Excellent Care for All
Quality Improvement Plans (QIP): Progress Report for the 2015/16 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.

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1	"Overall, how would you rate the care and services you received at the hospital?" (inpatient), add the number of respondents who responded "Excellent", "Very good" and "Good" and divide by number of respondents who registered any response to this question (do not include non-respondents). (%; All patients; October 2013 - September 2014; NRC Picker)	858	90.50	92.00	94.00	Our approach to continuously improving patient satisfaction at MGH is unique in that, rather than focusing solely on initiatives that address specific needs or issues, we direct our efforts to enhancing the culture of the organization. Through an emphasis on relationships and strategies focused on connecting staff with the patient perspective and re-engaging with the empathetic aspect of care, we have seen ongoing improvements in our patient satisfaction performance. This work requires a sustained effort and, each year, the strategies build on previous work so that they evolve and grow overtime, becoming increasingly embedded in the culture of care delivery at MGH. To illustrate, when patient stories were introduced into team discussions, the expectation was not that the patient

experience would change simply because we were asking patients for their stories but, rather, that the connections that were created through these conversations would support a changed staff perspective that would ultimately enhance care provision throughout the patient's stay.

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Change Ideas from Last Years QIP (QIP 2015/16)	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?
Standardize the capture of the TEGH Patient Experience	Yes	Aligning the 6 channels that capture patient feedback continues to be important work for the organization and is included in the QIP 16/17 workplan. The standardization of the collection and reporting of the data/information proved more time-consuming and challenging than initially anticipated. Considerable time has been spent over the past year meeting with stakeholders responsible for each of the channels, many of which are not centralized corporately but instead are program specific. The result of this past year's work is a greater understanding and appreciation of the information that that is being collected and used across the organization. From this learning, a framework for organizing the information, based on both the MGH Patient Centred Care plan, as well as Picker's principles of patient-centred care and is being rolled out to each of the channels in phases. While the information is complex, we believe that coordinating the data and then performing a regular integrated analysis of it will provide valuable perspectives and enable a bigger picture overview of the patient experience.
Coordinate and align organizational efforts to improve the patient experience	No	This change idea was amended. The diverse council that will review patient experience data from multiple channels has not yet been formed but will be included in the plan for the upcoming year. The council's creation and work is dependent on the standardization of patient experience data and, as already described, the timeline has been adapted in response to the complexity of the

| | | initiative. Moving forward, a phased approach is planned in which the trends from channels that have been updated will be discussed, rather than awaiting channels in all 6 areas. Our aim is to increase our understanding of the trends and common themes that emerge from the qualitative and quantitative information when analyzed as a whole. |
| Improve the patient experience in the emergency department | Yes | As a department we continue to focus on the culture of the patient experience and how we make sure the patient is at the center of all the work that we do. Over the past year, we have done this by timely and involved follow-up with patients following complaints or concerns, involving staff in the resolution process, training related to professional standards and accountability, rounding on patients, patient involvement in our QIP strategy, and patient experience panel representation. As leaders we try our best to model the way, and instill similar qualities upon our charge nurses, and have had some intentional development of this role. Furthermore we learned that by caring for our staff they in turn care for our patients and that has resulted in a number of items coming from our staff satisfaction surveys. |

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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; Jan 1, 2014 - Dec 31, 2014; Publicly Reported, MOH)	858	0.28	0.35	0.34	Clostridium difficile infection (CDI) remains an unpleasant, and potentially severe or fatal infection that occurs mainly in elderly and other vulnerable patient groups especially those who have been exposed to antibiotic treatment. For the better part of 2015, MGH was challenged with increased incidences of HAI related to Clostridium difficile. In September, we embarked on a number of interdisciplinary brainstorming sessions to heighten awareness of the problem and increase engagement organization-wide. As a result of these brainstorming sessions, 4 key initiatives were focused on in order to help shift the rate of transmission within the organization. • Incontinence Care • Shared Equipment Cleaning • Education • Extensive retrospective chart review An increased awareness of the issue of CDI and its transmission coupled with a concerted effort to increase the visibility and availability of the IPAC team has led to tremendous success. Since that time, we have seen significant improvement in our rates of transmission within the organization.

