



Integrated Quality and Patient Safety Plan

2021-2026

Patient Safety Plan 2021-2026

Introduction

Focus on Quality

In the past two decades, there has been a significant focus on improving quality and safety in healthcare in Canada, and this mirrors the quality and patient safety experience internationally. As a result, quality has become a strategic imperative in all healthcare organizations, and the notion of quality planning is central to creating long-term measurable, and sustainable change. A plethora of supports such as the Institute for Healthcare Improvement, the Canadian Patient Safety Institute, and Health Quality Ontario to name a few, have emerged over the past two decades to assist organizations to strengthen their capacity for quality improvement, monitoring, and reporting.

In addition to the evolving culture within individual organizations, governments have increased accountability through legislative channels and public reporting. Over the last several decades increasing examination of the quality of healthcare in the province has culminated in the crafting of the Excellent Care for All Act in 2010. This legislation has served to galvanize the commitment to quality healthcare for Ontarians and set the stage for an evolving Provincial Quality Reporting Framework.

Essential Elements of an Integrated Quality and Patient Safety Plan

Many of the current quality reporting frameworks describe a series of common elements that must be incorporated into an effective plan. These frameworks suggest that quality and safety planning is:

- Aligned with the organizational strategic plan and other relevant regional or LHIN based plans
- Associated with a quality framework
- Describe a natural progression from the previous year's plan
- Easy to understand and relevant to the care provider community.
- Have measurable goals and targets
- Realistic and achievable within the resources available
- Evaluated annually
- Act as a driver for influencing permanent cultural change.

Quality and Safety Planning - Alignments

To align quality and operational goals more firmly, a framework is being presented for use in planning quality and safety initiatives. This framework is anchored by the recent Strategic Planning work and an identified set of quality dimensions.

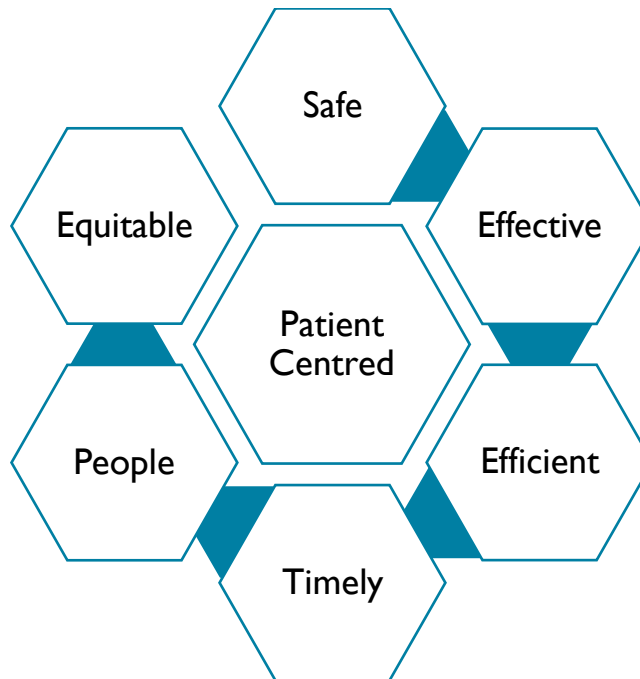
Strategic Priorities

In 2021, Halton Healthcare undertook a process to renew its corporate strategic plan. This strategic planning exercise was focused on developing renewed Mission, Vision, Values, and Strategic Priorities. Halton Healthcare had been led by a strategic plan that articulated a series of strategic components (i.e. Mission, Values and Directions) that sought to embody the concept of "Inspiring Care, 2021 and Beyond". As the new Plan is a living document, please refer to the following [link](#) to familiarize yourself with the objectives. The four strategic priorities will be the enablers to achieving our quality goals.

