SHN
SCARBOROUGH HEALTH NETWORK

SHN's Quality Improvement Plan (QIP)

2023/24 Progress Report & 2024/25 QIP Work Plan

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2023/24 YTD Q3 QIP Progress Report

Progress of 2023/24 QIP Indicators and Change Ideas

Quality Dimension	Quality Indicator 2023/24	Current Performance YTD	Target	Change Idea	Status of Work
Efficient	Conservable Beds- **Custom Indicator**	79 (Nov 2023)	74	Implement **Alternate Level of Care (ALC) Strategies** outlined by SOHT's cQIP	In-Progress
				Optimizing the **Estimated Discharge Date (EDD)** to set a target date for discharge	In-Progress
Patient Centered	Did patients feel like they received adequate information about their health and their care at discharge? **Priority Indicator**	81.1% (Dec 2023)	75%	Improve the rate of **MyChart activations**	In-Progress
				Implement **new patient experience platform (Qualitrics)**	Implemented
Safety	Rate of Hospital Acquired Pressure Ulcers per 1000 discharges- **Custom Indicator**	3.5 per 100 Discharges (Dec 2023)	4.6 per 1000 Discharges	**Implement specific unit-based action plans** to increase accountability and spread best practices	In-Progress
				Improve the quality of the Hospital Acquired Pressure Injury data though validation of the EPIC documentation	In-Progress
	Number of Workplace Violence Incidents – **Priority Indicator**	155 (Dec 2023)	155 Year (116.3 ytd)	Increase the number of staff attending **workplace violence education sessions**	In-Progress
				Leverage workplace **Violence Unit Level Risk Assessments (RA)**	In-Progress
				Conduct a comprehensive analysis of incident trends through a **quarterly review process**	Implemented

Status of work: Implemented | In-progress | Not Implemented

Progress of 2023/24 QIP Indicators and Change Ideas

Quality Dimension	Quality Indicator 2023/24	Current Performance (YTD)	Target	Change Idea	Status of Work
Effective	Medication Reconciliation on Discharge – **Priority Indicator**	92.2% (Dec 2023)	90%	**Improve data quality** within Epic through Regional Working Group and SHN Taskforce	Implemented
				Education of physicians to improve medication reconciliation workflow with a focus on targeted programs	Implemented
	Repeat ED Visits for Mental Health – **Custom Indicator**	17.3% (Oct 2023)	13.3%	**Build real-time EPIC reports** for patients returning to the ED	Implemented
				Implement individualized care plans for patients that have a high number of Emergency Visits for MHA related reasons	In-Progress
				Optimize schedules and align resources for MHA in the ED to meet patient demand	In-Progress
Health Equity	Number of Staff Attending Education/Training Sessions On Diversity, Health Equity, And Inclusion- **Custom Indicator**	1921 (Dec 2023)	2500 1875 (ytd)	**Reduce barriers to optimizing the patient experience** for marginalized, racialized and vulnerable population	In-Progress

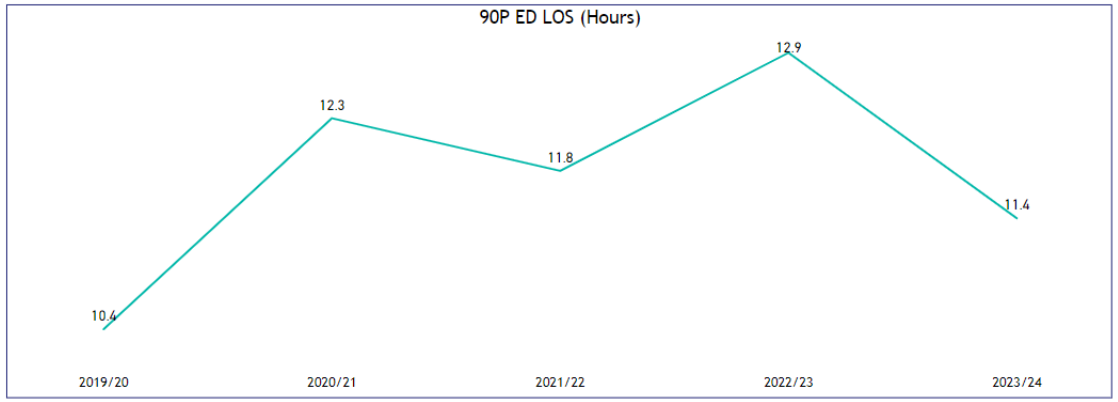
Status of work: Implemented | In-progress | Not Implemented

