

# **2020/21 Quality Improvement Plan**

## **Progress Report (for 2019/20 QIP)**

**Performance Monitoring & Quality Committee**

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# 2019/20 QIP Progress Report | Deprescribing Medications

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

QIP Indicator	Baseline	Target	Current Perf	Comments
Proportion of adult Inpatients admitted to Medicine reviewed for appropriate use of targeted medications	N/A  (new patient pop'n)	70%	71%  (Oct-Jan)	<ul style="list-style-type: none"> <li>Successfully established a stewardship team and targeted 5 selected over-prescribed medication classes.</li> <li>This pilot program is developing methods and systems that we can spread to other medication targets and additional patient service areas</li> <li>The team reviews an average of 200 patients per month, 35% of which have been provided with deprescribing recommendations that are discussed with the patient and mailed to their family physician.</li> </ul>

Change Idea	Implemented?	Accomplishments & Lessons Learned
<b>Build Deprescribing Stewardship Team</b>	Yes	<ul style="list-style-type: none"> <li><b>Goal: Establish dedicated team comprised of physician and pharmacy leadership for on-going polypharmacy evaluation and program oversight</b></li> <li>A Deprescribing Pharmacist was hired and an additional physician was on boarded.</li> <li>The screening and deprescribing process was streamlined and uses a patient-focused and individualized approach to medication changes.</li> <li>Engagement with our Patient Experience Panel led to the creation of a dedicated Deprescribing section on the hospital's website, along with pamphlets for targeted drugs.</li> <li>A critical success factor in this first year's program was building awareness and good communication amongst key stakeholders (clinical pharmacists and attending physicians in this case).</li> </ul>
<b>Update Cerner Reporting Tools</b>	Yes	<ul style="list-style-type: none"> <li><b>Goal: Design and implement Cerner Explorer reports to facilitate identification and tracking of patients on target drugs</b></li> <li>Daily report in place to identify patients on targeted drugs.</li> <li>Other reporting changes should be implemented once the screening process is sustained.</li> </ul>
<b>Update Cerner Documentation Letter for Community Provider</b>	Yes	<ul style="list-style-type: none"> <li><b>Goal: Design and implement Documentation Letter for deprescribing care plan for community pharmacists and doctors</b></li> <li>Created one single PowerNote with different headings for targeted drugs based on feedback from South East Family Health Team, Deprescribing team, Pharmacy team and attending physicians.</li> <li>Community engagement has been an important success factor to ensure patients benefit from deprescribing in the long run.</li> </ul>

# 2019/20 QIP Progress Report | Patient Experience

## Patient Oriented Discharge Summary (PODS)



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”? With a focus on Cardiac patients)	52.6%	> 58%	55.4% (YTD Nov)	<p>Improving patient experience is a complex process with many factors. This year we focused on cardiac patients admitted to our cardiac unit, and set a 10% improvement target – an aggressive target based on last year’s 36% improvement achieved in our In-patient Surgery unit.</p> <p>Despite successful implementation of our change ideas, the target wasn’t achieved. Our greatest challenge was the limitation of our measurement system. A significant number of patients admitted to the cardiac unit do not have a cardiac condition, therefore not every patient discharged from this unit received a PODS. Since our reporting system (NRC Health inpatient survey) cannot differentiate patients who received a PODS from those who did not, we believe the measure was skewed unfavourably.</p>
Change Idea	Implemented?	Accomplishments & Lessons Learned		
Health Literacy	Yes	<ul style="list-style-type: none"> <li>• <b>Goal: Build staff capacity in the area of health literacy</b></li> <li>• Used the content, methods, timelines and evaluation process for the education content re Health Literacy and Teach Back that we developed last year in partnership with Sunnybrook and our patient partners</li> <li>• Education was 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.</li> </ul>		
Automated Post Discharge Phone Calls (PDPC)	Yes	<ul style="list-style-type: none"> <li>• <b>Goal: Improve patient feedback and engagement with post-discharge phone calls</b></li> <li>• Used the manual PDPC PODs framework that we developed last year to create an automated PDPC process</li> <li>• Developed a caller tool kit to support staff making “warm” follow up calls to any patients who are flagged (didn’t understand their PODS information) during the automated call</li> <li>• Gaps and shout outs learned from patients/caregivers during warm calls shared with staff at unit huddles</li> <li>• Score card info graphic developed and publicly posted weekly on the unit to track progress</li> </ul>		
PODS for Cardiac Patients	Yes	<ul style="list-style-type: none"> <li>• <b>Goal: Design &amp; implement a paper-based PODS process for Respiratory patients</b></li> <li>• Worked with staff, physicians, patients, families, and a health literacy expert to create a paper PODS tool for each cardiac HIG group and some non cardiac diagnosis (e.g. renal).</li> <li>• Used a health literacy lens to revise additional patient learning materials (e.g. cooking with less salt - info sheet)</li> <li>• Successfully built the PODS conversation into the already existing MGH Ideal Patient Discharge Process.</li> </ul>		

