William Osler Health System

2022 Quality Improvement Plan
Improvement Targets and Initiatives

William Osler Health System, 2100 Bovaird Drive East,

Aim		Measure									Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) C = custom (add any other indicators you are working on)															
Theme I: Timely and Efficient Transitions	Safe	Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.	MANDATORY	Count / Worker	Local data collection / Jan - Dec 2021	951*	123	162	5% improvement on CY2021 target		1) Workplace Violence Prevention Training	Train employees on descalation techniques in high risk areas	# of Clinical Resource Team (CRT) nurses are trained # of Medicine Program nurses are trained	50% of CRT and 10% of Medicine Program nurses are trained by 31/08/21 80 CRT and 120 Medicine Program nurses will be trained by 30/11/2022	Continue with this indicator
											2) Communication system for aggressive patients	Develop and implement an identification and communication process.	Process approval. % Medicine leadership trained in the process % Medicine employees trained in the process Pilot at the EGH site	Complete process approval by 31/05/22 Finalize resources by 30/06/22 100% of leadership and 80% of staff are trained by 31/08/22 Go live with the communication system for aggressive patients process with Medicine program by 1/09/22	Continue with this indicator. Current state going through approval process
											3) Resources development for Communication system for aggressive patients	Develop resources for leaders and employees to use to identify and communicate information about aggressive patients	Finalizing the resources to support the process for leaders and employees to identify and communicate information about aggressive patients	Finalize resources by 30/06/22	
											Alerting System for Behavioural Care	Begin development of organization wide Alerting System for Behavioural Care: -seek senior leadership approval, determine technical (IS) requirements, establish organization wide working group	Process measures	Gain senior leadership approval by 15/08/21 Technical (IS) requirements, established by 15/10/21 Organization wide working group established by 31/12/21	This change idea spans 2 years. ON Hold pending EMR changes and review within the existing Electronic Medical Record (EMR) framework to store information.
											4) Learning from Workplace Violence Incidents	Review WVP incidents and corrective/preventative actions to mitigate and prevent future WVP incidents.	Corrective/preventative actions are assigned and implemented. Information in Incidents records is complete and accurate	80% of WVP incidents reviewed by leader and investigated. 100% of incidents investigated have corrective/preventative actions assigned within 3 business days. 80% of the WPV incidents investigated are closed out by month end by OHS with required information.	Managers need to be aware of their accountability to review and implement corrective actions - require Clinical Operations discussion

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Theme III: Safe and Effective Care	**Effective**	Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged.	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / Jan 2021 to Dec 2021	951*	87.30%	90.00%	3% improvement on CY 2021 performance		1) Optimize completion of best possible medication history (BPMH) at the time of admission, as this drives the discharge process.	1)Track and optimize the number of patients who have a best possible medication history (BPMH) completed at the time of admission 2) Track monthly compliance rates and managers to follow-up with staff to support the process. 3) BPMH working group to provide recommendations for improvement and standardization and to develop resources to support quality improvement.	1) Completion of BPMH 2) Quarterly review of unit/program performance with focus on areas with lowest compliance. 2021 year end programs/units for targetted approach include: Surgery (all units - BCH and EGH) BCH ICU BCH Cardiology BCH Neurology BCH Oncology Med PDS Med 6	1) 90% for all Units.	Programs listed based on 2021 Performance and will be updated quarterly.
											2) Targeted physician engagement in programs with compliance below 90% for Medication Reconciliation (MedRec) on discharge – identify opportunities for improvement, barriers to completion and ongoing support as required.	1) Obtain feedback from physicians leads regarding barriers to completion of MedRec on discharge in targetted areas.	1) Quarterly review at chiefs meeting regarding barriers in MedRec on discharge with focus on programs with lowest compliance. Year end areas of focus include: Surgery (both sites) EGH Mental Health EGH 9E EGH Critical Care BCH ICU MH - CHAD and INTEN BCH SIMCU	1) Obtain quarterly feedback for barriers around Med Rec on discharge and develop action plans. 2) Target 90% for all programs.	Programs listed based on 2021 Performance and will be updated quarterly.
											3) Create forcing function for MedRec on discharge.	1) Determine process to support forcing function to complete MedRec on discharge with input from physician leads, directors/managers and Access & Flow once BPMH is consistently above target in all program areas. 2) Finalize and implement escalation process when MedRec on discharge is not completed. 3) Obtain feedback and monitor escalation process. Adjust as required.	1) Completion rate of MedRec on discharge. 2) Escalation process feedback.	1) 90% Completion of MedRec on discharge by unit / program. 2) Escalation process to be implemented by Sept 2022.	
											4) Enable all programs to track and be self accountable for Med Rec on discharge process and performance.	1) Roll out Dashboards across all programs - BPMH, Med Rec on Admission, Med Rec on Discharge, Weekly Physician Compliance. 2) Dyads to incorporate metrics and dashboard discussion as standing agenda items into program quality committee for review. 3)Develop an action plan template containing timelines and targets for programs below target compliance rate. 4)Programs with compliance below target to develop action plans, monitor and adjust.	1) Compliance rate across all programs with utilizing dashboards and performance metrics as part of monthly quality review process in the program quality committee.	1) Quarterly review of action plans for non compliance.	

