Michael Garron Hospital
A Proud Member of TORONTO EAST HEALTH NETWORK
Formerly the Toronto East General Hospital

2016/17 Quality Improvement Plan (QIP)

"Improvement Targets and Initiatives"

AIM		Measure							Change				
Quality dimension	**Objective**	**Measure/Indicator**	**Unit / Population**	**Source / Period**	**Organization Id**	**Current performance**	**Target**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	Methods	Process measures	Goal for change ideas	Comments
Effective	**Maintain rate of QBP hospital readmissions**	MGH QBP Readmission Rate: Number of patients admitted for any non-elective cause to MGH within 30 days of discharge from MGH, for selected Quality based procedures (QBPs), divided by total patients discharged from same QBPs in prior 30 days	% / QBP patients: COPD, Stroke, CHF, Pneumonia	MGH Coded and Hospital Information System data / April 2015 - March 2016	858*	13.2	14.80	At MGH, QBP Readmission Rates are seen as one of the key quality of care metrics, directly linked to the hospital's HSFR (Health System Funding Reform) performance. Being one of the top performers in the TC LHIN with regards to the Readmission Rates, MGH aims to maintain the current excellent performance and to make sure that QBP Readmission Rates are accessible to the clinical teams on a near-real time basis and at the level of a specific patient. This will link the high-level metric with real patients' stories, enable chart audits, and facilitate seamless collaboration across continuum of care with regards to the most complex readmitted cases. Our findings showed that QBP Readmission Rates are highly variable, with many factors being outside of our control. In fact, in our opinion, a range of would be a better target for this specific metric. The target of 14.8% represents an upper limit of the range, to account for highly variable monthly results.	1)Ensure monthly results are visible to QBP teams	Ensure patient level data of all Readmitted cases are available to QBP leadership & establish monthly QBP reviews of key performance metrics, including Readmission Rate, in which improvement initiatives are identified, launched, and monitored	Number of monthly QBP Review meetings held as a proportion of all meetings which should be held. (100% = 4 QBPs x 12 months = 48)	90% achieved by Q4	
									2)Flag readmitted patients in patient chart	Design and implement system modification to electronic patient chart (eChart) to easily identify readmitted patients to care providers on wards	Percent of Readmitted patients with flag included in eChart	100% achieved by Q4	
									3)Develop profile of Readmitted patients	Classify characteristics of all Readmitted QBP patients, and plot on charts & Explore existence of patterns or trends that may inform improvement initiatives	Percent of Readmitted patients classified and charted	100% achieved by March 2017	
	Reduce overall caesarian section rate	C-section Rate: Total number of caesarian section deliveries divided by the total number of all deliveries x100	% / Maternity Patients	BORN (Better Outcomes Registry and Network) / Most recent quarter available	858*	29.1	25.00	Four population sub-groups (Robson 1, Robson 2, Robson 4 and Robson 5) have the most potential to be influenced through this initiative. The impact of improvement within this sub-group population on the overall c-section rate was evaluated when setting our target. The expected rate of change given the long-term nature of pregnancy was also considered.	1)Manage induction rates	1) Review standards for oxytocin use; 2) Review patient flow and scheduling/booking practices; 3) Review current standards regarding active labour; 4) Practitioner performance feedback	Percentage of low risk women with induced labours (Baseline: 25.39%)	21% by end of Q4	This objective is a Joint Centres spread initiative.
