SHN
SCARBOROUGH
HEALTH NETWORK

# Quality Improvement Workplan 2021-22

November 2021

SHN.ca

# Provincial direction for the 2021/22 is not available

- While Ontario Health (Quality) has not released its QIP guidance document for 2021/22, hospitals must continue developing a corporate QIP.
- The QIP process is entrenched into law through the Excellent Care for All Act and hospitals are required to develop one with Board approval.
- Indicators have been developed internally using guiding principles while challenging the status quo to “Set a New Standard for Exceptional Quality and Safety”.
- **At SHN, we will continue to share the Quality Plan internally and publicly while managing accountability through the Board Quality process**

# Guiding Principles of the Quality Improvement Plan

**Align indicators** with the seven dimensions of quality, and SHN strategy.

All indicators **drive performance** and are tied to a current or planned QI initiative.

Indicators should be **relevant** to the organization, represented by high quality **attainable data** and supported by evidence and best practice.

Indicators must be **driven from experience** surveys, patient and family advisory input patient relations data and/or safety incidents.

Initiatives will drive **local improvement** and support **strategic change**.

# SHN 2021-2022 QIP Indicators

| Quality Dimension | Quality Indicator | Current Performance (YTD Aug 2021) | Target |
|---|---|---|---|
| Efficient | Conservable Beds | 60 | 71 |
| Timely | 90P Time to Inpatient Bed (Mandatory) | 18.5Hrs | 20.9 hrs |
| Patient-Centred | % Positive Response – Did you receive enough information before discharge? (Priority) | 69.9% | 80.7% |
| Safe | Rate of patient harm per 1000 days (moderate +) | 0.9 | 0.6 |
| | Number of workplace violence incidents (Mandatory) | 97 incidents | Baseline to increase |
| Effective | Medication Reconciliation on Discharge (Priority) | 61.8% | 90% |
| | Repeat ED Visits for Mental Health (Priority) | 14.2% | 13.3% |

# QIP Workplan 2021/22

# Efficient Care

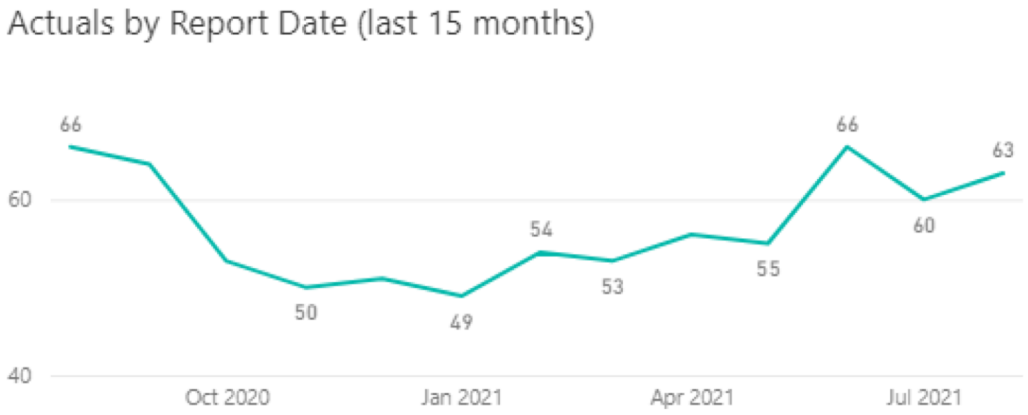
**Goal:** To utilize bed resources efficiently and safely for patient care

**Executive Lead – Dr. A Lauwers**

**Indicator:** Conservable Beds

**Definition:** The number of beds that might be conserved, if the hospital decreased the average ALOS from existing levels to benchmark

| FY2021 Target | Recommended Target FY2122 |
|---|---|
| 71 | 74 (new methodology and approach) |




| Change Idea | Methods | Process Measures | Lead |
|---|---|---|---|
| Refresh and spread **Advancing Care Daily** across all units. Including early mobilization and rehab referrals | • Estimated LOS targets updated in rounds and care planning<br>• Implement weekend bullet rounds | • ALC days<br>• Average LOS | Nancy Veloso, Director of Medicine, Transitional Care and Senior's Health<br>Dr. Elaine Yeung, Chief of Medicine and Transitional Care |
| Build on **ALC Diversion Strategies** | • Standard work for escalation of complex discharges<br>• Corporate Complex Discharge Rounds (CCDR) facilitates escalation processes | • ALC Days<br>• Avg Acute LOS<br>• % of patients with an ELOS documented | |

