MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

F2023/24 Quality Improvement Plan (QIP)

March 2023

Our Vision
Great care inspired by community

2023/24 QIP | Table of Contents

There are three required components to our Quality Improvement Plan submission to Ontario Health: the Narrative, the Work Plans and the 2022/23 Progress Report. The full submission is included in this package.

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THE NARRATIVE

2023/24 QIP Submission

Our Vision
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2023/24 QIP Narrative

Overview

Michael Garron Hospital (MGH), Toronto East Health Network is a vibrant community teaching hospital located in the heart of East Toronto. For almost 100 years, we have provided healthcare to nearly 400,000 people in 22 neighbourhoods, where over 50 languages are spoken.

Our team is made up of almost 3,000 staff, more than 530 physicians and over 500 volunteers. We have the honour of caring for people at every point of their lives. From welcoming a new baby and supporting children as they grow; to providing emergency, mental health and surgical services for people of all ages; to caring for patients with compassion and dignity at the end of life. We are here for our community

This year we launched our new 2023-25 Strategic Plan, summarized to the right. While all of the three Focus Areas impact our 2023/24 Quality Improvement Plan (QIP), the selected QIP indicators are aimed at improving patient and staff safety following the recent move into our new Thomson Patient Care Centre

Ove the last few years, MGH has made significant investments to develop and strengthen our Equity, Diversity, Inclusion, and Belonging strategy. For the first time, our QIP will include a quality indicator in this area.

The following page shows a summary of our 2023/24 QIP portfolio.

2023/24 QIP Narrative

Overview

QIP Indicator	Improvement Measure	Baseline	Target
ED Time to Inpatient Bed	**Number** of hours (90th Percentile) from Admission decision to Patient in Bed	22.2	≤ 22.2
Workplace Violence Prevention	**Number** of reported workplace violence incidents (average per month)	14.1	≥ 15.0
Transfer of Accountability	**Number** of Transfer of Accountability related Incidents	10.9	≤ 10.0
Falls with Harm	**Rate** of falls with harm per thousand inpatient days	0.41	≤ 0.39
Pressure Injuries	**Rate** of hospital acquired pressure injuries, Stage 2 or greater, per thousand inpatient days	1.20	≤ 1.10
Patient Satisfaction	**Rate** of patients satisfied with discharge information	45%	≥ 47%
Equity, Diversity, Inclusion & Belonging (EDIB)	**Rate** of staff and leaders completing anti-black racism training	(new metric, not available)	≥ 70 %

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Patient Engagement & Partnering

We continue to rely on our strong partnerships with patients and families to inform and advance our work. In 2022/2023, Patient Experience Partners had the opportunity to participate in committee meetings and interview panels for new staff and credentialed clinicians. They also had the opportunity to participate in the Patient Journey Simulations in preparation for moving into the Thomson Centre. The MGH Patient Experience Panel (PEP) continued to meet virtually, with 7 meetings over the past year. Meetings allowed PEP members the opportunity to contribute to 17 initiatives including the new MGH corporate strategic plan, the content for TV screens in waiting rooms, and the new hospital interpretation service. We welcomed four new Patient Experience Partners to the MGH PEP, as well as an additional four new Patient Experience Partners for the refreshed Renal PEP. The Renal PEP had its first meeting in September 2022, with meetings planned quarterly. In 2023/2024, we will continue to recruit Patient Experience Partners that represent the diverse population we serve, seeking innovate ways to engage with them. We also hope to re-establish other Program PEPs (Mental Health, Emergency Department and Maternal Newborn Child) that have been paused during the pandemic.

The MGH Care Partners program continues to support the inclusion of family caregivers as part of the patient's care team. Care Partners, a family member or friend chosen by the patient/substitute decision maker (SDM), support the physical, emotional and information needs of the patient. They are an important member of the patient's care team, and have an essential role in the quality, safety, and experience of patient care. In 2022/2023, we developed partnerships with the MGH Prolonged-Ventilation Weaning Centre of Excellence and Long-Stay Intensive Care Unit to introduce Care Partners early in each patient's admission. We have also had a research project approved to look at the experiences of patients and Care Partners in the Prolonged-Ventilation Weaning Centre. In 2023/2024, we will build on our partnership with the Seniors Friendly Strategy to more purposefully introduce Care Partners across the organization.

We recognize the importance of supporting patients with engagement and activities of daily living during their admission, even if they do not have a Care Partner. In partnership with the MGH Seniors Friendly Strategy, we are developing a Hospital Elder Life Program (HELP) to improve the experience of older adults admitted to MGH. We anticipate formally launching this program in 2023/2024.

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Provider Experience

Amidst high levels of burnout related to staff shortages and seasonal pressures on the healthcare system, we know that supporting our team members is vital to providing high quality patient care. We will address this complex issue with a multi-pronged approach, designed to acknowledge what our teams are experiencing while directly providing care to patients, and we will incorporate their valuable input and ideas for improvement.