									2)Improve supportive care in labour	1) Review current standards and practice regarding: active labour, use of telemetry, use of intermittent auscultation; 2) Determine the most influential elements of supportive care setting for patients; 3) Practitioner performance feedback; 4) Determine correlation between epidural use and length of labour	Percentage of women monitored with intermittent auscultation prior to 5 cm	5% increase by Q4	
									3)Increase rate of vaginal birth after caesarian section (VBAC)	1) Identify opportunities to improve marketing of and attendance to VBAC classes; 2) Practitioner performance feedback	Percentage VBAC attempted with patients with one prior C-section (baseline: 37.4%)	45% by Q4	
Efficient	**Reduce unnecessary time spent in acute care**	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	DAD, CIHI / October 2014 – September 2015	858*	13.43	12.50	MGH applies a proactive approach to management of patients (ALC avoidance) and develops strategies in consideration of root causes. Applying continued focused attention on this objective, while working alongside community partners, we expect to match the rate of improvement in the Toronto Central LHIN and of peers.	1)Facilitate transition planning upon admission enabled by a tool to assess risk for complex discharge (Blaylock)	1) Build on and learn from pilot unit; spread to 2 additional units for further evaluation before spreading to all inpatient units 2) Introduce Blaylock tool into electronic chart 3) Continue to engage interdisciplinary teams through intentional and structured communication planning 4) Ensure standard process/script is used during daily minute rounds 5) Monitor process steps (including frequency of completion, time to review scores, etc) through minute rounds at each unit	Percentage completion of Blaylock tool for all patients >65 years old within 24 hours of inpatient admission	90% by Q4	
									2)Introduce a clear process to increase awareness of Substitute Decision Maker (SDM) Responsibilities	1) Clarify roles and responsibilities; identify specific accountability per activity e.g. communication, providing information, follow-up, documentation 2) Develop process for early identification of, education to and contact with SDM 3) Develop and implement script for communication to patient/families from staff 4) Finalize information letter to be signed by SDM 5) Introduce proactive 'marketing' approaches such as brochures, videos for use in hospital 6) Develop system to monitor timeliness of SDM identification	Percentage of inpatients for which a SDM is identified, provided education, supplied contact information and documented within 48 hours of inpatient admission* *for those patients requiring an SDM	90%	
									3)Hardwire escalation process	1) Review and revise escalation processes currently in place (5) 2) Enhance approach to auditing occurrences of (or missed) escalations 3) Embed escalation discussion within weekly ALC rounds (2x/week)	Number of missed escalations	0 (zero)	
	Improve organizational financial health	Total Margin: Percent by which total corporate revenues exceed (positive number) or fall short (negative number) of total corporate expenses, excluding the impact of facility amortization, in a given year	% / N/a	OHRS, MOH / YTD/Q3 (April 2015 - December 2015)	858*	-0.84	0.00	Following 14 consecutive years of 0 (zero) or greater total margin, we continue to aim to achieve a balanced budget in the upcoming year.	1)Launch a Revenue Capture Improvement project	1) Improve billing processes, engaging both clinical and back-office staff, to ensure all earned revenue is properly recorded, submitted for payment, and collected 2) Select priority revenue streams 3) Conduct end-to-end process maps 4) Identify root causes 5) Design solutions 6) Design and implement performance measures 7) Implement solutions (including training and sustainability plan)	Percentage by which total 2016/17 revenue exceeds 2015/16 revenue (not including Global, HBAM, and QBP funding)	10%	
									2)Initiate monthly cross-functional team meetings focused solely on financial performance monitoring and improvement	1) Enhance ability to identify, launch and support improvement initiatives through monthly cross-functional team meetings focused solely on financial performance monitoring and improvement 2) Select meeting forum, format, and members 3) Design performance metrics and targets 4) Establish project management framework for delivery of operations improvement initiatives	Percentage of monthly meetings with 80% or more of selected leaders in attendance	100%	

Equitable	**Increase identification and documentation of patients' smoking status (create foundation for smoking cessation)**	"Ask" rate: Number of patients asked if they smoke divided by the number of patients admitted to an inpatient medicine unit for greater than 48 hours x100	% / patients admitted to inpatient medicine units greater than 48 hours	Hospital collected data / April 2015 - March 2016	858*	47.5	70.00	Each unit is performing at approximately 45-50% over the baseline reporting period. It was discussed that through the implementation of the change ideas (bullet/morning rounds, education to staff and regular audits) each unit has the potential to increase their ask by approximately 25-30 individuals resulting in a target performance of 70% of patients "Asked."	1)Increase awareness of smoking cessation initiative through discussion at morning/bullet rounds.	1) Daily and consistent content discussed at rounds 2) Awards and incentives to be presented to staff/floors with high performance	Percentage of rounds in which smoking cessation initiatives are discussed	100% by Q4	
