Thunder Bay Regional Health Sciences Centre

Quality Improvement Plans (QIP): Progress Report for 2018/19 QIP

ID	Measure/Indicator from 2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
1	Patients receiving enough information on discharge	68.00%	68.90%	Medicine has 13 condition-specific Patient Oriented Discharge Summaries (PODS) on the unit as well as 1 generic PODS. Surgery has developed the following 15 PODS to cover all of their patient conditions: Abdominal Surgery, Appendectomy, Chest Surgery, Laparoscopic Cholesysectomy, Hysterectomy, Inguinal Hernia Repair, Joint Surgery for Fractures, Mastectomy, Plastic Surgery, Prostatectomy, Small Bowel Obstruction, Total Hip Replacement, Thyroid Surgery, Primary Total Knee Replacement, Transurethral Resection of the Prostate. The PODS are currently in the final approval stages with the Surgical Council with a planed implementation by March 31st.

Change Ideas from Last Years QIP (QIP 2018/19)	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) Increase patient understanding on discharge.	The PODS tool gives a more involved conservation with patients, allowing them to ask questions before discharge and provides information in a way that is easier for them to understand.
2) Develop standardized process for patient discharge instructions.	Patients no longer receive the “old” discharge sheets/summary but instead receive a POD based on their diagnosis. Giving patients instructions earlier in their stay has helped in understanding and ensuring the best transition to home for patients. A key component to this is ensuring staff are giving out the appropriate PODS form and ensuring forms are explained to the patient upon discharge.

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2	Decrease 30 day Readmission for CHF	21.80%	19.30%	A process improvement Kaizen Event took place late Spring 2018 related to CHF pathway optimization. From this a working group was developed that is focused on rapid assessment and discharge algorithms for CHF patients. The group has completed work on the rapid assessment algorithm and a job description for the nurse practitioner roll is developed. The pilot project is expected to start in early Q4. The Coaching patients On Achieving Cardiovascular Health project was launched on September 22, 2018. This program will pilot a rapid assessment clinic for CHF patients. A nurse navigator will identify patients in the Emergency Department with CHF and look to place them with the appropriate service (either inpatient or outpatient). The goals are to avoid admissions, decrease length of stay both in the emergency department and inpatient units, and avoid readmissions. Patients are being referred to the clinic from the ER and inpatient units. The clinic is located within the Cath Lab.

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Change Ideas from Last Years QIP (QIP 2018/19)	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) Optimize CHF patient pathway.	The current discharge pathway is unclear and patients are not always being aligned with the proper available resources to manage their CHF in the community. This is resulting in higher readmission rates. The new pathway will ensure that patients are followed during their inpatient stay and appropriate follow up care is arranged before discharge.
2) Support adoption of Digital Order Sets for Quality Based Procedures	By properly identifying a patient upon admission and placing them on the appropriate order set, we ensure the best care plan is followed for the patient and the patient does not spend any additional time in hospital than is required to treat their acute care needs.

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3	Discharge summaries sent within 48hrs of discharge	-	-	A root cause analysis was conducted with physician representatives and health records in October 2018 to determine the gaps to complete a timely discharge summary. Various improvement ideas were identified from this analysis and will be explored for implementation in Q4. The Record Completion Timelines Policy was approved by MAC outlining expectations of physicians, however, delays due to Health Records implementing the new dictation system has put the roll out of the policy on hold. New anticipated implementation will be in Q4.

Change Ideas from Last Years QIP (QIP 2018/19)	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) Develop strategies to increase discharge summary completion within 48 hours.	The root cause analysis was conducted with all key stakeholders at the table. We began with a current state mapping so that each discipline understood what the other does, allowing an appreciation for the work everyone puts in. It also allowed for questions and answers to some processes that were not well understood. We then asked the stakeholders to develop solutions so we can meet our goal. Having the people who do the work develop the solutions is key for buy-in and allows participants feel valued and respected.
2) Ensure collection of reliable data.	We conducted various manual chart reviews to ensure data accuracy and consistency. When data appeared to be misaligned, we worked with our IS department to redesign the report.