# 2019/20 QIP Progress Report | Med Rec on Discharge

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 (Surgery, Mental Health, Medicine)	63.5%	68.0%	65.8% (Nov-Jan)	<ul style="list-style-type: none"> <li>Med Rec has been a historically difficult measure to change. There was a statistically significant improvement in Med Rec performance from April to September 2019. In late September we experienced a wide-spread and extended hospital information system failure (Code Grey), which negatively impacted subsequent performance.</li> <li>For the upcoming fiscal year, the scope will be expanded to all inpatient areas.</li> </ul>

Change Idea	Implemented?	Accomplishments & Lessons Learned
<b>Establish an accountability framework</b>	Yes	<ul style="list-style-type: none"> <li><b>Goal: Establish an accountability framework for medication reconciliation completion and sustainable forums to engage physicians</b></li> <li>Med Rec has been reported regularly at Surgery Council over the last year to raise awareness and discuss action plans. However, the team was unable to find a Physician Champion</li> <li>The “Health Records Completion Accountability Policy” has been revised and approved by Medical Advisory Committee in February 2020 and now includes Med Rec as outlined in the College of Physicians and Surgeons of Ontario continuity of care policy. This change idea will continue into FY2020-21 with a focus on program-targeted change ideas and performance targets.</li> </ul>
<b>Prescriber Education</b>	Yes	<ul style="list-style-type: none"> <li><b>Goal: Deliver prescriber education refresher</b></li> <li>Education sessions were held for CCC, MNC, and Surgery physicians.</li> <li>Pharmacists trained as Discharge Medication Reconciliation resources (ICU/H6/CCC)</li> <li>All residents receive Med Rec training upon orientation.</li> </ul>
<b>Technology Improvements</b>	No	<ul style="list-style-type: none"> <li><b>Goal: Explore further technology improvements to facilitate medication reconciliation electronic process</b></li> <li>Technology improvements were explored but it was not feasible to implement the “Plan Med Rec” functionality at this time.</li> </ul>

# 2019/20 QIP Progress Report | e-Monitoring Hand Hygiene

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

QIP Indicator	Baseline	Target	Current Perf	Comments
Percent mean monthly hand hygiene compliance  (Number of device activation divided by total opportunities)	63%	> 65%	62%  (Dec 2019 to Feb 2020)	In the second year of this QIP initiative, our aim was to spread the program to additional patient care units, and support the “hard-wiring” of best practices with an organizational accountability framework.  e-Monitoring dispensers were successfully implemented across three additional patient care units.

