MICHAEL GARRON HOSPITAL

TORONTO EAST HEALTH NETWORK

2019/20 Quality Improvement Plan

Progress Report (for 2018/19 QIP)

21 March 2019

Create Health. Build Community.

2018/19 QIP Progress Report | Table of Contents

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The following pages contain a progress report for each of the improvement initiatives we launched as our 2018/19 QIP. Progress reports address: 1) achievement of objectives ; 2) effectiveness of change ideas; and 3) lessons learned.

2018/19 QIP Progress Report | De-prescribing Medications

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Optimize use of commonly over-prescribed medications to improve patient safety and reduce costs

QIP Indicator	Baseline	Target	Current Perf	Comments
Percent adult patients admitted to Medicine reviewed for appropriate use of inhaled corticosteroids (ICS)	N/A	> 70 %	76 % (YTD Dec)	In first year of this QIP, we have raised awareness and implemented new processes to ensure appropriate chart reviews and follow up with patients and community care providers. Reduction of unnecessary prescriptions has increased patient safety, and also generated a drug cost savings of about $60,000 per year – a 50% reduction - that can be reallocated to other patient care needs. Lesson learned: To increase impact of this initiative, and prepare for spread to additional patient care units, a dedicated Deprescribing Team is required.

Change Idea	Implemented?	Accomplishments & Lessons Learned
Evaluate Polypharmacy	Yes	• **Goal: Use hospital admission to evaluate polypharmacy in all patients, working in collaboration with pharmacists and GIM physicians.** • Designed and implemented ICS detailed and summary reports for ad-hoc review • Designed and implemented daily electronic ICS audit for communication to De-prescribing Initiative (DPI) team • This year's focus was on Medicine program – we now have the foundation to spread to other service programs and drug targets
Engage with Patient	Yes	• **Goal: Engage and collaborate with the patient or substitute decision maker (SDM) regarding value/role of de-prescribing** • Designed and implemented a patient information pamphlet, to be finalized with input from Patient Experience Panel and care providers
Care Provider Education	Yes	• **Goal: Provide primary care physicians and community pharmacists with education and care plans regarding de-prescribing initiatives** • Designed and implemented a PowerNote template within our hospital information system (Cerner) to enable communication with primary care physicians • This will be the basis for expansion of communication to allied HCP in other areas

2018/19 QIP Progress Report | Patient Experience
Patient Oriented Discharge Summary (PODS)

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Improve patient experience

QIP Indicator	Baseline	Target	Current Perf	Comments
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"?	50%	> 52.5%	68.1% (YTD Feb)	We acknowledge that improving the patient experience is a complex process that includes many factors. When we looked at our NRC Picker results, this indicator was one area where we were scoring below our peer hospitals and the Toronto Central LIHN average. We also wanted to decrease hospital readmissions and ED visits by helping patients understand their information better, so they can manage their health at home. The goal was to improve patients' transition home, by using the PODS framework to improve the way we provide discharge information. We narrowed this indicator to the surgery in patient unit, since these patients are less complex, on pathways and have shorter lengths of stay, with the intention of using the learning s to expand PODS to other more complex patient populations such as CHF, COPD and pneumonia. Implemented change ideas helped us to successfully improve our top score in surgery inpatient unit.

Change Idea	Implemented?	Accomplishments & Lessons Learned
Building staff capacity in the area of health literacy	Yes	• Worked in partnership with Sunnybrook and our patient partners to determine the content, methods, timelines and evaluation process for the education content re Health Literacy and Teach Back. • Education was developed, implemented and evaluated and included an iLearn module on health literacy , a 30 minute on unit didactic learning session on health literacy and teach back and a 30 minute on unit simulation session to practice using these techniques with the PODS frame work.
Post Discharge Phone Calls (PDPC)	Yes	• Created and implemented a PDPC process using the PODS framework. This process includes a "caller instructions sheet", a guide that outlines how to make the calls , and a "summary sheet" with a script of questions to ask the patient. The script includes questions related to the five categories of PODS, such as if the patient knows how to take their medications, signs and complications to watch for etc. as well as questions about quality improvement opportunities and staff shout outs. The PDPC process was shared with Sunnybrook to use as part of our joint QIP work.
Identify the ideal paper pilot process to support a Patient Oriented Discharge Summery for a patient population in surgery	Yes	• Worked with staff, physicians, patients, families ,and a health literacy expert to create a paper PODS tool for each surgical group. • Used a health literacy lens to revise additional patient learning materials such as the ortho guide for patients having total joint replacements. • Successfully built the PODS conversation into the already existing MGH Ideal Patient Discharge Process. • Revising the electronic documentation tool using the PODS headings, to capture the patient education that is done and areas that require follow up teaching.

