Excellent Care for All
Quality Improvement Plans (QIP): Progress Report for the 2015/16 QIP

St. Joseph's Health Care London – Corporate (excluding Mount Hope)

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
3	From NRCC: "Overall, how would you rate the care and services you received at the hospital?" (percent of those responded Excellent) - PARKWOOD INSTITUTE COMPLEX CARE (%; Complex continuing care residents; 2014-2015; NRC Picker)	714	15.60	20.60	31.30	Target met and exceeded

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?
Implement leader rounding on patients.	Yes	Leader rounding on patients provided opportunity to improve the patient experience of our care. Information collected during rounding was used to identify improvement opportunities. The initiative provided impactful patient stories to motivate change among the team. Rounding allowed us to audit the success of Intentional Comfort Round (ICR) implementation and to collect the information to consider addressing the communication gaps for our patients.
Embed Intentional Comfort Rounding (ICR) into routine practise on all CCC units.	Yes	The intent was to embed an intentional approach to patient rounding. The approach enhanced the traditional nursing hourly checks to proactively address care needs to optimize satisfaction and patient safety (pain, positioning, environment, and toileting). Adoption was challenging as nurses struggled with the distinction between hourly checks and ICR. It was essential to engage front-line staff in integrating this best practice with others within the patient specialty and their shift work flows.
Enhance patient experience focusing on proactive communication to patients and families.	Yes	A review of all transition points was completed to ensure proactive communication was provided to patients. The focus was on patient safety and anticipating patient questions and concerns. Admission safety packages are now provided on admission. Checklists were created for all transition points to ensure consistency of essential communication for patient safety and experience of care.

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4	From NRCC: "Overall, how would you rate the care and services you received at the hospital?" (percent of those responded Excellent) - PARKWOOD INSTITUTE MENTAL HEALTH (%; Mental Health / Addiction patients; 2014-2015; NRC Picker)	714	22.80	27.80	14.50	Although the % excellent score decreased by 8.3%, the overall percent positive score increased by 4.16%. In 2015-16, 72.6% of patients answered “excellent”, “very good” or “good” to the question “Overall, how would you rate the quality of care and services provided?” as compared to 68.4% in 2014-15 and 66.7% in 2013-14.

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Continue with Patient Story Roll Out with revised plan Roll out to all IP and Ambulatory areas	No	The patient story tool has been partially rolled out to some of the inpatient units at both mental health sites. In these areas it has been successful in creating patient centred care plans and relevant patient engagement activities. Most units currently use the nursing history and create a safety plan. Our work plan for 2016/17 is to create a structured patient day inclusive of partnering with patients for care plan development, and the use of a patient story and nursing history tools to provide a recovery based, patient specific, care plan. Hardwiring leader rounding with staff was more of a challenge than anticipated. Q4 results marked significant improvement. Q3 progress included hardwiring leader rounding with patients and was initiated. Monthly targets set and measurement to begin April 1, 2016
Implement framework for use of AIDET by IP and OP staff on daily basis	No	The framework has been developed by a working group from Nursing Council. The intention was to roll it out simultaneously with another initiative and that has created a delay due to paucity in facilitation resources. This work is being introduced in the programs at the South West Centre and will continue to be implemented across all Mental Health units by the end of Q4 2016/17.
Continue to monitor and improve level of meaningful activities for patients by reporting and validating results with patient and family councils and Quality Recovery & Advisory Council.	Yes	A meaningful activity working group has been formed on partnership with patient and family council and input directly from patients. Impacts have been made by creating enhanced communications across programs about patient activities and new equipment and supplies have been purchased. Engagement with community partners has been initiated to create workshops and activities that will bridge transition to community. Recommendations support the engagement of passionate staff and this allows for innovation and partnership development. The patient survey results for 2015/16 indicated a 6.6% increase in leisure activities, an 8.7% increase in feeling safe in the hospital and an increase of 4.4% in feeling comfortable in asking questions about treatment (medication & counseling).

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				2015/16	2016	
5	Hand hygiene compliance(moment 1-before patient contact) (%; Observations (via audit); 2014-2015 (Q3); Hospital collected data)	714	92.00	95.00	93.00	This indicator is included in our 2016-17 QIP as we continue to work to meet the target.

