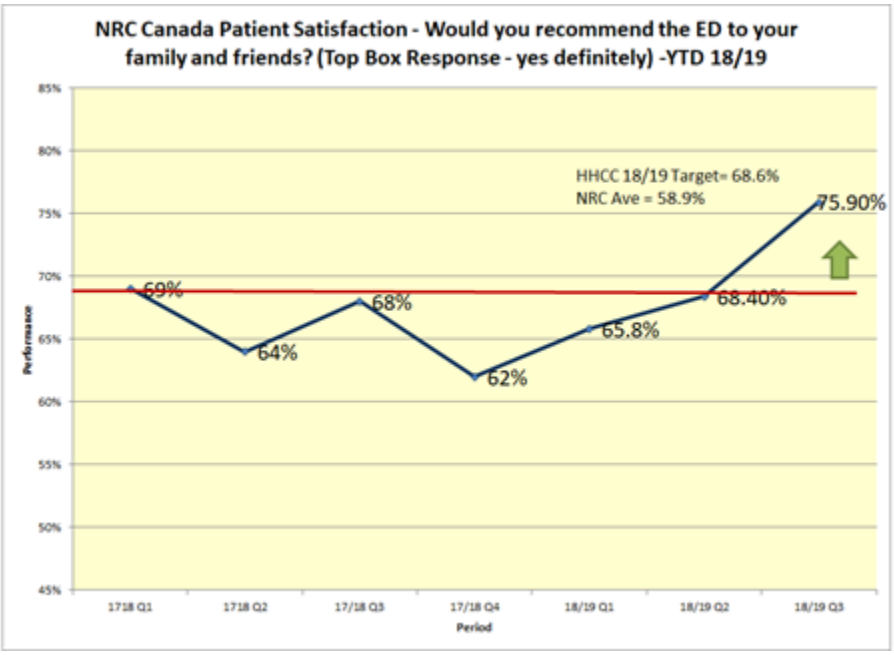
Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2018/19 QIP Final Approved

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 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
1	"Would you recommend this emergency department to your friends and family?" (%; Survey respondents; April - June 2017 (Q1 FY 2017/18); EDPEC)	916	68.60	68.60	65.80	Current performance data shows a increase of 10.8% at Q3 18/19 (75.9%) from Q1 18/19 (65.8%). All key drivers from NRC survey were within provincial benchmarks. Trends from themes for improvement included reducing wait time and talking to patients on arrival to ensure they are informed of wait times/delays. This is a focus for 19/20.



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Continued implementation of ED Flow Project to improve patient experience and increase patient satisfaction to improve % of patients who respond "would definitely recommend this emergency department".	Yes	Redesign of ED areas within Fast Track and Sub Acute areas,new processes established to support streaming patients to appropriate areas. Reduction in the number of patients leaving the ED area without being seen (LWBS) from 4.1 to 2.7 average, and improvement in initial physician assessment times (PIA)
Improve waiting room experience in ED and ensure patients are aware of any delays and their steps in care.	Yes	New signage introduced to demonstrate steps in care. 70% of patients reported that signage and ticket machine made a positive improvement to their experience.
From feedback themes in ED Patient Satisfaction Survey reduce common themes related to negative feedback to improve the patient experience to Yes Would definitely recommend.	Yes	Utilized Experienced Based Design (EBD)approach questionnaire in the summer to understand how patient feel about their experience.
Development and implementation of discharge advice/information for patients following treatment in ED ensuring that "steps in care" continue long after the patient is discharged and with the aim of reducing readmission.	Yes	Developed discharge advice for patients with COPD utilizing Patient Orientated Discharge Summary (PODS) approach. This was implemented within ED and inpatient areas. Drafted further instructions utilizing PODS template for implementation in 2019.

