MICHAEL GARRON HOSPITAL

TORONTO EAST HEALTH NETWORK

2021/22 Quality Improvement Plan

Work Plans

Performance Monitoring & Quality Committee

2 March 2021

Create Health. Build Community.

2021/22 QIP Work Plans | Table of Contents

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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.

2021/22 QIP Work Plans | Medication Reconciliation on Discharge

Increase the proportion of patients receiving medication reconciliation on discharge

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

#	Change Idea	Methods	Measure	Target
1	**Improve reporting and visibility of Med Rec stats**	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	Completion date	1. Q2 2. Q1 3. Q2
2	**Sustain Med Rec in areas where it has previously been rolled out**	1. Continue supporting CCC and MNC in sustaining their targets 2. Incorporate PODS Discharge Form completion as part of Med Rec monitoring for MNC	Completion date	1. Q1-Q4 2. Q1-Q4

2021/22 QIP Work Plans | Transfer of Care

Improve quality of information transfer at patient transition points

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Indicator	Unit of measure/ Patient population	Data Source/Period	Baseline	Target for 2021/22	Target Justification
% correct completion of IPASS at shift handover	Unit of Measure Percentage Patient Population All inpatient areas where IPASS has been implemented	Data Source Hospital collected data (i.e. observational audits of verbal handover) Reporting Period April 2021 – Mar 2022	77%	> 85%	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.

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

2021/22 QIP Work Plans | Patient Experience

Patient Oriented Discharge Summary (PODS)

Improve patient experience

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Indicator	Unit of measure/ Patient population	Data Source/Period	Baseline	Target for 2021/22	Target Justification
Percent of top box responses ("Completely") 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)	Unit of Measure Percent Patient Population All survey respondents discharged from Respiratory Unit	Data Source Canadian Institute for Health Information (CIHI), NRC Health Reporting Period January 2021-December 2021	61%	≥ 61%	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.

#	Change Idea	Methods	Measure	Target
1	**Post Discharge Phone calls (PDPCs) using the PODS framework**	Fully implement the automated Post Discharge Phone Call (PDPC) process , using the PODS framework ,for patients being discharged to home	% of patients who have a warm follow up phone call to address the flagged issues identified during the automated PDPCs by end of March	100%
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 frame work 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% 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

2021/22 QIP Progress Report | ETHP Collaborative

East Toronto Health Partners

Improve Patient Engagement in their Care

Partners: Providence, WoodGreen, VHA, SRCHC, SETFHT and Bridgepoint FHT

Indicator	Unit of measure/ Patient population	Data Source/Period	Baseline	Target for 2021/22	Target Justification
Percent of persons satisfied with their involvement in their planning of care and treatment	Unit of Measure Percent Patient Population Seniors with complex/chronic needs and their caregivers (focus on integrated care, eg: H2D)	Data Source CIHI CPES Survey question 35 & 36 (TBC) Reporting Period 2021/22	60 %	> 60 %	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.

#	Change Idea	Methods	Measure	Target
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 on-going coaching and support to support PFCC in their organization	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	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
			Complete Activity	1. Q1-Q4
				2. Q2
				3. Q3

2021/22 QIP Progress Report | Workplace Violence Prevention

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Reduction in workplace violence incidents

Indicator 1 (Mandated)	Unit of measure/ Patient population	Data Source/Period	Baseline	Target for 2021/22	Target Justification
Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.	Unit of Measure Count Patient Population All patient care units	Data Source Hospital collected data Reporting Period April 2021– March 2022	25.8/month 232/year	>26/mthly >312/year	Target will remain the same, as we were unable to completely implement our change ideas.

Indicator 2 (Custom)	Unit of measure/ Patient population	Data Source/Period	Baseline	Target for 2021/22	Target Justification
Number of workplace violence incidents reported resulting in Lost Time within 12 month period.	Unit of Measure Count Patient Population All patient care units	Data Source Hospital collected data Reporting Period Jan 20201- Dec 2021	13	< 13	Target will remain the same, as we were unable to completely implement our change ideas.

#	Change Idea	Methods	Measure	Target
1	**Behavioural Care Plan Alert for Patient & Worker Safety** Continue implementation of the Behavioural Care Plan Alert for Patient and Worker Safety	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.	1. Completion Date 2. Completion Date 3. Completion Date	1. TBD *associated with Powerchart upgrades 2. May 2021 3. September 2021
2	**Zero Tolerance Campaign & Strategy** Design and implement communication , education and proactive solutions to support our vision of a zero tolerance work environment	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 & identified high risk areas prioritized using recently adapted tool)	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	1. September 2021 2. TBD (Pulse survey or 2021 Employee Engagement survey) 3. 80% by Q3. 4. 80% by Q4

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

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Indicator	Unit of measure / Patient population	Data Source / Period	Baseline	Target for 2021/22	Target Justification
90th Percentile Emergency Department Wait Times for In-Patient Bed	Unit of Measure Hours from Disposition to Left ED for all admitted patients Patient Population All admitted patients	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)	16.8 hr	≤ 16 hr	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.

#	Change Idea	Methods	Measure	Target
1	Identify opportunities to streamline the patient flow journey	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	1. Interdisciplinary Participation in Workshops 2. Inter-Timestamp improvements on priority patient flow steps	1. 100% 2. TBD
2	Maximize Teletracking	1. Identify & 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)	1. Completion date 2. % of users trained 3. Time to access key info	1. September 2. TBD 3. Decrease by 50%
3	Focus on ALC Management	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)	1. ALC rate in acute care (%) 2. LOS for patients discharges to community with home care services	1. TBD 2. TBD