Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2014/15 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 2014/2015	Current Performance as stated on QIP14/15	Target as stated on QIP 14/15	Current Performance 2015	Comments
1	ED Wait times: 90th percentile ED length of stay for Admitted patients. Hours ED patients Q4 2012/13 – Q3 2013/14 CCO iPort Access		29.20	31.90	

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Change Ideas from Last Years QIP (QIP 2014/15)	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 Flow Management System – Move to full functionality including report generation.	Yes	All organizational leaders have access to, and have received education on the use of the patient flow management system. Some report functionality issues are still being seen and are being addressed.
Dedicated Bed Model – Implement the Dedicated Bed Model and open 21 additional beds at UH.	Yes	Bed moves were completed on February 9th and 21 additional beds were added to the system at University Hospital. Performance indicators are being populated and will be presented before the organizational utilization committee.

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2	ED Wait times: 90th percentile ED length of stay for Non-admitted patients (CTAS 4 & 5) Hours ED patients Q4 2012/13 – Q3 2013/14 CCO iPort Access	5.90	5.20	5.60	

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Emergency Department System Transformation - Will initially address the front end process to significantly reduce PIA time. Initial assessment and triage will be based on a First In First Out (FIFO) philosophy which will significantly reduce the LOS for this patient population.	No	Partial Implementation - Portions of this project are in the implementation phase while other elements are preparing for full system implementation in summer of 2015. The design/process decisions and tenure of a firm (for renovation purposes) put a delay on some of the anticipated successes of the EDST project in 2014/15.
Radiology Improvement in the Emergency Department - Designed to expedite diagnostics imaging testing and results delivery for patient in the Emergency Department.	Yes	Partial Implementation - Ongoing collaborative work with the Radiology department has taken place in order to decrease "time to test" and "time to report". Progress with report turnaround time has been noted. Efforts to streamline the "order process" are currently underway.

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3	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. % N/a Q3 2013/14 OHRS, MOH	0.78	0.00	-0.38	

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Submitting a Balanced Budget - As an organization, the budget must be balanced to meet the total margin target. Portfolios are working on saving strategies to balance the budget.	Yes	A balanced, Board of Directors approved budget was submitted to the LHIN on April 1, 2014.
Dollars and Sense Campaign - Through the Office of Innovation. This is an initiative collecting ideas on cost savings or revenue generation ideas that will be reviewed by organizational leadership.	Yes	Ideas generated under the dollars and sense campaign were reviewed by organizational leadership. A short-list of ideas (finalists) was sent to the CFO's office for review. All finalist ideas have been reviewed.
Tracking Portfolio's - Tracking the achievement of saving strategies for each portfolio through monthly variance analysis reports submitted to Finance.	Yes	Portfolios 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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4	HSMR: Number of observed deaths/number of expected deaths x 100. Ratio (No unit) All patients 2012/13 DAD, CIHI		88.00	87.00	

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Sepsis Management in the Emergency Department- Improve identification and treatment of sepsis in the Emergency Department.	Yes	Revised Sepsis guidelines were approved and implemented in the emergency department. A positive Sepsis screen medical directive was sent to initiate the approval process. Planning is underway with ED educators and the Sepsis working group.
Death Review Process Improvement - Develop education plan to support the implementation of the new death review process post HUGO. Review and audit death charts and capture data with a tool that includes the IHI Global Trigger Tool.	Yes	790 death chart reviews were completed in the 2014/15 fiscal year. A death review web application pilot was initiated in February 2015 in the Medicine Program. Some process issues were identified and are being resolved as it relates to the web based tool. System issues (identified in charts) are shared with the appropriate leadership for follow up.
Improvement in Clinical Documentation - Documentation of factors that impact the HSMR and creation of education/tools to support improved documentation.	Yes	The implementation of new tools (such as an inpatient face sheet) highlight key areas to be completed by physicians and enhance the capturing of information required for more accurate reporting the MoHLTC. The education that coders received was in line with identified opportunities for improvement in clinical documentation.

