# 2019/20 Quality Improvement Plan (QIP)

| Quality Aims | Goals | Measure | YE 2017/18 | | Current Performance YTD Q3 2018/19 | | 2019/20 Target | | | | Planned improvement initiatives (Change Ideas) | Methods | Process measures | Goal for 2019/20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Outcome Indicator | MSH | BH | MSH | BH | MSH | MSH Target Rationale | BH | BH Target Rationale | | | | |
| Safe | Eliminating preventable harm or death caused by healthcare associated infections (HAI) commonly experienced by patients in the delivery of care | C.Difficile - nosocomial (rate per 1,000 patient days) | 0.42 | 0.04 | 0.36 | 0.05 | 0.31 | Best Achieved Elsewhere | Maintain Indicator to be monitored through Infection Prevention & Control Committee | | Implement targeted strategies to improve appropriate antimicrobial prescribing (MSH) | Conduct quarterly hospital-wide audits of antimicrobial prescribing appropriateness using the NAPS (National Antimicrobial Prescribing Survey) tool and share audit results with prescribers. | % Antimicrobial prescribing appropriateness | 10% Improvement from 66% to 73% |
| | | | | | | | | | | | Improve hand hygiene adherence (MSH) | Create a forum to share and spread hand hygiene change ideas and implement at unit level.<br><br>Validate hand hygiene opportunities and implement change ideas in ICU as part of the multi-center study | % adherence to hand hygiene | MSH - overall 42% e-monitoring, 95% direct observation for units without e-monitoring devices |
| | | C.Difficile - nosocomial (number of patients) | 42 | 6 | 29 | 6 | -- | -- | | | Ensure sufficient amount of dedicated equipment for patients in infection control precautions (MSH) | Develop and implement a fleet management strategy for dedicated equipment. | % project milestone | 100% |
| | | | | | | | | | | | Conduct regular environmental services cleaning audits (MSH) | Design and implement a quality auditing program to ensure best practice standards for cleaning are met. Audit findings are shared with staff as a learning and development opportunity | # of quality audits completed | 100 quality audits / year |
| | | Catheter associated Urinary Tract Infection (per 1,000 catheter days) | NA | -- | Medicine - 4.5<br><br>Surgery - 3.9 | -- | Medicine - 3.4<br><br>Surgery - 2.9 | 25% Improvement | -- | -- | Implement the catheter-associated urinary tract infection (CAUTI) prevention bundle (MSH) | Re-launch the CAUTI prevention bundle in General Internal Medicine and launch in General Surgery. Bundle includes medical directives for insertion and discontinuation of indwelling catheters, use of nurse-driven removal of indwelling catheter guideline, use of catheter stabilization devices, and education of staff. | % of full time nurses in GIM and General Surgery units educated on the prevention bundle<br><br>% Adherence to medical directives (GIM and Surgical Units) | 80%<br><br>GIM Units - 75%<br>Surgical units - TBD |
| | | In-hospital sepsis (per 1,000 discharges) | 6.4 | -- | NA | -- | CB | New Indicator | -- | -- | Prevent and reduce central line infections by implementing best practice protocols (MSH - ICU) | Refresh the nursing staff education for use of Critical Care Ontario's central line prevention best practice toolkit in the ICU. | CLI per 1,000 Catheter Days<br><br>% of full time ICU nurses educated on best practice bundle | CB<br><br>80% |
| | | | | | | | | | | | Prevent and reduce surgical site infections by implementing best practices (MSH - Surgery) | Develop and implement targeted improvement strategies based on the data derived from the national surgical quality improve program (NSQIP) benchmarks | In-hospital sepsis occurring within 30 days of primary surgical procedure<br><br>% of full time surgical nurses educated on best practice bundle | CB<br><br>80% |
| Timely | Advance our system focus on throughput to ensure timely access to acute, complex, rehabilitative and community care for complex and specialized patients | New Indicator<br><br>Time to Inpatient Bed from Emergency Department (90th Percentile) | Not Applicable | | 18.4 Hours | | 18.4 Hours<br><br>Maintain performance of 90th percentile wait time of 18.4 hours. Sinai Health is the top performer among Ontario academic peer hospitals. | | -- | -- | Implement best practices to improve post-surgical care in the General Surgery population (MSH) | Refresh the use of Enhanced Recover After Surgery (ERAS) protocols post-surgery on 2 units (14 North and 14 South) | Conservable Days for 14N & 14S<br><br>% of FTE staff complete refreshed education on ERAS protocols | 14N - 35%<br>14S - 27%<br><br>80% |
