Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2016/17 QIP

The Progress Report is a tool that will help organizations make linkages between change ideas and improvement, and gain insight into how their change ideas might be refined in the future. The new Progress Report is mostly automated, so very little data entry is required, freeing up time for reflection and quality improvement activities.

Health Quality Ontario (HQO) will use the updated Progress Reports to share effective change initiatives, spread successful change ideas, and inform robust curriculum for future educational sessions.

Realizing that the QIP is a living document and the change ideas may fluctuate as you test and implement throughout the year, we want you to reflect on which change ideas had an impact and which ones you were able to adopt, adapt or abandon. This learning will help build capacity across the province.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
1	"Ask" rate: Number of patients asked if they smoke divided by the number of patients admitted to an inpatient medicine unit for greater than 48 hours x100 (%; patients admitted to inpatient medicine units greater than 48 hours; April 2015 - March 2016; Hospital collected data)	858	47.50	70.00	52.70	An approximate 10% improvement was achieved and we intend to continue to build on this in the coming year. As a new QIP in 2016/17, time and resources were required to set up the essential measurement and reporting systems. Competing priorities organization-wide affected our ability to provide consistent education and support required to introduce the change in behaviour and culture required when introducing discussions about smoking cessation. We will build on our learnings for the upcoming year as well as work with the stakeholders to address barriers in order to better integrate practice changes into daily processes.

Change Ideas from Last Years QIP (QIP 2016/17)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Increase awareness of smoking cessation initiative through discussion at morning/bullet rounds.	No	Frequency of discussions varied by unit and was dependent on the existence of a local champion. In the upcoming year, we will develop champions and provide unit-based data to help drive consistent discussions.
Inform/educate nurses and physician assistance regarding techniques to bring up the ‘Ask’ with the patient	Yes	Informal education and encouragement were provided that will increase in structure in the coming year. While our goal is to focus on the first step 'Ask,' we have realized that it is important to include the next step 'offer of Assistance' in order to provide nurses with the context and right tools to embrace this question.
Regularly monitor and report the performance of the objective through audits; inform units of individual performance to enable assessment and adjustment of activities	Yes	A data collection and reporting system was developed and performance for the organization as well as individual units is available. However, we are challenged with providing easy access to unit-based data so that teams can independently monitor their performance and continue to build this capacity.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
2	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI during the reporting period, divided by the number of patient days in the reporting period, multiplied by 1,000. (Rate per 1,000 patient days; All patients; January 2015 – December 2015; Publicly Reported, MOH)	858	0.34	0.26	0.07	Our performance was well under our target of .26. Although causality cannot be determined we believe our low CDI rate was related to a reduction in induced CDI through optimization of antimicrobial utilization and prevention of secondary spread through optimized IPAC practices. Change idea 1 (revision of signage and associated type of clean for patient rooms) was delayed due to strained resources. We still believe this is an important change idea and as a result it was continued on this year's QIP. Integrating the signage changes with current IT infrastructure will be challenging. Change idea 2 (interdisciplinary chart reviews for nosocomial CDI) was implemented and took place for 6/8 cases. The meetings have helped to create awareness around transmission of clostridium difficile, and an appreciation of the factors that influence disease. In addition, unit leaders and frontline staff involvement allowed for knowledge translation to front line

staff. We have modified the need for a meeting for every nosocomial CDI case. Currently the need for a meeting will be considered by the IPAC team and recommended if opportunities for improvement are identified. Change idea 3 (Introduction of a hospital grade disinfectant other than bleach for sensitive equipment) A new product was chosen and has been rolled out to approximately 20-30% of the hospital environment including administrative offices, outpatient services and in patient units. It is believed that this superior product along with the revision of the “how to clean” document will increase compliance of cleaning of shared equipment shared between patients resulting in less transmission. Antimicrobial stewardship continues to be a high priority for MGH. MGH IPAC mission and visions have been created to align with the MGH values. Through improved relationships with front-line staff the IPAC team will strive to facilitate ongoing quality-improvement projects with meaningful and measurable outcomes. Resources for implementation must be evaluated carefully. Implementing 3 change

					ideas with system-wide implications with limited resources proved to be challenging.

