Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2018/19 QIP

The Progress Report is a tool that will help organizations make linkages between change ideas and improvement, and gain insight into how their change ideas might be refined in the future. The new Progress Report is mostly automated, so very little data entry is required, freeing up time for reflection and quality improvement activities.

Health Quality Ontario (HQO) will use the updated Progress Reports to share effective change initiatives, spread successful change ideas, and inform robust curriculum for future educational sessions.

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP 2018/19	Target as stated on QIP 2018/19	Current Performance	Comments
1	Readmissions Rate for Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), (Gastrointestinal Disease) and Community Acquired Pneumonia (CAP). The Ministry-Local Health Integration Network Accountability Agreement (MLAA) readmission rate is used. It is risk-adjusted.	947	21.30% - updated to 15.60%; see comments	14.70%	15.50%	This indicator is now measured using the Hospital Service Accountability Agreement (HSAA) rate rather than the Ministry-Local Health Integration Network (LHIN) Accountability Agreement (MLAA) rate. The difference is that the HSAA is for readmissions back to the same hospital whereas the MLAA is for readmission back to any hospital in Toronto Central LHIN. This change in measurement was advised by TC LHIN and is how the indicator is being measured across multiple hospitals. As such, our "Current Performance as stated on QIP 2018/19" has been updated from 21.30 (MLAA) to 15.60 (HSAA). UHN continues to work to make small meaningful decreases in readmission rates for these patient cohorts.

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Change Ideas from Last Year's QIP (QIP 2018/19)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned (Some questions to consider): What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Utilize the patient identification tool to identify high-risk readmission patients.	No	Current research has shown that the patient identification tool previously selected (socioeconomic inputs) does not accurately identify patients at high-risk of readmission. There currently exists no tool or process to accurately identify high risk readmission patients. Considering research and insights from other healthcare organizations, the group has decided to classify all of the CHF, COPD, CAP and Liver Disease GI patients as high-risk for readmission.
Standardize discharge checklists to encompass teach-back, medication reconciliation and scheduling follow up appointments in the community.	Yes	Both sites at UHN have implemented standardized discharge checklists/Care Pathways with COPD patients, given its higher readmission rates. Care Pathways are being implemented that cover not only the discharge activities found within the discharge checklists but also activities that occur from the time of admission. The Care Pathways implementations has produced measurable improvements to the indicator and have allowed the sites to identify gaps in care as well as highlight the need for improved coordination and communication from the various healthcare teams. Care Pathways for CHF, CAP and Liver Disease GI are currently being implemented and should be complete by May/June 2019.
Standardize order sets for these high-readmission rate patients.	Yes	The adoption and usage of Standardized Order Sets has been poor given the difficulty in accessing them online. We are working with UHN Digital to determine if there is a way to flag patients within the electronic medical record (EMR) and have a notification pop up for clinicians to complete order sets online for that specific admission diagnosis. Currently, clinicians are inputting COPD, CHF, CAP and Liver Disease GI next to the patient's name to identify those with that condition and high-risk readmits.

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2	Overall rating from Canadian Patient Experiences Survey (Q41).	947	71.4%	70.0%	71.6%	

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Increase patient partnership recruitment to include representation from all sites and programs across UHN.	Yes	We continue to onboard new Patient Partners to the program at an appropriate rate. Time is taken to interview and orient new Patient Partners to ensure their experience is a positive and meaningful one. The team paused on new recruitment to focus on matching Patient Partners to important priorities in order to meet the needs of the organization as the demand for Patient Partners has increased exponentially. Despite this, the culture shift we have seen in patient engagement across the organization has allowed us to continue to track well toward our target of 20 new Patient Partners for the year. As part of our recruitment strategy, we have been working with programs across all UHN sites to increase engagement in these areas and we have been partnering with our existing Patient Partners on a referral process to the program. By Q4 we will be able to implement our complete recruitment strategy.
Evaluate the impact of patient engagement on UHN committees, working groups, etc., through the Patient Partnerships program.	Yes	Of note, in Q3 we achieved full Patient Partner membership on all UHN Safety & Quality of Care Committees across the organization including the Safety and Quality Committee of the Board. In Q4, we will trial our evaluation measures.