Change Idea	Implemented?	Accomplishments & Lessons Learned
<b>Accountability Framework</b>	Yes	<ul style="list-style-type: none"> <li>• <b>Goal: Design and implement a set of hand hygiene policies and care provider practice expectations that will be incorporated in staff performance evaluations.</b></li> <li>• Completed design of framework in collaboration with Human Resources</li> <li>• Developed supporting processes and tools and conducted tests of change on a patient care unit – delayed on account of a Code Grey (extended Health Information System downtime) and extraordinary surge levels</li> <li>• Broader implementation of this change idea will continue in F2020/21</li> </ul>
<b>Unit-specific goal setting &amp; QI Interventions</b>	Yes	<ul style="list-style-type: none"> <li>• <b>Goals: 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.</b></li> <li>• 3 month targets set and reviewed periodically to determine if targets need to be reevaluated</li> <li>• Introduced direct discussions with unit leadership to brainstorm new ideas for improved hand hygiene compliance. Meetings being held on a quarterly basis</li> <li>• Infection Prevention &amp; Control staff routinely attended care provider huddles for education on the dispensing system, how it automatically calculates performance results, and the important role hand hygiene plays in patient care</li> <li>• Implemented recognition program for high performers (personal email from medical director)</li> <li>• Various awareness and motivational programs are implemented, including daily compliance reports, posters, and staff contests.</li> </ul>

# 2019/20 QIP Progress Report | Workplace Violence Prevention

Increase in reported workplace violence incidents, while reducing incidents resulting in lost staff time



QIP Indicator	Baseline	Target	Current Perf	Comments
Number of workplace violence incidents reported by hospital workers (as by defined by OHS) within a 12 month period.	324	> 360	310 (Jan to Dec 2019)	The high number of incidents suggests that an environment has been created in which all employees feel safe to report any form of workplace violence. Along with encouraging increased reporting of incidents, we are developing strategies to reduce incidents of violence through collaborations with other organizations to identify and apply best practices.
QIP Indicator	Baseline	Target	Current Perf	Comments
Number of workplace violence incidents reported resulting in Lost Time within 12 month period.	6	< 5	8 (Apr 2019 – Jan 2020)	We have also designed and developed a new reporting system that stratifies reported incidents by severity and type of violence. As well as including lost time incident data. Upon reflection, the target for 2019-20 may have been overly aggressive, especially given the previous fiscal year had experienced 16 lost time incidents.

Change Idea	Implemented?	Accomplishments & Lessons Learned
<b>Behavioural Care Plan Alert for Patient &amp; Worker Safety (BCAWS)</b>	Yes	<ul style="list-style-type: none"> <li>• <b>Goal: Implement the new BCAWS set of electronic tools and processes</b></li> <li>• Completed MGH customization of Joint Centres policy and tool. As a result tool was newly named: Behavioural Care Plan Alert for Patient and Worker Safety (BCAWS).</li> <li>• Electronic tool and processes was piloted on Complex Continuing Care, with positive feedback both from staff and patients.</li> <li>• Designed and launched iLearn module to support education of the new tool and processes hospital wide, trained over 850 staff. Created on unit champions to support the larger rollout.</li> </ul>
<b>Zero Tolerance Campaign</b>	Partial	<ul style="list-style-type: none"> <li>• <b>Goal: Design and implement communication and education strategies to support our vision of a zero tolerance work environment</b></li> <li>• Working with union stakeholders, a two poster campaign was created: 1) for patients, hospital visitors and 2) for staff, highlighting the importance of reporting.</li> <li>• Poster draft for patients and hospital visitors was brought to Patient Experience Panel for patient feedback and will be launched, formally, in a hospital wide campaign.</li> </ul>
<b>Supervisor Competencies</b>	No	<ul style="list-style-type: none"> <li>• <b>Goal: Create an educational program for leaders to support work around workplace violence prevention</b></li> <li>• Change idea added later in the fiscal year as an action item out of the WVP Think Tank day.</li> <li>• Initiated collaboration with Union and external organizations regarding new programming, implementation has experienced delays but is on-going.</li> </ul>

# 2019/20 QIP Progress Report | ED Length of Stay (Time to Bed)

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

QIP Indicator	Baseline	Target	Current Perf	Comments
90th Percentile Emergency Department Wait Times for In-Patient Bed	16.8 Dec 2017 - Nov 2018	< 14.0	16.8 Dec 2018 - Nov 2019	Despite our continued focus on improving services and processes, and successfully implementing our change ideas aimed at better patient flow and surge planning, we were not able to achieve our target. Our greatest challenges related to uncharacteristically high summer volumes and chronic over-census of inpatient beds.