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Theme I: Timely and Efficient Transitions	**Patient-centred**	Percentage of respondents who responded "completely" 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?	C	% / All acute patients	In-house survey / Calendar year	951*	76.00%	78.30%	3% improvement on CY 2021 performance		1) Patient-Oriented Discharge Summary (PODS) Expansion.	1) Patient Experience Office (PEO) Leadership, Clinical Leadership support and access to IT resources 2) Explore and implement PODS roll out in Women and Children Program & specialized Mental Health Programs in FY 22/23 .	1) Reported outcome for PODS rollout in Women's and Children Program & specialized Mental Health Programs	1) 100% implementation of PODS in Women and Children program completed by FYQ3. 2) 100% implementation of PODS in Specialized Mental Health program completed by FYQ2.	
											2) Expand functionality and useability of digital self management tools.	1) Expansion of patient self management tools led by PEO in collaboration with Information Systems and Patient Family Advisory Committee (PFAC).	1)Increase MyChart utilization by current and new subscribers 2) Increase IBT utilization of select modules	1) Increase MyChart utilization by new and current subscribers by 10% 2) Increase IBT utilization of select modules by 10%	
											Registered Nurses Association of Ontario (RNAO) Best Practice Spotlight Organization (BPSO) People Centred Care (PCC) Best Practice Guideline (BPG)	1) Conduct People Centred Care (PCC) Best Practice Guideline (BPG) Gap Analysis, implement interventions and evaluate PCC BPG improvements.	1) Increase Balance Score Card (BSC) 'empathy' indicator Top Box results. 2) Establish baseline and increase 'involvement in care plan' indicator Top Box results. 3) Establish baseline and decrease complaints/1000 pt days or pt visits.	1) Increase BSC 'empathy' indicator Top Box results by 3%. 2) Establish baseline and increase 'involvement in care plan' indicator Top Box results by 1%. 3) Establish baseline and decrease complaints/1000 pt days or pt visits by 1%.	
											4) Review and define roles and responsibilities for Discharge process amongst interprofessional teams	Incorporate Access & Flow (AF) Lean Learnings, ongoing Patient Family Advisory Committee (PFAC) feedback, processes and workflow related to discharge planning & Command Centre. Further spread to surgery and medicine	1) Standard operating procedures established for interprofessional teams within Medicine with regards to transitions 2) Discharge checklist implemented within Medicine 3) Daily family communications updates to include updates on transition planning	Within Medicine: 1) 100% of role clarity established for interprofessional teams by Q4 2022 2) 100% Discharge checklist implemented by Q3 2022 3) 100% of medicine patients to have daily family communication by end of Q3	

