagement of staff to develop staff educational video, e-learning module to validate learning/competency and involving frontline staff early in the process and identifying unit champions to support the change in the Emergency Department. Lessons learned: When implementing this practice

		being mindful of staff learning styles and needs is imperative. Making certain that staff feedback reaches hospital leadership and is acted upon will enable sustainability strategies to be successful. Patients and families are directly engaged at the bedside during shift to shift report.
Operationalize and evaluate the newly opened Integrated Medical Rehab Services (IMRS) Unit to: a) improve care of seniors with focus on functional decline and delirium, b)reduce barriers to client flow(less moving of patients) and c) reduce LOS for Rehabilitation patients.	Yes	Work on the evaluation plan will continue into 2018-19. At time of writing, we are unable to demonstrate that this change initiative will have a measureable impact the percentage of patients who would recommend our hospital to their family and friends. The work of strengthening our existing Acute Care for the Elderly program will proceed in 2018-19. Patients and families engaged with the operationalization and evaluation of the IMRS unit through representation on the Acute Care of the Elderly Committee.

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2	"Would you recommend this hospital to your friends and family?" (Inpatient care) (%; Survey respondents; April - June 2016 (Q1 FY 2016/17); CIHI CPES)	745	61.50	65.00	65.50	Improving patient experience is a key priority and one that we have focused our improvement efforts on for several years. In 2017-18 by focusing on two evidence based nursing practices; bedside shift report and purposeful hourly rounding we have been able to meet our improvement targets for this initiative. Nurse shift changes require the successful transfer of information between nurses to prevent adverse events and medical errors. When nurses transfer this information at the patient's bedside, patients and families can play a role. Involve patients and families in their care will improve the patient's overall experience. Purposeful rounding is a proactive, systematic, evidence-based intervention that helps us anticipate and address patient needs. Effective purposeful rounding can promote patient safety, encourage team communication, and improve staff's ability to provide efficient patient care.

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Improving the quality of professional transfer of accountability will increase patient safety and patient involvement in the coordination of care plans.	Yes	The implementation of the nursing practice of bedside shift report is being rolled out in phases. Year to date results show that we have had a positive impact on two associated patient satisfaction survey questions related to good communication between staff and patient involvement in decisions about their care. We are predicting that we will meet our performance targets for these two measures. Improved scores on these two survey questions will impact the overall percentage of patients surveyed that would recommend our hospital to friends and family. Lessons learned: Set the practice expectations for new staff at general hospital orientation, make use of our Simulation lab to offer new nurses a chance to develop this skill. When training staff use multiple methods i.e) face to face, video, e-learning module, simulation lab. It is important to identify front-line champions to help drive the change as they are closest to the patient and offer valuable insight. Engagement of families and patients during report at the bedside offers patients ability to participate and provide any additional information. Qualitative feedback from both patients and families demonstrates appreciation for being included in this process. This feedback is shared by the managers with their staff.
Operationalize and evaluate the newly opened Integrated Medical Rehab Services (IMRS) Unit to: a) improve care of seniors with focus on functional decline and delirium, b)reduce barriers to client flow(less moving of patients) and c) reduce LOS for Rehabilitation patients.	Yes	Work on the evaluation plan will continue into 2018-19. We are unable to demonstrate that this change initiative will have a measureable impact the percentage of patients who would recommend our hospital to their family and friends. The work of strengthening our existing Acute Care for the Elderly program will proceed in 2018-19. Patients and families engaged with the operationalization and evaluation of the IMRS unit through representation on the Acute Care of the Elderly Committee.
Reduce variability in current purposeful rounding practice compliance and increase the use of specific rounding behaviours on inpatient units (S1, IMRS & C5).	Yes	The practice of purposeful hourly rounding was initiated at OSMH in 2015 despite the benefits realized from the implementation it has been a challenge to sustain this practice. Patient acuity, workload issues and staff buy in are frequently raised as barriers to consistent use of specific rounding behaviours. Our 2017-18 improvement efforts were focused on a robust program of Leader Rounding. OSMH leaders conducted structured patient and family-centered rounds to collect data from both patients and staff about their experience with this nursing practice. Leader rounding helps to set expectations, determine