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Revise cleaning protocols for changes in the isolation status of a room (discontinued, patient transfer, death or patient discharged home).	Yes	This change idea required a considerable amount of planning and feedback & delays were almost always dut to the IT component of the change idea. The feedback solicited from frontline staff prove valuable and helped with revision of the final product (signage) Careful planning of resources and key stakeholder involvement essential. Strong leadership to facilitate an institutional-wide practice change is essential. This change idea has been extended to this year's QIP. Prioritize change ideas and dedicate resources to a limited number of important change ideas
Develop a program that incorporates an interdisciplinary approach to addressing cases of C. difficile, including the creation of a "Trigger Tool"	Yes	This change idea improved relationships between IPAC and leadership. The case conferences need to be completed with a "just culture" mentality in order to determine opportunities. Booking the interdisciplinary chart reviews within a week of the HA-CDI case was challenging. This strategy was valuable to develop additional change ideas yet was not sustainable long term due to time commitments and challenges booking interdisciplinary chart reviews.
Streamline the disinfectant wipes used on all units and clarify instructions for use of wipes on sensitive equipment	Yes	Disinfection of common equipment is a complex challenge due to confusion around role responsibility and disinfection product to use. Simplifying this process maximizes the potential for impact. There is no single disinfection product that is suitable for all common equipment. A standard "how to clean" document is helpful to develop at change idea implementation. Develop a "how to clean" resource guide prior to implementation. Implement sequentially with recurrent audit of practice.

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3	C-section Rate: Total number of caesarian section deliveries divided by the total number of all deliveries x100 (%; Maternity Patients; Most recent quarter available; BORN (Better Outcomes Registry and Network))	858	29.10	25.00	28.00	• A considerable amount of focus this past year has been on developing high quality and accurate data reporting. The physician report card provides individualized data to identify personal c-section, VBAC and induction trends as well as other metrics. • • The influence of physician practice on c-section rate was likely underestimated and will be a primary driver going forward. The nursing staff has been successful in implementing supportive care tools and techniques, including the widely loved peanut balls. VBAC classes have been poorly attended over the past year. Strategies to enhance referrals to classes have been implemented. Alternative approaches to supporting, educating, and directing expecting mothers to this valuable resource will be pursued. The induction process requires further study, however best practices from peer hospital sites will provide an excellent framework to develop strong processes and policy.

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2016/17)	button)	impact? What advice would you give to others?
Manage induction rates	Yes	• Accurate data reporting is key to understanding of induction patterns. Developing appropriate reporting structures is laborious and time consuming, but all discussions require this quantitative reference. • Physician leadership buy-in is challenging to achieve, when attempting to adapt induction scheduling practices; the benefit of building off of peer best practice frameworks is invaluable. • The past year has been spent positioning the department for implementation of changes to induction booking practice, expected to be rolled out in the 2017-18 QIP. A significant impact to c-section rates is expected. • Fetal lactate machine was purchased, however requires consistent effort to improve uptake of the tool.
Improve supportive care in labour	Yes	• Supportive care tools and training have been implemented throughout this period. • Patients and providers have provided overwhelmingly positive feedback on the introduction of the peanut balls. • Funding challenges have delayed the installation of bath tubs on the unit. Goal to complete by end of March. • The team will investigate additional opportunities to encourage a supportive care environment for implementation into 2017-18 QIP. • Staff champions for supportive care in labour will receive additional training to support continued focus on supportive care • Fetal lactate machine was purchased, however requires consistent effort to improve uptake of the tool.
Increase rate of vaginal birth after caesarian section (VBAC)	Yes	• VBAC data shows clear movement in the number of VBACs attempted and the success rate. This initiative has capacity to further enhance c-section reduction. • Attempts to record and share patient experience videos of VBAC were not successful due to lack of videography resources and women willing to be recorded. Patient videos have proven to be powerful motivators and will continue to be pursued in 2017-18. • VBAC classes were poorly attended in 2016-17, thus attention of the 2017-18 year must shift to supporting practitioners to refer their patients to classes and providing multi-modal resources on VBAC. • Fetal lactate machine was purchased, however requires consistent effort to improve uptake of the tool.

