Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2017/18 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 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
1	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? (%; Survey respondents; April - June 2016 (Q1 FY 2016/17); CIHI CPES)	966	60.30	61.60	56.70	Bluewater Health changed their patient experience survey in 2016 and therefore the target was based on one quarter of data. Bluewater Health did not meet this target but continues to be above their peer comparators

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 2017/18)	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?
Develop standardised processes for nursing when discharging patient from inpatient departments	Yes	Discharge packages were reviewed and revised. The package contents were reviewed by PEPs (Patient Experience Partners). Education to nurses about the packages was completed. Lessons learned: It is difficult to audit whether the patient is given a package, this is not documented in the electronic system. We know that we are making up more packages regularly, done by volunteers, but we do not know the actual number of packages that are given and go home with patients. The packages outdate regularly and it is difficult to keep them revised routinely.
Develop a strategy to send discharge medication list to patient's pharmacy and primary care provider	No	A pilot diagnosis for COPD and CHF was trialed and then expanded to all patients on Medicine Unit, Telemetry and Surgery. It is difficult to audit this process. The current process include faxing to their pharmacist of choice. Learnings- Having pharmacist

team assistance helps with the compliance and quality of the medication reconciliations. A pilot project was started on the medicine units to include a pharmacy team member dedicated to these areas during the daytime hours. This has helped with both the compliance and quality of the work completed.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
2	Overall Rating of Experience in the Emergency Department. Answered on a scale where 0 is "I had a very poor experience" and 10 is "I had a very good experience." Add the number of respondents who responded “10” or “9” and divide by number of respondents who registered any response to this question (do not include non-respondents). (%; ED patients; Q1 & Q2 Apr to Sept 2017/18; EDPEC)	966	47.10	49.10	49.80	Bluewater Health met this target.

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 2017/18)	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?
Improve communication and awareness of patient experience data in the Emergency Department	Yes	The Patient Advocate met with all Clinical Managers and Professional Practice Supervisors to receive information on interpreting patient experience data. Scorecards for all areas are given monthly to managers which includes patient experience metrics. Feedback in the form of compliments and complaints are shared with managers who in turn share with their staff at huddles or on an individual basis depending on the concern. Lessons Learned- Complete packages need to be developed and distributed monthly to managers so that the process of changing over their huddle boards is more consistent and easier for them to do.
Implement a family presence policy that allows family to be present 24/7	Yes	A family presences and visitor/guest policy was developed in June 2017 recognizing the important role in the patient's healing process that family members and partners contribute. Family members and partners in care were welcomed 24 hours per day in accordance with the patient's preference. A quiet time in the hospital is designated between 2200 and 0700 every day to promote a restful healing environment for our patients. Visitor hours were extended from 1100hrs to 2030hrs daily.

	Patient's identify up to two family members or partners in care. These individuals are identified and documented in the admission screens and are allowed 24/7 visiting privileges.
Patient Experience Project	A student in the degree program completed a project on patient experience by pulling pertinent questions from the report. A global learning from the results helped staff see what impacted the patient's experience the most positively and negatively.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
3	Overall Rating of Experience: Inpatient Departments. Answered on a scale where 0 is "I had a very poor experience" and 10 is "I had a very good experience." Add the number of respondents who responded “10” or “9” and divide by number of respondents who registered any response to this question (do not include non-respondents). (%; Discharged patients ; Q1 & Q2 Apr to Sept 2017/18; CIHI CPES)	966	73.90	75.90	69.50	Bluewater Health changed their patient experience survey in 2016 and therefore the target was based on one quarter of data. Bluewater Health did not meet this target but continues to be above their peer comparators.

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 2017/18)	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?
Improve communication and awareness of patient experience data in the inpatient departments.	Yes	The Patient Advocate met with all Clinical Managers and Professional Practice Supervisors to receive information on interpreting patient experience data. Scorecards for all areas are given monthly to managers which includes patient experience metrics. Feedback in the form of compliments and complaints are shared with managers who in turn share with their staff at huddles or on an individual basis depending on the concern. Lessons Learned- Complete packages need to be developed and distributed monthly to managers so that the process of changing over their huddle boards is more consistent and easier for them to do.
Implement a family presence policy that allows family to be present 24/7	Yes	A family presences and visitor/guest policy was developed in June 2017 recognizing the important role in the patient's healing process that family members and partners contribute. Family members and partners in care were welcomed 24 hours per day in accordance with the patient's preference. A quiet time in the hospital is designated between

2200 and 0700 every day to promote a restful healing environment for our patients. Visitor hours were extended from 1100hrs to 2030hrs daily. Patient's identify up to two family members or partners in care. These individuals are identified and documented in the admission screens and are allowed 24/7 visiting privileges.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
4	Rate of patients with mental illness or an addiction who were discharged from hospital that are followed within 30 days by another mental illness or addiction admission. (%; For patients who were discharged following an inpatient stay that was greater than 72 hours.; April to March FY 2015/16; CIHI OMHRS)	966	18.50	16.50	10.80	Bluewater Health met this target by the collaboration with community partners and awareness of community services.