2018/19 QIP Progress Report | Med. Reconciliation on Discharge

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Increase the proportion of patients receiving medication reconciliation on discharge.

QIP Indicator	Baseline	Target	Current Perf	Comments
Proportion of discharged patients for whom a best possible medication discharge plan was created (ED, Surgery, Mental Health, Medicine)	54.9%	57.6%	63.5% (Q3 2018)	Medication reconciliation performance improved by 8% from previous year. However, performance remains low in the Surgery Department and it has proven difficult to engage physicians in a consistent manner. Next year, the team will focus on finding sustainable forums to engage physicians and emphasizing the patient safety impact of medication reconciliation.

Change Idea	Implemented?	Accomplishments & Lessons Learned
Surgeon Champion	Yes	• **Goal: Ensure Surgery physician engagement with a focus on Venous Thromboembolism (VTE) prophylaxis and opioids.** • A report focused on VTE/opioids medication reconciliation completion was created. However, performance in those areas was similar to overall performance which led the team to not focus on this particular aspect of medication reconciliation at this time. • Surgeons and residents were engaged through rounds, councils, meetings and e-mails to identify further barriers and discuss opportunities for improvement. • Lesson learned: For more impactful and sustainable results, it is important to find a surgeon champion for the initiative. This is in our plan for 2019/20.
Engage MNC and CCC	Yes	• **Goal: Engage Maternal Newborn & Child (MNC) and Complex Continuing Care (CCC) leadership and staff to prepare for spread into these programs in the following year.** • Maternal Newborn & Child and Complex Continuing Care medication reconciliation data was pulled and discussed preliminary to identify improvement ideas for next fiscal year.
Discharge Process	Yes	• Goal: Embed medication reconciliation best practices into our discharge processes • Many technological barriers identified by physicians were removed: printer profiles created , APS PowerPlan rule adjusted, smart templates for discharge summaries available. • Surgeons and residents expressed the need to be able to plan for med rec. The functionality was planned for roll out but then abandoned due to technical barriers and other risks identified.

2018/19 QIP Progress Report | e-Monitoring Hand Hygiene

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Drive improvement in hand hygiene compliance and reduce Hospital Acquired Infections (HAIs)

QIP Indicator	Baseline	Target	Current Perf	Comments
Number of units with a monthly mean Hand Hygiene Compliance rate above 60% over a three month period	1.0	> 2.0	2.5 (Oct - Dec)	We expect to exceed our targets in F2018/19. This initiative is a collaborative effort with four other hospitals (Lakeridge, Mt. Sinai, St. Mikes, and Sunnybrook), and successfully implemented innovative technology (hand wash dispensing devices with automated data capture capability) which enabled accurate counts of hand hygiene compliance by patient care unit. These eMonitoring devices were implemented in five patient care units this year (A5, H7, A3, B3 and F3). Compliance rates during weekends and holidays are significantly lower than the compliance rates during the weekdays– this will continue to be a target for improvement. We will be expanding and implementing electronic monitoring to three additional patient care units in Spring 2019/20.

Change Idea	Implemented?	Accomplishments & Lessons Learned
Unit-based quality improvement (QI)	Yes	• **Goal: ICPs will facilitate unit leadership to develop unit-based QI interventions to improve HHC rates.** • Successfully engaged clinical leaders in the five targeted patient care units to launch several QI interventions, including: posting HHC results on huddle boards, education sessions for patients and families, assignment of an HH champion for low performing shifts, installation of dispensers on Workstation on Wheels (WOWs), testing different washing lotions to address staff feedback, and organizing a variety of contests to create friendly competition among patient care units.
Leadership feedback of performance	Yes	• **Goal: The executive team will provide feedback to each unit quarterly** • Our Vice Presidents have been engaged with patient care unit leadership and care providers to share performance scorecards, provide recognition to high-performing teams, and generally support the communication of this initiative's importance.
Unit-specific goal setting	Yes	• **Goal: Each unit will set a short term (one month) and long-term (three months) goal.** • Compliance performance was monitored in each of the five patient care units, and targets adjusted on a monthly basis. This strategy worked well in creating an improvement road map seen to be achievable by care providers. • Lesson learned: In 2019/20 we will be using a more direct measure: Average compliance rate across patient care units equipped with eMonitoring devices. This should improve communication across the hospital.

