MICHAEL GARRON HOSPITAL

TORONTO EAST HEALTH NETWORK

# F2024/25 Quality Improvement Plan (QIP)

March 2024

**Our Vision**

Great care inspired by community

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# F2024/25 Quality Improvement Plan (QIP)

# Narrative

March 2024

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# 2024/25 QIP Narrative

## Overview

Michael Garron Hospital (MGH), Toronto East Health Network is a vibrant community teaching hospital located in the heart of East Toronto. For almost 100 years, we have provided healthcare to nearly 400,000 people in 22 neighbourhoods, where over 50 languages are spoken.

Our team is made up of almost 3,000 staff, more than 530 physicians and over 500 volunteers. We have the honour of caring for people at every point of their lives. From welcoming a new baby and supporting children as they grow; to providing emergency, mental health and surgical services for people of all ages; to caring for patients with compassion and dignity at the end of life. We are here for our community

Last year we launched our new 2023-25 Strategic Plan, summarized to the right. While all of the three Focus Areas impact our 2024/25 Quality Improvement Plan (QIP), the selected QIP indicators are aimed at improving Access and Flow, Equity, Experience and Safety. These priority issues align well with our Strategic Plan that is focused on improve the Care we provide, to support the People who work, volunteer and learn at MGH and to improve our support of the Community we serve.

Ove the last few years, MGH has made significant investments to develop and strengthen our Equity, Diversity, Inclusion, and Belonging strategy. Last year for the first time, our QIP included a quality indicator in this area. This year, we will have two indicators focused on Equity.

The following page shows a summary of our 2024/25 QIP portfolio.

# QIP Indictors and Targets for 2024/25

| Priority Issues | QIP Indicators | Baseline | Recommended Target |
|---|---|---|---|
| Access and Flow | 1. 90th percentile emergency department admitted length of stay* | 28.6 hours | ≤26.8 hours |
| | 2. Alternate level of care throughput ratio* | 1.03 | >1.0 |
| Equity | 3. Rate of staff and leaders completing mandatory cultural competency training* | No baseline | >80% |
| | 4. Percentage of (adult) day surgery patients who have completed the Health Equity Questionnaire | 22% | >32% |
| Experience | 5. Percentage of inpatient medicine and surgery patients reporting complete satisfaction with "Did patients feel they received adequate information about their health and their care at discharge?"* | 60.3% | >63.3% |
| Safety | 6. Number of workplace violence incidents reported per month* | 17.1/month | ≥18/month |
| | 7. Percentage of restraint events that have been audited by leadership within 72 hours | No baseline | ≥90% |

* Indicators recommended by Ontario Health for 2024/25 hospital Quality Improvement Plans (QIPs)

# 2024/25 QIP Narrative

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## Access and Flow

Access and flow optimization remains a core focus for MGH as we strive to continually enhance patient care, resource allocation, and overall operational efficiency. This year, we decided to utilize the Emergency Department Admitted Length of Stay and ALC throughput rate as key indicators, both of which serve as significant metrics signaling the organization's performance in managing patient flow.

A multidisciplinary access and flow committee has been established in the past year, comprising leaders from various departments within the organization. This committee adopts a data-driven approach to identify areas for improvement as part of our 2024/25 Quality Improvement Plan. Through this collaborative effort, we can accurately pinpoint specific challenges, analyze trends, and implement targeted interventions aimed at enhancing patient experiences and outcomes.

The expansion of our Teletracking system's functionality represents a strategic initiative to equip our support services teams with the necessary tools and resources for efficient and effective patient management. Leveraging the capabilities of Teletracking, our goal is to streamline the admission and discharge process while optimizing bed utilization across our facilities.

Cross-departmental collaboration is essential in our endeavor to optimize operational processes, improve staffing models, and standardize the discharge process. Involving stakeholders from Medicine, Patient Flow, Environmental Services, Emergency Department, Transition Navigator and Diagnostic Imaging, we aim to align workflows and implement best practices organization-wide. Through these efforts, we seek to minimize delays, reduce variability, and enhance the overall continuity of care for our patients.

The introduction of an Embedded Discharge Team within the emergency department underscores our commitment to proactive care management and patient-centric practices. This dedicated team collaborates closely with ED physicians and consulting physicians to ensure seamless transitions and prevent unnecessary readmissions through comprehensive case management and follow-up care initiatives.

Our ongoing efforts to streamline processes in the emergency department aim to reduce consult turnaround times and enhance the efficiency of clinical decision-making. By reviewing this process, we may uncover improvement ideas such as standardized protocols, technology solutions, or resource utilization practices, all of which could enhance patient outcomes while minimizing the risk of delays or adverse events.

In our emergency department, we are initiating a comprehensive review of diagnostic testing procedures. This includes analyzing the efficiency of our blood collection workflow and performance through time studies, with a focus on early implementation of medical directives and timely notification of pending blood orders or results. Additionally, we're evaluating diagnostic imaging efficiencies, particularly CT turnaround times, and aiming to enhance monitoring capabilities using existing internal dashboards. Through a collaborative, multi-departmental approach, we emphasize the critical role of the Quality Improvement Program (QIP) metric in enhancing patient outcomes across all aspects of care at MGH

Moreover, our efforts to achieve a >1.00 ALC throughput rate is on going. We aim to continuously provide education on the proper use of ALC orders to Medical, Surgical, CCC physicians and physician assistant with a target of 75 % of physicians receiving this education. We also aim to provide education to all staff that are responsible to enter accurate ALC designation with the goal of decreasing WTIS errors by 80% per month. Another focus of ours is on proactive transitions by implementing order set for older adults awaiting more comprehensive plan for transition to next best level of care. Transition protocols are in place that facilitate the timely communication of clinically relevant information to the older adult and their designated caregiver / SDM and primary care providers, including long term care homes. Furthermore, we will work towards a standardize process for establishing the estimated discharge date. This process must be specific to each older adult. We aim to achieve this by adding the standardize language and process to minute rounds, creating a mandatory field to the patient e-whiteboard, deliver a refresher on roles shared with clinical teams & physicians and build an interface to transfer EDD to bed capacity management tool. In addition, we aim to collaborate with HCCSS to support the implementation of "Actions for streaming referrals to Home and Community Care". Working closely with HCCSS leadership, efforts will be directed towards facilitating consistent and regular involvement of hospital coordinators in IP rounds. This will be complemented by the enhancement of localized information sharing mechanisms to collaboratively monitor and elevate the status of patients within the care planning and referral framework. Additionally, a specialized pathway for complex ALC discharges will be developed, tailored to address hospital-specific needs, while also ensuring timely referrals to HCCSS for in-home services prior to ALC designation. Through these strategies, we aspire to achieve our set targets for both indicators.

