

Emergency Department Wait Times (CTAS 4/5)

| Quality Dimension | | Efficiency | | |
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| Objective | Reduce wait times in the Emergency Department (ED) | | | |
| Indicator | Emergency Department Wait times: 90th percentile ED length of stay for non-admitted patients assigned CTAS IV and V. | Target justification | This target represents a 12.5% reduction from baseline. The change ideas address opportunities identified by the Emergency Department and the anticipated impact to performance. In addition we have accounted for the impact of our major redevelopment in the ED and new patient care tower which place additional constraints on the ability to consistently and reliably flow patients through the organization. | |
| Unit / Population of Focus | Emergency Department/Patients Triage as CTAS 4 or 5 | Target | 4.5 Hrs | |
| Baseline Source / Period | NACRS/ (Q4 15/16-Q2 16/17) | Current performance (Baseline) | 4.9 Hrs | |
| Change Ideas | | | | |
| Planned improvement initiatives | Methods | Process Measures | Goal for Process Measures | Comments |
| 1) Optimize the utilization of the eCTAS system | <ul style="list-style-type: none"> a. Identify eCTAS champion to work with physician lead to complete audits, case reviews and identify improvement opportunities b. Champions will develop guidelines and principles to support triage staff interacting successfully with new software c. CLM and Director to review guidelines and principles with all triage nurses d. Measure improvements using weekly data reports individualized per nurse e. Report challenges back to emergency department and IT teams on a regular basis for immediate response and solutions | <ul style="list-style-type: none"> • # of case reviews completed by the champions • % of manual adjustments to decrease the acuity of eCTAS score | <ul style="list-style-type: none"> • 30 case reviews completed by April 2017 • 0% of manual adjustments to decrease the acuity of eCTAS score by March 2018 | eCTAS is an electronic tool to document and categorize patients' care needs and prioritize them by urgency upon arrival to the emergency department. |
| 2) Smooth staffing to match demand and capacity in ED Minor | <ul style="list-style-type: none"> a. Complete data analysis to identify bottlenecks in patient flow through minor b. Identify patterns and opportunities to change sequencing of shifts NP/MD/PA c. Adjust schedules to respond to high volume / acuity surges through objective measures d. Develop mechanism to monitor impacts of scheduling changes | <ul style="list-style-type: none"> • Develop recommendations for changes in shift sequencing based on data analysis • Number of instances when the high demand/acuity action plan is triggered | <ul style="list-style-type: none"> • Recommendations for changes in shift sequencing developed by April 2017 • Reduce the number of instances the high demand/acuity action plan is triggered by March 2018 | |
| 3) Optimize patient flow functions within ED Minor | <ul style="list-style-type: none"> a. Review current roles and responsibilities for different support staff in Minor b. Work with staff to identify gaps and opportunities to improve the flow of patients from arrival to discharge/admission c. Identify resource to observe and provide patient flow coaching to staff in Minor d. Revise processes and roles and responsibilities to facilitate flow e. Educate and implement improvements throughout the unit | <ul style="list-style-type: none"> • Reduce non-value add time from triage to initial assessment by care providers • Refined patient flow roles and responsibilities created | <ul style="list-style-type: none"> • Reduction in non-value add time from triage to initial assessment by care provider by March 2018 • Patient flow roles and responsibilities refined by October 2017 | |

Patient Discharge Satisfaction

| | Quality Dimension | Patient Centeredness | |
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| Objective | Improve patient discharge satisfaction | | |
| Indicator | Patient Discharge Satisfaction: The percentage of positive responses 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?" | Target justification | This target is based on the continued expansion of PODS to high-volume services which presently under perform the hospital in this metric, such as Orthopedics and General Internal Medicine. With a combined 9% increase on these services while maintaining performance on other services, this will allow us to achieve our target. |
| Unit / Population | % / All inpatient units | Target | 65.0% |
| Source / Period | NRC Picker Survey / (April-December 2016 Target based on NRC responses received by Mar 30,2017) | Current performance (Baseline) | 62.3% |