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4	Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged. (Rate per total number of discharged patients; Discharged patients ; Most recent quarter available; Hospital collected data)	858	61.00	70.00	62.50	Engagement from the physician team in various areas was essential in achieving compliance for completed medication reconciliations on discharge. Due to differences in workflow throughout the hospital, it was found to be most beneficial when program specific improvement strategies were established. Training has been a major focus of this QIP during its implementation. The medication reconciliation must be documented using the Cerner tool in order for the data to be accurately captured. The medication reconciliation tool can be complicated and overwhelming to a new user; without adequate training, completion of med rec is highly unlikely to occur.

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Identify a physician resource to provide e-chart training/support to psychiatrist team in Mental Health	Yes	• Mental health has been a particularly challenging area, primarily due to the lack of physician engagement. Attempts to provide training sessions have been met with difficulty, although we did see

		improvements in the area since beginning to raise awareness of the process.
Remove barriers to the medication reconciliation on discharge process by continuing to improve medication reconciliation on admission rates. Review and streamline the discharge summary process, including the med rec on discharge process used by surgeons and residents, and provide additional training.	Yes	Standard work plans were implemented for the pharmacists in the surgical inpatient areas to improve the medication reconciliation on admission rates. In turn, this would reduce the barriers for physicians performing medication reconciliation on discharge. Though the med rec has been incorporated into the discharge plan, there are challenges in the process. Surgeons must be available to perform the medication reconciliation on discharge in a short time frame before the patient is discharged home. If the surgeon is not available, nursing staff will not delay the discharge due to an incomplete med rec, as the bed is needed to accommodate incoming patients from the OR.

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5	MGH QBP Readmission Rate: Number of patients admitted for any non-elective cause to MGH within 30 days of discharge from MGH, for selected Quality based procedures (QBPs), divided by total patients discharged from same QBPs in prior 30 days (%; QBP patients: COPD, Stroke, CHD, Pneumonia; April 2015 - March 2016; MGH Coded and Hospital Information System data)	858	13.20	14.80	12.90	As of the end of December (Q3) MGH is tracking toward exceeding the target. This measure however is highly variable, and therefore we are only cautiously optimistic. The regular reporting of readmission performance successfully heightened and sustained awareness among clinical leaders and direct care providers. The implementation of the automated flag to identify in the electronic patient chart all patients readmitted within 30 days of discharge, has supplemented the overall awareness with specific cases to focus on. There remains significant potential with this electronic Readmission Flag to change clinical practice for readmitted patients while they are in hospital. One of the change initiatives planned for next year is to build on the experience gained this year, and continue pursuing this potential.

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2016/17)	button)	impact? What advice would you give to others?
Ensure monthly results are visible to QBP teams	Yes	• Key Accomplishments: • • Implemented patient level reporting of all readmitted cases • Established regular review of reports with QBP leadership to enable on-going monitoring and identification of improvement opportunities Lessons Learned: • Regular performance reporting is an effective tool to build awareness and focus teams on improvement opportunities • Email broadcasting of performance reports is less effective than reviewing reports in leadership meetings to then trigger the cascading of issues, opportunities and targets to the frontlines
Flag readmitted patients in patient chart	Yes	• Key Accomplishments: • • Designed and implemented system modification to electronic patient chart (Powerchart) to easily identify readmitted patients to care providers on wards • Lessons Learned: • Leveraging the Readmission Flag to change practice leading to preventive measures requires significant engagement of clinical leadership and front line staff. The work completed this year will be foundational for building on our success to fully realize the potential of this Powerchart enhancement. We will pursue this as a change initiative in the 2017/18 QIP.
Develop profile of Readmitted patients	Yes	• Key Accomplishments: • • Designed methodology to classify characteristics of all readmitted QBP patients, to enable identification of trends that may inform improvement initiatives • Began to engage clinical leaders – but competing higher priority corporate initiatives resulted in lack of resources dedicated to this initiative Lessons Learned: • A large proportion of readmission causes are beyond the control of in-hospital care practices • While we got a good start in designing an approach to classify readmitted patients, we underestimated the time and effort required by clinical staff to develop the ideas and reach conclusions on the interpretation of patient data as it relates to controllable variables or meaningful predictors