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## Equity and Indigenous Health

As systemic racism, oppression and inequalities continue, equity, diversity, inclusion and belonging (EDIB) is a foundational area of focus for our hospital. Since its inception in 2020, The MGH Inclusion Alliance has been dedicated to utilizing a lens of inclusion to identify and address inequity and oppression within the hospital. At MGH, there is a strong belief that the commitment to equity and anti-oppression is the shared responsibility of our hospital's governance, staff, and all stakeholders, and as such, must be supported and guided by all levels of leadership. We continue to work with and remain accountable to indigenous advisors to improve the delivery of safe, culturally appropriate care for First Nation, Inuit and Metis patients at MGH.

In consultation with members of the Inclusion Alliance, and in collaboration with the hospital's existing working groups and sub-committees, a number of EDIB initiatives have commenced and/or continue to progress towards their intended objectives, including:

- Implementation of the EDIB action plan that sets out key focus areas that will support the execution of strategies necessary to operationalize this goal
- Ongoing Training and Education opportunities for MGH staff and leadership to build foundational knowledge in equity, diversity, inclusion and belonging, including cultural competency training and Indigenous cultural safety training
- Continue partnership with Indigenous communities to develop a work plan to enhance Indigenous care resources offerings
- Implementation of a monthly EDIB Bulletin to support awareness, connection, and community building by providing relevant resources, upcoming cultural/ commemorative dates, and education related to EDIB for our people in a dedicated, consistent manner
- Develop and launch a communication campaign to increase awareness and response to the Health Equity Questionnaire (HEQ), while engaging in a pilot project to increase HEQ response rates in the Day Surgery (adult) program
- Launch and enhance MGH Employee Resource Groups (ERGs) to provide additional support mechanisms for our staff and credentialed clinicians to join together based on shared interests, identities, and experiences
- Removing barriers that inhibit professional growth through the continuous improvement of the Emerging Leaders Program

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## Patient Experience

We continue to rely on our strong partnerships with patients and families to inform and advance our work. In 2023/2024, Patient Experience Partners had the opportunity to participate in committee meetings and interview panels for new staff and credentialed clinicians. The MGH Patient Experience Panel (PEP) continued to meet virtually, with seven meetings over the past year. Meetings provided PEP members with the opportunity to contribute to eighteen initiatives including co-creating patient information for our new policy on non-urgent patient transportation, providing input into the design of content for the new self-serve patient registration kiosks, contributing to the New Strategic Plan, Quality Improvement Plan, Health Equity Data Project, and the Wait Time Clock Project in the Emergency Department (ED), and reviewing ten new Patient Oriented Discharge Summaries (PODS) for content, readability, and health equity. We welcomed a new co-chair to PEP and recognized the out-going co-chair for six years of service on PEP. We welcomed an additional 12 new Patient Experience Partners for the refreshed ED PEP, the MGH ED Collaborative Provider Patient Panel. The ED Panel had its first meeting in December 2023 and they are working on wait time transparency. In 2024/2025, we will continue to recruit Patient Experience Partners that represent the diverse population we serve, seeking innovate ways to engage with them. We also hope to re-establish other Program PEPs (Mental Health, and Maternal Newborn Child) that have been paused since the pandemic.

In August 2023, MGH began using the Qualtrics XM platform for managing our Patient Experience survey process for patients discharged home from inpatient medicine and surgery, the emergency department, and the family birthing centre. To date, more than 3400 surveys have been returned with a response rate of 38%. While we are using the OHA standardized dashboard to share data with the clinical teams, we are continuing to learn about the new platform and develop customized dashboards in consultation with program leadership, to trend and share data in more meaningful ways. We are looking forward to having OHA benchmarking data as well as exploring our data from an equity, diversity and inclusion perspective to understanding our opportunities for improvement.

Patient Experience identified an increase in complaints regarding lost belongings and the cost of replacement. This is of particular concern when lost items are medically necessary (e.g. hearing aids, dentures), or have been taken from patients by the team (e.g. before transferring to O.R., admission to mental health). In collaboration with leaders we identified the need for a consistent process for determining reimbursement for lost items. Patient Experience completed an environmental scan, reviewed complaints from the previous year, shared results with leaders and are now trialing an equity based tool to guide reimbursement decisions. The next step is to evaluate the effectiveness of this tool for patients, families and leaders.

# 2024/25 QIP Narrative

## Provider Experience

Amidst high levels of burnout related to staff shortages and seasonal pressures on the healthcare system, we know that supporting our team members is vital to providing high quality patient care. We will address this complex issue with a multi-pronged approach, designed to acknowledge what our teams are  experiencing while directly providing care to patients, and we will incorporate their valuable input and ideas for improvement.

Adding to the complexity of care provision is the continual need for operational effectiveness in our new patient tower, the Ken and Marilyn Thomson Patient Care Centre. Though our teams have showed dedication and resiliency throughout the pandemic, we must support them to practice in a new space, with new work flows and technology. Our clinical leadership and operational readiness teams offer 24 hour support, 7 days a week to ensure staff feel supported across all shifts.

Last Spring, we launched an Engagement Survey to better understand how engaged and represented our staff and credentialed clinicians feel at MGH and engagement drivers of strength and areas of opportunity. Based on the survey results our teams have been working on co-creating local-level team action plans to maintain areas of strength and improve areas of opportunity. The survey results have also informed the creation of a corporate action plan to help address key areas important to our people and our Year 2 “People” priorities in our strategic plan.

We will build a healthy and supportive workplace for our MGH community by stabilizing our workforce, improving work life balance and providing opportunities for growth and development to the key members of our MGH community.

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## Safety

The prevention of workplace violence has remained a steadfast priority at MGH, underscored by our proactive approach through targeted educational programs, awareness campaigns, and reporting systems to monitor workplace violence incidents. Our strategic plan reflects our unwavering commitment to fostering a safe work environment. Our ongoing dedication to workplace violence prevention (WVP) is evident in its inclusion within our Quality Improvement Plan (QIP), ensuring regular updates on action plans and progress to stakeholders and leadership forums, including our board and sub-committees.

As we strive for a care environment free from violence, the refreshed WVP committee continuously reviews and adapts our initiatives. Employing a multipronged approach, we are addressing both immediate and long term goals:

1. Supporting staff and encouraging reporting by simplifying incident reporting processes, standardizing leadership approaches to investigations, follow-up and support, and improving educational opportunities.
2. Enhancing staff safety in critical situations, through the improvement of technology used in staff duress and code white incidents.
3. Identifying high-risk areas for violence, and implementing targeted tools and prevention practices.
4. Developing an organizational-wide Behavioural Care Plan process for patients at high risk for violence.

## Population Health Approach

Michael Garron Hospital is an anchor partner of East Toronto Health Partners (ETHP), a collective of 100+ health and social care partner organizations and individual patients, caregivers and community members who are working together to better integrate care for the people we serve.

ETHP serves a population of approximately 375,000 clients who live and/or receive care here. East Toronto includes 21 distinct neighbourhoods, including five designated Neighbourhood Improvement Areas which are Flemingdon Park, Oakridge, Taylor-Massey, Thorncliffe Park and Victoria Village. ETHP sees significant opportunities to improve care for our population and health system performance as we advance our efforts to create an integrated health system for our attributed population.

