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 emergency department to your friends and family?" ( %; Survey respondents; April - June 2017 (Q1 FY 2017/18); EDPEC) | 958 | 68.50 | 70.00 | 61.20 | The reporting period for this indicator is prior to the launch of this initiative. Performance has significantly improved in Q3 (69.1%) of 2018-2019 and is approaching our target. |

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 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? |
|---|---|---|
| Enhancing patient satisfaction in the Emergency Department | Yes | Planning and development required us to extend timelines and amendments were made based on feasibility (budget and resources), but concepts were developed. The impact was evident in team members who have become champions in providing patients with information which was identified from the patient surveys as a gap. |

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| 2 | 90th %ile ED LOS – Non-admitted CTAS I-III (hours) ( 90th percentile; Non-admitted ED patients; 2017; SMS (In-house registration system)) | 958 | 8.35 | 8.00 | 8.37 | Target was not achieved (See lessons learned). |

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| TOH-wide Implementation of the yellow dot moves | No | Data shows that a stable process to move patients on the yellow dot has been established at one campus, but the other campus still has patient flow variability, suggesting the process has not been locked in. This project evolved to support corporate patient flow strategies and 3 key strategies were tested: 1) Defining roles and responsibilities by utilizing the new service line delivery model. 2) Building system capacity 3) Improving system through-put. There has been a more collaborative approach to improving patient flow because a resilient system with effective patient flow processes is imperative to ensuring access to quality services for our community. Work on patient flow truly requires a system perspective since there are many competing priorities. We learned that we need to develop surge strategies earlier, avoid recycling old strategies and to factor in the Ministry impact on the funding model. Our original change idea, adoption of Yellow dot moves was not well aligned with the selected indicator hence the introduction of new change ideas. |

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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?<br>( %; Survey respondents; April - June 2017(Q1 FY 2017/18); CIHI CPES) | 958 | 63.06 | 65.00 | 65.20 | Target achieved. |

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| Systematic improvement of patient education information | Yes | All the proposed change ideas were adopted; none were abandoned, and the process was refined based on feedback from patient advisors and staff. This initiative is helping the hospital improve the quality of patient education documents, which will in turn increase patient satisfaction. Involving patients in our process has been overwhelmingly successful – it gives us valuable feedback to improve our documents, and patients are happy to see concrete results of their efforts. We met some challenges meeting timelines and it took longer than expected to establish all the support documents and systems to feed into the process, but we were able to create a sustainable process and adopt questionnaires that met the needs of all partners. These questions will be integrated into our new EMR. The collaborative project brought 5 different organizations together. Flexibility was a key component of our success. Patients are more than happy to help the hospital, especially when they can see the results of their feedback. Creating the process was relatively simple, but it took longer than anticipated to implement the process. Other hospitals are quite happy to share their documents, images, policies and procedures to improve the quality of patient education documents. |
| Continued optimization of Post-Discharge Phone Calls Program | Yes | All proposed changes were adopted and implemented as planned. We are excited to see this program embedded into the new electronic medical record. Engagement and common end goals were keys to our success. |

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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.<br>( Rate per total number of discharged patients; Discharged patients ; October – December (Q3) 2017; Hospital collected data) | 958 | 86.16 | 86.16 | 81.85 | The aim was to maintain baseline performance for this indicator, however performance slipped. The medication reconciliation process will be redesigned going forward with the introduction of an electronic health record. |

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| 5 | Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.<br>( Count; Worker; January - December 2017; Local data collection) | 958 | 228.00 | 251.00 | 429.00 | Target achieved. |

