MICHAEL GARRON HOSPITAL

TORONTO EAST HEALTH NETWORK

2020/21 Quality Improvement Plan

Work Plans

Performance Monitoring & Quality Committee

March 2020

Create Health. Build Community.

2020/21 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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2020/21 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 2020/21	Target Justification
Percent of discharged patients for whom a Best Possible Medication Discharge Plan was created.	Unit of Measure Percent Patient Population All in-patients excl. deceased, LOS < 24hrs, newborns	Data Source Hospital collected data Reporting Period Q3 (Oct-Dec) 2020	50	> 58	• Expanding scope to include Complex Care and Maternal Newborn Child in addition to Medicine, Surgery, & Mental Health • Baseline is lower than 2019-20 current performance because of additional clinical programs • Target is based on volume-weighted average of individual program targets

#	Change Idea	Methods	Measure	Target
1	**Establish an accountability framework for medication reconciliation on discharge**	1. Share report cards with program leadership on a monthly basis (expand to all programs and send to all Chiefs) 2. CPSO continuity of care policy content to be added to existing MGH Medical Records policy 3. Connect with PODS working group to explore integration	Completion date	1. Q1 2. Q1 3. Oct 2020
2	**Engage clinical programs in a coordinated strategic approach to med rec**	1. Establish a target based on weighted average of each program's goal. Each program will define their own change ideas and targets. 2. Establish a Med Rec Committee which includes medical representation	Completion date	1. Q1 2. Dec 2020

Note: Timelines are subject to change due to COVID-19

2020/21 QIP Work Plans | Transfer of Care

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Improve quality of information transfer at patient transition points

Indicator	Unit of measure/ Patient population	Data Source/Period	Baseline	Target for 2020/21	Target Justification
% correct completion of IPASS at shift handover	Unit of Measure Percentage Patient Population All inpatient areas where IPASS has been implemented	Data Source Hospital collected data (i.e. observational audits of verbal handover) Reporting Period July 2020 – Mar 2021 (i.e. Q2 - Q4)	N/A (baseline to be collected in Q1)	10% improvement from baseline performance	While the ideal target is 100% correct completion of IPASS at shift handover, a 10% improvement from baseline performance represents a realistic quality improvement, which will be an achievable goal for staff to strive towards in the first year of evaluation.

#	Change Idea	Methods	Measure	Target
1	**Support the ongoing education, socialization, and evaluation of the new IPASS tool at the unit-level**	1. Provide in-class training sessions for any staff to attend to practice using IPASS 2. Units continue refining their unit-specific IPASS tool via PDSA cycles 3. Refine audit tool and provide unit-specific data related to recurring gaps in correct IPASS use	Completion Date	1. April 2020 2. May-June 3. July-August
2	**Develop and implement use of IPASS for unit-to-unit transfers**	1. Revise current Transfer of Accountability ED-unit fax report form to incorporate IPASS principles 2. Develop standardized forms for unit-to-unit transfers using IPASS principles	Completion Date	1. April-May 2. June-July
3	**Develop standardized practice for physician handover**	1. Document work already done in areas where physician handover has been standardized (i.e. Respirology, Infectious Diseases) 2. Create standardized practices for org-wide roll out 3. Develop IT solution that integrates practices into PowerChart for physician handover 4. Complete training on new IT tool for physicians	Completion Date	1. June 2. July-August 3. Sept-Oct 4. Nov-Dec

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2020/21 QIP Work Plans | Patient Experience

Patient Oriented Discharge Summary (PODS)

Improve patient experience

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Indicator	Unit of measure/ Patient population	Data Source/Period	Baseline	Target for 2020/21	Target Justification
Percent of top box responses ("Completely") to the question "Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital"? (with a focus on Respiratory patients)	Unit of Measure Percent Patient Population All survey respondents discharged from Respiratory Unit	Data Source 1. Canadian Institute for Health Information (CIHI), National Research Council (NRC) Reporting Period Apr 2020 – Mar 2021	56% (Dec 2018-Nov 2019)	> 58%	For the purpose of aligning with OHT priority populations (seniors with chronic illnesses and their caregivers) this year we are planning to implement PODS for patients with chronic respiratory conditions . It is worth noting that the chosen unit for this year's implementation includes patients with diagnoses other than respiratory (e.g. oncology) who can not be differentiated when the data is sent to NRC Picker and to Vocantas (automated post discharge phone calls).

#	Change Idea	Methods	Measure	Target
1	**Post Discharge Phone calls (PDPCs) using the PODS framework**	Implement the automated Post Discharge Phone calls (PDPCs) using the PODS framework for patients being discharged to home from Respiratory Unit	Number of patients successfully called by end of Q1	100% by end Q1
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 Q3	100% by end of Q3
3	**Create the ideal discharge conversation using the PODS framework**	Work with staff, patients and families to create and implement: 1. The paper PODS tool for each diagnosis group 2. The process for having PODS discharge conversations on Respiratory Unit	Completion Dates	1. Q3 2. Q3

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2020/21 QIP Work Plans | ETHP Collaborative

East Toronto Health Partners

Improve Patient Engagement in their Care

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

Indicator	Unit of measure/ Patient population	Data Source/Period	Baseline	Target for 2020/21	Target Justification
Percent of persons satisfied with their involvement in their planning of care and treatment	Unit of Measure Percent Patient Population Seniors with complex/chronic needs and their caregivers (focus on integrated care, eg: H2D)	Data Source CIHI CPES Survey question 35 & 36 (TBC) Reporting Period (TBD)	Work Plan included developing 6 months of current performance	Collecting Baseline (Developmental)	This is the first year of our collaborative QIP. Accordingly, the F2020/21 year will be focussed on developing effective team dynamics, common measures and targets, and impactful change ideas to improve persons' involvement in their care and better position our partnership for F2021/22 and beyond.