Our work to improve population health is grounded in an equity and neighbourhood approach, starting with the five “Neighbourhood Improvement Areas” as defined by the City of Toronto. This neighbourhood-based approach is intended to help us address some of the priority equity considerations facing our population including a high proportion of newcomers and immigrants, patients who are uninsured, and individuals and families with lower socioeconomic status. Residents in these neighbourhoods are also disproportionately impacted by higher rates of chronic disease and lower access to primary care and other health services.

As one of the 12 initial OHTs selected to accelerate towards maturity, this means that our OHT will be moving at a faster pace towards the goal of providing a full and coordinated continuum of care for a defined population within our geographic region

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## Executive Compensation

Our executives' at-risk compensation is impacted by the performance of our QIP, as follows:

President & CEO – maximum at-risk compensation is 15% of total annual salary. For QIP, 25% of at-risk compensation is tied to QIP performance.

Vice Presidents – maximum at-risk compensation is 10% of total annual salary. For QIP, 25% of at-risk compensation is tied to QIP performance.

Chief Officers - maximum at-risk compensation is 15% of total annual salary. For QIP, 25% of at-risk compensation is tied to QIP performance.

The 25% of variable compensation tied to our QIP will be paid out according to the proportion of QIP targets that have been achieved, as set out in the table below.

| Ratio of QIP Targets Achieved: | <50% | 50% | 75% | 100% |
|---|---|---|---|---|
| Proportion of 25% variable compensation paid: | 0% | 50% | 75% | 100% |

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# F2024/25 Quality Improvement Plan (QIP)

# Work Plan

March 2024

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# 2024/25 QIP Work Plan | ED Admitted Length of Stay (page 1 of 2)

| Indicator | Unit of measure / Patient population | Data Source / Period | Baseline | Target for 2024/25 | Target Justification |
|---|---|---|---|---|---|
| 90th Percentile Emergency Department Admitted Length of Stay | **Unit of Measure**<br>Hours from patient arrival to Left ED<br>**Patient Population**<br>All patients admitted from ED | **Data Source**<br>OH ED P4R Ranking Report<br>**Reporting Period**<br>Dec 2023 to Nov 2024 (P4R cycle) | 28.6 | ≤26.8 | Utilizing last fiscal year's benchmark of 28.6 hours, our objective for this year is to attain a target of 26.8 hours or less by building off the momentum of the strong performance from our access and flow metrics. Achieving an improvement to 26.8 hours represents a 6.3% decrease and positions us ahead of the next hospital in the P4R rankings within sub-region #7 for ED Admitted LOS. |

| # | Change Idea | Methods | Measure | Target |
|---|---|---|---|---|
| 1 | Improved use of Teletracking | • Cerner and Teletracking integration to eliminate manual processes and extra steps – Scope the firstnet and Teletracking integration to facilitate the RTM process and work towards implementation<br>• Discharge feature implementation & changes to discharge process<br>• Bedtracking clean up next feature review and education – Prioritization of bed demands in the afternoon<br>• Continuously educate and train staff on the use of Teletracking. | • 90th Percentile ED to IP Bed Wait Time<br>• Average time between inpatient leaving hospital and discharge being recorded in Powerchart | • Maintain or improve |
| 2 | Flow Optimization | • Reallocate resources and extend existing processes to cover gaps, including Nursing, IPP, leadership, patient flow and transitions, bed allocators, porters, housekeeping, and physicians. This will optimize multidisciplinary resources as much as possible to have appropriate resource coverage and standardization of processes.<br>• Optimize afternoon EVS resources/shift schedule/work activities according to analysis performed. Escalation procedures to COMS for beds demand changes<br>• IP discharge planning improvements (Start with discharge process mapping)<br>• Pilot a Embedded Discharge Team that provides detailed case management on discharge from the ED to avoid complex admissions and deteriorating patient re-visits to the ED<br>• Work on a Staffing weekend support model to facilitate discharges<br>• Continually assess volume, bed capacity and clinical activity to ensure capacity meets demands. | • 90th Percentile ED to IP Bed Wait Time<br>• Number of days without IPP coverage | • Maintain or improve |
| 3 | Consult Process Review | • Process mapping the consult process in the ED<br>• Identify 1 opportunity to focus on | • PIA to Consult Order<br>• Consult Order to Consult Start | • Maintain or improve |

# 2024/25 QIP Work Plan | ED Admitted Length of Stay (page 2 of 2)

| Indicator | Unit of measure / Patient population | Data Source / Period | Baseline | Target for 2024/25 | Target Justification |
|---|---|---|---|---|---|
| 90th Percentile Emergency Department Admitted Length of Stay | **Unit of Measure**<br>Hours from patient arrival to Left ED<br>**Patient Population**<br>All patients admitted from ED | **Data Source**<br>OH ED P4R Ranking Report<br>**Reporting Period**<br>Dec 2023 to Nov 2024 (P4R cycle) | 28.6 | ≤26.8 | Utilizing last fiscal year's benchmark of 28.6 hours, our objective for this year is to attain a target of 26.8 hours or less by building off the momentum of the strong performance from our access and flow metrics. Achieving an improvement to 26.8 hours represents a 6.3% decrease and positions us ahead of the next hospital in the P4R rankings within sub-region #7 for ED Admitted LOS. |

| # | Change Idea | Methods | Measure | Target |
|---|---|---|---|---|
| 4 | Improving ED Lab Turnaround Time | • Collaborate with Lab leadership<br>• Preliminary baseline data analysis and review of the process to identify 1 opportunity to focus on<br>• Analyze current blood collection workflow through process mapping and performance through time studies<br>• Improve the application of medical directives for collecting blood earlier on in the ED patient's arrival<br>• Identifying an alerting system for pending blood collection orders as well as blood work completed result | • Time from collection to delivery | • Maintain or improve |
| 5 | Improving Diagnostic Imaging Wait Times (CT TAT) | • Improving CT time from DI order to DI test complete through process mapping analysis to identify opportunities for improvement.<br>• Utilize existing DI dashboards to expand monitoring capability for ED and inpatient units. | • CT Test TAT | • Maintain or improve |

