Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for the 2016/17 QIP

St. Joseph's Health Care London – Corporate (excluding Mount Hope)

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
3	Achieve Development Milestones for Improvement in Recovery Outcomes (Milestone Goals; Mental health patients; 2016-17; Hospital-collected data and OHMRS, CIHI)	714	CB	CB	NA	Safewards Program implementation milestone goals to achieve 50% (5/10) of interventions were achieved. Five of 10 interventions were successfully implemented. Patient partnership work has evolved at a corporate level and specific actions will arise out of this framework going forward.

Change Ideas from Last Years QIP (QIP 2016/17)	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?
Therapeutic Interventions Implement Safewards Program	Yes	Met target of implementing 50% (5/10) of the Safewards interventions. Key factors in the success were the secondment of a project leader and the use of a core team with representatives from both sites including advanced practice nurses and nurse educator. Director level leadership and support critical. Advisory committee with key stakeholders including patient and family representatives is key.
Patient Partnerships in Care Update care plans to indicate: a)If patient was present during planning; b)If not present, the date and sign off that the plan was reviewed with the patient, including patient signature	No	A patient partnerships framework was developed for the organization and will drive the actions for the next year. A review of patient care plans and processes revealed significant variation across units and sites. Current pilots are occurring which will incorporate patient participation in care planning (RAI-based care planning at Parkwood Mental Health and the Eharm tool in Forensic Psychiatry). The creation of standard processes for patient partnership in care planning across all programs will need to occur and will require dedicated resources.

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4	Achievement of Patient Partnership Development Milestone Goals (Milestone goals; N/a; To Be Determined; Hospital collected data)	714	CB	CB	NA	Framework completed in compliance with the strategic plan and approved by senior leaders.

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Develop operational foundation for Patient Partnership Project	Yes	Executive sponsorship was provided by the VP accountable for Quality. A dedicated project support was hired to complete the work of developing a Patient Partnership Framework.
Review current state of Patient Partnership from a staff / physician perspective	Yes	Consulted physicians and staff about current state: i) informed the current state analysis, the framework and recommendations that were included in the report, and ii) introduced the concept of patient partnership (versus patient centered care). Key learning include: i) the strategic priority is well supported by physicians and staff. What worked: i) use of pre-scheduled meetings to engage staff and physicians, ii) use of a structured questionnaire/format, iii) use of a recording to transcribe discussion
Conduct a current state analysis of our Patient Partnership with our patients, families and caregivers	Yes	Consulting with patients, residents and family about the current state: i) informed the current state analysis, the framework and recommendations that were included in the report, and ii) introduced the concept of patient partnership (versus patient centered care). Key learning include: i) patients, residents and family are enthusiastic about patient partnership, because of their experiences, ii) patients, residents and family have long memories and can recall negative encounters with the system 20 or more years ago and the facilitator needs to cognizant of this, iii) not until family have accepted their loved ones health status are they able to contribute to a higher level discussion. What worked: i) use of pre-scheduled meetings to engage staff and

		physicians, ii) use of a structured questionnaire/format, iii) use of a recording to transcribe discussion
Understand current best practices in Patient Partnership	Yes	A literature review and consultations with hospitals leading in this area illuminated best and innovative practices.
Develop framework for Patient Partnership ensuring alignment to current priorities of innovation in ambulatory surgery, rehab and recovery and chronic disease management, and our mission, vision and values	Yes	A patient partnership framework which is aligned with St. Joseph's mission, vision and values was approved by senior leaders on January 24, 2017. Patient partnership is fundamental to chronic disease management, as demonstrated in the literature and referenced by healthcare providers, and can improve the care experience in ambulatory surgery and rehab. A key learning is the importance i) of having a framework evolve as consultations with key stakeholders progress to obtain an outcome that reflects the organization, and ii) to present the evolution of the framework to enhance trust in the process through transparency.
Operationalize Patient Partnership Framework	Yes	A communication plan is being crafted for 2017/18. Three tactics that emerged from the work to create the framework will begin to be implemented in 2017/18. A grant from the Change Foundation will support work to enhance families' roles in the care environment. Family is represented in the framework.