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5	Percentage ALC days: Total number of acute inpatient days designated as ALC, divided by the total number of acute inpatient days. % All acute patients Q3 2012/13 – Q2 2013/14 Ministry of Health Portal		7.70	8.15	

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ALC Designation - Define our current state processes for ALC designation, identify process and documentation improvements, creation of a formal ALC policy, and new educational materials for providers.	No	Project re-launch will occur in 2015-2016.
Home First: Monthly ALC Reviews and ALC Long Term Care Sign Off - Sustainability strategy to review each ALC case on a monthly basis and build in accountability for designating patients as eligible for long term care home placements.	Yes	Monthly ALC reviews have proven to be very successful. A roll-out of the use of the ALC-LTC sign off process and documentation across LHSC is underway (currently only in use at VH Medicine). ALC reviews now include Director representatives from Parkwood Institute (providing inpatient complex care, rehabilitation, and specialized geriatric services).
Southwest LHIN Discharge Planning - SW LHIN Access to Care initiative that builds a framework to standardize discharge policies and practices across the hospitals.	Yes	The South West LHIN discharge planning toolkit is complete. The LHSC discharge policy revision process to be addressed in 2015-2016. A discharge summary to primary care project is underway with a similar aim to that of the LHIN based IDEAS project.

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6	Percentage of acute hospital inpatients discharged with selected Case Mix Groups (CMGs) that are readmitted to any acute inpatient hospital for non-elective patient care within 30 days of the discharge for index admission. % All acute patients Q2 2012/13-Q1 2013/14 DAD, CIHI	18.58	18.00	19.15	

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Implement HF-GAP "Heart Failure: Guidelines Applied in Practice" Tools in Cardiology at UH and VH, followed by implementation within Medicine at both sites.	Yes	The HF toolkit was implemented in Cardiac Care and currently data is being gathered related to the implementation in order to prepare for implementation in Medicine. Work will commence in 2015-2016 to establish a Heart Failure clinic at St. Joseph's Health Care.
COPD Clinical Pathway - Develop a clinical pathway for COPD patients to standardize the approach to care.	No	Partial Implementation - The COPD Clinical Pathway Team and education working group continue to develop the pathway and tools for patient care as well as determining appropriate education materials for both patients and educators. The work will continue into the 2015-16 fiscal year.
COPD QBP Communications to Respirologists - Earlier consultation with Respirology from ED physician and more timely access to follow-up in Respirology routine and urgent clinics.	Yes	Partial Implementation - Reviewing previous interventions that were implemented in order to build sustainability plan.

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7	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 acute patients Q3 2013/14 EMR/Chart Review	79.00	80.00	79.60	

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Provider Engagement in Medication Reconciliation - Ensure provider engagement in medication reconciliation at admission with HUGO functionality through support from SLT, Medical Affairs, Med Rec Sustainability Team and the HUGO Team. Use techniques of auditing, evaluation with feedback and also positive deviance to increase compliance. Collaborate with other institutions (as well as IMSP, SHN!) about their successes in electronic medication reconciliation. Revise workflows to increase compliance in areas that are struggling to meet targets.	Yes	The work to engage providers in Medication Reconciliation at Admission is still ongoing. Change ideas on the 2015-16 QIP are reflective of efforts to increase provider engagement and therefore improve compliance.
Emergency Department Pilot for Medication Reconciliation - Trial having pharmacy resources implemented in the emergency room (as this is a crucial entry point into the hospital) similar to the model that is currently in the Preadmission clinics at both University and Victoria Hospital. This would facilitate timely collection of the medication history into the electronic system. It would improve provider compliance to medication reconciliation	Yes	Pharmacy Technicians in the ED was a very successful pilot that saw a trend of increased quality in Medication Reconciliation at Admission. Best possible medication history was collected on admitted patients as the first step in the process and assisted in improving the Medication Reconciliation at Admission rates.

at admission as the first step (documenting the home medications) would be done. It would also improve the quality of the medication information being used since this is a proactive model of medication reconciliation (and the pharmacy staff would use various sources and unique medication expertise to obtain the best possible medication history).		
Utilization of Electronic Medication Reconciliation - Consider adjusting functions within HUGO to increase compliance with medication reconciliation at admission. For example: create alerts (or pop-up screens/reminders) that 'med rec needs to be completed'. Consider making medication reconciliation at admission a "forced function" by in turning off partial med rec capabilities.	No	Suggestions to improve functionality were itemized and prioritized. An optimization plan has been established and will be executed in Q1 & Q2 of the 2015-16 fiscal year.