Adding to the complexity of care provision this year is the need for operational effectiveness in our new patient tower, the Ken and Marilyn Thomson Patient Care Centre. Though our teams have showed dedication and resiliency throughout the pandemic, we must support them to practice in a new space, with new work flows and technology. Our clinical leadership and operational readiness teams offered 24 hour support, 7 days a week to ensure staff feel supported across all shifts.

This spring, we will launch our Engagement Survey and Workforce Census to understand how engaged and represented our staff and credentialed clinicians feel at MGH. We will learn from the survey responses to strengthen the Year 1 priorities of our strategic plan for “People” which includes increased efforts to recruit and retain (by using Stay Interviews), reinforcing the importance of employee wellbeing and safety (through the Workplace Violence Prevention Committee) and focusing on equity, diversity, inclusion and belonging (through the Inclusion Alliance Committee). All of these committees include a variety of staff from multiple areas across the organization.

We will build a healthy and supportive workplace for our MGH community by stabilizing our workforce, improving work life balance and providing opportunities for growth and development to the key members of our MGH community.

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Workplace Violence Prevention (WVP)

The prevention of workplace violence is an organizational priority at MGH. We have launched targeted educational programs, awareness campaigns, and reporting systems to monitor frequency and type of occurrences. Our recently refreshed strategic plan prominently features commitments to address the safety of our workplace. We have included WVP in our Quality Improvement Plan (QIP) for seven successive years, which involves monthly or quarterly updates on action plans and progress to various stakeholders and leadership forums, including our board and sub-committees of the board.

As we strive for a care environment free from violence, the various ongoing initiatives are regularly reviewed and adapted. We have recently reprioritized workplace violence prevention at an organizational level and refreshed our workplace violence prevention committee to develop a multipronged approach to address both short and long term initiatives. These improvements aim to:

1. Support staff and encourage reporting by simplifying the incident reporting process, standardizing leadership approach to investigation, follow-up and support, and improving opportunities for education.
2. Identify higher-risk areas for violence, and develop targeted tools and prevention practices.
3. Develop a Behavioural Care Plan for high-risk patients.

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Patient Safety

To sustain a culture of safety where we learn from patient safety incidents, and support our front line staff to continue to provide high quality care, a variety of processes rooted in the Canadian Patient Safety Institute's Incident Analysis Framework are used.

After a patient safety incident occurs, we ensure that the patient and family are supported and we ask for their input related to their experience of the event. Using information from multiple sources including the staff involved, we analyze the event by performing a systems review to determine root causes. We ensure that leaders of the care area, staff and credentialed clinicians are involved in planning action items that will address the root causes.

Learnings from the incident are shared using a standardized "Learning from Incidents Tool", designed to encourage dialogue within teams about how to prevent future incidents. Action plans are finalized with input from clinical teams, the patient and family and the Medical Quality and Patient Safety Committee with the intention of sharing the learnings across the organization.

When there is patient harm, Patient Relations and the clinical leadership team of the area disclose key facts to patients and families and share learnings to maintain transparency and to co-design further improvement actions at the time of the incident, and in the future.

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Health Equity

As systemic racism, oppression and inequalities continue, equity, diversity, inclusion and belonging (EDIB) is a foundational area of focus for our hospital. Since its inception in 2020, The MGH Inclusion Alliance has been dedicated to utilizing a lens of inclusion to identify and address inequity and oppression within the hospital. At MGH, there is a strong belief that the commitment to equity and anti-oppression is the shared responsibility of our hospital's governance, staff, and all stakeholders, and as such, must be supported and guided by all levels of leadership. In consultation with members of the Inclusion Alliance, and in collaboration with the hospital's existing working groups and sub-committees, a number of EDIB initiatives have commenced and/or continue to progress towards their intended objectives, including:

- Development of an EDIB action plan that sets out key focus areas that will support the implementation and execution of strategies necessary to operationalize this goal.
- Policy development to support MGH's commitment to the elimination of institutional discrimination and the promotion of diversity, equity, inclusion, belonging and anti-oppression practices and principles are integrated into all aspects of the hospital.
- Ongoing Training and Education opportunities for MGH staff and leadership to build foundational knowledge in equity, diversity, inclusion and belonging
- Collecting data on the makeup of our staff and credentialed clinicians through our Workforce Census
- Review of our current demographic data collection processes of the patients we serve to align with provincial patient health equity measurement guidelines
- Implementation of a cultural/ commemorative calendar to recognize the diversity of MGH
- Removing barriers that inhibit professional growth through the redesign and implementation of our Emerging Leaders Program

2023/24 QIP Narrative

Executive Compensation

Our executives' at-risk compensation is impacted by the performance of our QIP, as follows:

President & CEO – maximum at-risk compensation is 15% of total annual salary. For QIP, 25% of at-risk compensation is tied to QIP performance.

Vice Presidents – maximum at-risk compensation is 10% of total annual salary. For QIP, 25% of at-risk compensation is tied to QIP performance.

Chief of Staff - maximum at-risk compensation is 15% of total annual salary. For QIP, 25% of at-risk compensation is tied to QIP performance.

The 25% of variable compensation tied to our QIP will be paid out according to the proportion of QIP targets that have been achieved, as set out in the table below.