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 2017/18)	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?
Improved handover to community for follow up	Yes	Bluewater Health is involved with the Community Paramedic Program and refers clients with mental health illnesses that would benefit from this service. The goal of the service is to prevent Emergency visits. All patients that are seen in the Emergency Department and not admitted are offered a 48 hour follow up with Canadian Mental Health Association. The patients are assessed by the Psychiatric Assessment Nurse (PAN) and the services for CMHA are made accessible for the patient.
Improved access to outpatient services for patients presenting to the Emergency Department on weekends.	Yes	BWH had a goal of increasing collaboration with community partners to improve follow up of our patients and avoid readmissions. The "Weekend Project" involved utilizing Canadian Mental Health Association(CMHA) staff within the emergency department during the weekend hours. The goal of the project was to screen patients that would be best served in the community, rather than being admitted. As well, follow up was initiated, phone calls were made to the patient and home visits, if applicable, were established.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
5	Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort) (Rate; COPD QBP Cohort; January 2015 – December 2015; CIHI DAD)	966	17.72	16.90	16.97	Bluewater Health came close to this target.

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 2017/18)	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 opportunities for activation strategies to support function	Yes	Bluewater Health met this indicator target
Increase collaboration between BWH to CCAC	Yes	Bluewater Health initiated a collaborative cross sector team last year. The Health Quality Partners of Sarnia/Lambton collaborate bi-monthly and information sharing occurs. Validation of data on referrals was an objective to improve collaboration between BWH and Home & Community Care. The Health Quality Partners Team has given us the opportunity to collaborate on data to move forward with a collaborative QIP this upcoming here. Home and Community Care have been involved in Patient Quality Reviews and the referral process was found to be inconsistent. A faxing system has been implemented to improve upon the referral process, and as well BWH is retaining copies of the fax report so the data can be correlated with the Home and Community Care Data. .

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
6	Total ED length of stay (defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ED) where 9 out of 10 complex patients completed their visits (Hours; Patients with complex conditions; January 2016 – December 2016; CIHI NACRS)	966	8.30	8.00	9.10	Bluewater Health did not meet this target and continues to work on strategies to improve the length of stay for the Emergency Department patients.

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 2017/18)	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?
Corporate “Patient Flow and Access” initiative review and redesign	Yes	Bluewater Health assessed and revised the Geriatric Pathway for ALC avoidance. Every patient over the age of 70 are screened using an Assessment Urgency Algorithm (AUA). The nurse answers 5 key questions and a high score triggers a Geriatric Pathway referral. This referral includes a automatic referral to the Nurse Practitioner, Occupational Therapist, Physical Therapist and Social Worker. The geriatric pathway for ALC avoidance was assessed and revised. A Geriatric Nurse Practitioner was hired for the Emergency Department, this is covered Monday to Friday during the day time hours. The Geriatric NP sees all patients flagged with a high AUA score. The AUA score is completed on all high acuity patients over the age of 75 and sends an automatic geriatric pathway referral through the system. The referral does not triage the patients with the priority need, therefore the persons referred to may receive long lists and do not always know who to see first, who does not need to be seen and who is not appropriate based on medical condition. Currently we are working around this by the team of people conversing among themselves once the patient is assessed by the first oncoming person. Bluewater Health implemented an Oculys Stay Track system in all inpatient units which is becoming a part of daily rounds. Barriers to discharge are tracked and addressed on the electronic board daily. Learnings from this implementation were that the system

		is only as good as the user as it does not align with our current documentation system to pull automatic information and referrals to address barriers, these are manually entered on the Stay Track. Bluewater Health implemented Community Mental Health Association resources in the Emergency Department. BWH had a goal of increasing collaboration with community partners to improve follow up of our patients and avoid readmissions. The "Weekend Project" involved utilizing Canadian Mental Health Association(CMHA) staff within the emergency department during the weekend hours. The goal of the project was to screen patients that would be best served in the community, rather than being admitted. As well, follow up was initiated, phone calls were made to the patient and home visits, if applicable, were established.
Improve workflow processes within the ED to improve overall ED length of stay	Yes	The Clinical Decision Unit (CDU) appropriate designation was ensured to maximize daily parameters. Data was cross referenced monthly. We had approximately 240 patients designated every month, or 8-9 per day, as CDU patients. Audits were conducted to ensure the appropriate designation and as well to address when we are not using it appropriately. A Treatment Assessment Zone (TAZ) was developed and sustained. This zone is utilized during high volume times from 11 am to 11 pm daily and is staffed with registered nurses currently. Approximately 10-18 patients per day utilize this area, 7 days per week. The patients must fit the criteria and the nurse have the ability to monitor patients in this area on cardiac monitors. The area consists of 4 comfortable, lounge chairs and 1 stretcher. Ambulance offload times were improved after the initiation of the TAZ unit. It was realized that the area could be expanded upon and the area was moved to promote better staffing levels after it was initiated.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
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 2016 (Q2 FY 2016/17 report); WTIS, CCO, BCS, MOHLTC)	966	21.72	21.00	18.98	Bluewater Health met this target.