2024/25 QIP Work Plan

Timely Care

Indicator: 90 percentile emergency department length of stay (admitted and non-admitted)

Definition: Emergency department length of stay is the duration (total time elapsed) between time of triage or registration (whichever occurs first) and the time the patient leaves the emergency department



23/24 YTD	24/25 Proposed Target
11.4 Hours (Nov 2023)	10.4 Hours

Change Idea	Methods	Process Measures/Target	Lead
Establish **Standard Work for** Emergency/In-patient departments regarding **communication/TOA for Bed Ready** including an escalation process for any barriers that are leading to delays	• Establish standardized processes by defining clear roles, responsibilities and communicating protocols to ensure consistency in communication/TOA for Bed Ready • Establish a process to meet target to bed ready 45 minutes from bed ready to In-patient pull	• Standard work regarding communication/TOA has been developed and implemented into daily practice • Confirmed bed ready 45 minutes from bed ready to In-patient pull process developed	**Fred Go** Associate Vice-President of Clinical Program-Division Augment Surgery
Develop **net-new post-bed meeting standard work**: EVS/Transport, Bed Allocation and Patient Flow	• Establish a post bed meeting standardized process by defining clear roles, responsibilities that represent the best way to increase efficiency	• Standard work for each role (EVS, Transport, Bed Allocation and Patient Flow) developed and incorporated into daily practice	**TBD** Director of Patient Flow
Spread the Birchmount Emergency Department **Front End Model** to the Centenary and General Emergency Departments	• Develop a plan to incorporate lessons learned from the pilot at the Birchmount Hospital and spread the Front End Model in a phased approach to the Centenary and General Emergency Departments. • Establish reporting mechanisms and performance monitoring for continuous quality improvement	• Plan for spread has been developed and implemented at Centenary and General Emergency Departments • Reporting mechanism and performance monitoring developed and implemented	**Vlad Padure** Director of Emergency, Critical Care and Respiratory Services **Dr. Norman Chu** Chief and Medical Director, Emergency Medicine

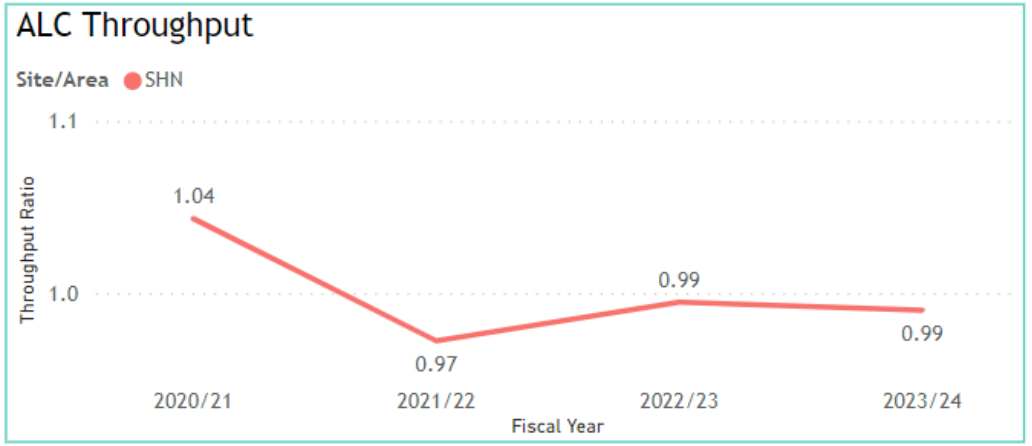
Data Source: National Ambulatory Care Reporting system

Efficient Care

Indicator: Alternate Level of Care (ALC) throughput

Definition: ALC throughput ratio reflects the rate at which patients are being discharged versus designated ALC in a given period. A rate of greater than 1 is desired.

