MICHAEL GARRON HOSPITAL

TORONTO EAST HEALTH NETWORK

2019/20 Quality Improvement Plan

Work Plans

Performance Monitoring & Quality Committee

21 March 2019

Create Health. Build Community.

2019/20 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.

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2019/20 QIP Work Plans | De-prescribing Medications

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

Indicator	Unit of measure/ Patient population	Data Source/Period	Baseline	Target for 2019/20	Target Justification
Proportion of adult Inpatients admitted to Medicine reviewed for appropriate use of targeted medications	Unit of Measure # patients reviewed divided by total medicine patients prescribed target medicines Patient Population Adult patients admitted to IP medicine who have been prescribed targeted medicines	Data Source Hospital collected data (Cerner eChart) Reporting Period April 1, 2019 - March 31, 2020	N/A (new patient pop'n)	70 %	• Continue to leverage gains with inhaled corticosteroid review • High risk sulfonylureas may lead to hypoglycemic episodes and ED admissions • PPI's are usually no longer appropriate in the long-term and may contribute to C.difficile risk • Anticoagulants are high risk and may be inappropriately dosed or prescribed • Medicine inpatient culture is amenable to deprescribing • Pharmacist resource allows increased capacity

#	Change Idea	Methods	Measure	Target
1	**Build Deprescribing Stewardship Team** Establish dedicated team comprised of physician and pharmacy leadership for on-going polypharmacy evaluation and program oversight	1. Define resource requirements 2. Finalize medicine targets, patient care units, and roll out timing (Preliminary list: inhaled corticosteroid, sulfonylurea, proton-pump inhibitors, anticoagulant) 3. Develop business case to support allocation of funding 4. Operationalize the team 5. Develop and launch strategy to build awareness and communicate patient benefits (target audience: patients, substitute decision makers, care providers)	Completion Dates	1. April 2. April 3. April 4. May 5. May
2	**Update Cerner Reporting Tools** Design and implement Cerner Explorer reports to facilitate identification and tracking of patients on target drugs	1. Define reporting requirements 2. Build and test reports 3. Implement the reports	Completion Dates	1. April 2. May 3. May
3	**Update Cerner Documentation Letter for Community Provider** Design and implement Documentation Letter for deprescribing care plan for community pharmacists and doctors	1. Define Summary report requirements 2. Build and test reports 3. Implement the reports	Completion Dates	1. May 2. June 3. July

2019/20 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 2019/20	Target Justification
Compliance with use of iPass tool upon inter-departmental patient transfers (number of iPass use divided by total patients transferred to another department)	Unit of Measure Percent Patient Population All inpatients in a patient care unit with iPass tool & method implemented	Data Source Hospital collected data Reporting Period Jan – Mar 2020 (Q4)	N/A (new system)	> 70	We will be implementing new methods and tools, and therefore do not have a baseline. The target is based on the knowledge of and consensus of the working group, comprised of leadership across the hospital, including physicians.

#	Change Idea	Methods	Measure	Target
1	**Implement Shift-Shift (Handover) Transfers of Care** Complete training for all nursing, Personal Support Workers, and Inter-Professional staff, and implement iPass principles and tools	1. Complete iLearn training (all Clinical Programs) 2. Implement pilot patient care units – plan: J5, H6 (Complex Continuing Care, Mental Health) 3. Establish core team of ToC Change Champions (from Unit Based Councils) for all clinical programs, and complete "train the trainer" education 4. Incorporate pilot lessons, and launch implementation in all clinical programs (Medicine, Surgery, Maternal Newborn Child, Complex Continuing Care/Rehabilitation, Emergency) 5. Complete implementation of Handover phase	Completion Dates	1. Apr 2019 2. May 3. May 4. Jun 5. Aug
2	**Implement Inter-departmental Transfers of Care** Spread use of iPass principles and tools to include interdepartmental patient transitions	1. Design, build, test and implement iPass tool in Cerner PowerChart 2. Design and launch physician engagement strategies and training 3. Implement pilot patient care units – plan: Operating Room-Intensive Care Unit, Emergency-Complex Continuing Care (H7) 4. Incorporate pilot lessons, revise Change Champion teams as required, and launch implementation in all clinical programs + Diagnostics 5. Complete physician training 6. Complete implementation of Inter-departmental phase	Completion Dates	1. Sep 2. Sep 3. Oct 4. Oct 5. Dec 6. Dec