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6	Physician Initial Assessment: 90th percentile time to physician initial assessment (Hours; ED patients; January 2015 - December 2015; Hospital collected data)	858	3.70	3.00	3.90	The 2016 calendar year proved to be a year of learning for all the various factors driving physician initial assessment. Our proposed initiatives sought to remove administrative barriers from physicians, explore opportunities surrounding nursing models in our mid-acuity zones and streamlining diagnostic services for patients. The QIP indicator proved to be too narrowly focused as it became vulnerable to many external influences including multiple neighboring ED closures, increased volumes in the TCLHIN & fiscal pressures. This year we will turn to our Length of Stay for Complex Non-Admitted patients which encompass physician initial assessment for the majority of ED visits. Much of the ground work surrounding diagnostic services and physician barriers completed in 2016 have enabled changes to happen to date in 2017.

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Reduce Barriers to Physician Assessments: Physician Navigator	Yes	The change idea encompassed 2 main sub tactics: (1) the possible addition of a

Pilot		Physician Navigator to offload administrative tasks and the alignment of physician scheduling to predicted ED volumes. These tactics required an extensive amount of time to demonstrate their value which contributed to a later implementation date, late 2016 - early 2017. 1. A 2 month trial for the physician navigator role was conducted and showed promise. However due to HR limitations, we were unable to hire into the role. Since then, this initiative has been put on hold and is being revised in 2017. 2. Different physician schedules were proposed over the year and evaluated for their potential gains. We've since moved from changing hours on one master schedule to creating 3 different schedule templates to accommodate different days of the week. The latest schedule will be implemented spring of 2017.
Reduce/eliminate processes for Emergency Department staff where work and tasks completed provided little or no value to the patient due to outdated policies or overlap in care	No	This change idea gravitated towards changing the nursing model in our mid-acuity zone which services the majority of our ED population. Several external pressures made such a large scale change difficult to implement. With the constant presence of these pressures (pop. growth & fiscal), we will consider changes on a much smaller scale and phase them in one at a time.
Partner with Diagnostic Imaging (DI) team to reduce DI (CT / Ultrasound) Turnaround Time	Yes	This change idea required multiple months for preparation in consultation with various stakeholders. Advance notice to staff was also required to expand the capacity of ultrasound to emergency department patients. This idea is currently going through multiple iterations post 2016 and will continue into the 2017 year.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
7	Positive Patient Experience: Percentage of top box response (“Definitely yes”) to the question “Would you recommend this hospital to your friends and family” (%; All inpatients (surgery/medicine); Not applicable (collecting baseline); Canadian Institute of Health Information (CIHI) Canadian Patient Experiences Survey-Inpatient Care (CPES))	858	CB	CB	54.20	In 2016/17, the data collected indicated a consistent result in Top Box responses related to the “Would you recommend” question. However, a lack of peer comparators provided challenges in ascertaining MGH’s contextual and relative performance in this indicator. Overall, though the proposed changes in this QIP were implemented successfully, it is difficult to conclude that the ideas were 100% influential in achieving the target. With a new survey tool launched in April 2016, it was challenging to compare the data from previous years. As a result, 2016/17 efforts were spent collecting baseline data for the reporting period of April 2016 to March 2017. To improve on this indicator, we will select change ideas that reflect the the highest correlated questions related to nurses’ listening and communication at the point of care.

