2018/19 Quality Improvement Plan
Improvement Targets and Initiatives

Scarborough and Rouge Hospital - SRH (Birchmount, General and Centenary Sites)

Quality Dimension	Objective	Site	Improvement Indicator	Baseline Value (Q3 2016/17 to Q2 2017/18)	Target
Safe	**Reduce hospital-acquired infection rates**	**SRH**	**% Hand hygiene compliance before patient contact**	**89%**	**90%**

Change Idea #1

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Strengthen use of the Hand Hygiene Accountability Framework to increase transparency and accountability for hand hygiene performance at all levels of the organization	Percent of times an action plan was developed when unit level performance falls below target and/or required number of audits not completed	Hand hygiene performance data sent to unit and department leadership with links to action plan and leadership rounding supporting documents Action plans to address gaps in performance reported on a monthly basis through the tiered quality improvement huddles	100% adherence to completion of action plans to address performance gaps Spread across all inpatient clinical units by end of Q1 and outpatient areas in Q3	This change plan builds on foundational work established as part of the 2017-18 QIP. It is a multi-year strategy. This is year 2 of the change plan
	Percent of clinical units and departments that have current hand hygiene performance data visible in public areas within the unit	Adherence to posting of current unit level hand hygiene performance data monitored through quality checks completed by ICPs	100% of clinical units and departments have hand hygiene performance data displayed by end of Q1	Spread of this change idea was initiated in 2017-18. Opportunities exist to increase adherence and stabilize practice as standard work
	Corporate level hand hygiene performance data and information visible in public areas at each site	Engage Corporate Communications and PFAs to establish a format for public display of performance data and information e.g., signs, public TVs	Q1: review of the survey results, engagement of the PFAC, finalize top 3 strategies Q2: engage corporate communication and option for public posting,	Greater visibility will increase awareness of hand hygiene, promote success and support establishing a culture of openness for patients and families to ask questions and increase trust

			trail posting of the information Q3: spread the posting of information to the organization Q4: evaluate and revise as required	in their care providers' compliance
	Percent of hand hygiene audits completed by the interprofessional team	Train interprofessional team members to complete hand hygiene audits Establish a process for tracking and set a monthly target for number of hand hygiene audits to be completed by the interprofessional group	Training of 10 interprofessional staff by the end the Q1 Have a minimum of 30 hand hygiene audits completed by the Interprofessional team on a monthly basis by Q2	

Change Idea #2

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Communication Theme Point of Contact: Treatment Continue development of awareness campaign for patients and families about the importance of hand hygiene	Date awareness campaign established	Reduce patient and family factors that can contribute to hospital acquired infections Based on analysis, work with staff and PFAs to select interventions and design implementation plan Work with pilot units to trial interventions and complete PDSA cycles to refine strategies and methodology Develop a plan to spread the awareness campaign throughout the organization	Complete thematic analysis of patient, family and staff surveys conducted in by beginning of Q1 2018/2019 Completion of the analysis and intervention selection by the end of Q2 Implement intervention strategies on pilot units in Q3 Development of the spread plan by end of Q4	This change idea builds upon preliminary work started as part of the 2017-18 QIP change ideas

Quality Dimension	Objective	Site	Improvement Indicator	Baseline 16/17 to Q2 17/18	Target
Safe	**Reduce patient falls**	**SRH**	**Inpatient falls rate per 1,000 patient days (moderate/severe harm)**	**0.16**	**0.14**

Change Idea #1

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Raise awareness of staff on SRH falls prevention policy including focus on reducing use of restraints, post fall monitoring and conducting a debrief after all falls	Percent of staff educated on SRH falls prevention policy	Develop a learning package highlighting key points and revisions to the new SRH policy Create a timeline and methodology, identify resources and deliver education to staff	80% of staff receive education on the falls prevention policy by end of Q2	This change plan builds on foundational work established as part of the 2017-18 QIP. It is a multi-year strategy and the spreading to other units will form the basis of the change plan for future QIP cycles. This is year 2 of the change plan
	Percent of times the falls debriefing tool was completed after a fall	Develop communications and education plan for clinical units	100% of moderate/severe and 80% of all other types of falls has a falls debriefing tool completed. Completion rates to be tracked on a monthly basis by the Falls Prevention Committee	
	Reduction in the number of falls from bed rails	Include content on safe use of bed rails in education plan Implement safe/unsafe bed position and bed rail signage across all sites	50% reduction in falls over bed rails as incident type by Q3	