# Timely Care

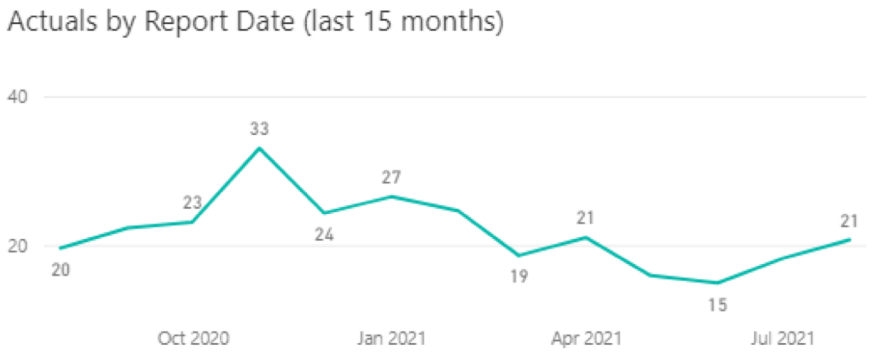
**Goal:** To improve the wait times in the Emergency Department for admitted patients

**Executive Lead – Dr. A Lauwers**

**Indicator:** Time to Inpatient Bed

**Definition:** 90th Percentile LOS from Time to inpatient bed for ED Patients from Admission Order to Leaving ED

| FY2021 Target | Recommended Target FY2122 |
|---|---|
| 20.9 | 20.9 (keep the same) |




| Change Idea | Methods | Process Measures | Lead(s) |
|---|---|---|---|
| Admissions are limited to patients that require inpatient acute care for more than 48 hours. All alternatives are explored to ensure anyone admitted could not be managed in a community care setting | • Assessment by GEM and HCC or SW before admission to understand if community management is possible<br>• Identification of complex clients at high risk of being ALC in ED during bullet rounds | • % of ALC within 48 hrs (pre-assessed by discharge team)<br>• % of attendance of GEM/SW/HCC staff in ED bullet rounds | • Frederick Go, Director of Surgery, Ambulatory Care and Patient Flow<br>• Nancy Veloso, Director of Medicine, Transitional Care and Senior's Health<br>• Dr. Norman Chu, Chief of Emergency |
| All patients and family are provided with an EDD shortly following admission **(dependent on EPIC)** | • Develop and implement a process for establishing the EDD (i.e. Quality Based Procedures, Case Mix Index, etc.)<br>• The EDD, discharge plan and discharge expectations are communicated to the patient/family within the first to 2-7 days of admission and documented on the patient chart<br>• Implement Whiteboard (WB) updating process on all inpatient units<br>• Use of real-time patient experience surveys to assess overall patient engagement | • % of patients with ELOS documented on whiteboard<br>• % of patients with communicated EDD within 2-7 days<br>• % of patients with documented EDD within 2-7 days by program<br>• % of WB utilized as designed per program<br>• % of **'top-two box'** for NRC-Picker survey question: Would you recommend this hospital to friends and family? | Frederick Go, Director of Surgery and Patient Flow |

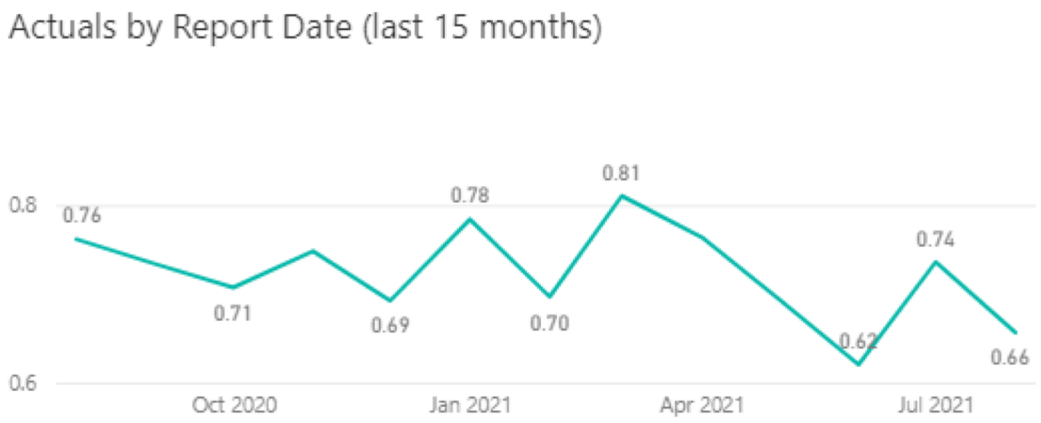
# Patient-Centred

**Goal:** To improve the patient and family experience

Executive Lead – G. Boatswain

**Indicator:** % Positive Response - Did you receive enough info. from staff prior to discharge? (LQ2F, QIP)

**Definition:** Percent of patients who responded positively (Completely or Quite a Bit) to "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? " question for inpatient Medicine, Surgery and Cardiology units.