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Improve provider hand hygiene compliance before patient contact	Yes	At MGH we have a well established leadership auditing system that emphasizes to frontline staff the importance of appropriate hand hygiene practices. To build on this successful longstanding program, the introduction of audits by unit supervisors proved to create awareness of staff that were non-compliant and the addition of positive reinforcement for compliances was well received. Continued direct observation auditing by leadership throughout the organization has reinforced the commitment and importance of Hand Hygiene compliance. The Infection Prevention and Control team experienced significant staff changeover in 2015, which resulted in less visibility over a period of time and perhaps affected the hand hygiene performance rates.
Increase team capacity, by empowering and educating Personal Care Assistants to identify, document and isolate patients suspected of clostridium difficile	Yes	By empowering PCA's with the knowledge to identify, document & isolate patients suspected of CDI it was thought that this early identification would decrease risk of transmission. This idea change was successful: the staff complied at 100% in the randomly audited charts. Lesson learned: Timely and consistent documentation continues to be a challenge and will be a focus for future initiatives.
Utilize ultraviolet disinfectant technology to clean rooms which have been isolated due to C.diff positive patients upon discharge and test the efficacy of sanitation using an ATP audit.	Yes	Effective cleaning of the environment around patients who have CDI is essential in limiting the acquisition and spread of C. difficile. Lesson learned: Clearly outline the need for physical, manual cleaning with a sporicial agent to eliminate spores and educate more clearly on the value of UV light disinfection as an adjunct to appropriate clean.
Random ATP audit on non-isolation rooms in clinical units	Yes	There was value in diversifying our approach in deploying our resources. We decided to measure our non-isolation room randomly. By increasing the audit on the regular patient room, we intended to ensure a clean environment at all time. Lesson learned: Consider resources carefully & the ability to implement change

ideas without appropriate resources.

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3	Falls with harm: Total number of falls divided by the number of patient days, multiplied by 1000. (Rate per 1,000; All patients; 2015/16; Hospital collected data)	858	0.42	0.42	0.42	Hardwiring the initiatives is key. In order to sustain our performance and prevent falls, strategies need to continually be revisited and recommunicated. The Falls Prevention Action Team (FPAT) meets monthly and analyzes each fall ensuring that opportunities for improvement are continually identified and addressed. Addressing the entire patient journey in the hospital enhances patient safety; e.g. integrating ED into process through their participation in early flagging of patients with a potential for falls and/or confusion.

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Sustain and hardwire falls prevention standard work.	Yes	Ensuring that the importance of the objective remains top of mind is essential and is supported, in part, by reporting and discussing data that is meaningful to the unit. In the Fall, each unit received a visit to discuss the Falls strategy and review metrics from the past year, along with fresh set of tools that they need to do the work. Monthly outcomes reports are sent to unit leadership, enabling an individualized understanding of and response to the unit's performance.
Increase staff capacity and engagement by empowering Personal Care Assistants (PCA) to design and implement	Yes	Through 6 focus groups with PCAs from across the hospital, 60 ideas for fall prevention were brainstormed. Engaging and empowering all staff that interact with patients created 'falls

a unit specific falls prevention strategy		advocates' for each of the units. Clarity around the role and expectations of all providers enables shared accountability and a team approach.
Prevent the deterioration of patient mobility by ensuring the implementation of a mobilization strategy for each patient.	Yes	The mobility strategy has been rolled out organization-wide. However, sustainability is variable across units. The initiative lost some momentum due to competing priorities but we intend to continue to complete this work, but with adaptations. The charting employed proved to be the greatest challenge; it was cumbersome and became a disincentive to mobilizing patients. A clear visual of a patient's mobility status enabled us to partner with families as, with a clear understanding of their loved one's mobility status, they are able to encourage patient's mobility as well.

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4	Medication Reconciliation on Discharge: Total number of medically complex discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion of the total number of medically complex patients discharged. (%; ♣ Indicator excludes hospital discharge that is death, newborn, or stillborn. ♣ Surgery patients discharged in less than 48 hours & Patients discharged in less than 24hours; 2015/16; Hospital collected data)	858	65.00	68.00	77.00	Engagement from the physician team in various areas was essential in achieving compliance for completed medication reconciliations on discharge. Due to differences in workflow throughout the hospital, it was found to be most beneficial when program specific improvement strategies were established. Training has been a major focus of this QIP during its implementation. The medication reconciliation must be documented using the Cerner tool in order for the data to be accurately captured. The medication reconciliation tool can be complicated and overwhelming to a new user; without adequate training, completion of med rec is highly unlikely to occur.