Ratio of QIP Targets Achieved:	<50%	50%	75%	100%
Proportion of 25% variable compensation paid:	0%	50%	75%	100%

2023/24 QIP | Sign-off

I have reviewed and approved our organization's Quality Improvement Plan

_____	_____	_____
Dr. Moez Rajwani Performance Monitoring and Quality Committee Chair	Lovisa McCallum Board Chair	Wolf Klassen President & Chief Executive Officer (Interim)

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THE WORK PLANS

2023/24 QIP Submission

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F2023/24 QIP Indicators

QIP Indicator	Improvement Measure	Baseline	Target	Target Description
ED Time to Inpatient Bed	**Hrs**. wait time for inpatient bed	22.2	≤ 22.2	Maintain current performance
Workplace Violence Prevention	**#** of reported workplace violence incidents (average per month)	14.1	≥ 15.0	6% improvement compared to 2022
Transfer of Accountability	**#** of Transfer of Care related Incidents	10.9	≤ 10.0	Target and Baseline unchanged from last year
Falls with Harm	**Rate** of falls with harm per thousand inpatient days	0.41	≤ 0.39	Target and Baseline unchanged from last year
Pressure Injuries	**Rate** of hospital acquired pressure injuries, Stage 2 or greater, per thousand inpatient days	1.20	≤ 1.10	Target and Baseline unchanged from last year
Patient Satisfaction	**Rate** of patients satisfied with discharge information	45%	47%	5% improvement compared to baseline
Equity, Diversity, Inclusion & Belonging (EDIB)	**Rate** of staff and leaders completing TAHSN Anti-Black Racism training	(new metric, not available)	≥ 70 %	Organizational goal

2023/24 QIP Work Plan | ED Time to Inpatient Bed

Reduce Emergency Department wait times

Indicator	Unit of measure / Patient population	Data Source / Period	Baseline	Target for 2023/24	Target Justification
90th Percentile Emergency Department Wait Times for In-Patient Bed	**Unit of Measure** Hrs from Disposition to Left ED **Patient Population** All patients admitted from ED	**Data Source** P4R **Reporting Period** Dec 2022 to Nov 2023 (P4R cycle)	22.2	≤ 22.2	Targeting to maintain last year's baseline of 22.2 while recognizing the continued significant performance compared to our peers and provincially who have seen worsening performance on this indicator. This is evidenced by our current rank of 1 within sub-region #7 for ED to IP P4R Rankings. Secondary targets aim to maintain the current rank of 1 in the ED to IP P4R Ranking.

#	Change Idea	Methods	Measure	Target
1	**Improved use of Teletracking**	• Cerner and Teletracking Integration to eliminate manual processes • Discharge feature implementation & changes to discharge process • Re-configure BedTracking module so that vacant beds are treated as priority when they enter the queue. • Continuously educate and train staff on the use of Teletracking. • Form a truly centralized Patient Placement department. This, along with the automated interface into BedTracking module for discharges will create seamless, real time dirty bed notification.	Completion Date to create reporting for average time between inpatient leaving hospital and discharge being recorded in Powerchart	Q1
2	**Flow Optimization**	• Reallocate resources and extend existing processes to cover gaps, including Nursing, IPP, leadership, patient flow and transitions, bed allocators, porters, housekeeping, and physicians. This will optimize multidisciplinary resources as much as possible to have appropriate resource coverage and standardization of processes. • Continuously monitor, assess and leverage the impact of the new Thomson Centre and the affect it will have on our ED to IP Bed flow	Completion Date to create reporting for number of days without IPP coverage	Q2

3	**Reassessment and Stabilization**	• Based on the changes from the Thomson Centre, Teletracking solutions and flow optimization techniques, assessment and stabilization will include.
		  • Identified new and improved monitoring ideas for our teams
		  • Continuously monitor, assess and evaluate overall effectiveness and impacts of the new Thomson Centre, Teletracking and flow optimization from a patient flow perspective.
		  • Adjust the alignment of resources to high demand times to improve patient flow
		  • Creation of a dashboard to monitor flow processes
			Completion Date	Q3

4	**Benchmark performance monitoring against provincial peers**	• Create a report/dashboard to portray monthly ED to IP Bed P4R Rankings to be presented internally to increase awareness and promote motivation for this work.	ED to IP Bed P4R Ranking (sub-region #7)	Rank = 1

2023/24 QIP Work Plan | Workplace Violence Prevention (DRAFT)

Reduction in workplace violence incidents

Indicator	Unit of measure / Patient population	Data Source / Period	Baseline	Target for 2023/24	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** Jan to Dec, 2023	14.1 / month	≥ 15	Due to significant underreporting of workplace violence incidents since the beginning of the pandemic, our target is to improve reporting of workplace violence incidents.

