Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2014/15 QIP

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	ED Wait times: 90th percentile ED length of stay for Admitted patients. Hrs/ED patients CCO iPort Access / Q4 2012/13 - Q3 2013/14	22.45hrs	21 hrs	20.5	Achieve and sustain 14/15 target, incremental step towards continued improvement. Focus on ED in Sarnia as CEEH performance of 7.03hr is already better than the target.

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N/A	Yes	Linked to corporate strategy for patient flow in 2015/16; elevates support for change across the corporation. Converts to “Time to In-patient Bed” monitoring for in-patient departments for 2015/16. Advice: determine supportive mechanisms by determining whole process. Therefore, focus support to lagging segment in whole wait time measured.

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	Total Margin (consolidated): % by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expense, excluding the impact of facility amortization, in a given year. % / Na OHRS, MOH / Q3 2013/14	-1.44%	0%	-0.09%	Year-end forecast of 0.28%.

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	Percentage ALC days: Total number of acute inpatient days designated as ALC, divided by the total number of acute inpatient days. % All acute patients Q3 2012/13 – Q2 2013/14 Ministry of Health Portal	14.96%	9%	11.3%	Decision to focus on Bluewater Health in Sarnia as CEEH current performance of 7.15% is already better than the target. Align with LHIN target as a stepping stone to align with the Provincial Target of 9.46% Continue to encourage collaboration and cooperation with community stakeholders for timely discharge. Encourage proactive case finding for early identification of complex patients for discharge.

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1. Raise organizational and community awareness regarding our new Discharge Framework.	Y & N	- Discharge information folders created and fact sheet distributed at time of admission – sustainability has been challenging. Trialed different mechanisms to get information to patients/families. Increase awareness through CDR team and community partners, and through one-on-one conversations with physician groups. Intent to deliver key messages to physician groups at planned meetings didn't get completed.
2. Establish weekly Community/Hospital Complex Discharge Review Team (CDRC) meetings.	Y	- CDR meeting established and improvement with collaboration and earlier identification of complex patients. Challenges with role clarity and standard work that we are currently developing.
3. Complete "huddles" and status reports for care and discharge planning.	Y & N	- Bullet rounds with inter-professional team identify patients for CDR and start discharge planning sooner. Challenges with role clarity and status of patients with respect to feedback. Looking at mechanisms and technology to improve communication. Completing standard work for CDR processes including identification, communication and reporting.

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	Percentage of acute hospital inpatients discharged with selected Case Mix Groups (CMGs) that are readmitted to any acute inpatient hospital for non-elective patient care within 30 days of the discharge for index admission. % / All acute patients Q2 2012/13-Q1 2013/14 DAD, CIHI	14.50	13.50	14.6	- Consider readmit within 7 days as an initial “discharge failure”. - Linked to ED LOS for Admitted patients: conservable beds days may be identified by reducing patient readmissions thereby increasing bed capacity for admitted patients in ED. - Linked to ED P4R Action Plan 2014/15. - Linked to NP interventions described above. - Linked to P4R Action Plan 2014/15 - Huddles routinely completed on general medicine and telemetry medicine units. EDD not consistently applied therefore other actions not consistently undertaken. - Planned discharges supports Medicine Program goal of discharge rate before 1100 hrs. - Linked to P4R Action Plan 2014/15 (ED Quality Leader).

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1. Examine readmissions into 2 categories: readmits within 7 days and readmits within 8 – 30 days. Current performance = 50% readmissions occur within 7 days therefore refocus on supported discharge from initial hospitalization.	Yes	Many variables associated with readmissions that are not within hospital direct control however, maximum effort taken in 2014/15 by the interdisciplinary team to best prepare patient for discharge.
2. Implement HQO's bestPATH Transitions of Care module in the General Medicine and Telemetry Medicine Units.	No	Primary care follow-up process improvement with hospital-discharged CHC and FHT piloted in February 2015 to align 7-day PCP follow up with examination of readmissions.
3. Daily interdisciplinary huddles for discharge planning preparation.	Yes	
4. Implement standardized written discharge instructions from Emergency Department to support patient transitions of care to primary care provider.	Yes	

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	From NRC Picker: "Overall, how would you rate the care and services you received at the hospital (inpatient care)?" (add together % of those who responded "Excellent, Very Good and Good"). % / In-Patients NRC Picker / Oct 2012 - Sept 2013	95.6%	97%	Not Available	- Return to and sustain previously achieved high score of 97.7 which is stats. sig higher than the ON comm hosp avg of 92.4. - Catalyst is a new reporting system that is designed to make access to data timely and easy to understand promoting Patient Centered Care.

