2021/22 Quality Improvement Plan

Work Plans

Performance Monitoring & Quality Committee

Create Health. Build Community.
The following pages contain a work plan for each of the improvement initiatives. Work Plans articulate the: 1) improvement objective; 2) measure to track improvement; 3) improvement target; and 4) change ideas that will drive the improvement.

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<th>Improvement Initiative</th>
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<td>Medication Reconciliation on Discharge</td>
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<td>ED Length of Stay (Time to Bed)</td>
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### 2021/22 QIP Work Plans | Medication Reconciliation on Discharge

Increase the proportion of patients receiving medication reconciliation on discharge

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Unit of measure/ Patient population</th>
<th>Data Source/Period</th>
<th>Baseline</th>
<th>Target for 2021/22</th>
<th>Target Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of discharged patients for whom a Best Possible Medication Discharge Plan was created.</td>
<td>Unit of Measure Percent</td>
<td>Data Source Hospital collected data</td>
<td>Reporting Period Q1-Q4 2021/2022</td>
<td>61.5%</td>
<td>&gt; 64%</td>
</tr>
<tr>
<td></td>
<td>Patient Population</td>
<td></td>
<td></td>
<td></td>
<td>• Score will continue to include Complex Care and Maternal Newborn Child in addition to Medicine, Surgery, &amp; Mental Health</td>
</tr>
<tr>
<td></td>
<td>All in-patients excl. deceased, LOS &lt; 24hrs, newborns</td>
<td></td>
<td></td>
<td></td>
<td>• Baseline is based on FY 2019/2020 YTD average</td>
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<tr>
<td></td>
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<td></td>
<td></td>
<td>• Target is based on 5% improvement on baseline score</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#</th>
<th>Change Idea</th>
<th>Methods</th>
<th>Measure</th>
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</tr>
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<tbody>
<tr>
<td>1</td>
<td>Improve reporting and visibility of Med Rec stats</td>
<td>1. Include Discharge Med Rec stats as part of the required Discharge Summary dashboard 2. Introduce Discharge Med Rec for all COVID-19 vaccine recipients 3. Review reporting post-Cerner upgrade to enhance automation</td>
<td>Completion date</td>
<td>1. Q2 2. Q1 3. Q2</td>
</tr>
<tr>
<td>2</td>
<td>Sustain Med Rec in areas where it has previously been rolled out</td>
<td>1. Continue supporting CCC and MNC in sustaining their targets 2. Incorporate PODS Discharge Form completion as part of Med Rec monitoring for MNC</td>
<td>Completion date</td>
<td>1. Q1-Q4 2. Q1-Q4</td>
</tr>
</tbody>
</table>
## 2021/22 QIP Work Plans | Transfer of Care

Improve quality of information transfer at patient transition points

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<thead>
<tr>
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</tr>
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<tbody>
<tr>
<td>% correct completion of IPASS at shift handover</td>
<td>Unit of Measure Percentage</td>
<td>Data Source Hospital collected data (i.e. observational audits of verbal handover)</td>
<td>77%</td>
<td>&gt; 85%</td>
<td>The target represents a 10% increase from last year’s target. Given that COVID-19 will continue to be a top organizational priority for the remainder of the 21/22 FY, a 10% increase is reasonable. Specific work on the final component of IPASS (i.e. Synthesis by Receiver) will need to be completed to reach this target.</td>
</tr>
<tr>
<td>Patient Population All inpatient areas where IPASS has been implemented</td>
<td></td>
<td>Reporting Period April 2021 – Mar 2022</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Change Idea

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<tr>
<td>1</td>
<td>Sustain and improve upon the changes made last QIP cycle</td>
<td>1. Transition TOA QIP oversight from the TOA project team to clinical operations.</td>
<td>Completion Date</td>
<td>1. Q1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Continue to support teams in completing the required 10 audits per month.</td>
<td></td>
<td>2. Q1-Q4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Provide support to teams who have found the synthesis portion of IPASS challenging.</td>
<td></td>
<td>3. Q2-Q4</td>
</tr>
<tr>
<td>2</td>
<td>Develop standardized practice for physician handover</td>
<td>1. Create interdisciplinary committee whose goal is improving physician handover.</td>
<td>Completion Date</td>
<td>1. Q2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Work with IT to explore potential solutions for a standardized physician handover tool in PowerChart.</td>
<td></td>
<td>2. Q2-Q4</td>
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## 2021/22 QIP Work Plans