Change Idea #2

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Spread and strengthen implementation of unit specific falls prevention and injury reduction strategies	Percent of clinical units that have implemented unit specific falls prevention strategies	Complete a corporate inventory of falls prevention strategies in place on a quarterly basis Recruit falls prevention champion(s) for all clinical units Create an electronic falls prevention resource binder and make available through easily accessible intranet links Engage and involve patients and families in review of current status of falls and implementation of prevention strategies	100% of clinical units will have falls prevention strategies implemented to address the specific safety issues associated with their patient population by end of Q1 2 falls prevention champions recruited per clinical unit by end of Q2 100% of falls prevention initiatives are co-designed with patients and families. To be monitored through biannual falls prevention strategies audit	This change plan builds on foundational work established as part of the 2017-18 QIP. It is a multi-year strategy and the spreading to other units will form the basis of the change plan for future QIP cycles
	Standard work for purposeful rounding for falls prevention spread to inpatient units	Establish expectations for clinical team and leadership unit rounding in relationship to falls prevention Develop a corporate spread plan	80% of inpatient units will have purposeful rounding implemented by Q3	To facilitate accountability for patient safety

Quality Dimension	Objective	Site	Improvement Indicator	Current Performance	Target
Safe	**Enhance medication safety for patients**	**SRH**	**% Medication reconciliation at discharge**	**85%**	**90%**

Change Idea #1

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Communication Theme Point of Contact: Discharge/Transfer Refresh medication reconciliation communication and education for physicians, staff, and patients	Completion and rollout of identified communication and education methods	Multidisciplinary approach: (1) one of the monthly education focuses for nurses will include Medication Reconciliation (2) routine patient education (3) education for role of the unit clerk	(1) Completion of education refresh at monthly nurse training by May 2018 (2) Ongoing patient education across all sites (3) Create and publish education content for unit clerks by July 2018; 100% unit clerks trained by August 2018	

Change Idea #2

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Standardize discharge prescription form across all sites	Activation of form across all units at Centenary and training of physicians	Initial pilot on one Medicine unit at C site before full rollout; Provide physician education on the discharge prescription form	Form is live and 100% physicians trained across Centenary site by July 2018	Requires support from Medicine program and physicians.

Change Idea #3

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Communication Theme Point of Contact: Discharge/Transfer Roll out audit process for medication reconciliation at discharge across all sites	Percent of in-patients with medication reconciliation at discharge audit completed	Duplicate screens and reports from Centenary site Meditech to General and Birchmount sites after computer upgrade. Hands on training with unit clerks, Clinical Practice Leaders, and Managers	80% of in-patients across all 3 sites have the audit completed by June 2018	Requires IT support for form development following Meditech upgrade.

Quality Dimension	Objective	Site	Improvement Indicator	Baseline	Target
Timely	**Reduce wait times in the ED**	**SRH**	**90th percentile emergency department length of stay for complex patients**	**10.7**	**9.7**

Change Idea #1

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Implement a Virtual Medical Short Stay Unit (MSSU) in order to reduce Length of Stay (LOS)	Spread Medicine Short Stay Unit (MSSU) to General and Birchmount	Standardize processes at Centenary and expand to General and Birchmount Evaluate impact of MSSU at Centenary site to determine spread plan for General and Birchmount sites	MSSU operational across all sites by December 2018	

Change Idea #2

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Standardization of corporate overcapacity protocols for admitted patients waiting in ED	Corporate overcapacity protocols standardized and surge strategies are initiated when threshold criteria is met	Develop standard triggers for surge processes across all sites Identify groups of admitted patients with longest waits and develop standard, associated strategies	Corporate standard practice implemented by June 30, 2018 Data analysis completed by June 30, 2018	Patients requiring isolation and patients requiring specialized care, such as telemetry, are examples. Strong collaboration and partnerships with internal teams will support successful implementation.

