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
1	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)	674	100.00	100.00	81.00	81% based on February data, we expect to meet the target in March.

Realizing that the QIP is a living document and the change ideas may fluctuate as you test and implement throughout the year, we want you to reflect on which change ideas had an impact and which ones you were able to adopt, adapt or abandon. This learning will help build capacity across the province.

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?
The following two key parameters are essential to completing a medication reconciliation on admission: 1. There is a documented Best Possible Medication History (BPMH) 2. There is evidence (which could be done retrospectively) to show that admission orders are reconciled against the BPMH. This project will ensure that the above 2 items are complete with 83% of patients at the West 5th campus at St. Joe's.	Yes	What worked well: Considerable background work had been completed to bring us to a state of readiness before the initiative began. The working definitions for what constituted medication reconciliation and best-possible medication history for the organization had been carefully described in advance not only at a theoretical level, but practices and tools to support these definitions had been readied. Then dedicating a clear resource whose principal goal was to complete the med rec process in our new building created capacity and clear accountability. The new approach also resulted in greater pharmacist involvement on the units, and the team,

particularly psychiatrists, found the new information to be helpful which reinforced this initiative as something clinically relevant. A virtuous cycle of capacity building and utility was created. Challenges included staff absences, to which we were vulnerable since the number of staff supporting this practice was quite limited. Very short, “after hours” admissions were sometimes a challenge as there was not enough time for the process to work for 100% of admissions. Lessons learned: To accomplish dedicated and expert clinical work, a specific resource should be trained, tasked, and accountable for that work. Contextual factors will be important, supplying consistent tools and definitions allowed this process to come to full speed in a short time frame.

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2	Number of patients with NEWS scoring system applied. (completed on chart; All patients on 2 surgical units; By end of 2015/16; Hospital collected data)	674	0.00	100.00	100.00	SJHH has committed to implementing NEWS on 2 in patient surgical units by year end. We were successful in implementing on 3 in patient surgical units.

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To improve the early detection of sepsis. Early warning signs often go unnoticed. We will implement the evidence-based documentation of vital signs using the NEWS scoring system.	Yes	• Started with a unit that was ready. This is a unit with a very active Nursing Council. The new vital signs tool was tested on this unit; the members of the interdisciplinary team on this unit (including nurses, residents, and staff physicians) were pleased to be able to provide the implementation team with daily feedback. The teams assisted in making improvements and also initiated a nursing research project and clearly identified that patients with a history of COPD consistently scored high with the NEWs tool. • COPD- due to the underlying comorbidity associated with these patients, it became clear that NEWS was not appropriate. This finding set us on the journey to find CREWS, NEWS like tool, developed and tested in Wales. SJHH is adopting CREWS for our large COPD patient population. • New vital signs policy was needed. This project required a standard approach to frequency of measurement of vital signs and the need for all areas to include pain assessment as part of their routine vital signs approach. • NEWS has provided the clinical teams with a common language for describing a patient's status. Having a numeric score to attach to a clinical scenario appears to be especially helpful to new practitioners who are perhaps less skilled at detecting subtle changes in a patient's condition that could herald significant deterioration. Using a NEWS score at time of transfer from Unit to Unit gives staff assuming

care for a patient an instant picture of the general condition of the patient. • Having a strong and committed project implementation team which included Senior Executives, Quality Team Members, Nursing Leadership/Education, and Physicians was invaluable to managing the implementation and the change associated with implementation of this tool. • Tell stories- the team was able to identify incidences of patients being identified early due to their NEWs score which positively impacted their care and outcome.

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3	Patients who receive a plan of care within 48 hours of admission (chart completion; All acute General Intarnal medicine patients in GIM beds; End of 2015/16; Hospital collected data)	2003	0.00	0.50	0.26	The LHIN directed Home First Refresh initiative first started at SJHH in late 2014. A corporate advisory committee was struck with representation from all clinical service areas and the LHIN toolkit was shared. Key milestones in the Home First Refresh include the 48 hour conversation, a family meeting (formal or informal such as a phone call), ALC designation as appropriate with a CCAC referral happening beforehand. This project focused solely on the 48-hour conversation.

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Implement standardized and documented practice to discuss the care plan with patients and families and to discuss iwth the Family physician.	Yes	The 48-hour conversation includes diagnosis, estimated date of discharge, and identification of discharge barriers. A process was developed by which a bright orange sticker that includes all of the pieces which need to be documented. The sticker is flagged by the charge nurses, and brought to rapid rounds where it is distributed to the teams. On non-rounding days the sticker is simply placed in the chart in the physician progress notes. Most recent audits show we are able to get the stickers consistently on to 50% of the charts, and 34% of our patients have a documented conversation. There is still work to be done, but the basic process has been developed, and week over week we are seeing improvement. A large hurdle for us is our mostly paper-based charting and the

need to develop an electronic method of tracking the progress of this implementation. Lessons learned are very similar to other large changes; start small and engage stakeholders early in the process. The success gained so far is due largely to the fact that the process was brought to the clinicians respecting their already busy day. We are pushing this target to 80% for next year and anticipate seeing an improvement in patient satisfaction related to communication as well as contributing to a decrease in ALC days as patients and families will be better informed from the start.

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4	Percent of inpatient units at Charlton Campus that have implemented daily safety briefings. (Number of units; Inpatient units at Charlton; By end of fiscal 2015/16; Hospital collected data)	674	10.00	70.00	81.00	This has been a successful initiative; involving more inpatient units than initially intended.

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Standardize safety briefings on 70% of our inpatient units, plus the Emergency Department and the Operating Room, with the use of at least 1 safety cross.	Yes	There were 3 key success factors to this initiative: - the leading of the safety briefings to a charge nurse or team leader so not dependent on the clinical manager - frequent feedback and monitoring of the implementation of the process - strong leadership presence to stress the commitment and importance of this initiative.