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4	Decrease Average Length of Stay	5.10	5.27	A rehabilitation services workflow review was completed and the following improvements were trialed; a model of collaboration whereby the rehabilitation team identifies and assesses the highest priority patients across the inpatient units, daily; education materials for clinical staff on how to access physical therapy/occupational therapy (PT/OT) assessments, and; a short-form summary for PT/OT notes containing the key clinical information related to readiness for discharge.

Further, the business plan for expanded Polymerase chain reaction (PCR) testing was completed and additional testing for admitted patients approved. An infection control design event was held in September 2018 and has resulted in the following change initiatives: 1) An updated medical directive to ensure PCR testing is completed on all appropriate patients admitted through the ED; 2) ED nursing staff will complete PCR swabs before the patient is transferred; and 3) updated fields on the SBAR transfer form will inform the inpatient unit of the status of swabs.

In addition, a complete review of the patient flow software was completed in Q2 and changes were made to the system. New criteria for collection of delay reasons was developed and updated within the system. Go-Live on the changes happened in September 2018. A new real time occupancy report was developed and will be implemented in Q4. The report is automatically generated three times daily and used during bed rounds to facilitate discussions on patient flow.

Also, a new method for real time reporting on Expected Length of Stay for the working diagnosis have been developed. The admitting department is entering this information in the EMR on admission. The next steps is to provide this information to the physicians on their rounding reports in order to ensure they have a working target for care plans.

Finally, a pilot project is underway to test the effectiveness of a geographically model for the Hospitalist service. A dedicated Hospitalist is now caring for the medical patients on a single unit.

Change Ideas from Last Years QIP (QIP 2018/19)	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) Leverage Patient Flow Software to identify Length of Stay (LOS) Improvement opportunities.	By leveraging patient flow software, the hospital has been able to better identify barriers to patient discharges and seek out removing these barriers in real time. Even in cases where these is concerns over data quality, there is valuable insight that can be gained through the data. Often one of the overlooked barriers to advancing a patient care plan is all members of the care team not communicating the plan effectively. Monitoring of the coded data has drawn attention to these areas so that the team can improve their team collaboration.
2) Reduce gap between ALOS and ELOS.	Real time monitoring of ELOS is key to improving the gap between actual and expected length of stay. While many other strategies have been implemented in order to improve patient experience, care plan progression and overall patient flow, the savings on ALOS are only marginal. By providing the care team with real time access to ELOS for their patients, we provide them with a true goal for the care plan.
3)Leverage technology to improve infection control clearance protocols	Improved infection control clearance protocols provide us with better understanding of isolation requirements, ensure appropriate cohorting of patients and reduce hospital acquired infections. All of this leads to fewer blocked beds, which in turn means we maintain appropriate occupancy capacity.

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5	Readmission for mental health & addictions	-	-	Our Brief Intervention Treatment Team provides short-term psychiatry follow-up in hospital. In addition, we are participating on the Thunder Bay Mental Health and Addictions Network Committee. This committee is doing engagement with mental health organizations across Thunder Bay to determine what mental health and addiction services are needed. However, the development of a Day Hospital is not a current priority for community organizations and will not be pursued.

Change Ideas from Last Years QIP (QIP 2018/19)	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) Improve access to mental health and addiction services upon discharge from the hospital	Ensuring all stakeholders are at the table is key to success in a collaborative initiative such as this.
2) Ensure collection of reliable data.	Manual data collection is difficult to ensure reliability. We continue to pursue electronic options with key stakeholders.

ID	Measure/Indicator from 2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
6	Improve Patient Satisfaction-All Dimensions - In-patient	66.60%	68.70%	Patient Oriented Discharge Summary (PODS) is the corporate approach for the 2018/2019 Patient Experience Action Plans. All areas have incorporated a version of PODS. Surgery has developed 15 while Medicine has developed 13. Other areas that are developing PODS include: Mental Health within the Brief Intervention Treatment Team (BITT); Women and Children's Program within the Paediatric, maternal/newborn, and CAMHU areas; Renal, Retail Pharmacy, Diagnostic Imaging, and the Regional Stroke Network. Patient satisfaction results have improved since PODS was implemented. In some areas, it was noted that patients didn't have enough time to review the discharge information, therefore, there units are now giving the forms out ahead of time so that the patient can review and have a better understanding at time of discharge. This has allowed the patient to ask specific questions and has led to less anxiety for the patient.