Change Idea #3

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Reduce wait time for diagnostic test(s)	Percent of ED patients requiring ultrasound and CT scans who meet 2-hour turnaround time target	Understand variation in practice across all sites and develop associated strategies	70% of ED patients with ultrasound and CT scans will meet 2-hour turnaround time target by January 31, 2019	Extended ultrasound after-hours implemented across all sites in 2017/18.

Quality Dimension	Objective	Site	Improvement Indicator	Baseline Oct 2016 – Sept 2017	Target
Timely and Effective	**Reduce readmissions for Mental Health**	**SRH**	**Inpatient readmission back to same institution within 30 days of initial discharge**	**10.0%**	**10.0%**

Change Idea #1

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Retrospective readmission trend analysis	Number of charts reviewed to determine reason for readmission	Data analysis and chart reviews on readmitted patients to determine factors leading to readmission and develop associated strategies to address root cause(s)	Analysis/review complete by June 30, 2018	

Change Idea #2

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Communication Theme Point of Contact: Discharge/Transfer Improve availability of resources post-discharge for mental health patients	Number of discharge education packages created with involvement of PFAs	Establish a working group with PFAs to understand challenges experienced upon discharge that may lead to readmission Update and standardize the resources/information provided to mental health patients at time of discharge	Complete 3 discharge packages for mental health patients by December 2018	

Change Idea #3

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Develop an automatic flag to identify to staff when a mental health patient has been readmitted for a mental health-related condition	Daily report created to flag readmitted patients	Explore methods used at other organizations to flag readmitted mental health patients	Investigation of options completed by June 30, 2018	Requires IS department support to determine options in Meditech

Change Idea #4

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Communication Theme Point of Contact: Discharge/Transfer Implementation of post-discharge follow-up phone calls for mental health patients at-risk of readmission	Number of mental health patients called within a week of discharge	Based on the analysis of factors leading to readmission, determine criteria for patients at risk that would benefit from a follow-up phone call Develop and implement standard work for follow-up calls	Standard work implemented by December 2018	

Quality Dimension	Objective	Site	Improvement Indicator	Current Performance	Target
Effective & Efficient	**Reduce COPD readmissions**	**SRH**	**30-day readmission rate to own facility – Chronic Obstructive Pulmonary Disease (COPD)**	**18.2**	**15.9**

Change Idea #1

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Communication Theme Point of Contact: Discharge/Transfer Revise and spread standardized COPD education on self-management and resources	Percent of COPD patients receiving the information package	Spread implementation of patient COPD education package to Medicine units across all sites	70% of COPD patients receiving the information package by September 2018	This change plan builds on foundational work established as part of the 2017-18 QIP. It is a multi-year strategy and the spreading to other units will form the basis of the change plan for future QIP cycles. This is year 2 of the change plan.

Change Idea #2

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Communication Theme Point of Contact: Discharge/Transfer Standardize and spread post discharge follow-up for COPD patients	Percent of COPD patients that are referred to a post discharge clinic Percent of COPD patients that receive post discharge follow-up call	Spread the COPD post discharge clinic follow-up clinic across all sites in alignment with QBP clinical handbook guidelines Spread post discharge phone calls for all COPD patients across the Medicine program	80% of COPD patients referred to a post discharge clinic at each site by September 2018 80% of COPD patients receive post discharge follow-up call by September 2018	COPD clinic only operates at Birchmount. Spread planning underway. Monitor monthly post discharge phone call report for trends/themes in gaps of information provided at time of discharge. Target of patient referred will be dependent on clinic being operational at each site.

