2018/19 Quality Improvement Plan
Workplan: Improvement Targets & Initiatives

Michael Garron Hospital
Toronto East Health Network

MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

AIM		Measure							Change			
Quality dimension	Issue	Measure/Indicator	Type	Unit / Population	Source / Period	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) A= Additional (do not select from drop down menu if you are not working on this indicator) C = custom (add any other indicators you are working on)												
Effective	Effective transitions	Risk-adjusted 30-day all-cause readmission rate for patients with CHF (QBP cohort)	P	Rate / CHF QBP Cohort	CIHI DAD / January - December 2016	16.00%	15.20%	Represents a 5% improvement.	1)Update order sets to align with internal readmission working group.	1. Assess existing MGH order sets. 2. Review literature and peer hospital best practices. 3. Engage MGH clinical leaders to identify opportunities to improve care pathways and supporting order sets. 4. Present findings.	Percentage of order sets completed.	By end of Q2 100% Order sets are designed. Implement 100% orders sets by Q4.
									2)Leverage Readmission Flags within electronic patient record that will prevent readmissions.	1. Gather learnings and ideas from care providers since the flag was implemented. 2. Literature review. 3. Develop proposal for new processes or practices (stakeholder interviews, workshops). 4. Present findings, conclusions and recommendations	Percent completion of Readmission Flags.	Working group develops a feasibility for use of the flagging and understands the flagging process by Q2. 100% Implementation by Q4.
									3)Review current practices and identify improvements with discharge planning processes that may prevent readmissions.	1. Assess existing MGH discharge processes and supporting Powerchart technology with focus on COPD. 2. Aligning best practices that are being developed by other groups at MGH. 3. Establish protocol for Primary Care follow-up.	Milestone measures related to review of current practices and alignment of best practices.	Work is completed by Q4.
		Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort)	P	Rate / COPD QBP Cohort	CIHI DAD / January - December 2016	21.00%	20.00%	Target represents a 5% improvement.	1)Update order sets to align with internal readmissions working group.	1. Assess existing MGH order sets. 2. Review literature and peer hospital best practices. 3. Engage MGH clinical leaders to identify opportunities to improve care pathways and supporting order sets. 4 Present findings	% of order sets completed.	Be end of Q2, 100% of order sets designed. By end of Q4, 100% of order sets implemented.
									2)Leverage readmission flags within electronic patient record that will prevent readmissions.	1. Gather learnings and ideas from care providers since the flag was implemented. 2. Literature review. 3. Develop proposal for new processes or practices (stakeholder interviews, workshops) 4. Present findings, conclusions and	Per cent completion of Readmission Flags.	Working group develops a feasibility for use of the flagging and understands the flagging process by Q2. By Q4, 100% implementation of the flags.
									3)Review current practices and identify improvements with discharge planning processes that may prevent readmissions.	1. Assess existing MGH discharge processes and supporting PowerChart technology with focus on COPD. 2. Aligning best practices that are being developed by other groups at MGH. 3. Establish protocol for primary care follow-up.	Milestone measures related to review of current practices and alignment of best practices.	Work is completed by Q4.
	Effective transitions	Patient Experience: Did you receive enough information when you left the hospital? (with a focus on surgical patients)	C	% / Survey respondents	CIHI CPES / April 1, 2018 - March 31, 2019	50.00%	52.50%	Weighted average over a 12-month period with a 5% improvement target. In previous years, we were challenged by the complexity of this indicator. This target is realistic and achievable.	1)Building staff capacity in the area of health literacy.	Identify a learning module that works for MGH related Health Literacy and Teach Back. Use the Surgical Council to engage physicians and medical leadership regarding the content and process.	# of surgical staff who complete the module.	By end of Q2 the module is developed; by Q4, all full time/part time nurses have completed the module on Surgery.
									2)Post Discharge Phone Calls (PDPC)	Implement Post Discharge Phone calls with a select population.	# of PDPCs completed with the question asked, "How well do you feel staff prepared you to go home?" (NRC library of tested question)	100% of patients from the surgical population will receive a PDPC by Q4.