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3	Employee Engagement	947	CB	55%	58%	

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Improve response rate to the employee engagement survey.	No	Final response rate for UHN in the 2018 employee survey was 64%. This is the highest we have ever achieved, but did not meet the 75% QIP goal. Survey closed at the end of October and lessons learned were included in Q2 reporting in detail.
Focus and align efforts to improve engagement across UHN.	Yes	58% of Employees were engaged; exceeded our goal by 3%. This reflects the focus that senior and local team leadership has had on engagement in the time between surveys, for instance: - Active participation of front line staff in Caring Safely initiatives - Increased responsiveness to staff issues through regular 'huddles' and escalation procedures - Expansion of resiliency and wellness initiatives - Increased focus on improving leadership capability through expanded programming - Improved relationships and 'helping' behaviors through Crucial Conversations curriculum - Expansion of formal recognition programs Comments in the survey reveal high engagement due to medical and patient care efforts and initiatives at UHN. The lowest score (41%) is relative to the engagement driver: Senior Management Relationships. All five questions in this driver category scored low and stand out against the other largely positive results. Positive comments also reflect relationships within teams but draw attention to the possibilities for increased effectiveness with greater focus on improving relationships between teams and across the organization. Negative comments point to the impact of workload as a disengagement factor in both low scores and comments. The questions on Senior

		Management Relationships explore 'followership' in the organization. As such, we need to acknowledge the changes in senior leadership in the last four years, subsequent changes in direction and some reversals of decisions that might cause employees to pause and consider their level of commitment to followership. This information is relatively new to the senior leaders and more analysis is required to engage staff and understand what actions on behalf of senior leaders will make a difference.
All units/departments develop and implement an engagement improvement action plan.	Yes	There is some evidence that employees doubt the commitment to change based on the survey results. Sharing the action plans they collaboratively create with leaders will help address this perception. This creates knowledge sharing opportunities for leaders to adjust plans and 'find' each other when there is common commitment to a course of action to share lessons learned. More rigor needs to be put in place to communicate broadly the connection between the results of action plans and the input employees provide. Lastly, using technology and other venues to connect with broader populations of employees on a more regular basis to collect their input and then communicate back how the input informs decisions made or actions taken will make a difference. HR is exploring the effectiveness of different tools; for example, HR is piloting ThoughtExchange. For the first time UHN will transparently post all team level action plans on an Employee Engagement SharePoint site constructed specifically for this purpose.

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4	The number of same day cancellation and number of scheduled cases each month (excluding “organ unacceptable” and “organ unavailable” for transplant patients). The same day cancellation rate was calculated by dividing the number of same day cancellations by the number of scheduled cases.	947	6.50%	5.00%	5.57%	

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Work towards having a dedicated surgical stream for transplants at Toronto General Hospital (TGH) and not mixing these with the other elective/non-elective surgical patients.	Yes	TGH increased their emergency OR rooms to 2 on days and evenings, as of January 7, 2019. The full implementation of 2 rooms 24/7 will occur in April 2019.
Addition of two OR Rooms per week at Toronto Western Hospital (TWH).	Yes	TWH has now implemented 5 emergency OR rooms per week to help address cancellations due to emergency/unscheduled activity.

