Quality Improvement and Patient Safety Forum 2016
Welcome to the Quality Improvement and Patient Safety Forum 2016

Dear Colleagues,

It is our pleasure to welcome you to the Inaugural Quality Improvement and Patient Safety Forum. This event, organized by the Centre for Quality Improvement and Patient Safety (C-QuIPS) and Improving & Driving Excellence Across Sectors (IDEAS), speaks to the spirit of collaboration and partnership that are key ingredients to advancing quality improvement (QI) work, across the province.

Over the past several years, both C-QuIPS and IDEAS have been running very successful meetings for their communities, but both events had overlapping communities and goals. With the support of HQO, we have combined these events to create QIPSF2016. As a result of this partnership, the Forum has grown to 700 attendees, bringing together an even wider range of participants from across the province than just the C-QuIPS and IDEAS communities.

We’ve developed our program so that you can take away something from the Forum whether you’re a novice or are already entrenched in leading or supporting the operational and/or academic work in this field. Helen Bevan, Chief Transformation Officer at the Institute of Innovation and Improvement of the NHS, will deliver the opening keynote address on her experiences with organization and system-wide change, and Trey Coffey, Medical Officer at SickKids, will speak on her experience of spearheading an initiative to turn an already renowned institution into a high reliability organization.

Rounding out these presentations to all attendees, participants can choose from a range of breakout sessions that look at the local improvement work, such as the Local Innovations and Choosing Wisely workshops, beginner and advance data for QI, human factors, incident analysis and audit and feedback to provide grounding in practical methods for tackling healthcare quality and safety problems. Others sessions address patient engagement, becoming change agents, creating joy at work and HQO’s provincial QI strategy aim to encourage changes in our health system to improve patient and provider experience.

Leading, sustaining and spreading QI and patient safety initiatives in health care is complex and often a team effort. We hope that the interactive nature of our program supports inter-professional discussion, networking and knowledge exchange opportunities in our growing quality improvement and patient safety community.

Thank you for attending QIPSF 2016,

Dr. Joshua Tepper
President & Chief Executive Officer,
Health Quality Ontario

Dr. Steini Brown
Institute of Health Policy, Management & Evaluation
University of Toronto

Dr. Kaveh Shojania
Director, Centre for Quality Improvement and Patient Safety

Dr. Ross Baker
Institute of Health Policy, Management & Evaluation
University of Toronto

Dr. Michael Schull
President & Chief Executive Officer,
Institute for Clinical Evaluative Sciences
The Centre for Quality Improvement and Patient Safety (C-QuIPS) is a joint partnership between the University of Toronto’s Faculty of Medicine and two of its major teaching hospitals, Sunnybrook Health Sciences Centre and the Hospital for Sick Children. C-QuIPS provides leadership in quality improvement and patient safety education complemented by research programs and collaborative networks within the Toronto Academic Health Science Network (TAHSN) and the broader healthcare system.

Recognizing that the science of quality improvement and patient safety involves not just traditional biomedical sciences and health services research but also other disciplines, including human factors engineering, cognitive psychology, complexity science and information technology, the educational and research activities of the Centre draws on individuals and institutions in diverse disciplines and professions. The Centre’s educational efforts share the underlying goal of instilling frontline providers and middle managers with the tools required to undertake successful improvement projects in their practice settings. C-QuIPS education and training programs seek to develop a cadre of clinicians from different professions and practice settings who can lead or meaningfully support such local improvement activities.

C-QuIPS core and affiliated members engage in a broad range of research, mostly in the acute care setting, but also focused on improved care coordination and transitions across settings of care. Specific research topics include clinical informatics, medication safety, usability and human factors engineering, fatigue, handoffs between providers, innovative models for teaching the concepts and methods of quality improvement, and improving methods for identifying patient safety problems. In addition, C-QuIPS seeks to foster connectivity between groups working in patient safety and quality improvement, so that groups working on the same problems can learn from each other and also so that groups using different techniques and methods can benefit from collaboration.
About IDEAS

IDEAS (Improving & Driving Excellence Across Sectors) is a comprehensive, province-wide initiative aimed at enhancing Ontario’s health system performance by building capacity in quality improvement (QI), leadership and change management across all healthcare sectors.

IDEAS’ two accredited programs – the IDEAS Advanced Learning Program and the IDEAS Foundations of Quality Improvement (formerly called the IDEAS Introductory Program) – were designed in Ontario for Ontario healthcare professionals.

To date, IDEAS has trained more than 2,400 healthcare professionals. IDEAS Advanced Learning Program graduates have launched 127 initiatives aimed at introducing quality-based procedures into practices, improving the coordination of care of complex patients and enhancing the patient experience through better-integrated care delivery. Since 2014, the IDEAS Foundations program has been delivered across the province, in partnership with all the Ontario medical schools.

Recently, the Ministry of Health and Long-Term Care committed to funding IDEAS for an additional three years (2016 – 2019). In this next phase, IDEAS will be focused on supporting and expanding QI training across the province by offering programs that blend e-learning and in-class teaching, continuing to partner with the Ontario medical schools and partnering with healthcare organizations in delivering IDEAS programs.

Additionally, IDEAS develops and provides online QI resources – including IDEASOnline and ShareIDEAS, a resource of QI projects, from across the province.

IDEAS supports an active alumni community. By participating in IDEAS events (such as the Quality Improvement and Patient Safety Forum 2016), sharing their learnings with healthcare professionals across the province and collaborating with colleagues to lead new improvement projects, IDEAS graduates are actively developing a vibrant QI culture and community within Ontario’s health system.

Funded by the Ministry of Health and Long-Term Care, IDEAS was created and is delivered through a collaborative partnership among the six Ontario medical schools, Health Quality Ontario (HQO), the Institute for Clinical Evaluative Sciences (ICES), and the Institute of Health Policy, Management and Evaluation (IHPME) at the University of Toronto.
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<td>8:15am – 8:45am</td>
<td>Registration and Breakfast</td>
<td>Level 600 South Registration East</td>
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| 9:00am – 10:15am | **Keynote Address**  
|               | *How to Create Change that Sticks*                                   | Level 700 Room 718AB          |
|               | Dr. Helen Bevan  
|               | Chief Transformation Officer  
|               | NHS Institute for Innovation and Improvement                           |                               |
| 10:15am – 10:45am | Break and Poster Viewing                                             |                               |
| 10:45am – 12:15pm | **Concurrent Workshops**                                             | Level 700                    |
|               | 1 Audit and Feedback                                                  | Room 717B Room 716            |
|               | 2 Rocking the Boat but staying in it: How to be a Great Change Agent  |                               |
|               | 3 A Healthcare System Focused on Quality for All in Ontario:          |                               |
|               | An overview of HQO’s Provincial QI Strategy                           |                               |
|               | 4 Data 101: Data for Quality Improvement                             |                               |
|               | 5 Human Factors and Building Resilience in Your Healthcare System     |                               |
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|               | 7 Creating Joy in Work: The fourth pillar of the triple aim           |                               |
|               | 8 Top Abstracts                                                       |                               |
|               | 9 Patient Engagement in Action                                        |                               |
|               | 10 Teaching Quality Improvement and Patient Safety                    |                               |
| 12:15pm – 1:00pm | Networking Lunch                                                      | Room 718AB                    |
| 1:00pm – 1:45pm | Poster Viewing                                                        | Level 700 Room 718AB          |
| 1:45pm – 3:15pm | **Concurrent Workshops**                                             | Level 700                    |
|               | 1 Audit and Feedback                                                  | Room 717B Room 717A          |
|               | 2 Choosing Wisely Canada                                              |                               |
|               | 3 A Healthcare System Focused on Quality for All in Ontario:          |                               |
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|               | 6 Human Factors and Building Resilience in Your Healthcare System     |                               |
|               | 7 Incident Analysis                                                  |                               |
|               | 8 Creating Joy in Work: The fourth pillar of the triple aim           |                               |
|               | 9 Patient Engagement in Action                                        |                               |
|               | 10 Local Innovations                                                 |                               |
| 3:15pm – 3:30pm | Break                                                                 |                               |
| 3:30pm – 4:30pm | **Closing Keynote Address**                                          | Level 700 Room 718AB          |
|               | *Highlights of the Early Safety Journey*                              |                               |
|               | Dr. Trey Coffey, MD, FAAP, FRCRC  
|               | Medical Officer for Patient Safety, The Hospital for Sick Children   |                               |
|               | Associate Director, Centre for Quality Improvement and Patient Safety |                               |
| 4:30pm – 6:00pm | **IDEAS Alumni Achievement Awards**                                   | Room 718AB                    |
|               | Reception and Presentation                                           |                               |
SECTION B
The Metro Toronto Convention Centre

Level 600 – Registration, Coat Check and Parking

Level 700 – Keynote/Plenary Address, Workshops, Networking sessions

WIFI
Complimentary Wifi is offered at Metro Toronto Convention Centre. Please use the following info:
Network: QIPSF
Passcode: 4Quality
SECTION C
Keynote Speakers

Dr. Helen Bevan

How to Create Change that Sticks

Around the world, we see a consistent picture; many promising pilots in the healthcare improvement and implementation field have little overall impact when applied more broadly. Researchers suggest that the typical effect sizes of spread activities are perhaps 10-20% at best. If we want to buck this trend, we need to create the conditions so our improvement efforts can spread widely and create an impact across our organizations or even across a whole country.