2018/19 QIP Progress Report | Workplace Violence Prevention

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Reduction in workplace violence incidents

QIP Indicator	Baseline	Target	Current Perf	Comments
Number of reported workplace violence incidents (average per month)	Not Available	> 25.0	27.0 (Jan to Dec, 2018)	In the first year of this QIP initiative, we have successfully created an environment in which all staff feel safe to report any form of workplace violence. We are achieving our target of > 300 reported incidents in a 12 month period. Along with increasing reporting of incidents, we are developing strategies to reduce incidents of violence through collaborations with other organizations to identify and apply best practices. We have also designed and developed a new reporting system that stratifies reported incidents by severity and type of violence.

Change Idea	Implemented?	Accomplishments & Lessons Learned
Training	Yes	• **Goal: Increase accountability of workplace violence training among leadership** • Developed and implemented training programs tailored to staff position type, along with organizational scorecard to track completion rate by program
Flagging	Yes	• **Goal: Implement the new Joint Centres Alert for Behavioural Care (ABC) Plan.** • Completed customization Joint Centres policy to suit TEHN experience & expectations • Delivered ABC Plan training for all care providers • Designed and installed modifications to electronic patient record system – waiting for Cerner system upgrade to fully implement (in progress, planned roll-out in Spring 2019)
System Leadership	Yes	• **Goal: Implement innovative ideas related to advancing the delivery of positive practice that will further position MGH as a system leader** • Completed several collaborations with other organizations (eg: Joint Centres, CAMH) to share experiences and ideas, including the development of the *Workplace Violence Playbook* to facilitate spread of best practices • Delivered two presentations at International WVP Conference • Designed and completed our Think Tank Day – a collaboration of leaders from several organizations to brainstorm innovations and practical solutions

2018/19 QIP Progress Report | ED Length of Stay (Complex, Non-admitted)

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Reduce patient length of stay in the Emergency Department

QIP Indicator	Baseline	Target	Current Perf	Comments
90th Percentile Emergency Department Length of Stay for Complex Non-Admitted Patient Visits(CTAS 1-3)	7.5 Hrs	< 7.5 Hrs	7.6 Hrs (Oct 2017 – Nov 2018)	Over the 2018/19 year, we continue to focus on the complex non-admitted patient population. Through increased collaboration with our mental health service team, we have been able to improve access to mental health services in the late evenings and overnight to reduce time to consultant services. We realized that successful implementation of the change ideas was a result of increased planning, engagement and staff buy-in to adopt the initiatives and change workflow. Ongoing evaluation has enabled greater sustainability and allowed staff to better overcome barriers and challenges to implementation. With this indicator, we found the greatest challenges were related to cultural and behaviour changes and we helped mitigate this aspect through recognition of the time required to bring about change. Despite our continued focus on improving services and processes that contributed to a longer length of stay , we were not able to achieve the set out target. The department was challenged with a significant increase in patient complexity and acuity, some of which could be attributed to the Sunnybrook EMS Diversion initiative. Going forward, we will continue test new ideas, evaluate and make necessary adjustments to the current initiatives.

Change Idea	Implemented?	Accomplishments & Lessons Learned
Mental Health Capacity Building	Yes	Over the last year, we learned that close partnership and ongoing communication with a different department is key to successful implementation. The ED and mental health teams have started to huddle on a daily basis to discuss the plans of care for our mental health patient population. This process helps to streamline care by early identification of a plan to facilitate timely and appropriate care. We have made revisions and relaunched the CIWA protocols. In May of 2018, an overnight crisis worker shift was added to increase access to mental health resources overnight. In 2019/20, we will continue to build on this partnership by collaboratively re-designing the mental health space in the emergency department. This new space will increase privacy and comfort for our mental health population. Patients and families will be included in the re-design to ensure we build a space that meets the users needs.
Building Assessment Capacity	Yes	In 2018, we continued to build on the physician navigator role by increasing patient patient facing tasks in their responsibilities. The navigators proactively address patient inquiries and provide updates as patients progress through their emergency visit journey. They continue to facilitate better flow by taking on non-clinical tasks previously performed by nurses and doctors. This role continues to be beneficial to staff, patients and the department. A physician assistant role was briefly trialed to help streamline upfront processes to reduce redundant physician interaction. This short trial was shown to have minimal benefit to the patient and saw only a slight reduction in physician assessment times. In 2019, we launched a new process in the ambulatory areas to facilitate earlier physician assessment by redistributing the order of nursing tasks. This process will be evaluated later this year. Though reducing length of stay is a complex issue, this tactic has helped to improve patient satisfaction, as well as increase patient flow through the ED.
ED Bed Capacity	Yes	8 additional ED assessment spaces were created in the medical short stay area. This additional space allowed for a better caring environment for patients requiring a longer emergency visit stay and not admission. The re-design of the mental health space will look increase bed capacity from 3 to 8 beds.