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		give to others?
Align and analyze data from different patient feedback channels through standardization of data collection and reporting	Yes	Aligning and analyzing the data from six channels continues to be important work for the organization and is included in the 2017/18 QIP workplan. However, given the complexity of standardizing and managing the data sources, MGH has reduced the channels from six to three. In fact, the exercise of aligning and standardizing proved more time consuming than originally anticipated. Similarly, while considerable progress was made in 2016/17 with alignment, challenges remain with analysis, translation and spread of this data to frontline staff. The result of this past work has resulted in a desire to continue with this change idea, but in a simplified format and a greater emphasis on analysis and knowledge spread. Another challenge was limited resources related to decision support. As this change idea continues to mature in 2017/18, a working group will be struck to assist with not only analysis, but also translation to useful information for clinical area. While this change idea is complex, we believe that with further development and continuation, a valuable databank/repository of patient experience data will provide greater insight into the patient experience.
Continue to foster a culture that facilitates the intentional inclusion and participation* of the patient and family in care	Yes	While we implemented this idea successfully, we have realized the challenges related to cultural change. As a result, the impact and progress of this tactic was much slower than we had originally anticipated. Staff have found it rewarding to engage in meaningful work with patients and families.
Highlight the impact of system-level collaboration* by Patient Experience Partners across the organization	Yes	There was no shortage of avenues, including the hospital newsletter to highlight the impact of patient experience partners at MGH. In fact, celebrating the impact of patient experience partners helped to add a total of 10 new PEPs as well as continue to increase the number of patients on committees and councils in 2016/17. Most recent additions include patient/family reps on the Infection Control Committee, Organ and Tissue Donation Committee, Workplace Violence Committee, Cancer Care Committee, Clinical and Operations Advisory Council. Opportunities exist to better facilitate the inclusion of patient partners by helping hospital leaders understand how to include PEPs in their

councils and committees.

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8	Rescue Index: Number of “unexpected” adult inpatient decedents per thousand discharges. (Numerator excludes 1) patients under age of 18, 2) patients with DNR (Do Not Resuscitate) status, 3) decedents discharged from special care unit (eg: ICU); Denominator includes all adult discharges) (Number; All discharged adult patients; April 2015 - March 2016; Hospital collected data)	858	1.60	1.60	1.10	As at end of Jan, the Rescue Index measure reflected improvement in organizational capability to identify and appropriately respond to patients at risk of deteriorating. The highlight was four consecutive months (Aug to Nov, inclusively) with no “unexpected deaths”. We fully expect to sustain the gains and exceed our target at the end of the 2016/17 year. Our on-going communication strategies played an important role to build awareness across the hospital, and to support consistent practices relating to identification of at-risk patients and – as required – escalating the need for additional care providers not presently on the ward. These communication strategies clarified the benefits to patients, and were multi-layered in that they addressed the general aim of becoming a highly reliable organization, and also addressed the specific goals of each change initiatives. The ER-STOP change initiative

						was implemented fully as envisioned at the start of year. Research has demonstrated a significant positive impact, as measured by a reduction in the number of admitted ED patients requiring CCRT responses within 24 hours of admission (from 4.5 to 1 per month). While the Early ID change initiative was only partially implemented as initially envisioned, we learned from our stakeholders and have evolved our ideas to develop a change plan for 2017/18 that will build on our experience and success of this year. We plan to implement a “Daily Safety Check” program that will better address the requirements of the Early ID objective. The Key Performance Metric change initiative was not implemented. TEHN/MGH operational priorities in other areas placed insurmountable constraints on our information technology resources. We did, however, sustain gains made in the prior year, and collect additional design ideas from stakeholders that will be used in our plans for 2017/18.

Change Ideas from	Was this change	Lessons Learned: (Some Questions to Consider)

Last Years QIP (QIP 2016/17)	idea implemented as intended? (Y/N button)	What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Implement ER-STOP (Emergency Room Safer Transfers On-purpose Pause)	Yes	• Key Accomplishments: • • Maintained and evolved our communication strategy • Designed and delivered a Training Program • Designed and implemented a compliance monitoring system • Completed an impact evaluation, showing we now have fewer CCRT responses within 24 hours of admission (from 4.5 to 1 per month) Lessons Learned: • This change idea has proven to be an impactful method to ensure appropriate care paths/protocols are provided to admitted ED patients who indicate risk of deterioration • Care providers in ED are typically challenged with multiple concurrent patient demands within a fast-paced and quickly changing environment. This was exacerbated this year with increased patient volume. The key to successful implementation was 1) communication strategy to provide convincing evidence that this change will benefit patients; and 2) continuous follow-up, including on-going education and sharing of performance indicators
Early Identification: Identify ward patients at-risk of deteriorating and communicate to key care providers	Yes	• Key Accomplishments: • • Implemented a sustainability plan for the Medicine Program • Developed a strategy to spread to Surgery and CCC, but not fully implemented – decided to rethink strategy and tactics • Designed and developed a Communication Strategy based on an innovative “Comics for Quality” platform, as an enabler of our plan to build on this year’s gains in Early ID with a “Daily Safety Check” initiative in 2017/18 • Lessons Learned: • Hospital-wide change to day-to-day care provider practices is highly dependent on a strong communication plan to make the case for change, and subsequent recruitment of leaders (both admin and physician) in each patient care unit to act as champions of change • Persistent follow-up and listening to stakeholders leads to different (better) approaches. In this case, we have evolved our thinking and have developed an approach we believe will better achieve our goals to quickly identify patients at risk of deteriorating across the entire hospital. • For next fiscal year, we will ensure the communication and buy-in is in place before implementing major changes to care provider practice, and plan to launch a “Daily