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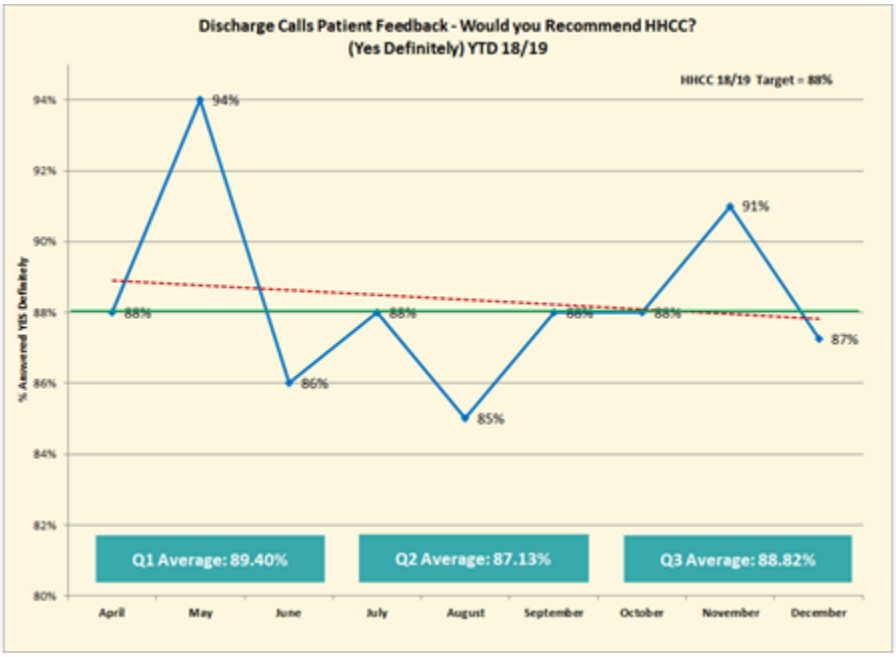
2	"Would you recommend this hospital to your friend and family?" (inpatient care) (%; All inpatients; April to June 2017; Inpatient Discharge Calls)	916	84.48	88.00	89.40	Our improvement for inpatient experience "Would you recommend" is really due to the improvement in communication (hourly rounding, bedside shift report etc.) and ensuring patients are partners in their care, knowing what is important to them.



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Redesign and implementation of patient Whiteboards to improve communication with patients, families and care team.	No	Abandoned.Following extensive efforts, the proposed amendments to the whiteboards did not warrant expense associated with a refresh. Making every dollar count, we recommitted to using the whiteboards available at the bedside.

Refresh of inpatient unit daily team performance huddles to communicate inpatient discharge survey feedback and improve awareness and effectively communication of themes that impact "would you recommend".	Yes	Team Huddles refreshed and Communications Boards updated. Work continues to set out relevant metrics to support patient safety and team problem solving/opportunities for improvement. Standard work for leaders in areas.
Establish Patient Engagement Strategy and improve methods for patient engagement which will support improvement of patient engagement.	Yes	Three year roadmap to enhance Patient Family Engagement developed and approved. Recruitment drive during Spring which assisted in recruiting 10 Patient Family Advisors (year to date)with the development of a recruitment flyer and role outline for Patient Family Advisors. Established the Patient Family Advisor Partnership at the later end of the year and will continue to build and develop the strategy over the next two years.
Address common themes arising from monthly inpatient survey relating to professionalism and communication. Completion of College of Nursing Learning Modules relating to nurse-client relationships and professional relationships.	Yes	Learning module uploaded to Learning Management System for e-learning. Staff can take modules independently and will move to being assigned to staff later this year (this was due to technical issues with the Learning Management System).
Adopt "bedside shift report - Transfer of Accountability" with 1:1 nursing on inpatient units.	Yes	Bedside shift report implemented on two inpatient units with transfer of accountability (TOA) occurring on a 1:1 nursing basis and involvement of patients and loved ones. Resulted in improved patient/nurse relationship and trust.