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| Continued implementation of violence in the workplace initiatives | Yes | We achieved our target to increase reporting and adapt our safety learning system to discriminate between employee and patient safety events. It was a challenge to administer training over the summer months, but we have engaged our safety office team to provide impromptu training and are developing enhanced and refresher training modules. As a multi-year initiative, we can plan for summer in-servicing for FY19/20. We have also engaged more of the Safety Office team in providing in-servicing, with the goal of being able to engage with staff and set up more impromptu in-services when there are opportunities. We will also plan to attend existing safety huddles to in-service more frequently. We are still working on piloting enhanced delivery of violence prevention training. The process of establishing a refresher program once peer leaders were identified has taken time to coordinate with peer leaders, and there is not a single approach that suits all pilot areas. We are still looking for the best way to evaluate our training strategy and plan on spending time with peer leaders and front-line staff to test and trial. |
| Continued implementation of a Just Culture | Yes | We educated more than half of our leaders on how to conduct a staff or patient safety incident investigation using our Just Culture methods. In-person classroom training is challenging to use as a method of education. Clinical schedules and operational priorities can be a barrier to this education format. As such we were unable to reach all leaders this year. We have however |

incorporated all leader training for Just Culture (the principles, decision algorithms and incident investigation) into our Leader Onboarding Program. We continued with enhancements to our Safety Learning System, working to capture and align the Just Culture incident investigation method and create dashboards for leaders to better understand, trend and keep on top of the types and frequency of incidents in their areas.

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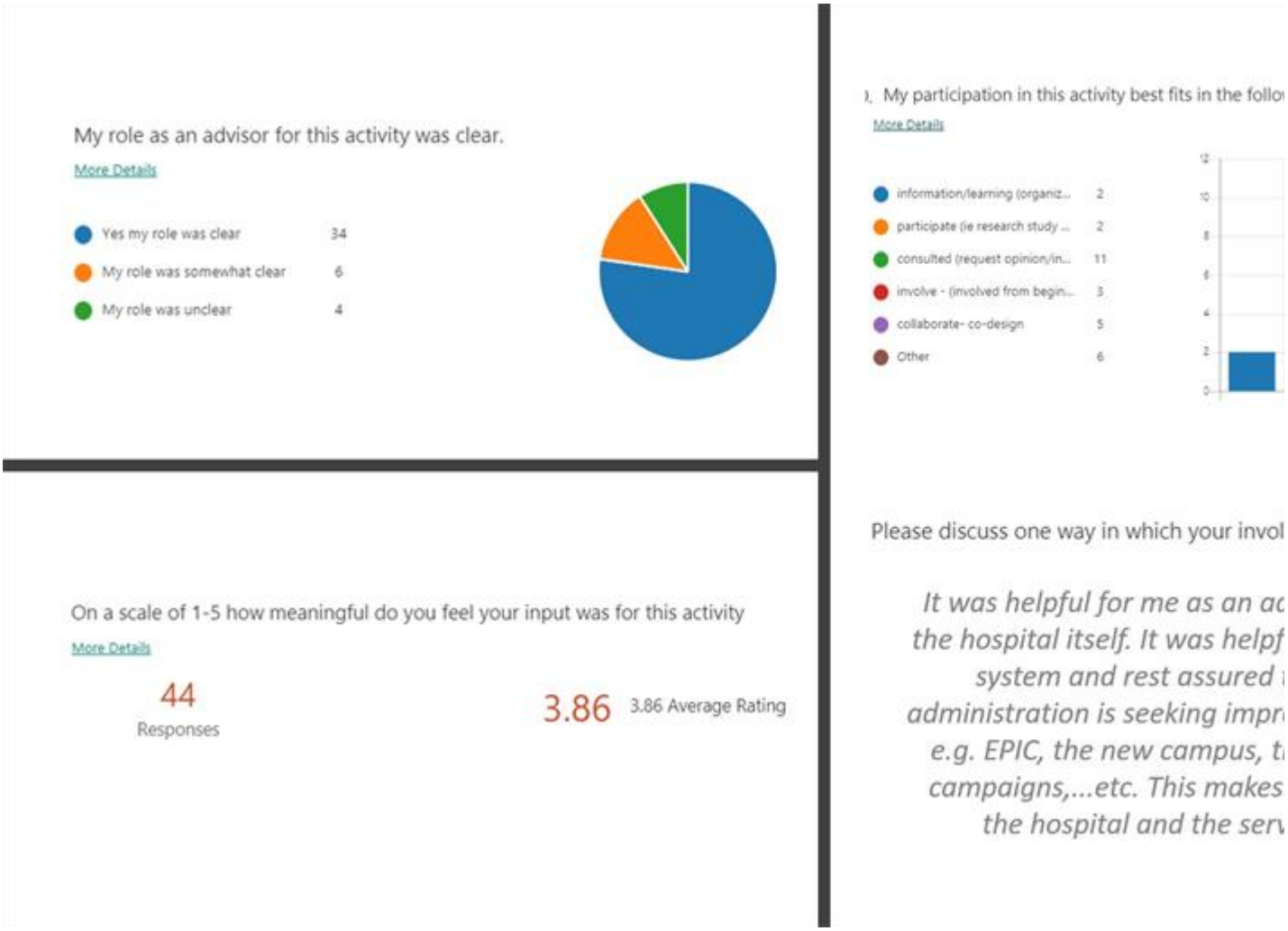
| 6 | Overall Rating of Experience Inpatient survey ( %; All inpatients; Nov/16 - Oct/17; CIHI CPES) | 958 | 69.80 | 72.00 | 72.00 | Target Achieved. |

