Baycrest

Baycrest Hospital

2024-25 Quality Improvement Plan Workplan

Patient Experience (Inpatient Hospital): Percent positive responses ("always" and "most of the time") to the question - Are you kept well-informed about your progress in areas that are important to you?

2024-25 Target	Target Justification
80% in Calendar Year 2024 **Current performance:** 76% in calendar year 2023 (highest percent positive responses since 2017 – 80%)	In addition to the current focus on providing information upon on admission, the inpatient hospital units will expand efforts to ensure patients and families are kept well informed throughout their hospital stay. Information exchange is critical to ensure patients and families can be true partners in their care. The scope of this work will include efforts to ensure patient and family participation in decision-making and goal setting. The 2023 indicator regarding information provided upon admission will continue to be monitored via internal scorecards.

Change idea	Methods	Process measure	Target
Identify and capture patient and family preferred methods and frequency of receiving updates during their stay in the hospital	▪ Create an inventory of available communication methods ▪ Designate a role responsible for asking patients and families for their preferred communication method ▪ Determine process to inform the interprofessional team regarding preferences ▪ Explore location in the Health Information System (HIS) to capture preferred method and frequency for information updates	Percentage of new admissions on the pilot unit who have preferred method of receiving updates captured	100% by June 30, 2024
Communicate the estimated discharge date to patients and families, as well as revisions to the discharge date	▪ Explore roles on the interprofessional team to determine which role can support with communicating information related to discharge dates ▪ Outline standard work for communicating discharge dates	Collect baseline data for the metric "percentage of newly admitted patients who have their estimated discharge date communicated within 4 days of admission" on applicable units	By June 30, 2024
Expand patient and/or family presence at interprofessional rounds	▪ Conduct internal environmental scan of interprofessional rounds across all units ▪ Identify gaps in current structure for rounds and determine what opportunities exist to involve patients/families in interprofessional rounds	Spread learnings from the Behavioural Neurology unit to one Rehabilitation unit, with action plan outlined to implement	By September 30, 2024

	▪ Revise standard work for facilitation of rounds to include a section to communicate next steps to staff as well as to patients and families	patient/family presence at rounds	
Implement patient-centred whiteboards in each patient room	▪ Conduct internal environment scan of whiteboards ▪ Gather patient and family feedback on whiteboards ▪ Co-design patient-centred whiteboards with staff, physicians, patients and families	Percentage of units with a patient-centred whiteboard implemented in each room	100% by December 31, 2024

Safe & Effective Care: Pressure injury (PI) incidence rate, stage 2 or greater

2024-25 Target	Target Justification
0.18 in Quarters 1 to 3 **Current performance:** FY 2023-24, Q1-Q3 performance 0.11	Baycrest will continue its focus on pressure injury prevention. Although the target was met between Q1 to Q3 of 2023-24, the historical target of 0.18 will be maintained for fiscal year 2024-25. Improvement efforts will continue to focus on mobilization, repositioning and real-time tracking of pressure injuries, with a recommendation to shift to a revised indicator for 2025-26.

Change idea	Methods	Process measure	Target
Track incidence of Baycrest-acquired pressure injuries in real-time based on documentation in the Health Information System (HIS)	▪ Based on a gap analysis conducted in 2023-24, revise documentation fields within the current wound assessment intervention to capture new pressure injuries ▪ Generate monthly reporting to collect baseline data for revised outcome indicator (tracked via documentation in HIS)	Revised outcome indicator in place (with baseline data collected and validated)	By Dec 31, 2024 on all three complex continuing care (CCC) units
Implement and sustain a strategy for repositioning and mobilization	▪ Establish a process to conduct turning audits and clarify the definition of turning (such as full turn, partial turn, transfer from bed to chair) ▪ Identify resources to support turning audits ▪ Ensure turning audits are completed regularly and results are reviewed at improvement huddles	Percentage of all CCC patients who are at risk of pressure injuries and are repositioned every 2 hours	90% by September 30, 2024
Design a standardized process to maintain an inventory of equipment used for prevention and management of pressure injuries	▪ Identify gaps related to the inventory of pressure injury-related equipment ▪ Establish standardized process to maintain inventory ▪ Determine an action plan (phased approach with an initial focus on equipment supporting with repositioning and mobilization of patients)	Standardized process implemented	June 30, 2024
Ensure pressure injury risk assessment is completed for new admissions and interventions are tailored accordingly	▪ Develop an algorithm for Braden score follow-up and clarify organizational expectations for the frequency of re-assessment • Identify centralized location in the HIS to document tailored interventions for patients at risk for developing pressure injuries (based on algorithm developed)	▪ Percentage of new CCC admissions with a Braden score less than 18 who have interventions documented in the HIS as per developed algorithm	90% of new CCC admissions by September 30, 2024

		▪ Identify a method for tracking Braden re-assessment and appropriateness of interventions as per developed algorithm	September 30, 2024
Sustain standardized Wound Rounds across CCC units	▪ Design a centralized location in the HIS and process to capture discussions from Wound Rounds ▪ Dedicate quarterly touchpoints at working group meetings with a focus on Wound Rounds sustainability	Discussions from Wound Rounds captured in a centralized location in the HIS	All three CCC units by September 30, 2024

Safe & Effective Care: Percentage of patients screened for delirium within 24 hours of admission (rehabilitation units 7E and 7W)

2024-25 Target	Target Justification
90% Quarters 1 to 3 **Current performance:** 81% (median performance), 80% (average performance) in fiscal year 2023	The proposed target is ambitious noting that the rehabilitation program will also be transitioning from using the Confusion Assessment Method (CAM) to the 4AT Rapid Clinical Test for Delirium Detection.