#	Change Idea	Methods	Measure	Target
1	**Implement processes to support and encourage the reporting of workplace violence incidents**	• Simplify the incident reporting process, education of updated process to all staff • Create tools to standardize leadership investigation, follow-up and staff support following an incident of workplace violence, and dissemination/training for its use	• Completion date	• Q3
2	**Implement methods to reinforce workers in feeling safe, prepared and supported in their work environment**	• Improve security presence and measures in the Emergency Department • Education: Evaluate and develop corporate education for workplace violence prevention practices for patient facing staff, create quick tools for leaders to provide staff with safety tips as ongoing refreshers, implement safety related discussions into daily huddles • Perform regular risk assessments in high risk areas • Supplement existing poster campaign	• Completion date	• Q3
3	**Behavioural Care Plan Alert for Patient and Worker Safety**	• Develop a program-specific plan to implement the behavioural care plan, focusing on areas at the highest risk for violence	• Completion date	• Q4

2023/24 QIP Work Plan | Transfer of Accountability

Improve quality of information transfer at patient transition points

Indicator	Unit of measure / Patient population	Data Source / Period	Baseline	Target for 2023/24	Target Justification
# of Transfer of Accountability (TOA) related Incidents	**Unit of Measure** Number, incidents per month **Patient Population** All inpatient areas	**Data Source** RL Datix incident reports **Reporting Period** April 2023 to March 2024	10.9	≤ 10	As anticipated, there was a small increase in the number of transfer of accountability (TOA) incidents reported in the past year. With the recent move to the new care centre, many staff are working in new care environments, and learning new processes and technologies to provide care. Being sensitive to this, our target is to maintain our current target and performance.

#	Change Idea	Methods	Measure	Target

1	**Improve the quality of ToA when patients are transferred from one unit/department to another** by reviewing and refining the current ToA tool	• Gather a team of stakeholders from clinical, quality improvement and patient experience to review the current inpatient TOA tools (digital and paper):
		  • Review TOA incidents for themes/trends and revise the tools as required
		  • Create an audit process to ensure staff are completing the TOA forms properly and accurate information is being communicated to the receiving units for patients to receive safe care
			Completion Date	Q3

2	**Standardize the quality of ToA from clinician to clinician on a unit**	• Refresh the standardized process (IPASS) for nurses to complete an effective, comprehensive bed-side TOA, include patients and family in the ToA conversation. • Implement in the moment coaching for nurses during TOA .	1. Completion Date for refresh of standardized IPASS process 2. 80% of unit nurses receive in the moment coaching by charge nurse/CRL/supervisor	1. Q2 2. Q4
3	**Develop recommendation for opportunities to standardize hand over between credentialed clinicians**	• Many divisions are developing new approaches to support handover between credentialed clinicians • Sub-committee of the Medical Advisory Committee to develop a recommendation for opportunities to standardize handover between credential clinicians	Completion Date (Recommendation developed and presented to MAC)	Q4

2023/24 QIP Work Plan | Falls with Harm Prevention

Reduction in Total Falls and Falls with Harm

Indicator	Unit of measure / Patient population	Data Source / Period	Baseline	Target for 2022/23	Target Justification
Number of patient falls with harm per thousand inpatient days.	**Unit of Measure** Rate **Patient Population** All patients	**Data Source** Falls Report **Reporting Period** April 2023 to March 2024	0.41	≤ 0.39	Maintain current target. The new Thompson Centre has opened (Feb 2023), need to assess impact of new environment and technology to patients and staff.

#	Change Idea	Methods	Measure	Target
1	**Standardize and enhance auditing process for falls prevention strategies applied to patients at risk for falls**	• Standardize falls prevention audits using one audit template that will track when patients and families receive patient education regarding falls. Patient education will include teaching delivered by a member of the care team. • This audit will be conducted via a new electronic tool for organizational consistency. • Implement process to review and share audit data with front line staff at huddles and with the Falls Prevention Action Team as a mechanism to increase learning and generate further improvement ideas. • Leaders will provide support to frontline staff to encourage use of falls prevention strategies when units are faced with high acuity, staffing challenges and other barriers to care.	1. Completion Date for new e-audit tool 2. Number of Unit Leadership audits completed (patient charts per month)	1. Q1 2. 5

2	**Provide re-education on falls prevention strategies to staff in alignment with the Accreditation Required Organizational Practice for Falls Prevention**	• New Employee Orientation to MGH will include falls prevention strategies
		• Update the Falls Standard Work for All Units poster to reflect changes in the Thomson Tower and to continue to support units in the Legacy building.
		• For all new and existing staff:
		  • Mandatory iLearn module: Falls Prevention
		  • Unit education by Managers, Supervisors, CRLs and Quality Specialist
		  • Training for use and access to all Falls Prevention equipment and patient education resources (i.e. socks, posey alarms, mats, etc.).
			1. Completion Date for Falls Std Work
			2. Completion rate for iLearn module (all interdisciplinary staff, all units)
			3. Audit of staff knowledge at huddles by using teach back method to support staff use of the Morse falls risk screen.
				1. Q1
				2. 80%
				3. 80%