In this session we will examine some of the latest evidence and methods for spread and sustainability of change.

Helen Bevan has been a leader of large scale change in the English National Health Service (NHS) for more than 20 years. Helen has been at the forefront of many NHS improvement initiatives that have made a difference for thousands of patients ever since. In 2010, Helen’s team launched a call to action, utilizing social movement leadership principles, which contributed to a 51% reduction in prescribing of antipsychotic drugs to people with dementia across the country. Helen initiated NHS Change Day, in partnership with a group of young clinical and managerial leaders in 2012. Helen also conceived the School for Health and Care Radicals, which is currently included on Britain’s 50 new radicals list sponsored by the Observer.

Helen Bevan is acknowledged globally for her expertise in large scale change and ability to translate it into practical action and deliver outcomes. She provides advice, guidance and training on transformational change to leaders of health and care systems across the world.

Dr. Trey Coffey, MD FAAP FRCPC

Highlights of the Early Caring Safely Journey

SickKids has embarked on this transformative safety journey, guided by principles of High Reliability and Safety Culture, in partnership with University Health Network and the 100-member Solutions for Patient Safety network. Trey will share stories which illustrate some of the key personal and organizational learnings from the first two years of Caring Safely.

Trey Coffey joined the University of Toronto and Hospital for Sick Children in 2005. While working as a hospitalist, Trey completed the U of T Certificate in Patient Safety and Quality Improvement, and become steadily more involved in projects ranging from hospital level to international. Her implementation and research interests have included medication reconciliation, disclosure, handoff, epidemiology of adverse events and high reliability organizations.

Trey is fortunate to enjoy improvement activities across borders with her combined roles of Associate Director at the University of Toronto Centre for Quality Improvement and Patient Safety, Medical Officer for Patient Safety at SickKids, executive member of the Pediatric International Patient Safety and Quality Community and core clinical steering team of Solutions for Patient Safety, a network of over 100 hospitals.

Co-leading Caring Safely at SickKids is Trey’s greatest challenge and joy to date and she looks forward to sharing this at the 2016 QIPS Forum.
SECTION D
Breakout Workshops

AM Workshops

Session 1: Audit and Feedback

All too frequently, when quality improvement (QI) interventions are tested in trials, the effects are less than expected. This talk will review the empirical evidence for one of the most common QI strategies, audit and feedback, as an intervention to improve quality of care and summarize best practices in the design of interventions that include feedback of performance metrics. This presentation will also explore how those leading QI initiatives can simultaneously contribute to the underlying science regarding how the effectiveness of such interventions can be optimized. Finally, this talk will explore how the lessons from the literature regarding audit and feedback can inform adoption and implementation of changes related to funding reforms including Quality-Based Procedures. Participants will have the opportunity to apply learnings in a case study group activity.

Dr. Noah Ivers is a Scientist at Women’s College Research Institute and a Family Physician at Women’s College Hospital. He is also an adjunct scientist at the Institute for Clinical Evaluative Studies. His research is focused on systematically developing and evaluating initiatives that aim to improve quality in primary care. He uses principles from clinical epidemiology and health services research to conduct pragmatic evaluations of complex interventions. He focuses on use of data to drive healthcare decisions through initiatives such as performance feedback to health professionals as well as tailored reminders to patients to enable both evidence based and patient centred care. He is supported by New Investigator Awards from CIHR and from the Department of Family and Community Medicine, University of Toronto.

Session 2: Rocking the Boat but staying in it: How to be a Great Change Agent

Change is hard and challenging the status quo too often results in resistance, negativity and defeat. Yet it is through the passionate efforts of committed individuals who are prepared to risk being labelled trouble makers that improvements happen, so how then do we lead change that energizes and creates alliances around a shared purpose? This talk discusses leading change that connects individuals rather than isolates, promotes passion rather than anger, creates possibilities rather than problems and generates energy rather than depletes it.

Helen Bevan has been a leader of large scale change in the English National Health Service (NHS) for more than 20 years. Helen has been at the forefront of many NHS improvement initiatives that have made a difference for thousands of patients ever since. In 2010, Helen’s team launched a call to action, utilizing social movement leadership principles, which contributed to a 51% reduction in prescribing of antipsychotic drugs to people with dementia across the country. Helen initiated NHS Change Day, in partnership with a group of young clinical and managerial leaders in 2012. Helen also conceived the School for Health and Care Radicals, which are currently included on Britain’s 50 new radicals list sponsored by the Observer.

Helen Bevan is acknowledged globally for her expertise in large scale change and ability to translate it into practical action and deliver outcomes. She provides advice, guidance and training on transformational change to leaders of health and care systems across the world.
Session 3: A Healthcare System Focused on Quality for All in Ontario: An Overview of HQO’s Provincial QI strategy.

This workshop will describe the current context of health care in Ontario. As well, opportunities and challenges for the implementation of a culture of quality, across the province, will be examined. Health Quality Ontario’s quality improvement (QI) strategy – including clinician engagement and accountability, regional quality tables, the implementation of Quality Standards – will be discussed. The audience will be engaged in a discussion of opportunities for ongoing engagement and partnership in advancing the goal of a culture of quality for all in Ontario.

Lee Fairclough is Health Quality Ontario’s Vice President, Quality Improvement. The Quality Improvement branch facilitates improvement in Ontario’s health system through the provision of system-level training and education and by working with the system on quality improvement initiatives and approaches in all sectors, including Quality Improvement Plans and knowledge transfer and exchange platforms such as the Quality Compass. Lee has a diverse background with extensive experience in health care delivery as a radiation therapist, health research and informatics, systems planning and policy, and institutional board membership.

Prior to joining HQO, Lee was the Vice President of Strategy, Knowledge Management & Delivery at the Canadian Partnership Against Cancer (CPAC), a national organization responsible for improving cancer control in Canada in a coordinated way with the cancer community for over six years. She initially joined as a member of the executive team to establish the newly created organization. She was also the Director of the first Toronto Regional Cancer Programme, as well as the Director of Informatics and of the Clinical Research Unity at the Princess Margaret Hospital. She’s gained knowledge of policy and funding reforms through experiences at the MOHLTC Health Results team and work with the Joint Policy in Planning Committee in 2002. Lee has also served as a member of the advisory board of the Institute of Health Sciences and Policy Research (IHSPR), and as a board member for a number of community agencies.

Lee holds an undergraduate degree in Biology and Mathematics from McMaster University, is trained as a radiation therapist through Sunnybrook and the University of Waterloo, and holds a Master of Health Sciences from the University of Toronto. In May 2014, she was awarded the inaugural Louise Lemieux Charles Emerging Health Leaders award from the Society of Graduates. She is an adjunct professor with the Institute for Health Policy Management and Evaluation (IHPME) at the University of Toronto.

Jeffrey Turnbull received his Doctorate in Medicine at Queen’s University and later achieved specialty certification in Internal Medicine through the Royal College of Physicians and Surgeons of Canada in 1982, in addition to a Bachelor’s degree in Science (University of Toronto) and a Master’s degree in Education (University of Western Ontario).

Dr. Turnbull has been the Vice Dean of Medical Education at the University of Ottawa (1996-2001), the President of the Medical Council of Canada (1998- 2001), the President of the College of Physicians and Surgeons of Ontario (2006-2007) and finally the President of the Canadian Medical Association (2010-2011).

Dr. Turnbull has pursued an interest in poverty and its effect on health nationally and internationally. He is one of the founders and is currently the Medical Director of Ottawa Inner City Health for the homeless which works to improve the health and access to health care for people who are chronically homeless. As well, he has been involved in education and health services initiatives to enhance community and institutional capacity and sustainable development in Bangladesh, Africa and the Balkans. He is the recipient of several national and international grants and awards, including the Order of Canada, the Order of Ontario, the Queen Elizabeth II Diamond Jubilee Medal and an Honorary Degree of Law from Carleton University.
Session 4: Data 101: Data Collection and Graphing for Quality Improvement

During the workshop, we’ll cover the lifetime of a Statistical Process Control chart, from collecting baseline data to learning from PDSA cycles, to monitoring the process afterwards to ensure that improvements are sustained. The workshop will also examine considerations of sample size, subgrouping, and stratification – all of which are important in order to ensure that you can learn as much possible from the data you worked so hard to collect.