| | | | | | | | | | | | Enhance communication between the General Surgery and GI Clinical Teams (MSH) | Establish and conduct multi-disciplinary General Surgery-GI rounds to determine patient care plans | General Surgery-GI rounds being conducted every week | TBD |

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| Timely | Advance our system focus on throughput to ensure timely access to acute, complex, rehabilitative and community care for complex and specialized patients | New Indicator<br><br>Time to Inpatient Bed from Emergency Department (90th Percentile) | Not Available | | 18.4 Hours | | 18.4 Hours<br><br>Maintain performance of 90th percentile wait time of 18.4 hours. Sinai Health is the top performer among Ontario academic peer hospitals. | | -- | | Improve flow by smoothing the elective surgical schedule (MSH) | Complete review and implement a strategy that will optimize the operating room utilization to match to surgical volumes and inpatient and ICU bed capacity. | % project milestone | 100% |
| | | | | | | | | | | | Implement Oculys bed management system on surgical units (MSH) | Re-design workflow to support the roll out of the electronic white boards and Implement the use of estimated discharge date | # of units with Oculys visual management implemented | 10 units |
| | | | | | | | | | | | Ensure timely discharge on patients expected date of discharge to conserve inpatient days and improve patient flow (BH) | Develop and implement a tracking and visual management tool to ensure estimated discharge dates are visible. Monitor new indicators 'conservable days' through adherence to expected discharge date.<br><br>Complete needs assessment and determine a strategy for procurement and implementation for Oculys. | Orthopedic Length of Stay: Hip, Knee, Hip Fracture | Hip & Knee - 11 days<br>Hip Fracture - 23 days |
| | | | | | | | | | | | Implement geographic cohorting for GIM patients to enable accountable care unit design principles (MSH) | Re-design and implement processes related to geographic cohorting including bedside rounding with patients and families, standardization of discharge planning, and appropriate staffing (MD, RN, Allied) ratios that meet variation in demand to ensure team balance. | Conservable Days (GIM)<br><br>% project milestone for geographic cohorting | 22.5%<br><br>100% |
| | | | | | | | | | | | Develop and implement ALC strategies (SHS) | Conduct root cause analysis and implement top 3 change ideas. | ALC Rate - acute medicine & CCC<br><br>ALC Throughput | Acute medicine: 22%<br>CCC: 23.2%<br>Throughput: 1.0 |
| | | | | | | | | | | | Maintain patient flow in the ED during redevelopment (MSH) | Develop a plan and operationalize the ED Annex | % project milestone | 100% |
| | | | | | | | | | | | Anticipate and manage unexpected patient volume surges in the Emergency Department by using predictive analytics (MSH) | Participate in Emergency Department forecasting partnership to anticipate and manage unexpected patient volume surges | % project milestone | 100% |
| | | | | | | | | | | | Enhance medical rehab system capacity to increase flow (BH) | Opening and operationalizing a new medical rehab unit. | % project milestones | 100% |
| | Advance our system focus on throughput to ensure timely access to acute, complex, rehabilitative and community care for complex and specialized patients | New Indicator<br><br>Time to Post-Partum Bed from Case Room | Not Available | Not Available | -- | New Indicator | -- | CB | -- | | Increase post-partum capacity to enhance patient flow from the case room (MSH) | Open and fully operationalize the 17th Level for post-partum care | % project milestones | 100% |
| | | | | | | | | | | | Develop and implement an enhanced nursing model to increase patient flow in triage (MSH) | Develop medical directives for nurses to establish a discharge disposition for the appropriate patient population (i.e. NST assessment and discharge from triage). | % meeting OTAS wait time for OTAS 4 and 5. | 45% within 120 minutes for OTAS level 4 and 5. |