### Improve patient experience

#### Patient Experience

**Patient Oriented Discharge Summary (PODS)**

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<tr>
<td>Percent of top box responses (&quot;Completely&quot;) to the 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”? (with a focus on Respiratory patients)</td>
<td>Unit of Measure: Percent</td>
<td>Data Source: Canadian Institute for Health Information (CIHI), NRC Health Reporting Period: January 2021-December 2021</td>
<td>61%</td>
<td>≥ 61%</td>
<td>For the purpose of aligning with OHT priority populations (seniors with chronic illnesses and their caregivers) this year we will continue implementing PODS for patients with chronic respiratory conditions. Although the change ideas were not fully implemented due to the COVID 19 pandemic, the target was achieved. Our target reflects a small increase from last year (58%) that should be sustained once our change ideas are fully implemented.</td>
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<tr>
<td>1</td>
<td>Post Discharge Phone calls (PDPCs) using the PODS framework</td>
<td>Fully implement the automated Post Discharge Phone Call (PDPC) process, using the PODS framework, for patients being discharged to home</td>
<td>% of patients who have a warm follow up phone call to address the flagged issues identified during the automated PDPCs by end of March</td>
<td>100%</td>
</tr>
</tbody>
</table>
| 2 | Build staff capacity in the area of health literacy and teach back | 1. Verify /complete staff training including NRT staff: 
   a) iLearn module on health literacy 
   b) Didactic session on health literacy and teach back 
   c) Simulation session using teach back and PODS framework 

2. Observe staff during PODS conversations and documentation and provide in the moment coaching and feedback. | % of staff who complete d iLearn module and attended didactic and simulation sessions by end of May | % of staff who have had in the moment coaching by end of June | 100% |
| 3 | Create the ideal discharge conversation using the PODS framework | Work with staff, patients and families to refresh the ideal discharge process including PODS (pamphlet, expected date of discharge (EDD) on whiteboard, daily conversation, preparing to go home conversation and day of discharge conversation) | Completion Date | Oct 2021 |
## Indicator

**Percent of persons satisfied with their involvement in their planning of care and treatment**

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<th>Unit of measure/ Patient population</th>
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<tr>
<td><strong>Unit of Measure</strong></td>
<td><strong>Percent</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Patient Population</strong></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Seniors with complex/chronic needs and their caregivers (focus on integrated care, eg: H2D)</td>
<td>Data Source CIHI CPES Survey question 35 &amp; 36 (TBC) Reporting Period 2021/22</td>
<td>60 %</td>
<td>&gt; 60 %</td>
<td>Organizations will continue to use their own organizational data in their QIP and can set an internal target if they feel they are ready to do so. Our baseline is based on last year’s actual performance (Jan to Dec), and our target is a 5% improvement.</td>
</tr>
</tbody>
</table>

### Change Idea

**1. Introductory Training on Person and Family-Centred Care for Staff & Providers**

1. Continue to roll out PFCC eLearning module across ETHP
2. Leverage BPSO Steering Committee to ensure regular meetings for knowledge sharing
3. Support Champions to receive and provide ongoing coaching and support to support PFCC in their organization

### Methods

**Complete Activity**

1. Q1-Q3
2. Q1-Q4
3. Q1-Q4

**2. Completion of Advanced Clinical Practice Fellowship**

1. Phase 1: literature search and finalizing interview questions and consent forms
2. Phase 2: Through interviews and observation, study experiences of PFCC across the ETHP integrated system of care
3. Phase 3 disseminate findings and develop action plan

### Methods

**Complete Activity**

1. Q1
2. Q1
3. Q2-Q3

**3. Data collection & Quality Improvement**

1. Jointly submit indicator through the Enquire database and leverage BPSO champions to share learnings and improvement opportunities
2. Jointly implement or expand data collection in two ETHP initiatives:
   1. Home2Day initiative
   2. HUBS
3. Develop and implement one Quality Improvement initiative based on the data within the HUBS & H2D initiatives

### Methods

**Complete Activity**

1. Q1-Q4
2. Q2
3. Q3
# Indicator 1 (Mandated)

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<tr>
<th>Unit of measure/Patient population</th>
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<th>Baseline</th>
<th>Target for 2021/22</th>
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<tbody>
<tr>
<td>Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.</td>
<td>Data Source Hospital collected data Reporting Period April 2021– March 2022</td>
<td>25.8/month 232/year</td>
<td>&gt;26/mthly &gt;312/year</td>
<td>Target will remain the same, as we were unable to completely implement our change ideas.</td>
</tr>
</tbody>
</table>