Laura Maclagan is a Quality Improvement Epidemiologist and Health Services Researcher at the Institute for Clinical Evaluative Sciences (ICES) in Toronto, Ontario. Laura began her work with IDEAS in February 2016. Laura provides support to IDEAS teams regarding data collection and analysis for their quality improvement projects. Laura holds a Master’s degree in Epidemiology from McGill University and an undergraduate degree in Biology from Queen’s University in Kingston, Ontario.

Ruth Croxford is a Quality Improvement Epidemiologist and Health Services Researcher at the Institute for Clinical Evaluative Sciences (ICES) in Toronto, Ontario. She has been associated with IDEAS since cohort 1, providing support in the areas of data acquisition and interpretation, statistical process control charts, and the analysis of cost data.

Ruth holds a Master’s degree in Statistics from the University of Toronto, and a Master’s degree in Computer Science from Queen’s University in Kingston, Ontario.
Session 5: Human Factors and Building Resilience in Your Healthcare System

The complex, dynamic, and at times unpredictable nature of healthcare environments often place unreasonable demands on clinicians to be more accurate and efficient than is possible. Safety management should therefore focus on both a Safety-I approach (which defines safety as the absence of errors) and a Safety-II approach (which defines safety as the system's ability to adapt under varying conditions). This session will highlight the benefits of applying a combination of theoretical frameworks/approaches when identifying and developing error mitigation strategies. In particular, it will focus on strategies that provide clinicians with the tools to be the adaptive component in the larger healthcare system. By including these strategies in improvement efforts, our healthcare system can move from brittle (where negative outcomes occur as soon as unexpected situations arise) to resilient (where adaptive solutions emerge when unexpected situations are encountered).

Patricia Trbovich, Badeau Family Research Chair in Patient Safety and Quality Improvement at North York General Hospital, is Associate Professor of Quality Improvement and Patient Safety in the Institute of Health Policy, Management and Evaluation and in the Institute of Biomaterials and Biomedical Engineering at the University of Toronto, where she leads the HumanEra team. She is also an Affiliate Scientist within TECHNA at the University Health Network. Her areas of expertise include human factors, patient safety, and behavioural change. Her research program aims to develop a fundamental understanding of how to design IT to support high order cognitive functions while striking a balance between automation and human operation. She has also conducted extensive research on mitigation of interruptions on delivery of high-risk medical procedures. She is collaborating with researchers in Brazil and Spain to develop of human factors expertise in their healthcare systems.

Sonia Pinkney is a Human Factors Engineer with HumanEra, University Health Network (UHN), Toronto, Canada. She is also a Manager of the Medical Engineering Department at UHN. She has over fifteen years experience working on diverse healthcare and technology-related projects in both operational and research roles. Sonia’s expertise spans the entire life cycle of technology, including: designing award-winning technology; procuring the implementing diverse medical technology; managing critical patient safety incidents; and researching how to improve patient safety. She joined Human Era in 2007, where her current area of focus is on using human factors methods to improve the safety of intravenous infusions.

Mark Fan is a member of HumanEra and helps conduct human factors studies in his role as a research manager at North York General Hospital’s Centre for Research and Innovation. He has a Masters of Health Science in clinical engineering from the University of Toronto. He studies how the design of technologies, staff training, hospital environments and clinical workflows can contribute to errors in a variety of contexts including, in-situ trauma resuscitation, usability assessments of emerging technologies, intravenous medication administration, and regulatory environments. He has spoken locally and internationally on human factors and HumanEra’s findings.
**Session 6: Incident Analysis**

This session will take the attendees through the incident management continuum using an illustrative case study (where the audience will assist in the immediate management of this patient safety incident). The elements of the continuum will be underpinned by key ideas of root cause categories and just culture. Legislation pertaining to incident analysis will also be discussed.

**Amir Ginzburg** is a specialist in internal medicine and Trillium Health Partners’ Chief of Quality and Medical Director of Medical Administration. He has led improvement efforts in critical incident management, interprofessional communication, avoidable hospitalization and the use of standardized order sets in clinical care. He has participated in cross-sectoral improvement initiatives in primary, community, and long term care. Amir served as the inaugural Medical Lead for Health System Funding Reform at the Mississauga-Halton LHIN and is currently their Clinical Quality Lead in partnership with Health Quality Ontario. He is a Master Facilitator for the Patient Safety Education Program Canada, and an Assistant Professor at the University of Toronto’s Institute of Health Policy, Management and Evaluation. In 2013, the Canadian Patient Safety Institute honoured Amir by including him in a select group of influencers of patient safety in Canada.

**Session 7: Creating Joy in Work: the Fourth Pillar of the Triple Aim**

Evidence shows that achieving joy in work leads to more engagement, greater satisfaction (for both patients and staff), and better outcomes. However, evidence also shows that obtaining joy in work is often challenging, and increasingly care providers are reporting burnout, dissatisfaction, and a loss of purpose. In this session, participants will reflect on the attributes of a care environment that promote or inhibit joy in work and the important connection with person- and family- centered care and the achievement of the Triple Aim.

**Christopher Hayes** is a 2013-14 Canadian Harkness/IHI Fellow in Health Care Policy and Practice, has been at St. Michael’s Hospital in Toronto since 2005, where he is the critical care response team site director and the medical director of quality and performance. He is an assistant professor at the University of Toronto in the Department of Medicine and the Institute for Health Policy, Management and Evaluation. He is a core faculty member of the IHMPE Masters in Quality Improvement and Patient Safety and Improvement Advisor and Faculty with the Canadian Foundation for Healthcare Improvement. From 2008 to 2015, was the medical officer for the Canadian Patient Safety Institute, where he chaired the Canadian Safe Surgery Saves Lives program. He is a recognized leader in patient safety and quality improvement, working with regional, national, and international organizations.
Session 8: Top Abstracts

This session consists of four “Top Abstracts” oral presentations. These abstracts were chosen from the over 75 poster abstract submissions. Each presenter will have ten minutes to present followed by five minutes of questions and discussion.

**Targeted deprescribing in an outpatient hemodialysis unit: A study to decrease polypharmacy**

**Presenter:** Marisa Battistella, BSc Phm, Pharm D, ACPR, University Health Network, Leslie Dan Faculty of Pharmacy, University of Toronto

Marisa is a pharmacist in the nephrology program at the University Health Network and Assistant Professor at the University of Toronto, Leslie Dan Faculty of Pharmacy. As Pharmacy Clinician Scientist, Marisa’s primary research interests are in the areas of infections, pharmacokinetics and pharmacogenomics in the dialysis population.

**Enhancing patient experience with follow-up diabetes care while increasing efficiencies using quality improvement methods**

**Presenter:** Margaret De Melo, RD, CDE, MSc, Toronto Western Hospital, University Health Network

Margaret De Melo is a practice leader in Clinical Nutrition at the Toronto Western Hospital, University Health Network. She is a registered dietitian and certified diabetes educator. Margaret completed her MSc degree in Quality Improvement & Patient Safety at the University of Toronto’s Institute of Health Policy, Management & Evaluation in 2015 – the program’s first RD. Her research interests have focused on diabetes self-management education and service utilization. She served the UoT’s Banting and Best Diabetes Centre, Diabetes Research, Care & Education Committee as a volunteer member for over ten years. Margaret is recognized as a pioneer in the development of several culturally-tailored diabetes programs, and is recipient of several local and national research and education awards for her work.

**Use of Patient-Oriented Discharge Summaries (PODS) at time of discharge from the clinical teaching unit improves transitional care by targeting patient education and access to timely follow-up**

**Presenter:** Erin Spicer, MD, MSc, General Internal Medicine PGY4, Western University

Erin Spicer received a HBSc. in Biomedical Sciences and a M.Sc. in Biology at University of Waterloo (UW). She worked as an interim lecturer for the department of biology at UW for one year before attending the University of Toronto for medical school from 2009-2013. She completed her core internal medicine training at Western University as well as the 5-year General Internal Medicine fellowship program. Her hope is to complete a Master’s Degree in Quality Improvement next year.

**Reduction of severe intraventricular hemorrhage in the micropremature population**

**Presenter:** Sabrina Wong, MSc, NP-Paediatrics, Sunnybrook Health Sciences Centre

Sabrina Wong is a Neonatal Nurse Practitioner at Sunnybrook Health Sciences Centre in Toronto, Ontario. She studied biology and nursing at Queen’s University and received her Master’s of Science and her Advanced Neonatal Nursing Diploma at McMaster University. With more than 13 years’ experience in the NICU her non-clinical interests include informatics and the prevention and reduction of intraventricular hemorrhages in the neonatal population.
Session 9: Patient Engagement in Action

Participants will experience first-hand the wealth of knowledge gained from patient and caregiver partnerships through this dynamic workshop, co-facilitated by patient and family advisors. Using established patient engagement principles and QI methodologies, participants will partner with HQO advisors to discover how these voices can join to improve the health system. Participants will learn tangible skills that they can bring into their work and leave feeling confident in their ability to partner with patients, their caregivers and other healthcare professionals from across the health system.