| FY2021 Target | Recommended Target FY2122 |
|---|---|
| 80.7% | 80.7% (keep the same) |

| Change Idea | Methods | Process Measures | Lead(s) |
|---|---|---|---|
| **Optimize the information** given and supports provided to our patients post discharge | • Working with new CIS EPIC to align information provided on discharge process to align with the needs of our patient population<br>• Optimize existing internal and external resources to ensure a smooth transition from hospital to community | • Number of patients registered into "My chart"<br>• Number of patients referred to CELHIN rapid response nurse and post discharge follow-up clinics. | Stephanie Robinson, Director of Quality, Patient Experience and Patient Safety<br><br>Dr. Praby Singh, Medical Director of Quality and Patient Safety |

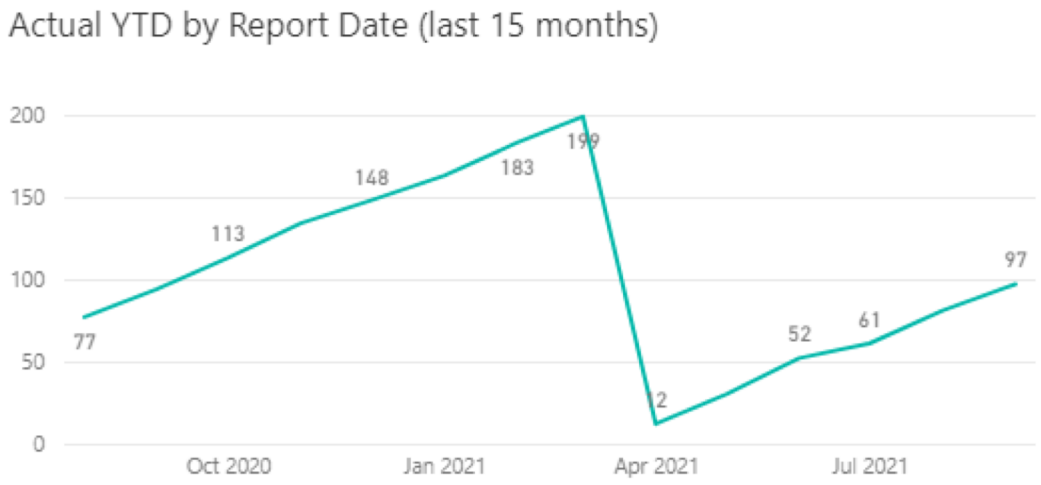
# Safe Care

**Goal:** To reduce harm caused to staff and physicians

## Executive Leads – M. James and G. Boatswain

**Indicator:** Workplace Violence Incidents

**Definition:** The number of reported workplace violence incidents by hospital workers.




| FY2021 Target | Recommended Target FY2122 |
|---|---|
| No target | No target |

| Change Idea | Methods | Process Measures | Lead(s) |
|---|---|---|---|
| **Flagging and Violence Assessment Tool** Implementation | • Implementation of paper tool in progress in all inpatient areas with iLearn module, huddles and education to staff<br>• EPIC implementation will allow for visible flagging in the chart | • # of incidents resulting in injury<br>• % of deliverables completed within timelines | Ann Sideris, Director of Workplace Health and Safety<br>Minette MacNeil, Director of Professional Practice<br>Dr. Joyce Zhang, Medical Director of Workplace Health and Safety |
| Purchase **staff duress systems** | • Request for Proposal (RFP) criteria features include Global Positioning System (GPS) tracking.<br>• Staff duress system will be sourced for Emergency Department and Mental Health Units (high priority areas) | • # of incidents resulting in injury<br>• % of deliverables completed within timelines | |
| Develop an **escalation process** for senior leadership awareness of workplace violence | • Provide visibility to senior leadership about incidents involving staff | • Process in place | |