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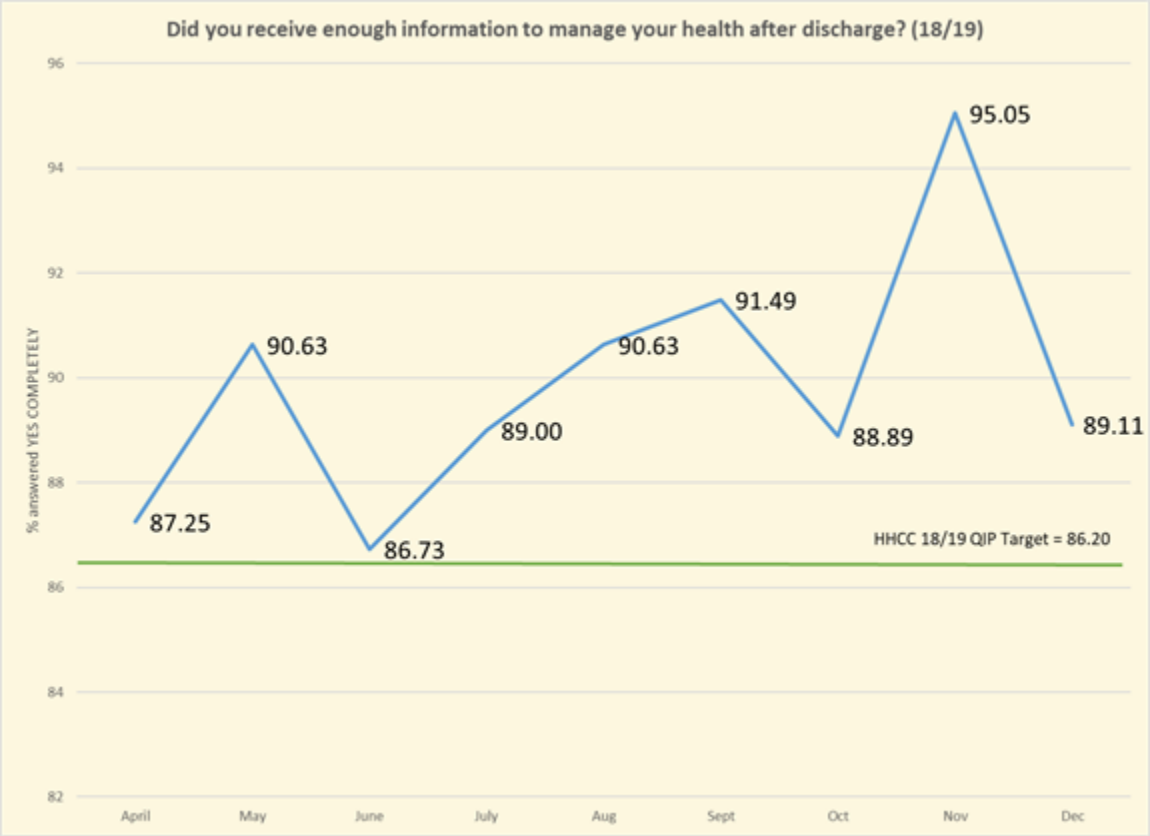
3	Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital? (%; All inpatients; April to June 2017; Inpatient Discharge Calls)	916	86.20	86.20	88.20	We are really pleased that our patients have the information they need in order to manage their health condition after they are discharged, and who to contact. There has been a continued focus on discharge practices and management to ensure that patients needs are met and they are supplied with all the information they require. Utilizing PODS has been one initiative that we are hoping to spread further during 19/20.



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Development and implementation of Discharge Checklist for patients and clinical teams to ensure that early preparation for discharge is commenced on admission.	No	Development of the checklist became part of the Patient Orientated Discharge Summary (PODS) via the Patient Care Guide and through teach-back methods with patients. A separate checklist was not developed as further exploration deemed not value-added.
Design discharge patient information package to provide helpful essential information to patients when being transferred from hospital to home.	Yes	Utilizing Patient Orientated Discharge Summary (PODS) methodology a Patient Discharge Care Guide template was developed for COPD patients, with the intention of continuing with PODS for other specialities and programs over the next year.
Educate staff in the principles of teach-back methods as a strategy to enhance patient education and support post discharge.	Yes	Teach-back e-learning module developed and assigned to all nursing teams. Clinical Resource Nurses implementing PDSA cycle for COPD Patient Discharge Care Guide demonstrated teach-back methods with patients for education and learning of the wider nursing teams.
Review and refresh of Patient Whiteboards communication tools on inpatient units.	No	Following extensive engagement efforts, the proposed amendments to the whiteboards did not warrant expense associated with a refresh. Making every dollar count we recommitted to using the whiteboards available at the bedside.

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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. (Rate per total number of discharged patients; Discharged patients ; October – December (Q3) 2017; Hospital collected data)	916	84.22	84.22	94.07	Our improvement in performance can be attributed to the great safety culture we have at Headwaters. Teams recognize the importance of medications management and ensuring patients are aware of their medications, therefore medication reconciliation at discharge has been a priority.