		barriers to practice and to celebrate and share when great practice is observed

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3	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; Hospital admitted patients; Most recent 3 month period; Hospital collected data)	745	66.00	80.00	80.00	Overall, med rec on admission is being completed for the majority of our admitted patients. There are many good stories where discrepancies in medications are caught before they reach the patient. Patients are actively engaged in the process of medication reconciliation at admission as they are the primary resource when collecting information related to their medications. Lessons learned: Data quality remains a challenge. The electronic report generated in our EMR does not accurately reflect the work being done to generate complete Best Possible Medication Histories (BPMH). Our sustainability committee is working with pharmacy and nursing staff to correct this issue. Resources to complete this task are limited.

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Best possible medication history (BPMH) is available on admission for all admitted patients.	Yes	Best possible medication history (BPMH) is available on admission for all admitted patients, Planned changes to have ED nursing staff complete the BPMH have not been successful. Many meetings have been held to determine who the right person to complete this task is. Nurses in ED are challenged to care for immediate patient care. Sustainability committee has come to agreement that pharmacy is best suited to complete the BPMH. Nurses can still complete a primary med history which will assist in the process.

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4	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)	745	81.00	80.00	72.00	We anticipate that we will exceed our stated target. The practice of completing a medication reconciliation form on discharge is embedded in our daily practice. Our success is due in large part to the great work done by our physician champion from the Sustainability Committee. Patients receive a comprehensive list of medications that they will take at home. They also take this list to their retail pharmacy. This engages them in their own care. Lessons Learned: Data quality may be affecting our results as this is a very manual process. Continued engagement with physicians is imperative for the ongoing success of this initiative.

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Standardize the Med Rec at Discharge process through the use of a standardized template in our electronic medical record.	Yes	Standardizing the med rec at discharge process hospital-wide is challenging as units have different patient populations. Work is ongoing to educate staff of the importance to use a standard tool for accurate reporting, accurate messaging to patients and streamlining workflow for staff who work in many different units.

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5	Percent of patients with new pressure ulcers (stage 2 or higher) on Soldiers 1, IMRS, C5 & ICU. This will be a cumulative quarterly point incidence rate using the measure of: total number of patients with new ulcers divided by the total number of patients reviewed in the quarterly incidence survey. This indicator is reported on a quarterly basis. (Total # of patients with new ulcers divided by the total number of patients reviewed in the quarterly incidence survey. Adult Inpatient; Adult inpatient; Q4 16/17 to Q3 17/18; In house data collection)	745	4.80	4.70	4.70	Over the past three to four years, significant resources have been committed to reducing pressure ulcers at OSMH. The ongoing work of the Skin and Wound Advisory committee combined with deployment of new ISO air surfaces and introduction of a staff e-learning module will help us to sustain improvement gains.

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No active change initiatives for this indicator in 17/18.	Yes	See Comments below.

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6	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. (%; Discharged patients ; Most recent 3 month period; Hospital collected data)	745	66.00	70.00	79.00	The focused attention on this 17-18 QIP indicator will result in long term gains. The high level of physician engagement has been a highlight of this change initiative. Targeted education and increased communication has enabled the physicians to meet dictation targets. The planned launch of voice recognition (Dragon Medical) and enabling the Power notes feature of EMR will result in improved turn- around times in 2018-19. In the fall of 2017 our Patient and Family Advisory Council will be participating in a review of this initiative for their information and feedback.