Change Idea	Implemented?	Accomplishments & Lessons Learned
<b>Streamline Patient Flow</b>	Yes	<ul style="list-style-type: none"> <li>• <b>Goal: Identify &amp; implement process improvements in patient flow</b></li> <li>• Access &amp; Flow committee launched June 2019</li> <li>• Establishment of Patient Access &amp; Transition Hub (PATH), by centralizing key players in the patient flow process to collaboration in patient care.</li> <li>• Upgrade of Teletracking underway with a plan to increase utilization across the organization. Teletracking upgrade delayed due to Code Grey and new proposed launch date is March 2020.</li> </ul>
<b>Surge Planning</b>	Yes	<ul style="list-style-type: none"> <li>• <b>Goal: Improve strategies &amp; tactics to prepare for surge periods</b></li> <li>• Implementation of frequent daily bed meetings during times of surge.</li> <li>• Hospital was in surge during the summer months, requiring increased in-patient capacity. To meet the needs capacity was created through interdepartmental off servicing of patients.</li> <li>• Surge command center worked to help lessen the anticipated increase in LOS of Admitted patients over the winter months.</li> </ul>

# 2019/20 QIP Progress Report | Rescue from Danger

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	0.8	< 0.5	0.9 (Apr to Feb)	This year's target was extremely aggressive. We encountered organizational challenges with an extended system downtime (Code Grey) and unexpectedly early and high surge levels, which strained resources and resulted in the reallocation of resources away from this initiative and toward other priorities.  While we did not achieve target, we were able to sustain performance levels and operational practices implemented in the prior year.

Change Idea	Implemented?	Accomplishments & Lessons Learned
<b>Automate System Scorecard</b>	Partial	<ul style="list-style-type: none"> <li>• <b>Goal: Build reporting system to enable timely on-going system monitoring</b></li> <li>• Completed design &amp; build of reporting system, and initiated report testing/validation</li> <li>• On account of extended hospital information system (HIS) downtime (Code Grey) followed by HIS planned change freeze (to enable HIS upgrade), this change idea was not completed.</li> </ul>
<b>TAHSN Escalation of Care Maturity Model</b>	Partial	<ul style="list-style-type: none"> <li>• <b>Goal: Establish baseline using self assessment tool, and demonstrate increase in maturity level on at least two dimensions by end of year</b></li> <li>• Completed organizational survey to self-assess maturity across all six dimensions, and selected two for improvement targets: 1) Patient/Family Engagement, 2) Policies &amp; Procedures</li> <li>• On account of extended hospital information system (HIS) downtime (Code Grey) followed by unexpectedly early and high surge levels, this change idea was not completed</li> </ul>
<b>(NEW) Focussed Event Debriefs</b>	Yes	<ul style="list-style-type: none"> <li>• <b>Goal: Co-design community of practice specific action plans with care providers</b></li> <li>• This change idea was added during the current fiscal year</li> <li>• Completed design and supporting data to hold a series of structured debrief sessions with respective clinical leaders (admin. &amp; physician) by community of practice</li> <li>• Several debrief / co-design sessions were completed, and action plans for next year are in development</li> </ul>

# 2019/20 QIP Progress Report | Transfer of Care

Improve quality of information transfer at patient transition points

QIP Indicator	Baseline	Target	Current Perf	Comments
<p>Compliance with use of IPASS tool upon inter-departmental patient transfers</p> <p>(number of IPASS use divided by total patients transferred to another department)</p>	<p>Not Available</p> <p>(new system)</p>	> 70%	Not Available	<p>The Transfer of Care/Accountability (TOA) initiative first appeared on our QIP in the 2019/20 fiscal year. The target of 70% compliance was set based on the assumption that the electronic IPASS tool would be able to be built into our electronic medical record. However, due to ongoing IT challenges and a Code Grey (extended Health Information System downtime), the IPASS tool was not able to be integrated into Cerner, and baseline data was not able to be collected.</p> <p>In spite of this setback, change ideas such as the development of an electronic education module, an IPASS toolkit, and a Pilot in Complex Continuing Care were successful. In learning from last year's barriers, TOA will remain on the QIP for the 2020/2021 fiscal year, and data will be collected through a new mechanism (i.e. observational audits).</p>