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5	Number of workplace violence incidents (overall).	947	585 (January 2017 - December 31, 2017)	603	517 (January 1, 2018 – December 31, 2018)	

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Launch New Workplace Violence, Domestic Violence and Harassment policy and program.	Yes	The number of workplace violence incidents (overall) is lower than the target following the launch of this program. There has been an increase in awareness around workplace violence, domestic violence, and harassment in the organization. There has been 95% training compliance since January 1.
Continue with Safe Management Group (SMG) Crisis Intervention Training in high and moderate risk areas.	Yes	Program has been implemented. Currently renewing contract and implementing refresher training for high and moderate risk areas.
Develop summary of findings for risk assessment completed in high risk areas and determine corrective actions.	Yes	Have completed workplace violence risk assessments (WPVRA) in high risk areas and some moderate risk areas. Have revised WPVRA form in alignment with Public Services Health and Safety Association. Will continue to conduct WPVRA in high and moderate risk areas using the new form.

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6	Workplace Violence: Percent of Lost Time.	947	0.57% changed to 1.67%; see comments	0.54% changed to 1.59%; see comments	1.55% (January 1 2018 – December 31, 2018)	Following the submission of the 2018/19 QIP work plan, the workplace safety team discovered an error in the calculation of the Workplace Violence: Percent of Lost Time indicator's current performance and target. Data from 2016/17 instead of 2017/18 was used to calculate our current performance and inform our QIP target. We originally reported current performance as 0.57% and set a 5% reduction target of 0.54%. This has since been updated to 1.67% for "Current Performance as stated on QIP 2018/19" and 1.59% for "Target as stated on QIP 2018/19".

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Conduct workplace violence risk assessments for all areas previously identified as moderate risk.	Yes	Have revised workplace violence risk assessment (WPVRA) form in alignment with Public Services Health and Safety Association. Will continue to conduct WPVRA in high and moderate risk areas using the new form.
Develop policy and procedure to apply Behavioral Safety Alert.	Yes	Policy and Program was released.

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7	Number of persons developing a new pressure injury per 1,000 acute inpatient days (Incident Density Rate).	947	3.97 changed to 4.01; see comments	3.83	4.42	The methodology for calculating the pressure injury (PI) incident density rate was updated in FY2018/19 to align with the National Pressure Ulcer Advisory Panel (NPUAP) definition of hospital acquired PI incident density. "Current Performance as Stated on QIP 2018/19" has been updated from 3.97 (old methodology) to 4.01 (new methodology). "Current Performance 2018" was calculated using the new methodology. The change in methodology was not a significant contributor to the increase in the rate over FY 2018/19. **Explanation for rate increase:** Pressure injuries are complex and multifactorial. We speculate and are attempting to validate that the PI rate increase is driven in part by more consistent pressure injury documentation in the electronic medical record, which has been encouraged by the organizational focus on PI prevention and the implementation of the PI prevention bundle. This has likely resulted in a more accurate reflection of the true PI incidence. However, we are still in the process of data analysis to better understand this and other extrinsic factors causing the increased incidence. We are reviewing two patient care areas in particular: palliative care and radiation medicine units at Princess Margaret; both have increased incidence of PI. A possible explanation is that palliative patients may acquire pressure injuries near end of life due to tissue failure, and we are aware that the patient acuity has significantly increased on the radiation medicine units, which would impact PI risk. Another possible contributor to

						the increase in PI rate is the upward trend of identification and documentation of medical device-related PIs.

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Roll out pressure injuries prevention bundle to clinical units outlined in the FY 2018/19 Hospital Acquired Conditions (HAC) program implementation plan.	Yes	Implementations are underway and on track to be completed by end of 2018/19 in 12 acute care units as planned. Improved documentation of care plan and interventions were implemented in collaboration with these units. Patient education material was enhanced to better engage patients in their care, and the working group is currently reviewing and updating policies and procedures. We are noting a variance across units with consistent completion and documentation of Skin and Risk Assessments at the appropriate frequency. The existing hybrid electronic/paper system continues to be a risk and creates workflow challenges for point of care staff, negatively impacting completion rates.
Standardize pressure injury incident reviews.	Yes	A Post-Pressure Injury Discussion Tool has been developed and is in the process of being rolled out to staff to support pressure injury incident debriefs. Gaps remain in staff recognizing preventability and staging of pressure injuries. Also continue to leverage opportunities to clarify the distinction between prevention and management of a wound. The UHN Skin Health Steering Committee is reviewing all pressure injury incidents on a quarterly basis to identify trends.