# Safe Care

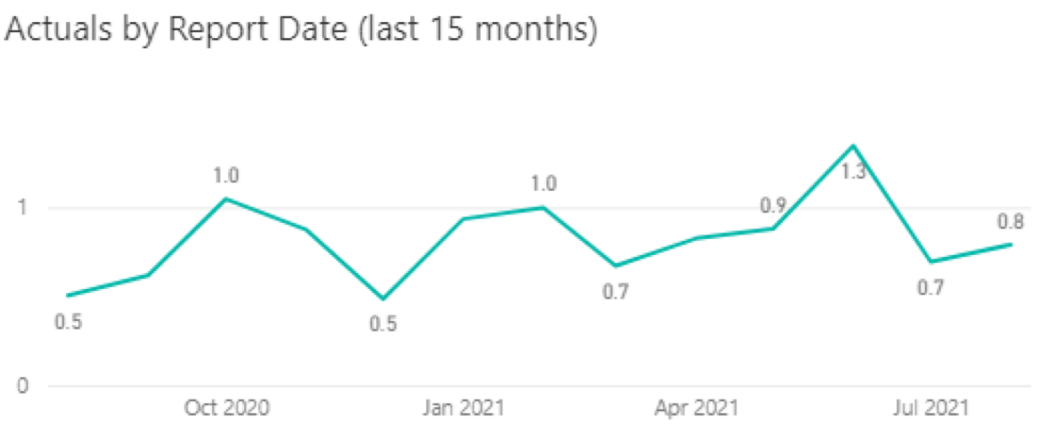
**Goal:** To reduce harm caused to patients

Executive Lead – R. Harvey and G. Boatswain

**Indicator:** Rate of patient incidents with moderate harm or higher (per 1000 patient days)

**Definition:** The number of patient incidents related to moderate and severe injuries for Inpatient and Day Surgery as a rate per 1000 patient days (excluding nurseries)

| FY2021 Target | Recommended Target FY2122 |
|---|---|
| 0.6 | 0.6 (keep the same) |




| Change Idea | Methods | Process Measures | Lead(s) |
|---|---|---|---|
| Develop a **comprehensive strategy for top Patient Safety** areas (i.e. Falls, Sepsis, Nursing Sensitive Adverse Events, Patients, Medication events) | • Workplan for Falls Prevention Committee<br>• Early Warning System<br>• Sepsis Early Identification Treatment and Prevention | • % of workplan completed | Stephanie Robinson, Director of Quality, Patient Experience and Patient Safety<br>Dr. Praby Singh, Medical Director of Quality and Patient Safety |
| Improve **patient safety incident reporting** and quality of care reviews | • Review opportunities to streamline and improve Quality of Care Review recommendation follow-up.<br>• Education of leaders on managing incidents. Escalation process for incidents that are remain open | • Number of QCR reviews and satisfaction with improvement plans<br>• Number or incidents that remain open/in progress | |

# Effective Care

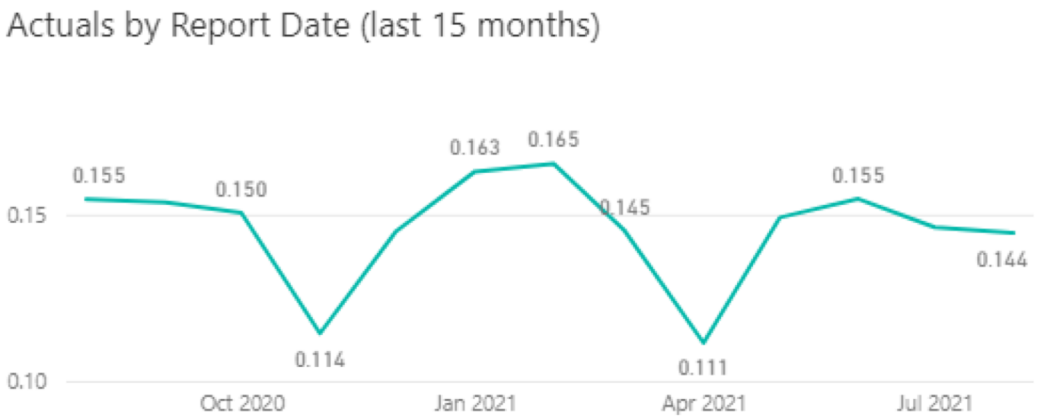
**Goal:** To provide appropriate care for mental health patients

