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?"	936	69.00	74.00	64.4	Target Not Met to Date 

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?
(Patient Experience and Safety)Implement targeted "Always" behaviour(s) at key patient interaction points within the Emergency Department, ensuring adherence to Code of Conduct, while creating a culture of preferred service delivery.	No	Multiple initiatives underway in the ED that were of a higher priority required delaying implementation of this initiative. (i.e., access and off load delays) Since we were unable to implement the above initiative we refocused our efforts to better understand the complaints for the area by trending information of AEMS complaint and compliment categories. New Patient Relations Specialists have been hired with specific focus for this area with on-going recruitment of additional Patient and Family Advisors to support this work across the organization. Key learnings include the need to assess the ability to take on new initiatives while being able to effectively influence a cultural change.

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(Emergency Department) Implement the Mental Health 120 Day Action Plan specific to Emergency Department focused recommendations for quality of care (improved coordination of care) and timely access to care for all patients.	No	This indicator is inherently tied to patient length of stay in the ED. Significant improvement of this indicator cannot be achieved without a reduction in overall ED length of stay. Key learnings: Engage patient and family advisors and survey feedback to better understand where and how to focus energy to address this indicator. In addition to the actions targeting length of stay, initiatives related to ambulance offload processes, cleanliness of wait areas, security anxiety, patient awareness of wait time/access information, and more entertaining dissemination of educational information were undertaken.

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2	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?	936	66.20	71.00	59.2	Target Not Met to Date 

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(Patient Experience) Implementation of a patient-friendly discharge summary	No	This is a corporate wide initiative – currently Medicine Unit is piloting a "Patient Oriented Discharge Summary (PODS). Information from this trial will be used to help support similar initiatives in other clinical areas. Learnings included that use of the PODS template through UHN open lab may have facilitated a quicker development of this process.

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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	936	82.80	85.00	87.5	Target Met 

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(Pharmacy) Enhance pharmacy technician resources in the Emergency Department.	No	The expansion of techs in ED to 24 hours was not accomplished in this fiscal year due to lack of funding. The change initiative of implementing a risk assessment tool in the ED was not completed. The risk assessment tool was to be used to ensure that pharmacy techs were seeing high risk patients (e.g. high risk for med errors). The risk assessment tool was not implemented due to other competing priorities in the ED throughout the year (as agreed upon by the ED Director and Pharmacy Director). The pharmacy department continued to staff technicians at both EDs for 16 hours/day, 7 days a week throughout the year to document the BPMH, and support medication reconciliation at admission. Key learnings on this would be to ensure an understanding of other risk assessment tools in the area, and assess the impact of a new one to frontline staff.
(Pharmacy) Fully launch the Healthcare Undergoing Optimization (HUGO) Application across the organization.	Yes	The HUGO Optimization project on medication reconciliation was completed in F2018. There were no system or functionality improvements for medication reconciliation. The optimization team focused on revitalizing education and training for electronic medication reconciliation in the LHSC online health information system. This education was disseminated across the organization in the summer of 2017. After this dissemination of education compliance to

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		medication reconciliation improved in some areas of the hospital. However, without a corporate focus on compliance to medication reconciliation at the time that the education was released, the compliance improvements were not widespread. Convening a corporate team dedicated to disseminating the education may have resulted in better overall knowledge and compliance. With LHSC preparing for the 2018 Accreditation Canada survey, this education/training will be used by the Corporate medication reconciliation steering committee to enhance awareness of medication reconciliation practices and accountabilities across the organization.
(Pharmacy) Enhance Medication Reconciliation reporting to enable unit level improvement.	Yes	Medication reconciliation indicators are on the portfolio and corporate balanced score cards, and have proved to be an effective way to track and trend med rec compliance across the organization. The reports have been enhanced to include unit specific information. This information has been given to portfolio directors upon request. Decision support is working on having this data available to all directors (e.g. dashboard). New in the Q3 reporting cycle, medication reconciliation reports are now being distributed to physician leaders (with drill down capabilities) in alignment with the physician balanced score card.
(Mental Health Program) Improve medication reconciliation compliance by aligning practice behaviours and electronic system requirements to patient safety and health outcomes.	Yes	Mental Health leveraged processes created by other clinical areas, partnership with Pharmacy, and reports created by Decision Support to address an opportunity to improve medication reconciliation at admission for both Adult and Child and Adolescent Mental Health. By the end of Q2 Mental Health leadership met with Pharmacy and Decision support to understand our data and where the opportunity exists. Mental Health opted for a strategy which had been previously proven in the Women's program. Managers, Coordinators, and representatives from the Women's program conferred with leadership from Mental Health and created a process for MH. In brief, there is a review of the electronic patient record for each