| | | | | | | | | | | | Re-design workflow to enhance patient flow in triage for low acuity patients (MSH) | Develop and implement a streamlined process to care for patients who have repeat appointments for procedures such as IV iron, IVIG. | | |

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| Effective | Improve care outcomes by embedding best practices and innovation to meet fundamental patient care needs | Falls with injury (levels 3,4,5) per 1,000 patient days | 0.03 | 0.09 | 0.12 | 0.07 | 0.06 | 40% Improvement | 0.04 | 30% Improvement | Install SmartCells flooring in selected rooms on medical/surgical units (MSH)<br><br>Evaluate the effectiveness of SmartCells flooring (SHS) | Implement processes to triage high falls risk patients into SmartCells rooms.<br><br>Evaluate the effectiveness of SmartCells flooring across BH and MSH. | % of falls resulting in serious injury/death in the rooms with SmartCells flooring<br><br>Occupancy in the new SmartCells room with appropriate high risk patients | 0<br><br>80% |
| | | | | | | | | | | | Implement and evaluate falls video monitoring technology (SHS) | Operationalize video monitoring technology and implement processes to effectively triage high risk patients to receive the technology. | % of falls prevented/intervened in the rooms where the technology is being used to monitor at risk patients | >80% |
| | | Falls with serious injury/death (number of patients) | 2 | 10 | 4 | 2 | 0 | Theoretical Best | 0 | Theoretical Best | Increase mobilization by spreading a targeted mobility/walking program (MSH) | Implement a mobility/walking program to ensure early and increased mobilization to 1 unit | # of unit spread<br><br>% appropriate patients enrolled into the mobility program | 1 unit<br><br>70% |
| | Improve care outcomes by embedding best practices and innovation to meet fundamental patient care needs | Hospital acquired pressure injuries stage 2 and above (% of eligible patients) | 3.1% | 4.6% | 2.6% | 3.2% | 2.2% | 15% Improvement | 2.9% | 10% Improvement | Complete a gap analysis with Health Quality Ontario (HQO) & Healthcare Insurance Reciprocal of Canada (HIROC) healthcare associated pressure injuries (HAPIs) standards and implement targeted prevention and treatment strategies (SHS) | Ensure patients at high risk of HAPIs (low braden scores in activity and mobility) have a positioning plan in place and implemented (BH - 6th and 9th floors)<br><br>Develop and implement a set of targeted prevention strategies (MSH):<br>(1) Standardize and adhere to pressure injury assessment documentation frequency<br>(2) Develop an admission order set for pressure injury prevention and visual wound assessment trending in the electronic medical record<br><br>Develop and implement a set of targeted wound care management strategies (MSH):<br>(1) Develop a referral algorithm for wound care management<br>(2) Standardize advanced wound care supplies including dressings and equipment for debridement | % of patients at high risk of HAPIs have a positioning place completed and implemented<br><br># of stage 2+ hospital acquired pressure injuries on targeted units<br><br>Adherence to documentation frequency<br><br>% project milestone | 80%<br><br>Reduce by 10%<br><br>75%<br><br>100% |
| | | Hospital acquired pressure injuries stage 2 and above (number of patients) | 31 | 65 | 19 | 34 | -- | -- | -- | -- | Develop a strategy for procurement and management of pressure redistribution devices (SHS) | Current state analysis of pressure re-distribution surfaces and develop a fleet management strategy (SHS)<br><br>Develop a support surface choice algorithm (MSH) | % project milestone | 100% |

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| | | Outcome Indicator | MSH | BH | MSH | BH | MSH | MSH Target Rationale | BH | BH Target Rationale | Planned improvement initiatives (Change Ideas) | Methods | Process measures | Goal for 2019/20 |