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1. Formally engage front-line managers, staff, Best Practice Champions, and Patient Experience Partners in improvement initiatives specific to the roll-up questions for this dimension which includes: - Nurse discussed anxieties/fears - Family talked with doctor enough - Did everything to control pain - Enough to say about treatment 2. Implement NRCC Catalyst 3. Embed "Provider Question" page into the Patient and Family guide to prompt pts and families to capture questions for physicians and include question: Is there something you would like to ask/say about your treatment?" - Revise the Patient and Family Guide to include the new page.	Yes	Nursing charting screens were updated December 2013 for nurses to chart on patients ‘worries and concerns’ each day and monitored through 2014-15. Data on Q1 and Q2 “anxieties/fears has been shared at the PFCC Advisory Council, the Patient Experience Partner Council and Operational Leadership Council. New front-line managers received education on reading this data and utilizing the priority matrix during their Innovative Management training sessions. The anxieties/fears have been shared using a monthly run chart with comparators for the NRCC Top 10% and the Ontario Community Hospital Average. In a chart audit of Q3 64% of patients were asked about their worries and concerns. Instructions for how to use Catalyst have been shared with the Executive Council, Directors, Clinical Managers and their administrative assistants. The reports are available on the hospital’s intranet for easy access. The data was has also been printed and shared at hospital front line Huddle Boards in the emergency units and IP surgical units. IP surgical held a celebration and Appreciative Inquiry event to celebrate their above average scores. The Patient and Family Guide was revised to include a blank page for patients and families to capture questions they would like to ask.

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	From NRC Picker: Respect for Patient Preferences Dimension Score (roll-up score of "Treated you with respect/dignity". "Enough say about treatment", "Drs and nurses did not talk in front of you as if you weren't there" In-Patient Hrs/ED patients %/In-Patients NRC Picker / Oct 2012 - Sept 2013	80.9%	85%	Not Available	- This team has begun to meet though has yet to establish its own ToR, goals, complete membership. - Completion of an awareness campaign (we are going to do this anyway). - Completion of a recruitment campaign.

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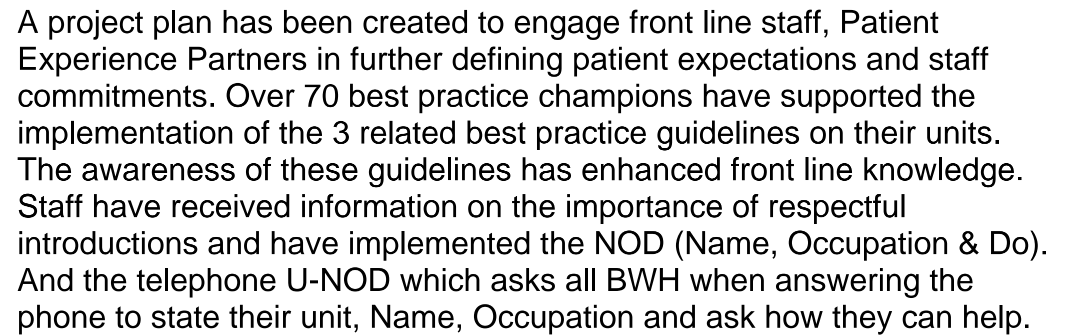
1. Establish a Patient and Family-Centred Care(PFCC) Committee 2. Strengthen effectiveness of Patient Experience Partner (PEP) Council 3. Increase knowledge, skills and abilities of staff, volunteers and physicians to communicate I Care and I Respect You	Yes	December 2013 documentation was changed to include the patients preferred name. PFCC Advisory Committee has completed Terms of Reference. Membership includes Patient Experience Partner co-chairs. The executive sponsors have also engaged in the Experience Innovation Network. The group is engaging the organization, PEPs and the advisory panels in completing a PFCC survey. A draft action plan is completed for 2015-16. Three RNAO best practice guidelines have been implemented including: Client Centred Care, Establishing Therapeutic Relationships and Supporting and Strengthening Patients and Families in Expected and Unexpected Life Events. December 2013 patient Daily Goals was added to Nursing Documentation to engage patients and determine what their priority for the day is, which is not always related to their medical treatment. In Q3 73% of patients were asked about their goals. PEP Council has grown to 20 members who are involved in a number of quality improvement initiatives including medication reconciliation, prevention of violence in the workplace, ethics education, PFCC education and electronic messaging. PEP co-chairs have Lean training with one achieving yellow belt certification. PEPs have their own Lean huddle board where they monitor a number of metrics e.g. PEPs as committee members. Co-chairs are currently defining their standard work. The council has implemented a new service for the organization to refresh existing patient information documents for their readability and patient friendliness. A PEP specific orientation was held in January 2015 to increase their knowledge of PFCC, Story Telling, Patient Satisfaction Data, Effective Committee Member and more.



A project plan has been created to engage front line staff, Patient Experience Partners in further defining patient expectations and staff commitments. Over 70 best practice champions have supported the implementation of the 3 related best practice guidelines on their units. The awareness of these guidelines has enhanced front line knowledge. Staff have received information on the importance of respectful introductions and have implemented the NOD (Name, Occupation & Do). And the telephone U-NOD which asks all BWH when answering the phone to state their unit, Name, Occupation and ask how they can help.