									2)Inform/educate nurses and physician assistants regarding techniques to bring up the 'Ask' with the patient	1) Recurring Lunch & Learns with guest speakers 2) Visuals, posters, flyers to be designed with a more socializable slogan other then 'Smoking Cessation' for the public to understand	Number of Lunch and Learn sessions delivered	Minimum 1 per quarter	
									3)Regularly monitor and report the performance of the objective through audits; inform units of individual performance to enable assessment and adjustment of activities	1) Produce regular unit reports on performance 2) Develop guiding questions to support self-assessment on units	Percentage of units for which audit is completed and reported	100% per selected reporting period (TBD) by Q4	
Patient-centred	**Improve the patient experience**	Positive Patient Experience: Percentage of top box response ("Definitely yes") to the question "Would you recommend this hospital to your friends and family"	% / All inpatients (surgery/medicine)	Canadian Institute of Health Information (CIHI) Canadian Patient Experiences Survey-Inpatient Care (CPES) / Not applicable (collecting baseline)	858*	CB	CB	A new survey tool will be introduced during this fiscal year. Following the collection of baseline data, a target will be set. Over the course of the fiscal year, the organization will monitor month over month performance to set short-term targets and drive improvement.	1)Align and analyze data from different patient feedback channels through standardization of data collection and reporting	1) Roll out standard data reporting framework (8 patient centred care dimensions) to all 6 channels through a phased approach 2) Develop a centralized process to gather data from 6 channels 3) Form a new Patient Experience Council consisting of diverse members: leadership, clinicians, patients, etc 4) Present consolidated qualitative and quantitative data via regular report to new council for review and discussion 5) Begin analysis by focusing on frequency within individual dimensions to identify areas for further exploration	Percentage of the 6 channels that reporting framework is applied to and that data is submitted by monthly	100% (6 of 6) channels per month by end of Q2	
									2)Continue to foster a culture that facilitates the intentional inclusion and participation* of the patient and family in care	1) Formally define the role of patients/family as partners at the bedside 2) Roll out family presence policy to enable partner role and outline expectations to staff 3) Highlight existing examples of patient/family participation to encourage spread across the organization 4) Embed participation and partnership within foundational clinical practices e.g. Care Rounds, Bedside shift report	Proportion of staff that have received education regarding the role of family as partners at the bedside	100% FT/PT staff by Q4	*As referenced in the MGH Patient Centred Care Framework (2014)
									3)Highlight the impact of system-level collaboration* by Patient Experience Partners across the organization	1) Profile and celebrate impactful experiences to foster understanding and spread 2) Centralize capture of activities occurring throughout the organization ie. departments, corporate 3) Report activities across the organization that have included patient experience partners 4) Utilize varied mediums to communicate eg. In General newsletter, website, video, etc	Number of instances that activities of Patient Experience Partners are showcased	Minimum 1 per month	*As referenced in the MGH Patient Centred Care Framework (2014)
Timely	**Reduce wait times in the ED**	Physician Initial Assessment: 90th percentile time to physician initial assessment	Hours / ED patients	Hospital collected data / January 2015 - December 2015	858*	3.7	3.00	The Canadian Association of Emergency Physicians suggests having a PIA target of 3.0 hours at the 90th percentile in order to balance ED overcrowding and to manage adverse patient outcomes (Affleck MD, Parks MD, & Dummond MD, 2013). A 90th Percentile PIA of 3.0 hours is the current provincial median for PIA. We are currently an outlier when compared to peer hospitals. A PIA target of 3.0 hours will align us with our peers, assuming our peer hospitals improve at a comparable rate to 2015.	1)Reduce Barriers to Physician Assessments: Physician Navigator Pilot	1) Partnering with an ED Physician familiar with the Physician Navigator role at other hospital sites 2) Co-develop the roles and responsibilities for this potential new role 3) Determine scalability of Physician Navigator resource (i.e. multiple Physician to 1 Physician Navigator) 4) Pilot role to formulate business case	Number of patients seen by a physician during a shift when given the opportunity to do so (without barriers)	At least 22 patients per shift	