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8	Number of acute inpatients newly diagnosed with nosocomial C. Difficile Infection (CDI) per 1,000 acute inpatient days.	947	0.51	0.48	0.38	

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Roll out CDI prevention bundle to clinical units outlined in the FY 2018/19 Hospital Acquired Conditions (HAC) program implementation plan.	Yes	Implementations are underway and on track to be completed at the end of the 2018/19 as planned. Documentation of stool patterns and patient education has been embedded into the new standardized nursing documentation form. Multi-modal approaches are being used to reinforce stool pattern documentation for all units. Increased adherence is anticipated in the coming months. Standardization of housekeeping practices remains a challenge given resources. Strategies to increase consistency include education, visual reminders, modification in workflow and auditing.

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9	Number of acute falls (Serious Safety Events 1-5) per 10,000 adjusted patient days.	947	0.35	0.35	0.17	

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Roll out falls inpatient Prevention Bundle to clinical units outlined in the FY 2018/19 Hospital Acquired Conditions (HAC) program implementation plan.	Yes	Planned implementations completed as per 2018/19 implementation plan. Average adherence to the Falls prevention bundle is 80-90%. Patient Partners engaged to develop patient engagement questions on the weekly audit tool, which assesses patients' knowledge of their fall risk, prevention strategies in place, and their role in fall prevention. We have identified opportunities to improve the manner in which we provide education to patients and their families, including: 1) ensuring that we connect the recommendations/instructions to the overall goal of fall prevention, 2) ensuring patients and families are included in the development of individualized falls prevention plans and 3) utilizing white boards in each patient room to communicate key messages. Utilizing a Quality metric within daily Unit/Site Huddles to highlight Falls.
Improve consistency of classification of Falls as preventable.	Yes	With enhanced safety culture, teams are more receptive to learnings, preventability and are improving in their ability to classify falls. Teams are currently focused on falls causing serious harm; however, several groups are also reviewing minor/near miss falls for learnings and preventability. There is effective representation of subject matter experts from the site-based falls committees at each debrief, and the Post Fall Discussion Tool helps guide the incident debrief following a fall. One component of the Post Fall Assessment includes a discussion with the patient (or their family, if appropriate) in order to better understand what the patient's goal was at the time of the fall and how they experienced the fall. The patient's perspective assists with the classification of preventability.

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10	Number of rehabilitation/Complex Continuing Care (CCC) falls (Serious Safety Events 1-5) per 10,000 rehab/CCC adjusted patient days.	947	0.50	0.50	0.17	

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Ensure effective Falls Risk Screening is occurring in all outpatient areas and appropriate actions for those identified as high risk are in place.	Yes	Change idea has been initiated and is on track per the 2018/19 implementation plan. We are currently trialing falls risk screening questions in various outpatient areas to standardize screening. We have incorporated additional visuals in response to feedback from patients. Falls committee members will conduct spot audits to identify further opportunities for improvement.
Standardize Post Fall Debriefs.	Yes	Units/teams are improving their ability to classify falls as preventable. We have good representation of subject matter experts from the site-based falls committees at debriefs, and the Post Fall Discussion Tool helps guide the incident debrief following a fall. One component of the Post Fall Assessment includes a discussion with the patient (or their family, if appropriate) in order to better understand what the patient's goal was at the time of the fall and how they experienced the fall; this assists with the classification of preventability.
Standardize Falls Patient Education Materials: 1) Pamphlets and 2) Posters.	Yes	This change idea has been initiated and is on track per the 2018/19 implementation plan. We have held a focus group with Patient Partners to inform revision of education materials. We will continue to partner with patients/families as we improve falls prevention patient education materials and are exploring opportunities to utilize the myUHN Patient Portal for patient education.