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?
Ensure consistent knowledge and understanding of requirements	Yes	New e-learning on hand hygiene was developed and rolled out to all staff and physicians regarding proper technique and expectations. During development of the e-learning it was very helpful to gain input from various roles to ensure content was understandable by various roles with different levels of education and experience. Creating our own module enabled us to make learning more relatable to St. Joseph's staff by including scenarios specific to our organization. It also allowed us to link the learning to our strategic priorities (embracing the relentless pursuit of safety, ensuring patients and families are partners in their care). Lastly we were able to include terms and phrases familiar to St. Joseph's that describe key Vital Behaviours expected of all staff and physicians to achieve compliance with hand hygiene. Anecdotal feedback has been positive indicating the learning is more interactive, relevant and clearly outlines expectations.
Strengthen and clarify expectations of staff/physicians to comply with hand hygiene	Yes	The corporate policy on hand hygiene was revised. It was effective to gain support from various groups regarding inclusion of more specific expectations and accountabilities prior to presenting changes for final approval. Outlining clear leadership accountabilities in the policy allowed for leaders to develop more effective 90 day plans to meet their accountabilities, as part of the overall plan to meet the strategic indicator of 95% compliance with hand hygiene.
Define tiered accountability structure	Yes	A framework to address individual and unit accountability was developed. SLT and MAC engaged. Being clear about leadership accountabilities and holding leaders accountable gets results. Leaders reporting up to VPs on strategies to achieve results appears to have been effective (reporting on Influence Plans as well as through LEM 90 day plans). SLT engaged. Leaders submitting written action plans with clear timelines are essential. Establishing a specific and consistent method of reports would improve the quality of reports. (Two methods were used last year- The Influence Plans and LEM 90 day plans.) SLT engaged. Acknowledgment of improvements and accomplishments is critical for success. Further enhancements tour accountability framework are planned for next year. For example, engaging physicians in determining methods of ensuring accountability among peers has only partially occurred and remains essential.
Focus on expectations re hand hygiene as	Yes	Leaders completed routine practice audits and identified strategies to

part of routine practices in ambulatory care areas		address barriers to hand hygiene compliance specific to their areas. It proved helpful to focus on hand hygiene as part of a broader audit of practices/environment to support routine practices in reception areas. This reinforced the importance of hand hygiene as one component of routine practices. Completing the audit with a clinician and leader from the area, an ICP and a member of Facilities was helpful to problem solve any issue on the spot that required Facilities interventions.
Ensure placement of ABHR at Parkwood Institute and SWC in all in-patient care areas.	Yes	A review of ABHR dispenser placements was coordinated by IPAC and completed for Parkwood Mental Health Building and Southwest Centre. Leaders are accountable for the ongoing assessment and maintenance in their areas. Coordinating the review with Facilities personnel is essential to avoid delays in installations. Future refurbishing of space should include a review of dispenser placements as part of planning process. Clinical perspectives related to risk of having dispensers/contents in mental health areas is important and needs to be balanced with requirements to meet standards to prevent infections. Also clinical input is necessary to discern key locations related to work flow.
Focus strategies to improve likelihood of staff /physicians adopting 3 vital behaviours for hand hygiene compliance	Yes	The Influencer model was used to create corporate and program specific plans to ensure all staff adopt vital behaviours. Having a corporate Influence Plan created an example and provided consistent expectations of all clinical areas/leaders. Making this an expectation of each clinical area was effective in engaging staff to provide input into strategies unique to their programs. Finding methods to share creative strategies among teams is important to grow and acknowledge leading practices.
Improve patient and family engagement in ensuring hand hygiene practices	Yes	A model was developed whereby patients/families and visitors can provide feedback on the healthcare providers hand hygiene practice. Linking this initiative to the strategic priorities of embracing the relentless pursuit of safety, and ensuring patients and families are partners in their care, helped everyone understand its importance. Having large visual reminders (elevator wraps, posters, buttons) inviting patients and families to ask clinicians if they have washed their hands seems to have also had the positive effect of having patients/families clean theirs as well. Other methods used within specific clinical programs have also demonstrated the willingness and gratitude of patients/residents and families to be engaged in ensuring hand hygiene practices.
Ensure observations are consistently being performed in all areas by nonbiased trained observers	Yes	Leaders contributed auditors. There is a process to ensure all areas audited, ideally with different auditors. It is helpful for smaller programs to share an auditor. While ideally auditors should be from different programs, it is challenging within many environments to do this without being noticed. Setting targets for number of audits to be completed and providing auditors and leaders with actual number of audits completed has proven helpful to ensure adequate number is being completed for reliable data. Reviewing auditing practices regularly among auditors is necessary to ensure

		consistency in auditing practice.
Across outreach programs where direct observation audits cannot be performed, self-auditing and regular education with Glow Germ (to provide feedback on technique) was implemented.	Yes	While not included in this QIP indicator, it is essential to ensure methods are in place to educate and monitor compliance with hand hygiene in areas where direct observation is not achievable. Having various methods of evaluation enables community based clinical staff to also be engaged, participate and receive feedback on their contribution towards the strategic priority of the relentless pursuit of safety – everywhere, related to hand hygiene.