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Quality Dimensions

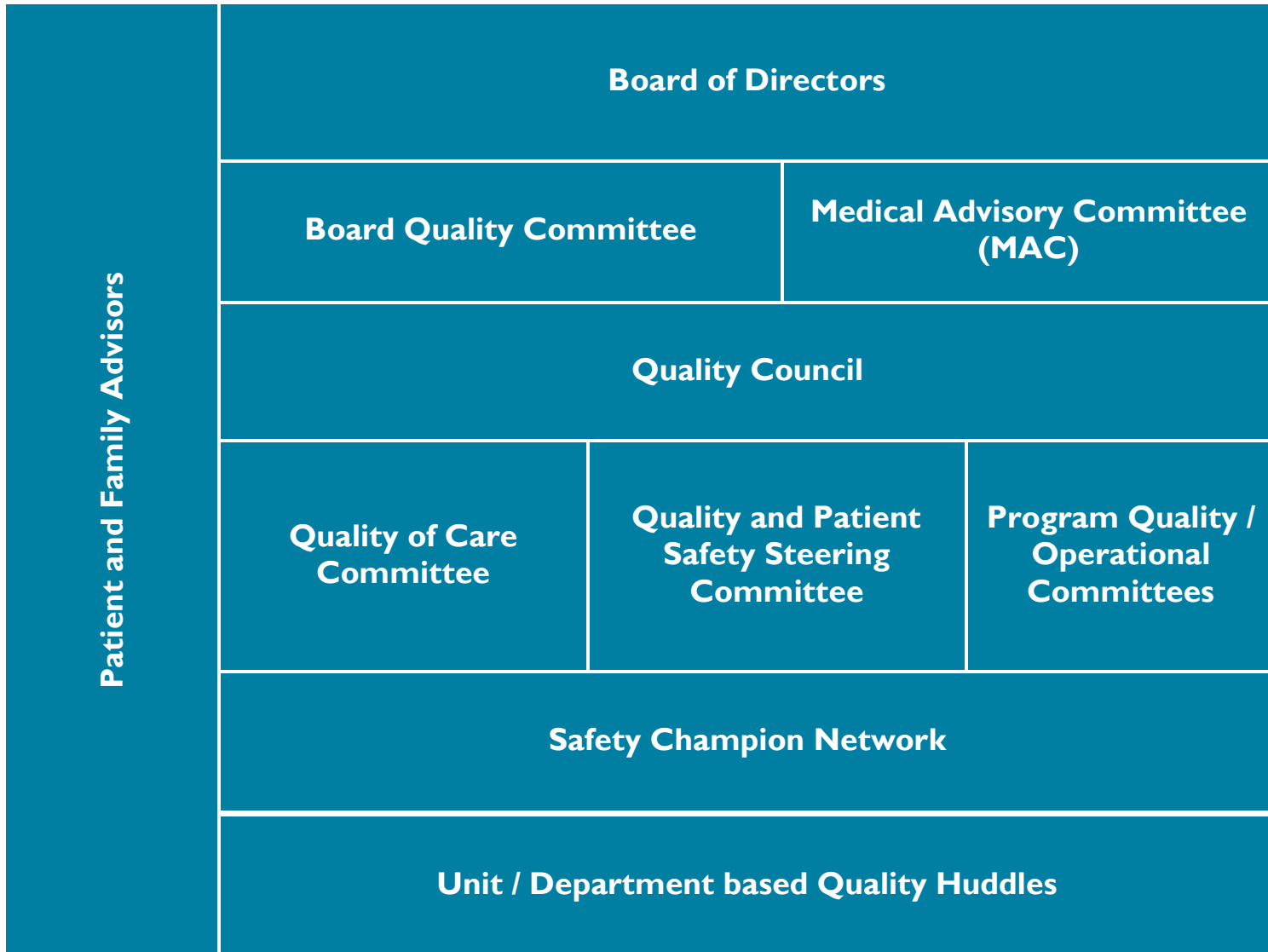
Another orientation for quality and safety planning involves the notion of quality dimensions. Thinking about goals through this lens allows the program to strategically analyze all aspects of the care delivery process in a balanced way for the purpose of understanding common quality issues and identifying improvement opportunities. Since many of these dimensions are universal, the quality dimensions allow for a connection to quality issues beyond our organization. In terms of structure, these dimensions are somewhat independent; a program may excel in one area yet identify a need for improvement in another. Yet there are examples where an improvement in one dimension negatively impacts the performance of an indicator in another dimension. For each of the quality goals developed, teams are asked to identify which of the quality dimensions the goal addresses. It is desirable to attempt to have at least one goal for each of the Quality Dimensions and to note the relationship between them.