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Roll out BPMH (Best Possible Medication History)into Day Surgery and Obstetrics	Yes	Medication reconciliation upon discharge was implemented successfully in obstetrics. BPMH in Day Surgery implementation continues.
Expand nursing training for BPMH and Medication reconciliation. Improve knowledge and standard of collection of BPMH within the nursing teams on inpatient units.	Yes	Learning module available from September 2018. Assigned to OBS nurses first to ensure successful roll-out of medication reconciliation on discharge. Delays occurred with this initiative due to recruitment/transition of Leadership in Pharmacy. Audit of nursing documentation on transfer between units for BPMH demonstrated 70% completed accurately.
Refresh education materials relating to roles and responsibilities in medication reconciliation in order to support expansion of nursing taking BPMH on inpatient units and support of	No	Due to recruitment/transition of Leadership in Pharmacy and emerging priorities this change idea was not implemented.

wider interprofessional team members.		
Patient and public awareness campaign to increase awareness of "knowing your medications".	No	Due to recruitment/transition of Leadership in Pharmacy and emerging priorities this change idea was not implemented in it's entirety. Medications Management and Awareness was completed as part of Patient Safety Week leveraging the "Know Your Medications" campaign.

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5	Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period. (Count; Worker; January - December 2017; Local data collection)	916	45.00	45.00	28.00	Unfortunately we had limited success this year relating to change ideas for reducing workplace violence incidents. Our goal for 19/20 is to support teams through education/training and enhance the reporting culture in order that staff feel confident to report workplace violence incidents. While not all of the change initiatives for this indicator were completed, we implemented several changes to mitigate risks of workplace violence within our hospital.

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Develop Sub Committee steering group which reports to Joint Health and Safety Committee	No	Sub-committee not developed but leveraged Joint Health and Safety Committee. Plans to develop the sub-committee have been rolled over to QIP 19/20 plan.
Conduct a workplace violence risk assessment survey to assess the current risks of workplace violence to inform revisions to workplace violence prevention policy and programming.	No	Delayed. Pre-risk Assessment and Risk Assessment survey scheduled for Spring 2019 and this change initiative has been rolled over to QIP 19/20 plan.
Introduce new workplace violence indicators to Headwaters' corporate dashboard to engage stakeholders in the monitoring of	No	Delayed. Rolled over to QIP 19/20 plan

metrics related to workplace violence		
Revise employee Safety Quality Information System (SQIS) to enhance information gathering related to workplace violence events so that themes can be readily identified and addressed.	No	Delayed. We are unable to modify SQIS at present due to capacity issues with technical experts. We have however modified our reporting of incidents and have established a tracking baseline for FY 2017/18 are trending it against FY 2018/19. Benchmarking will be completed in Q4 2018/19. Rolle dover to QIP 19/20 plan.
Complete and validate a workplace violence prevention training needs analysis that will inform our educational needs and requirements.	No	Delayed. Rolled over to QIP 19/20 plan.

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6	Percent of palliative care patients discharged from hospital with the discharge status "Home with Support". (%; Discharged patients ; April 2016 - March 2017; CIHI DAD)	916	91.89	91.89	85.00	Change ideas related to this indicator proved challenging, due to the collaborative nature of the ideas and requirements to gather data between partner organizations. This continues to be a focus for Headwaters and we are evaluating and investigating data collection and sources and understanding the new QIP 19/20 indicators relating to palliative assessments.

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Early identification of patients who are palliative when attending in Emergency Department and on admission to inpatient unit.	No	Explored mechanisms for early identification for palliative needs in the Emergency Department and discussed with community partners in Home and Community Care and Family Health Teams. We continue on this improvement journey in 19/20.
Socialize the HQO Quality Standards for Care for Palliative End of Life patients (DRAFT)with the multi-disciplinary team in order to embed the quality standards of care.	Yes	Standards socialized with Clinical Leaders for review and action planning during 2019.
LEAP (Learning Essentials Approaches to Palliatve)Training to be accessed for interprofessional training relating to palliative care/end of life care practices and shared knowledge.	No	Abandoned with LEAP training not delivered during this year. Reviewing education needs/gaps for Approaches to Palliative Care/Needs.
Implementation of enhanced Palliative Order Set which is based	Yes	Palliative Order Set approved and implemented. Next steps include review

on best practice evidence of palliative care.

of compliance ensuring palliative care approaches are adopted.