Change

| Planned improvement initiatives | Methods | Process Measures | Goal for Process Measures | Comments |
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| a) Continue rollout of patient oriented discharge summaries (PODS) to Cardiovascular Surgery, Trauma, Nephrology and General Internal Medicine | a. Work with multidisciplinary teams to create standardized PODS content for four new services b. Build service specific content into the electronic discharge system c. Partner with nursing education staff on each service to include an overview of teachback techniques as a part of staff education d. Implement PODS tool for patients discharged from each service | <ul style="list-style-type: none"> • Develop standard discharge teaching for all PODS services • % of full and part-time RNs to receive PODS overview on each service • % of patients discharged receiving PODS document prior to discharge | <ul style="list-style-type: none"> • Complete content development on all four services by December 2017 • 70% of full and part-time RNs complete training by March 2018 • 85% of patients to receive PODS prior to discharge on all implemented services by March 2018 | PODS is currently implemented on Urology, Neurosurgery, General Surgery/Acute Care Surgery (ACS), Cardiology and Orthopedics. The method for tracking the receipt of the PODS document will be based on discharge summary completion data. |
| b) Refine methods for delivering PODS content to patients | a. Review opportunities to deliver PODS content earlier in the patient's stay b. Where applicable, ensure content delivered in the pre-admission facility (PAF) is the same as material outlined in PODS c. Revise methods for tracking delivery of PODS to allow for clearer documentation | <ul style="list-style-type: none"> • # of services using "Care Guides" with their patients • Align PAF information with PODS templates • Develop metric to track delivery of PODS to patients | <ul style="list-style-type: none"> • Increase number of services using care guides to a minimum of two services by March 2018 • Update of PAF material to align with PODS material on a minimum of two services by March 2018 • Method to track the delivery of PODS is implemented by March 2018 | "Care Guides" are reusable placards that were developed to allow patients to receive discharge material earlier in their stay. Currently "Care Guides" are used on the Cardiology service for patients with a confirmed diagnosis. |
| c) Expand methods to obtain patient feedback regarding discharge experience | a. Utilize patient feedback phone calls for all services using PODS 48-72 hours post-discharge b. Qualitative evaluation of both patients and providers interacting with the PODS document on General Surgery/ACS c. Expand on-the-spot feedback to patients on day of discharge, to obtain real-time understanding of patient discharge experience d. Perform focus group with patients and families to help identify opportunities for improvement | <ul style="list-style-type: none"> • # of services where feedback phone calls are performed • Development of qualitative evaluation framework • # of services where day-of-discharge feedback services are completed • # of focus groups completed corporately | <ul style="list-style-type: none"> • 9 services where feedback phone calls are completed by March 2018 • Development of qualitative evaluation framework by May 2017 • 9 services perform day-of-discharge feedback by March 2018 • Complete patient focus group and compile recommendations by March 2018 | Recommendations for updating the use of PODS tool will stem from the evaluation, focus groups, and other feedback tools. Results will be compiled and put forward to the Patient Discharge Satisfaction steering committee for approval and implementation. |

Staff Safety

| Quality Dimension Safety | | | |
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| Objective | Improve staff safety in connection with patient mobilization | | |
| Indicator | The number of staff incidents related to patient mobilization including lifts, transfers and repositioning. | Target justification | Represents a 10% decrease in the number of staff incidents related to patient mobilization that result in injury. Although there are a small number of these incidents (n < 57) annually; any averted occurrences are better for our staff. |
| Unit / Population of Focus | # of incidents / All staff (excluding students and physicians) | Target | 51 |
| Baseline Source / Period | Internal Database /March 2015-April 2016 | Current performance (Baseline) | 57 |