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 2017/18)	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 ALC avoidance strategies to reduce acute and post acute ALC's.	Yes	The Geriatric Pathway for ALC and Admission avoidance in the Emergency Department was revised and implemented. Every patient over the age of 70 are screened using an Assessment Urgency Algorithm (AUA). The nurse answers 5 key questions and a high score triggers a Geriatric Pathway referral. This referral includes a automatic referral to the Nurse Practitioner, Occupational Therapist, Physical Therapist and Social Worker. The geriatric pathway for ALC avoidance was assessed and revised. A Geriatric Nurse Practitioner was hired for the Emergency Department, this is covered Monday to Friday during the day time hours. The Geriatric NP sees all patients flagged with a high AUA score. The AUA score is completed on all high acuity patients over the age of 75 and sends an automatic geriatric pathway referral through the system. The referral does not triage the patients with the priority need, therefore the persons referred to may receive long lists and do not always know who to see first, who does not need to be seen and who is not appropriate based on medical condition. Currently we are working around this by the team of people conversing among themselves once the patient is assessed by the first oncoming person. Bluewater Health initiated a pilot project to increase rehab resources on weekends in

	the Medicine department. From April 1st to June 30th, therapies were added to be dedicated to the medicine unit with the goal of 7 day a week therapy. The objective of the project was to decrease length of stay, promote discharging of patients 7 days per wee and decrease the cost per patient day. The project was completed and we say that progress had occurred and the number of patients discharged on the weekend increased. The project relied upon 3 factors- increase to 7 day per week therapy, added Home and Community Care on weekend and discharge rounds being completed 7 days per week. After the project ended it was difficult to decide which of the three implemented processes had the greatest effect. The project could not continue because the Home and Community Care services were not accessible on the weekend past the 3 month project. The weekend rounding with flow coordinators and frontline staff have continued. As well, patients that are on priority service, such as QBP patients, were continued to be seen on weekends as before. Bluewater Health initiated a complex discharge screening tool on admission. The screening tool was implemented and is completed by nurses. If the patient is determined to be a possible complicated discharge, based on score, an automatic referral is sent to the Discharge and Transition Coordinator of Clinical Services. The patients progress is discussed at Complex Discharge Rounds and barriers to discharge are addressed early in the hospital stay. Bluewater Health revisited ALC avoidance principles and strategies with community partners. A symposium was held with over 80 people from the Sarnia/Lambton Community cross sector partners on "Care Transitions". Group work involved strategizing to overcome barriers to Home First. Bluewater Health will host an additional symposium this upcoming June with an objective of strategizing for positive transitions across the sectors. Complex Discharge Rounds are held weekly and co-chaired by Bluewater Health and Home & Community Care.
Provide ongoing Education of ALC and "Home First" Strategies to the organization with community partners.	Bluewater Health initiated Home First educational refresh for physician , staff and community partners. Home First information pamphlets are given to patients on admission. There is ongoing education for physician, nurses, managers and social work on ALC avoidance strategies. This is done through team huddles, at discharge bullet rounds and family meetings. A concentrated effort to educate physicians occurred. Physician engagement on education programs for Home First is limited,

although on our smaller site 8 physicians attended the learning out of a small team of practitioners. A standardized discharge policy for the ESC LHIN is being developed but has not yet been established.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
8	When offered the chance to answer “yes” or “no”, the percentage of patients from the Emergency Department who answer “yes” to the question “Before leaving the emergency department, did you understand what symptoms or health problems to look out for when you left the emergency department?” (%; ED patients; Q1 & Q2 April to September 2016/17; EDPEC)	966	79.00	81.00	81.30	Bluewater health met this target.

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 2017/18)	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?
Develop standard work for nursing, physicians and pharmacists on information shared with patients on disposition from the Emergency Department	Yes	1. Implementing Emergency Department Standards for assessment and discharge. The ED standards were developed in collaboration with the Professional Practice Supervisor, Clinical Managers and Frontline staff. The team worked on standards to align with best practice and College of Nurse Standards. The standards include appropriate discharge process, information to give patients and documentation of the follow up discussed. The standards have been developed and started but the education for sustainability has not been completed. Bluewater Health participates in the ED Quality Return Visit Audits on a monthly basis. ten charts per month are audited by a team of nurses and physicians on a rotating basis. Learning from these audits are shared across the department to improve the discharge process, prevent patients from returning to the ED and improve the standards of care provided. 2. Updated discharge instruction sheet for patients A discharge form was developed and trialed in both Emergency Departments. The trial was completed with a paper document as per physician request. During the trial it became evident that an electronic system would be easier to track, audit and

complete. Only 2 of the physicians utilized the paper form and were not consistent in the information completed. Currently an electronic document is being planned