The Strategic Priorities and the Quality Dimensions form the framework for quality and performance monitoring and planning at Halton Healthcare.

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Governance



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Halton Healthcare Integrated Corporate Quality & Patient Safety Plan 2020-2022

| Opportunity | AIM | Change Ideas | Process Measure | Accountability | Status / Comments |
|--|--|---|--|----------------|---|
| QUALITY DIMENSION → SAFE | | | | | |
| Reduce harm from inpatient falls ROP | Decrease the rate of falls with serious harm by 10% by March 2023. | Implementation of FALLS TIPS (Tailoring Interventions for Patient Safety) across clinical areas. | 1. Percentage / number of clinical units where Falls TIPS has been successfully implemented. | | Requires partnership with Professional Practice |
| Enhance Medication Safety QIP | Increase compliance to Best Possible Medication Discharge Plan <u>Current Performance</u> 82.1% (December 2021) <u>Target</u> 90% | Optimize new prospective Best Possible Medication History/Med Rec on Admission processes. | 1. % of BPMH's collected prospectively | | In progress |
| QUALITY DIMENSION → EFFECTIVE | | | | | |
| Reduce the effects of pressure injuries on our patients ROP | Decrease the incidence of pressure injury in hospital by 10% by March 2023. | Resume annual prevalence study Refresh unit based wound champion initiative Braden scale compliance audits | 1. Completion of the annual study 2. # of new wound champions signed up 3. # of clinical areas with Braden compliance on Scorecard | | |
| Enhance the availability of an inpatient bed. Maintain patient flow. QIP | Average Acute LOS-selected CMGs, CHF, COPD, Stroke <u>Current Performance</u> 8.86 (Q2 2021/22) <u>Target</u> 6.64 | Optimize use of existing Care Plans in Meditech Expanse. (CHF, COPD, Stroke) | 1. % of Care Plans available in Expanse 2. % of patients with Care Plan in place (if available) | | Interchange optimization |
| Advance how we deliver care. | Complete evaluation of Benefits Realization work by December 2022. | Complete Benefits Realization evaluation framework and provide leadership to working group. | 1. # of working group meetings hosted 2. Development of Evaluation metrics | | |
| QUALITY DIMENSION → PATIENT CENTRED | | | | | |
| Engage Patients QIP | Number of Patient and Family Advisors registered at Halton Healthcare. From 15 to 40 by Dec 2022 | Refresh/relaunch Patient and Family Advisory Committee. (Role description, orientation, leader guide, engagement approach etc.) | 1. Launch of social media campaign 2. # of units with meal tray post card delivered | | In progress |

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|--|---|---|--|----------------|-------------------|
| | | | <ol style="list-style-type: none"> 3. Completion of updated orientation material 4. # of programs / departments who have received an refresher session | | |
| Prepare for Accreditation Canada survey & ensure compliance with other Accreditation processes (Lab & Pharmacy). | To successfully achieve accreditation with exemplary standing through Accreditation Canada by April of 2023. | Enterprise-wide participation in Accreditation Canada preparation activities. | <ol style="list-style-type: none"> 1. Completion of Patient Safety Culture Survey Action Plan. 2. Completion of Program Self-Assessment Questionnaires and develop Action Plan 3. Representation from all programs attendance at Accreditation Council meetings. 4. Program / dept leads to conduct regular mock tracers | | |
| Leverage successful innovative processes or technologies implemented during the COVID 19 pandemic experience. | Identify successful processes or technologies that should be continue or expanded by December 2022. | Establish a working group to develop inventory of processes. Create framework for evaluation. | <ol style="list-style-type: none"> 1. Approved Terms of Reference for Working Group. 2. Inventory list of successful processes / technologies completed. | | |
| Increase and embed the voice of the patient in all our work. | Increase the number of senior level / governance meetings to include standing agenda item around a patient harm story by 15% | Update agendas to include patient harm story. Update Terms of Reference to include a Patient and Family Advisor. | <ol style="list-style-type: none"> 1. % of meetings with Patient Story as a standing agenda item 2. # of TOR updated to include Patient and Family Advisor | | |
| QUALITY DIMENSION → EFFICIENT | | | | | |
| Enhance the Patient experience QIP | Improve performance on indicator: "Did you receive enough information % after you left the hospital?" from 48% Q2 2021/22) to 60% by March 2023 | Optimize use of Patient Oriented Discharge Summaries (PODS) and associated processes. | <ol style="list-style-type: none"> 1. % of Discharged patients who received a POD on discharge. | | In progress-Data |