3	**Improve tracking and documentation of falls over the course of a patient's hospitalization**	• Create Cerner report to identify patients who have had multiple falls over their hospital stay, and review findings with the Falls Prevention Action Team	Completion Date	Q2
4	**Review availability of falls prevention equipment required to meet patients' needs**	• Perform inventory of falls prevention equipment on all units for the Falls Prevention Action Team to make recommendations on opportunities for improvement	Completion of Inventory	Q1
5	**Review the call bell response time in the Thompson Centre.**	• Develop data collection and reporting system via the Mobile Connex tool to measure response time. • Track incidents related to response time via RL incident reporting.	Completion Date	Q2

2023/24 QIP Work Plan | Pressure Injury Prevention

Prevention of pressure injuries and reduction in the incidence of stage III and IV pressure injuries

Indicator	Unit of measure / Patient population	Data Source / Period	Baseline	Target for 2023/24	Target Justification
Number of hospital acquired pressure injuries, stage 2 or greater per thousand in-patient days.	**Unit of Measure** Rate **Patient Population** In-patients	**Data Source** Audit done only on Hospital Acquired cases. **Reporting Period** April 2023 to March 2024	1.20	≤1.10	Maintain current target. The new Thompson Centre has opened (Feb 2023), need to assess impact of new environment and technology to patients and staff.

#	Change Idea	Methods	Measure	Target
1	**Improve staging and assessment of pressure injuries across all in-patient units.**	• Create pressure injury prevention curriculum by end of Q2 and incorporate into the skin rounds implementation process, for all staff • Expand skin rounds to all inpatient units	1. Completion Date for development of iLearn module 2. Percent of staff completing iLearn course at end of Q4	1. Q2 2. 90%
2	**Standardize process for implementation of RNAO best practice initiatives.**	• Create PowerChart trigger for nurse orders for patients with Braden score <18.	1. Completion Date for Electronic report pulled from Cerner	1. Q3
3	**Improve tracking and auditing of Pressure Injuries hospital-wide**	• Create and validate audit sheet • Develop process for audits (timing, equipment, people) • Create scorecard for audit completion and central repository for audits and share results monthly at PIPAT • Create audit to monitor PI information provided to patients and families	1. Completion Date for increase of frequency of skin rounds to once per week for all inpatient units 2. Number of Risk Assessment (skin) audits completed weekly by Clinical Resource Leaders	1. Q2 2. 5

2023/24 QIP Work Plan | Patient Satisfaction

Improve patient satisfaction with discharge information

Indicator	Unit of measure / Patient population	Data Source / Period	Baseline	Target for 2023/24	Target Justification
% answering "Completely" to survey 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?"	**Unit of Measure** Percent Top Box Response ="Completely" **Patient Population** T7, T8, T9	**Data Source** Qualtrics XM Vocantas **Reporting Period** April 2023 to March 2024	45%	47%	We are collecting baseline data for the T 7 and T8 patient population for the first time. Improving the patient experience is a complex process that includes many factors. Further, staff are adapting to a new care environment with reduced human health resources.

#	Change Idea	Methods	Measure	Target
1	**Post Discharge Phone Calls (PDPC) using the Patient Oriented Discharge Summary (PODS) Framework**	• Implement the automated PDPC process, using the PODS framework, for patients being discharged to home • Implement a process for warm follow up phone calls for patients with flagged concerns on the automated calls	Percent of patients who have a warm follow up phone call to address the flagged issues identified during the automated PDPCs by the end Q1	1. 100%

2	**Build staff capacity in health literacy**
	(Teach back)
		• Nursing/IPP staff (including NRT) will complete:
		  • The iLearn module on the health literacy
		  • A didactic education session on health literacy, teach back, PODS
		  • A simulation session using teach back and the PODS framework
		• Observe staff during PODS conversations and provide in the moment coaching and feedback.
			1. Percent of staff who completed iLearn module and attended didactic and simulation sessions by end of October
			2. Percent of staff who have had in the moment coaching by end of October
				1. 90%
				2. 90%

3	**Create the environment for staff to have Patient Oriented Discharge Summary (PODS) conversations**	• Develop 15 new PODS with input/ feedback from staff, credentialed clinicians, PEP and health literacy • Nursing/ IPP staff will document PODS conversations in PowerChart • Develop a process for reviewing/ updating PODS • Explore with IT the possibility of automating PODS documents	1. Number of new PODS developed by end of Q4 2. Percent of PODS conversations documented in PowerChart 3. Completion Date for process to review PODS	1. 15 2. 60% 3. End of Q4

2023/24 QIP Work Plan | Equity, Diversity, Inclusion & Belonging (EDIB)

Improve anti-Black racism awareness through training

Indicator	Unit of measure / Patient population	Data Source / Period	Baseline	Target for 2023/24	Target Justification
Rate of staff and leaders completing TAHSN Anti-Black Racism training	**Unit of Measure** Completion Rate **Patient Population** All staff and leaders	**Data Source** Hospital Data through Learning Management System (iLearn) **Reporting Period** April 2023 – March 2024	(new metric, not available)	≥ 70%	• Typical overall completion rate for learning modules • NOTE: learning modules typically are not completed until Nov & Dec of each year, hence Change Idea #1