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5	Hand Hygiene Compliance Before Patient Contact (Moment 1) (%; Observed hand hygiene opportunities all sites (LTC excluded); Q3 2015-16; Hospital collected data)	714	93.00	95.00	96.90	

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Further define tiered accountability structure	Yes	Medical Advisory Committee (MAC) engagement and expectations of physicians sharing accountability for results proved effective. Letters reviewing quarterly results from Integrated VP Medical Affairs and Infection Prevention and Control (IPAC) leadership to operational and physician leaders helped elevate awareness of shared leadership accountability. The requirement of operational leaders in areas below target to have written 90 day plans to improve performance kept leaders focused on hand hygiene compliance as a priority.
Improve patient and family engagement in ensuring hand hygiene practices	Yes	Signs (elevator wraps, buttons, posters) and patient materials encouraged patients and families to be partners in their care by cleaning their own hands and reminding care givers to clean theirs. Clinical programs developed initiatives to involve patients, unique to their program and shared successes among programs. Creating fun opportunities to engage patients e.g. Viva Hand Hygiene with Elvis was very well received and helped make messages stick. Having patients be the observer and complete surveys about care givers compliance was another engagement method. Further opportunities exist to enhance strategies to help patients be empowered to ask their care givers to clean their hands.
Ensure/validate consistency of audit practice	Yes	Discussion and review of different hand hygiene observation case scenarios during meetings and rounding with auditors improved understanding and consistency of the audit practice. In order to regularly evaluate the audit practice an on-line module was developed, ready for launch for Q1 of the next fiscal year.

Improve reliability and functionality of hand hygiene database.	Yes	A new database to track hand hygiene compliance with direct observation is in the late stages of development, and will be operational for Q1 of the next fiscal year. Key stakeholders have been engaged in its design to be user friendly and to ensure the reporting measures meet internal and external expectations.
Focus strategies to improve likelihood of staff /physicians adopting 3 vital behaviours for hand hygiene compliance in areas where compliance is less than 95%	Yes	Strategies for improvement were developed using the Influencer Model looking at six sources of influence to improve the likelihood of care givers cleaning their hands. The corporate influence plan was refreshed and program specific plans were modified with support from infection control practitioners, who focused on areas not meeting target. Quarterly letters to physician and operational leaders acknowledging performance improvement and areas requiring improvement. Success stories were highlighted and shared corporately and recognized in the High Achievers Club.

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7	Number of Medication Errors: Wrong Drug / Wrong Patient (Number; All patients receiving medication administration; Q3 2015-16; Patient Safety Reporting System)	714	4.00	0.00	5.00	Bar code scanning did result in reduced errors, and further changes will focus on additional factors that have been identified.

Change Ideas from Last Years QIP (QIP 2016/17)	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?
Continue to improve compliance with barcode scanning.	Yes	Additional factors beyond barcode scanning were identified. We have learned that there are other processes impacting compliance such as interruptions/distractions during med administration, compliance with “failed scan” policy, perceived barriers to managing failed scans, adherence to alerts, etc. Work on processes to make it easier to comply with armband and medication scanning will continue.
Enhanced medication error review with pharmacy and nursing leaders and sustainable process in place for review of errors at a system level	Yes	Each wrong drug/wrong patient (WD/WP) error is reviewed by Director of Pharmacy and Director of Professional Practice, and local teams on the unit where the incident occurred. One Director has done a deep dive following an incident on her unit where they identified process issues and system changes required going forward.

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8	Number of Patient Falls Resulting in Injury (Number; Parkwood Institute Main Building Patients; Q3 2015-16; Patient Safety Reporting System)	714	46.00	45.00	40.00	Established processes and practices including post falls huddles, standardized reporting and changes to intentional comfort rounds have directly contributed to reducing the number of falls/quarter and sustaining these results.

Change Ideas from Last Years QIP (QIP 2016/17)	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?
Continue improvements to Intentional Comfort Round (ICR) processes	Yes	Engaged staff across all units/programs and professions to gather and evaluate intentional comfort rounding practices which were implemented in 2012. From the feedback, changes were made in the documentation tool and this enabled teams to customize the frequency of Intentional Comfort Rounding (ICR). Training and resource tools were reviewed and updated. Videos were also created to provide visual examples to staff on how to properly perform ICR. Staff/observation practice tools were also developed to enable/encourage peer feedback and auditing on the quality of ICR. Audit tools were also reviewed and further developed. All programs across the Parkwood Institute site, Main Building have reintroduced ICR in Q3 and are regularly auditing. In Q4 the site team will be meeting to evaluate and review audit results. Regular review and evaluation will be embedded into program and site specific committees to ensure sustainability. Formal evaluation will be completed by Q2 FY 17/18 to monitor progress and stakeholder satisfaction.
Review and assessment of current screening tools at Parkwood Main Building (Morse, Schmidt, RAFT)	Yes	A comprehensive review of all falls risk assessment tools was completed. A literature review was conducted to assess the validity and reliability of each tool. The RNAO best practice guidelines were also reviewed to ensure alignment with the falls prevention program, and findings findings were presented to the Corporate Falls Prevention Team. All programs are utilizing a falls risk assessment tool and have established processes aligned with RNAO best practice guidelines. Post falls huddles are completed across the site within 72 hours of a fall.
Increase sharing of Program	Yes	Parkwood Institute Main Building Quality & Safety Committee was created