Aman Sium is a community educator with an interest in health care access and equity. He has over a decade of experience in anti-racist policy and practice, youth employment counselling, and patient and family education in the hospital sector. Aman is currently a Knowledge Transfer & Exchange Specialist working with Health Quality Ontario’s Patient, Caregiver and Public Engagement team. His work includes leading the planning of regional events highlighting engagement practices across the province and working with health system users and providers to create resources to support their engagement activities.

Patient Panelist
Gene Szabo  |  Barbara Sklar  |  Katherine Chan  |  Kathy Greiner

Session 10: Teaching Quality Improvement and Patient Safety

The session will begin with a brief overview of the evolution of patient safety and QI education over the past 15 years, with specific focus on the expected competencies that health professionals should have with respect to patient safety and QI. Participants will then work together to explore and practice different approaches to teaching patient safety and QI, including facilitated small group learning, case-based learning, and project-based learning.

Brian Wong is an Associate Professor and the Director of Continuing Education and Quality Improvement in the Department of Medicine at the University of Toronto, and the Associate Director for the Centre for Quality Improvement and Patient Safety at the University of Toronto. Clinically, he works as a general internist in the Division of General Internal Medicine at Sunnybrook Health Sciences Centre. Over the past 5 years, he has trained hundreds of interprofessional trainees and faculty through various educational activities at the local and national level.

He created an innovative ‘co-learning’ model of QI education, whereby faculty learn alongside residents to develop expertise in carrying out and teaching QI. More broadly, he chaired the Patient Safety/Quality Improvement Expert Working Group for the Royal College of Physicians and Surgeons of Canada and generated a series of recommendations that led to the integration of patient safety and QI as core competencies in the updated CanMEDS 2015 framework.
**PM Workshops**

**Session 1: Audit and Feedback**

All too frequently, when quality improvement (QI) interventions are tested in trials, the effects are less than expected. This talk will review the empirical evidence for one of the most common QI strategies, audit and feedback, as an intervention to improve quality of care and summarize best practices in the design of interventions that include feedback of performance metrics. This presentation will also explore how those leading QI initiatives can simultaneously contribute to the underlying science regarding how the effectiveness of such interventions can be optimized. Finally, this talk will explore how the lessons from the literature regarding audit and feedback can inform adoption and implementation of changes related to funding reforms including Quality-Based Procedures. Participants will have the opportunity to apply learnings in a case study group activity.

**Dr. Noah Ivers** is a Scientist at Women’s College Research Institute and a Family Physician at Women’s College Hospital. He is also an adjunct scientist at the Institute for Clinical Evaluative Studies. His research is focused on systematically developing and evaluating initiatives that aim to improve quality in primary care. He uses principles from clinical epidemiology and health services research to conduct pragmatic evaluations of complex interventions. He focuses on use of data to drive healthcare decisions through initiatives such as performance feedback to health professionals as well as tailored reminders to patients to enable both evidence based and patient centered care. He is supported by New Investigator Awards from CIHR and from the Department of Family and Community Medicine, University of Toronto.

**Session 2: Choosing Wisely Canada**

The session will begin with a brief didactic presentation highlighting implementation principles and strategies. Attendees will work in small groups to apply theory to address common challenges facing resource utilization implementation. Participants will have the opportunity to share their own experiences in reducing unnecessary use of resources.

**Jerome Leis** completed medical school at the University of Ottawa followed by postgraduate training in Internal Medicine and Infectious Diseases at the University of Toronto. After completing a Masters of Science in Quality Improvement and Patient Safety, he started on Faculty in the Division of Infectious Diseases at Sunnybrook Health Sciences Centre. Dr. Leis’ research program is focused on developing new models of care that promote improved infection-related hospital outcomes using less healthcare resources. He is the hospital’s Physician Lead in Antimicrobial Stewardship and co-chair of the Choosing Wisely campaign for the Association of Medical Microbiology and Infectious Diseases of Canada.

**Christine Soong** is an academic hospitalist and an Assistant Professor in the Division of General Internal Medicine at the University of Toronto. She completed her medical degree at Western University, family medicine residency at the University of Toronto, and a Master’s degree in Quality Improvement and Patient Safety at the Institute of Health Policy, Management and Evaluation in 2013. Dr. Soong the Director of the UHN/MSH Hospital Medicine program and clinical fellowship. She is the chair of the Quality Improvement Committee of the Canadian Society of Hospital Medicine and leading the Choosing Wisely Committees for the Canadian Societies of Internal Medicine, and Hospital Medicine. Her research and QI interests include utilization and appropriateness, novel models of inpatient care, and transitions of care.
Session 3: A Healthcare System Focused on Quality for All in Ontario: An Overview of HQO’s Provincial QI strategy.

This workshop will describe the current context of health care in Ontario. As well, opportunities and challenges for the implementation of a culture of quality, across the province, will be examined. Health Quality Ontario’s quality improvement (QI) strategy – including clinician engagement and accountability, regional quality tables, the implementation of Quality Standards – will be discussed. The audience will be engaged in a discussion of opportunities for ongoing engagement and partnership in advancing the goal of a culture of quality for all in Ontario.

Lee Fairclough is Health Quality Ontario’s Vice President, Quality Improvement. The Quality Improvement branch facilitates improvement in Ontario’s health system through the provision of system-level training and education and by working with the system on quality improvement initiatives and approaches in all sectors, including Quality Improvement Plans and knowledge transfer and exchange platforms such as the Quality Compass. Lee has a diverse background with extensive experience in health care delivery as a radiation therapist, health research and informatics, systems planning and policy, and institutional board membership.

Prior to joining HQO, Lee was the Vice President of Strategy, Knowledge Management & Delivery at the Canadian Partnership Against Cancer (CPAC), a national organization responsible for improving cancer control in Canada in a coordinated way with the cancer community for over six years. She initially joined as a member of the executive team to establish the newly created organization. She was also the Director of the first Toronto Regional Cancer Programme, as well as the Director of Informatics and of the Clinical Research Unity at the Princess Margaret Hospital. She’s gained knowledge of policy and funding reforms through experiences at the MOHLTC Health Results team and work with the Joint Policy in Planning Committee in 2002. Lee has also served as a member of the advisory board of the Institute of Health Sciences and Policy Research (IHSPR), and as a board member for a number of community agencies.

Lee holds an undergraduate degree in Biology and Mathematics from McMaster University, is trained as a radiation therapist through Sunnybrook and the University of Waterloo, and holds a Master of Health Sciences from the University of Toronto. In May 2014, she was awarded the inaugural Louise Lemieux Charles Emerging Health Leaders award from the Society of Graduates. She is an adjunct professor with the Institute for Health Policy Management and Evaluation (IHPME) at the University of Toronto.

Jeffrey Turnbull received his Doctorate in Medicine at Queen’s University and later achieved specialty certification in Internal Medicine through the Royal College of Physicians and Surgeons of Canada in 1982, in addition to a Bachelor’s degree in Science (University of Toronto) and a Master’s degree in Education (University of Western Ontario).

Dr. Turnbull has been the Vice Dean of Medical Education at the University of Ottawa (1996-2001), the President of the Medical Council of Canada (1998- 2001), the President of the College of Physicians and Surgeons of Ontario (2006-2007) and finally the President of the Canadian Medical Association (2010-2011).

Dr. Turnbull has pursued an interest in poverty and its effect on health nationally and internationally. He is one of the founders and is currently the Medical Director of Ottawa Inner City Health for the homeless which works to improve the health and access to health care for people who are chronically homeless. As well, he has been involved in education and health services initiatives to enhance community and institutional capacity and sustainable development in Bangladesh, Africa and the Balkans. He is the recipient of several national and international grants and awards, including the Order of Canada, the Order of Ontario, the Queen Elizabeth II Diamond Jubilee Medal and an Honorary Degree of Law from Carleton University.
Session 4: Data 201: Data Collection and Graphing for Quality Improvement

During the workshop, we’ll cover the lifetime of a Statistical Process Control chart, from collecting baseline data to learning from PDSA cycles, to monitoring the process afterwards to ensure that improvements are sustained. The workshop will also examine considerations of sample size, subgrouping, and stratification – all of which are important in order to ensure that you can learn as much possible from the data you worked so hard to collect.

Laura Maclagan is a Quality Improvement Epidemiologist and Health Services Researcher at the Institute for Clinical Evaluative Sciences (ICES) in Toronto, Ontario. Laura began her work with IDEAS in February 2016. Laura provides support to IDEAS teams regarding data collection and analysis for their quality improvement projects. Laura holds a Master’s degree in Epidemiology from McGill University and an undergraduate degree in Biology from Queen’s University in Kingston, Ontario.