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Increase proportion of patients receiving medication reconciliation on admission.	Yes	By making medication reconciliation on admission data readily available to the pharmacy team via huddles, and improving the documentation for ease of use of tool, the pharmacists were able to make and sustain improvements to the proportion of patients receiving medication reconciliation on admission. With a target of 80% of patients receiving

		medication reconciliation on admission, there is still room for improvement which will help to improve the proportion of patients receiving medication reconciliation on discharge by their attending physicians. In the next QIP, focus will be placed on specific programs or departments that are struggling to consistently achieve med rec on admission rates above the organizational goal of 80%.
Define and standardize a clear process and expectations for medication reconciliation on discharge.	Yes	Standardized e-chart training was provided to physicians to ensure consistency in documentation. This was implemented as a pilot with the surgical residents, and later opened to the other surgeons. This change idea will be spread to other areas of the hospital in the coming year(s). In addition, a priority for the hospital over the past year has been creating an ideal discharge plan, which incorporates the medication reconciliation on discharge into an informational handout created for the discharged patient to take home.
Drive performance improvements in targeted units which display compliance below the organizational average.	Yes	Efforts were placed on the surgery inpatient units by implementing training on the medication reconciliation tool in Cerner for surgical residents during orientation. Surgeon support and pharmacist champions on the units were crucial in ensuring the success of this project. Improvement efforts were successful; however sustainability proved to be a challenge, due to the quick turnover of surgical residents, and the low attendance at orientation training sessions. This will continue to be a focus in the 2016/17 QIP.
Data Quality Review	Yes	Revise the current report structure; expand to capture different patient populations. The 2015/16 QIP captured medication reconciliation on discharge data for patients that were medically complex, defined as discharged after 48 hours or more, taking 10 or more medications, on an anticoagulant or any drug with the word insulin, fentanyl or hydromorphone in the name. Further changes have been made to the reporting structure of medication reconciliation on discharge for the 2016/17 QIP.

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5	Patient experience with hourly rounding ('care rounds'), measured through post-discharge phone calls. Patients will rate their experience on a 5-point scale. The indicator will be percent of responses with positive score (4 out of 5 and above). (%; All patients; 2015/16; Post Discharge Data Collection)	858	75.00	80.00	84.00	• With the help of the Late Career Nursing Initiative (LCNI), the process of rounding on patients was redesigned. Key learning's include: • The involvement of frontline staff in the planning and development of the initiative. Staff engagement increased participation and adoption of the proposed changes. • The need to commit resources. • anchoring other initiatives and processes into the model e.g. mobility plans, discharge planning, medication administration and bedside shift report. • Re-evaluating the previous metric of electronic record documentation as it did not reflect the actual care provided during rounding Evaluation • The majority of patients were satisfied with the care they received in hospital. Challenges • Conflicting priorities and challenges committing project resources. Future goals • A future metric of call bell usage that is incorporated into the daily conversation is currently being explored. There needs to be daily tracking and conversations to sustain these changes. •

| | | | Hardwire the current process to include staff check ins and opportunities to address problems and revise processes in a timely manner. |

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Based on the output of the Late Career Nurse Initiative, the care rounds model will be redesigned and rolled out to all medical & surgical units.	Yes	• The previous 4P rounding model was not carried out by the frontline as originally intended. The metric was measuring the consistency of nursing documentation instead of measuring the nurse meeting the patients care needs. The 4P model encouraged an individual approach and was associated with a lengthy script. Through the LCNI, all stakeholders were involved (nurses, educators, patient care assistants and management) in the design. The redesigned model included a simplified script, adjusted rounding times to accommodate work flow and integrate a team based approach. • • It was a challenge to roll out the redesigned model to the entire organization as units had other conflicting priorities. 3 out of 10 units have adopted the redesign as of March 15, 2016. There are plans to continue to roll out to the entire organization throughout 2016. The pilot units (A3 & B3) had a 4% increase in patient satisfaction scores when compared to the entire organization. For the 2016-2017 year, the Rounding for Quality QIP will be incorporated into the Patient Experience QIP. This will ensure continued to monitoring of the roll out and evaluation of the rounding redesign and the impact on patient experience. Advice to others: Consider the impact of other organizational wide initiatives or conflicting priorities.
Patients will be educated regarding the care rounds model in an effort to manage expectations and create a pull-mechanism for high quality rounding.	Yes	Through the LCNI, we created and trialed "rounding clocks" and patient education on rounding pamphlets. The rounding clocks were paper clocks designed to inform the patients of when to expect the next time the nursing team would round on the patient. Random audits, found