2019/20 QIP Work Plans | Positive Patient Identification (PPI)

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Improve patient safety through increased compliance with positive patient identification protocol

Indicator	Unit of measure/ Patient population	Data Source/Period	Baseline	Target for 2019/20	Target Justification
Percentage of PPI correctly completed	Unit of Measure Percent Patient Population Selected patient care units	Data Source Hospital collected data (observational audits or patient surveys) Reporting Period Oct 2019 – Mar 2020 (Q3+Q4)	N/A (baseline to be collected)	> 10% improvement over baseline	A 10% percent improvement over baseline has been selected, to be determined once data is collected, to provide a realistic and achievable goal to support communication to staff. However, MGH aims to achieve a 'theoretical best' target of 100%.

#	Change Idea	Methods	Measure	Target
1	**Empower patients to 'speak up for safety' re: PPI by creating an environment in which they feel safe voicing concerns**	1. Partner with Pt Experience Partners (PEP) to develop a communication strategy 2. Identify opportunities to educate patients re: PPI and encourage them to speak up (ie. channels + key messages) 3. Complete an environmental scan to understand peers' success factors 4. Increase awareness to and receptivity by staff via patient-driven expectation	Ideas generated by PEP Improvements implemented focused on patient voice	New patient focused improvement implemented by end of Q1
2	**Identify process improvements to remove barriers to PPI**	1. Analyze current state processes at points of care 2. Identify gaps and opportunities 3. Develop and prioritize improvement ideas 4. Review practices in areas of high performance (positive deviance)	Review of PPI process for identified points of care	Review PPI process for selected points of care by end of Q2
3	**Reinforce PPI education and awareness to providers**	1. Identify opportunities for unit level engagement 2. Improve/hardwire loopback and discussion of PPI incidents 3. Explore opportunities for patient care unit level tracking 4. Leverage safety behaviour recognition program to recognize high performers	Frequency of discussion of PPI and/or incidents on patient care unit	Discussion of PPI minimum 1x per week on each patient care unit

2019/20 QIP Work Plans | Patient Experience

Improve patient experience

Patient Oriented Discharge Summary (PODS)

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Indicator	Unit of measure/ Patient population	Data Source/Period	Baseline	Target for 2019/20	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 CIU patients)	Unit of Measure Percent Patient Population All survey respondents discharged from Critical Care Unit	Data Source Canadian Institute for Health Information (CIHI), National Research Council (NRC) Reporting Period Apr 2019 – Mar 2020	52.6	> 58.0	Last year , this indicator was measured using in-patient surgery patients with a 5% improvement target. Applied change initiatives helped us to improve this indicator by 36% in surgery in-patient unit (performance rate at the time was 50% and current YTD performance is 68.1%). Hence, this year we believe weighted average over a 12-month period with a 10% improvement target is realistic and achievable.

#	Change Idea	Methods	Measure	Target
1	Post Discharge Phone calls (PDPCs) using the PODS framework	Pilot automated Post Discharge Phone calls (PDPCs) using the PODS framework for patients being discharged to home	Number of patients successfully contacted via automated calls at MGH	100% of eligible patients from CIU will receive PDPCs by Q2
2	Building staff capacity in the area of health literacy and teach back	Staff will complete: 1. iLearn module on health literacy 2. A didactic learning session on health literacy and teach back 3. A simulation session using teach back and PODS frame work	% of staff who completed iLearn module and attended didactic and simulation sessions by end of Q4	All staff have completed the iLearn module, didactic and simulation sessions by the end of Q4,
3	Create the ideal discharge conversation using the PODS framework	Work with staff, patients and families to create: 1. The paper PODS tool for each HIG group 2. The process for having PODS discharge conversations in CIU	Completion Dates	1. By the end of Q3,the paper version of the PODS tool is completed for each cardiac diagnosis 2. By the end of Q4, staff will be having PODS conversations using the PODS tools

2019/20 QIP Work Plans | Medication Reconciliation on Discharge

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Increase the proportion of patients receiving medication reconciliation on discharge