| Effective | Improve care outcomes by embedding best practices and innovation to meet fundamental patient care needs | Medication incidents (levels 3,4,5) causing serious harm/death (# of incidents) | NA | 0 | 1 | 0 | 0 | Theoretical Best | 0 | Theoretical Best | Implement closed-loop medication management system (SHS) | Complete pharmacy renovation, procure and implement the automation technology in the pharmacy (MSH)<br><br>Complete implementation of computer physician order entry (CPOE) , eMAR and bedside medication verification on 14 units (BH) | % project milestone<br># of actual incidents and near misses leaving the pharmacy<br><br>% project milestone | 100%<br>0<br><br>100% |
| | | | | | | | | | | | Implement technological solution for monitoring of respiratory status in high risk patients (MSH - surgical units - narcotic use) | Develop criteria/protocol based on technological solution, educate staff, and implement on 1 pilot unit | % project milestone | 100% |
| | | % Reduction in BPSD symptoms among diagnosed patients | Adopted 2 quality statements | | *NEW Indicator*<br><br>Collecting Baseline in 2018/19 across SHS | | CB | | | | Build team capacity and skills to support the care of older adults living with complex medical conditions and associated behavioural changes (BH) | Educate staff on the Transitional Care Unit (TCU) on the P.I.E.C.E.S. framework for assessment and supportive care strategies to promote patients' physical, intellectual, emotional health, by maximizing their capabilities, social and physical environment, and social self. | % full time staff on TCU trained | 80% |
| | | | | | | | | | | | Automation of BPSD pathway and patient care plans (MSH) | Collaborate with Informatics to build (1) the electronic decision support pathway for patients identified with BPSD and (2) BPSD care plans into Cerner/Powerchart. | % of patients with BPSD have pathway initiated<br><br>% of patients with BPSD have care plans initiated | 80%<br><br>80% |
| | | | | | | | | | | | Implement non-pharmacological interventions to promote a supportive physical and social environment (SHS) | Implement a communal dining program for patients on the Transitional Care Unit. (BH)<br><br>Conduct a current state analysis and trial the use of animated toys (pets and dolls) for patients with BPSD. (SHS)<br><br>Complete an environment assessment and implementation of strategies to reduce exit seeking and unsafe wandering behaviours on the Transitional Care Unit (BH) | % of patients participating in dining program<br><br># of appropriate patients offered animated toys<br><br>% Project milestone | 60%<br><br>CB<br><br>100% |

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| | | **Outcome Indicator** | **MSH** | **BH** | **MSH** | **BH** | **MSH** | **MSH Target Rationale** | **BH** | **BH Target Rationale** | | | | |
| Effective | Improve care outcomes by embedding best practices and innovation to meet fundamental patient care needs | Pain and opioid management (did everything to control pain) | | | | | | | | | Standardize pain assessment and re-assessment practices (SHS) | Implement comprehensive assessment and re-assessment practices including standardized documentation practices | % completion of comprehensive assessment<br><br>% completion of pain-re-assessment post-PRN medication | 80%<br><br>80% |
| | | General medicine | 57% | -- | 56% | -- | 62% | 10% Improvement | -- | -- | | | | |
| | | General surgery | 70% | -- | 70% | -- | 77% | 10% Improvement | -- | -- | Develop and implement a multi-modal pain management strategy for opioid naïve patients (SHS)<br><br>Explore other strategies to reduce opioid use in surgical patients such as the increased use of regional nerve blocks (MSH) | Develop and implement a multi-modal pain management strategy including: an order set for opioid naïve patients, education strategy for staff and patients/caregivers, and an automated report for opioid administration use (SHS)<br><br>Review opioid usage among surgical patients and identify other appropriate pain management options (MSH) | % project milestone<br><br>% project milestone | 100%<br><br>100% |
| | | Orthopedic rehab | -- | 66% | -- | 70% | -- | -- | 74% | 5% Improvement (NRC Benchmark) | Develop and implement a diversion prevention strategy (SHS) | Conduct a current state analysis and develop a diversion prevention strategy. Implement top 3 change ideas in 1 targeted area at BH and MSH | # of areas implemented | 2 |
