2019/20 Quality Improvement Plan

"Improvement Targets and Initiatives"

Baycrest Hospital (North York) 3560 Bathurst Street

Measure							Change			
Measure/Indicator	Unit / Population	Source / Period	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure
Total number of alternate level of care (ALC) days contributed by ALC patients within the specific reporting month/quarter using near-real time acute and post-acute ALC information and monthly bed census data	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July - September 2018	12.59	13.97	Target reflects Hospital Services Accountability Agreement		1)Implement revised policy, process and tools including patient and family facing information.	Monitor progress of development of the streamlined information package according to the project plan.	Implementation of revised policy, process and tools including patient and family facing information	Revised package will be complete by end of Q1 and implemented by end of Q2.
							2)Implement a method that streamlines documentation and enables visual management of patient flow and discharge/transition plan milestones, to enhance team communication and trigger interventions to facilitate patient flow.	Monitor milestones against project plan. Develop evaluation method (i.e. survey) for managers and team members who regularly participate in patient flow and ALC-avoidance processes, and review results.	Implementation of new system. % positive responses to survey.	New process implemented by the end of Q3. 80% of team members surveyed view new process favourably by end of Q4.
# of new patients accessing Ambulatory care services	Number / Clients	Hospital collected data / Q1- Q3 2018	3514	3661.00	The target was calculated based on the expected growth driven by the upcoming year's community engagement from the Inter-professional primary care team. The target factors in additional effort to offset the negative growth over the last three years (-4%). The goal for 2019/20 is to increase volumes slightly above the previous year by 5% while maintaining established service agreement volumes.	Toronto North Support Service, Toronto Central LHIN - Home and Community Care, Toronto Central LHIN , Toronto Central LHIN - Primary Care, Otter Creek Family Health Team, the Doctor's Office (491 Lawrence), Sunnybrook Academic Family Health Team, Unison, Vibrant Health Alliance, SPRINT, LOFT, Lumacare, , Pine Villa, North York Community House, LHION, Toronto Community Housing Corporation - Seniors Housing Unit, North Toronto Sub-Region Advisory Council, Neighbourhood Care Team (Englemount-Lawrence), Neighbourhood Care Team (Mount Pleasant West, IDEAS Project, Translational Research Program - University of Toronto, North York General Hospital, Circle of Care, Harvest Food Bank, Hatzoloh, Toronto Paramedic Services, SCOPE,, TIPP	1)Conduct drop-in clinics in community settings	Manual tracking by Secretary of drop-in clinics conducted. Display on visual management board.	Number of drop-in clinics conducted.	25 by Q3/19
							2)Building relationships through community engagement by IPCT.	Manual tracking by Secretary of organization-organization engagements. Display on visual management board.	Number of community engagements conducted.	20 by Q3/19
							3)Meetings with physician offices who refer to Baycrest.	Manual tracking by Secretary of physician office meetings. Display on visual management board.	Number of physician offices meetings with IPC program.	5 by Q3/19
							4)Standardize referrals to Ambulatory Services for new admissions Apotex and Terraces	Monthly reconciliation of admission list vs. referrals to Audiology and Dentistry. Meditech report from Decision Support. Displayed on visual management board.	Percentage of new admissions to the Apotex and Terraces referred to the Audiology Clinic and Dentistry Clinic	70% by Q3/19
Percentage of referrals assigned to appropriate program within target time (3 business days)	% / Clients	Hospital collected data / Q1-Q3 2018	53	70.00	The target time to assign referrals to the appropriate program within 3 business days aligns with the standard by the Regional Geriatric Program (RGP). Currently there is significant variation amongst the different programs within the ambulatory care program from the triage time in each of the individual areas. The Central Intake Pilot is scheduled to start in Q1, with that first quarter focusing on the implementation and refining of the process.		1)Implement a standardized paperless process for handling referrals to improve efficiencies and workflow	Decision Support will generate a report using Meditech data and the Central Intake referral log to identify both the referrals that adhered to or deviated from the standard paperless process. Data will be monitored and shared with the team at huddles.	Percentage of referrals processed by Central Intake that adhered to the new paperless process	95% by Q2/19
							2)Establish a standardized process to accurately assign patient referrals to the most appropriate program	Central Intake Triage will track referrals initially assigned that did not meet the program criteria and that need to be redirected (the reason for redirection will be also tracked). The information captured will be reviewed by the team and used to help further refine the program assignment criteria.	Percentage of referrals triaged sent back for re-triage by the assigned program	5% by Q3/19
							3)Establish a protocol to ensure referrals are handled within the target timeframe.	A process for flagging unassigned referrals that are nearing the target timeframes will be established. That will trigger Central Intake to prioritize those referrals. An audit will be conducted to determine the reason for not meeting the target and the team will discuss strategies to reduce occurrence	Percentage of referrals above the target timeframe that adhere to the protocol	85% by Q3/19
Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital.	% / Discharged patients	Hospital collected data / Most recent 3 month period	60.5	71.00	In 2018/19, the team successfully doubled the percentage of summaries sent within 48 hours of discharge on our high intensity rehabilitation unit (3W). The focus in 2019-20 is to spread the work to the low intensity rehabilitation unit (7E) and target 71%. To achieve this target, there must be a 20% improvement for Friday discharges and a 10% improvement for discharges Monday – Thursday, from current performance.		1)Create process map of the discharge process to identify root causes and opportunities for improvement. Develop and implement standard processes where appropriate.	Using lean mapping, quality department will work with team to document current state of discharge process.	Completion of current state review.	Current state documented by end of Q3. At least 2 new opportunities for improvement identified by end of Q3.
