Theme I: Timely and Efficient Transitions | Timely | Priority Indicator

Indicator #4

Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital. (Quinte Healthcare Corporation)

Last Year		This Year	
CB	CB	CB	--
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

Creation and implementation of a standard discharge template for physicians to reduce the incidences of missing information and associated rework and follow-up

Target for process measure

- Discharge summary implemented in 5 areas by the end of Q4

Lessons Learned

Standardized template created and rolled out in Q3. Currently manual audits and exploring alternative solutions for monitoring compliance. This has had a positive impact on the volume of charts that are sent back for clarification/missing information which reduces delays in transcription.
Providing regular reports to physicians on performance specific to template use has been identified as an important step towards compliance and sustainability.

Change Idea #2

Create and distribute a physician report card outlining discharge to dictation time frames (average, median, min/max)

Target for process measure

- Physician report cards will be implemented by end of Q1

Lessons Learned

Report cards for individual physician times (discharge to dictation) have been created and are being delivered.

Change Idea #3

Reduce the transcription turn around time for discharge summaries.

Target for process measure

- 30% of discharge summaries transcribed within 48 hours of discharge.

Lessons Learned

In Q3 79.7% of transcriptions were occurring within 48 hours of discharge.
As we improved transcription processes we created a new bottleneck at the point of scanning. Current activity is focused on addressing this new delay.

Change Idea #4

Obtain a clear picture of how discharge summaries are currently sent to primary care providers and identify how each method impacts delivery time

Target for process measure

- Define potential improvements to process by end of Q2.

Lessons Learned

Mapped the Current Process in Health Records. Looking at Forward Advantage to take all the Current discharge summaries from Lanier and AutoFax them to the Doctors directly (Change in Scope to look at “ALL” reports from multiple systems that are not in HRM to be Faxed). Progressing with the vendors on the mechanism that needs to be in place. Will require extensive communication out to the Doctors. Also reminding the Doctors that they can use cNEO and HRM with their EMR to look up the data as well. As we feed these Province repositories 100% in Real Time.

Theme I: Timely and Efficient Transitions | Timely | Mandatory Indicator

Indicator #6

The time interval between the Disposition Date/Time (as determined by the main service provider) and the Date/Time Patient Left Emergency Department (ED) for admission to an inpatient bed or operating room. (Quinte Healthcare Corporation)

Last Year		This Year	
22.05	**20**	**35.47**	**20**
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

Optimize use of surge funding to open additional beds and add allied resources.

Target for process measure

- A planning team that includes representation from stakeholders will be identified by the end of Q1.

Lessons Learned

Capacity & Surge Planning Committee implemented in May 2019 and continues to meet monthly.
Surge planning for surge/winter season completed.
Additional temporary surge plan has been developed (Sills 4 plan) and implemented Jan 6th to April 30th to further support surge and capacity.

Change Idea #2

Continued support of the early ED assessment team (PT/OT) to assess for and manage opportunities for admission diversion

Target for process measure

- Monitor trends and and analyze peaks/dips for root causes

Lessons Learned

While the % assessed has gone down actual volumes have gone up
Challenges at this time include:
• Coverage at times with sick calls
• D/C issues with equipment not available or being delivered by the LHIN.
• Staffing issues such as a lack of PSW to support in the community if this has been recommended by ED assessment team. Currently, the LHIN have provided us with a 'backup' plan of a few pieces of equipment that can be sent out directly from QHC until the supplier delivers to community so we are hopeful this will help.

Change Idea #3

Monitor pull times for admitted patients from ED in real time to identify patterns and opportunities for process improvement

Target for process measure

- By the end of Q1 discussion of bed empty time is a component of the Standard Work for Bed Traffic Controllers during every bedscrum.

Lessons Learned

Status changes added from bed pending to bed ready at BGH ED. Next step will be to pull data on time to bed and compare to manual comparison.
Average pull times are reported on bedscrum report. Unchanged – will follow up with IS as HIS project completed- we may want to wait until HIS and implementation confirmed.

Change Idea #4

Verify accuracy of reported wait times related to decision to operate and transfer to the OR.

Target for process measure

- Assessment and optimization will be completed by Q3

Lessons Learned

Update on Progress:
Completed at end of February

Theme I: Timely and Efficient Transitions | Efficient | Custom Indicator

Indicator #1

30-day QHC Readmission Custom Rate for Patients with COPD from NACRS (Quinte Healthcare Corporation)

Last Year		This Year	
20	**18.30**	**20.80**	**--**
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

Confirmation of COPD diagnosis

Target for process measure

- Collecting baseline

Lessons Learned

Activity to date:
Diagnosis by spirometry is the 1st of 14 HQO Quality Standards for COPD and was not readily available in the Quinte community prior to FY 1920. Testing began in Q3 with 135 community tests completed at 4 team based centers as of Dec 30. On track to reach an average of 500 community tests per year by FY 2021.

Change Idea #2

Timely screening of patients with suspected/confirmed respiratory disease to facilitate appropriate management and followup

Target for process measure

- 75% of COPD patients have a MRC assessment and score during admission by Q4.

Lessons Learned

Activity to date:
MRC is a standard tool used for defining perceived breathlessness for COPD. 4 of 6 primary care teams now using MRC tool to assess breathlessness for COPD clients. Last 2 primary care teams & QHC looking at a Q4 implementation.