#	Change Idea	Methods	Measure	Target
1	**BPSO Training** Complete Best Practice Spotlight Organization (BPSO) Champions training on person & family centred care	1. Complete BPSO (Best Practice Spotlight Organization) Champion training 2. Leverage BPSO Steering Committee to ensure regular meetings for sharing and on-going partnership development 3. Identify Champions to receive on-going coaching and support 4. Champions will spread methods & tools within TEHN	Completion Dates	1. Feb 2020 2. Q1 3. Q1 4. Q3
2	**Gap Analysis** Complete gap analyses and develop implementation plans for improvement	1. Complete gap analysis in each respective partner organization 2. Identify and assign priority to improvement opportunities 3. Engage with patients/persons to conduct tests of change on selected improvement opportunities 4. Develop implementation plans for successful tests of change	Completion Dates	1. Q1 2. Q1 3. Q2 4. Q4
3	**Key Performance Indicators (KPIs)** Develop data collection and reporting systems to support the common quality indicator	1. Jointly develop common: • Definitions of key performance indicators (KPIs) • Methodology and sources of performance/baseline data • Methodology and systems for regular reporting 2. Establish baseline of current performance	Completion Dates	1. Q3 2. Q4

Note: Timelines are subject to change due to COVID-19

2020/21 QIP Work Plans | Workplace Violence Prevention

Reduction in workplace violence incidents

Indicator 1 (Mandated)	Unit of measure/ Patient population	Data Source/Period	Baseline	Target for 2020/21	Target Justification
Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.	Unit of Measure Count Patient Population All patient care units	Data Source Hospital collected data Reporting Period April 2019 – March 2020	25.8/mthly 232/year (YTD)	>26/mthly >312/year	Target was slightly decreased 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 (Custom)	**Unit of measure/ Patient population**	**Data Source/Period**	**Baseline**	**Target for 2020/21**	**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 2020 - Dec 2020	13 (Avg of prior 2 yrs)	≤ 12	Baseline based on average of actual for prior 3 years, adjusted with assumptions to account for changes in legislation (i.e: inclusion of Post Traumatic Stress Disorder claims) which became effective May 2018.

#	Change Idea	Methods	Measure	Target
1	**Behavioural Care Plan Alert for Patient & Worker Safety** Continue implementation of the Behavioural Care Plan Alert for Patient and Worker Safety	1. Increase spread of staff education through the Clinical Resource Leaders and unit level champions and iLearn module. 2. Staff education and rollout of electronic tool. 2-3 units identified every 3 months, prioritizing high risk to patient and staff. 3. Evaluation of tool and associated processes conducted every 3 months	1. % of completed iLearns for inpatient areas employees 2. # of high risk areas with the tool implemented 3. Completion Date	1. 80% in Q4 2. 75% in Q4 3. Q1
2	**Zero Tolerance Campaign & Strategy** Design and implement communication , education and proactive solutions to support our vision of a zero tolerance work environment	1. Design and implement campaign for patients, hospital visitors and staff 2. Develop communication and education materials to support workplace violence prevention (i.e. Close loop communication on reported incidents) 3. Regular risk assessments (JHSC audits & identified high risk areas prioritized using recently adapted tool)	1. Completion date of campaign 2. % of staff feel action is taken when attacked, bullied, harassed by patients/public/staff 3. # of safety audits completed 4. # assessments completed	1. December 2020 2. TBD (Pulse survey or 2021 Employee Engagement survey) 3. 100% by Q3. 4. 80% by Q4

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2020/21 QIP Work Plans | ED LOS (Time for Inpatient Bed)

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

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Indicator	Unit of measure / Patient population	Data Source / Period	Baseline	Target for 2020/21	Target Justification
90th Percentile Emergency Department Wait Times for In-Patient Bed	Unit of Measure Hours from Disposition to Left ED for all admitted patients Patient Population All admitted patients	Data Source P4RHospital data; National Ambulatory Care Reporting System (NACRS); Data provided to HQO by Cancer Care Ontario Reporting Period Dec 2019 to Nov 2020 (P4R cycle)	16.8 Dec 2018 to Nov 2019	≤ 14.0	We have carried over the same target we set in the previous year. We did not achieve the target last year, but we have done so in prior years. This year, the Emergency and In-patient departments will work collaboratively to optimize patient flow.

#	Change Idea	Methods	Measure	Target
1	**Identify opportunities to streamline the patient flow journey**	1. Interdisciplinary facilitated workshop in March to map patient journey (last completed ca. 2015) and identify pain points 2. Prioritize top 3 patient flow pain points, and develop and implement interventions	1. Interdisciplinary Participation in Workshops 2. Inter-Timestamp improvements on priority patient flow steps	1. 100% by September 2. TBD-November
2	**Maximize Teletracking**	1. Identify & automate at least 3 key metrics from Teletracking for performance monitoring to inform changes 2. Train users on new system 3. Increase visibility of key information for key users (e.g. ED Charge Nurse, Portering, IP Clerks)	1. Completion date 2. % of users trained 3. Time to access key info	1. September 2. TBD-October 3. Decrease by 50% by November

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