that the clocks were not utilized consistently with the care teams. The value of the clocks will continue to be monitored and revised to meet patient and staff needs. The "patient education on rounding" pamphlets were created. Initially, volunteer services agreed to provide these pamphlets to every patient on units associated with the redesign. However, due to a lack of resources, this process was unable to be sustained. The patient education on rounding information has been now added to the MGH Patient and Family Guide (February, 2016). The Patient and Family guide is provided to all new admitted patients. The target this year was to achieve 75% positive response rate on patient education of rounding process. Unfortunately, the target was not achieved. A 64% positive response rate was achieved. This was likely due to the inconsistency in pamphlet distribution. An increase in positive response rates is anticipated with the patient education on rounding being integrated into the patient and family guide. Advice: Explore the sustainability of methods chosen when communicating information to patients; Determine how this education using the MGH Patient and Family Guide can be incorporated into an Ideal Admission process.

The quality of care rounds will be assessed by hospital leadership through rounding on patients.	No	Change idea was amended. Leadership rounding questions were created with the help of patients. Some patients had difficulty differentiating the "rounding" process from their overall care experience. Based on this feedback, questions were created to measure the patients overall experience with their care. These questions were placed on survey monkey allowing leaders to utilize their cell phones and Ipads to capture the data. This format was trialed but was not formalized. Barriers identified included a lack of time and technology. There was also difficulty interviewing patients with language barriers, cognition issues and unwillingness to participate. During the 2015-16 fiscal year, the patient experience through leadership rounding was not captured Future strategies include: • Continuing to work with the leadership team to build leadership rounding into their daily standard work. • increasing the availability of technology to support timely submission and aggregate of results from manager rounding, • Scheduling rounds into calendars and allotting time in their daily work to round. • Comprehensive Leadership rounding
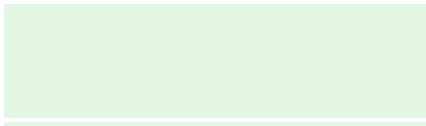
across other initiatives Advice: Explore leadership priorities and ability to complete rounding. Ensure leadership buy in to the process

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6	Patient Survey Participation Rate: Number of patients who participate in the TC-LHIN Health Equity survey divided by the total number of patients surveyed (%; All Contacted Patients; Most recent; Hospital collected data)	858	60.00	70.00	82.00	The survey questions and overall process is facilitated by Mt. Sinai Hospital. A significant amount of time was spent designing, building and testing the electronic storage of this data in the patient record. The process had to be modified part way through the project when it was identified that the information was only to be refreshed every 2 years for any given patient. Pre-registered patients such as Family Birthing and Dialysis are able to spend time and fill the information out at their leisure. This has worked very well. The Emergency Department implementation is more real-time data collection and we anticipate much lower participation rates (60% was what we were able to achieve in a pilot in ER). Other hospitals will be monitoring our success with ER since many have not extended their reach to collect data in this area.

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Progress: Implement patient surveying process across all	No	The electronic data collection process required re-design part of the way through the project

coded inpatient areas of the hospital.		due to a change in the LHIN requirements (collect data only once every 2 years). This required additional building and testing of the tools and re-writing of the reports that contain health equity data. This is now complete but took much longer than expected. Change idea was adapted. Combining demographic data with outcomes information is still not possible. We were anticipating submission of the data to CIHI to assist with the analysis of outcomes. This was not possible so a partnership with ICES is being explored by the LHIN.
Contact Rate: Ensure that patients are provided a TC-LHIN health equity survey in targeted regions of the hospital.	No	The electronic data collection process required re-design part of the way through the project due to a change in the LHIN requirements (collect data only once every 2 years). This required additional building and testing of the tools and re-writing of the reports that contain health equity data. This is now complete but took much longer than expected. Change idea was adapted. Combining demographic data with outcomes information is still not possible. We were anticipating submission of the data to CIHI to assist with the analysis of outcomes. This was not possible so a partnership with ICES is being explored by the LHIN.
Information Rate: Establish process and communication platform that allow patients to feel comfortable completing the TC-LHIN health equity survey.	Yes	Data entry process is a separate data collection form in the Registration system. Clerks cannot view the data once it is entered. Only specific items, such as ethnic group, religion, and language are available to view in the electronic patient chart. The survey process in Emergency is designed to keep the survey responses in a separate box for data entry after patient registration and will only be identified by MRN.

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7	Physician Initial Assessment: 90th percentile Time to Physician Initial Assessment (Hours; ED patients; 2015/16; Hospital collected data)	858	4.40	4.00	3.58	A group composed of department leadership, front line nurses, physicians and clerical staff ensured our QIP initiatives had constant attention from various staff members and disciplines. The most successful change idea resulted in reorganizing the way we allocate our resources for certain patient population. Accompanied by the distribution of data and improvement education disseminated across staff helped provide buy-in for change and sustainability.