									2)Reduce/eliminate processes for Emergency Department staff where work and tasks completed provided little or no value to the patient due to outdated policies or overlap in care	1) Interdisciplinary ED workgroup (Physician, Registered Nurse, Registered Practical Nurse, Clerk, Patient Rep, ED Leadership) will identify high impact areas for improvement 2) Projects will be formed from these improvement opportunities 3) Projects will go through quality improvement cycles with feedback from patients and staff members 4) New projects will be generated and started as existing projects end	Number of projects per month facilitated through Quality Improvement Workgroups composed of front-line nurses, physicians and leadership that result in quantifiable gains* for patients or staff. *Reduction of wait times for patients at various steps in the patient journey; decrease in tasks performed by staff that provide little to no value to patient care	1 per month	
									3)Partner with Diagnostic Imaging (DI) team to reduce DI (CT / Ultrasound) Turnaround Time	1) Determine cross-departmental goal for DI turnaround time for ED patients (benchmark required) 2) Align opportunities with existing projects underway 3) Create a smaller sub-group which will drive the reduction of report turnaround time	Number of hours decreased in Emergency Department/Diagnostic Imaging (CT and Ultrasound) turnaround time	TBD following site visits and peer benchmarking	

Safe	**Increase proportion of patients receiving medication reconciliation upon 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.	% / All patients	Hospital collected data / Most recent quarter available	858*	61	70.00	Building on the work of the previous QIP cycle, the population has shifted from only medically complex patients to all inpatients. There is no established benchmark for this indicator, though peer hospitals have identified a 75% rate. This is a stretch target for MGH that we plan to achieve over a two year period. By focusing efforts on specific areas of the hospital that consistently show compliance below the organizational average, we hope to drive up the proportion of inpatients across the hospital receiving medication reconciliation on discharge.	1)Identify a physician resource to provide e-chart training/support to psychiatrist team in Mental Health	1) Support the transition from a primarily paper-based discharge process to an electronic approach 2) Identify a champion physician with the e-chart medication reconciliation process 3) Provide training to Mental Health physicians.	Percentage of in-patient psychiatrists trained on medication reconciliation process in Cerner	100% of in-patient psychiatrists trained by August 2016	
									2)Remove barriers to the medication reconciliation on discharge process by continuing to improve medication reconciliation on admission rates. Review and streamline the discharge summary process, including the med rec on discharge process used by surgeons and residents, and provide additional training.	1) Revisit med rec on admission compliance, as it has been identified as a barrier to med rec on discharge when not completed. 2) Examine the discharge summary process, streamline the med rec on discharge process by removing non-value added steps. 3) Provide structured training to residents as well as staff physicians in surgery.	Percentage completion of medication reconciliation on admission rates for A5 and B5 (surgical in-patient units).	Medication reconciliation on admission completed for 80% of surgical inpatients (A5/B5) by September 2016	
	Reduce hospital acquired infection rates	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	Publicly Reported, MOH / January 2015 – December 2015	858*	0.34	0.26	The target selected by MGH represents a 25% improvement over our performance in 2015. A rate of 0.28 has been achieved in the recent past (2014) and we aim to exceed our past 2 year performance. We are encouraged by our past performance and aim to exceed the results reported by other large community hospitals in the Toronto Central LHIN. This target is aligned with the provincial average. Key internal stakeholders involved in the decision-making process agree that this stretch target can be achieved.	1)Revise cleaning protocols for changes in the isolation status of a room (discontinued, patient transfer, death or patient discharged home).	1) Eliminate confusion around what type of cleaning needed/when and ensure appropriate clean is completed based on potential for contamination and transmission (i.e. reduce unnecessary terminal cleans & ensure terminal clean when high risk present). 2) Revision and approval of signage posted on doors for isolated patients (mid Q1) 3) Direction and tracking of ALL cleans using teletracking electronic system, eliminating the need for direction from nursing staff & IPAC (early Q1) 4) Implement double terminal clean for all C. difficile positive rooms in accordance with PIDAC guidelines. 5) Test in ICU (mid Q1) 6) Training of ICU and Environmental Services staff assigned to trial unit (ICU) on new definitions of cleaning jointly by Environmental Services, Infection Prevention and Control (IPAC), and unit manager (early Q1) 7) Hospital wide roll-out through series of PDSA cycles (by end of Q2) 8) Environmental Services to audit appropriateness of cleaning assignment in teletracking via page alerts	Percentage of double terminal cleans completed upon end of isolation status of rooms with C. difficile as per revised protocol	100%	This objective is a Joint Centres spread initiative.