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		admitted patient within 7 days of admission to see if a medication reconciliation had been completed on admission. If the completed flag in the electronic patient record is not present, an escalation process is started to address the non-compliance. Lessons learned: • Understand data. Understand where the opportunity exists. • Share detailed data regarding where opportunities exist with physician leaders to partner with them on the improvement plan. • Change the processes to better support the patients. • Build reports to support the work. • Find monitoring measures and report regularly. • Work with the Chief Resident to understand how to engage the residents in this process since they are highly likely to be involved in this action. This needs to be a team approach all the gains cannot be realized unless everyone is aware and involved.

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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.	936	72.00	77.00	66.4	Target Not Met to Date

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(Pharmacy) Expand the use of the Medication Reconciliation Discharge Reports organizationally.	Yes	Discharge medication reconciliation is on the portfolio and corporate balanced score cards. Drill down capabilities were provided to physician leaders in alignment with their physician balanced score cards (as was done with admission medication reconciliation). This was launched in Q2 F2018.
(Pharmacy) Enhance Medication Reconciliation reporting to enable unit level improvement.	Yes	See notes above.
(Mental Health and Children's Hospital) Improve medication reconciliation at discharge ensuring compliance by aligning practice behaviours and electronic system requirements to patient safety and health outcomes.	No	In the process of working on this change idea Children's Hospital realized that in order to reap the maximum benefits related to discharge medication reconciliation we had to first focus our attention on maximizing our efforts on improving medication reconciliation compliance at admission. The program had reasoned that because we were generally performing better at admission that the processes, practices, and behaviours that produce a high level of compliance were better established on the admission side. However, upon review of performance and discussions with stakeholders, it became clear that there were gaps which needed to be addressed. Our key learnings were that we could not underestimate the level of education, focus

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		and attention it would require on admission medication reconciliation before focusing on the discharge medication reconciliation process. We could not assume that people knew how to do the process regardless of how much education/training had been done before – We had to go back to basics with all stakeholders. Physician leaders taking ownership of the metrics was a key enabler to the success of this change. Medication reconciliation on admission increased by 16.7% in Q3 compared to Q2. We instituted weekly audits, reports, and an escalation process to address non-compliance in order to manage processes, clarify expectations, and drive accountability for performance.

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5	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	936	11.40	10.30	12.8	Target Not Met to Date 

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(Inpatient Medicine) Continue to build on and optimize the Admission and Discharge System Design (ADSD) Strategy to improve the discharge process, standardize the care of patients admitted with complications of intravenous (IV) drug use and improving the process for transitions between Long Term Care Homes (LTCH's) and London Health Sciences Centre	Yes	Consistency and perseverance were truly important factors in making these changes sustainable. It took time for staff and physicians to truly buy into changes to the discharge processes and even more time for those changes to become the norm. In the process of addressing change ideas related to the People Who Inject Drugs (PWID) patient population, it was discovered that there are a lot of resources in the community of which we were not previously aware. Establishing and strengthening community connections and aligning resources as appropriate were important factors in impacting patient care processes at LHSC. At the same time, it was determined that there was a real need for hospital staff to have an opportunity to work through their own biases working with this patient population in order for changes to have full impact. Education sessions in partnership with our community partners were well received and recommended for wider dissemination. Key learnings: • Perseverance is key to making a change stick. Knowing that you are doing things for the right reason (patient care) and being prepared to work through resistance.

