Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2016/17 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 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
1	# of workplace violence incidents that result in lost days (Counts; all hospital personnel; 2016; Hospital collected data)	905	3.00	0.00	0.00	This indicator is one of the Joint Centre strategies

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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?
Staff training Patient identification and care planning Culture change strategies related to zero tolerance for violence (signage, joint committee work, visible rounding for safety, safety audits)	Yes	Staff training (Workplace Violence Prevention Core Curriculum) was completed by 90% of all Full time and Regular Part Time staff; **This process measure was linked to Executive Compensation.** A Working Group as part of the Joint Centres (5 other Hospitals) was established to develop a "playbook"; Completed an environmental scan and obtained staff feedback on leading practices to be incorporated; The key learning was that there were common challenges across the 6 hospitals, and there were great opportunities to share and learn from each other.

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2	“Would you recommend this hospital to your friends and family?” Add the number of respondents who responded “Definitely, Yes” and divide by number of respondents who registered any response to this question (do not include non-respondents). (%; Adult Inpatient (Medical / Surgical); April 1st 2016 - March 31st 2017; CIHI CPES-IC (Adult Inpatient) survey)	905	CB	CB	70.00	This was a baseline year, as a new survey tool and methodology were introduced

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Participate in "Better Together" campaign to review, develop and implement policies and practices supporting presence and meaningful participation of family members in the process of care	Yes	The current "Visitors and Support Accompaniment" policy was reviewed to identify gaps related to best practices in supporting presence and meaningful participation of family members in the process of care; A Working group was established to develop an implementation plan for the following year; A key learning was that patient and family input is very important in improving care processes.

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3	CDI (C-Difficele) rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI during the reporting period, divided by the number of patient days in the reporting period, multiplied by 1,000. (Rate per 1,000 patient days; All patients; January 2015 – December 2015; Publicly Reported, Ministry of Health)	905	0.17	0.17	0.22	A new target is proposed for 2017/18, as the target stated on the previous QIP (21016/17) is very difficult to maintain, as the new building in Markham site is getting older. York Region Public Health set the target for the Markham site at 0.29 based on a retrospective analysis of the past 8 years and the trends of peer community hospitals (similar bed capacity) in the region. The current performance is 0.22, which is 25% better than the set target by YRPH.

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Develop program to support the expanded use of Nocospray	Yes	Implemented Nocospray in the regular Environmental Services schedule and there has been a request made for additional machines; The key learning is that Nocospray is not effective if the surfaces have not been cleaned first, as it is a easy to use disinfectant (not cleaner).
Review different alcohol based hand rub (ABHR) formats i.e. gel, foam, personal carriage formats, single use personal wipes, single use hand towel wipes, etc.	Yes	Multiple products have been reviewed with staff. There was variation in feedback due to personal preference and skin allergies/sensitivities.

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4	ED Wait times: 90th percentile ED length of stay (LOS) for Admitted patients. (Hours; ED patients; January 2015 - December 2015; CCO iPort Access)	905	28.20	26.70	26.20	There has been continuous improvement in the ED LOS for admitted patients

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Reduce Total ED LOS for admitted patients by addressing wait time from decision to admit to the patient leaving the ED	Yes	A Bed Team was implemented with increased scope and this improved bed clean turnaround time by 50%; A process mapping session identified additional improvement opportunities, which will be addressed over the following year.

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5	Medication reconciliation at discharge: The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital (%; Medicine Program patients; 2016-17 Q3 YTD; Hospital collected data)	905	CB	CB	76.00	The data collection is based on a manual audit

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Improve Quality of Medication reconciliation discharge process in the medicine program utilizing Safer Health Care Now	Yes	The Safer Healthcare Now guidelines were shared to physicians and other Health Care Providers; Audits were conducted to ensure appropriate documentation (97% compliance to process); The key learning was the importance of communication and auditing to improve the quality of a process.