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Continuous Improvement Education	Yes	Multiple strategies beyond the classroom were needed in order to reach to as many staff as possible. A combination between focus project groups, interested employees, newsletters, in-services and videos were utilized to educate staff. The classroom combined with dedicated resources for coaching and mentoring provided to have the highest yield as members were also able to apply and implement their learnings. A similar model will be considered in the upcoming year
Regular Distribution of Real-time Patient Wait time Data	Yes	Depending on staff members and their disciplines, only specific information was relevant to each group. As staff members were able to quantify their performance, an increasing awareness to improve and identify where issues lied increased. In the upcoming year, more focus will be placed on separating and pushing the necessary information to the right parties.
Targeted Process Improvement Projects	Yes	It was discovered that as opportunities were identified, resulting projects had a normal implementation sequence for which the rate of success would increase. As a result certain project required more time and resources than

others. During this process a large amount of time was put into change management and getting buy-in from various staff members. Communication proved key in moving our initiatives forward. A balance between small and large projects were also necessary to ensure (1) perceived progress of change and (2) managing the mental load changes placed on the department.

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8	Rescue Index Number of in-patient ward decedents with full cardiac pulmonary resuscitation status per 1000 discharges (Rate per 1,000; Excludes in-patient decedents from special care units; 2015/16; Hospital collected data)	858	X	10.00	1.60	The 2015/16 year was successful in so far as defining the objectives and scope of the Rescue from Danger (RfD) program, and launching several change initiatives impacting all MGH clinical services. The initial challenge lay in stakeholder communication. As a new program affecting all clinical services, we invested significant time and effort to explain why this program was critically important to our patients' safety and quality of care, and how it is in fact a key component of MGH's overarching ambition to continuously move toward becoming a High Reliability Organization. The RfD team deployed various communication approaches via numerous channels, including hospital newsletters, leadership committees, general staff "town-halls", and focused presentations to and workshops with influential stakeholders. At the on-set of the RfD program, we did not have any baseline metrics – for our own hospital, nor for peer hospitals. While our initial Rescue Index Target – based on a set of assumptions made by our physician leadership team – was in retrospect set too high, we are pleased to have designed and implemented a meaningful outcome measure that we

can use on our continuous quality improvement journey. Perhaps the single most important change initiative completed in 2015/16 was the set of process and balancing key performance metrics (KPMs) that have been defined. The mere process of cross-functional care providers discussing and debating the appropriate KPMs to govern all supporting quality improvement process changes served to clarify purpose, respective roles, and collective "buy-in" to the program's importance.

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Design and implement Key Performance Measures.	Yes	This change initiative proved to be challenging on account of the complexity of different perspectives and processes across the clinical services. We underestimated the degree of inconsistency, as well as the effort required to collect data easily and on a timely basis so that regular KPM reports can be generated. While we were pleased with the design and implementation of the outcome measure (the Rescue Index), we did not fully implement all the process and balancing measures defined by the RfD working groups in the early months of 2015/16. All of the desired process and balancing measures have been designed, but the implementation has been staged for delivery in phases. Phase 1 was completed, which gives us monthly reports on: • number of Critical Care Response Team (CCRT) responses, by service area • number of transfers from Ward to Intensive Care within 24 hours of admission • number of transfers from Ward to Intensive Care beyond 24 hours of admission The successes gained in 2015/16 will be the foundation for on-going development of KPMs in 2016/17 – namely

		"Phase 2" and other metrics deemed to be important.
Ensure hospital-wide coordination and focus on Quality Management and Quality Assurance initiatives.	Yes	An important outcome of our extensive stakeholder assessment and communication strategies was the re-design of the existing RfD Steering Committee. We do not believe this would have been possible without the focused attention on communicating a compelling case for change. Today, we have an invigorated committee with new members, and terms of reference with heightened attention to reviewing KPMs of the "RfD System" with the goal of continuous quality improvement.
Ensure Emergency Department patients are transferred to the appropriate ward at the right time.	Yes	This initiative was an important indicator of physician engagement. A physician resident worked closely with the respective physician leaders of Emergency, General Medicine, and Surgery to complete the research study and present conclusions and recommendations. In mid-2015/16, the recommendation to implement the ER-STOP program was accepted, and a team was formed to transform the program from a "test" to regular clinical practice. Today the ER-STOP program is fully operational. The key success factors are: 1) the level of physician engagement, and 2) the deliberate communication with and ultimate involvement of nursing staff in Emergency and all subsequent patient care units in the hospital.