		Safety Check” program.
KPMs: Develop Key Performance Metrics	No	• Key Accomplishments: • • Sustained gains achieved in prior (2015/16) QIP change initiative • Incorporated feedback from stakeholders in design of planned KPM reporting system • Code documentation elements have been created, and all of the codes are being consistently documented • The reporting is outstanding due to resource constraints. Competing higher priority corporate initiatives resulted in lack of resources dedicated to this initiative (this was identified as a risk in 2016/17 planning phase)

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9	Total Margin: Percent by which total corporate revenues exceed (positive number) or fall short (negative number) of total corporate expenses, excluding the impact of facility amortization, in a given year (%; N/a; YTD/Q3 (April 2015 - December 2015); OHRS, MOH)	858	-0.84	0.00	0.50	As at end of February, 2017 we are cautiously optimistic that we will achieve our target. We expect March performance to suffer as “winter surges” continue to generate increased operating expenses and deplete some of the surplus built up to-date. The executive team launched several targeted initiatives aimed at better aligning our cost structure with expected funding. We also implemented new meeting forums, and used existing forums, to: 1) improve our ability to communicate the strategic imperative to key stakeholders; and 2) shift resources to better align activity and priority.

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Launch a Revenue Capture Improvement project	Yes	• Key Accomplishments: • • Created a portfolio of change initiatives aimed at optimizing revenue and realizing in-year financial gain of $570,000 • As at end of February, forecasting actual in-year improvement of $540,000 with annualized value of improvements estimated to be greater than $1,000,000 Lessons Learned: • Data required for accurate and timely collection of all earned revenue spans many hospital departments, including clinical

		operations • This initiative has accentuated the need for processes spanning multiple departments to be well defined, and well understood to enable effective collection of earned revenue
Initiate monthly cross-functional team meetings focused solely on financial performance monitoring and improvement	Yes	• Key Accomplishments: • • Implemented several new meeting forums to launch and monitor improvement initiatives, including: • Monthly Resource Management Committee • Enhanced budget reviews between Exec Team and budget owners • Added “Financial Update” to several existing meeting forums (to enhance awareness and accountability) • Implemented several initiatives aimed at better aligning our cost structure with expected funding, including: • Structured budget reviews and adjustments (an enhancement of existing practice) • Programmatic change initiatives, in clinical and non-clinical areas • Engagement of external consultants to recommend operational changes leading to sustainable cost reduction • Lessons Learned: • Significant changes to clinical programs require highly developed change management capability, and often require more time and effort than originally planned

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10	Total number of inpatient days where a physician (or designated other) has indicated that a patient occupying an acute care hospital bed has finished the acute care phase of his or her treatment, divided by the total number of inpatient days in a given period x 100. (%; All acute patients; October 2014 – September 2015; CIHI DAD)	858	13.43	12.50	12.20	Addressing ALC can be challenging and requires an interdisciplinary, cross-continuum, multimodal approach. Through constant and focused attention as well as established structures, MGH continues to achieve improvement. Having the right people at the table has been a key enabler - this includes leadership, unit managers and community partners. With an understanding that ALC is not simply a "discharge challenge," we target our initiatives at all points along the patient's journey, e.g. ED, acute and post-acute care. Discussion and escalation are hardwired through twice weekly meetings to discuss potential and current ALC patients. The ALC Avoidance framework has driven an approach that considers diverse contributing factors and provides a means of self-assessment, while facilitating continuous improvement and prioritization. A highly structured and standardized process for monitoring and reporting

					ALC at both the patient and organizational level has built capacity and maintained the sense of urgency required to achieve improvements. Building on our successes, we will continue to use the ALC Avoidance framework to identify new priorities for the upcoming year in order to sustain our successes and meet our goal of reducing each patient's ALC stay by at least one day, in order to theoretically create one additional acute care bed per year.