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6	Hours of seclusion and restraint per Quarter at Parkwood Institute Mental Health and Southwest Centre for Forensic Mental Health Care (Hours; Mental Health / Addiction patients; 2014-2015 (Average Q1-Q3); Hospital collected data)	714	6349.00	5714.00	11009.00	Monitoring of trends over quarters revealed peaks and troughs with an overall increase in total hours of seclusion and restraint. Analysis indicated that a small number of patients were consistently accounting for a large percentage of the hours.

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?
Leadership Towards Organizational Change	Yes	Significant emphasis on leadership accountability and monitoring is required. Unless there are formalized processes, the leadership oversight and monitoring can be inconsistent.
Use of Data to Inform Practice	Yes	Considerable time and effort was committed to understanding the results we were seeing. This review has led us to revising our indicators going forward. A significant learning has been that we jumped quickly to a quantitative outcome (# hours) without paying enough attention to process measures which, if not hardwired into practice, would prevent us from reaching our targeted outcome.
Use of Data to Inform Practice	Yes	Ongoing analysis and testing of a number of different indicators to better understand the clinical significance of the data and impact of a small number of outliers was very helpful and has enabled us to develop improved metrics to measure our progress going forward (e.g. median and 90th percentile hours of seclusion and restraint per 100 patient hours, number of episodes and % of episodes with debrief).
Use of Data to Inform Practice	Yes	Data quality was an issue requiring attention. Audits revealed discrepancies in documentation of seclusion incidents in the patient safety reporting system and power chart resulting in a lack of confidence in our data. Advice is to assess and confirm data quality early on to ensure valid baseline and implement standard audit processes.
Workforce Development	Yes	
Use of Alternatives to Seclusion and Debriefing Practices	Yes	Audits revealed personal safety plans were being completed on all patients, however, increased attention was required to ensure that the plans were being revisited and revised as necessary based on results from the post seclusion debriefs (plans as a living document vs. completed and filed).
Policy Update- Three aspects of our evolving work require inclusion in the current Minimal Use of Restraint Policy	Yes	

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7	Medication Errors per Quarter Classified as Wrong Drug/Wrong Patient (Counts; All Medication Administration Events; 2014-2015 (Average Q1-Q3); Hospital collected data)	714	8.00	3.00	4.00	This has been a quality improvement success story, with a sustained decline over the past 2 years from 21 errors in Q3 2013-14 to 4 errors in Q3 2015-16. This indicator will continue in the 2016-17 QIP.

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Ensure clarity around expectations of process for medication administration	Yes	Better understanding for lack of compliance seen at times
Enhanced medication error review with detailed information distributed regularly to leaders within pharmacy and nursing	Yes	Agreement on definition of “wrong drug/wrong patient” is required
Continue to improve compliance with barcode scanning.	Yes	There are still opportunities for bypassing scanning processes

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8	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; 2014-2015 (Average Q1-Q3); Hospital collected data)	714	84.10	95.00	90.20	This indicator is included in our 2016-17 QIP as we continue initiatives to meet the target.

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?
Increase compliance with completing med rec on admission	Yes	In specific pilot areas
Increase quality of med rec on admission	Yes	In specific pilot areas

D	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
11	Number of patient falls per Quarter resulting in injury at Parkwood Institute Main Building. (Counts; Inpatients Parkwood Institute Main Building; 2014-15 (Average Q1-Q3); Hospital collected data)	714	50.00	45.00	46.00	Focus of 15/16 was embedding post falls processes within clinical teams. Processes (including documentation) were reviewed and improved, and refresher education provided as needed.

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Enhance level of communication of falls, falls strategies, and successes at Parkwood Institute Main Building.	Yes	Processes implemented include immediate assessment (captured within our Patient Safety Reporting System) and printing the Falls Summary / placing on the chart) and the interdisciplinary team debrief (post falls huddle). Post falls huddles and printing of PSRS Falls Summary document in clinical record was effective in streamlining huddles and supporting timely communication and accurate reporting of falls details. The Parkwood Falls QIP Committee formalized meeting structure, refreshed membership and redefined objectives/goals to ensure alignment with the Corporate Falls Committee.
Embed post-fall reviews and Intentional Comfort Rounding (ICR) into routine practices on all Parkwood units.	Yes	Post falls reviews/huddles are occurring consistently within teams. Follow up is completed by unit leaders. Embedding new practices, including changes to the Patient Safety Reporting System (PSRS) takes a great deal of time. We have seen success in FY 15/16 in embedding these changes into practice. A PSRS upgrade in Q3 FY 14/15 (included modifications of the fall witnessed/patient risk level section, falls prevention intervention section and contributing factors section) provided opportunity for improved documentation which was reinforced and reviewed with clinical teams within each program.