23/24 YTD	24/25 Proposed Target
0.99 (Sept 2023)	1.0



Change Idea	Methods	Process Measures/Target	Lead
Develop **Standard Work** for proactively **identifying Estimated Date of Discharges (EDDs) for the weekends** on Fridays	• Develop standard work and implement into daily bullet rounds • Retrospective review of Monday's discharges to see if any additional strategies would have supported a weekend discharge and incorporate those learnings into future discharges.	• Increase weekend discharges to 20% • Decrease weekend ALC orders • 80% of the discharges over the weekend were identified on the previous Friday	**Nancy Veloso** Director of Medicine and Transitional Care **Dr. Alexis Gordon** Chief and Medical Director, Medicine
Behavioural Support Transition Team (BSTT) to support **the transition of patients** with responsive behaviours to return home/alternate facilities.	• Patients who have responsive behaviours are identified in bullet rounds and referrals to the BSTT team are made.	• Increase in the BSTT referral volumes to the target of 300 patients.	
Enhance the **HomeFirst philosophy** by early identification (day 3) for reactivation/rehabilitation needs to support the transition home.	• Leverage bullet rounds to proactively identify reactivation/rehabilitation need on day 3 of the patient's admission	• 80% of patients have their reaction/rehabilitation needs assessed on day 3 of their admission	

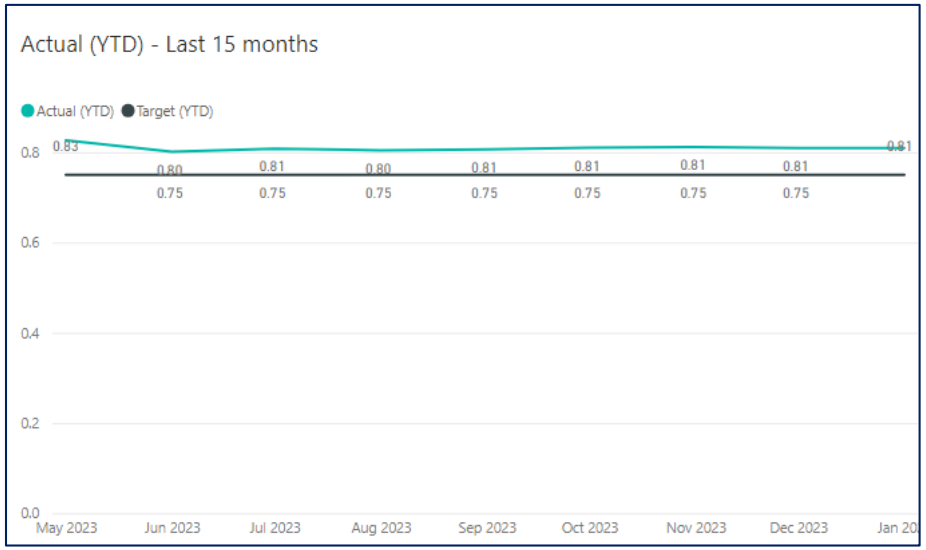
Data Source: Wait time information system

Patient-Centred

Indicator: Did patients feel like they received adequate information about their health and their care at discharge?

Definition: Percentage of respondents who responded “completely” or “quite a bit” to the following 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?”

23/24 YTD	24/25 Proposed Target
81.0% (Jan 2024)	85%



Change Idea	Methods	Process Measures/Targets	Lead
Increase the **utilization of Lexicomp** in EPIC to provide comprehensive health information to our patients at discharge	• Develop and implement a strategy to increase the utilization of Lexicomp in EPIC	• Strategy to increase utilization of Lexicomp is developed and implemented across SHN Inpatient Programs. • Lexicomp utilization has increased by 20%	**Melitta Chan** Interim Director of Quality, Patient Safety and Patient Experience **Dr. Ilan Fischler** Chief & Medical Director, Psychiatry
Utilize feedback from patient experience surveys from Qualtrics platform to identify **discharge specific improvements**	• Disseminate analyzed survey responses to leadership and departments to address improvement opportunities • Action plans are developed and implemented	• All survey responses are analyzed and sent to leadership and program heads and action plans are created.	