Specific Falls prevention strategies		with representatives from each program and discipline. This interdisciplinary committee is accountable for monitoring and evaluating quality and safety metrics and sharing experiences (what is working or not working) across the site. This committee was initiated September 2016 and meets monthly. Falls metrics are reviewed quarterly and a “deep dive” meeting was held dedicated to falls review. Programs presented metrics, strategies and lessons learned. This was an effective strategy and information was then taken back to programs. We have seen adoption/learning/sharing as the result of this strategy site wide.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
9	Percent Medication Reconciliation at Inpatient Admission (%; All inpatients; Q3 2015-16; Hospital collected data)	714	90.20	95.00	96.00	The target was reached in Q3.

Change Ideas from Last Years QIP (QIP 2016/17)	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?
Increase feedback to providers	Yes	St. Joseph’s Hospital Inpatient Surgery, Parkwood Institute Mental Health Care Building, Southwest Centre for Forensic Mental Health Care and Parkwood Institute Main Building all implemented varying strategies to provide direct feedback to the prescribers who did not complete medication reconciliation at admission. We learned that direct feedback to the prescriber seems to increase medication reconciliation compliance rates. In some areas the frequency of prescriber feedback was also increased.
Enhance medication reconciliation accountability and workflow	No	Pending the outcome/product from the Cerner Optimization project, the medication reconciliation at admission policy will be re-written.
Increase quality of medication reconciliation on admission	No	As above, pending optimization work. We will look to strike a task force for Q1 2017/18 to determine a work plan addressing quality of information collected during medication reconciliation at admission.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
10	Percent of Moderate and Severe Stroke Rehab Patients Meeting Active Length of Stay Target (%; Parkwood Institute Rehabilitation Program patients with moderate or severe stroke; 2015-16 Q3; and National Rehabilitation System (NRS))	714	72.00	85.00	90.60	All team members have a good understanding and received education regarding the value and impact LOS has on patient care and system flow. Processes to improve LOS have been embedded into daily work routines and conversations such that goals and patient outcomes align realistically with patient outcomes. Monthly review processes are completed to analyze progress and inform the team of sustainability, i.e. weekly LOS targets reviewed and used at team rounds, standard monthly agenda item at team meetings, root cause analysis of outliers is completed.

Change Ideas from Last Years QIP (QIP 2016/17)	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?
Improve transition from University Hospital (UH) 7 IP (acute care) to rehab admission.	Yes	Multiple strategies were developed to improve transitions: 1) One page referral process pilot, 2) Parkwood Access Office prioritization for stroke referrals, 3) Implementation of a Stroke Navigator role, 4) Day of transfer pilot. All strategies have made a positive impact on the target. All change ideas were adopted and sustained. Key learning was to include front line involvement and feedback in process change and final implementation. Additionally, this was a collaborative process (both the acute care hospital and rehabilitation hospital) to ensure all stakeholders, inclusive of the patient, were involved. The motto “2 sites, 1 team” was developed and adopted. Outcomes are now monitored through an integrated dashboard developed and visible to both organizations. All four strategies followed a formal process improvement approach utilizing PDSA cycles and evaluation metrics.
Improve discharge planning process.	Yes	Improved collaboration with CCAC and other community providers in addition to communication with patients and families were key drivers to the success of this change idea. This included a rigorous QI process to ensure completion of discharge summaries for all patients at time of discharge. Discussion and documentation at weekly rounds now includes an anticipated discharge date

		and community support required.
Improve access to ambulatory services	Yes	Referral directly from acute to outpatient services has been improved with the utilization of the stroke navigator role. An enhanced process for referral confirmation and anticipated wait time has been implemented. Community Outpatient Rehab (CORP) team has implemented bi-weekly waitlist review meetings. Prioritization streams have also been developed to ensure those at risk and newer strokes are seen in a timely manner.