#	Change Idea	Methods	Measure	Target
1	Revise current communication practices for overall Curriculum Training	1. Review current practices for communication of overall Curriculum 2. Seek opportunities for improving current communication practices 3. Develop new communication plan, pushes in summer 4. Implement/launch updated communication plan 5. Review completion rate of TAHSN Anti-Black Racism training on a quarterly basis throughout reporting period	Completion Dates	1. March 2023 2. March 2023 3. April 2023 4. April 2023 5. June, September 2023 December, March 2024
2	Measure completion rate of all credentialed clinicians	1. Include TAHSN Anti-Black Racism training into 2024 Credentialed Clinician Credentialing Curriculum 2. Review completion rate of TAHSN Anti-Black Racism training by credentialed clinicians at end of Credentialed Clinician Credentialing Curriculum time period	Completion Dates	1. January 2024 2. March 2024
3	Measure completion rate of all new MGH hires with a start date within the reporting period	1. Include TAHSN Anti-Black Racism training into New Hire Training Curriculum 2. Configure iLearn Administrative dashboard to include monthly completion rate of TAHSN Anti-Black Racism training 3. Review completion rate of TAHSN Anti-Black Racism training by all new hires on a monthly basis throughout reporting period	Completion Dates	1. April 2023 2. April 2023 3. April 2023-March 2024

MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

2022/23 PROGRESS REPORT

2023/24 QIP Submission

Our Vision
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2022/23 QIP Progress Report |ED Time to Inpatient Bed

Reduce Emergency Department wait times

QIP Indicator	Baseline	Target	Current Perf	Comments
90th Percentile Emergency Department Wait Times for In-Patient Bed (Hours)	21.6	≤ 19.4	22.2 (Dec 2021 – Nov 2022)	We did not reach the target that was set out, which could be attributed to several factors throughout the year. The fall 2022 influenza season brought record volumes of acute patients coming to our ED with respiratory illness (30-40% increase from previous year average). Similarly in January 2022 during the Omicron wave, we were in surge which led to a 32 hour ED to IP Bed time for the month which ultimately skewed performance for the remainder of the year. We also opened up and transitioned the new Thomson Centre which reprioritized several IT and Flow resources. However, overall we performed extremely well by maintaining our previous year performance and ranking #1 among P4R Toronto peers.

Change Idea	Implemented?	Accomplishments & Lessons Learned
Improved use of Teletracking	Yes	We improved the use of Teletracking by changing the admission process with the introduction of the Ready-to-Move feature. There was also a change of the Porter job assignment with the intent to improve resource flow. The Nursing, Support Services and Environmental Service (EVS) staff were provided hand-held mobile devices in order to improve their workflow, which in-turn decreased transport response times. The mobile devices were equipped with different Teletracking applications based on the user-type. The applications provide information on patients, unit capacity and bed status which improves patient flow and patient safety. Nurses now receive notifications alerting them that a patient will be coming to the unit as well as Digital Transfer of Accountability availability in PowerChart. Training was also introduced to all inpatient nursing, Portering and EVS staff (approximately 380 nursing and 190 support staff) regarding the new Teletracking features and upgrades through in-person training and iLearn modules. With the development of the Thomson Centre, there were internal IT resource constraints, which led to delays with the Teletracking Integration to Cerner initiative. This project was expected to contribute further to the improvement of the ED to IP Bed Time, and will continue in F2023/24.
Build out 24/7 flow processes	Yes	Continuing through the F2022/23 year, there is still ongoing work with Inter-professional Practice (IPP), Internal Medicine Physicians and the Medicine Leadership teams to identify gaps in flow processes. Throughout the year the team introduced a Clinical Operations Manager and eventually extended the role to 24-hour coverage including weekends. The Geriatric Emergency Management team coverage was also extended to provide coverage to 7-days a week to help assist with discharge planning among our geriatric population in the ED. Work was also done with our Physician and IPP team to optimize their scheduling to facilitate discharge planning. Flow optimization remains a priority for MGH especially with the Thomson Centre opening.
Identify and execute further improvements	Yes	Throughout the F2022/23 year, several improvements ideas were identified and implemented. This work includes: 1) a re-introduction of Alternative Level of Care (ALC) Leadership huddles that include community partners to review complex cases and ensure timely attention to extended Length of Stay cases, 2) Refreshing of the Patient Flow dashboard to ensure the most appropriate and significant metrics are displayed to drive awareness and decision support, and 3) A data dive to understand and predict what causes a surge in our ED which ultimately contributes to admit rates.

2022/23 QIP Progress Report | Workplace Violence Prevention

Reduction in workplace violence incidents

QIP Indicator	Baseline	Target	Current Perf	Comments
Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.	310	≥ 312	172 (Jan – Dec)	As a result of global and organizational challenges in the last few years, we have seen a significant decrease in the number of reported workplace violence incidents at our organization. Through staff and leader engagement, we learned that while rates of violence have remained relatively unchanged, several factors have led to staff underreporting of workplace violence incidents. Due to competing operational priorities and challenges, we have not completely implemented all of our change ideas. We have recently re-established a WVP committee with representation across the organization to reprioritize workplace violence prevention. The committee is taking a multifaceted approach by implementing various short and long-term initiatives which will promote staff safety, encourage reporting of workplace violence incidents and support the care of high risk patients. Workplace violence prevention requires an organizational commitment of resources, and a diverse approach that addresses people and processes, and physical environment, both proactively (eg: training) and reactively (eg: post-incident support and follow-up).