Ruth Croxford is a Quality Improvement Epidemiologist and Health Services Researcher at the Institute for Clinical Evaluative Sciences (ICES) in Toronto, Ontario. She has been associated with IDEAS since cohort 1, providing support in the areas of data acquisition and interpretation, statistical process control charts, and the analysis of cost data. Ruth holds a Master’s degree in Statistics from the University of Toronto, and a Master’s degree in Computer Science from Queen’s University in Kingston, Ontario.

Session 5: Hot Topics in Quality Improvement and Patient Safety: Selected Papers Advancing the Field in the Past Year

The breadth of fields relevant to quality improvement (QI) and patient safety and the wide range of sources in which new research appears can make it difficult to keep abreast of important developments in QI and patient safety. In this session, the presenters will discuss the most notable research of the past year and address how the evidence-based QI and patient safety interventions and effective strategies identified in these papers can be translated into practice.

Dr. Kaveh Shojania is the Director of the Centre for Quality Improvement and Patient Safety (C-QuIPS) at the University of Toronto, where he also sees patients as a general internist at Sunnybrook Health Sciences Centre.

He has published on a range of topics related to healthcare quality, including in high impact journals such as the New England Journal of Medicine, Lancet, and JAMA. In 2004, Dr. Shojania received one of the John M. Eisenberg Patient Safety Awards from the US Joint Commission and the National Quality Forum for work in patient safety that has had an impact at a national level. He has twice delivered invited lectures to the US Institute of Medicine. Since January 2011, he has been the Editor-In-Chief of BMJ Quality and Safety. For several years, he has delivered an annual ‘year in review’ keynote at the US National Patient Safety Foundation annual meeting.
Session 6: Human Factors and Building Resilience in Your Healthcare System

The complex, dynamic, and at times unpredictable nature of healthcare environments often place unreasonable demands on clinicians to be more accurate and efficient than is possible. Safety management should therefore focus on both a Safety-I approach (which defines safety as the absence of errors) and a Safety-II approach (which defines safety as the system's ability to adapt under varying conditions). This session will highlight the benefits of applying a combination of theoretical frameworks/approaches when identifying and developing error mitigation strategies. In particular, it will focus on strategies that provide clinicians with the tools to be the adaptive component in the larger healthcare system. By including these strategies in improvement efforts, our healthcare system can move from brittle (where negative outcomes occur as soon as unexpected situations arise) to resilient (where adaptive solutions emerge when unexpected situations are encountered).

Patricia Trbovich, Badeau Family Research Chair in Patient Safety and Quality Improvement at North York General Hospital, is Associate Professor of Quality Improvement and Patient Safety in the Institute of Health Policy, Management and Evaluation and in the Institute of Biomaterials and Biomedical Engineering at the University of Toronto, where she leads the HumanEra team. She is also an Affiliate Scientist within TECHNA at the University Health Network.

Her areas of expertise include human factors, patient safety, and behavioural change. Her research program aims to develop a fundamental understanding of how to design IT to support high order cognitive functions while striking a balance between automation and human operation. She has also conducted extensive research on mitigation of interruptions on delivery of high-risk medical procedures. She is collaborating with researchers in Brazil and Spain to develop of human factors expertise in their healthcare systems.

Sonia Pinkney is a Human Factors Engineer with HumanEra, University Health Network (UHN), Toronto, Canada. She is also a Manager of the Medical Engineering Department at UHN. She has over fifteen years experience working on diverse healthcare and technology-related projects in both operational and research roles. Sonia’s expertise spans the entire life cycle of technology, including: designing award-winning technology; procuring the implementing diverse medical technology; managing critical patient safety incidents; and researching how to improve patient safety. She joined Human Era in 2007, where her current area of focus is on using human factors methods to improve the safety of intravenous infusions.

Mark Fan is a member of HumanEra and helps conduct human factors studies in his role as a research manager at North York General Hospital’s Centre for Research and Innovation. He has a Masters of Health Science in clinical engineering from the University of Toronto.

He studies how the design of technologies, staff training, hospital environments and clinical workflows can contribute to errors in a variety of contexts including, in-situ trauma resuscitation, usability assessments of emerging technologies, intravenous medication administration, and regulatory environments. He has spoken locally and internationally on human factors and HumanEra’s findings.
Session 7: Incident Analysis
This session will take the attendees through the incident management continuum using an illustrative case study (where the audience will assist in the immediate management of this patient safety incident). The elements of the continuum will be underpinned by key ideas of root cause categories and just culture. Legislation pertaining to incident analysis will also be discussed.

Amir Ginzburg is a specialist in internal medicine and Trillium Health Partners’ Chief of Quality and Medical Director of Medical Administration. He has led improvement efforts in critical incident management, interprofessional communication, avoidable hospitalization and the use of standardized order sets in clinical care. He has participated in cross-sectoral improvement initiatives in primary, community, and long term care. Amir served as the inaugural Medical Lead for Health System Funding Reform at the Mississauga-Halton LHIN and is currently their Clinical Quality Lead in partnership with Health Quality Ontario. He is a Master Facilitator for the Patient Safety Education Program Canada, and an Assistant Professor at the University of Toronto’s Institute of Health Policy, Management and Evaluation. In 2013, the Canadian Patient Safety Institute honoured Amir by including him in a select group of influencers of patient safety in Canada.

Session 8: Creating Joy in Work: the Fourth Pillar of the Triple Aim
Evidence shows that achieving joy in work leads to more engagement, greater satisfaction (for both patients and staff), and better outcomes. However, evidence also shows that obtaining joy in work is often challenging, and increasingly care providers are reporting burnout, dissatisfaction, and a loss of purpose. In this session, participants will reflect on the attributes of a care environment that promote or inhibit joy in work and the important connection with person- and family- centered care and the achievement of the Triple Aim.

Christopher Hayes is a 2013-14 Canadian Harkness/IHI Fellow in Health Care Policy and Practice, has been at St. Michael’s Hospital in Toronto since 2005, where he is the critical care response team site director and the medical director of quality and performance. He is an assistant professor at the University of Toronto in the Department of Medicine and the Institute for Health Policy, Management and Evaluation. He is a core faculty member of the IHMPE Masters in Quality Improvement and Patient Safety and Improvement Advisor and Faculty with the Canadian Foundation for Healthcare Improvement. From 2008 to 2015, was the medical officer for the Canadian Patient Safety Institute, where he chaired the Canadian Safe Surgery Saves Lives program. He is a recognized leader in patient safety and quality improvement, working with regional, national, and international organizations.

Session 9: Patient Engagement in Action
Participants will experience first-hand the wealth of knowledge gained from patient and caregiver partnerships through this dynamic workshop, co-facilitated by patient and family advisors. Using established patient engagement principles and QI methodologies, participants will partner with HQO advisors to discover how these voices can join to improve the health system. Participants will learn tangible skills that they can bring into their work and leave feeling confident in their ability to partner with patients, their caregivers and other healthcare professionals from across the health system.

Aman Sium is a community educator with an interest in health care access and equity. He has over a decade of experience in anti-racist policy and practice, youth employment counselling, and patient and family education in the hospital sector.

Aman is currently a Knowledge Transfer & Exchange Specialist working with Health Quality Ontario’s Patient, Caregiver and Public Engagement team. His work includes leading the planning of regional events highlighting engagement practices across the province and working with health system users and providers to create resources to support their engagement activities.

Patient Panelist
Gene Szabo | Barbara Sklar | Katherine Chan | Kathy Greiner
Session 10: Local Innovations

In this session, the speakers will share lessons learned from the design and implementation of local innovations to improve patient safety and the quality of care.

Dr. Vicky Stergiopoulos will present lessons learned from efforts to support transitions of care and service coordination for people who are homeless or frequent users of emergency departments. Barriers and facilitators to continuity of care for these populations will be discussed. As well, health and service use outcomes of brief inter-professional interventions implemented in a large urban centre to bridge hospital and community care will be described.

Dr. Teodor Grancharov will review the impact of objective and reliable assessment on quality of surgical education and safety. He will present lessons learned from the implementation of successful training strategies from other high-risk, high-performance, such as the “blackbox” used in the airline industry. As well, Dr. Grancharov will highlight the implementation of modern risk reduction strategies in surgery.

Vicky Stergiopoulos is a clinician scientist and the Physician-in-Chief at the Centre for Addiction and Mental Health. She is also an Associate Professor and Director of the Division of Adult Psychiatry and Health Systems at the University of Toronto, and a clinician scientist at the Centre for Urban Health Solutions, the Li Ka Shing Knowledge Institute, St. Michael’s Hospital. Her research focuses on the design, implementation and evaluation of interventions aiming to improve housing stability, service integration, and recovery for adults experiencing complex mental health and social needs, including people experiencing homelessness or making frequent use of emergency departments.