Change Ideas

| Planned improvement initiatives | Methods | Process Measures | Goal for Process Measures | Comments |
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| 1) Develop a standard training process for onboarding Clinical Assistants (CAs) to safely mobilize patients | <ul style="list-style-type: none"> a. Conduct an internal scan of current education for Clinical Assistants(CAs) b. Conduct an external review of best practice for safe patient mobility c. Create educational material d. Develop methods to best provide material to CAs upon hire e. Identify and pilot on-boarding education on one ward unit and one intensive care unit (ICU) | <ul style="list-style-type: none"> • % of CAs on pilot units have completed patient mobilization education • Develop revisions to the Safe Patient Minimal Lift Policy and Procedures to incorporate education and training requirements | <ul style="list-style-type: none"> • 80% of CAs on pilot units have completed patient mobilization education by December 2017 • Revisions to the Safe Patient Minimal Lift Policy and Procedures incorporating education and training requirements is completed by March 2018 | Providing a safe workplace begins from day one for staff. Ensuring onboard training helps contribute to reduction in workplace incidents. |
| 2) Identify and implement improvements in high risk clinical areas | <ul style="list-style-type: none"> a. Joint Health and Safety Committee (JHSC) Over exertion Quality Improvement team to review injury/incident reports and identify high risk areas b. Complete root cause analysis of incidents and identify opportunities and trends based on the data c. Provide recommendations to JHSC for improvement d. Support the implementation of improvement initiatives | <ul style="list-style-type: none"> • Number of root cause analyses completed • Number of recommendations to reduce the number of patient mobility incidents implemented | <ul style="list-style-type: none"> • Four root cause analyses of incidents completed by March 2018 • Two recommendations in high risk clinical areas are implemented to reduce the number of patient mobility incidents by March 2018 | Proactive identification and management of hazards within the workplace allows for the reduction and/or elimination of incidents. |
| 3) Develop a method for ongoing education of frontline staff on safe mobilization of patients | <ul style="list-style-type: none"> a. Form working group with key stakeholder representation b. Complete internal and external review of patient mobilization education provided to frontline staff c. Identify opportunities and gaps to improve ongoing training for frontline staff d. Develop training plan for frontline staff e. Identify method(s) of training frontline staff | <ul style="list-style-type: none"> • Form working group with representation from Nursing and Health Disciplines Professional Practice, Education, Occupational Health and frontline staff • Identify method for providing ongoing education to staff regarding patient mobilization • Develop content of patient mobilization education for staff | <ul style="list-style-type: none"> • Working group formed with representation from Nursing and Health Disciplines Professional Practice, Education, Occupational Health and frontline staff by June 2017 • Method for providing ongoing education to staff regarding patient mobilization identified by December 2017 • Content developed for patient mobilization education for staff by January 2018 | There is an opportunity to increase the frequency of competency training for lifts and transfers. Training is not currently scheduled at regular intervals and is often initiated in response to an incident or new equipment. |

Hand Hygiene

| | Quality Dimension | Safety | |
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| Objective | Reduce hospital acquired infection rates | | |
| Indicator | Hand hygiene compliance: Number of times that hand hygiene was performed before initial patient contact during the reporting period, divided by the number of observed hand hygiene opportunities before initial patient contact per reporting period, multiplied by 100. | Target justification | This target represents the impact of a 5% to 10% increase on units implementing SmartPump and a 2% increase in all other inpatient units including four ICUs. |
| Unit / Population of Focus | % / Health providers in the entire facility | Target | 66.0% |
| Baseline Source / Period | Publicly Reported, MOH / January 2016 - December 2016 | Current performance (Baseline) | 63.6% |

Change Ideas

| Planned improvement initiatives | Methods | Process Measures | Goal for Process Measures | Comments |
|---|--|---|--|--|
| 1) Pilot test of SmartPump - Electronic Compliance Monitoring System | <ul style="list-style-type: none"> a. Assemble project team with participating units b. Test and validate SmartPump values through direct observation c. Identify timing and content of compliance reporting via SmartPump d. Provide education sessions to frontline staff upon rollout e. Designate a lead to review, disseminate and respond to compliance changes as necessary with support of Smart pump data | <ul style="list-style-type: none"> • % of units disseminating SmartPump data to frontline staff on a biweekly basis • % of units that increase their SmartPump derived compliance by 10% | <ul style="list-style-type: none"> • 100% of units disseminating SmartPump data to frontline staff on a biweekly basis, by March 2018 • 50% of units increase their SmartPump derived compliance by 10% by March 2018 | The eight units participating in the pilot have been randomized into either an early or late phase. This will allow the organization to test the impact of receiving regular performance data and how this when partnered with improvement efforts affects compliance. |
| 2) Implement an awareness campaign, highlighting hand hygiene importance from the patient's perspective | <ul style="list-style-type: none"> a. Support grassroots/unit-driven communications by linking with corporate communication team and infection prevention and control (IPAC) stakeholders b. Hold a focus group with patient and family advisors (PFA) to capture the importance of hand hygiene from patient's perspective c. Survey front-line staff to identify best practices for hand hygiene communications d. Implement time-limited corporate screensavers | <ul style="list-style-type: none"> • # of PFA focus groups completed • % of inpatient units who participated in a staff survey • % of inpatient units receiving corporate screensaver for at least 3 weeks | <ul style="list-style-type: none"> • 2 PFA focus group completed by October 2017 • 100% of inpatient units participated in a staff survey by August 2017 • 100% of inpatient units receive a corporate screensaver for at least 3 weeks by March 2018 | A number of units have started to develop material to support their staff in seeing the patient's perspective of the importance of hand hygiene. Our corporate teams will support these groups in developing and sharing their material. |
| 3) Support units in developing and implementing unit specific action plans to improve compliance | <ul style="list-style-type: none"> a. Review historical data with unit leadership and hand hygiene champions b. Discuss barriers and enablers, unit leadership to identify action plan c. Each unit to identify target for improvement for this fiscal year d. Unit to complete rapid cycle improvements and monitor progress via direct observation data reports and/or SmartPump data reports | <ul style="list-style-type: none"> • % of units that improve their compliance from baseline • % of units that achieve their unit specific target | <ul style="list-style-type: none"> • 90% of units improve their compliance from baseline by March 2018 • 50% of units achieve their unit specific target by March 2018 | The intensive care units were able to achieve a 14% improvement last fiscal year, this group will focus on sustaining their initiatives from last year and achieving small incremental improvements. |

