Excellent Care for All

**Quality Improvement Plans (QIP): Progress Report for the 2015/16 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 2015/16 | Org Id | Current Performance as stated on QIP2015/16 | Target as stated on QIP 2015/16 | Current Performance 2016 | Comments |
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| 1 | "Overall, how would you rate the care and services you received at the hospital?" (inpatient), add the number of respondents who responded "Excellent", "Very good" and "Good" and divide by number of respondents who registered any response to this question (do not include non-respondents). ( %; All patients; October 2013 - September 2014; NRC Picker) | 936 | 95.20 | 96.00 | 96.06 | See lessons learned. |

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| Change Ideas from Last Years QIP (QIP 2015/16) | 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? |
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| Increase Patient and Family Engagement in Councils, Committee and Improvement Projects | Yes | Two new councils were formed in cardiac care and intensive care. Patient advisors are now up to 129.Over time we believe authentic patient and family engagement will be a major indicator helping us to transform our culture to be more patient and family-centred and improve experience. We acknowledge that this takes time to plan and apply and it is important for leaders and teams to be ready and mindful integrating this approach with other priorities. We have taken an approach to support Leaders and find the best place to start, start small and this has been successful. We have learned that easy to follow guides and internal networking is key to spreading. |
| Embed Patient and Family Centred Care Principles and Behaviours in Staff Orientation, Education Curriculum, and Performance Development. | Yes | All new hires receive patient experience education in orientation. Interactive workshops have been delivered with Nurses in the Emergency Department, Communication Clerks in Radiology and Technicians in Ultrasound. Patient Experience is embedded as part of performance management across the hospital. Through evaluations we have learned that patient and family stories embedded into our curriculum has been very beneficial to provider engagement and reflective practice. This seems to aid in identifying their behaviours and actions related to patient and family-centred care. |

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| 2 | Total Margin (consolidated): % by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expense, excluding the impact of facility amortization, in a given year.<br>( %; N/a; Q3 FY 2014/15 (cumulative from April 1, 2014 to December 31, 2014); OHRS, MOH) | 936 | -0.38 | 0.00 | -1.59 | See lessons learned. |

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| Submitting a Balanced Budget | Yes | A balanced, Board of Directors approved budget was submitted to the LHIN on April 1, 2015. |
| Tracking Portfolio's Performance | Yes | Portfolios have submitted monthly variance reports throughout the fiscal year. Each area had ongoing tasks to complete in order to be in line with budget expectations. |

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| 3 | Readmission within 30 days for Selected Case Mix Groups ( %; All acute patients; July 1, 2013 - Jun 30, 2014; DAD, CIHI) | 936 | 19.15 | 18.00 | 17.62 | Used select HIGs as the result, given that data for CMGs was discontinued. |

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| Heart Failure Clinic - establish a heart failure clinic to avoid admissions and provide follow-up care with an identified portion of patients post discharge. | Yes | The heart failure clinic is now in place at St Josephs Health Care operating on 3 days a week with the plan to increase to 5 days a week. The heart failure navigator position is currently being recruited for, with anticipation of hiring before the end of March. Lessons learned: The data we receive for this indicator is usually three months behind actual date. The clinic and navigator position are still too new to assess impact or define lessons learned |
| Chronic Obstructive Pulmonary Disease (COPD) Clinical Pathway and Case Management - development of COPD pathway, standardized patient education materials, and patient navigator support for the Victoria Hospital Respirology unit. | Yes | COPD pathway, education tools and navigator implemented as planned. Physician leadership and staff engagement are key. Patient experience and input is essential when building tools, especially discharge education and strategy. Success is dependent on consistent use of tools for all appropriate COPD patients by all disciplines. |

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| 4 | CDI 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; Jan 1, 2014 - Dec 31, 2014; Publicly Reported, MOH) | 936 | 0.55 | 0.40 | 0.33 | See lessons learned. |

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| Antimicrobial Stewardship - enhancement of the program in acute medicine. | Yes | In 2015/16, Antimicrobial Stewardship was initiated in Internal Medicine at Victoria Hospital and spread to University Hospital (2-3 times per week by Antimicrobial Stewardship Pharmacist and Antimicrobial Stewardship Physician). |
| Enhance Cleaning Protocols - targeted cleaning products and processes for specific patient populations. | Yes | Xenex Pulsed UV Disinfection Solution is being used in Oncology at Victoria Hospital.Environmental Services recently introduced a new cleaning audit focused on foundational cleaning practices to ensure optimum wiping efficacy and thorough cleaning in Medicine at University Hospital. It was learned that a Quality Assurance program relating to cleaning audits for the organization should be released on a routine basis to stakeholders. This indicator primarily involves the support of the environment services group. The small numerator/denominator values make change impact difficult to assess over a relatively short period of time. If current rates are manageable, ensure foundational practices are in place before focusing on extra measures. |