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8	From NRC Picker: "Overall, how would you rate the care and services you received at the hospital (inpatient care)? (% of those who responded "Excellent" only) % All patients Q3 2012/13 – Q2 2013/14 NRC Picker	47.40	50.00	45.44	

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Patient and Family Advisors - Involved in different quality and planning committees.	Yes	LHSC now has 95 Patient and Family Advisors and is currently in the process of onboarding 22 additional advisors. The advisor roles are proving to be a great success in bringing the voice of the patient and/or family to the forefront in quality and planning considerations.
Patient and Family Engagement - In projects and on committees (e.g. EBD, patient shadow mapping, membership, surveys) to advise in formulating solutions, and to be incorporated in decision making to the maximum extent.	Yes	Several corporate projects have had and continue to have Patient and Family engagement on various levels. Patients and Families have participated in interviews, analysis of current state processes and assisted with the creation of future or new processes.
Key Standards & Behaviours for Recruitment - Orientation and Education, and Performance Development - Patient and Family Centered Care (PFCC) and Service Excellence. Goal is to have patient concerns and aspirations inspire and educate about vital behaviours and system changes for PFCC.	Yes	A number of PFCC education events have taken place at LHSC during the 2014-15 year. Patient advisors have presented at program rounds, as well as at community advisory council. Telling patient stories and communicating the importance of PFCC principles are becoming common practice at LHSC.
Patient Experience Office & Resource Centre - Establish a Patient Experience Office and Resource Centre On-site at Both Hospitals to increase accessibility to the office and supportive resources.	No	The Patient Experience Office & Resource Centres are not yet established. Working with Facilities to secure appropriate space within both hospitals has taken longer than first anticipated.

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9	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1,000 - Average for Jan-Dec. 2013, consistent with publicly reportable patient safety data. Rate per 1,000 patient days All patients 2013 Publicly Reported, MOH		0.40	0.55	

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Outbreak Management System - Utilization of standardized outbreak management alert system and accountability checklists.	Yes	Outbreak Management System was submitted to Accreditation Canada as a leading practice.
Improvement in Medication Related Risk Factors and Treatment of C. Difficile Patients - Pharmacist review of antibiotics for patients newly diagnosed with c-difficile, preprinted orders for treatment.	Yes	University and Victoria Hospital have seen greater than 95% of all C. Difficile patients antibiotics reviewed. The uptake of recommended therapy change continued to be high throughout the year. This initiative was accepted by Accreditation Canada as a leading practice.
Cleaning Pilot Utilizing New Cleaning Agent with Sporicidal Properties - 4 IP medicine UH is considered an endemic unit and therefore will be the focus on this pilot to determine efficacy and feasibility in broader deployment.	Yes	4IP Medicine at UH decreased its rate for C. Difficile by 100% over the last year.

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10	tPA Administration Rates for Eligible Stroke Patients: The number of times that tPA was administered on eligible stroke patients as a proportion of the total number of eligible stroke patients. % Eligible Stroke Patients Q1 2013/14 - Q3 2013/14 Hospital collected data	CB	80.00	80.88	

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Stroke Standardized Care Pathway - Develop hyperacute stroke standardized care pathway.	Yes	The Ontario Stroke Network report card indicator represents an increase of 19% over the last report and outperforms the benchmark hospital rate of 66%. A dashboard was established and regular quarterly reviews of data occurred.
New Stroke Unit - Opening of hyperacute stroke unit on 7IP UH with exclusive tPA bed.	Yes	The Hyperacute Stroke Unit went into full operation during the 2014-15 year and results were monitored on a monthly basis.
Code Stroke Process - Defined and initiated for admitted patients at both UH and VH.	Yes	Code Stroke Process was fully operational at both sites. Process improvements were addresses as they arose and ongoing education and communication continue into the 2015-16 fiscal year.