Reduce unnecessary "routine" blood work

| Quality Dimension | | Safety | | |
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| Objective | Reduce repetitive 'routine' blood work for inpatients at St. Michael's | | | |
| Indicator | Volume of blood drawn per inpatient day* - The total number of blood draws for routine tests multiplied by the volume contained in a single blood tube (4.5ml) divided by the total number of inpatient days *Blood volume is based on routine tests only - CBC, Lytes, Creatinine, LFTs, PT and PTT | Target justification | This target represents a 10% reduction in blood volume per inpatient day for 'routine' testing and is reflective of the change ideas to provide ongoing education and orderset changes on the General Internal Medicine (GIM) service. | |
| Unit / Population | Mililiters per inpatient day, General Internal Medicine | Target | 5.64 ml per inpatient day | |
| Source / Period | Lab Information System (LIS) / October 2015 - September 2016 | Current performance (Baseline) | 6.27 ml per inpatient day | |
| Change | | | | |
| Planned improvement initiatives | Methods | Process Measures | Goal for Process Measures | Comments |
| 1) Partner with services to perform education and awareness campaigns on the harms associated with 'routine' blood work | a. Perform targeted education initiatives with the ordering clinicians on each unit b. Raise awareness through e-mail updates and poster reminders identifying the harms associated with unnecessary blood work c. Present education material at various rounds and education forums across the hospital | <ul style="list-style-type: none"> # of services with targeted education material # of sessions held which outline the harms associated with routine blood and opportunities for improvement | <ul style="list-style-type: none"> 9 services using targeted education material by March 2018 3 sessions held by March 2018 | At St. Michael's residents are the clinicians most commonly ordering blood work therefore resident education needs to be robust. Making residents partners and leaders of the education on their services will create a greater opportunity for success. |
| 2) Implement revisions to inpatient order sets | a. Systematically review inpatient order sets with key stakeholders on each service b. Identify open-ended orders and replace with applicable service specific orders that contain firm stop dates. c. On each service review design and accessibility of orders with key stakeholders to ensure admission order sets are easy to access. This will help guide ordering clinicians to the correct order set d. Monitor changes and review with stakeholders should additional changes be required | <ul style="list-style-type: none"> % of admissions where an admission order set was used on the GIM service % of patients with routine blood draws on 3 consecutive days on the GIM service % of "routine" tests sent as "Stat" blood work on the GIM service | <ul style="list-style-type: none"> 50% of admissions where an admission order set was used on GIM 45% of patients with routine blood draws on 3 consecutive days (reduction from 47%) 20% of all routine blood work sent "Stat" GIM service (maintains rate from baseline period) | An increase in stat blood work ordered would indicate that the order set changes may be hindering clinicians from ordering necessary blood work. This will be monitored as a balancing measure. |
| 3) Develop consistent feedback loop to ensure services are aware of their performance | a. Develop refined metrics and elicit feedback from service stakeholders b. Create and distribute a service specific scorecard utilizing key metrics related to bloodwork c. Develop a process for ongoing review and discussion of scorecard metrics with services to better understand further improvement opportunities | <ul style="list-style-type: none"> Create service specific scorecard # of services receiving routine blood scorecard | <ul style="list-style-type: none"> Service specific scorecard is created by July 2017 9 services receiving routine blood scorecard by March 2018 | The aim of the scorecard is to be a tool for service leaders to reflect on their ordering practices and identify opportunities for further investigation. |
| 4) Perform data analysis to identify opportunities for further intervention | a. Review blood volume drawn per in patient day on each service to identify opportunities for improvement outside of the GIM service b. Engage with clinician leaders on those services c. Develop change strategy tailored to their local environment | <ul style="list-style-type: none"> # of services engaged in active change initiatives | <ul style="list-style-type: none"> 9 services engaged in active change initiatives by March 2018 | |