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11	Percentage of New Pain Program Patients With Referral to Initial Physician Consult Wait Time Within Target (%; St. Joseph's Hospital Pain Management Program, New Patients; 2015-16 Q3; Hospital collected data)	714	CB	CB	193.00	The indicator was changed from percent within target to median wait time as a provincial target has not been set. In Q3 2016-17, wait time from referral has decreased by 14 days. The department of Anesthesia is actively recruiting physicians and a new physician will be on boarded in July 2017. Since FY 2015-16 there has been a loss of 3 physicians (retirements, other reasons. All patients are seen sooner in the Orientation Session and provided with general guidance to support their pain management prior to their first visit with the physician.

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Improve active review of wait time from initial referral to patient orientation to initial physician consult to inform clinic processes.	Yes	Monthly data related to wait times and volumes of new patients is posted and shared by the Medical Director. Reporting to all physicians of wait times for new patients and cumulative number of new patients seen YTD has had a positive impact. Observed changes in physician practice include increasing number of new appointments and accelerating the triage of new referrals.
Implement a discharge RN role to increase new physician consult times as patients' transition to the discharge RN.	No	This is planned to be implemented in Q4. Standardized clinical pathways are nearing completion to support this new RN position. A new RN position is being recruited to support this work. The number of annual patient discharges was reviewed. The low number of discharges has highlighted the need for clinical pathways to standardize clinical practice. Implementation of new standardized clinical pathways will increase the number of discharges and increase access.
Increase clinic time for physicians	Yes	The Medical Director has encouraged physicians to open new appointments in order to increase access for new patients. The Medical Director is working with the Department of Anesthesia and has been

		successful to have existing physicians scheduled less in the Operating Room and more time in the Clinic.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
16	Percentage of Seclusion and Restraint Episodes with Staff Debriefing Completed (%; All Mental Health inpatient programs; Q3 2015-16; Hospital collected data)	714	25.00	75.00	45.80	Several factors were seen to impact the ability to meet target including leader buy-in, clarity of accountabilities and data collection issues.

Change Ideas from Last Years QIP (QIP 2016/17)	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?
Consistent leader understanding of expectations and accountability regarding debrief process.	Yes	Repeated messaging of both leader accountabilities and where the accountability rested in the case when leaders were not immediately available was required. Strengthening the “why” message from the outset is helpful.
Increase frequency of reporting of episodes with debrief for early identification of gaps in debriefing	Yes	This has just been implemented in Q4 2016-17. It is recommended that frequent and regular reporting of metrics be built in early in the process. In this way, strategies and course correction measures can be implemented sooner to support achievement of target. Sharing of leader performance in terms of debriefing rates appeared to be an effective strategy for bringing poor performers along.
Review debriefing tool: ensure patient, environment, staff and organizational contributing factors	Yes	Modifications were made to the tool after the first quarter based on staff input. This helped to make the tool more meaningful and increase staff buy-in.
Improve metrics for monitoring and trending seclusion and restraint hours and increase review	No	A decision was made to continue to focus on hardwiring the debriefing processes. We continue to monitor the median and the 90th percentile seclusion and restraint hours, but have not set related targets.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
17	Percentage of Urology Centre Cancer Surgery Patients With Referral to Initial Physician Consult Wait Time Within Target (Wait 1) (%; St. Joseph's Hospital Urology Centre, Prostate and Genitourinary Oncology Surgery (Treatment) patients, Priority 2/3/4; 2015-16 Q3; Provincial Wait Time Information System)	714	45.00	85.00	70.00	General trend to improvement and target of 85%. At the end of January, our performance was 79%. Low volumes have impacted fluctuation in performance.

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Develop prospective review of wait time for initial consults booked, for GU and prostate cancer referrals	Yes	Specific appointment types were implemented to support enhanced monitoring and feedback related to open cases. On a monthly basis the data is reviewed and follow up with the surgeon/secretary office is completed. A prostate diagnostic assessment program (pDAP) was launched in Q3 2016-17. The creation of specific appointment types supported enhanced monitoring of performance. The pDAP was launched in October 2016. Preliminary data for patients suspected of cancer and referred to this program suggest that their assessment time is shortened.
Increase knowledge of Wait 1 targets for Oncology in Urology service.	Yes	One on one meeting with the physician secretaries, as well as team sessions to increase awareness have been helpful. Process reviewing including documentation of current state was completed. One on one meetings were key to understanding the current state, allowing for dedicated time to review the details of wait one, expectations and targets. Documenting the current state provided opportunities to identify gaps and waste to improve performance.