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12	Number of Programs with standardized processes implemented (Number of Ambulatory Areas; Pain Management Program and Urology Centre; 2014-2015 Q4; Hospital collected data)	714	0.00	2.00	2.00	Both the Urology Centre and the Pain Management Program completed implementation of standardized processes in 2015-16. The 2016-17 QIP builds on this work and includes indicators and specific targets related to the wait time from referral to initial consult

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Develop standardized intake and triage guidelines per Clinic (Urology and Chronic Pain).	Yes	We learned that each office in urology has subspecialty by surgeon and therefore a standard triage guideline was not possible across all subspecialties. Each office does have a standardized approach to intake within the office, however a centralized referral intake was not feasible due to the variation of subspecialty that each of the urologists supports. In the Pain Management Program, a system was in place for centralized referral intake and triage. The tracking of time from referral to triage to booked orientation session was implemented and provided data that was used to identify opportunities.
Create booking system for first available appointment (Chronic Pain).	Yes	This provided insight into the different sub-specialties of physicians.
Understand current wait times and variation in wait times (Urology and Chronic Pain).	Yes	
Develop acceptable wait time benchmarks per clinic (Urology and Chronic Pain).	Yes	The Pain Management Program developed an internal benchmark of an average of 6 months.
Develop patient discharge criteria (Chronic Pain).	Yes	Discharge criteria are specific based on each sub-specialty. The learning on discharge with this patient population is the importance of the necessary support systems with primary care, social work, etc. is required for success. The concept of a discharge nurse has been developed to support the discharge process. This role has not yet been implemented.

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
13	Percentage of Moderate and Severe Stroke Rehab patients meeting QBP target for Active Length of Stay (%; Moderate and Severe Stroke Rehab; 2014-2015; Hospital collected data)	714	58.00	85.00	72.00	Q1 79%, Q2 80% and Q3 achieved 72%.

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?
Length of Stay targets were changed to match Quality Based Procedures (QBP) guidelines. Work with Stroke team to meet targets.	Yes	Our experience highlighted that the algorithm to determine the RPG and LOS target has shortcomings in its role to provide this calculation. It is based upon FIM which is a burden of care tool but was used in the absence a better option. As a result certain RPG's especially 1130, is neither inclusive nor sensitive enough of cognitive elements to accurately determine the best LOS target for those patients with significant cognitive deficits. Consequently a number of our patients are not able to achieve the LOS target (25 days for 1130) as they are not safe and have not progressed enough to discharge on the designated day 25. Education of team and doctors regarding this indictor and its relevance overall to QBP and potential funding helped to improve efforts to work toward achieving the LOS target and promoted focused discussions at Rounds when a patient is at risk of not meeting LOS target and possible solutions. We are advocating working with others to create a new algorithm/tool that incorporates cognitive elements and other relevant stroke factors that are more sensitive and therefore more accurate in determination of realistic LOS targets. This change did improve our overall score in meeting LOS targets for severe and moderate strokes.

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
14	Percentage of Priority 3 CT Scans completed within target (%; Priority Level 3 CT Scans; 2014-2015 Q3; CCO iPort)	714	34.00	45.00	73.00	Target was met and exceeded.

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Increase CT Technologist resources to 2014 level	Yes	A three Technologist model on days provides efficiencies and break relief that allowed for an increase in contrast studies by 29% versus the two technologist model. This change allowed for an increase in P3 cases to be scheduled with the 10 day time line. Annual reflection on slot use and duration are necessary to align resources with changing demands.
Prioritize improvement initiatives for key services with referrals for CT.	Yes	Block booking for key programs such as Urgent Care, Hand and Upper Limb Clinic, ENT, Cardiac, GI, and Urology. This allows same day and next day access for subspecialty services and assists them in managing their access issues and time lines. The service is also more willing to be engaged in managing their requests when volumes increase.
Increase allocation of P3 CT slots to reach target and determine re-allocation required from P4	Yes	Increased the contrast studies by 23 per week. Moved non contrast studies to Saturday. Allowed for an additional 36 non contrast studies with the same resources. This changed assisted in managing the impact to P4 cases. Working Saturdays also eliminated the majority of the call back for CT's from Urgent Care since the Technologist was on site when Urgent Care was open. Resources can be allocated differently to provide better access.
Identify opportunities for efficient allocation of MRI resources with increasing referral volume	Yes	MRI schedule was rebuilt to focus appointment slots for in house services. Provided referring physicians with time frame of their patient's appointment up front prior to booking. 75% of these referrals chose to go to another location with better access. Providing referral physicians with choice removes patients from the queue. Exam slots need to be reviewed annually and adjusted by number and exam time to make improvements in the schedule to adjust to changing demands.