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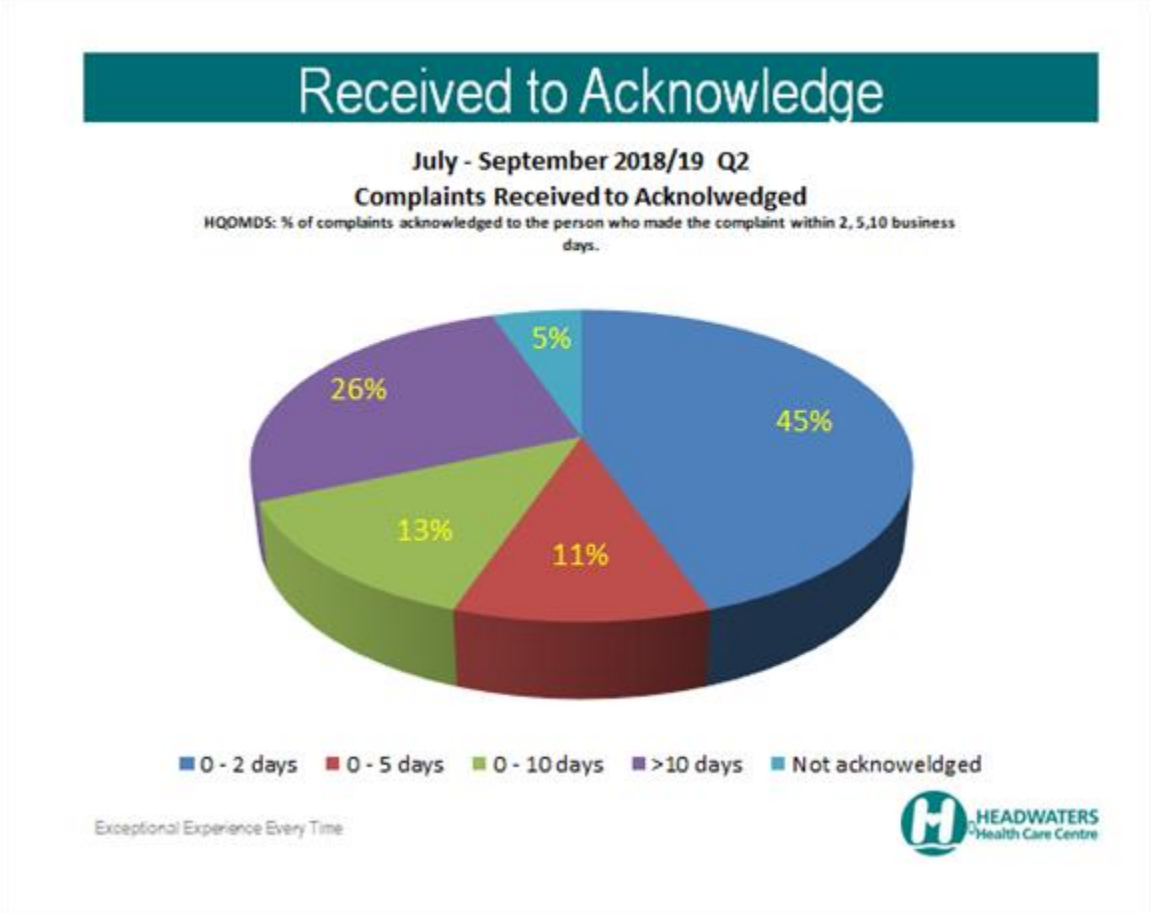
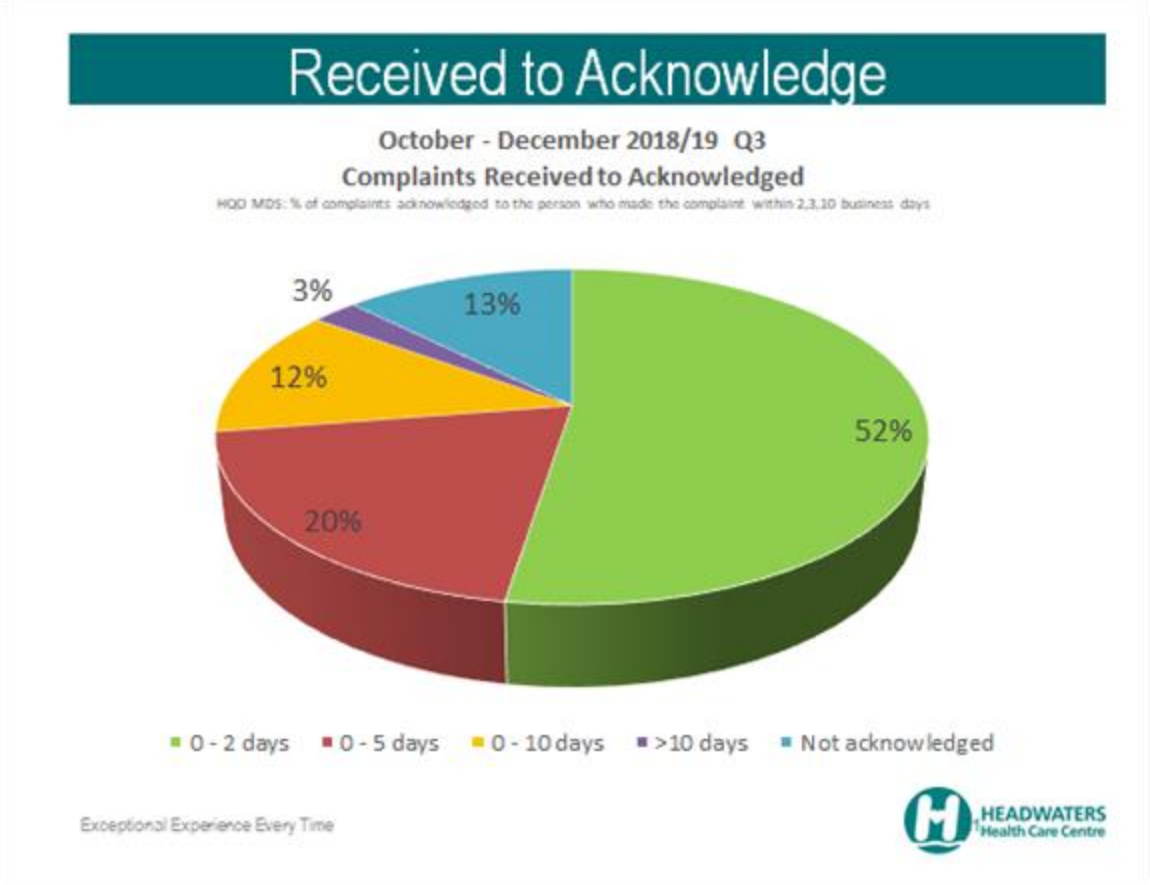
7	Percentage of complaints acknowledged to the individual who made a complaint within three to five business days. (%; All patients; Most recent 12 month period; Local data collection)	916	CB	CB	61.00	Through review of complaints our anecdotal belief is that complaint feedback experience is more consistent, with process and policy being followed. Our existing reporting systems and mechanisms are under review with further improvement to be made during 19/20. Please note our performance is based on 6months of data during 18/19.