									3)Identify the ideal paper pilot process to support a Patient Oriented Discharge Summary for a patient population in surgery.	1) Understand the relations between PODS elements and C-HOBIC concepts that will inform a PODS process. 2) Determine the who will have the discharge conversation; where they will this conversation and how they will have the conversation. 2) Using the best practice framework of the PODS process (ARTIC spread project) introduce a Paper-based version of a PODS.	Milestone measures	1. By end Q2, 100% of the audit of C-HOBIC and PODS elements completed and the process understood. 2. By the end of Q3, the paper-based version of a PODS is completed. 3. By end, Q4 complete a pilot of the paper-based PODS.
Equitable	Equity	Smoking Cessation: Number of patients prescribed nicotine patches in in-patient medicine (greater than 48 hours, excluding mental health.)	C	Number / All inpatients	Hospital collected data / April 1, 2018 - March 31, 2019	52.00	61.00	10% improvement increase based on Q3 monthly average.	1)Improve data collection to enable the measure of an "assist rate" related to smoking cessation. This measure will tell us the frequency of how often patients are helped by providing a prescription related to nicotine replacement.	Partner with IT to design, develop and implement a report to measure the rate of nicotine replacement therapy prescribed per 100 Medicine patients (LOS>48 hours) who are declared smokers.	Milestone measures	By end of Q3, a documentation process that adds an additional question to the Patient Profile page on Cerner has begun.
									2)Provide education and training to frontline providers to increase offer of assistance to smoking cessation candidates.	Design and develop training material and delivery strategies. Create standard education/in-service material to use in other venues including orientation etc.	# of education sessions % of staff participation	By Q4, 1 session per each medicine unit completed with 70% staff participation.
									3)Provide patient education tools and processes.	Source and/or create educational tools and resources with patient feedback and engagement. Disseminate materials.	Milestone measures	By Q2, tools are drafted and follow "patient-friendly" guidelines. By Q4, tools are rolled out to 100% of medicine units.
Safe	Safe care/ Medication safety	Medication reconciliation (med rec) 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.	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / October – December (Q3) 2017	54.88%	57.60%	5% improvement from baseline.	1)Engage and develop relationship with surgeon champion with a focus on opioids and VTE prophylaxis medication reconcilation.	1. Engage with eChart to determine feasibility, documentation process and ways to extract information. 2. Engage with Chief of Staff to identify a surgeon to champion medication reconciliation and drive support among medical peers. 3. Define a process in collaboration with surgeons to complete medication reconciliation for opioids/VTE prophylaxis only.	Rate or % of surgery patients for whom medication reconcilation was completed. (Those who had a prescription during hospital stay for opioids/VTE prophylaxix.	Determine baseline by Q4
									Engage Family Birthing Centre (FBC) and Complex Continuing Care (CCC) to discuss medication reconciliation for implementation in 2019/2020 QIP.	1. Discuss med rec process for future implementation with CCC and FBC, using baseline data.	# of meetings held with CCC and FBC regarding med rec process.	3 meetings by Q4
									3)Embed the process of medication reconciliation in the discharge process.	Work with and engage physicians and champions to identify and remove technological barriers that prevent physicians from completing medication reconciliation.	% of barriers identified and removed.	100% of barriers identified and removed by the end of Q4.

AIM		Measure							Change			
Quality dimension	**Issue**	**Measure/Indicator**	**Type**	**Unit / Population**	**Source / Period**	**Current performance**	**Target**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) A= Additional (do not select from drop down menu if you are not working on this indicator) C = custom (add any other indicators you are working on)												
Safe	**Safe care/ Medication safety**	De-prescribing Medications : Number of adult patients admitted to IP Medicine Service reviewed for appropriate use of inhaled corticosteroids.	C	Number / Adult patients admitted to IP medicine	Hospital collected data / April 1, 2018 - March 31, 2019	CB	70.00	We believe that this is a realistic target, given our financial and HR constraints.	1)Use hospital admission to evaluate polypharmacy in all patients, working in collaboration with pharmacists and primary care physicians.	1. Develop protocol for pharmacists to evaluate corticosteroid use. 2. Train pharmacists to use this tool. 3. Build and implement an electronic alert and notification for physicians and community pharmacists in PowerChart.	1. % development of the protocol. 2. % completion rate. 3. % implementation	1. 100% completion in Q1. 2. 100% of in-house pharmacists using protocol by Q1. 3. 100% complete by Q1.