2018/19 QIP Progress Report | Rescue from Danger

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Improve quality of response to deteriorating patients

QIP Indicator	Baseline	Target	Current Perf	Comments
Rescue Index: Number of unexpected adult ward deaths per thousand discharges	1.6	< 1.0	0.8 (YTD Feb)	This is an organization-wide, complex change initiative involving adoption of new methods and tools and significant culture shifts. We have successfully reduced the Rescue Index by about 50%, and our now focussed on fully operationalizing the changes for on-going sustainability and continuous improvement.

Change Idea	Implemented?	Accomplishments & Lessons Learned
Increase situational awareness	Yes	• **Goal: Provide performance feedback to individual wards** • Designed and implemented weekly "Days Since by Ward" reports sent to physician and admin leadership across the hospital • Has served to raise awareness, but exploring new strategies to increase level of front-line engagement
Automate System Scorecard	Partial	• **Goal: Build reporting system to enable timely on-going system monitoring** • Designed reporting format of Rescue from Danger Scorecard, and implemented required modifications to our hospital information system (HIS) electronic patient chart system • Demands on our Information Technology Services team have been extraordinary this year, to address the strategic imperative to complete a major upgrade to our HIS hardware and software – lesson learned: more detailed resource planning
Hot Debriefs of Code Blues	Yes	• **Goal: Facilitate timely debriefs, and capture lessons for on-going improvement** • Implemented a mobile app. designed to facilitate documentation of debriefs – including training for clinical staff across the hospital • Adoption rate is high in some service areas, but not at target in others. Lesson learned: Do not underestimate the time & effort required to implement system wide change to clinical practice.
OM-3 Model (Mortality & Morbidity)	Yes	• **Goal: Adapt Ottawa M&M model to improve structure and quality of M&M rounds across different specialties** • Program launched in seven communities of practice, including documentation of baseline OM3 maturity model status • Designed and implemented prototype of email-based communication tool to facilitate maintenance of database – this in turn enables generation of reports to inform system wide improvement opportunities • Work completed this year will be foundation for continued spread to additional communities of practice in next fiscal year

2018/19 QIP Progress Report | Readmissions (COPD, CHF)

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Reduce patient readmissions within 30 days

QIP Indicator	Baseline	Target	Current Perf (YTD Jan)	Comments
Percent of patients readmitted within 30 days, for any cause, to own hospital	COPD 21.0 % CHF: 16.0 %	< 20.0 % < 15.2 %	25.2 % 21.0 %	We do not expect to meet our targets by end of Fiscal 2018/19. We've successfully redesigned order sets (presently in Information Technology Services' work queue for implementation), improved our discharge process, and are leveraging the Cerner Readmission Flag. We've learned that many factors are in play in patients' home and community and beyond our ability to directly impact. In addition, it should be noted that the size of this patient population is quite small (average/month of 33 for COPD and 18 for CHF) – which means a difference of 1 or 2 readmissions causes large variation independent of improvements implemented.