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| Antimicrobial stewardship - surgery | There have been several Grand Rounds and Resident Education sessions on Intra-Abdominal Infection Best Practice Guidelines. A pilot of Weekly Antimicrobial Stewardship Rounds on 3/5 of Surgical Teams at UH was launched - (with Antimicrobial Stewardship Pharmacist, Surgical NP and Surgery Pharmacists) The results of of the pilot were presented to all Surgeons at Grand Rounds. Expanded to daily Antimicrobial Stewardship Pharmacist/Senior Surgical Resident Informal Stewardship Rounds on all 5 Surgical Teams at UH (based on identified need to ensure individualized review of each patient). |

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| 5 | ED Wait times: 90th percentile ED length of stay for Admitted patients.<br>( Hours; ED patients; Jan 1, 2014 - Dec 31, 2014; CCO iPort Access) | 936 | 31.90 | 25.00 | 27.60 | See lessons learned. |

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| LHSC Transformational Project: a) EDST - introducing a new model of care in the ED that delivers a multi-disciplinary team approach to manage care and waiting. b) MHSD - reduce the LOS for admitted patients in the ED, facilitate patient flow and care pathways on the mental health unit, and improve utilization of the urgent clinic. c) ADSD - streamlining the flow of patients into and out of the hospital, reducing the volume of admitted patients and expediting/transitioning to discharge sooner. | No | a) Partially implemented. When implemented significant impact with reduction in p4R metrics (PIA, LOS), reduced LWBS and improved staff, patient and learner satisfaction. The specific metric for this table is LOS for admitted patients and is mostly controlled by factors external to EDST. However EDST process reduces this metric by 3 to 6 hours independent of the non-ED factors when implemented. Initial barriers to implementation were staff engagement, staff readiness and occupancy / boarding in ED. Current barrier to implementation is boarding in ED. High current risk of losing staff engagement and readiness due to inability to implement. Advice to others includes - don't wait for perfection, every challenge is an opportunity, always implement in phases (ie never big bang) and always look to front line for solutions. b) The ALOS of our Mental Health inpatient population is under review with our Decision Support consultants with the goal to prepare a psychiatrist-specific profile of the ALOS. Subsequently, readmission rates will be added to scorecards. c) Challenging to make progress with a focus on 10 Kaizens. Work has been streamlined to focus on Discharge Processes, Care of the Patient with Complications from Intravenous Drug Use and Repatriation. Important to engage the appropriate stakeholders, establish clear project deliverables and set time-lines/targets for completion of actions. Progressing well with a re-energized project management and LEAN approach. |

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| Reducing Occupancy to 95% | No | Challenges relate to transformational project as well as front line / staff and physician engagement in goal across organization (ie achieving buy-in to the goal for all staff and doctors regardless of what program they work in). |

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| 6 | 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 ( %; All patients; most recent quarter available; Hospital collected data) | 936 | 79.60 | 85.00 | 81.09 | See lessons learned. |

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| Provider Audit and Feedback - a multidisciplinary working group has been established to monitor and review progress and implement change ideas. | No | This indicator was a good idea to track and monitor the compliance rate. However, it was not executed fully as changes were needed to the report, and they are still not complete (by ITS/CI). The changes were needed to make sure that the providers who are responsible for med rec are being tracked correctly. Once tracked correctly, the multidisciplinary group had planned to give provider feedback. This change idea will be applied to the next fiscal year once the report is ready from ITS/CI. |
| Education - a multidisciplinary working group has been established to create educational materials to support Medication Reconciliation at Admission. | Yes | The working group was successful at revamping the med rec educational tools (job aids and videos). This did support further knowledge of the med rec functionality in the system. As changes are made in the system with med rec optimization, revised educational materials will be needed. |
| Workflow/Functionality Enhancement/Improvement - Medication Reconciliation at Admission is one of the HUGO optimization projects. The Medication Reconciliation workflow/functionality will be enhanced/improved and available in September 2015. | No | This change idea was not executed as the Med Rec Optimization project did not start as it was supposed to in Fall 2015. |

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| 7 | Total number of inpatient days where a physician (or designated other) has indicated that a patient occupying an acute care hospital bed has finished the acute care phase of his or her treatment, divided by the total number of inpatient days in a given period x 100.<br>( %; All acute patients; October 2014 – September 2015; DAD, CIHI) | 936 | 8.15 | 7.70 | 6.97 | See lessons learned. |

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| South West LHIN Discharge Planning - LHSC is reviewing current discharge policies and practices and updating accordingly to align with the South West LHIN access to care initiative framework that was developed to standardize discharge policies and practices across hospitals. | Yes | Required broad stakeholder engagement. Revised policy implemented in December 2015, so in early phase for education and spread. Would have benefited from a corporate education strategy and roll-out due to significance of this policy in day to day practice. |
| ALC Designation (timeliness and accuracy) - revise current processes for timely and appropriate ALC designation to ensure that LHSC aligns with the MOHLTC provincial policy. | No | Delay in project launch (December 2015). All relevant stakeholders need to be at the table. Have completed 2 current state mapping sessions, which has allowed us to surface the complexity and diversity of the ALC designations process by program, as well as, each discipline. |