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| | “would you recommend this hospital to your friends and family?” CIHI CPES | Evaluate bedside handover program to ensure compliance across all clinical areas. | 1. Stakeholder group 2. Current state analysis 3. Opportunities identified 4. Implementation plan created | | |
| | | Evaluate Hourly Rounding-Program and ensure compliance across all clinical areas within the program | 1. Stakeholder group 2. Current state analysis 3. Opportunities identified 4. Implementation plan created | | |
| Enhance Corporate Organ and Tissue Donation Program and publicly reported indicators. | To improve on Provincial Targets for RNR, Conversion Rate and Eligible Approach Rate by March 2023. | Update the ICU Withdrawal of Care order set. Provide focused education to the EDs and ICUs related to WDLS call before withdrawal | 1. Stakeholder engagement meetings related to updating order set. 2. # of units who have received focused education event. | | |
| QUALITY DIMENSION → TIMELY | | | | | |
| Improve access to care & Optimize Patient Flow QIP | Reduce the time to inpatient bed from 34hrs to 20hrs by March 2023 | Conduct process improvement initiative for pathology services. | 1. Completion of process improvement event 2. Implementation of new tissue processor 3. Formal evaluation of new tissue processor | | |
| | | Implement Surgical Innovation Fund project in Diagnostic Imaging (DI) to reduce wait times for MRI. | 1. Submission of completed application to the Surgical Innovation Fund. | | |
| | | Complete educational program for perioperative nurses and develop tri-site shared resource pool of surgical nurses. | 1. % of staff enrolled in the program 2. % of staff enrolled with Perioperative certificate | | |

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| | | | | | |
| | | Implement the newly designed Care Pathways for patients with a diagnosis of Heart Failure, Stroke and Chronic Obstructive Pulmonary Disease associated with the Interchange launch. | <ol style="list-style-type: none"> 1. % of care pathways implemented 2. % Care Pathways utilized in selected areas | | |
| | | Continue to advocate for build out of shelved in space at OTMH (3N, 4N and the 8th Floor). | <ol style="list-style-type: none"> 1. Continuation of engagement meetings with Ontario Health. 2. Completion of “Construction Ready” documents 3. Number of user group meetings conducted | | |
| | | Continue to advocate to strategic partners to advance approvals to complete the high fidelity fit out of MDH Med Surge 12 bed POD. | <ol style="list-style-type: none"> 1. Continuation of engagement meetings with Ontario Health. 2. Completion of “Construction Ready” documents 3. Number of user group meetings conducted | | |
| | | Build out two additional endoscopy rooms expand endoscopic procedure (Oakville Hospital). | <ol style="list-style-type: none"> 1. Completion of variance issued 2. Number of staff engagement meetings conducted 3. Start date of construction | | |
| | | Install specialized laser to expand urology procedure capacity (Milton Hospital). | <ol style="list-style-type: none"> 1. # of SSW Engagement meetings completed 2. Definition of procurement team 3. Completion of specifications | | |