Change Ideas from Last Years QIP (QIP 2017/18)	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?
Sustain dictation complete to transcription complete within 24 hours for all discharge summaries.	Yes	Physician Dictation Results: 80% of the time physicians' discharge summaries are dictated within 24 hours. This represents a measureable improvement. This improvement is likely related to: a targeted education blitz; positive reinforcement and recognition from CEO and Chief of Medical Staff to high performing physicians and peer to peer coaching, tips and information sharing. Lessons learned: With awareness and tips from their successful peers, physicians have found strategies to complete Discharge Summaries quicker, helping their partners in the community including family doctors, specialists, etc. This results in quicker follow-up and improved patient care Transcription Results: We are unlikely to meet our transcription turn-around time target. Barriers include: higher than anticipated volumes, abuse of "priority" dictation line which results in reassignment of resources. Lessons learned: Moving discharge summaries up one level in priority sequence queue will improve turnaround time, but must be done in the context of turnaround times for all transcribed reports (ie: consultation and OR notes). Prime vacation time in Q2 impacts transcriptionist's ability to meet turnaround time targets.
Improve consistency in information sharing between OSMH and primary care providers.	Yes	Results: Our timelines for this initiative were planned to beyond the fiscal year 17-18. Our goal to have a standardized Discharge Summary template ready for PDSA trial in January 2018 has been met. Education and measurement scheduled for spring 2018. Lessons learned: Enlisting a primary care physician as our physician champion was key, he brought the perspective of a physician dictating from our organization as well as a physician who relies on a timely, quality discharge summary to care for his

		patients. The template was audited by five physicians throughout summer of 2017. Their feedback is incorporated in the final template.

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7	Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort) (Rate; COPD QBP Cohort; January 2015 – December 2015; CIHI DAD)	745	20.16	17.95	16.88	We anticipate meeting our 17-18 target by March 31, 2018. Our focus continues to be on strengthening care transitions across the continuum through cross sector collaboration. In 17-18, NSM LHIN Home and Community Care, Couchiching Health Link and Couchiching Family Health Team met with OSMH regularly to implement and monitor a series of collaborative change ideas such as: increasing number of appropriate Health Link referrals, physician education, flagging COPD patients as Health Links patients in OSMH electronic health record when patient arrives in OSMH Emerg. Dept. Staff education, unit huddles and audit and feedback to staff have helped us to consistently meet the COPD care pathway length of stay of 5.4 days.

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Increase the % of discharge summaries sent to primary care providers at Couchiching Family Health team (CFHT) within 48 hours of discharge from OSMH.	Yes	This change initiative was developed and is monitored in collaboration with community partners (Couchiching Family Health Team, Community Care Access Centre (CCAC) and Health Links Coordinator). It is a goal of Orillia Soldiers' Memorial Hospital to ensure that discharge summaries for all patient discharges are available to primary care providers within 48 hours of patient discharge, as referenced by Health Quality Ontario's "Transitions Between Hospital and Home" guidelines. We anticipate that we will meet our target for this initiative by March 31, 2018.. In 2017 in a report to the Board of Directors, fourteen OSMH physicians were recognized for championing this initiative and consistently managing to achieve dictation of discharge summaries within 24 hours of discharge. A timely high quality discharge summary optimizes continuity of patient care.
Improve patient management and care transitions across the continuum through cross sector collaboration.	Yes	We anticipate that we will meet our target for this change initiative. We are in the process of recruiting a COPD patient or family member representative to sit on our Medical Care team.
Improve the discharge process for COPD patients	No	This change initiative was not implemented in 2017-18.
Meet care pathway LOS of 5.4 days for COPD patients on a COPD order set and care pathway.	Yes	We have exceeded our goal for this change initiative. Changes have led to measureable improvement. Raising staff awareness at unit level staff huddles, providing staff education and performing chart audits in real time to progress us to stated goal. Feedback from staff indicated that they appreciate hearing COPD readmission rate results each quarter. New staff have shown an eagerness to adopt the COPD pathway.
Meet care pathway LOS of 5.4 days for COPD patients on a COPD order set and care pathway.		
Increase the number of appropriate referrals to Health Links coordinator post hospital discharge.	Yes	Health Links staff to provide OSMH staff with education and engagement about Health Links and appropriate referral process. To prevent admissions to the ED a 4 hour care guideline specific to COPD was implemented. One of the discharge planning steps guides the patient navigator or clerk to a Health Links referral (if not previously referred) and to notify Health Links if patient is already referred
Maximize the efficiency/effectiveness of the Pulmonary Rehab Program.	No	We did not meet our target for this change initiative. We currently are undertaking a program review. We are working with our partners to regionalize and standardize program components

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8	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; January 2016 – December 2016; CIHI NACRS)	745	9.00	8.40	9.80	2017-18 presented significant operational challenges for OSMH. Many Ontario hospitals faced similar challenges. The Ontario Hospital Association continues to monitor this operational crisis and is in regular contact with the government at various levels to ensure that the situation is known and the urgency for solutions is understood. In April 2017 the average number of beds used in our Emergency Department for admitted patients was 6.6 to the end of August 2017 versus 4.9 beds in August of last year. ED length of stay can be attributed to the volume of admitted patients blocking treatment areas within the emergency department impacting flow of ED patients.