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| Continued Implementation of Patient and Family Engagement Framework | Yes | This project exceeded expectations. Advisor recruitment was embedded into the Post-Discharge Phone Calling Program and this design was a key to the success of the entire program. All patients that are contacted post-discharge are asked if they would like |

to become an advisor (when appropriate). This also allows us to identify specific patients to meet specific advisor needs. Currently we have 130 advisors. A 2nd key to success is the strong leadership support for this program at TOH. This helps provide resources and eliminate barriers while creating enthusiasm around this type of work. We have also developed online resources to support the process for engaging advisors and co-designed evaluation tools to collect data and improve the process as well as the advisor and hospital staff experience. Next year we plan to double the number of advisors and will rollout exciting projects focused on patients as storytellers, an ideation platform and we will continue to grow the patients as partners in research program. We will also recognize the contributions of advisors with a yearly recognition event. Using a Patient and Family Engagement Framework was key to systematically monitor and evaluate our efforts while ensuring that we are focused on all 5 priority areas of patient engagement. This initiative would not have been nearly as successful without this framework. By monitoring efforts according to our pillars of focus, we have successfully embedded patient engagement in all facets of the organization. Co-designing the entire program with patient advisors has built a process that allows them to have a voice from day 1 and has built a system that allows advisors to be involved in meaningful and satisfying work that helps creates a better health care system for everyone. Overall patient satisfaction is a very broad indicator which could be discouraging since so many factors influence performance, however monitoring process metrics allowed us to track the progress and success of this project directly.

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| 7 | Percent of palliative care patients discharged from hospital with the discharge status "Home with Support". ( %; Discharged patients ; April 2016 - March 2017; CIHI DAD) | 958 | 91.42 | 90.50 | 88.10 | Target was not achieved (See lessons learned). |

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| Optimization of palliative support | Yes | The intent of the project was to develop and implement tools to ensure quality transitions in care from the acute care setting to home for patients wishing to die at home. The development and implementation of the tool went well. The idea was to train other professionals on the pilot units to use it and to empower them with organizing successful transitions to the community. The pilot project outcomes were excellent but unfortunately the uptake and use of the tool was sub-optimal on other units as a result of competing priorities. Our team is now using the discharge checklist for patients we are involved with, who wish to die at home. It helps to ensure that proper arrangements are made prior to discharge, thus ensuring smooth transitions in care. In retrospect, we believe it would have been helpful to have the pilot unit leads (admin and physician) involved in the development of the QI initiative. This would have allowed both teams to analyze the situation and ensure that stakeholder engagement was confirmed. |

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| 8 | Proportion of Admitted Patients whose ED LOS was less than 24 hours ( %; Admitted ED patients; 2017; SMS (In-house registration system)) | 958 | 76.10 | 80.00 | 80.10 | Target achieved |