									2)Develop a program that incorporates an interdisciplinary approach to addressing cases of C. difficile, including the creation of a "Trigger Tool"	1) Create a "Trigger Tool" with a threshold for bioburden that prompts an escalated and action-oriented response (e.g. increased hand hygiene audits, extra cleaning of shared equipment, enhanced cleaning on unit by Environmental Services, environmental audits and attendance at unit huddles by Infection Prevention and Control team) 2) Provide education regarding Trigger Tool and purpose and expectations of meetings that will be called in response to cases of C.difficile. 3) Obtain commitment from unit managers, supervisors, ASP team, IC officer, ID physicians to participate in process 4) Create guidance materials for meetings and trigger tool including definition of what triggers action on each unit/service and expectations for each role (end of Q1) 5) Perform quarterly audits of awareness of roles and actions to measure uptake and sustainability	Percentage participation of required stakeholders at every meeting called	100%	
									3)Streamline the disinfectant wipes used on all units and clarify instructions for use of wipes on sensitive equipment	1) Eliminate alcohol based product and replace with a cost effective hospital grade disinfectant wipe. 2) Replace existing bleach wipe with one that is less wet, yet still effective when used appropriately (kill time followed) decreasing damage to sensitive equipment. 3) Revise guide to cleaning sensitive equipment (Q2 or Q3); trial in ED upon approval. 4) Provide training regarding accountability for cleaning of shared equipment (i.e. USER is responsible for cleaning of shared equipment). 5) Infection Prevention and Control member to partner with Clorox representative to lead education on new wipes at unit huddles (to frontline and environmental services).	Percentage of hospital using new wipes	1) 5% by end of Q1 2) 10% by end of Q2 3) 25% by end of Q3 4) 50% by end of Q4	

	Improve quality of response (timely & appropriate interventions) to deteriorating patients	Rescue Index: Number of "unexpected" adult inpatient decedents per thousand discharges. (Numerator excludes 1) patients under age of 18, 2) patients with DNR (Do Not Resuscitate) status, 3) decedents discharged from special care unit (eg: ICU); Denominator includes all adult discharges)	Number / All discharged adult patients	Hospital collected data / April 2015 - March 2016	858*	1.6	1.60	This indicator is measuring an infrequent event, and thus can be highly variable. Since this is a custom indicator, no external comparators are available. As this indicator is new (total of 10 months of historical data), low confidence in predictive value.	1)Implement ER-STOP (Emergency Room Safer Transfers On-purpose Pause)	1) This initiative was introduced in 2015/16 as a trial; it was successful and will now be implemented as standard operating practice 2) All admitted ED patients are assessed using ED-STOP criterion to ensure safe transfers to most appropriate care unit. 3) By identifying at-risk patients as soon as possible (in ED), care providers can ensure the patient is placed in the appropriate care unit, and transferred with appropriate precautions. 4) The focus for this year is to ensure the ER-STOP protocol is sustained as standard practice for all ED and inpatient care providers: i) Maintain delivery of communication strategy ii)Design and deliver a Training Program iii)Design and implement a compliance monitoring system	Percentage provider compliance with ER-STOP protocol	Q1 – 80%; Q2 – 90 %; Q3 – 95%; Q4 – 100%	
									2)Early Identification: Identify ward patients at-risk of deteriorating and communicate to key care providers	1)In 2015/16, we trialed (in Medicine wards only) a Patient at Risk Dashboard to identify and post – on a daily basis – patients that may need additional monitoring. 2)The list of at-risk patients are posted in the hospitals electronic patient record (PowerChart) and also listed on the daily PFC (Patient Flow Coordinator) Report. 3)The PowerChart and PFC reporting introduces a standard practice for early identification of at-risk patients and helps to ensure key care providers outside the patients' ward are aware of (and can plan appropriately for) the identified patients. i) Implement sustainability plan for Medicine Program ii) Design and deliver Spread Strategy for Surgery and CCC iii) Design and deliver Communication Strategy for Surgery and CCC	Percentage of Surgery and Complex Continuing Care (CCC) units adopting the dashboard	Q1 - 20%; Q2 – 50 %; Q3 – 80%; Q4 – 100%	