## Indicator 2 (Custom)

<table>
<thead>
<tr>
<th>Unit of measure/Patient population</th>
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<th>Target for 2021/22</th>
<th>Target Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of workplace violence incidents reported resulting in Lost Time within 12 month period.</td>
<td>Data Source Hospital collected data Reporting Period Jan 20201- Dec 2021</td>
<td>13</td>
<td>&lt; 13</td>
<td>Target will remain the same, as we were unable to completely implement our change ideas.</td>
</tr>
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<tr>
<td>1</td>
<td>Behavioural Care Plan Alert for Patient &amp; Worker Safety</td>
<td>1. Full implementation of the care plan alert in PowerChart 2. Full implementation of the tool, staff education in one unit, prioritizing high risk to patient and staff. 3. Modelling the success of the one unit implementation, increase spread of implementation through dedicated resources and/or unit level champions.</td>
<td>1. Completion Date 2. Completion Date 3. Completion Date</td>
<td>1. TBD *associated with Powerchart upgrades 2. May 2021 3. September 2021</td>
</tr>
<tr>
<td>2</td>
<td>Zero Tolerance Campaign &amp; Strategy</td>
<td>1. Implement campaign for patients, hospital visitors and staff 2. Develop communication and education materials to support workplace violence prevention (i.e. Close loop communication on reported incidents) 3. Regular risk assessments (JHSC audits &amp; identified high risk areas prioritized using recently adapted tool)</td>
<td>1. Completion date of campaign 2. % of staff feel action is taken when attacked, bullied, harassed by patients/public/staff 3. # of safety audits completed 4. # assessments completed</td>
<td>1. September 2021 2. TBD (Pulse survey or 2021 Employee Engagement survey) 3. 80% by Q3. 4. 80% by Q4</td>
</tr>
</tbody>
</table>
## 2021/22 QIP Work Plans | ED LOS (Time for Inpatient Bed)
Reduce the time interval between the Disposition to Patient Left ED for admission to an inpatient bed or operating room

<table>
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<th>Target Justification</th>
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<tbody>
<tr>
<td>90th Percentile Emergency Department Wait Times for In-Patient Bed</td>
<td>Unit of Measure Hours from Disposition to Left ED for all admitted patients</td>
<td>Data Source P4RHospital data; National Ambulatory Care Reporting System (NACRS); Data provided to HQO by Cancer Care Ontario Reporting Period Dec 2020 to Nov 2021 (P4R cycle)</td>
<td>16.8 hr</td>
<td>≤ 16 hr</td>
<td>To recognize the impact of COVID-19 we have increased the target to ≤ 16 hr – however we aim to achieve ≤ 14 hr in the following year (F2022/23). COVID-19 has further highlighted the importance of moving patients quickly from the ED once admitted, to ensure there is adequate space to safely care for those patients arriving to the ED.</td>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>Identify opportunities to streamline the patient flow journey</td>
<td>1. Interdisciplinary facilitated workshop in June to map patient journey and identify pain points 2. Prioritize top 3 patient flow pain points, and develop and implement interventions</td>
<td>1. Interdisciplinary Participation in Workshops 2. Inter-Timestamp improvements on priority patient flow steps</td>
<td>1. 100% 2. TBD</td>
</tr>
<tr>
<td>2</td>
<td>Maximize Teletracking</td>
<td>1. Identify &amp; automate at least 3 key metrics from Teletracking for performance monitoring to inform changes 2. Train users on new system 3. Increase visibility of key information for key users (e.g. ED Charge Nurse, Portering, IP Clerks)</td>
<td>1. Completion date 2. % of users trained 3. Time to access key info</td>
<td>1. September 2. TBD 3. Decrease by 50%</td>
</tr>
<tr>
<td>3</td>
<td>Focus on ALC Management</td>
<td>1. Leverage available funding to support offsite bed operations to offset significant increase in ALC patients in acute care beds. 2. Reduce LOS for acute medical patients through the implantation of creative discharge models, including short term comprehensive discharge support (e.g. HISH – High Intensity Supports at Home program)</td>
<td>1. ALC rate in acute care (%) 2. LOS for patients discharges to community with home care services</td>
<td>1. TBD 2. TBD</td>
</tr>
</tbody>
</table>