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Revision of Patient & Family Feedback Management Policy to enhance policy, process and education for teams relating to patient feedback and compliant process.	Yes	Revision of policy, approved and disseminated.
Revision of Safety Quality Information System (SQIS) in order to ensure reporting categories are aligned with HQO framework.	Yes	Revised Safety Quality Information System (SQIS) to facilitate reporting as per HQO requirements to identify complaint themes and proactively look to ways of reducing complaints in these areas. Report is shared quarterly with Clinical Leadership Team.
Revision of Safety Quality Information System (SQIS) in order to accurately calculate time to acknowledge complaints	Yes	Development of data extract report from Safety Quality Information System (SQIS)facilitating accurate reporting of acknowledgement times

as per HQO standards of 3 to 5 business days.		for complaints. Report is shared quarterly with Clinical Leadership Team.
Provide education and learning on new process and categories for Leaders managing complaints through the Safety Quality Information System (SQIS).	Yes	Education sessions delivered during April and June 2018 with handouts on how to file feedback and manage feedback in the system to closure. Education conducted with new leaders as they join the organization.

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8	Rate of psychiatric (mental health and addiction) discharges that are followed within 30 days by another mental health and addiction admission (Rate per 100 discharges; Discharged patients with mental health & addiction; January - December 2016; CIHI DAD,CIHI OHMRS,MOHTLC RPDB)	916	20.79	20.79	20.30	Calendar year for 2017 readmission for internal readmissions was 7.6% during 2018 readmission rate increased to 8.6%. Overall for readmissions to all facilities rate decreased.

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Evaluate Health Quality Ontario (HQO) Quality Standards for Major Depression in order to assess adherence and compliance with recommendations and quality statements.	Yes	Quality Standards circulated to Leaders and Physicians for consideration and understanding the current state.Standards reviewed as part of Management of Aggressive Behaviours training which has been completed in the organization by 101 staff.
Patient have a coordinated crisis care plan when they are assessed in Emergency Department.	No	The team spent some time reviewing the change idea and realized that 100% of patients identified by ED team as requiring crisis plan have a plan completed. Further work to review coordinated crisis care plan needs.
Continue to work and support the Sub-Region Collaborative for Mental Health initiatives	Yes	Leadership attendance at Sub-Region Collaborative meetings with themes, work plans shared.
Continue to work with William Osler Health System to improve access to Ontario Telemedicine Network (OTN) and psychiatry services.	Yes	In house OTN psychiatry services available via OTN 4 days a week 6 hours session

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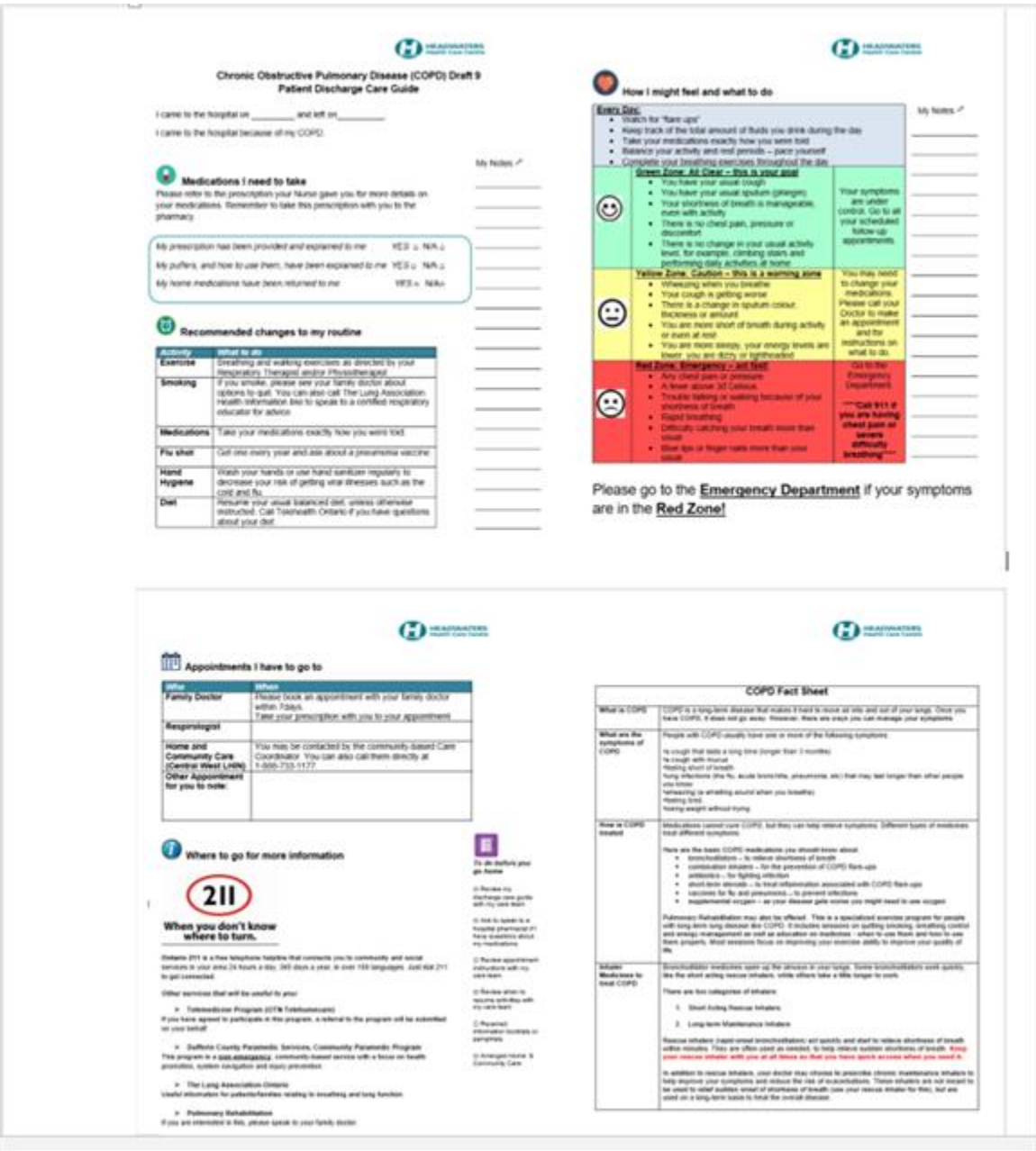
9	Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort) (Rate; COPD QBP Cohort; January - December 2016; CIHI DAD)	916	18.57	16.57	20.26	It will take time to seek the improvement from the change ideas in the COPD readmission data (all admissions) as the data requested for comparison is 2017.