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		• Leaders need to think about change management. Be respectful of where people are at, while forging a path for them to move forward. Detailed baseline and ongoing data is needed to quantify the impact of the changes made.
(Mental Health) Implement the Mental Health 120 Day Action Plan to increase Emergency Department capacity by reducing the number of long stay patients occupying inpatient beds.	Yes	Mental Health Emergency Department length of stay has multiple variables which contribute to prolonged length of stay including extended length of stay on inpatient care floors due to patient complexity, and an inability to transition patients to tertiary mental health care or community services in a timely manner. Through the process of implementing the 120 day action plan, Mental Health has created a cross-sectorial table to review long stay complex cases and identify opportunities to assist moving patients safely to the community. Lessons learned: It was identified that there was a clear need to strengthen our partnerships with community and regional supports. There needed to be a dedicated resource focussing on transitions out of the acute care. There also needed to be an opportunity to discuss options to avoid admission for each patient who presents at the ED. Mental Health is continuing to push forward by exploring the use of the health links coordinated care planning process to support complex patients.

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(CNS)Realign the stroke process in the University Hospital Emergency Department to facilitate earlier consultation with Neurology for patients assessed as stroke.	Yes	Prior to the implementation of this change idea, the Clinical Neurological Sciences (CNS) department had one Consultant on call for the Emergency Department (ED), this was causing high wait times for consultation and led to long transfer times. As a Regional Stroke Centre for all of Southwestern Ontario and one of seven Designated Stroke Centres in Ontario, volumes of patients coming to UH were increasing and new processes had to be developed to manage the pressure. The number of physician consultants assigned to Emergency Department CNS patient consults was increased from one to two. The increase in on-call consultants allowed responsibilities to be realigned to streamline services. One consultant was dedicated to stroke patients and the other consultant was dedicated to non-stroke neurological patients. Because stroke is a difficult diagnosis, University Hospital gets a high volume of stoke mimics, or TIAs that may have gone to other hospitals if they had been identified earlier. The realignment permitted actual stroke patients to be identified and assessed earlier than in the previous model. A key learning from implementing this idea is that realigning the CNS ED processes had downstream effects which had to be managed. For example, a higher than anticipated volume of Endovascular Treatment (EVT) stokes meant a higher need for procedures performed by Interventional Radiology (IR). In order to maintain faster consult and transfer times CNS partnered with IR to revise their on-call, patient flow, and room turnover processes to meet the increased need.

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(CNS) Increase Clinical Neurological Sciences bed capacity at University Hospital; enabling improved access and flow of Clinical Neurological Sciences patients moving from the Emergency Department in a more effective method.	Yes	CNS has done a great deal of work to ensure people have knowledge of, and access to stroke resources at LHSC. The number of CNS beds was increased in order to improve access and flow from the Emergency Department. The work to determine the required increase in bed capacity was done in partnership with EMS, ED and Neurology. The patient volume projections have thus far accurately predicted the number of dedicated stroke beds which are required to manage the increase in stroke patients. However, because patient volumes have generally increased across all neurology, non-stroke patients are sometimes assigned to those stroke beds. The result is that even with the additional beds, CNS finds itself challenged to manage capacity and resources. CNS needs to consider if, and how to protect those stroke beds while still managing increased patient volumes from Neurology and Neurosurgery. Because of the challenges managing the dedicated stroke beds, the stroke bypass protocol, which would have all patients in the London Middlesex Oxford Stroke District presenting with symptoms of an acute stroke redirected or transported to UH, has not been fully implemented.
(Emergency Department) Improving Emergency Department access and flow through the implementation of a new mode of care, focused on improving coordination and timeliness of care in the areas of Mental Health and diagnostic discrepancies.	No	Impacting this indicator takes a collaborative approach with all inpatient services to reduce overall ED length of stay. The pressure of year over year increasing ED volumes has made this a challenging indicator to address. Key learnings: You have to look at all factors which lead to patients coming to the Emergency Department (e.g. direct referrals, regional pressures) as well as processes for managing ED capacity (e.g. decanting escalation processes, workflow) to surface and address opportunities to decrease patient length of stay. Timely data is needed to have relevant conversations with inpatient services.