Executive Lead – R. Harvey

**Indicator:** Repeat ED Visits for Mental Health patients

**Definition:** Percent of unscheduled repeat emergency visits following an emergency visit for a mental health condition

| FY2021 Target | Recommended Target FY2122 |
|---|---|
| 13.3% | 13.3% (keep the same) |




| Change Idea | Methods | Process Measures | Lead(s) |
|---|---|---|---|
| Initiate referrals to the Adult Crisis Clinic from the Emergency Department | • Develop pathway for Emergency physicians to refer to the Adult Crisis Clinic | • Number of referrals from the Emergency department<br>• Referrals contacted within 1 business day<br>• ED length of stay for mental health patients | Sari Greenwood, Director of Mental Health |
| Improve outreach to support further access to the RAAM clinic from Centenary and Birchmount | • Education to ED physicians who do not currently work in RAAM to increase comfort to initiate treatment | • Increase treatment starts (relevant to AUD or OUD) in the ED for follow-up in RAAM<br>• Drug utilization for OUD<br>• Referrals to medical Day-Detox Program | Dr. Ilan Fischler, Chief of Psychiatry |

# Effective Care

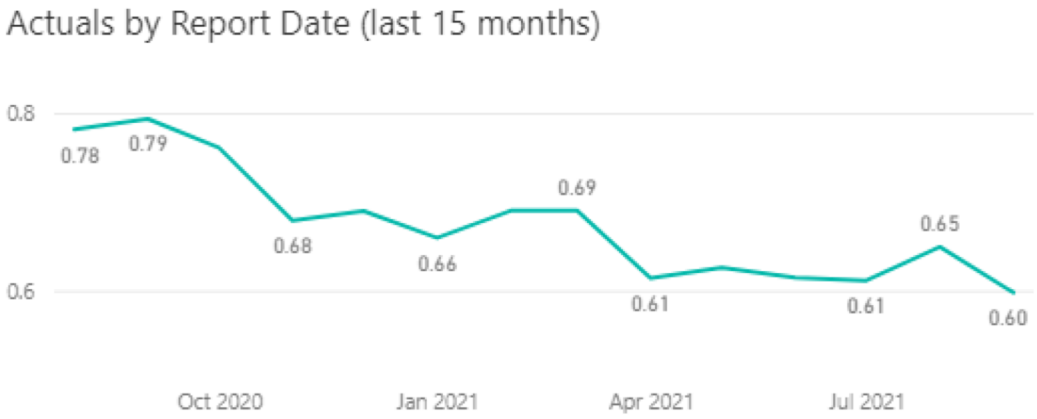
**Goal:** To enhance medication safety for patients

Executive Lead – G. Boatswain

**Indicator:** Medication reconciliation at Discharge

**Definition:** The percentage of BPMH has reviewed, completed and signed by MD based on the total number of audit (Total BPMH reviewed). Numerator (# of completed audit) divided by denominator (total audit)

| FY2021 Target | Recommended Target FY2122 |
|---|---|
| 90% | 90% (keep the same) |




| Change Idea | Methods | Process Measures | Lead(s) |
|---|---|---|---|
| Improve on established **process for medication reconciliation** at discharge processes (7 days a week) | • Evaluating the use of Pharmacy students over the weekends<br>• Discontinuation of the Ontario Drug Viewer | • % workplan completion | Shelley Dorazio, Director of Pharmacy Services |
| Review **medication reconciliation workflows** with the implementation of EPIC and provide education to physicians | • Hiring students to educate physicians 7 days a week<br>• Targeted education for programs with lower compliance | • Number of physicians educated<br>• Survey "Comfort level" with workflow | |

# Target Setting

| Indicator | Proposed Targets | Rationale |
|---|---|---|
| Conservable Beds | 74 | Using new methodology, we aim to save 1 bed for cases with 2+ conservable days above expected LOS. |
| Time to Inpatient | 20.9 hrs | Maintain previous target for QIP with internal targets set for each site. |
| % Positive Response - Did you receive enough info. from staff prior to discharge? | 80.7% | Maintain previous target which was based on the 2018/2019 Ontario GTA Average Top Two Box score for this question |
| Workplace violence incidents | No target | Improve reporting of incidents |
| Rate of patient incidents with moderate harm or higher (per 1000 patient days) | 0.6 | Maintain target from 2020/21 which was 5% improvement from 2019/20 |
| Repeat ED Visits for Mental Health patients | 13.3% | HSAA Target |
| Medication reconciliation at Discharge | 90% | Maintain and revisit target post EPIC implementation |

# SHN's 2021/22 QIP Board of Directors Approval

On November 9, 2021, our  2021/22 Quality Improvement Plan was approved by SHN's Chief Executive Office Liz Buller, President & CEO and signed-off by the following  members of SHN's Board of Directors:

- Board Chair: Matt Ainsley, Board Chair
- Board Quality Committee Chair:  Lianne Jeffs, Quality Committee of the Board Chair

# THANK YOU