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Change Ideas from Last Years QIP (QIP 2018/19)	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) All clinical areas will develop patient experience improvement action plans that will address communication to patients on discharge	Developing a modified version of PODS in each area has been instrumental in improving communication with patients upon hospital discharge and ultimately leading to a better patient experience and improved patient satisfaction results. Staff and patient communication has increased and patients' anxiety is decreased as they are more informed and aware of what is happening after they leave the hospital.
2) All non-clinical areas will develop action plans	All action plans are passed through the Patient and Family Centred Care Council. This allows for all areas to hear the focus of each action plan. This has allowed for great collaboration on all initiatives. All non-clinical plans support the clinical areas and where possible, the implementation of PODS.
3) Engage physicians on the development of the action plans	Having physician and staff feedback to inform action plans and engaging them on a regular basis has led to increased interest and collaboration to improve results, ultimately leading to better patient care. Physicians and staff are engaged on a regular basis through council meetings, email, and dyad meetings regarding patient experience results.
4)Implement action plans	Ensuring action plans are being implemented is the key to success. Once the plans are written it's crucial for the "most responsible" to report progress and make sure communication is taking place to all involved.

ID	Measure/Indicator from 2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
7	Improve Patient Satisfaction-All Dimensions – ED	68.90%	73.20%	The ED has developed both departmental and corporate action plans. The departmental action plan focuses on the comfort of patients waiting in the ED as well as improving communication with patients and families/care partners about the admission process. The corporate action plan focuses on the Patient Oriented Discharge Summary (PODS) of understanding discharge information on high risk geriatric patients prior to leaving the ED. The focus on both the departmental and corporate plans has led to significant improvements in patient satisfaction results. The ED staff, Patient & Family Advisors & Volunteers collaborated and identified areas for improvement to increase the comfort of patients waiting in the ED. These areas include charging stations, food carts and sleep kits. The ED also changed the hours that volunteers are available to patients to provide more support and comfort. The interdepartmental transfer policy was updated and staff were educated to indicate 'family notified prior to transfer' on the SBAR form to improve communication with families/care partners on the admission process. The eSBAR trial has been completed, introduced hospital wide, and the new process has been

			incorporated into practice. The ED Geriatric Coordinators currently perform the PODS in the ED and focus on discussing follow up care before leaving the ED. 15 PODS per week are given out. Results on the NRC survey in relation to “Someone discussed follow up care before leaving" now exceed the provincial target.

Change Ideas from Last Years QIP (QIP 2018/19)	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)The Emergency Department (ED) will develop patient experience improvement action plans that address lowest category results	Narrowing in on key areas of improvements led to increased focus and more productivity in these areas. Working with stakeholders to identify gaps in patient understanding of discharge information and the coordination of transitional care needs led to a more positive patient experience.
2)Engage physicians and staff to increase awareness and understanding of patient experience results	Having physician and staff feedback to inform action plans and engaging them on a regular basis has led to increased interest and collaboration to improve results, ultimately leading to better patient care. Physicians and staff are engaged on a regular basis through council meetings, email, and dyad meetings regarding patient experience results.
3)Implement action plans	Ensuring action plans are being implemented is the key to success. Once the plans are written it’s crucial for the “most responsible” to report progress and make sure communication is taking place to all involved.

ID	Measure/Indicator from 2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
8	Decrease Violence in the Workplace Incidents	200	52	The action plan was developed to ‘keep staff safe’. This plan included four areas of focus; review of the current security model to control and limit access in the facility; review the violent incidents to assess for trends and determine root causes of such trends; identify needs and facilitate the development of policies, procedures and processes to mitigate risk related to workplace violence; and, develop training and educational requirements based on level of risk identified through workplace violence risk assessments.

Change Ideas from Last Years QIP (QIP 2018/19)	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)Strengthen leadership and Worker commitment to Work place Violence Prevention	Senior Leader champions were identified. A review corporate strategy was completed and revisions made, as required. An integrated committee structure was created with processes and reporting matrix to senior leadership, Board and across organization. A review of current annual policies and processes was completed to reflect compliance with legislation and safety in the workplace.