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6	Medication reconciliation at transitions in care: The total number of ED patients of a specific population with medications reconciled as a proportion of the total number of patients discharged from the ED without a decision to admit (%; Specific ED population without a decision to admit; 2016-17 Q3 YTD; Hospital collected data)	905	CB	CB	CB	Collaboration with Emergency Department

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Medication reconciliation is initiated for clients without a decision to admit who are at risk for potential adverse drug events and who would improve flow of patients through the ED.	Yes	Have identified the population with the ED Geriatric Emergency Management (GEM) Nurse Practitioner team based on the referral tool currently used.

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7	Overall, how would you rate the care and services you received at this emergency department? “Using any number from 0 to 10, where 0 is the worst care possible and 10 is the best care possible, what number would you use to rate your care during this emergency department visit?” For "top box”, add the number of respondents who responded “10” or “9” and divide by number of respondents (%; ED patients; April 1st 2016 - March 31st 2017; Ontario EDPEC (Emergency Department))	905	CB	CB	55.00	This is a baseline year, as new survey tool and methodology was introduced.

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Implementation of standardized process for providing discharge instructions	Yes	All patients received discharge instructions at registration and there was 10% improvement in nurses completing their discharge notes.

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8	Overall, how would you rate the care and services you received at this hospital? “Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?” For "top box”, add the number of respondents who responded “10” or “9” and divide by number of respondents (%; Adult inpatient (Medical / Surgical); April 1st 2016-March 31st 2017; CIHI CPES-IC (Adult Inpatient) survey)	905	CB	CB	60.00	This was a baseline year, as a new survey tool and methodology was introduced.

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Review and implement a Way finding and Signage improvement project	Yes	Updated signage and education was implemented; There were no formal complaints related to way finding; Staff provided positive feedback in finding their way around the hospital better. **This initiative was linked to executive compensation.**
Create a permanent way finding concierge program based on the success of the pilot and implement the concierge model in a minimum of one clinic / department	Yes	Roles and deployment plan were developed and rolled out in 2 Clinics; an evaluation of the pilot in one of the clinics demonstrated positive feedback from the patients and volunteers. **This initiative was linked to executive compensation.**
Implement year 1 deliverables for Team-based care redesign project	Yes	A project plan was developed to test the Team Based care model in 3 clinical units; a key learning was involvement of patients/family member was very important to introduce process changes.

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9	Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort) (Rate; COPD QBP Cohort; January 2014 – December 2014; CIHI DAD)	905	18.89	17.50	18.46	Based on the complexity of the disease management, this was a very difficult measure to move.

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Expand beyond pilot phase the 12-week supervised Breathe Better program offered through the Centre for Respiratory Health COPD clinic and Cornell Community Centre	Yes	The Breathe better program was implemented and patients reported significant improvements in level of ability to engage in activities of daily living and social activities (based on pre and post surveys); the survey data was reviewed quarterly to flag any improvement opportunities.
Improve the quality of the documentation and coding by aligning current practices with data standards outlined in the Clinical Documentation Improvement (CDI) Tool Kit	Yes	Physician lead and champions were identified; tip sheets were developed and education to ensure best practices are followed; A key learning was that improvements in documentation and coding may have resulted in a slight increase in the re-admission rate.

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10	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 2015 – September 2015; WTIS, CCO, BCS, MOHLTC)	905	11.20	10.42	13.02	ALC is a provincial challenge and the rate is projected to increase, however, the MSH rate is significantly below the C-LHIN average

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Develop / adopt an ALC risk screening process	Yes	A project plan was developed and a screening tool was implemented for all patients over 65 admitted to the hospital; this supported the identification of high risk ALC patients earlier in the process
Pilot an ALC assessment 'Swat' team to consult to team on discharge plan for patients who screen as high risk for ALC	Yes	A review of the current processes were conducted before implementing the ALC swat team; this concept was shared with the C-LHIN and they are very interested in the pilot for the following year

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11	Would you recommend this emergency department to your friends and family? Add the number of respondents who responded “Definitely, Yes” and divide by number of respondents who registered any response to this question (do not include non-respondents). (%; ED patients; April 1st 2016-March 31st 2017; Ontario EDPEC (Emergency Department))	905	CB	CB	64.00	This was a baseline year, as a new survey tool and methodology was introduced

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