Teodor Grancharov completed his surgical training at the University of Copenhagen, and a doctoral degree in Medical Sciences at the University of Aarhus in Denmark. Dr. Grancharov is a staff surgeon at St. Michael’s Hospital and a Professor of Surgery at the University of Toronto. He holds a Canada Research Chair in Simulation and Surgical Safety.

Dr. Grancharov’s clinical interest is the area of minimally invasive surgery, with a focus on foregut disease including cancer and revisional bariatric surgery. Dr. Grancharov’s area of academic interest is in the field of minimally invasive surgery, surgical education and patient safety. He has become internationally recognized as a leader in this area with a focus on curriculum design, assessment of competence and impact of surgical performance on clinical outcomes. Dr. Grancharov developed the surgical black box concept, which aims to transform the safety culture in medicine and introduce modern safety management systems in the high-risk operating room environment.

Dr. Grancharov has more than 120 peer-reviewed publications and more than 130 invited presentations in Europe, South- and North America. He sits on numerous committees with The American College of Surgeons (ACS), The Society of the American Gastrointestinal and Endoscopic Surgeons (SAGES), and The Association for Surgical Education (ASE). He sits on the Editorial Boards of The British Journal of Surgery and Surgical Endoscopy.
www.shareideas.ca

ShareIDEAS is designed for health care professionals, managers and executives in Ontario to help you advance quality improvement (QI) work in your own organization or sector.

Our database and search tool allows you to quickly find results, key learnings and insights from relevant QI projects that you can apply in your own setting.

We also provide contact information for each project so you can connect and learn directly from others with related knowledge and experience.

All applied projects that have gone through the IDEAS Advanced Learning Program are featured on ShareIDEAS. Check it out!
SECTION G
Centre for Quality Improvement and Patient Safety

Educational Programs
The Centre focuses on capacity building through education and training in the methods of quality improvement as well as patient safety. Equipping a cadre of individuals from a wide range of clinical settings to develop improvement projects in their own clinical settings (sometimes in partnership with experts at C-QuiPS) offers them the opportunity for local improvements and academic productivity.

The Centre has developed educational programs at both undergraduate and post graduate levels of learners. Please see below for more information about our programs.

1) Quality Improvement Workshops
Interactive workshops geared towards those with little to no background in this field and would like to learn more, but do not have the time to devote to a course running over several months. The two-part workshop is delivered to professional groups of 15-20 participants. Aspects of the workshop are customized to meet the distinct needs of the individual group, introducing clinicians and administrators to the basic principles and processes needed to successfully design and implement quality initiatives within their local contexts. Topics covered include: Characterizing quality problems, Leading Change, QI tools including Ishikawa diagrams and process mapping, Understanding variation with run charts, The role of qualitative methods in improvement, etc.

2) Certificate Course in Patient Safety and Quality Improvement
The Certificate Course is aimed at clinicians and administrators whose work relates to patient safety or quality improvement, as well as senior trainees considering a focus on quality improvement for their careers. The course consists of approximately 60 in-class hours over 10 months, covering core concepts in patient safety and methods of quality improvement, using a mixture of didactic lectures, interactive workshop-type sessions, and project presentations by class participants to receive feedback on the QI project each is developing. Please note that due to the nature of the program, preference will be given to applicants who can apply a quality improvement or patient safety project in a work-place setting with the support of their sponsor.

*Admission Requirements: A completed application consists of: 1) Applicant Information & Abbreviated CV (4 pages max) 2) Personal Statement (300 words) 3) Two Letters of Support (to be completed by referees) from your current institution where you will undertake the QI project. Applications will be available for download from the Centre’s website in mid-March, 2017 and are due mid-May, 2017.
3) Masters Degree Program in Quality Improvement and Patient Safety

The Institute of Health Policy Management and Evaluation (IHPME), in collaboration with the Centre for Quality Improvement and Patient Safety, offers the concentration in Quality Improvement and Patient Safety, providing MSc students with the opportunity to focus their research and learning on all aspects of improvement science, current issues in healthcare quality and safety and relevant leadership and influencing skills. The program is offered in a modular format to allow individuals to earn this research degree in one year without interrupting their careers. The transdisciplinary curriculum provides a solid foundation in quality and safety improvement theory and research methods as they apply to the current Canadian health care context. Students will also explore best practices in implementing quality improvement and develop the necessary leadership and change management skills to lead improvement across the system. More information related to Masters Degree program admission requirements and suitability can be found on the IHPME website.

4) VA Quality Scholars Program (VAQS)

The VAQS program began in the late 1990’s and has been recognized as one of the most comprehensive and established Quality Improvement (QI) training programs. It is designed using a ‘hub and spoke’ model and consists of 8 sites across the United States as well as Toronto, the ninth and the only non-American site. The program runs for two years and is designed to nurture fellows and junior faculty and allow them to develop a career in research, in QI and health services, or in QI within the framework of a position in medical administration, education, or clinical practice. Fellows engage in projects and experiential learning opportunities at their sites, as well as with the VAQS didactic curriculum. The VA Quality Scholars curriculum consists of four courses – Foundations of Quality, Quality Improvement Methods and Skills, Professional Development and Leadership, and Fellows’ Forum. Each week, a course is presented through the virtual platform to each of the nine sites throughout North America. Please visit the Centre’s website for more information about the application submission process.

5) Faculty Resident Co-Learning Curriculum in Quality Improvement

Many residency programs are committed to teaching QI to their trainees, but lack the faculty capacity to deliver a formal QI curriculum. The Faculty-Resident Co-Learning Curriculum in QI, created by Drs. Brian Wong and Kaveh Shojania, addressed this need by taking the innovative approach of teaching faculty and residents together, with the goal of producing a cadre of faculty members that can teach QI to learners in their own educational contexts. This curriculum seeks to develop quality improvement (QI) knowledge and skills among senior-level trainees, and engage them in team-based quality improvement initiatives under the mentorship of their faculty members (both the program director and a designated faculty lead). Residents work together with the faculty leads to carry out a single QI project throughout the academic year. QI projects generally align with divisional quality priorities—wherever possible, the focus of the improvement activities also generally align with ongoing quality initiatives. Ideally, programs should try to provide some protected time every 2-3 weeks to allow project teams to come together to plan and carry out their project. Please visit the Centre’s website for more information on how to get your hospital division involved in this collaborative program.
C01) Cardiac Care Flow Project
Tina Oliveira, Dr Ron Butler, Eleanor Marris Rogers
(London Health Sciences Centre)

Aim/Objectives: Big Dot AIM: By September 2016 we will decrease the delays in the transfer of post-operative cardiac surgery patients from the Cardiac Surgery Recovery Unit (CSRU) to the in-patient ward (6IP) by 50%.

Small Dot AIM: We will improve the communication (quality and timeliness) between 6IP and CSRU related to patient transfers as measured by our team survey.

Intervention/Change Ideas: Issue log created to review current trends, identify areas for improvement and create PDSA cycles. Small group sessions were held to vet ideas and work on opportunities to improve the communication between 6IP and CSRU. Nurse shadow opportunities were established to develop relationships between 6IP and CSRU and understand the impact and barriers related to delays in transfer. We identified areas for improvement in corporate processes related to bed assignment and transfer process. A new transfer list was developed outlining patients ready for transfer in order of readiness with an overview of acuity. The transfer of information report changed to face to face report involving a safety check.

Evaluation/Measures: Pre and post staff surveys assessed for a cultural shift with staff. Critical Care Information System data provided transfer delay data.

Spread/Sustainability: A transfer algorithm has been developed in conjunction with Access and Flow to set guidelines related to MSICU/CSRU transfers to floor units citywide. We are working with the pre admit clinic to develop a methodology to identify high risk patients who may have discharge delays and offering them resources prior to their surgery.

Key Lessons Learned: The project was more complex and larger than initially thought. Staying within scope; understanding the time constraints and ensuring that all key stake holders were involved from the start of the project were lessons learned.

C02) Emergency Department - AIDET
Lisa Groulx, BScN, RN, ENCC, Kim Crawford RN(EC), MN, ENC, Janice DiReto, RN, Janice Cox, RN
(Guelph General Hospital)

Aim/Objectives: Guelph General Hospital Emergency Department (GGH ED) set out to improve the communication and information sharing between staff and patients.

Intervention/Change Ideas: The intervention developed to achieve our aim was training staff in the use of a standardized communication tool AIDET and to measure this intervention on patient experience in the emergency department.

Evaluation/Measures:
Outcome measures:
1. Number of staff trained in the use of AIDET (graph 1)
2. A pre and post patient satisfaction survey established if the interventions resulted in an improvement.