Indicator	Unit of measure/ Patient population	Data Source/Period	Baseline	Target for 2019/20	Target Justification
Percent of discharged patients for whom a Best Possible Medication Discharge Plan was created.	Unit of Measure Percent Patient Population Admitted ED patients, all patients discharged from Medicine, Surgery (LOS > 24 hrs), and Mental Health patient care units	Data Source Hospital collected data Reporting Period Oct 2019 – Mar 2020 (Q3+Q4)	63.3	68	• 8% increase between F2017-18 and F2018-19 represents significant improvement (outside statistical Upper Control Limit) • Historically difficult measure to change – slow and steady

#	Change Idea	Methods	Measure	Target
1	**Establish an accountability framework** Establish an accountability framework for medication reconciliation completion and sustainable forums to engage physicians	1. Define sustainable forum for physician engagement on medication reconciliation topic 2. Define roles and responsibilities of surgical residents for medication reconciliation completion as well as supervisory responsibilities 3. Define overall accountability framework for medication reconciliation completion: non compliance management, appraisal process for high completion through the use of report cards	Completion Dates	1. Sep 2019 2. Dec 2019 3. Feb 2020
2	**Prescriber Education** Deliver prescriber education refresher	1. Establish strategy for providing one-on-one review of medication reconciliation process with prescribers. 2. Deliver education refreshers through to Q4.	% of surgeons who have completed medication reconciliation Refresher	100%
3	**Technology Improvements** Explore further technology improvements to facilitate medication reconciliation electronic process	1. Identify system capabilities with e-chart team. 2. Identify process improvement opportunities with Ortho./General Surgery surgeons and resident feedback. 3. Implement solutions based on feasibility.	Completion Dates	1. May 2. June 3. October

2019/20 QIP Work Plans | e-Monitoring Hand Hygiene

Drive improvement in hand hygiene compliance and reduce Healthcare Associated Infections (HAIs)

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Indicator	Unit of measure/ Patient population	Data Source/Period	Baseline	Target for 2019/20	Target Justification
Percent mean monthly hand hygiene compliance (Number of device activation divided by total opportunities)	Unit of Measure Percent Patient Population All care providers in eight selected patient care units	Data Source Hospital collected data (eMonitoring device) Reporting Period Jan – Mar 2020 (Q4)	52	> 65	First year (2018/19) of this program included 5 PCUs, with a target of 40% (2 of 5) sustaining a HHC above 60% for a 3 month period. For 2019/20, we will be spreading to three additional patient care units. The patient care unit compliance rate target for the 5 existing units will be increased by 10 percentage points (to 70%), and the target for the 3 new units will be set at 60% (same starting point as in 2018/19).

#	Change Idea	Methods	Measure	Target
1	Accountability Framework Design and implement a set of hand hygiene policies and care provider practice expectations that will be incorporated in staff performance evaluations. The objective is to identify patient care units where low hand hygiene compliance is co-related with an HAI. Identification of an HAI would trigger an investigation into compliance rates and if below target, a visual audit led by patient care unit leadership. Results of such investigations and audits may lead to performance management discussions with staff found to be in chronic non-compliance with HH policies.	1. Design the framework with Human Resources, to ensure alignment with collective bargaining agreements and effective change management strategies 2. Develop a roll-out plan, and complete stakeholder communication 3. Implement framework in selected patient care units (may be a phased approach) 4. Operationalize framework, along with on-going evaluation of issues and impact on hand hygiene compliance	Completion Dates	1. Q 1 2. Q 1 3. Q 2 4. Q 3
2	Unit specific goal setting and QI Interventions	1. Establish short term (one month) and long term (three month) compliance targets in each patient care unit 2. Continue targeted Quality Improvement interventions tailored to each patient care unit, including Leadership Feedback strategy	% of units with short and long term targets	100%

2019/20 QIP Work Plans | 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 2019/20	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 – Dec, 2018	324	> 360	Target was increased based on data collected from previous year's QIP data- more accurately reflects the number of reports received. An increase in reporting of WV incidents is a sign of strong reporting culture.