Change Idea #3

In-person follow-up assessments completed in the community within 7 days of discharge.

Target for process measure

- Potential methods are identified by Q2.

Lessons Learned

Difficult to understand progress on this metric. Implementation of a new version of SHIIP that went live in September will improve primary care awareness of acute hospitalization.

Change Idea #4

Follow-up assessments completed using OTN within 7 days of discharge for patients with no primary care provider.

Target for process measure

- 50% of orphaned COPD patients receive follow-up within 7 days of discharge using OTN.

Lessons Learned

Impact of stipend removal that comes into effect in April has had a negative impact on this activity. Physicians who had been supporting initiatives like this have withdrawn as a result.

Theme II: Service Excellence | Patient-centred | Priority Indicator

Indicator #5

Percentage of respondents who responded "completely" to the following question: 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? (Quinte Healthcare Corporation)

Last Year		This Year	
50.50	**57.10**	**57**	**--**
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

Provide patients with diagnosis specific information and teaching prior to discharge.

Target for process measure

- 90% of appropriate patients will receive a PODS at discharge

Lessons Learned

Discharge PODS for COPD, pneumonia, stroke, fracture hip, COPD urosepsis and generic implemented on appropriate units.
Plan to implement PODS in ER for admitted patients DC home. Developing a report to ensure 90% of patients receive PODS on DC. Generic PODS implemented.

Change Idea #2

Follow-up with patients who received a Patient Oriented Discharge Summary (PODS) to determine if content and preparation for discharge were adequate.

Target for process measure

- 85% of PODS patients will receive a follow-up phone call.

Lessons Learned

Just in time surveys being trialed on acute medicine to ensure patient receiving information throughout hospital stay.
Development of a strategy to maintain follow-up phone calls as the volume of patients receiving PODS grows is important to ensure their ongoing value to patients.
Developing sustainability plan for the project. Each quarter post-discharge surveys show 87-88% of patients find the PODS they received to be helpful/very helpful.

Theme III: Safe and Effective Care | Effective | Priority Indicator

Indicator #2

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. (Quinte Healthcare Corporation)

Last Year		This Year	
CB	CB	CB	CB
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

Develop a strategy to reliably measure percentage of medication reconciliations completed on discharge

Target for process measure

- A consistent process will be established by the end of Q1.

Lessons Learned

Method for capturing med rec on discharge has been implemented but data is not reliable. This indicator will be included on 2020/21 QIP with a focus on accurate tracking of med rec at discharge. Currently the region is working towards a regional HIS so the organization is working within existing software which is less than optimal for this purpose.

Change Idea #2

The current vendor for the software in which BPMH is collected has discontinued the application so a change in the software is required in order to maintain a stable and consistent location for BPMH to be captured.

Target for process measure

- The Meditech BPMH platform will be in use by the end of June 2019

Lessons Learned

This switch occurred in June 2019.

Change Idea #3

Implement a multidisciplinary approach to obtaining BPMH with a focus on timeliness and consistency.

Target for process measure

- 80% of admitted patients will have a BPMH completed within 2 days of admission by Q4.

Lessons Learned

Update on Progress:
Working to improve this number by training additional existing staff in the process and lean out other Pharmacy tasks in order to free up additional technician resources to dedicate to med rec.
Gains made through involvement of nursing in short stay areas (maternal child) and outpatient services (oncology and pre-operative screening) to obtain timely Best Possible Medication Histories.
October – December saw progressive increases in %:
Oct – 24.2%
Nov – 26.2%
Dec – 38.6%

Theme III: Safe and Effective Care | Safe | Mandatory Indicator

Indicator #3

Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period. (Quinte Healthcare Corporation)

Last Year		This Year	
103	**103**	**142**	**110**
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

Sustain the work from 18/19 focused on reporting and root cause analysis of all workplace violence incidents.

Target for process measure

- Each quarter a minimum of 75% of workplace violence incident reviews are completed (includes VP sign-off) within 10 business days of submission.

Lessons Learned

Timely analysis of the events leading up to all workplace violence incidents by the manager is occurring within the specified time frame (10 day) with great consistency. This is monitored through Occupational Safety.

Change Idea #2

Enhance the awareness and knowledge of QHC staff and volunteers specific to responsive behaviours.

Target for process measure

- By the end of Q3 85% of QHC staff and volunteers will have completed de-escalation training using either QHC's online de-escalation training module or have obtained de-escalation training in a small group session.

Lessons Learned

Staff results as of December 31 for completion of mandatory de-escalation e-learning module was 91%. All staff entering the organization are provided with information on de-escalation strategies and techniques
The importance of ensuring our volunteers received training cannot be emphasized enough as they are often the first point of contact for patients and families. Training now delivered to all new volunteers during orientation.

Change Idea #3

Continuation of work from 18/19 focused on appropriate identification of patients with a potential/actual risk for violence.

Target for process measure

- 100% of flags applied in the ED's are appropriate and a result of a DASA assessment.

Lessons Learned

This work was delayed as a result of staff change over. Implementation of the RNAO's Preventing Violence in the Workplace BPG is beginning Q4 of 2019/20 and will extend into 2020/21 and include organization wide rollout of DASA and careplan development for those flagged as at risk.
Continued focus through an established mechanism (in our case the Best Practice Spotlight Organization activity) needed to be established prior to removing strategic focus in order to sustain improvements.