Balancing measures:
1. Team climate survey pre and post improvement
2. Support staff adopting AIDET

Sustainability: Staff report that they have retained their training and use AIDET on a daily basis and interdisciplinary staff have been trained in the use of AIDET.
- Visual management has been maintained and continues to be integrated in any new ways.
- The patient satisfaction survey designed in the IDEAS project is scheduled to be used routinely as a measurement tool for patient satisfaction

Spread:
- To other clinical units in hospital - through quality forums
- ED physicians
- To our patients: TV with educational channel for key waiting areas
- Volunteer services through surveys developed in the project - ED orientation & resource nurse training

Key Lessons Learned:
- Engage front line staff and all stakeholders early in process
- Consider where your team’s “limit of tolerance” sits and how to get them into the “productive zone”
- Ensure the collection of good quality data drives your change process
- PDSA’s when used properly, work well to sustain change
- Involve patients in clinical change processes.

C03) Improving Medication Reconciliation on Admission
Marina Strzelecki, Sheila Rowed
(Hospital for Sick Children)

Aim/Objectives: Improve medication reconciliation on admission for patients admitted to Plastic Surgery from the current year to date average of 74% to the corporate target of 85% or greater by February 1, 2016

Intervention/Change Ideas: Using multiple QI tools we were able to develop three change ideas in order to achieve our improvement aim. These included:
- Review and clarify roles and responsibilities using one on one and group sessions, and poster reviews
- Ensure home medications are entered by using daily audit and feedback, and ”tips and tricks” to ensure the BPMH note is completed
- Encourage families to bring all medication information on admission with a reminder during the pre-op phone call.
Evaluation/Measures:
Outcome: Admission medication reconciliation complete
Process:
• Outpatient medication history complete
• Best Possible Medication History (BPMH) complete
• Admission order reconciliation complete
Balancing:
• Staff satisfaction

Spread/Sustainability: Change ideas such as the one on one sessions have been trialed in other surgical departments resulting in noticeable improvements in admission med rec scores. Creation of brief instructional videos on specific parts of the process has been implemented hospital wide. Changes have been made to the daily audit tool in order to make the tracking process more efficient for frontline staff. Dissemination strategies have included email communication, presentations at leadership meetings as well as departmental education sessions. A limitation to the sustainability of the project is the high turnover of incoming physician trainees responsible for the process requiring continued support in navigating the system

Key Lessons: Learned Using adaptive leadership to address challenges and recognize when to “raise and lower the heat”. Having key stakeholder involvement from the get go in order to help address the challenge of multiple priorities and limited resources. Lastly, implementation of sustainable change ideas.

C04) Improving the Experience of COPD patients at Chatham-Kent Health Alliance
Nancy Kay, Lisa Northcott, Oz Eren, Lead, Performance (Chatham-Kent Health Alliance)

Aim/Objectives: Our aim was to reduce the number of ED visits by patients with a primary diagnosis of COPD by 20% by January 2016. We will do this by ensuring that 90% of COPD patients discharged from CKHA will have the COPD discharge bundle completed upon discharge.

Intervention/Change Ideas:
• Standardize/Provide Evidenced Based Care to our patients living with COPD
• Develop standardized Discharge education/tools/support to these patients
• Provide our team with resources to provide this care

PDSA/Strategies used:
• Easily identifying patients with COPD
• Methods of ensuring timely discharge follow-up
• Frequent meetings with providers to assess how things were working for them
• Patient Engagement/Follow-up calls

Evaluation/Measures: Outcome measures included: percentage of patients discharged with the bundle, number of nurses trained on the bundle and 30day re-admissions, Patient Experience

Spread/Sustainability: Ramp up to full implementation of all pieces of the bundle, ie including order set in ED, have started roll out to ICU/PCU, application of these learnings / experiences to roll out other QBPs, ie CHF

Key Lessons Learned: We were reminded that patient stories are powerful tools. We struggled with competing organizational priorities and scope creep. And we learned that data can be fun!

CO5) MedRec Initiation for Non-admitted Medically Complex Patients in Sunnybrook’s ED
Dr. Rahul Jain, Patti Madonn, Vincent Teo (Sunnybrook Health Sciences Centre)

Background: In an evaluation of the reasons for Emergency Department (ED) visits or hospital admissions of medically complex patients at Sunnybrook Health Sciences Centre (SHSC), 15-20% of visits included medication-related issues as a contributing factor. Initiating Medication Reconciliation (MedRec) in the ED can facilitate improved medication communication across healthcare sectors, patient safety and may decrease frequency of preventable ED visits.

Aim/Objectives: By March 30, 2016, 50% of non-admitted medically complex patients at SHSC will have MedRec initiated in the ED and communicated to the patient, their community pharmacist, primary care provider and CCAC (if applicable). Medically complex patients were defined as patients with at least 4 ED visits or 3 hospital admissions within 6 months AND age > 65 years old. The overall aim of the project is to increase this number to 80% of eligible patients by June 30, 2017.

Intervention/Change Ideas: Using existing databases, a report was developed to facilitate the identification of eligible patients. Once notified, the ED pharmacist completed a BPMH which was documented in Sunnybrook’s electronic healthcare record. In collaboration with the Geriatric Emergency Medicine (GEM) team, a copy was provided to the patient, the primary care provider, the patient’s community pharmacy and CCAC (if applicable).

Evaluation/Measures: Baseline data was obtained to determine the number of eligible patients in our defined population. The number of completed and communicated MedRecs was measured daily before and after implementation. A balance measure of average length of stay (LOS) was collected to ensure patients who had MedRec versus no MedRec initiated did not experience an increased LOS in the ED.
C06) Opening the Door to Mental Health: Improving access to psychiatric assessment

Jared R. Peck, MD FRCPC, Allison Hughes, MSW, Sami-Beth Kuchar, MSW (Mount Sinai Hospital)

Aim/Objectives: This project aimed to reduce the wait time for assessment in the Mount Sinai Department of Psychiatry general assessment clinic from 14 weeks to 4 weeks, as per the Canadian Psychiatric Association guidelines.

Intervention/Change Ideas: We sought to balance supply and demand. We reviewed and refined our triage process, reducing unnecessary steps and ensuring that we were following our inclusion and exclusion criteria. We formalized assessment slots through the week, increased the number of slots per week, and adopted the option of alternative assessments such as less time intensive MD to MD phone consults.

Evaluation/Measures:

Outcome: Wait time as measured by the number of weeks from date of referral to date of assessment (decrease from 14 weeks in Aug 2015 to 11 weeks in Jan 2016 to 8 weeks in July 2016).

Process: Triage initiation as measured by the number of days from the referral to first patient contact (decrease from 54 days in Aug 2015 to 3 days in Jan 2016 to 2 days in July 2016).

Spread/Sustainability: Our project has not spread beyond our department. We have continued to modify our triage process and data base which we hope to share with other clinics in our department. Increased administrative support has facilitated our ability to sustain the project and further modify our processes to reduce unnecessary work.

Key Lessons Learned: Change is very difficult. Empowering all members of the team to develop and test change ideas is essential. Maximizing standardization of processes and continually reviewing data are key to achieving gains.

C07) Optimizing Perioperative Glucose Control to Improve Surgical Site Infections

Janine Malcolm, Filomena DeSousa, Jim Worthington, Sylvain Gagne, James Chan, Laura Hopkins, Caleb Hui (University of Ottawa/The Ottawa Hospital)

Aim/Objectives: Hyperglycemia in the perioperative period is a well-known risk factor for increased morbidity and mortality among hospitalized patients, particularly among patients without a previous diagnosis of diabetes. Dysglycemia often goes undiagnosed and screening prior to surgery may provide an opportunity to apply strategies to reduce the risk of perioperative infections. The objective of the IDEAS project was to screen a target of 80% of patients undergoing vascular surgery at the Ottawa Hospital for risk of hyperglycemia with a serum A1c and notify screen positive patients and their community care providers of their risk.

Intervention/Change Ideas: A corporate multidisciplinary program to screen, identify and manage patients at risk of hyperglycemia undergoing vascular surgery at The Ottawa Hospital and link patients to community diabetes care post discharge was developed. Interventions for change included an education program for vascular surgeons, nurses, administrative assistants, and clinic staff, audit and feedback of screening rates, engagement of a physician champion, increased scope of activities (phlebotomy) for clinic nurses, and modification of clinic environment to facilitate the screening process.

Evaluation/Measures: Primary outcomes was the percent of elective vascular surgery patients with A1c drawn pre-operatively. Process measures included the percent of screen positive vascular surgery patients notified of their hyperglycemia risk, the proportion of screen positive patients referred to the Internal Medicine Pre-operative Assessment (IMPAC) clinic, and the percent of screen positive patients referred to diabetes education programs. Patient satisfaction with the screening process was also collected.

Spread/Sustainability: This project has expanded to include the intra-operative and post-operative phases of perioperative glucose management. Data since the end of the IDEAS project has indicated a trend towards decreased surgical site infections in patients screened during the pilot period of this project. This program is currently running in gynecology oncology and is in the process of being spread to colorectal surgery.