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9	Medication reconciliation admission	62.00%	50%	A pilot was conducted with a dedicated resource in the ED to perform Best Possible Medication History (BPMH) assessments. This pilot was successful and a business plan was developed to support a dedicated staff model. The business plan recommended an investment of dedicated trained clinicians, Pharmacy Technicians or Registered Practical Nurses, to perform BPMH on admission. In January 2018, the business plan for a dedicated staff model (i.e. 3 positions in 2018-19) was approved for a phased in approach over 3 years. The model requires pharmacy to perform audits to monitor improvements in quality and compliance, and a method to quantify potential cost savings related to improved medication reconciliation. Staff were recruited in November, however, challenges in back-filling vacancies have caused a delay in the first phase of implementation.

Change Ideas from Last Years QIP (QIP 2018/19)	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) Commit dedicated resource (Nurse/Pharmacy Tech) in Emergency to ensure completion and quality of Best Possible Medication History (BPMH) assessments.	A dedicated resource will improve the quality of BPMH that will lead physician compliance with medication reconciliation. Ensuring the people with the correct skills are doing the job leads to better quality services.
2) Engage physicians in medication reconciliation process.	Fully engaging the physicians cannot be completed until the dedicated resource for completing BPMH assessments is in place.
3) Improve participation and completion of medication reconciliation by physicians at admission.	Not implemented.
4) Allocate resource and develop work flow process for medication reconciliation audits.	Not implemented.

ID	Measure/Indicator from 2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
10	Decrease 90th % ER wait for admitted patients only	31.00	40.1	Two Kaizen Events took place late Spring 2018, related to COPD and CHF pathway optimization. From this two working Groups were developed that are focused on rapid assessment and discharge algorithms, for CHF and COPD patients. Metrics have been developed and a meeting is booked with Decision Support to analyze data related to increase in cardiology admissions.

			The 1.8 FTE ED Geriatric Coordinators are in place. From October to December 2018, the coordinators screened 806 high risk geriatric patients in ED and provided in-depth targeted assessments to 185 of these patients. As a result of these assessments, 101 of these patients were discharged and in particular 17 patients had rapid access Geriatrician consult as an outpatient at St Joseph Care Group. The coordinators also provided 115 follow-up phone calls to patients that were discharged and sent 96 referrals to community agencies for ongoing support (Community Para-medicine, Home Care, Alzheimer Society). For the 85 geriatric patients that were assessed and required admission, 73 referrals were made to the Hospital Elder Life Program (HELP) to assist in reducing their length of stay. The Nurse Led Outreach Team Nurse Practitioners work assignments have changed as of June 2018 to improve consistency and to target facilities with greatest need in an effort to reduce ED visits from LTC, Supportive Housing & select retirement homes. Weekend on-call Nurse Practitioner coverage to support Long Term Care Homes continues and an analysis is underway to review impacts.

Change Ideas from Last Years QIP (QIP 2018/19)	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) Implement strategies to avoid admissions for patients.	Avoidable admission strategies such as the Frail Seniors Pathway and CHF/COPD pathways continue to show a benefit by ensuring the patients are identified and diverted from the Emergency Department to proper outpatient services where they are better managed. These patients avoid a length of stay at the hospital and free up valuable resources that can then be used for patients who require the services of an acute care hospital.

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11	Identify patients with complex health needs (Health Links)	-	-	2018-19 Q2 data has been extracted and is ready to go to the NWLHIN, however the required data sharing agreement remains outstanding. The issue has been escalated to higher leadership at NWLHIN and a meeting is planned with NWLHIN in Q4 to review the data sharing agreement and move it forward.

Change Ideas from Last Years QIP (QIP 2018/19)	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) Ensure TBRHSC patients meeting Healthlinks criteria are identified and communicated to the NWLHIN	Anonymized data will be forwarded to ensure a clear understanding of the situation and requirements.
2) Seek support from NWLHIN in ensuring required services for Healthlinks patients are readily available and that patients are referred to appropriate providers for care	Undertake escalation efforts when they first present themselves to avoid delays.