									3)KPMs: Develop Key Performance Metrics	1) The ability to monitor performance through regular reporting of key indicators will enable us – particularly the RfD Steering Committee - to quickly identify improvement opportunities and initiate appropriate change initiatives to continuously drive toward a lower Rescue Index 2) In 2015/16, we designed a set of outcome, process, and balancing measures, and implemented a portion of them, namely: i) the Rescue Index – our primary outcome measure ii)Number of Outreach calls, by ward iii) Number of Code calls, by Code Type, by ward iv) Number of transfers from Ward to ICU or CIU, within 24hrs of admission •Number of transfers from Ward to ICU or CIU, beyond 24hrs of admission 3) In 2016/17 we plan to expand our RfD Performance Monitoring capability with the development and implementation of additional process and balancing metrics. •Confirm user requirements specification •Design database architecture and interfaces •Design and develop reporting system •Test reporting system •Implement (includes Training)	Percentage completion	Q1 - 20%; Q2 – 75 %; Q3 – 100%	
	Reduce incidents of workplace violence	Workplace Violence Incidents: Total number of workplace violence incidents that result in lost days over 12 month period	Number / All MGH employees* (*on payroll; part- and full-time)	Hospital collected data / April 2015 - March 2016	858*	4	0.00	Our goal is to proactively continue on a journey of safety excellence. We will work towards reducing all incidents of workplace violence and focus especially on incidents that result in lost days. Through the implementation of several change ideas, we would like to strive for the absence of workplace violence incidents that result in lost days.	1)Increase the spread of Workplace Violence Prevention training	1)Create and spread online modules and video vignettes 2)Drop in refreshers to review the physical maneuver component of the WVP training	Percentage of employees who have attended a workplace violence prevention training session by Q4	100% of staff in high risk areas (ED, Mental Health service, food service workers, MCU, A3 and B3); 70% of staff in lower risk areas	This improvement objective will be supported through structured Joint Centres spread processes for learning, sharing and adapting leading practices.
									2)Increase compliance with the completion of a behavioral profile after patients are identified for potential Acting Out Behaviour (AOB)	1)Review the current process of identifying patients for AOB and look for opportunities to revise or lean out the process (particularly using PSHSA risk screen as 1st step) 2) Reintroduce/ educate frontline staff and leaders on the AOB process through education and daily huddle conversations 3)Explore changes in the electronic medical record to increase compliance (prompts, more intuitive/user friendly format)	Percentage of behaviour profiles completed for patients identified for potential acting out behaviour	80% by Q4	
									3)Implement a more patient centered approach to Workplace violence communication	1)Review current messaging and look for opportunities to change the messaging to reflect a patient centered approach while maintaining the zero tolerance culture 2) Look for opportunities to highlight/share success of the workplace violence prevention and MGH's culture 3) Look for opportunities to share best practices of MGH's workplace violence prevention program with other organizations i.e. MGH's WVP day, presentations, information sharing, and innovation fair. 4) Look for opportunities to merge workplace violence prevention with wellness	Percentage of applicable posters, videos and training sessions that have had their messaging changed to reflect a patient centred approach, while maintaining the zero tolerance culture	100% of applicable communication channels by Q4	