Change Idea #3

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Integrate the COPD discharge order set into the discharge planning process on the inpatient units	Percent of COPD discharge order sets utilized	Develop standard work to initiate COPD discharge order set within bullet round process for discharge	70% of COPD patients with a COPD discharge order set in their chart by June 2018	

Quality Dimension	Objective	Site	Improvement Indicator	Current Performance	Target
Effective & Efficient	**Increase Patient Satisfaction**	**SRH**	**% Patient Satisfaction: 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? (medicine inpatients)**	**45.9%**	**53.3%**

Change Idea #1

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Communication Theme Point of Contact: Access/Entry Discharge/Transfer Spread the utilization of a unit specific information brochure for all medicine units at SRH	Percent of patients that receive the information brochure	Customize each unit based procedure to reflect specific features of medicine units across the program Work with PFAs to determine what follow-up instructions/ information and contact numbers are required in the brochure to support transition from hospital to home if patients are worried and/or have questions post discharge	70% of patients receive the information brochure per medicine unit by September 2018	Draft brochure developed with PFA input to co-design for pilot unit. Spread plan underway.

Change Idea #2

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Communication Theme Point of Contact: Discharge/Transfer Standardize and spread COPD education on self-management and resources	Percent of COPD patients receiving the information package	Spread implementation of patient COPD education package to Medicine units across all sites	70% of patients receive the information package by December 2018	Change idea is also noted for COPD readmission indicator.

Change Idea #3

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Communication Theme Point of Contact: Discharge/Transfer Develop and implement a standardized Patient Discharge Summary for patients and families	Percent of patients that receive the discharge summary	Engage PFAs to develop a template to be shared with patients/families to support discharge transition Develop a process to complete the discharge summary and share with patients/families Explore the PODS (Patient Oriented Discharge Summary) toolkit.	70% of patients receive the discharge summary by December 2018 on pilot unit	Consider 1-2 medicine units in initial pilot for implementation

Quality Dimension	Objective	Site	Improvement Indicator	Baseline (Q3 2016/17 to Q2 2017/18)	Target
Patient-centred	**Improve patient satisfaction**	**SRH**	**% Patient satisfaction: 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? (surgical inpatients)**	**45.9%**	**53.3%**

Change Idea #1

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Communication Theme Point of Contact: Access/Entry Treatment Discharge/Transfer Enhance communication with patients and families to help navigate hospital processes, address patient expectations and improve patient experience	Develop standardized 'Your Surgical Journey' booklet Streamline and standardize information provided in Pre-Admit clinic Develop more comprehensive discharge education material for patients and families	Review existing patient communication brochures to standardize into one booklet Review and refine existing patient education materials and staff education points for pre-admit clinic across all sites to achieve standardized content Review and standardize discharge education to ensure explanations of what medications are for and their side effects	Patient Handbook is standardized across all sites and in multiple languages by December 31, 2018 Pre-admit clinic patient education material is standardized across all sites and in multiple languages by December 31, 2018 Patient discharge education materials augmented with information patients indicate as useful by December 31, 2018	

Quality Dimension	Objective	Site	Improvement Indicator	Baseline Q3 2016/17 to Q2 2017/18	Target
Patient-centred	**Improve patient satisfaction**	**SRH**	**% Patient satisfaction in the ED: Would you recommend emergency department?**	**48.8%**	**50.2%**

Change Idea #1

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Communication Theme Point of Contact: Access/Entry Treatment Discharge/Transfer Standardize and spread a framework to gather real-time feedback from patients	Percent of patients and/or their families that provide real-time feedback while in the ED	Implementation of Patient feedback survey within mobile app “DashMD” platform Spread the use of patient feedback tool “I-Pillar” to Birchmount and General to capture real-time feedback from patients and families Process standardization for volunteers to gather patient feedback tickets	Gather feedback from at least 5 ED patients or family members per day per site by June 30, 2018	Currently I-Pillar is being used in the ED at SRH-C. PFAs are engaged on the working group for DashMD and volunteer initiative.

Change Idea #2

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Communication Theme Point of Contact: Access/Entry Treatment Discharge/Transfer Continue Kano analysis to understand patient expectations and identify factors influencing patient satisfaction and dissatisfaction	Kano analysis is completed across all sites	Engage PFAs in the design and process to conduct a patient satisfaction analysis using Kano model Develop implementation plan for top 3 attributes identified to improve patient satisfaction	Kano analysis is completed across all sites by June 2018	Service attributes could be physical layout, staff interactions, professionalism, and outcome of the service provided. Implementation plan will inform development of 2018-19 goals and objectives for the ED program.