# 2024/25 QIP Work Plan | ALC Throughput (page 1 of 2)

| Indicator | Unit of measure / Patient population | Data Source / Period | Baseline | Target for 2024/25 | Target Justification |
|---|---|---|---|---|---|
| ALC throughput rate | **Unit of Measure**<br>Discharged ALC cases / Newly added ALC cases<br>**Patient Population**<br>All patients admitted from ED | **Data Source**<br>**Reporting Period**<br>Dec 2023 to Nov 2024 (P4R cycle) | 1.03 | >1.00 | The regional baseline is 0.96 with the provincial target being > 1.00 . The team would also like to align with the provincial target of > 1.00. |

| # | Change Idea | Methods | Measure | Target |
|---|---|---|---|---|
| 1 | When to recommend an ALC designation | • Provide education to Medical, Surgical and CCC physicians and physician assistants about proper use of ALC orders.<br>• Provide education to all staff that are responsible to enter accurate ALC order destinations. | • Total number of physicians provided education<br>• Track WTIS errors generated by incorrect ALC destination | • 75% of physicians received education and report improved understanding of ALC designation.<br>• Decrease WTIS errors by 80% per month |
| 2 | Proactive Transitions #8 | • Implement order set for older adults awaiting more comprehensive plan for transition to next best level of care<br>• Pilot a Embedded Discharge Team that provides detailed case management on discharge from the ED to avoid complex admissions and deteriorating patient re-visits to the ED<br>• Work on a Staffing weekend support model to facilitate discharges | • Complete review of best available evidence, sf guidelines and local experts to inform order set development<br>• Complete staff orientation of orderset for staff<br>• Finalize orderset, approved by department leadership | • Use of order set for >80% of patients held in short stay unit/overnight for disposition planning<br>• Over 80% of ED physicians using new orderset |

# 2024/25 QIP Work Plan | ALC Throughput (page 2 of 2)

| Indicator | Unit of measure / Patient population | Data Source / Period | Baseline | Target for 2024/25 | Target Justification |
|---|---|---|---|---|---|
| ALC throughput rate | **Unit of Measure**<br>Discharged ALC cases / Newly added ALC cases<br>**Patient Population**<br>All patients admitted from ED | **Data Source**<br>**Reporting Period**<br>Dec 2023 to Nov 2024 (P4R cycle) | 1.03 | >1.00 | The regional baseline is 0.96 with the provincial target being > 1.00 . The team would also like to align with the provincial target of > 1.00. |

| # | Change Idea | Methods | Measure | Target |
|---|---|---|---|---|
| 3 | There is a process for establishing the Estimated Discharge Date (EDD). This process must be specific to each older adult and not dependent upon blanket EDD assumptions. | • Add standardized language and process to minute rounds: mandatory field to Patient whiteboard, scripting for minute round, refresher on minute round process and roles shared with clinical teams and physicians, and longer term as it involves technical build, transfer of EDD to bedded capacity management tool. | • # of teams who have received minute rounds refresher, including scripting.<br>• Addition of mandatory field<br>• Interface to pull EDD data from EMR to Bed capacity management tool build | • 80% of all teams have received minute rounds refresher.<br>• Week over week improvement in EDD compliance compared to baseline.<br>• 80% of all patients will have an EDD specific to their plan of care entered in the electronic whiteboard within 48 hours of admission. |
| 4 | Collaborate with HCCSS to support the implementation of required actions as laid out in the Jan 30, 2024 OH memo “Actions for Streamlining Referrals to Home and Community Care” | • Work with HCCSS leadership to ensure consistent and sustained participation at IP rounds by HCCSS hospital coordinators.<br>• Implement/build on local information sharing tools to jointly track and escalate patients’ status in the care planning and referral process.<br>• Develop a hospital specific escalation case conference pathway for specific complex ALC discharges.<br>• Ensure referrals to HCCSS for in home services are sent before an ALC designation is made. | • Rounds coverage via sustainable schedule is developed.<br>• Pilot info sharing tool with HCCSS<br>• Escalation process implemented.<br>• % of referrals to HCCSS for in home services that are sent prior to ALC designation. | • Maintain or improve |

# 2024/25 QIP Work Plan | Equity, Diversity, Inclusion & Belonging (EDIB)

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Improve cultural competency through training

| Indicator | Unit of measure / Patient population | Data Source / Period | Baseline | Target for 2024/25 | Target Justification |
|---|---|---|---|---|---|
| Rate of staff and leaders completing mandatory cultural competency training | **Unit of Measure**<br>Completion Rate<br><br>**Patient Population**<br>All staff and leaders | **Data Source**<br>Hospital Data through Learning Management System (iLearn)<br><br>**Reporting Period**<br>April 2024 – March 2025 | (new metric, not available) | ≥ **80%** | • Typical overall completion rate for mandatory learning modules<br>• Increased target from last year's mandatory EDIB training, which was exceeded |

| # | Change Idea | Methods | Measure | Target |
|---|---|---|---|---|
| 1 | Measure completion rate of all credentialed clinicians | 1. Include cultural competency training into 2025 Credentialed Clinician Mandatory Credentialing Curriculum<br>2. Review completion rate of cultural competency training by credentialed clinicians at end of Credentialed Clinician Mandatory Credentialing Curriculum time period | Milestone Dates | 1. January 2025<br>2. March 2025 |
| 2 | Measure completion rate of all new MGH hires with a start date within the reporting period | 1. Include cultural competency training into New Hire Training Curriculum<br>2. Configure iLearn Administrative dashboard to include monthly completion rate of cultural competency training<br>3. Review completion rate of mandatory cultural competency training by all new hires on a monthly basis throughout reporting period | Milestone Dates | 1. April 2024<br>2. April 2024<br>3. April 2024-March 2025 |
| 3 | Launch more comprehensive training on cultural competency for leaders | 1. Include cultural competency for leaders training (60-90 min in-person workshop) as part of LEEP Excellence<br>2. Review completion rate of cultural competency for leaders training on a quarterly basis throughout reporting period | Milestone Dates | 1. May 2024<br>2. April 2024-March 2025 |

# 2024/25 QIP Work Plan | Equity, Diversity, Inclusion & Belonging (EDIB)

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Improve Day Surgery Health Equity Questionnaire response rate

| Indicator | Unit of measure / Patient population | Data Source / Period | Baseline | Target for 2024/25 | Target Justification |
|---|---|---|---|---|---|
| Rate of Day Surgery Patients (adults) completing the Health Equity Questionnaire | **Unit of Measure**<br>Completion Rate<br><br>**Patient Population**<br>Day Surgery Patients (Adults) | **Data Source**<br>Health Equity Questionnaire<br><br>**Reporting Period**<br>April 2024 – March 2025 | 22%<br>(Apr 2022 – Dec 2023) | ≥ 32% | • Overall response rate for our Health Equity Questionnaire is 35% |

| # | Change Idea | Methods | Measure | Target |
|---|---|---|---|---|
| 1 | Increase patient education and awareness of Health Equity Questionnaire | 1. Develop patient education materials to provide information about the purpose of the Health Equity Questionnaire, intended use, etc.<br>2. Imbed evidence from the literature on inequities in healthcare access, outcomes, and quality among diverse patient populations | Milestone Dates | 1. May 2024<br>2. May 2024 |
| 2 | Review and revise current process for collecting Health Equity Questionnaires | 1. Review current Health Equity data collecting process among Day Surgery patients<br>2. Imbed Health Equity Questionnaire into patient in-take package | Milestone Dates | 1. April 2024<br>2. June 2024 |
| 3 | Increase frequency of reporting of completion rate for the Health Equity Questionnaire | 1. Review completion rate of Health Equity Questionnaire on a monthly basis throughout reporting period | Milestone Dates | 1. April 2024-March 2025 |