Data Source: Hospital Collected Data April 2023 to March 2024

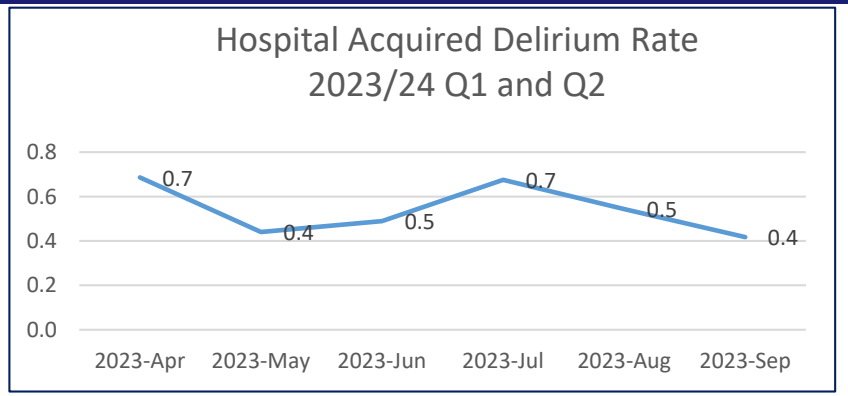
External Collaborator: Central East Region EPIC Hospitals

Safe Care

Indicator: Rate of Hospital Acquired Delirium among inpatient hospitalizations in acute care

Definition: Rate of Hospital Acquired Delirium among inpatient hospitalizations in acute care. The indicator is presented as a proportion of all hospitalizations.

23/24 YTD	24/25 Proposed Target
0.6 (2023/24 Q1/Q2)	0.55



Change Idea	Methods	Process Measures/Target	Lead
Explore opportunities to **reduce Benzodiazepines and other-hypnotics** in older adults who have had Orthopaedic Surgery post fracture.	• Review Post-Operative order sets for opportunities to decrease Benzodiazepine and hypnotics usage • Encourage other non-Benzodiazepine strategies for sedation post operatively with a focus on Orthopaedic surgeons. • Awareness and education for Medicine Internists who co-manage surgical patients.	• All Orthopaedic Order Sets have been reviewed • Current usage has been evaluated and opportunities to reduce usage explored • Data for Benzodiazepine usage by provider is shared with providers	**Dr. Mark Glube** Medical Director Anesthesia **Fred Go** Associate Vice-President of Clinical Program-Division Augment Surgery
Implement Best Practice Guidelines for reducing delirium in older adults within the Medicine and Seniors' Health Program	• Leverage RNAO Best Practice guidelines for reducing delirium in older adults. • Delirium and Confusion Assessment Method (CAM) screening education provided to 100% of new nursing staff	• 95% of eligible patients are screened using the Confusion Assessment Method (CAM) tool	**Minette MacNeil** Director Interprofessional Practice and Allied Health **Nancy Veloso** Director of Medicine and Transitional Care
Reduce dehydration and improve nutrition status prior to surgery	• Utilization of Evidence Based protocols for NPO timing pre-operatively • Utilization of Evidence Based Carbohydrate Protocol	• 20% reduction in patients who are NPO longer than the evidence based protocol	**Dr. Mark Glube** Medical Director Anesthesia **Fred Go** Associate Vice-President of Clinical Program-Division Augment Surgery