Change Idea	Implemented?	Accomplishments & Lessons Learned
<b>Implement Shift-Shift (Handover) Transfers of Care</b>	Yes	<ul style="list-style-type: none"> <li>• <b>Goal: Complete training for all staff, and implement IPASS principles and tools</b></li> <li>• Education strategy included unit-level education (with customization to incorporate unit-specific processes and information), along with organization-wide education</li> <li>• Clinical inpatient areas have started or fully completed training and implementation of verbal IPASS tool, along with bedside shift report</li> <li>• Use of IPASS in areas that have completed roll-out is being evaluated via observational auditing</li> <li>• Newly developed audit tool measures both the quality and frequency of IPASS handover</li> </ul>
<b>Implement Inter-departmental Transfers of Care</b>	Partial	<ul style="list-style-type: none"> <li>• <b>Goal: Spread use of IPASS principles and tools to include interdepartmental patient transitions</b></li> <li>• Pilot work for transfers between Post-Anesthetic Recovery Room to Inpatient Surgery &amp; Intensive Care Unit completed and changes have been sustained</li> <li>• Work ongoing to update and develop inter-departmental reports and tools (both written and verbal) which incorporate IPASS principles</li> <li>• Development of new reports and tools for transfers between Diagnostic Imaging and Inpatient units, along with other Outpatient clinics and Inpatient units, to commence as part of QIP 2020/2021 work</li> </ul>

# 2019/20 QIP Progress Report | Positive Patient ID (PPI)

*Goal:* Improve patient safety through increased compliance with positive patient identification protocol

QIP Indicator	Baseline	Target	Current Perf	Comments
Percentage of PPI correctly completed	47%  (July-Sept/19))	> 57%	54%  (Q3+Q4) (Oct/19-Jan/20)	<p>MGH continues to aim for a theoretical best target of 100%. As planned, Q1 focused on the development of an electronic audit tool to facilitate ongoing measurement and awareness.</p> <p>Initial baseline data was collected over a 3 month period. Performance was then assessed following identification of gaps and opportunities and implementation of improvements. There is variability in performance per month dependent on the units completing audits; consistent auditing is expected in the upcoming months. Many improvements are still in progress and further improvement is expected upon implementation.</p>

Change Idea	Implemented?	Accomplishments & Lessons Learned
<b>Empower Patients</b>	Yes	<ul style="list-style-type: none"> <li>• <b>Goal: Empower patients to ‘speak up for safety’ by creating an environment in which they feel safe voicing concerns</b></li> <li>• A patient co-design session took place in Summer 2019 to direct the work of this change idea. A key learning was the discomfort by both staff and patients with an assertive approach to speaking up and so, instead, a focus on collaboration was applied through “Expect a Check” and “Ask Us” messaging.</li> <li>• This change idea requires a change in culture for both staff/physicians and patients/families and improvement efforts will continue over the long-term.</li> </ul>
<b>Remove Process Barriers</b>	Yes	<ul style="list-style-type: none"> <li>• <b>Goal: Identify process improvements to remove barriers to PPI</b></li> <li>• Identification of barriers was facilitated through the completion of audits and several improvement opportunities were identified including refinement of process for photo identifiers, support for PPI completion for familiar patients, understanding of use of armband as an identifier, etc.</li> <li>• Focus on system barriers enables sustainable improvement of PPI and encourages engagement with providers through demonstration of organizational support for PPI performance</li> </ul>
<b>Education</b>	Yes	<ul style="list-style-type: none"> <li>• <b>Goal: Reinforce PPI education and awareness to providers</b></li> <li>• Audit tool and results used as a mechanism for communication, feedback and engagement.</li> <li>• Several tools developed for use at unit level e.g.. Learning from Incidents (for loopback of PPI incidents), visual tracker (for monitoring of performance), updated messaging including patient stories, etc.</li> <li>• Local leadership engagement is required for success as ongoing communication of importance, process and necessity of PPI is a key enabler.</li> </ul>