Indicator 2 (MGH Custom)	Unit of measure/ Patient population	Data Source/Period	Baseline	Target for 2019/20	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 2015– Dec, 2018	6.3	< 5	Baseline based on average of actual for prior 4 years, adjusted with assumptions to account for changes in legislation (ie: inclusion of Post Traumatic Stress Disorder claims) which became effective May 2018

#	Change Idea	Methods	Measure	Target
1	**Alert for Behavioural Care and Worker Safety (ABC-WS)** Implement the new Alert for Behavioural Care and Worker Safety (ABC & WS) set of electronic tools and processes	• Rollout of electronic tool • Staff education • Evaluation	1. % of patient facing staff in high risk area (Complex Continuing Care) trained 2. % of eligible patients (Complex Continuing Care) with screening tool completed on admission and within 3 days 3. % of patients (Complex Continuing Care) with a score of >2 with individual care plans	1. 80% by end Q2 2. 75% by end Q3 3. 60% by end Q3
2	**Zero Tolerance Campaign** Design and implement communication and education strategies to support our vision of a zero tolerance work environment	1. Design campaign 2. Develop communication and education materials 3. Launch roll-out	Completion Dates	1. May 2019 2. Nov 2019 3. March 2020

2019/20 QIP Work Plans | ED LOS (Time for Inpatient Bed)

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Reduce the time interval between the Disposition to Patient Left ED for admission to an inpatient bed or operating room

Indicator	Unit of measure/ Patient population	Data Source/Period	Baseline	Target for 2019/20	Target Justification
90th Percentile Emergency Department Wait Times for In-Patient Bed	Unit of Measure Hours Patient Population All admitted patients	Data Source Hospital data; National Ambulatory Care Reporting System (NACRS); Data provided to HQO by Cancer Care Ontario Reporting Period Dec 2018-Nov 2019	16.8 Oct 2018-Dec2018	< 14.0	MGH improved wait time to inpatient bed by 3.2 hours from 17.4 hrs to 14.2 over the 2018 calendar year. This significant improvement was facilitated through the use of surge protocols and increased focus on the ALC population. This target is based on our ability to maintain these newer processes going forward.

#	Change Idea	Methods	Measure	Target
1	**Identify opportunities to streamline the patient flow journey**	1. Identify key opportunities and strategies 2. Establish plan s to implement opportunities 3. Implement key opportunities and strategies	Completion Dates	1.Identify key opportunities and strategies by Q2 2.Establish plan to implement opportunities by Q3 3.Implement key opportunities and strategies by Q4
2	**Identify opportunities to improve the current consultation process**	1. Identify key opportunities and strategies 2. Establish plan s to implement opportunities 3. Implement key opportunities and strategies	Completion Dates	1.Identify key opportunities and strategies by Q2 2.Establish plan to implement opportunities by Q3 3.Implement key opportunities and strategies by Q4

2019/20 QIP Work Plans | Rescue from Danger

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Improve quality of response to deteriorating patients

Indicator	Unit of measure/ Patient population	Data Source/Period	Baseline	Target for 2019/20	Target Justification
Rescue Index: Frequency of unexpected ward deaths	Unit of Measure Number per thousand inpatient discharges Patient Population All adult inpatients, excluding patient coded DNR (Do Not Resuscitate), and patients in special care units (eg: ICU)	Data Source Hospital collected data Reporting Period Apr 2019 – Mar 2020	0.8	< 0.5	Baseline is based on YTD actual performance (from Apr 2018 to Feb 2019) Following three consecutive years of significant improvement (50% reduction), our goal is to continue driving toward "never event" while fully operationalizing for sustainability

#	Change Idea	Methods	Measure	Target
1	**Automate System Scorecard** Build reporting system to enable timely on-going system monitoring	1. Improve eChart documentation processes at patient care units 2. Increase eChart documentation compliance (of required data entry) 3. Refine report format to optimize ease of use 4. Fully operationalize through education about use at key forums (eg: Medical Quality &Patient Safety Committee, Ops Huddle)	Completion Dates	1. Q1 2. Q2 3. Q3 4. Q4
2	**TAHSN Escalation of Care Maturity Model** Establish baseline using self assessment tool, and demonstrate increase in maturity level on at least two dimensions by end of year.	1. Complete self-assessment 2. Select improvement targets 3. Develop improvement plan for selected targets, including measures and assignment of teams 4. Implement improvement plans and monitor progress 5. Complete evaluation and recommendations for additional improvement opportunities	Completion Dates	1. Apr 2. May 3. June 4. Q2-Q4 5. Q4