Change Idea	Implemented?	Accomplishments & Lessons Learned
Zero Tolerance Campaign & Strategy Continue implementation of communication, education and proactive solutions to support our vision of a zero tolerance work environment	Yes	The risk assessment tool was streamlined, and has made the process for performing and documenting environmental risk assessments more efficient. A target/schedule has been set for the number of high risk areas to be assessed per quarter. Our Zero Tolerance campaign has continued, however some of the new education/communication materials such as closed loop communication for incident reporting were not fully completed this year due to competing priorities. Leadership follow-up and closed loop communication was identified through staff surveys as a high priority action item, and as such, was brought forth as a primary focus in the upcoming 2023/24 QIP.
Workplace Violence Prevention Dashboard Develop a dashboard with several key performance measures, for e.g.: total incidents reported resulting in lost time, breakdown by type, severity, patient care unit, Staff training completion rates	Yes	A WVP dashboard was developed and shared with key stakeholders in Q3. Data is regularly disseminated through the workplace violence prevention committee as a means of bringing awareness to the frequency of incident reporting, the types of incidents and staff most affected, as well as a glimpse at the compliance to annual e-learning.
Behavioural Care Plan Alert (BCPA) for Patient & Worker Safety Continue implementation of the Behavioural Care Plan Alert for Patient & Worker Safety	Partial	BCPA has been implemented on paper in one area only. Challenges have been identified in standardizing the process to a point where the care plan could be implemented in the electronic chart. The Violence Assessment Tool (VAT) has been fully implemented. Compliance to the VAT completion will need to be monitored in order to fully evaluate its impact.

2022/23 QIP Progress Report | Transfer of Accountability

Improve quality of information transfer at patient transition points

QIP Indicator	Baseline	Target	Current Perf	Comments
Number of Transfer of Accountability related Incidents per month	10.9	≤ 10.0	8.20 (Apr – Feb)	The aim of the 2022-23 QIP project was to create an electronic handover tool to facilitate safe patient transfers in an efficient manner. To facilitate the opening of our new Thompson Centre tower and to ensure our commitment to safe transfer of accountability, it was decided that the focus should be on emergency department to inpatient transfers. A comprehensive electronic TOA tool was created by an interdisciplinary team and was implemented on January 2023 with concurrent in-scope staff education. The tool remains live and is used daily and has received strong feedback from staff for its comprehensiveness and its efficiency in daily practice.

Change Idea	Implemented?	Accomplishments & Lessons Learned
Improve Transfer Of Accountability (ToA) processes from unit to unit Review and refine current IPASS tool for when patients are transferred from one unit to another	Yes	An in-disciplinary team was formed to create a new electronic ToA process with multiple stakeholder input from various care-providers in different areas of the hospital. A tool was created to facilitate emergency department to inpatient unit transfers in a safe, comprehensive manner. The digital tool consists of a Transfer of Accountability sheet including auto-populated relevant fields such as vitals, code status, diet with open fields to allow staff to input items like “what to watch for” and “relevant history” for facilitate comprehensive handover of patients. The tool was then implemented in January of 2023 and is undergoing a regular improvement process with staff input and regular training by clinical resource leaders. Given the success of this tool, we plan to expand its use over F2023/24 to our pediatric mental health areas, which will likely require further revisions to achieve speciality specific information transfer.
Improve the quality of Transfer Of Accountability at shift handover through organization-wide education	Yes	A ToA iLearn was created for ED to inpatient transfers (57% completion rate). Inpatient nurses also received this TOA education from an inpatient angle. Regular spot-training was achieved by clinical resource leaders and demonstration in the days before the tools went live including round-back education on areas of improvement and deficit. New ToA workflow was implemented into huddles, as information was disseminated throughout the hospital. One-on-one coaching for the new TOA practice was provided in both ED and Inpatient units. New hires to both inpatient units and the emergency department will receive orientation on the new digital ToA process.

2022/23 QIP Progress Report | Medication Administration

Reduction in medication incidents

QIP Indicator	Baseline	Target	Current Perf	Comments
Rate of medication incidents per thousand patient care days	3.50	≤ 3.10	1.87 (Apr - Feb)	As at the end of Q3, we have exceeded our performance target. This was achieved by identifying and removing barriers to double-check processes, creating heightened awareness with a performance dashboard, and improving access and reliability of scanning equipment. We fully expect to continue achievement of target, and plan to carry on with continuous monitoring and improvement in the coming year.