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Theme I: Timely and Efficient Transitions	**Timely**	The time interval between the Disposition Date/Time (as determined by the main service provider) and the Date/Time Patient Left Emergency Department (ED) for admission to an inpatient bed or operating room.	M A N D A T O R Y	Hours / All patients	CIHI NACRS, CCO / Oct 2021– Dec 2021	951*	28.8	40.9	3% improvement on CY2021 target		1) Conduct Operational Command Centre Review	1)Develop and roll out standardized roles and responsibilities for the Operational Command Centre (OCC). 2) Plan and implement Phase Two of OCC. - Review current work flow processes, to support effective and efficient utilization of data and tools for decision - Explore further opportunities for automation of information from Meditech to the dashboard. - Develop and roll out New Dashboard (i.e. a)Rehab Wait List, b) Surgical Dashboard c) Echocardiogram Dashboard d) Bullet Rounds Dashboard refresh e) Pre-Gridlock/ iGridlock f) Interfacility Dashboard 3) Develop integrated communication plan for New Dashboard to support leaders to integrate OCC dashboards into daily operations. 4) Highlight units with bullet round compliance. Share monthly compliance data with	1) Roles and Responsibilities of OCC 2) All New Dashboard live and operational (i.e. a)Rehab Wait List, b) Surgical Dashboard c) Echocardiogram Dashboard d) Bullet Rounds Dashboard refresh e) Pre-Gridlock/ iGridlock f) Interfacility Dashboard 3) Bullet round compliance	1) Roles and responsibilities for OCC completed and rollout by Q2 22 2) All New Dashboards in Phase 2 developed and live by Q4 22 3) 100% compliance of Bullet Rounds being conducted across all medicine units.	
											2) Estimated Date of Discharge (EDD) and 11 am discharge .	1) EDD to be provided for all patients upon admission, physician to identify, EDD to be entered as Order in Meditech 2) Incorporate EDD data on Bullet Round Dashboard - Dashboard to optimize patient of list approaching EDD. 3) Utilize Bullets Rounds to highlight barriers in meeting the current EDD and discharge by 11am. Leverage interdisciplinary team including physicians at unit to participate in the discussion. 3) Develop messaging for staff to utilize whiteboard to inform patients of potential EDD. 4) Revisit discharge order process through inpatient units and admitting, metrics discussion at bed meeting and unit huddles, provide targets to units to meet i.e.. 1-2 discharges before 11 am.	1- EDD compliance 2- EDD data available on dashboard 3- 11am discharges	1) 100% compliance of hospitalist and surgeons to enter approximate EDD by Q3 22 2) Add EDD data on Bullet Round Dashboard by Q2 22 2)30% of discharges to occur by 11 am by FY Q3 22	
											3) Electronic Transfer of Accountability (eTOA) process improvement in Emergency Department	1) ED workflow to be re-evaluated to support and prioritize eTOA 2) Re-evaluating alerts and corresponding accountabilities in ED and Access and Flow 3) Escalation process of alerts to be further clarified 4) Explore further opportunities to integrate technology in ED processes (Point of Care devices) 4) Visibility of Dashboard in ED to review data 6) Explore eTOA process improvement opportunities between Mental Health and ED	1- eTOA workflow in ED 2- ED and Access and Flow accountabilities (Roles & Responsibilities) for alerts 3) eTOA Process improvement between Mental Health and ED	1) ED workflow processes to review to prioritize eTOA to by Q3 22 2) Review accountabilities, roles and responsibilities for ED and Access and Flow to handle alerts by Q3 22 3) Process improvement between Mental Health and ED by Q3 22	
											4) Increase in weekend discharges	1) Leverage EDD and predictive discharges to support further smoothing of discharges seven days a week (usage of order set by MRP) 2) Review discharge orderset data by physician to identify opportunities 3) Engage physicians in Admission Avoidance strategy. 4) Develop a repository of services available during the weekend, as well as services that are available through on-call/escalation process to support 7 day a week discharges.	1) Discharge order set data by physician in medicine and surgical program 2) Repository of available services	1) 5-10% increase in weekend discharges by Q3 22 in Medicine & Surgical programs 2)Develop repository of available services by Q2 22	