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Operationalize and evaluate the newly opened Integrated Medical Rehab Services (IMRS) Unit to: a) improve care of seniors with focus on functional decline and delirium, b)reduce barriers to client flow(less moving of patients) and c) reduce LOS for Rehabilitation patients.	Yes	Work on the evaluation plan will continue into 2018-19. We are unable to demonstrate that this change initiative will have a measureable impact the Emergency Department length of stay for complex patients. The work of strengthening our existing Acute Care for the Elderly program will proceed in 2018-19. Patients and families engaged with the operationalization and evaluation of the IMRS unit through representation on the Acute Care of the Elderly Committee.
Maximize our partnership with Health Links Coordinator Increase potential for admission avoidance.	Yes	This change initiative has been met and we are now monitoring for sustainability. The Health Link coordinator continues to work with OSMH data team to access daily reports. One barrier that remains is the difficulty in creating reports in the electronic medical record to enable data trending and tracking. Improved access to care plans enables continuity of care and better outcomes for our patients. Potential clients/families were engaged in this initiative through the process of obtaining informed consent to participate in a Health Links flagging system.
Maximize the efficiency/effectiveness of the Pulmonary Rehab Program.	No	We did not meet our target for this change initiative. We currently are

		undertaking a program review. We are working with our partners to regionalize and standardize program components
Improve physician initial assessment time.	Yes	We will continue to work toward target of 2.7 hours with the support of the organization in moving the admitted patients to the appropriate care areas outside of the ED to improve flow of the emergency patients. With over capacity now and potential flu surge approaching, caution given around ability to meet target. A root cause of current performance is related to admitted patients blocking treatment space in the Emergency Department. Continued focus on capacity needs within the organization to improve the flow of admitted patients out of the Emergency Department.
Promote timely discharge by developing policy and procedure for harm reduction strategies for intervenous drug users.	Yes	Developing Standard of Care for Safe discharge IV Drug User. Planned roll out in February 2018. During the development of the standard of care we actually had patients that we have successfully discharged. We incorporated our learning into our standard of care.
Use visual management tools to communicate expected date of discharge (EDD) to patients and families.	Yes	The practice of updating patient whiteboards has been built into the roll out of bedside shift to shift reporting practice. Staff use patient whiteboards as a tool to communicate expected length of stay to patients and their families. When patients understand the expected date of discharge early in their hospital stay they are better able to plan for discharge. Timely, effective discharges improve the flow of patients throughout the hospital.
Maximize the efficiency/effectiveness of the Acute Cardiac Evaluation Services Clinic (ICU).	Yes	No data available. Next steps for this change initiative are to begin data collection through a point-in-time audit. Celebrate and share: Zero wait list.

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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 (Rate per 100 inpatient days; All inpatients; July – September 2016 (Q2 FY 2016/17 report); WTIS, CCO, BCS, MOHLTC)	745	18.03	17.00	19.71	The continued efforts of OSMH and our community partners has resulted in marked improvement in our ability to transition OSMH patients to their next level of care. Here are some of the ways we are working to lower our ALC rate: •Weekly meetings with hospital staff and community partners. •Engaging physician champions as key liaisons for communication •Enabling culture change through a focus on the Home First Philosophy, by senior leaders, medical directors, patient flow team and staff. •Working directly with community agencies to support the availability of transitional and palliative care beds.

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Monitoring only in 17/18. No new change initiatives.	Yes	Continued collaboration with community partners with a focus on North Simcoe Muskoka LHIN standard of care for ALC designation. •Ongoing work with NSM Home &Community Care to rule out barriers to discharge with lack of Personal Support Worker (PSW) supports. •Ongoing development and distribution of communication tools. •Ongoing discharge and transfer information with long term care homes.