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Facilitate transition planning upon admission enabled by a tool to assess risk for complex discharge (Blaylock)	Yes	While successes were achieved during the evaluation/validation and pilot stages of this work, challenges were faced when spreading to additional units. This was due largely to competing organizational priorities as well as the expected challenges of changing culture. Much work was required to develop processes and structures to create the foundation for this change and involved many stakeholders to ensure that changes could fit within existing practices and needs. It is recognized that this is a 'hard to do' and long-term initiative; it has been recognized as beneficial by all stakeholders including patients, staff and physicians and we look forward to continue this work in the coming year.
Introduce a clear process to increase awareness of Substitute Decision Maker (SDM) Responsibilities	Yes	In collaboration with the LHIN and the Advocacy Centre for the Elderly (ACE), key messages were developed that outlined the responsibilities of the SDM. A letter was created that would be used to support the discussion with the SDM and then scanned into the chart. This has been implemented

		and the organization will continue to work on ensuring that it is hardwired into daily processes.
Hardwire escalation process	Yes	Existing escalation processes were reviewed to evaluate if they were being sustained. The requirement to escalate to a manager when short choices for long-term care were not provided was reviewed and updated and re-education took place to ensure its continued completion.

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11	Workplace Violence Incidents: Total number of workplace violence incidents that result in lost days over 12 month period (Number; All MGH employees* (*on payroll; part- and full-time); April 2015 - March 2016; Hospital collected data)	858	4.00	0.00	3.00	The 2016/17 year was successful in so far as defining the objectives and scope of the workplace violence prevention program. Our partnership with the Joint Centres hospitals has strengthened our practical knowledge and expertise on workplace violence prevention strategies. The standardization of workplace violence prevention strategies across the hospitals proved more time consuming and challenging than initially anticipated. Considerable time has been spent over the past year in putting together a Workplace Violence Playbook which was released in February of 2017. The Playbook is a compilation of workplace violence prevention practices throughout the partner hospitals. The standardized best practices will be rolled out in phases over the 2017/18 year. While lost time incidents can be an indication of the highest level of severity, the Joint Centres hospitals also recognizes the impact that incidents requiring the provision of Health Care have on our teams. Therefore, for the 2017/18

QIP year, we decided to internally measure and reduce the number of workplace violence incidents that result in the provision of health care.

Change Ideas from Last Years QIP (QIP 2016/17)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Increase the spread of	Yes	This year, we continued to struggle with the ability

Workplace Violence Prevention training		to pull clinical staff to attend. This was partially due to an inability to replace staff secondary to a hiring freeze. We have since asked the leadership team to stress the importance of training. Leadership buy-in has increased attendance at training sessions. An online eLearning course was created and is now a yearly requirement for all staff. A fresher program was created and will be rolled out in April, 2017. The goal of 100% of staff in high risk areas complete in-class workplace violence training will continue to be our focus going into the 2017/18 year.
Increase compliance with the completion of a behavioral profile after patients are identified for potential Acting Out Behaviour (AOB)	Yes	The idea was amended to align with the upcoming changes to the flagging and behaviour care planning processes at the Joint Centres Hospitals. This change initiative proved to be challenging on account of the complexity of the flagging processes across the clinical services. A current state audit was conducted and we underestimated the degree of inconsistency, as well as the effort required to collect data easily and on a timely basis so that reports can be generated. This audit will inform the changes to flagging and behaviour care planning processes at the Joint centres Hospitals. Once revised, the flagging and behaviour care planning best practices will be implemented at MGH. We will implement regular auditing of revised processes.
Implement a more patient centered approach to Workplace violence communication	Yes	This initiative was an important indicator of patient centered care. In November of 2016, a patient experience partner was chosen to work with the workplace violence committee to review policy updates and changes. The patient experience partner has recently joined the workplace violence QIP team to inform future initiatives. We will continue to work with the Joint Centres to move towards patient centered workplace violence messaging.