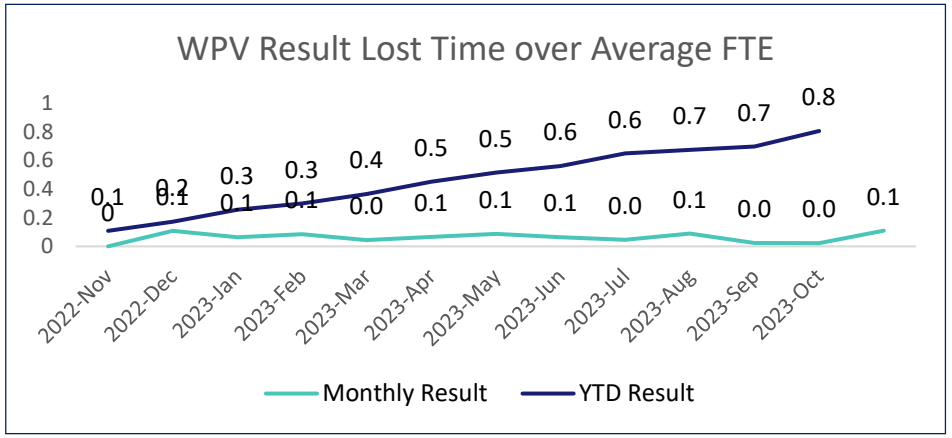
Data Source: Discharge Abstract Database

Safe Care

Indicator: Workplace Violence Incidents Resulting in Lost Time

Definition: The rate of reported workplace violence incidents resulting in lost time reported by hospital workers within a 12-month period.

23/24 YTD	24/25 Proposed Target
0.8 (Oct 2023)	0.76



Change Idea	Methods	Process Measures/Target	Lead
Development of a **WSIB dashboard** that facilitates data driven actions by providing visibility to metrics of allowed claims by type (lost time vs no lost time).	• Dashboard is developed initially across programs and further optimized to provide visibility at the department level	• Dashboard developed and 100% of units are included in dashboard	**Ann Sideris,** Director Workplace Health and Safety **Minette MacNeil,** Interprofessional Practice and Allied Health
Leverage **Workplace Violence Unit Level Risk Assessments** and action plans to mitigate risk across all programs	• Unit level risk assessments completed and information is analyzed to identify potential risk and implement preventive measures across all programs	• 100% of high-risk units completed annually • 100% of the lower risk units completed every 3 years	
Track and **analyze incidents by type** (e.g. patients, staff, physicians)	• Develop Unit Level Safety Plans that addresses potential threats and risk to employees are developed and implemented	• 100% of units that are identified as requiring support have unit level safety plans in place	

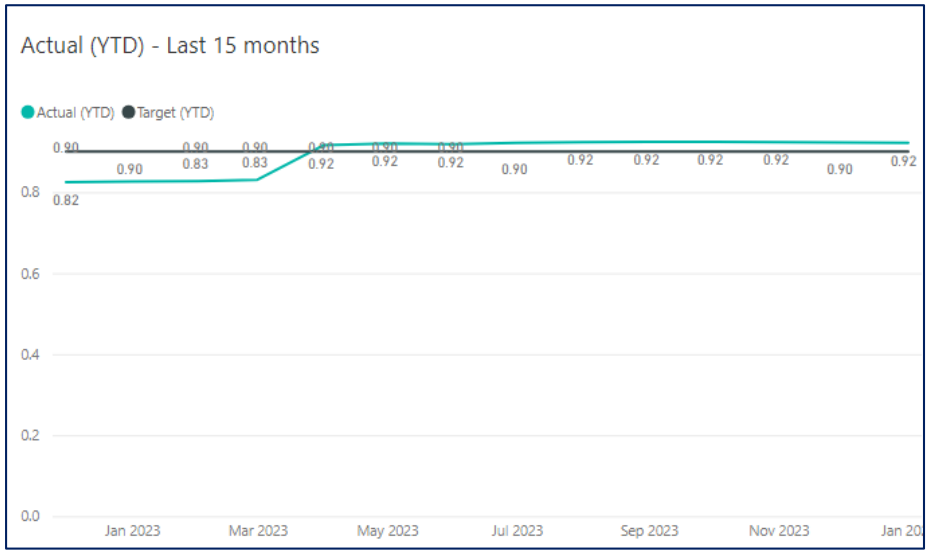
Data Source: Parklane Internal Data Source

Effective Care

Indicator: Medication Reconciliation at Discharge

Definition: Number of discharged patients for who a Best Possible Medication Discharge Plan was created out of the total number of discharge patients.