# 2024/25 QIP Work Plan | Patient Satisfaction

| Indicator | Unit of measure / Patient population | Data Source / Period | Baseline | Target for 2024/25 | 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"? | **Unit of Measure**<br>Percent<br>**Patient Population**<br>All survey respondents discharged from medicine and surgery units | **Data Source**<br>Qualtrics<br>**Reporting Period**<br>April 2024 to March 2025 | 60.3 % | 63.3%<br>(5% increase) | Our target is to increase by 5 %. We acknowledge that improving the patient experience is a complex process that includes many factors. Further, we recently adopted a new survey platform (Qualtrics XM) that uses email addresses to send patient experience surveys. This method may limit our ability to reach all patients , ultimately losing the voice of some patient populations. Consequently, we may not be meeting the discharge needs of all patients so it will be important to understand the survey responses by demographic. |

| # | Change Idea | Methods | Measure | Target |
|---|---|---|---|---|
| 1 | **Continue to implement the PODS Framework** | 1. Create guideline that outlines how to develop, validate and review PODS (Patient Oriented Discharge Summary)<br>2. Continue to support staff during PODS conversations and provide in the moment coaching and feedback<br>3. Explore the possibility , when patients are discharged back to long term care (LTC) of reviewing PODS content with LTC staff | 1. Guideline created<br>2. # of LTC who know about PODS | 1. Dec 2024<br>2. 5 |
| 2 | **Improve collaboration with patients and caregivers and support readiness to transition through implementing elements of the RNAO Transitions in Care Best Practice Guideline** | 1. Working closely with HCCSS and other community partners, ensure that all patients with complex needs transitioning home receive and have reviewed with them a written summary of the service plan prior to leaving hospital, including a contact name and number. | 1. % of patients with complex needs transitioning home receive and have reviewed with them a written summary of the service plan prior to leaving hospital | 1. 80% |
| 3 | **Understand survey responses by demographic** | 1. Explore the ability to analyze patient experience data by demographic and identify improvement opportunities<br>2. Explore survey options for non English speaking patients | 1. Number of surveys available in languages other than English | 1. More than 1 |
| 4 | **Increase community awareness of survey availability** | 1. Improve email collection process for each survey population<br>2. Create a public awareness campaign for patient experience surveys<br>  1. Information to display on TV screens in waiting areas<br>  2. Information for MGH external website<br>  3. Refresh content in Patient Guide | 1. % of survey responses received | 1. Maintain or Improve |

# 2024/25 QIP Work Plan | Workplace Violence Prevention

Increase reporting of workplace violence incidents

| Indicator | Unit of measure / Patient population | Data Source / Period | Baseline | Target for 2024/25 | Target Justification |
|---|---|---|---|---|---|
| Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period. | **Unit of Measure**<br>Count<br><br>**Patient Population**<br>All patient care units | **Data Source**<br>Hospital collected data<br><br>**Reporting Period**<br>Jan to Dec, 2024 | 17.1 | ≥18 | Due to ongoing significant underreporting of workplace violence incidents, our target is to improve the reporting of workplace violence incidents. |

| # | Change Idea | Methods | Measure | Target |
|---|---|---|---|---|
| 1 | Implement processes to support and encourage the reporting of workplace violence incidents | 1. Launch the rapid workplace violence reporting form in other high risk areas.<br>2. Create tools to standardize leadership investigation, follow-up and staff support following an incident of workplace violence, and dissemination/training for its use (i.e. Leadership Excellence workshop) | 1. Completion date | 1. Dec 2024 |
| 2 | Implement methods to reinforce workers in feeling safe, prepared and supported in their work environment | 1. Improve/Enhance technology used in staff duress/code whites to ensure staff in immediate danger receive help as appropriate i.e. RTLS and mobile devices<br>2. Improve preventative security measures in the Emergency Department<br>3. Perform regular risk assessments in high risk areas | 1. Completion date | 1. March 2025 |
| 3 | Behavioural Care Plan Alert for Patient and Worker Safety | 1. Build the behavioural care plan in Powerchart<br>2. Train staff org-wide on the use of the behavioural care plans alerts (i.e. violence assessment tool and visual cues), how to create and follow an individualized behavioural care plan<br>3. Implement mental health specific violence assessment tool in the in-patient mental health program i.e. DASA tool | 1. Completion date | 1. March 2025 |

# 2024/25 QIP Work Plan | Restraint Use in Inpatient Mental Health Services

Improve compliance with new restraint policy in inpatient Mental Health

| Indicator | Unit of measure / Patient population | Data Source / Period | Baseline | Target for 2024/25 | Target Justification |
|---|---|---|---|---|---|
| % restraint events that have been audited by leadership within 72 hrs | Audits<br>Mental Health (T5, T7E, PICU) | **Data Source**<br>Patient Chart<br><br>**Reporting Period**<br>April 1 2024-March 31 2025 | N/A | ≥90% | New restraint process put in place in Mental Health, auditing processes need to be refined. |

| # | Change Idea | Methods | Measure | Target |
|---|---|---|---|---|
| 1 | Design effective processes to review audit findings with leadership and staff | 1. Co-design with Mental Health leadership and staff | 1. Completed design of written process | 1. May 2024 |
| 2 | Expand new restraint process to MHEAZ/ED and begin chart audits | 1. Liaise with MH and ED leadership to educate and support staff | 1. Implementation of restraint process in MHEAZ | 1. May 2024 |
| 3 | Establish and roll out education in trauma informed care and least-restraint culture | 1. Environmental scan for education that already exists and obtain input from staff and leadership | 1. Completion of education plan | 1. December 2024 |
| 4 | Launch organization wide least-restraint policy and practices using learnings from mental health | 1. Gather stakeholders, complete environmental scan, and confirm Executive sponsorship | 1. Launch of least restraint committee | 1. September 2024 |

MICHAEL GARRON HOSPITAL

TORONTO EAST HEALTH NETWORK

# F2024/25 Quality Improvement Plan (QIP)

# Progress Report

March 2024

**Our Vision**

Great care inspired by community

# 2023/24 QIP Progress Report | ED Time to Inpatient Bed

Reduce Emergency Department wait times

MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

| QIP Indicator | Baseline | Target | Current Perf | Comments |
|---|---|---|---|---|
| 90th Percentile Emergency Department Wait Times for In-Patient Bed (Hours) | 22.2 | ≤ 22.2 | 19.5 | *The 23/24 ED Time to Inpatient QIP has successfully reached the predetermined target established at the start of the fiscal year. This noteworthy accomplishment is a direct result of the comprehensive change ideas implemented by our dedicated team. Furthermore, the team actively engaged in continuous improvement practices by responding to various analyses and fostering a culture that values perpetual enhancement. Based on the analysis, several other changes were implemented. With the transition to the Thomson Center in February 2023, several new workflows were implemented that positively impacted the ED Time to Inpatient Bed indicator. A Teletracking steering committee was established last year to oversee and provide guidance on all changes related to Teletracking, our patient flow tool. This steering committee has since evolved into an Access & Flow multidisciplinary working group, comprising of key stakeholders such as the patient flow manager, ED manager & director, Medicine manager & director, support services director & manager, Transition navigator supervisor, DI & IPP directors, and internal consultants. The achievement of our target can be directly attributed to the commitment of this dynamic working group. Through their collaborative efforts, creative solutions were consistently identified to enhance the flow throughout the organization. The Access & Flow working group played a pivotal role in continuously monitoring all metrics impacting the ED Time to Inpatient Bed indicator, demonstrating agility in identifying and promptly mitigating potential issues.* |

