Grey Bruce Health Services Quality Improvement Plans (QIP): Progress Report for 2018/19 QIP

ID	Measure/Indicator from 2018/19	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	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 2017(Q1 FY 2017/18); CIHI CPES)	Collecting Baseline	Collecting Baseline	65.40	Compares favorable as OHA average is 57.6%

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?
Implement patient discharge process improvements	Yes	IDEAL discharge planning framework introduced as part of Accreditation planning work
Track and trend issues from discharge phone calls, readmissions within 48 hours, Patient Relations feedback and Patient Safety reports to further identify patient discharge areas for improvement	Yes	The Quality department has been reviewing trends from Patient safety and relations reports and working with leadership to identify and implement improvements

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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. (Rate per total number of discharged patients; Discharged patients ; October – December (Q3) 2017; Hospital collected data)	50.90	80.00	67.95	GBHS achieved peak performance of 73.6% in Sept 2018 Current performance represents Q4 18/19 performance

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Complete discharge med rec process improvements identified during med rec discharge Kaizen	Yes	Quality teams were able to meet all accreditation standards for discharge med rec in April 2018
Complete Med Rec policy update and education roll-out to increase clarity on internal and external patient transfers and discharges	Yes	Policy updated to provide clarity regarding internal transfers and discharges. Opportunity exists to complete further education and process improvement on the documentation within the clinical record
Improve med rec auditing report to address data quality issues to provide tool that provides accurate data to measure discharge med rec compliance	No	Once all process issues on documentation are completed, quality auditing will begin

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3	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)	52.00	100.00	91.00	Data is reported on 2018 calendar year

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Improve the reporting of workplace violence at GBHS	Yes	Collaboration between Patient Safety and OH&S has helped to identify staff safety issues identified through patient safety reports
Complete workplace violence risk assessments for all areas	Yes	Standardized workplace violence assessments were completed for all areas in 2018
Improve patient flagging system to establish a method for staff to identify patients who have demonstrated violence through the use of a temporary alert code order	Yes	A temporary alert for violent patient process was introduced in March 2018 to provide for a way to alert other of potential for violence as an interim measure until an assessment and application of a permanent violent flag is attached to the patient record
Implement daily workplace violence risk assessment discussions during inpatient mental health huddles	Yes	Daily situational awareness discussions are occurring at mental health and all patient care areas huddles to increase staff knowledge of the potential for violence in their areas.

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4	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 - December 2017; CIHI NACRS)	6.20	6.00	6.20	Q3 results which captures the most complete quarter of coded data

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Increase the visibility of the Patient's Expected Discharge Date	Yes	Discussions with physician staff have occurred. Visibility is occurring in some areas but standard approach still required to be implemented
Develop a strategy to promote discharge orders written 24 hours prior to patient discharge	Yes	Discussions with physician staff have occurred. This is occurring in some areas but standard approach still required to be implemented
Increase the use of evidenced based patient pathways	No	Completing work with partners to implement common evidence based care order sets and pathways has impacted timelines on this work
Spread the strategy to support physician rounding before 10am	No	Discussions still ongoing with physician group
Implement visual management electronic bed tracking tool		An electronic bed board was implemented in Oct 2018. All GBHS leadership has access to this tool which provide real time data on patient
Introduction of PMF flow managers to support decision making		PMF managers hired in June 2018 and available to support staff and on-call to address patient flow issues on evenings and weekends
Implementation of weekly Patient Flow rounds		Weekly Patient Flow rounds started in Oct 2018 to engage leadership in supporting actions to address patient flow challenges