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 Integrated Stroke Unit? (Number of Patients; Discharged Patients from Integrated Stroke Unit; April 1, 2017 - March 31, 2018; In-house survey)	4471	CB	CB		

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 post discharge support for stroke patients and/or identified support person by providing follow-up phone call within 48 hours of discharge home other than long term care (LTC).		
CHANGE PLAN 1: • An attempt will be made to contact 100 percent of stroke patients with a follow-up phone call within 48 hours of discharge home (other than long term care) from the Integrated Stroke Unit by January 31, 2018		**Experience with indicator** Goal to attempt post-discharge phone call within 48 hours to 100% of patients was a challenge. Goal achieved with 93% of patients. Factors related to not achieving 100% included miscommunication, availability of staff to make the call and/or timing of discharge. **Learnings**: • Expand the team to include any clinician that can make the follow-up call. • Paper based process for tracking patient

follow-up phone call responses increases risk of missed data

Impact:

- Increased patient compliance with follow-up appointments
- Medication issues identified and corrected in timely manner, potentially avoiding return to hospital or clinic

Advice:

- Utilize a higher number of team members that would be accountable to make the follow-up phone call.

CHANGE PLAN 2:
100 percent of contacted patients with identified issues will have a recommended plan in place by end of the phone call.

Experience with indicator
Goal to provide post discharge support by identifying and addressing any issues related to follow-up care, medications, symptoms in the early days post-discharge was realized by our team.

Learnings:

- Patients benefit from written, more comprehensive discharge instructions
- Guided script for those making the calls works well for continuity and keeping the conversation focussed with the patient/caregiver

Impact:

- Increased patient compliance with follow-up appointments
- Medication issues identified and corrected in timely manner, potentially avoiding return to hospital or clinic

Advice:

- Establish an electronic database or the ability to track follow-up phone call results in the EMR