							2)With physicians and health records staff, identify opportunities to modify the dictation template to streamline auto faxing to community care providers.	Work with health records to understand current template; seek input from physicians and provide education to improve utilization of the template; Monitor adherence to new template.	Number of enhancements to template implemented.	Enhancements implemented by end of Q2
							3)Explore automation of physician discharge summary notification report. Continue to send physician performance reports monthly.	Work with informatics to automate notification report.	Completion of enhancements.	Initial enhancements completed by end of Q1.
							4)Continue to monitor Friday discharge volumes.	Review Friday discharge volume and monitor performance with team.	Percentage Friday discharge summaries delivered to primary care provider within 48 hours of patient's discharge.	55% for Friday discharges sent within 48 hours of discharge.

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Number of patients who are offered a new coordinated plan developed through Health Links approach to care.	Number / at-risk cohort	Hospital collected data / Q1-Q3 2018	4	38.00	38The goal for this year is to implement the development of a new coordinated care plan (CCP) to the most complex/unique patients. The target for CCP completion reflects the 1% of the population served by the identified teams (approximately 3,800 patients) who are expected to have their first visit with the identified programs over Q1, Q2, and Q3 combined. There is confidence that the change ideas planned by the Inter-professional primary care team are expected to meet the proposed target by the end of Q3.		1)Provide education to staff from the following teams: Geriatric Outreach Team (ICCT), Interprofessional Primary Care Team (IPCT), Geriatric Day Hospital (DTC), Psychiatric Outreach Team (GPCS), Psychiatric Day Hospital (PDH) on how to use electronic Coordinated Care Plans.	Count of number of staff with eCCP login credentials (training is required for credentials). Count provided by UHN Connected Care.	Number of staff with Health Partner Gateway login credentials on the CHRIS system.	20 by Q1/19
							2)Embedding a LHIN Home and Community Care Coordinator within the IPCT. LHIN Home and Community Care Coordinators can assist with arranging provider meetings and writing the Coordinated Care Plan.	IPC will report the presence or absence of embedded Home and Community Care Coordinator	Hiring of Home and Community Care Coordinator with IPCT	hired by the end of Q1/19
							3)Building on virtual capacity of the team to enable coordinated care plan meetings through the Telemedicine Impact Plus Program (TIPP)	Count of staff with OneID access to the OTN for clinical login to virtual care platform and access to eReferrals. Data provided by OTN at Virtual Care Nurse request.	Number of staff with OneID	10 by Q2/19
Percent of patients surveyed will respond "always" to the question "Are you involved in as much as you want to be in decisions about your care and treatment?"	% / All inpatients	In-house survey / January 1 - December 31 2018	69.2	80.00	An important measure of our success is that patients and families will have an exceptional experience. The focus in 2019-20 is to continue strengthening our relationships and empowering those we serve as equal partners in their care. The target represents 10% improvement from the 2017/18 performance.	North York General Hospital , Humber River Regional Hospital , Sunnybrook Hospital	1)Continue existing improvement work to streamline and standardize content of the hospital admission package and process of admission. This will include collaboration with patients and families to inform the revised admission content and process.	Monitor the development process of the streamlined information package according to the project plan. Pilot process planned on transfers from an acute care hospital to 1 Complex Continuing Care and 1 rehabilitation unit.	Development of streamlined package and process.	Revised package and process will be complete by end of Q3.