23/24 YTD	24/25 Proposed Target
92.2% (Jan 2024)	90



Change Ideas	Methods	Process Measures	Lead
Maintain **Discharge Medication Reconciliation** data quality within the EPIC (Regional Working Group and SHN Monthly Task Force)	• Regional Med Rec Working Group continues to review Medication Reconciliation improvements • Optimizing the dashboards in EPIC	• EPIC Dashboard monitoring ongoing • Data accurately reflects the performance for Discharge Medication Reconciliation	**Swasti Bhajan** Director of Pharmacy Services **Dr. Susan John** Medical Director of Pharmacy
Education of physicians to maintain medication reconciliation performance with a focus on targeted programs	• Targeted education on areas with the most improvement needs and leverage learnings from higher performers	• The percentage of physicians educated	

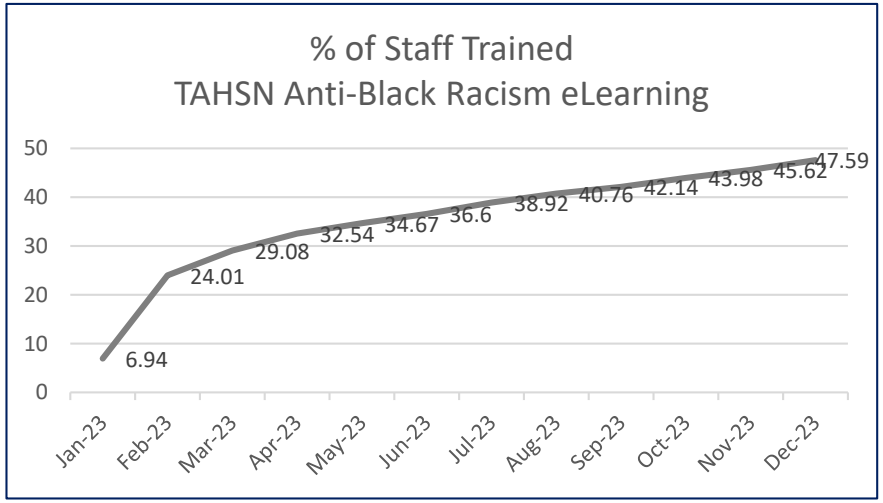
Data Source: Hospital Collected Data through EPIC

Equitable Care

Indicator: Percentage of staff who completed relevant equity, diversity, inclusion and antiracism education (For this indicator, SHN will focus on the TAHSN Anti-Black Racism eLearning module.)

Definition: Percentage of staff participating in equity, diversity, inclusion and antiracism education during reporting period

23/24 YTD	24/25 Proposed Target
47.59% (Dec 2023)	75%



Change Idea	Methods	Process Measures/Target	Lead
Launch a **refreshed communication strategy** to share the purpose of, and promote completion of, the **TAHSN Anti-Black racism eLearning module** across SHN.	• Utilize existing forums, trainings, meetings and communication avenues (e.g. PeopleFirst Compassionate Care, Stand Up for Health (SU4H), My Network News, Directors' Forum, Managers' Forum, Leadership Forum, MAC, targeted email messages, Staff Town Halls, new hire orientation, ICARE huddles, etc.) to promote the purpose and encourage completion of the TAHSN Anti-Black Racism eLearning module • Engage SHN's Equity Diversion and Inclusion (EDI) network to act as champions in promoting this eLearning (e.g. Communities of Inclusion, Health Equity Certificate Program participants and graduates, SU4H facilitators, etc.)	• Communication strategy to promote completion of, the TAHSN Anti-Black racism eLearning module across SHN is developed and implemented .	**Christa Hruska** Director, Health Equity & Health System Integration