| Person Centred | Be a top system performer in patient and staff experience through enculturation of Joy in Work and Patient & Family engagement strategies | **PATIENT & CAREGIVER EXPERIENCE** | | | | | | | | | | | | |
| | | Overall patient experience (would recommend) | 76% | 81% | 74% | 81% | 80% | 5% Improvement | 86% | 5% Improvement | Enact year 3 work plan for Cultivating Care: Caregiver Friendly Hospital and Community Hub: C- communication, A- caregiver assessment, R- caregiver recognition, E- education and resources, operationalize caregiver resource center (SHS) | Develop and implement workplans for NICU, as well as stroke and palliative care workstreams in partnership with WoodGreen and evaluate.<br><br>Co-design the space and contents of Caregiver Resource center. | # of family caregivers enrolled in E-rounds<br><br># of caregivers enrolled in CARERS<br><br>% project milestone | TBD<br><br>TBD<br><br>100% |
| | | | | | | | | | | | Spread and Sustain: Better Together Pledge - Family Presence Policy (SHS) | Assess feasibility and implement the Quiet Hours policy where possible at MSH. | % project milestone | 100% |

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| Person Centred | Be a top system performer in patient and staff experience through enculturation of Joy in Work and Patient & Family engagement strategies | Continuity & Transition | 66% | 63% | 64% | 66% | 69% | 5% improvement | 69% | 5% improvement | Enable spread of the Patient Oriented Discharge Summary (PODS) tools to the Chinese population to support safe and timely discharge (BH) | Partner with patients, caregivers, and external community agencies to co-design and develop culturally sensitive and translated discharge tools for the Chinese population as part of the Canadian Foundation for Healthcare Improvement (CFHI) Bridge to Home collaborative | % project milestone<br><br>% discharged patients in targeted population given discharge tool | 100%<br><br>80% |
| | | | | | | | | | | | **MEDICATION RECONCILIATION** | | | |
| | | | | | | | | | | | Roll out Cerner discharge medication reconciliation tool (MSH) | Re-design workflow to ensure the tool is used and medication reconciliation is completed on discharge. | % of discharge medication reconciliation completed for eligible patients (exclude WIH) | CB |
| | | | | | | | | | | | Spread BPMH and medication reconciliation to the remaining ambulatory care clinics (BH) | Engage with the ambulatory care team to re-design workflow to ensure BPMH and medication reconciliation are being completed as appropriated based on selected criteria | Implement in all appropriate ambulatory care clinics<br><br>% BPMH and medication reconciliation completed | All outpatient physician clinics<br><br>70% |
| | | Informed care | 53% | 49% | 51% | 55% | 54% | 8% Improvement | 59% | 5% Improvement | Spread access for MyChart Patient Portal (SHS) | Create workflow to enable patient enrolment across MSH and BH in alignment with electronic health card validation availability. | # of large volume registration areas at MSH<br><br>% project milestone at BH | 3 registration areas<br><br>100% |
| | | **STAFF EXPERIENCE** | | | | | | | | | | | | |
| | | Workplace Violence Incidents (# of reported cases) | 114 | | 78 | | 125 | | 10% Improvement in Reporting | | Reduce workplace violence incidents in targeted areas (SHS) | Implement specific interventions in targeted areas that have high volume of incidents (MSH - Emergency Department, 9 South; BH - Transitional Care Unit, Acquired Brain Injury Unit) | Reduction in # of workplace violence incidents in targeted areas | 10% reduction in workplace incidents in targeted areas |
| | | New Indicator<br><br>Psychological Safety | Not Available | | Not Available | | New Indicator | | CB | | Incorporate TASHN Escalation of Care into regular care processes (MSH) | Complete baseline assessment of the TASHN escalation of care ladder and implement 1 top change idea in one surgical area. | % project milestone | 100% |
| | | | | | | | | | | | Implement a second victims program (code lavender) to respond to team members who were impacted by patient safety events (MSH - WIH) | Design program, recruit and train staff, and launch in the Women's and Infant's Program. | % project milestone<br><br># of full time staff trained in targeted areas<br><br>Number of code lavenders called | 100%<br><br>80%<br><br>CB |