									2)Engage and collaborate with the patient or substitute decision maker (SDM) regarding value/role of deprescribing.	1. Engage in conversations with patients at the bedside. 2. Explore value of educational brochure.	1. % of patients engaged in conversation with physician/pharmacist related to deprescribing 2. Milestone measures related to creation and dissemination of educational brochure to patients.	1. 100% of 70% cohort of targeted patients engaged by Q4. 2. By Q4, brochure is created and is being disseminated for use by patients.
									3)Provide primary care physicians and community pharmacists with education and care plans regarding deprescribing initiatives.	Create PowerNote/summary of deprescribing in PowerChart for community pharmacists and family doctor.	Completion and implementation of PowerNote/Summary.	By Q2, note is completed and 100% of family doctors and pharmacists of the 70% targeted patient cohort receive note.
		Monthly Hand Hygiene Compliance Rate (HHC) among eMonitoring Units.	C	Number of in-patient units greater than 60% over a three-month period/in-patient medicine units	Hospital collected data / April 1, 2018 - March 31, 2019	1	2	Given current performance, this target is realistic and achievable in the time period. We also want to align our current target with our multi-centre study partners.	1)Implement unit-based Quality Improvement related to Hand Hygiene.	Infection Control Practitioners (ICPs) will facilitate unit leadership and foster relationship with local champions to develop unit-based quality improvement (QI) interventions to	# of unit-based quality improvement interventions.	1 per unit/per month
									2)Foster culture of leadership feedback related to performance.	The executive team will provide feedback to each unit quarterly. For example, customized email sent out by the executive team to provide feedback to units to show leadership support, engagement and organizational confidence.	# of leadership emails	3 emails/ quarter /unit
									3)Encourage unit-specific goal-setting related to hand hygiene compliance.	Each unit will set a short term (one-month) and long-term (three months) goal. These goals will be revisited quarterly.	# of goal-setting sessions facilitated by Infection Control Practitioner/unit/month.	20 goal-setting sessions arranged by Q2 2018/19. 40 goal-setting sessions by Q4 2018/19.
		Reduce the incidence of (Stage 2 or greater) hospital acquired pressure injuries.	C	Number per month / All adult in-patient units	Hospital collected data / April 1, 2018 - March 31, 2019	10	< 9	This target represents a 10% reduction that we believe is a standard best practice, realistic and achievable in the reporting period.	1)Apply the Braden Scale Assessment consistently into daily nursing work.	1. Establish a current state audit of Braden Scale Assessments hospital-wide. 2. Partner with IT and eChart to build the Braden Scale interface into iView.(PowerChart documenting system)	1. Milestone target: % completion of audit. 2. Milestone target: % partnership with eChart and IT	1. In Q2, 100% of the audit complete. 2. By mid-Q3, 100% roll out of Braden Scale Assessment interface into iView. (PowerChart documenting system)
									2)Ensure PSWs consistently document pressure injuries in the electronic medical record.	1. Partner with PSWs and Nursing Assembly to review and review PSW competency framework. 2. Implement competency framework in trial units (J5, A3 and ICU).	1. Milestone target: % completion of competency framework. 2. % improvement of PSW documentation.	1. By the end of Q1, 100% completion of competency framework. 2. 80% of PSW staff document on the electronic medical record.
									3)Improve accuracy and consistency of staff reportage of pressure injuries.	1. Use results from the Prevalence Study to understand current state. 2. Roll out Pressure Injury and Prevention iLearn (in-house learning module) on trial units. 3. Confirm validity of documentation of pressure injuries with Decision Support.	1. Milestone measure for analysis of Prevalence Study. 2. % completion of iLearn modules on trial units. 3. % of accurate staging	1. Prevalence study results analysis completed by Q1. 2. 90% of staff on trial units complete iLearn by Q3. 3. 100% accurate staging of pressure injuries in target units by Q4.
		Rescue Index: Number of "unexpected" adult inpatient decedents per one thousand discharges. Numerator excludes patients under the age of 18; patients with a Do Not Resuscitate (DNR) status; and decedents discharged from a special care unit such as the Intensive Care Unit (ICU). Denominator includes all adult discharges.	C	Number per 1000 all discharged adult patients	Hospital collected data / April 1, 2018 - March 2019	1.0	<1.0	The absolute target is LESS than 1.00 to signifiy an improvement. This target allows for seasonal variation.	1)Increase situational awareness through enhancement of the Daily Safety Check.	Provide performance reports to individual units.	Days since last event.	Each unit exceeds their target performance over the last 18 months, defined by days since last rescue event.
