Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2016/17 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 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
1	Acute inpatient falls per 1,000 acute inpatient days (harm level 3-6) (Rate per 1,000; All acute patients; January - December; NHS Incident Reporting System)	962	1.77	1.69	1.78	Target not met

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Change Ideas from Last Years QIP (QIP 2016/17)	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?
Maintain standard that Falls Risk Assessment and Intervention Tool (FRAT) completed within 24 hours of admission	Yes	Falls risk assessment and Intervention Tool (FRAT) is embedded into daily practice. With collaboration from ICT we have developed an audit tool in Meditech that will let us know percentage completed within 24 hours and identify follow-up to occur by the Charge Nurse or Clinical Manager. Next steps to ensure integrating the required interventions/compliance into the daily flow sheets.
Medicine Program- focus on reducing the average number of falls per month and reducing the severity of all fall incidents to L3 or less (Quality & Safety priority)	Yes	The Medicine Program focus on reducing the monthly falls to the target was met 5 of the 12 months. Overall Falls from 2015 to 2016 was reduced by 11 falls.
Work with Professional Practice to identify improvement opportunities related to: • Delirium Screening Tools • Use of Foley Catheters • Restraint Use • Medication Practices	Yes	The Intentional (purposeful) hourly rounding (iRounding) is (January 2016) being introduced as part of the Strategic Plan under the Area of Focus Extraordinary Care. The interprofessional team is comprised of professional practice, clinical directors, quality & patient safety, clinical educators, clinical managers, physiotherapist, social work, discharge planner and occupational therapist. Senior Friendly Hospital Initiative is under way to address the Delirium Screening tools as one of the

		Geriatric Assessment Nurses are completing a Fellowship by rolling out delirium education across Niagara Health. There is an interprofessional team currently collecting data on the Use of Foley Catheters to look at the current practice and implementing next steps. The Least Restraints committee has developed a new policy and procedure and currently developing an education plan to spread across Niagara Health. The Medication Safety Pharmacist has completed a comprehensive data collection on medication safety incidents and reporting this information to Safety Council in January 2017. Action plan will be developed once reviewed with Safety Council on any improvement ideas.
Post Fall Environmental audit tool	Yes	A post fall environmental audit tool was developed during the Complex Care pilot and shared with the Corporate Fall's Steering Committee as a tool that was recommended from the front line. This will be shared with the clinical managers for feedback. Other improvement ideas were around additional education for proper use of bed alarms.

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2	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI during the reporting period, divided by the number of patient days in the reporting period, multiplied by 1,000. (Rate per 1,000 patient days; All patients; January 2015 – December 2015; Publicly Reported, MOH)	962	0.45	0.41	0.33	Target Met: NH continues to monitor and implement best practice recommendations to prevent and control hospital acquired C.difficile infections.

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Root cause analysis of all Hospital Acquired Infection (HAI) CDI cases	Yes	The IPAC team conducts a robust surveillance of every CDI case (HAI or non HAI). Surveillance includes analyses of various risk and contributing factors (e.g. age, procedures, medications, environmental and others). Other initiatives implemented and ongoing include: Prompt identification and placement of patients requiring additional precautions. Development of CDI order set; use of Bristol stool chart, fast TAT for CDI testing and results; quality review of patients that meet criteria for severe C.difficile infection; unit audit and regular IPAC education.
Continue to provide appropriate cleaning practices using cleaning agents that provide Sporicidal properties to reduce hospital acquired CDI infection rates, train and audit performance of Support and Clinical Staff through improved cleaning audit compliance and awareness to changes in process.	Yes	Ongoing use of bleach product for all patients on isolations including C diff cases. Ongoing EVS audit of cleaning practices
Antimicrobial stewardship interventions to optimize antimicrobial use	Yes	ASP program under the leadership of Dr. Ali has been implemented at SCS & GNG. Future roll out in Welland will be determined.