Chronic Obstructive Pulmonary Disease (COPD) Draft 9
Patient Discharge Care Guide

Medications I need to take

Recommended changes to my routine

How I might feel and what to do

Please go to the Emergency Department if your symptoms are in the Red Zone!

Appointments I have to go to

Where to go for more information

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When you don't know where to turn.

COPD Fact Sheet

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Implement Enhanced COPD Order Set	No	Delays encountered. Order set revisions proposed and awaiting approval for implementation during 2019.
Develop and implement enhanced COPD Education for staff.	Yes	Teach back e-learning module developed and assigned 100% of nursing teams together with COPD Patient Discharge Care Guide (PODS)
Identification and referral of patients at high risk for readmission to HealthLinks Program.	Yes	Implementation completed. Blaylock score is communicated during rounds, patients at high risk pf readmission based on this score will be recommended for HealthLinks during morning rounds. Triggers Home and Community Care referral which links to Healthlinks.
Development of discharge information package for COPD patients.	Yes	COPD Patient Discharge Care Guide developed as part of PODS initiative. Headwaters is a member of the Community of Practice for PODS, gathering and sharing ideas to develop new PODS. Feedback sought from inpatients during design phase. Completed PDSA cycle gathering feedback from patients within the inpatient and Emergency Department areas. Received positive feedback from 3 patients.
Explore opportunities to optimally link patients with remote monitoring program from Paramedic Dufferin Services.	Yes	Data shows a decline in referrals to this program since 2015 (from 230 to 109). Working with Paramedic Dufferin Services to review communication/marketing of the program to ensure patients and staff are aware and data recording is ongoing.

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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 - September 2017; WTIS, CCO, BCS, MOHLTC)	916	13.34	13.34	7.81	Headwaters continues to have a low ALC rate and the improvement in performance is a testament to the hard work related completed this year through our change initiatives.

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Implementation of Blaylock Risk Assessment Screen Tool (BRASS) for early warning of increased length of stay and therefore can assess needs of elderly patients who are ALC and assess their needs as early as possible.	Yes	Blaylock tool implemented in three inpatient areas in July 2018.August 2018 audit data showed 309 admissions/309 audited (July 36/60 had tool applied, Aug 69/119) 20 patients readmitted.
Inpatient Care Team Education relating to ethical dilemmas, substitute decision making, Power of Attorney in order to support the discharge process and therefore reduce ALC days.	Yes	Four sessions offered. This education ensures that care providers are aware of current process and policies concerning ethical dilemmas, substitute decision making, power of attorney and can provide support required to patients and families relating to decision making.
Positive identification of ALC patients on discharge promotion whiteboard to improvement discharge planning and provide support to patients and families.	Yes	Charge Nurses review Bed Roster by nursing unit which designates ALC patients and at Daily Discharge Promotion Round and ALC Weekly Meeting to review and expedite patients and ensure appropriately indicated as ALC. Improvement seen in ALC rates by 5%

Improve coding for ALC patients. Review of coding on a quarterly basis.	Yes	Partially achieved. Audits completed earlier in the year found some coding errors relating to Mental Health patients which was corrected. Bed Meeting and Reporting Tool has improved discussion around ALC status and team work around allocation of ALC patients