Change idea	Methods	Process measure	Target
Transition from the CAM to the 4AT delirium screening tool. This change idea is required to improve screening rates; given that current methods are not seen as value-add as positive screenings are very infrequent.	The percentage of patients screened for delirium on admission using the 4AT will be monitored via organizational scorecards and unit-based performance boards. The ability to introduce real time notifications identifying patients without a 4AT completed will be explored.	Transition to the 4AT	April 30, 2024
Initiate tracking of delirium acquired during hospitalization.	Once a standardized location for the documentation of delirium diagnosis is confirmed, generate regular reports from the Health Information System (HIS).	Collecting baseline to inform future monitoring of the outcome indicator - delirium onset during hospitalization	December 31, 2024
Standardize the treatment of delirium through the introduction of order sets. Establishing standardized protocols following positive delirium screening and confirmed diagnosis not only supports safe and effective care, but reinforces the value of regular screening using a validated tool.	Audit the use of order sets for those patients with documented delirium diagnosis	Percentage of patients with documented delirium diagnosis whose treatment is guided by use of an order set	60% by December 31, 2024

Apotex & Hospital

Safe & Effective Care: Number of workplace violence incidents

2024-25 Target	Target Justification
450 reported incidents in calendar year 2024 **Current performance:** There were 407 incidents reported in calendar year 2023.	The target represents a 10% increase in the number of reported incidents. Internally, the lost time injury due to workplace violence will be monitored.

Change idea	Methods	Process measure	Target
Streamline the Safety Event Reporting System & clarify reporting requirements (e.g., responsive behaviours currently require the submission of two incident reports)	Comparison of the number of fields pre and post template updates	Reduced number of fields required to complete a workplace violence incident report	June 30, 2024
Communications campaign regarding the importance of workplace violence reporting and supports available	Regular status updates to monitor completion of the following activities: ▪ Launch of Violence/Harassment in the Workplace Posters – April 1, 2024 ▪ Leadership / management training - September 30, 2024 ▪ Huddles with point of care staff (Apotex, inpatient & ambulatory hospital)	All planned activities complete	September 30, 2024
Address all high priority recommendations as per the WPV Risk Assessment	Confirmation that all high priority risks have been addressed with review at the Intercorporate Coordinating Group	All high priority risks addressed	September 30, 2024
Update the Workplace Violence and Respect in the Workplace, Anti- Harassment and Discrimination Policy	Refresh the current policies to reflect emerging equity, diversity and inclusion considerations and enhance process clarity to ensure a standardized organizational response following incidents	Policy approved and changes communicated to impacted individuals	June 30, 2024

Equity: Percentage of client-facing staff and physicians who participate in equity, diversity and inclusion training

2024-25 Target	Target Justification
50% of part-time and full-time client-facing staff by Q3*	The proposed target is ambitious but reflects our commitment to ensuring client-facing staff are supported to provide inclusive care. Training will be provided through online and in-person learning opportunities. **Calculation excludes individuals who have not completed their probationary period*

Change idea	Methods	Process measure	Target
Outline and execute an equity, diversity and inclusion (EDI) organizational curriculum for the year, leveraging expert speakers	Through oversight provided by the Organizational Effectiveness and Corporate and Hospital Human Resources Departments, regular learning opportunities (formal and informal) to advance EDI will be identified and provided. Session completion will be tracked.	Date of first session /event Total number of education sessions offered / topics covered within calendar year 2024	May 2024 Five
Expand completion of relevant EDI e-Learning modules (confirmation of modules completed by April 31, 2024)	e-Learning module completion will be tracked through Surge and Learning Management Systems EDI learning opportunities will be explored for volunteers	Percentage of Hospital and Apotex staff who have completed relevant modules	40%
Provide education to staff and physicians on the use of available technology with the goal of increasing the number of interpreter-supported encounters	Track the number of interpreter-supported client encounters	Number of interpreter-supported client encounters	Average of 72 encounters per quarter
Roll-out the “we ask because we care” campaign in the Hospital which aims to support teams to understand how health equity information can be used to provide inclusive care	Under the leadership of the Organizational Effectiveness department and Hospital leaders, participation in “we ask because we care” training sessions will be tracked	Percentage of Hospital staff who have participated in the education (individuals who have not completed their probationary period excluded)	60% of part-time and full-time client-facing staff by Q3
Inventory current health equity initiatives, learning opportunities and resources available to Baycrest for use or adaptation	Under the leadership of the Measuring Health Equity Working Group, findings will be presented to the Apotex and Hospital Quality Committees	Inventory and report summarizing current health equity activities and resources complete	June 30, 2024