Collect baseline data for proton pump inhibitor (PPI) use	No	Discussed but was not completed this year.
Improve hand hygiene compliance to moment #1- before patient/patient environment contact	Yes	The organization continues to focus and review compliance to 4 moments of HH. All managers have been trained and are trained to do HH audits throughout the NH. Current hand hygiene program is currently under review.

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3	ED Wait times: 90th percentile ED length of stay for Admitted patients. (Hours; ED patients; January 2015 - December 2015; CCO iPort Access)	962	41.00	28.00	45.9	Target not met

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Implementation of Timed Up and Go initiative in ED.	Yes	Assess and Go Strategy was piloted at GNG ED in non-traditional work hours, utilizing a tool developed by Physio/OT, to assess impact on admission rate of nurse led mobility safety assessment. Pilot results demonstrated no significant change on admission rate. Strategy suspended.
Develop discharge criteria to be used on medical units to determine readiness for discharge.	Yes	Acute medicine team at GNG developed standardized discharge criteria to be used to determine readiness for discharge to facilitate discharge focused discussions at bullet rounds. The strategy was successful and has been expanded to include EDD tactic below. Site spread plan currently in progress.
Develop Quick Response Team (QRT) in ED.	Yes	QRT has been implemented across all (3) Emergency Departments. This has been a highly successful strategy in safe admitted patient discharge directly from ED and as an admission avoidance strategy. We have expanded discharge planning and allied health service hours in ED in response to access issues/site pressures. This has resulted in a further increase volume of referrals across all (3) ED and an increase in discharges/avoided admissions.
Systemic approach and implementation of “Estimated Date of Discharge (EDD)” tactic.	Yes	EDD Strategy has been embedded as part of standard work and has been highly successful on GNG Acute Medicine Units. EDD is set on first day of admission and must be determined within 48 hours. Through daily bullet rounds, the EDD is reviewed and any barriers discussed. The full clinical team remains focussed on eliminating/escalating barriers to discharge. System metrics are captured and reported to the clinical managers for action. Site spread plan currently in progress.

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4	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 (Rate per total number of admitted patients; Hospital admitted patients; most recent quarter available; Hospital collected data)	962	12.60	43.40%	38.0%	Improvement achieved towards target: YTD results reflective of an ongoing upward trend

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Introduce Pharmacy Technicians into ED for purposes of Best Possible Medication History (BPMH) gathering and documentation as per budget allocation	Yes	The improved metrics can be attributed to the introduction of pharmacy techs in the ED.
MedRec Quality audits with feedback to programs	Yes	Quality audits are ongoing. They provide excellent learning opportunities from a practice management perspective.
Introduction of BPMH process in surgical program	Yes	The surgical metrics are improving. Focus is gathering BPMH in pre-op clinic wherever possible then on inpatient side if not obtained in pre-op clinic.

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5	Percent of complex continuing care (CCC) residents who fell in the last 30 days. (%; Complex continuing care residents; July – Sept 2015 (Q2 FY 2015/16 report); CIHI CCRS)	962	12.08	10.00	19.2	Target not met

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Complex Care Clinical Protocol/Nursing Plan of Care: Falls Prevention	Yes-as a pilot project at PCG.	During the pilot the new falls care plan form was developed and introduced. The team is considering abandoning this document and integrating the required interventions/compliance into the daily flow sheets. Barriers identified during the pilot include the amount of time required to complete this document; as well it lacked utility as a daily reminder tool for falls interventions, to engrain consistent daily practice. A post fall environmental audit tool was developed during the above pilot and shared with the Corporate Fall's Steering Committee. The pilot also included additional education for proper use of bed alarms (knowledge gap identified during post fall environmental audit), trialing interdisciplinary falls team walkabouts, and completing the online education for falls prevention. The inventory of beds with exit alarms is underway. The 4P rounding concepts have been introduced in Complex Care huddles (laminated sheets at point of care)-iRounding will be introduced as a Corporate strategy in the New Year.
Introduce Serious Injury Risk Screening and intervention concepts	No-this has not been formally implemented.	The Complex Care Program is reviewing the current Complex Care falls assessment forms. The IRS reporting fields for falls was updated to align with injury severity reporting.