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9	TEGH QBP Readmission Rate (%) Number of patients admitted for any non-elective cause to TEGH within 30 days of discharge from TEGH, for selected Quality based procedures (QBPs), divided by total patients discharged from same QBPs in prior 30 days. (%; "Patients" defined as all patients discharged from one of the following QBPs:; 2015/16; TEGH Coded and Hospital Information System data)	858	14.80	14.80	13.20	Extensive work with clinical teams and sharing encounter- and patient specific information on readmissions allowed for detailed reviews of readmission causes. The reviews found that the majority of readmissions were not directly linked to the preceding episode of care; many of the readmitted patients had substantial socio-economic issues, which could affect health in a negative way. To reinforce the importance of proactive management and prevention of readmissions, an innovative approach is being developed: flagging all readmitted patients in an electronic patient chart in a near-real time way to facilitate clinical teams to review the potential causes for readmission and adjust the care plan, if needed.

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Ensure monthly results are visible to QBP teams.	Yes	Bringing information on readmissions from a level of an abstract rate (percentage value) to the level of a specific patient and episode of care was very well received by the

		clinical teams and allowed to engage all key QBP leads, including Physicians, in charts review with the following discussion of findings.
Flag readmitted patients in patient chart.	Yes	It was very important to ensure that flagging of the readmitted patients is well aligned with day-to-day activities of the clinical teams rather than to create a standalone solution that could be less effective. Collaboration and work as a team with Health Informatics and QBP clinical teams is seen a key success factor.
Develop profile of Readmitted patients	Yes	Two iterative versions of the Readmitted Patient Profile were developed during the fiscal year, and population of the tool with the most up-to-date data is ongoing. One of the lessons is that it is important to involve clinical teams into the process of designing the tool from day one, making sure that the data captured is meaningful for the clinicians and allow for review of both trends and specific encounters

ID	Measure/Indicator from 2015/16	Org Id	Current Performance as stated on QIP2015/16	Target as stated on QIP 2015/16	Current Performance 2016	Comments
10	Total number of inpatient days where a physician (or designated other) has indicated that a patient occupying an acute care hospital bed has finished the acute care phase of his or her treatment, divided by the total number of inpatient days in a given period x 100. (%; All acute patients; October 2014 – September 2015; DAD, CIHI)	858	15.48	14.00	13.43	Addressing ALC can be challenging and requires an interdisciplinary, cross-continuum, multimodal approach. Through constant and focused attention as well as established structures, MGH continues to achieve improvement. Having the right people at the table has been a key enabler - this includes leadership, unit managers and community partners. With an understanding that ALC is not simply a "discharge challenge," we target our initiatives at all points along the patient's journey, e.g. ED, acute and post-acute care. Discussion and escalation are hardwired through twice weekly meetings to discuss potential and current ALC patients. The ALC Avoidance framework has driven an approach that considers diverse contributing factors and provides a means of self-assessment, while facilitating continuous improvement. We enter the next QIP cycle with a better understanding of the underlying factors that contribute to ALC, for example the awareness of the Substitute Decision Maker's role in care. We have learned that we can

		likely reduce delays by providing the right information and support to those needing to make decision in a patient's care.

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 2015/16)	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?
Identify patients at risk for complex discharges within the Emergency Department	Yes	The feasibility and validity of the Blaylock tool for risk assessment of complex discharges was tested and confirmed. Being able to identify patients who were at high risk of discharge delays would enable us to prioritize our resources. A standard process was developed for response to a threshold score and is in the process of being rolled out. Dedicating time to a deliberate communication strategy provided a foundation for success on the trial unit - staff understood the value of the new process to their work and were eager to participate.
Providing escalating measures of leadership support to staff managing complex ALC discharges.	Yes	Outlining clear actions and expectations to 5 key scenarios was helpful in proactively mitigating issues that could complicate discharge but could be avoiding. Recently, it has been noticed that not all processes have been sustained and it has become clear that more attention needs to be paid to hardwiring the process through regular refreshers and clear and regular reporting of the team's performance with this initiative.
Empower staff and physicians by providing tools, workshops and ethical training on managing complex patient scenarios related to ALC discharges.	Yes	All of the planned workshops were completed and regular capacity building now takes place. To maintain and grow the desired skills, regular (approximately every 2 months) as well as ad hoc education is essential.