| Change Idea | Implemented? | Accomplishments & Lessons Learned |
|---|---|---|
| **Improved use of Teletracking** | Yes | *Following multiple site visits from the Teletracking client director, multiple changes were applied to the bed tracking module. In particular the bed tracking module was reconfigured so that vacant beds can be treated as priority when they enter the queue. Moreover, several changes were made to the bed tracking alerts going out to EVS supervisors to enhance situational awareness. The introduction of the Ready to Move feature has proven instrumental in enhancing awareness within the flow team. This feature notifies the team when a patient is both clinically and physically ready to move, resulting in a notable improvement in the Time to Inpatient Bed metric. Despite our best efforts, certain proposed changes faced hurdles. Challenges related to the rollout of mobile devices technology, turnover in EVS supervisor roles, budget constraints, and delays in the redevelopment project contributed to the decision not to implement certain changes. Our team remains committed to address these challenges in future initiatives. To guide the successful implementation of change ideas, our team has developed a comprehensive 4-step roadmap. The first two steps are deemed prerequisites, laying the foundation for the subsequent implementation of the 3rd and 4th steps. This roadmap ensures a systematic and effective approach to change implementation.* |
| **Improving DI Capacity (New)** | Yes | *Under DI & flow leadership, a dashboard was created showing wait time for ED and TAT for IP. This also allowed DI to share the performance to the clinical teams (CT,ECHO,MRI). The DI tests TAT were reviewed to identify potential challenges that could contribute to increased Length of Stay (LOS). The team carefully reviewed this data, leading to the formulation of action plans to address identified challenges. Some ideas included: running a pilot of adding 2 more slots daily for urgent post-discharge ECHO for IP units, sharing of DI dashboard to increase awareness broadly an increasing CT capacity during the day.* |
| **Reassessment and Stabilization** | Yes | *In an effort to monitor critical operational metrics, a dedicated Patient Flow Dashboard was developed. This dashboard tracks key indicators such as transport time, bed cleaning time, response time, Turnaround Time (TAT), the number of transport jobs, admissions from the Emergency Department, discharges from all Inpatient units, and the number of found dirty beds. The integration of this dashboard, alongside the ED Scorecard reporting, has streamlined our monitoring processes into a singular and centralized stream. The Access and Flow working group conducts a weekly review of the established KPIs to closely monitor patient flow, assess the health and status of operational metrics. These dashboards serve as instrumental tools in gauging the overall status of the organization. In the event of any decline in these metrics, the working group promptly conducts analyses to identify root causes. Mitigation strategies are then discussed to address the identified issues swiftly, ensuring the ongoing optimization of operational processes.*<br><br>*In collaboration with an external consultant, particularly with support from MGH, the idea of developing a forecasting model to predict Total ED visits and Total admissions was explored. While the model was successfully developed, an evaluation of the forecasting accuracy and percentage errors revealed that it did not meet the required level of precision. Consequently, it was determined that the model, in its current state, does not provide a sufficiently accurate basis for sound decision-making by MGH leadership.* |

# 2023/24 QIP Progress Report | ED Time to Inpatient Bed

Reduce Emergency Department wait times

MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

| Change Idea | Implemented? | Accomplishments & Lessons Learned |
|---|---|---|
| **Flow Optimization** | Yes | *In response to the surge season, a strategic measure was implemented with the establishment of a 6-bed admission lounge. This initiative aimed to efficiently decant admitted patients within the ED and consequently, mitigate ED overcrowding. The implementation of the admission lounge has yielded positive results, notably contributing to the improvement of the ED Time to Inpatient Bed indicator. Moreover, to assist with RFI reviews, a Transition navigator student was recruited to support the review of Request for Information, with the primary objective of reducing the overall number of RFIs. As part of our flow optimization strategy, the team extensively leveraged data analysis and hypothesis testing to inform decision-making. Analysis of HCCSS & REHAB/CCC data, encompassing RFIs, Admitted and Denied Referrals, Completion Time, Follow-up Time, Assessment Time, and Overall Referral Time, was conducted to identify areas for improvement. An idea that was explored to proactively address discharge entry delays, a report comparing discharge time to discharge entry time was shared with clinical managers on an ad-hoc basis. In addition, collaborative efforts were undertaken with the IPP team to provide further education on discharge best practices and decision time for discharges to Home/Rehab. This collaboration ensures alignment in optimizing patient discharge processes across departments.*<br><br>*At one point, recognizing a notable variability in admission rates over several weeks, our team initiated an analysis to determine the significance of this fluctuation. The question asked was, "Is the day-to-day variability in admission rate we observe unusual?" Subsequent investigation revealed that the observed day-to-day variation in admissions falls within the expected random range. This suggests that additional factors or variances may be influencing this variability, prompting the team to explore further.*<br><br>*A more in-depth analysis focused on identifying common characteristics on busy days with high admission rates. The objective was to develop a system/trigger for future alerts to help in more effective planning. The findings highlighted the need to review the ED consult process and consider implementing triggers to inform the team of high admission days. The working group extended its analysis to examine ALC orders numbers, seeking insights into trends, data quality issues, units with elevated ALC numbers, and the ultimate discharged destinations. This comprehensive review aimed to enhance our understanding of ALC patterns and inform targeted interventions.*<br><br>*Following up on the trigger regarding high admission days, a tool was built, analyzing the average 24-hour consults per consult type and historical admission rates for admitting programs. This tool, embedded within the bed meeting spreadsheet, serves as a resource, projecting anticipated admissions in advance. Building upon previous hypotheses and conclusions, the team conducted a thorough analysis of average turnaround time by consult type, ED time to consult, and historic trends in LOS. A noteworthy observation was the higher-than-usual number of patients experiencing a one-day LOS, prompting further investigation into post-consult processes. Two key areas for improvement were identified. Firstly, the team wanted to explore safer alternatives to admitting patients with only one day of LOS post-consult. Additionally, attention was directed towards implementing a robust coverage model over weekends and statutory holidays to facilitate in-patient discharges. An analysis of discharge data for weekends and statutory holidays in 2022 (no weekend coverage) and 2023 (with weekend coverage) revealed a significant 36% increase in discharges on those days. This data highlights the potential to save 1 to 3 days of LOS by strategically discharging patients over weekends.*<br><br>*In response to these findings, the team is exploring the feasibility of extending staff coverage over weekends. Furthermore, a proposal has been outlined for the creation of an embedded discharge team, comprising a pharmacist, physiotherapist, nurse lead, and potential future additions such as a physician assistant, nurse specialist, transition navigator, navigator, community program worker, and GEM nurse. This multidisciplinary team aims to disrupt the pathway from consult to admission by offering viable alternatives to hospitalization through comprehensive discharge planning and community support linkages. After implementation of this strategy, the team will closely monitor the data to determine any improvement made or lessons learned. These initiatives align with our commitment to enhancing patient care, optimizing resource utilization, and ensuring a seamless continuum of care.* |

