Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2018/19 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 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)	968	64.40	70.00	65.00	The ED rate is below the target but exceeds the NRCC community average of 54.5%. In order to reach our target, MAHC is undertaking the following initiatives: - Leader Rounding by Senior executives and Clinical Leaders - Patient and Family Advisory Committee has been lending their voice to initiatives that impact the patient experience. - Bedside shift report - Standardized whiteboards - Purposeful Rounding - Patient satisfaction results, complaints and compliments data is reviewed by PFAC, Family Practice and ED Committees. - Teleconference with Thunder Bay Regional Health Centre regarding their work as a high achiever of patient satisfaction. Three key practices identified as related to the increase in patient satisfaction: purposeful rounding, whiteboards and daily huddles. - Daily huddles targeted to be implemented consistently to maintain a positive work environment, which has shown to translate into higher levels of patient satisfaction.

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 2018/19)	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?
Audit NRCC survey data to identify trends quarterly.	Yes	
Engage ED Committee and PFAC (Patient and Family Advisory Committee) on patient and family feedback, resulting in change ideas and a work plan from quarterly review of data.	Yes	
implement purposeful rounding by nurses in the ED.	Yes	
Continue to monitor and improve flow through the ED with the Distribution Policy.	Yes	

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2	Hand Hygiene Compliance Before and After Patient Contact: The number of times that hand hygiene was performed before initial patient contact and following patient contact divided by the number of observed hand hygiene indications for before initial contact multiplied by 100. (Compliance with Hand Hygiene; Health providers in the entire facility; April 1, 2018 to March 31, 2019; Internal observational audits)	968	88.30	91.40	88.30	Current Performance Before Patient Contact = 90.6% Current Performance After Patient Contact = 97.1% Both metrics are within or exceeding the target for the most current period of January 2019.

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Continue to perform 150 hand hygiene observations per site per month.	Yes	Increased auditing has improved compliance.
Mandatory Hand Hygiene education module to be completed by all staff, physicians and volunteers by March 31, 2019.	Yes	Added to Education Plan and Learning Management System. Reminder to all staff, physicians and volunteers to complete by March 31, 2019.
Refresh Hand Hygiene Working Group.	No	Conflicting organizational priorities (i.e. Accreditation Survey, Document Management System Implementation, etc.).
Continue to provide monthly results by site, unit and quarterly by provider.	Yes	Distributed to all managers, posted in units, reviewed at huddles, Leadership Team Meetings and Quality Council meetings monthly. Reviewed bi-monthly by IPAC & MDRD Committee

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3	Medication reconciliation at admission: The total number of patients with medication reconciled as a proportion of the total number of patients admitted to the hospital. (Rate per total number of admitted patients; Hospital admitted patients; October to December (Q3) 2017/18; Hospital collected data)	968	80.00	82.00	77.30	Med Rec on Admission values has been good for the first 4 months of 2018/19 with meeting or almost meeting the target in each period. The metric is currently trending downward as a result of multiple staffing vacancies compounded by the continued high occupancy rate at both sites.

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Streamline Medication Reconciliation process and documentation to improve efficiency and accuracy of BPMH (Best Possible Medication History).		

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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)	968	1.00	80.00	CB	Med Rec on discharge values are a manual audit of randomly selected charts. The electronic format is not yet available but is expected by year end.

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All patients being discharged will have a complete medication reconciliation completed and communicated at that time.	No	Several attempts to develop or acquire a Med Rec on discharge tool that will facilitate reconciliation and enable an electronic count of all discharge med rec have been unsuccessful to date. An internally modified report has been developed with the assistance of IT and input from the physicians and implemented for a first trial in October 2018. Results have been discussed and identification of process improvements (i.e. accurate documentation of med rec when completed) has occurred.

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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)	968	CB	CB	9.00	Once a complete year of baseline data has been collected, a team will then analyze for trends such as department specific and location specific. At this time the numbers are too small to make any assumptions.

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Collect and analyze data from incident reports to identify trends and highlight areas for improvement, utilizing the OHA "Preventing Workplace Violence in the Healthcare Sector" toolkit.	Yes	An organizational risk assessment has been completed with input from staff and leaders with respect to the risks of workplace violence prevalent at MAHC. Associated with each risk are opportunities to reduce the risk of workplace violence occurring.

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6	Risk-adjusted 30-day all-cause readmission rate for patients with stroke (QBP cohort) (Rate; Stroke QBP Cohort; January - December 2016; CIHI DAD)	968	10.07	14.00	12.20	There are not as many Stroke QBP cases as other QBP groups so the resulting low numerator and denominator may result in high readmission rates.

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Review and analyze readmission data for previous 2 fiscal years.	Yes	Ongoing chart audits reported monthly to Quality Council and Inpatient Managers.
Ensure Stroke Order Set is utilized.	Yes	
Ensure Stroke Care Pathway is utilized.	Yes	Inpatient Managers and Clinical Leads are aware of the importance of using the Clinical Pathway for affected admitted patients to ensure that this important tool is incorporated into each admission. Weekly audits by Inpatient Unit Managers and Clinical Leads to ensure that appropriate clinical pathway is included in the chart.
Identify number of patients referred to Stroke Clinic.	Yes	

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7	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)	968	13.96	16.00	20.97	OVERALL VALUES FOR 2018/19 exceed the target. PSW support for Muskoka has not been readily available since May 2017. This lack of resource availability has resulted in loner ALC days. As well, there are insufficient long-term care beds available in our area and there are no plans to increase these beds in the immediate future. The NSM LHIN Leadership is aware of challenges at MAHC. MAHC is also meeting with Home and Community Care to process map the ALC placement process and have included members of the planning division of the NSM LHIN as well.

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Continue to collaborate with HCC (Home and Community Care) on Home First Initiative.	Yes	Weekly ALC rounds with HCC and other community partners that focus on challenging discharges.
Continue to monitor implementation of ALC Designation Policy to identify areas for improvement.	Yes	The Senior Team is aware of the ALC weekly data. Given the systemic pressures, which are beyond MAHC's ability to impact, at the request of the Board, two internal metrics are being tracked, as implemented in November 2018 to

		monitor the efficiency of internal flow processes and joint accountability of MAHC and HCC. These metrics are: - % patients who become ALC, designated by day 3 of their stay. - % of patients with ALC checklist completed by day 4 of designation.
Continue daily bed rounds with a focus on identifying at risk for ALC patients and to ensure appropriate referrals are started, as appropriate, by day 3 of admission.	Yes	Family meetings between the clinical team and the patient/family occur within 48 hours of admission on those patients who are deemed "at risk of becoming ALC". Chief Nursing Executive and Clinical Services receives a daily ALC report from the Clinical Teams and intervenes to remove barriers.
Continue to advocate for additional LTC options and HCC support for Muskoka.	Yes	Concerns related to transitions of ALC patients are escalated to LHIN Leadership.