									2)Identification of patients predicted to be most at-risk on in-patient units.	Hardwire collecting and reporting to Daily Safety Check with new enabling processes/systems.	% of at-risk patients reported to Daily Safety Check.	100% in units selected for pilot implementation by Q4.
									3)Capture learning from "Hot Debrief" of Code Blues to generate on-going improvement initiatives.	Develop methods and tools (including IT solutions) to facilitate timely debrief.	% of Code Blues that had a "Hot Debrief."	100% by Q4.
									4)Improve Morbidity & Mortality (M&M) rounds practice.	Adapt best practices developed by The Ottawa Hospital, for example "OM3" (Ottawa Hospital M&M Rounds model).	% of Communities of Practice that have completed implementation in selected patient units.	100% in Communities of Practice selected for pilot implementation by Q4.
	Workplace Violence	Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.	MANDATORY	Count / Worker	Local data collection / January - December 2017	26/month YTD	25/month	MGH has an established reporting culture related to workplace violence incidents and though this data has been collected in the past, in 2018/19, we want to ensure its consistency in setting the most appropriate target.	1)Increase accountability of workplace violence training among leadership.	Create a quarterly scorecard to track workplace violence training and implement the distribution of the scorecard. Integrate this information with the hospital's process related to the Daily Safety Check.	1. Milestone measure: % progress completion of the scorecard. 2. Milestone measure: % progress integration into the Daily Safety Check.	1. Creation of the scorecard by the end of Q2. 2. Implementation and integration of the scorecard into the Daily Safety Check by the end of Q4.
									2)Implement the new Joint Centres flagging tool, Alert for Behavioural Care Plan (ABC).	1. Educate frontline staff on the ABC Plan. 2. Establish changes to electronic health record to increase spread.	1. # of clinical staff, joint health and safety and union partners educated on the ABC plan. 2. Milestone measure: % refresh of IT and visual management system to incorporate the new ABC plan.	1. By Q4, 100% of nursing team leaders have received education of ABC plan. 2. By the end of 2018 (Q3), 100% refresh of IT and visual management system to incorporate the new ABC plan.
									3) Build staff awareness and maintain MGH's position as a system leader through knowledge translation.	1. Commit to one abstract for a 90-minute presentation related to workplace violence prevention at an international conference. 2. Create a "Good Catch" campaign to encourage continued reporting. 3. Visit facilities that practice leading practices and consider the adoption of best practices.	1. Milestone measure: % completion of abstract and presentation. 2. # of times a "Good Catch" is celebrated and recognized among staff. 3. # of	1. Presentation completed and presented by Q3. 2. Recognition/Celebration every 50th "Good Catch" related to workplace violence prevention with a target of three celebrations by the end of Q4. 3. Visit two facilities by the end of Q4.
Timely	**Timely access to care/services**	90th percentile emergency department length of stay for complex patients (CTAS 1-3) non-admitted	C	Hours / All patients	Hospital collected data / January - December 2018	7.50	7.50	Though we have made significant gains in 2017, the challenge for 2018 is to maintain performance amidst known volume increases (+1,800 CTAS 3 EMS patients = 4.5% increase in overall CTAS 3 population).	1)Increase access to mental health services through overnight Emergency Department Crisis Worker	Increase access to resources for Mental Health patients/clients (Overnight Emergency Department Crisis Worker) will help support Emergency Department physician dispositions and help streamline the necessary resources for	Overnight mental health patients in Emergency Department unseen (determined number of outstanding psychiatry consults by	0 patients with mental health issues in the Emergency Department overnight by end of Q3.
									2)Build Assessment Capacity, specifically time to physician initial assessment (PIA)	Reviewing the pre-assessment workflow in our ambulatory zone to help streamline the process and ensure our patients are ready to be seen.	Time to physician initial assessment	4.0 hours by end of Q3.
									3)Optimize Emergency Department bed capacity.	Ensure we have appropriate processes to open additional acute beds in our ED to enable patients to be seen and assessed.	Time to assessment for patients triaged to our Blue Zone.	4.0 hours by end of Q3.