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| Build partnerships with community to enhance spiritual care services. | To increase the number of spiritual care partnerships in the community by 5 by March 2023. | Survey partners to explore interest. | 1. # of community partners / partner groups surveyed | | |
| QUALITY DIMENSION → EQUITABLE | | | | | |
| To increase the awareness of the ethical framework throughout the organization. ROP | To increase the number of new members on the Ethics forum by 5 before March 31, 2023 | Monitor consult volumes Continue with ethics forum work plan Substitute Decision Maker Determination Diversity, Equity and Inclusion Working Group | 1. Ethics report quarterly at Quality Council 2. # of new member on the Ethics Forum 3. % of units with representation on DEI working group | | |
| Increase awareness and education of Substitute Decision Maker legislation. | Increase the number of patients with SDM Intervention utilized by 10% by March 2023. | Launch of SDM Intervention with Interchange go live. | 1. Successful creation and testing of SDM intervention. | | |
| QUALITY DIMENSION → PEOPLE | | | | | |
| Decrease the risks associated with maternal newborn care. QIP | To complete a three-year certification in the Salus Global moreOB program by 2025. | Launch Year I Managing Obstetrical Risk Effectively (MORE OB) Program. | 1. Successful recruitment of moreOB coordinator 2. Identification and launch of first Milestone at each hospital site. 3. % of eligible staff participating in Milestone activity | | |
| Decrease the amount of risk across programs by adopting the mitigation strategies with HIROC. | To decrease the number of unmet mitigation strategies to zero by March 2023. | Launch Cycle 3/Year One of HIROC's Risk Assessment Checklist Program and focused attention on the top three risk categories. | 1. Number of programs / units with a goal to meet unmet mitigations in the upcoming year. | | |

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| Support staff, physician patient safety education through Patient Safety Week events. | To increase the number of initiatives featured by 10% for the 2022 Patient Safety Expo. | Refresh / restart tri-site Patient Safety Expo post COVID pandemic. | <ol style="list-style-type: none"> 1. Establishment of working group 2. Develop implementation / marketing plan to support staff in completing their poster boards. 3. # of poster boards featured at the Expo | | |
| Increase awareness and learning from reported incident and incident analysis. ROP | Ensure every new leader (including professional staff leaders) receive an orientation package by March 2023. | Physician engagement Leader education Leverage various leader forums to share dashboard and support improvement initiatives stemming from incident themes. | <ol style="list-style-type: none"> 1. Creation of Physician toolkit 2. Completion of new leader orientation package | | |
| Increase program initiation of focused / targeted Quality of Care Review. | Increase the number of program based QCR being done by 5% by March 2023. | Refresh Quality of Care Review tools and process. Launch pre and post QCR meetings between leaders and Quality Team. | <ol style="list-style-type: none"> 1. Completion of gap analysis. 2. Determination of opportunities 3. Creation of education / implementation plan. | | |
| Build leadership development and safety culture improvement by pushing out customized reporting data at regular intervals. CAN-PSCS | Increase the number of Huddle Boards with Incident Report Data posted / discussed by 10% by March 2023. | Develop standard, easy to use report with meaningful data provided to managers monthly. | <ol style="list-style-type: none"> 1. Incident Management Policy revision 2. Update / Refresh Huddle Board template and toolkit | | |
| Promote / increase reporting of incidents and build confidence as a “just culture”. CAN-PSCS | Increase the number of resolved incidence with follow up to submitter by 10% by March 2023. | Regular messaging for PCMs to be role models in just culture and speaking points to take that messaging to the Daily Huddle Boards. | <ol style="list-style-type: none"> 1. # of units participating in daily huddles where IRS data is discussed | | |
| Ensure best staffing ratios | Employee Engagement Score-Pulse Survey | Launch of innovative retention and recruitment strategy. | <ol style="list-style-type: none"> 1. Completion of best practices information gathering | | |

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| | 5% improvement from baseline | | <ol style="list-style-type: none"> 2. Development of action plan 3. Reduction in vacancy rate | | |
| Increase Senior Leader visibility to safety concerns identified by staff. CAN-PSCS | Increase the number of senior leaders attending unit-based Huddles by 50% by December 2022. | Create a structure and process for Senior Leaders to attend Huddles across all three hospitals. | <ol style="list-style-type: none"> 1. Update posted schedule 2. Development of objectives for SLT 3. Monitor the number of senior leaders attending huddles. | | |
| Increase ease of use and knowledge level for end-users of RL6. CAN-PSCS | Increase the number of staff who have completed annual education refresher by 20% by March 2023. | Create mandatory annual e-Learning module to be incorporated in Core Curriculum. | <ol style="list-style-type: none"> 1. Striking of education working group. 2. % completion of content for learning module. | | |