Change Idea	Implemented?	Accomplishments & Lessons Learned
Standards of Medication Administration Reinforce patient/medication barcode scanning and independent double check processes	Yes	Selected forums (eg Safe Medication Practice committee) were leveraged to reflect on incidents/near misses, build awareness of best practice, and to target interventions in areas identified as improvement opportunities. These collaborations were then used to support the successful design and roll-out of automated dispensing units across the hospital as a standard of practice. As ADUs were implemented, routine rounding and PDSA mechanisms allowed the timely provision of feedback to support usual best practices for medication administration during peak change periods.
Medication Safety Dashboard Develop a dashboard with several key performance measures to monitor medication safety for e.g.: medication incidents, patient/medication barcode scanning compliance, independent double check compliance	Yes	Key performance metrics displayed on an easy-to-read dashboard greatly enhanced our ability to identify and act on improvement opportunities. The dashboards were available at various leadership forums and at Pharmacy team huddles, providing an important way to align all stakeholders toward the improvement target and support the change management of implementing automated dispensing units.
Scanning Equipment Review availability and condition of medication scanning equipment to determine if there are appropriate resources to increase scanning compliance and ensure consistent scanning practices across all care areas	Yes	We worked with our information & technology teams to complete an environmental scan of medication administration equipment, generating action plans to ensure necessary equipment was in adequate supply and in proper working order. This also resulted in a medication cart replacement program to further improve medication administration on the wards.

2022/23 QIP Progress Report | Falls with Harm Prevention

Reduction in Total Falls and Falls with Harm

QIP Indicator	Baseline	Target	Current Perf	Comments
Number of patient falls with harm per thousand inpatient days.	0.41	≤ 0.39	0.35 (Apr – Feb)	We successfully achieved our performance target for this year, as at end of Jan. Our focus on patient education and staff awareness contributed significantly to our success. While not all change ideas were fully implemented, we will keep this indicator as a priority in our 2023/24 QIP. Communication and monitoring will be particularly important as we transition to modified space, processes and technology in our new Thompson Patient Care Centre.

Change Idea	Implemented?	Accomplishments & Lessons Learned
Standardize and enhance auditing process for falls prevention strategies applied to patients at risk for falls	Yes	A standardized tool was developed and sent to leaders to support auditing. Leadership was engaged and a new electronic tool has been developed and will launch in Q1 23/24 for real-time audits. Patient care unit specific targets were monitored and consistently met by teams, leading to a marked decrease in total falls.
Provide re-education on falls prevention strategies to staff in alignment with the Accreditation Required Organizational Practice for Falls Prevention	Yes	We experienced a high rate of organizational uptake with all front-line staff (including new hires) to complete the Falls iLearn module, which contributed to the overall reduction in falls.
Improve tracking and documentation of falls over the course of a patient's hospitalization	Yes	These events are tracked through various methods: safety incident reporting, Transfer of Care processes, and review in our Falls Prevention Action Team meetings. Learnings were shared across teams, which assisted in the spread of improved processes, including into out-patient programs.
Review availability of falls prevention equipment required to meet patients' needs across the organization	Partial	All leaders (in-patient and out-patient departments) were asked to review the equipment and supplies needed to support safe patient care delivery in supporting falls prevention. An inventory was completed in our Legacy building, and the resulting replenishment of needed supplies led to a decrease in Falls. The Thompson Centre is currently being assessed as patient care commenced in February 2023.

2022/23 QIP Progress Report | Pressure Injury Prevention

Prevention of pressure injuries and reduction in the incidence of stage III and IV pressure injuries

QIP Indicator	Baseline	Target	Current Perf	Comments
Number of hospital acquired pressure injuries PIs, stage 2 or greater per thousand in-patient days.	1.20	≤ 1.10	0.89 (Apr – Feb)	While not all of our change ideas were fully implemented, we were able to significantly exceed our performance target. Our focus on the quality of bed surfaces, replenishing needed equipment, communication with leadership and staff contributed to our success. Given our recent move into our new Thomson Centre, with its modified space, processes and technology, this indicator will continue to be a priority, and will carry over into our 2023/24 QIP.

Change Idea	Implemented?	Accomplishments & Lessons Learned
Reducing all hospital acquired pressure injuries and preventing stage III and IV pressure injuries with improved tracking and adoption of RNAO best practice guideline	Partial	While not fully implemented, we made improvements to the Pressure Injury report, specifically the patient data, demographics, and the report to include lab work. We also launched Skin Rounds, enabling staff to recognize and learn about pressure injury staging at the bedside and to support patients in a timely manner. This change idea will carry over into our F2023/24 QIP work plan.
Standardize process for skin assessments and documentation	No	We were not able to develop the curriculum due to the competing priorities of the planning and preparation for the move into our new Thomson Centre. This change idea will be included in our F2023/24 QIP work plan
To provide patients and families education on how to prevent and manage pressure injuries during hospital admission and post discharge	Yes	The Pressure Injury Patient Orientated Discharge Summary (POD) was developed along with making Elsevier Patient information sheets available on PowerChart. We will be further developing a process to audit patient education delivery as part of our F2023/24 QIP work plan.
Review availability of pressure injury prevention equipment to determine if there is an appropriate supply to meet patients' needs across the organization	Yes	Gaps in access to needed equipment were identified, and led to the purchase of beds with pressure relieving surfaces. All staff were trained on the new bed features to best support patient care as it relates to pressure injury prevention.