Blaine

# 2023/24 QIP Progress Report | Workplace Violence Prevention

Reduction in workplace violence incidents

| QIP Indicator | Baseline | Target | Current Perf | Comments |
|---|---|---|---|---|
| Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period. | 14.1 | ≥15 | 17.1 | With the recent relaunch of a dedicated committee focused on advancing initiatives to improve workplace violence at MGH, there have been moderate improvements to the reporting of workplace violence incidents, and our target for this year was met, and exceeded. |

| Change Idea | Implemented? | Accomplishments & Lessons Learned |
|---|---|---|
| Implement processes to support and encourage the reporting of workplace violence incidents | Yes | - A rapid workplace violence reporting form launched by a QR code was implemented in the emergency department. Reporting in the ED immediately increased, but after several months fell back to baseline. Staff feedback<br>- Easy to use tools were created to aid leaders in supporting their staff after a workplace violence incident. More work is forthcoming on communicating how to effectively use these tools, |
| Implement methods to reinforce workers in feeling safe, prepared and supported in their work environment | Yes | - After conducting a comprehensive analysis, which included findings from a risk assessment, staff engagement survey results, and other department-specific needs assessments, it became evident that the entrance and triage area of the Emergency Department posed a vulnerability due to inadequate security monitoring. In response, resources were allocated to ensure that this critical area of the ED is now staffed with a security guard around the clock, enhancing safety and security measures.<br>- A refreshed WVP poster campaign was launched; comprehensive communication about WVP resources was disseminated across various forums, ensuring widespread awareness and accessibility to essential support avenues.<br>- WVP education and awareness were promoted through a targeted campaign developed by subject matter experts and delivered by our esteemed leaders. Efforts were also directed towards increasing attendance at full-day WVP workshops, aiming to empower our staff with the knowledge and skills necessary to create a safer work environment. |
| Behavioural Care Plan Alert for Patient and Worker Safety | No | The Behavioral Care Plan Alert (BCPA) emerged as a significant organizational project, yet it quickly became apparent that our current resources were insufficient for its success. Consequently, this QIP cycle prioritized the establishment of a robust business case for securing a dedicated resource capable of spearheading the development and implementation of the BCPA, ensuring its effective execution and long-term viability. |

# 2023/24 QIP Progress Report | Transfer of Accountability

Improve quality of information transfer at patient transition points

MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

| QIP Indicator | Baseline | Target | Current Perf | Comments |
|---|---|---|---|---|
| # of Transfer of Accountability (TOA) related Incidents<br><br>Unit of Measure - Number, incidents per month<br>Patient Population – All Inpatient Areas | **10.9** | ≤ 10.00 | **6.60**<br>(April 23- Jan 24) | Over the past year, the Quality team has placed a significant emphasis on refining our Transfer of Accountability (TOA) processes between areas. Concurrently, we have been steadfast in our pursuit of best practices by digitalizing multiple areas to electronic TOA formats. Each initiative aims to support clinicians in providing a structured and standardized handover process.<br>With each new area onboarded into this digital format, we have observed a notable decline in our indicator - the number of Transfer of Accountability Related Incidents. This decline has consistently surpassed our goals, demonstrating our commitment supporting our staff to ensure safe patient care. |

| Change Idea | Implemented? | Accomplishments & Lessons Learned |
|---|---|---|
| Improve the quality of ToA when patients are transferred from one unit/department to another by reviewing and refining the current ToA tool | Yes | Throughout the year, the Quality Team collaborated closely with multiple departments at MGH experiencing disproportionate TOA incidents within their services. Partnering with these teams and their receiving areas, we worked collaboratively with staff to refine their TOA processes, tailored to the needs of each stakeholder, while prioritizing the patient experience.<br><br>Our partnerships extended to the ER, Withdrawal Management Services, Inpatient Pediatric areas, and Diagnostic Imaging areas, where we focused on refining TOA processes to align closely with best practices. Through various strategies such as enhancing communication methods and digitalizing and standardizing TOA reports, significant progress was achieved across these areas. These efforts resulted in a remarkable reduction in TOA incidents within the organization, far surpassing our goals.<br><br>Furthermore, we launched a refreshed digital TOA audit tool, utilized by leaders throughout the organization as a foundation to support the quality of TOA on their respective floors. |
| **Standardize the quality of ToA from clinician to clinician on a unit** | Yes/Somewhat | Through an environmental scan of the best-practice components of a comprehensive bedside TOA process, we have integrated these key components into our TOA auditing process, that bridges into our IPASS framework. In turn, through the auditing process, our Clinical Resource Leaders then coach staff to integrate these refreshed core components into their daily shift report for a quality bedside TOA.<br><br>In-the-moment coaching is ongoing with CRLs and their staff through this Quality TOA auditing process. Currently, over 106 staff members have received TOA coaching sessions. However, due to the time involved in facilitating comprehensive TOA coaching sessions and the round-the-clock nature of our staffing schedules, we do not anticipate that we will reach our target of providing in-the-moment coaching to 80% of our total nursing staff. |
| **Develop recommendation for opportunities to standardize hand over between credentialed clinicians** | Yes | As part of our 2023/24 TOA Quality Improvement Plan, we formed a breakout group within our Medical Advisory Committee to develop an initial recommendation for a standardized and structured Transfer of Accountability report for our credentialed clinicians. This structured TOA process aims to standardize and enhance the quality of handover between credentialed clinicians, ultimately supporting patient safety.<br><br>A sub-group of our Medical Advisory Committee was established, which led to the initial recommendation of adopting a modified IPASS system as the chosen structured tool to facilitate credentialed clinician handover. |