Change Idea #3

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Communication Theme Point of Contact: Access/Entry Improve the availability of ED wait time information with patients/families	Wait times information displayed in the ED waiting room across all sites	IT to support continuous feed of data to live televised screen in ED waiting rooms Implementation of "What to Expect in the ED" information package within DashMD platform	Wait times displayed in the ED across all sites by September 2018 Mobile App "DashMD" available to patients at all 3 EDs by June 30, 2018	General and Birchmount previously had wait time data shared in ED but requires a continuous reliable connection.

Change Idea #4

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Communication Theme Point of Contact: Access/Entry Improve the patient experience by timely acknowledgement upon arrival to the ED	Number of ED staff trained in customer service model Patients greeted by volunteers in ED waiting room during peak hours	Implementation of Communicate with H.E.A.R.T customer service model Re-integration of volunteer greeters in the ED with standard work	80% of ED staff across all sites are trained in customer service model by January 31, 2019 Volunteers present in the ED 12 hours daily by June 30, 2018	PFAs engaged in the development of volunteer initiative

Quality Dimension	Objective	Site	Improvement Indicator	Current Performance	Target
Patient Centred	**Ensuring efficient, timely and optimal support for patients and families with negative experiences/complaints**	**All**	**% of complaints closed within 60 days**	**94%**	**98%**

Change Idea # 1

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Educate team and stakeholders on harmonized patient relations policy	Education across all sites completed by April 30, 2018	Create an educational package on the patient relations process and deliver to teams and key stakeholders Consistent application of Patient Relations Policy across all sites	100% of newly on boarded Complaint Leads (Program Managers, Directors and Chiefs) will receive education and support on the harmonized Patient Relations policy.	Ongoing policy/process refreshers will be offered based on trends complaint resolution improvement opportunities identified.

Change Idea # 2

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Patient relations representative to offer local/program level support based on identified complaint trends	Consistent patient relations support tri site to programs identified with an increased volume and/or repeated similar themes of complaints	Complaint trends analysis, including the analysis of patient relations surveys (administered biannually). Build capacity for point of service complaint resolution	90% of patients and families surveyed would access patient relations support in the future by July 31, 2018.	

Quality Dimension	Objective	Site	Improvement Indicator	Current Performance	Target
Our People	**Overall Incidence of Workplace Violence**	**SRH**	**# of reported incidents of workplace violence**	**establishing baseline**	**establishing baseline**

Change Idea #1

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Establish a Corporate Workplace Violence Prevention Committee	Committee meets as scheduled to monitor progress of work	Establish mandate and schedule for committee Develop a work plan and communication strategy for the committee that will address the action items surfaced during the Rapid Improvement Event	Committee meets as scheduled by end of Q1 2018/19	

Change Idea #2

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Develop a process for assessing patients for acting out/violent behaviours and a methodology for identifying risk to the care team and others	Number of patients identified as at risk for acting out or violent behaviours (establish current state) No change or a decrease in the number of incidents with moderate/severe harm AND/OR Decrease in the number of incidents resulting in lost time at work	Implementation of a patient risk assessment tool Conduct an environmental scan of systems and processes used to identify risk to the care team and others Select and trial a patient identification system on pilot units	Patient risk assessment trialed on pilot unit(s) by October 2018 External environmental scan completed by June 2018 Internal environmental scan completed by July 2018 Visual identification system trialed on pilot units by September 2018	

Change Idea #3

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Improve processes for reporting violent incidents	Increase in the number of reported violent incidents	Review and standardize fields and use of online incident reporting tool	Standardized reporting process across SRH by end of 2018/19	

Change Idea #4

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Assess the level of risk for workplace violence across the organization	Number of units assessed using Public Service Health and Safety Association (PSHSA) Environmental Risk Assessment Tool	Review current state of each unit and department using PSHSA tool Develop risk mitigation plans for Mental Health and Emergency, the areas in the hospital at the highest risk for workplace violence, based on results of the assessment	30% of units and departments assessed by end of 2018/19 Risk mitigation plans for Mental Health and Emergency developed by end of September 2018 At least one strategy from risk mitigation plan initiated by December 2018	