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	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. Hrs/ED patients % / All patients Hospital collected data / Most recent quarter available	88.62% Q3 2013/14	90%	92.3%	Med. Rec. remains one of our three Strengthening our Capacity initiatives and has a team working toward achieving the targets. Med Rec completion remains consistent at 89%, and the team is encouraged by the sustainability of this target. Currently two Late Career Nurses are performing manual chart audits to look at compliance with intentional and unintentional discrepancies, and quality of the discharge Med Rec being done. We will be able to report this data to Safer Health Care Now (SHN) for BWH corporately for the first time and to compare ourselves with other hospitals.

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1. Employ strategies to more actively engage Patients and Families in the Medication Reconciliation (Med Rec) Process.	Y	Both the strategies and improving accuracy have impacted and improved Med Rec completion rate.
2. Improve accuracy related to collection of the best possible medication history.	Y	Pharmacy Techs play an important role in improving the accuracy and completion for Med Rec. They are important collaborative partners in the healthcare team. Further engaging the community will also help to improve Med Rec success.
3. Establish a process to assess quality and accuracy of reconciliation.	Monthly Safer Health Care Reporting	Chart Audits have been completed on all inpatient units up to March 31, 2015. Data will be submitted to Safer Health Care Now, and reports will be distributed to the participating units/programs.

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	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, and multiplied by 1,000 - Average for Jan-Dec. 2013, consistent with publicly reportable patient safety data. Rate per 1,000 patient days / All patients Publicly Reported, MOH / 2013	0.23 Jan - Dec 2013	0.25	0.16	

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N/A	BWH continued with the plan to always use best practices for environmental cleaning in the event of a case of CDI as well as to continue with antibiotic stewardship practices and focused infection prevention practices as related to CDI	It seems that although some CDI cases are expected, by following persistent environmental cleaning practices regardless of the number of cases of CDI in a facility, it may be possible to significantly eliminate the CDI organism from the environment, reducing the number of hospital acquired cases over a period of time. During the same period, active antibiotic stewardship continued, as well as high levels of hand hygiene compliance, all of which also most likely had a positive impact in reducing CDI cases over a period of a year. Early in 2014/15 there was a spike in cases – although investigated, we were unable to identify why – what we learned from that is a facility can not let their guard down around CDI.

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	**Falls: Prevent harm from falls. Number of Category 3 and 4 falls: Total reported in-patient events. Total reported events for Jan-Dec 2013 # / All inpatients Publicly Reported, MOH / 2013	11 Jan - Dec 2013	9	5	The prevention of falls is an ongoing initiative supported by front line staff and management. The tools and processes have been imbedded into the work flow to ensure a high level of compliance.

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1. Continued implementation of RNAO Best Practice Guidelines	Note: Data looks at Calendar Year – Organization Wide Falls Rate/1000 Days Q4 2014 Mean 4.11	Units Participating : Acute Medicine A/G, CEEH – Acute and Continuing care, Complex Continuing Care, Cognitively Complex Care, Inpatient Surgery, ICU, Medical Telemetry, Palliative Care, Inpatient Rehab,
- Identification of all adult patients at increased risk of falls on admission using a validated tool.	Yes Q4 2014 MEAN 98.99%	Doing Very Well.
- Assess risk for fall AFTER every fall using a validated tool	Yes Q4 2014 MEAN 57.39%	All staff to complete Falls Risk Assessment using MORSE Scale followed by BEEEACH Assessment following a fall. Documentation adjusted in January 2015 – to further encourage compliance. Variable across units with some units at 100% compliance and others at 33%. This has been the most challenging practice change.
- Post-fall assessments by the interprofessional team with the involvement of the patient/family	Yes Implemented - post fall Huddle, Patient/Family Fall Prevention Brochure	
- Implementation of multi-factorial falls prevention/injury reduction interventions to prevent further falls/injuries	Yes - BEEEACH Q4 2014 MEAN 88.13% **substantial improvement	BEEEACH: B Behavior Change E Education E Equipment E Environment A Activity Consideration C Clothing/foot ware H Health Management (medications, nutrition, hydration, chronic disease)
- Falls Prevention Program updated to include Best Practice recommendations	Fall Prevention in ALL Ambulatory Care Setting, Implementation Plan in place. Implementation Date: April 2015	All adult patients will be screened for falls risk upon registration using 3 standard question.. Yellow armbands will be applied and fall prevention measures put in place as required. All patients wearing yellow armbands will be considered a falls risk. Yellow armbands will be spread to the inpatient units replacing the yellow dot. New documentation includes “falls documentation, which was not present in outpatient settings.
2. Equipment and inventory and assessment.	Purchased 5 Fall Injury Mats 30 Seatbelt / chair alarms	Implemented and in use. Problem: Mat - Discolouration of the floor. This did not occur in the trial. Investigation under way.