# 2023/24 QIP Progress Report | Patient Satisfaction

Improve patient satisfaction with information provided at discharge

| QIP Indicator | Baseline | Target | Current Perf | Comments |
|---|---|---|---|---|
| % answering "Completely" to survey 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?" | 45 % | 47 % | | We've been working on PODS for several years, in various inpatient units, to hardwire the use of best practices that support patients and families understanding their discharge instructions. This year we met our target with the inpatient medicine units and we were able to develop fifteen new PODS for patient groups that did not have this resource. We will continue the PODS work as part of our QIP next year, and implement the best practice guideline on Transitions in Care (Registered Nurses Association of Ontario [RNAO])as we work toward Best Practice Spotlight Organization OHT in partnership with ETHP. |

| Change Idea | Implemented? | Accomplishments & Lessons Learned |
|---|---|---|
| Post Discharge Phone Calls (PDPC) using the Patient Oriented Discharge Summary (PODS) Framework | yes | PDPCs using Vocantas were rolled out to medicine inpatient units (T7, T8, T9). Warm follow –up calls were implemented by the Patient Experience team for patients with flagged responses from the automated call. Weekly dashboards were sent to unit leadership to share with staff, so they were able to track progress for patients' understanding of their discharge instructions. Staff were recognized for documenting PODS education in the health record (a metric that is tracked for our BPSO-OHT designation). Unfortunately, Vocantas stopped providing automated calls on December 31, 2023 and there are no other vendors that provide this service. As a result, four questions from the automated calls have been added to the Patient Experience survey that is sent out through Qualtrics. |
| Build staff capacity in health literacy (Teach back) | partial | Reviewed the content of the iLearn module for health literacy and teach back. All inpatient medicine staff have been enrolled and 52% have completed the module. This module is a required course in orientation for all new staff who will be working on inpatient medicine and surgery. In addition, didactic education sessions have been provided and 62% of staff have attended. We will continue this education until the end of March. While some in the moment coaching has been done, we will continue this work as part of the 2024/25 QIP work. |
| Create the environment for staff to have Patient Oriented Discharge Summary (PODS) conversations | yes | Fifteen new PODS have been developed and validated for the inpatient medicine population. We continue to identify opportunities to create additional PODS. PODS have been uploaded to iCare, making them readily available for staff to use.<br>We will continue to monitor staffs' documentation of PODS conversations as part of the BPSO-OHT work. We've been working on a formal process that outlines how to create, validate and refresh PODS. We will create a written reference tool for these processes as part of the 2024/25 QIP work. |

# 2023/24 QIP Progress Report | Falls with Harm Prevention

Reduction in Total Falls and Falls with Harm

| QIP Indicator | Baseline | Target | Current Perf | Comments |
|---|---|---|---|---|
| Number of patient falls with harm per thousand inpatient days. | 0.41 | ≤ 0.39 | 0.23 | The Fall Prevention Action Team (FPAT), is encouraged with the QIP work achieved this year. Falls with harm across the organization have decreased, consistently coming in under baseline and target month after month. The use of the audit tool and the success of information sharing across MGH – Legacy, Thompson Centre and Kew has been beneficial to the teams to work together towards standardized care. Although we did not fully meet our education plans, there will be new work put in place to re-invigorate this as we work towards Accreditation readiness. |

| Change Idea | Implemented? | Accomplishments & Lessons Learned |
|---|---|---|
| **Standardize and enhance auditing process for falls prevention strategies applied to patients at risk for falls** | Yes | An electronic audit was created and rolled out successfully to leadership across MGH. The ability to access results in real-time is beneficial to leaders as they can take this data back to the frontline and provide 'Just-In-Time' feedback and this information is also shared across programs. Leaders can share lessons learned with other teams. |
| **Provide re-education on falls prevention strategies to staff in alignment with the Accreditation Required Organizational Practice for Falls Prevention** | Partial | Although the work was completed in all the areas of by the recommended timeline of Q1:<br>• New Employee Orientation to MGH will include falls prevention strategies<br>• Update the Falls Standard Work for All Units poster to reflect changes in the Thomson Tower and to continue to support units in the Legacy building.<br>• For all new and existing staff:<br>  • Mandatory iLearn module: Falls Prevention<br>  • Unit education by Managers, Supervisors, CRLs and Quality Specialist<br>  • Training for use and access to all Falls Prevention equipment and patient education resources (i.e. socks, posey alarms, mats, etc.).<br>Not all areas were able to meet the target of 80% of all staff. This is partially due to staff and leadership turnover and other competing priorities. |
| **Improve tracking and documentation of falls over the course of a patient's hospitalization** | Yes | This report was created and the information is shared monthly by our data analyst at the monthly FPAT meetings. |
| **Review availability of falls prevention equipment required to meet patients' needs** | Yes | A complete inventory was completed and FPAT successfully obtained an equipment list to share with all the teams to ensure fall prevention equipment is available for leaders to obtain for their clinical areas. |
| **Review the call bell response time in the Thompson Centre.** | No | This metric was not able to be evaluated due to issues with Mobile Connex tool and the accuracy of the tools. |

# 2023/24 QIP Progress Report | Pressure Injury Prevention

Prevention of pressure injuries and reduction in the incidence of stage III and IV pressure injuries

| QIP Indicator | Baseline | Target | Current Perf | Comments |
|---|---|---|---|---|
| Number of hospital acquired pressure injuries, stage 2 or greater per thousand in-patient days | 1.20 | ≤1.10 | 0.67 | The Pressure Injury Prevention Action Team (PIPAT) continued to meet throughout the year to address QIP tactics and to review 'never event' action plans from unit teams. Some of the challenges were due to membership (changes in leadership) and attendance. This would hinder the roll out of some of the initiatives. As leadership is more stable and process and tools more formalized, future action items will be met.<br>Overall, stage III and IV have decreased across the organization. |

| Change Idea | Implemented? | Accomplishments & Lessons Learned |
|---|---|---|
| **Improve staging and assessment of pressure injuries across all in-patient units.** | Partial | Although pressure injury prevention curriculum was not able to be rolled out. Discussion did occur on the curriculum content. This will be a combination of didactic and iLearn.<br>PIPAT was able to expand skin rounds to some of the units – CCC and T9 |
| **Standardize process for implementation of RNAO best practice initiatives.** | No | This change idea was not completed as there was competing priorities within the eChart team. This item will rollover over to next year QIP. |
| **Improve tracking and auditing of Pressure Injuries hospital-wide** | Yes | An electronic audit tool has been developed with the PIPAT and planned to roll out for next year's QIP for Q4. The delay was due to the organizational change to MS Forms. |

# 2023/24 QIP Progress Report |Equity, Diversity, Inclusion and Belonging

Improve anti-black racism awareness through training

| QIP Indicator | Baseline | Target | Current Perf | Comments |
|---|---|---|---|---|
| Rate of staff and leaders completing mandatory Anti-Black Racism training | (new metric, not available) | ≥ 75% | 88% | In 2023/24 we surpassed our target for completion of the mandatory Anti-Black Racism training. 88% of our staff and 90% of our leaders successfully completed this training. |

| Change Idea | Implemented? | Accomplishments & Lessons Learned |
|---|---|---|
| Revise current communication practices for overall Mandatory Curriculum Training | Yes | An enhanced communication campaign was successfully developed and implemented to help increase Anti-Black Racism training completion. Completion rates were monitored and reviewed on a quarterly basis to inform a targeted communication approach. |
| Measure completion rate of all credentialed clinicians | Yes | Anti-Black Racism training was successfully incorporated as part of the annual credentialing process for our credentialed clinicians. |
| Measure completion rate of all new MGH hires with a start date within the reporting period | Yes | Anti-Black Racism training successfully incorporated into the new hire onboarding curriculum to ensure the learning is sustained as new staff join MGH. The iLearn Administrative dashboard was also configured to include monthly completion rate of the Anti-Black Racism training. |