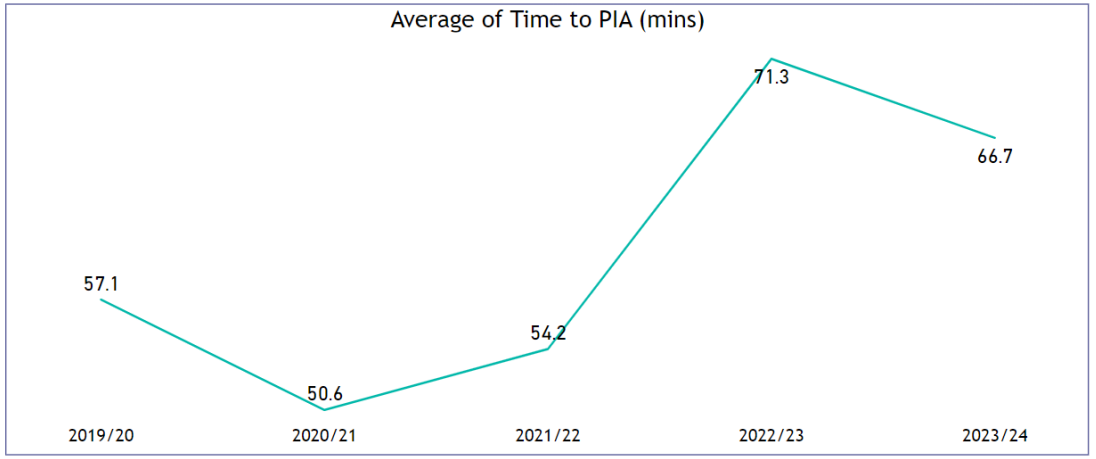
Data Source: Hospital Collected Data

Equitable Care

Indicator: Average ED wait time to PIA for individuals with Sickle Cell Disease (CTAS 1 or 2)

Definition: Emergency Department wait time to Physician Initial Assessment (PIA) is the duration (time elapsed) between triage and physician initial assessment for patients with Sickle Cell Disease who have been triaged CTAS level 1 or 2.

23/24 YTD	23/24 Target
66.7 (2023/24 Q2)	15 mins



Change Idea	Methods	Process Measures/Targets	Lead
Provide **Emergency Department and Pediatric Clinicians** with **education and training** to ensure timely and appropriate identification, triage, and treatment of patients presenting with Sickle Cell Disease	• Leverage Sickle Cell Awareness Group of Ontario's (SCAGO) educational modules • Nursing focused Lunch and Learns • Simulation training exercises • Physician focused education	• 80% of ED and Pediatric staff have completed Sickle Cell Disease Education	**Dr. Peter Azzopardi** Chief of Pediatrics **Michelle O'Connor** Director, Women and Children's Program **Dr. Norman Chu** Chief and Medical Director, Emergency Medicine **Vlad Padure** Director of Emergency, Critical Care and Respiratory Services
Adapt and leverage existing order sets to support the prompt assessment and treatment of patients with Sickle Cell Disease	• Existing order sets have been reviewed and adapted to improve the time between triage and PIA • Strategy to increase the utilization of the Sickle Cell Disease order sets has been developed and implemented	• All existing Sickle Cell Disease order sets have been reviewed and updated as required • 10% Increase in SCD order set utilization each quarter	
Optimize **EPIC to flag known patients with Sickle Cell Disease** upon presentation to the Emergency Department	• Flagging of Sickle Cell Disease patients have been implemented in EPIC • Staff are educated on the purpose of the flag and BPAs are utilized to improve timeliness of care to PIA	• Flagging and BPA process has been initiated in EPIC • All Emergency Room Staff and physicians are aware of the flagging	

Contact Information

If you would like to learn more about the activities described in Scarborough Health Network's 2024/25 QIP, please contact Melitta Chan, Interim Director of Quality, Patient Safety & Patient Experience at mchan1@shn.ca