Change Idea	Implemented?	Accomplishments & Lessons Learned
Update Order Sets	Partial	• **Goal: Ensure order sets reflect "best practice" and are applied with high compliance rate** • Completed comprehensive review and updating of COPD and CHF order sets, involving physicians and aligned with the Ministry's published best practice guidelines (ie: QBP clinical handbooks) • Implementation of revised order sets presently dependent on availability of our Information Technology Services resources – who are dealing with many high priority projects including a major software and hardware upgrade of our hospital information system .
Improve Discharge Planning	Yes	• **Goal: Develop improved practices that may prevent readmissions, and include in Order Set updates** • Implemented several improvements including: revised discharge protocols in order sets, and improved coordination with Virtual Ward, Palliative consults, and Dietician consults
Leverage Readmission Flag	Yes	• **Goal: Develop and implement ideas on how to use Cerner (eKardex) Readmission Flag to deliver targeted care plans** • Completed idea generation and awareness building campaigns among care providers • Implemented new processes to provide flagged patients with tailored care plans, including use of post-discharge phone calls to support appropriate follow-up in home and community care • Initiated patient chart reviews of all readmitted patients with goal to identify patterns that will further inform tailored care paths –in progress

2018/19 QIP Progress Report | Smoking Cessation Assist

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Help IP medicine patients understand their options related to smoking cessation and assist them with options to quit

QIP Indicator	Baseline	Target	Current Perf	Comments
Percent of Medicine In-patient smokers prescribed Nicotine Replacement Therapy (NRT)	52 %	> 60.0 %	61.0 % (YTD Feb)	In the first year of this QIP initiative, we have successfully designed and implemented a reporting system to facilitate targeted patient engagement. Combined with our education strategy for patients and care providers, we are (as at end of Feb) successfully achieving our improvement target.

Change Idea	Implemented?	Accomplishments & Lessons Learned
Data Collection	Yes	• **Goal: Improve data collection to better understand current assist rate related to smoking cessation** • Designed and implemented a data collection and reporting tool at the unit level within our hospital information system (Cerner) to measure and monitor performance.
Education and Training	Partial	• **Goal:Provide education and training to frontline providers to increase offer of assistance** • Prepared learning material and established strategy to rotate interested nurses through smoking cessation clinics • Resource constraints resulted in delays to roll out this change idea – implementation in progress • Lesson learned: To engage with more patients, and increase impact, additional resources are required. We are exploring ways to more effectively engage nursing staff in this initiative.
Patient Education	Yes	• **Goal: Provider patient with education tools and processes.** • Designed materials with input from nurses and patients

2018/19 QIP Progress Report | Pressure Injuries

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Reduce incidence of (>stage 2) hospital acquired pressure injuries

QIP Indicator	Baseline	Target	Current Perf	Comments
Average number of hospital acquired pressure injuries (Stage 2 or greater) per month	10.0	< 9.0	8.5 (YTD Feb)	Over the 2018-2019 year, we focused on electronic documentation and education to reduce the incidence of hospital acquired pressure injuries. We successfully implemented daily electronic charting of pressure injuries on all inpatient care units. The QIP achieved its target and will now focus on strategies to sustain gains and continue to improve accuracy and consistency of reporting.

Change Idea	Implemented?	Accomplishments & Lessons Learned
Braden Scale	Yes	• **Goal: Understand the feasibility of bringing the Braden Scale Assessments into daily nursing work** • Identified gaps with accurately staging pressure injures , documenting skin assessments , and identifying patients at risk. • Created electronic chart content with frontline staff input. All patient care units are now conducting daily Braden Scale Assessments and documenting it electronically. • Developed iLearn and didactic training courses for frontline staff highlighting correct staging of injuries. Achieved 76 % completion rate for the elearning component. 200 staff attended the open sessions in January, since then CRLs are training staff in individual units with approximately a further 160 staff trained. Implemented new report to monitor compliance of daily Braden documentation with ability for managers to understand individual staff compliance. IT team will also change nomenclature in the EHR based on feedback from nurses (April/May 2019).
Personal Support Workers	Yes	• **Goal: Standardize the work of Personal Support Workers (PSWs)** • Created community of practice education sessions for PSWs. However, sessions were not well attended due to staff availability to leave units. We are considering other strategies on top of education to sustain it.
Reporting	Yes	• **Goal: Improve accuracy and consistency of staff reportage of pressure injuries** • Implementing weekly report that sends information of hospital acquired pressure injuries to individual Clinical Resource Leaders (CRLs) to review. The CRL audits the electronic health record in detail and connects with staff to coach and teach in the moment. The CRL also assists in modifying documentation for accuracy. This coaching process , review and discussions with staff at huddles is expected to build and sustain knowledge capacity at the bedside. • Reports continue to show patients counted multiple times and we are exploring options to introduce human factor technology within the electronic health record to improve documentation processes.