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| Optimization of flow | Yes | This initiative was rolled out as a pilot on one unit and implemented as intended. The following benefits were perceived by the team: Improved flow, improved confidence the patient discharge needs are being met, improved consultations to allied health professionals, improved ability for MD to interact with patients to discuss care plan, improved ability to obtain discharges before 11 AM. Data from the corporate dashboard identified a small reduction in overall LOS and an increase in discharges before 11 AM on this unit. Although we had consensus on roles and responsibilities, there were several aspects of the work that will require further design in order to roll the initiative out on a larger scale. |
| TOH-wide Implementation of the yellow dot moves | No | This is a repeated change idea. See comments for 90th %ile ED LOS – Non Admitted CTAS I-III 2017 field for details. |

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| 9 | Readmissions - 30 day unplanned (%) ( %; Discharged patients ; Nov/16-Oct/17; SMS (SMS (In-house registration system)) | 958 | 9.70 | 9.40 | 9.90 | Target was not achieved. The change ideas were implemented as intended, however, there are many different variables affecting performance on this indicator thereby making it challenging to capture the direct impact of this initiative. |

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| Continued optimization of Post-Discharge Phone Calls Program | Yes | This is a repeated change idea. See comments for 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? field for details. |

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| 10 | Risk-adjusted 30-day all-cause readmission rate for patients with CHF (QBP cohort)<br>( Rate; CHF QBP Cohort; January - December 2016; CIHI DAD) | 958 | 21.07 | 20.90 | 22.40 | Target was not achieved (see lessons learned). |

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| Continued implementation of Ottawa Smoking Cessation Model | No | Audits for smoking cessation identifying the smoking status of admitted patients were completed by the NPPD prevalence audits in April and November 2018. Additionally, the Annual Ottawa Model for Smoking Cessation (OMSC) Performance Summary was completed with the 2017-2018 results available. The OMSC data showed the positive impact of the dedicated Smoking Cessation Nurse at one campus in terms of 1) offering tobacco addiction treatment; 2) enrollments of admitted smokers into OMSC IVR for follow-up; 3) estimated number of 30-day readmissions prevented 4) estimated number of bed days saved in 1 year and 5) estimated quitters. Unfortunately, the role of the smoking cessation nurse was eliminated so new strategies are being considered including use of the new electronic health record. |

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| 11 | Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort)<br>( Rate; COPD QBP Cohort; January - December 2016; CIHI DAD) | 958 | 20.80 | 20.10 | 16.50 | Target achieved. |

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| Continued implementation of Ottawa Smoking Cessation Model | No | This is a repeated change idea. See comments for Risk-adjusted 30-day all-cause readmission rate for patients with CHF (QBP cohort) field for details. |

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| 12 | The number of antimicrobial-free days (both antibacterial and antifungal) in ICU for the reporting period ( Rate per 1,000 patient days; ICU patients; Most recent quarter available; CCIS) | 958 | 518.45 | 565.00 | 395.44 | Target was not achieved (see lessons learned). |

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| Continued implementation of an Antimicrobial Stewardship Program | No | We were challenged with determining what a suitable measure of antimicrobial use in the ICU would look like given there is no standardization for case mix, no accounting for prophylaxis, nor for antimicrobial therapy for community acquired infections, nor are we able to assess for appropriateness of antimicrobial use systematically. We are hopeful that our new electronic health record will be able to improve use of pathways and guidelines. |

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| 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; All inpatients; July - September 2017; WTIS, CCO, BCS, MOHLTC) | 958 | 14.47 | 12.50 | 14.98 | Target was not achieved, change ideas were implemented as intended but would need to implemented on a larger scale to impact this indicator. |

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| Optimization of patient flow | Yes | This is a repeated change idea. See comments for Proportion of Admitted Patients whose ED LOS was less than 24 hours ( %; Admitted ED patients;) field for details. |

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| 14 | Urgent surgical cases (A-E) performed within target (%) ( %; All urgent surgeries; 2017; SIMS (In-house surgical system)) | 958 | 75.20 | 85.00 | 75.80 | Target was not achieved. This change idea was amended several times throughout the process due to feedback from key stakeholders. |

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| Improve access to urgent surgery through use of operations research analytics and quality improvement methods | No | Although the change idea was not implemented as intended, there were several small process changes that have led to improved processes and flow. Stakeholder buy-in is essential, as well as a defined workplan and timeline for implementation. Massive change involving a large group takes time. This is easy to underestimate. |