							2)Develop a Rehabilitation Patient Goals and Transfer tool based on the Functional Independence Measure that is currently used on rehabilitation.	Physiotherapists/Occupational Therapists on the rehabilitation units will conduct regular audits on the use of the Rehab Patient Goals and Transfer Tool.	% of newly admitted patients with rehab goal tool in place.	50% by end of Q3.
Proportion of hospitalizations where patients with a progressive, life-threatening illness have their palliative care needs identified early through a comprehensive and holistic assessment.	Proportion / at-risk cohort	Local data collection / Most recent 6 month period	CB	CB	As a new HQO priority, the hospital will use this first year to explore how best to collect and measure current performance. This will inform future target setting.		1)Develop a process to consistently identify patients who may benefit from a palliative care approach on a pilot unit	Review best practice literature; conduct chart review to inform current state; consult with physicians, and provide education as required. Liaise with health informatics to identify the best way to include early identification in the medical record. Audit charts as part of the pilot	Identification of approach confirmed; % adherence to standard tool on pilot unit.	Approach confirmed by end of Q1. At least 75% adherence to standard tool for new admissions on pilot unit by Q3
							2)Deliver education to physicians and staff on pilot unit with respect to "early palliative care" that is aligned with HQO Quality Standard	Track participation at education sessions.	% of staff and physicians trained on pilot unit.	80%of staff trained by Q4
							3)Review and modify existing validated tools and processes for holistic needs assessment and implement on pilot unit.	Audit will be completed on the pilot unit. Seek input from patients and families throughout pilot process on assessment. Look for opportunities to integrate existing assessment tools, where clinically appropriate.	Assessment tool developed. Adherence to use of standard assessment tool	Assessment tool implemented by end of Q2 60% adherence with completing assessment tool where early risk identified by Q4
Pressure injury incidence rate	Rate / Patients	Hospital collected data / Q3 2018	0.32	0.26	In 2018/19 the pilot unit met and surpassed the target. Root cause analysis revealed additional work required on the additional two complex care units where the incidence rate was higher than target for both quarters last year. While there have been improvements in the incidence rate in CCC over the past year (from 0.67% to 0.32% in Q3), the goal for 19/20 will be to continue to strive for a rate of 0.26%, which is a significant improvement from historical performance.		1)Sustain the new quarterly nursing-led Prevalence & Incidence (P&I) studies on all three CCC units	Pressure injury prevention team leaders will conduct quarterly bedside audits.	Number P&I studies completed across CCC.	At least 4 P&I studies completed across CCC program by end of Q4
							2)Improve documentation practices by auditing patient record against P&I studies and provide feedback to point of care staff.	Quarterly audit completed.	% of audited patient charts where documentation matches P&I results.	At least 80% by Q4.
							3)Revise pamphlet: "Pressure Injury Prevention: information for Patients and Families" and standardize distribution of pamphlet upon admission to CCC units	Monitor progress of pamphlet revision milestones conduct consultation with patient and families.	Completion of the pamphlet.	Pamphlet is completed by Q2.
Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.	Count / Worker	Local data collection / January - December 2018	166	175.00	Baycrest continues to strive towards a workplace free of violence and aims for zero violent incidents. Employee safety is a strategic priority and it is essential to continue to build a culture that supports reporting incidents by all staff including near misses, no harm, first aid, medical aid and critical injuries. Monitoring performance indicators, including lost time injuries will continue. Increased reporting will inform the building of systems and processes that will help prevent severe incidents from occurring. The goal is to increase the reporting of workplace violence incidents by 5%.		1)System Improvement: Continue to support improvement in our culture of reporting of all hospital workers, including employees, physicians, volunteers, contractors etc. Facilitate reporting of Workplace Violence Incidents and improve accuracy of data.	A Safety Event Reporting System Working group has been established to identify system modification capabilities and user requirements to improve ease of using the system.	Reduced time required for staff to complete a workplace violence incident report.	Modifications to be implemented by Q4 2019/20.
							2)Corrective Action: Complete an inventory of risk identification, as identified through the 2018 Workplace Violence Risk Assessment.	HR/OHS will triage and all risks identified through WPV risk assessment, and partner with various stakeholders throughout Baycrest to accomplish action plan execution.	100% of identified high risks will have action plans to address risks.	High risk items to have action plans by Q4 2019/20.
							3)Engagement and Communication: Ensure that we are enhancing our safety culture and prevention, including conducting a psychological safety assessment for the Hospital, and Workplace Violence Prevention marketing campaign.	Review employee engagement survey results regarding safety and OHS to distribute a psychological safety assessment.	Increased awareness/visibility of WPV prevention programing.	OHS to present on WPV prevention programming to 100% of team meetings by Q3 2019/20.