Key Lessons Learned: Multifaceted change in a large organization is challenging. Physician buy-in and support of the project were essential for success. A continuous communication strategy for stakeholders and a robust data collection/measurement strategy were key elements required for success.
C08) Optimizing the Diagnostic Journey for Rectal Cancer Patients
Alexandra Boasie, Dr. Grant Moffat, Dr. Patrick Tawadros, Karen Dudzinski
(Trillium Health Partners)

Aim: To develop a treatment plan within 21 days for patients seen within the Rectal Diagnostic Assessment Program.

Intervention: The project team implemented a Rectal Diagnostic Assessment Program (DAP), which was designed to manage and coordinate all diagnostic care for patients with symptoms or screen detected abnormalities until a definitive diagnosis and treatment plan are defined. Patients with suspicious rectal cancer(s) are referred to the DAP and cared for by a multidisciplinary team. The change ideas included process mapping to standardize care, engagement of providers and patients, develop a streamlined referral form and criteria, develop partnerships with other hospital based programs, utilize evidence-based guidelines, and develop a communication tool for providers. Twenty-one PDSA cycles were completed between October and March.

Evaluation: A number of outcome, process and balance measures were identified in order to measure impacts. Data is collected manually by the Nurse Navigator in an Access or Excel Database. Patient and family feedback is collected in person or over-the-phone by the Nurse Navigator and/or Patient Care Manager; a set of four questions have been developed to determine satisfaction (a patient feedback survey is also mailed out at the end of the treatment journey).

Spread & Sustainability: Since program launch (November 2015), over 55 patients have been diagnosed through the Rectal DAP. The program launched with two surgeons and now three active surgeons work within the clinic. The project team ensured that the goals of the Rectal DAP aligned with the strategic priorities of the organization; this assisted the team in obtaining buy-in. Ongoing stakeholder engagement was pertinent to change attitudes, create a collaborative environment, and on board an extended team, all working towards the same end-goal.

All models of care, process maps, data collection management, etc. have been well documented and established. In addition, change concepts were carefully selected and tested to ensure they helped achieve the overall aim of the Rectal DAP. Multiple change cycles (Plan-Do-Study-Act cycles) were completed which allowed new processes to be tested in small environments first; when necessary, changes were introduced, the processes were tested again, and finally rolled out on a larger scale for broader uptake. This assisted in receiving buy-in from various departments and providers, and ultimately creates a sustainable model.

Lessons Learned: A strong, cohesive aim statement is important to develop a program and align stakeholder objectives. Stakeholder engagement and adaptive leadership is very important throughout project planning, implementation and evaluation phases. Additionally, a robust evaluation plan ensures appropriate metrics are being tracked. These metrics can be monitored to ensure the developed model is sustainable over time.

C09) Patient At Risk Trigger huddles for Improving Neonatal Outcomes (PARTINeo):
The use of trigger tool identified situational awareness huddles to reduce escalated care events in neonates
Dr. Jennifer Twiss MSc, MD, FRCP, Dr. Sandesh Shivanda, Gillian Dyck, Debie Paterson, Stephanie Becker (McMaster Children’s Hospital)

Aim/Objectives: Our goal was to improve the situational awareness of the bedside team in attempt to mitigate and prevent escalated care events in our patients and improve the disease free survival of infants admitted to the NICU. Specific aim: Decrease the frequency of escalated care events by 10% within the first four weeks of life in infants by the end of June 2016.

Intervention/Change Ideas: We created tools to use at the bedside to enhance team communication and situational awareness, rolled out in 3 phases. PHASE 1: Developed a set of calling criteria to proactively identify neonates at risk of deterioration. PHASE 2: Education and simulation training for bedside staff in the use of the calling criteria. PHASE 3: Implemented bedside team huddles for infants identified by the calling criteria to increase situational awareness and proactively predicted, prevented and prepared for anticipated deteriorations.

Evaluation/Measures: The outcome measure was the number of Escalated Care Events (ECE). The processes that we used: number of huddles, percentage of early warning signs reported by staff. Our key balancing measures were patient/parent and bedside provider satisfaction, and patient mortality and morbidity.

Spread/Sustainability: We have presented our findings in numerous national and local conferences. This work has been submitted to peer review journals for publication. Huddles and standardized communication about patients have been integrated into clinical practice

Key Lessons Learned: Projects lead by multidisciplinary teams are effective in creating motivation and buy in from frontline staff. Leadership and stakeholder support is critical to the success of a QI project. Integration of feedback in real time is effective for implementation of QI projects.
C10) Quality Improvement for Early Pregnancy Clinic (EPC) Patients

Dr. Prema Vaidyanathan, Karen Carr, Nyla Chattergoon-Vilkhu, Joan Iginua-Osoyibo
(William Osler Health System)

Aim/Objectives: By March 31, 2016, 100% of the women seen in the Early Pregnancy Clinic will rate their experience of care as Very Good or Excellent.

Intervention/Change Ideas: This project is based on six change ideas that were created as a result of survey feedback from staff, physicians, and patients.

The first PDSA (Plan, Do, Study, Act) was to place a consistent RN (Registered Nurse) in the clinic to improve efficiency, provide continuity for patients and physicians, and enhance communication.

The second PDSA was focused on revising the EPC referral form. This was to improve the referral process for the ED (Emergency Department) physicians and patients. We attended ED huddles to educate the ED staff on providing accurate information to patients when referring to the EPC.

The third PDSA was to create a private consultation room to improve the patient experience and increase patient satisfaction.

The fourth PDSA focused on educating staff on how to care for patients experiencing perinatal loss through partnership with PAIL (Pregnancy and Infant Loss Network). This was to increase the staff’s knowledge in providing sensitive care to patients experiencing early pregnancy loss.

The fifth PDSA was to update and implement an EPC Medical Directive. This will enable the EPC RN to perform certain care procedures/treatment prior to the obstetrician seeing the patient. This PDSA helped in expediting care to EPC patients, thus leading to patient satisfaction.

Lastly, the sixth PDSA focused on collaborating with the laboratory department at Osler to expedite test results for EPC patients.

Evaluation/Measures: Separate surveys were conducted for staff, physicians and patients to assess their satisfaction before and after changes were implemented to the EPC. Also, the EPC RN monitored the volume of inappropriate referrals received from the ED. The time patients spent in the clinic was measured along with indicators related to patient perception of wait time.

Spread/Sustainability: A full-time position covering the EPC and Non-Stress Test (NST) has been created which will be implemented as of October 2016. A formal education program has been arranged with PAIL to provide bereavement care for patients experiencing pregnancy loss.

The Women’s and Children’s Program has also improved our website pages and perinatal loss is an area that will be developed to meet the needs of this patient demographic.

Our work has been shared with colleagues, multi-disciplinary teams, and forums and we have planned to implement these change ideas at the new EPC opening at Peel Memorial Integrates Centre for Health and Wellness. We are modelling the care that will be offered at the new EGH patient tower.

Key Lessons Learned: We learned from our patients that they have unique and specific needs during this unexpected event in their lives. We learned that the quality of the patient experience and their medical care are equally important.

C11) Reducing Same Day OR Delays & Cancellations Using the Model for Improvement

Melyssa Stoute, Martin Koyle, Vannesa Chin, Megan Saunders
(Hospital for Sick Children)

Background/Context: Greater than 20% of scheduled operative procedures are cancelled or delayed on the day of surgery at our institution. We hypothesized that this was primarily attributable to patient/caregiver factors, with a “biased” opinion that they had “no skin in the game” in a single payer system.

Aim/Objectives: We aim to decrease the delays associated with late 8 AM OR (operating room) times starts & cancellations from >20% to <5% over 9 month period and ultimately maximize OR utilization.

Measures: We measured on time starts and cancellations compared to historic controls and how this affected OR time utilization & potential costs.

Improvement/Innovation/Change Ideas: Patients signed a contract in clinic agreeing to adhere to an extended NPO (1 additional hour) & early arrival protocol (arrive 3 hours prior to surgery rather than 1). We put their “skin in the game” by stating in the contract that the patient would be delayed or cancelled if they did not comply with this contract. We implemented a teach-back session for patients to ensure their understanding of this information and had them take a photo of the contract with their cellphones to review before surgery.

Impact/Lessons Learned/Results: 100% of 65 children / families were satisfied with the extended fasting and early arrival protocol. This resulted in 1.7 days or 14 OR days not being utilized due to increased efficiency with 13/14 OR days starting on time and all but 1 OR day finishing on time. This additional unused OR time creates an opportunity to reduce waiting lists for surgery by proper scheduling.

Discussion/Spread: Patients and families can be compliant with extended guidelines which may create opportunities to maximize OR utilization and hence benefit additional patients. Spread will be the major challenge due to the inherent culture of silos within our institution. However, since the initiation of this project, a “fast line” concept based on similar cases but for simple, rapid turnover cases is being trialled.
C12) Reducing Wait Times at Hotel Dieu Hospital Breast Assessment Program
Erin Brown, Ashley Hendry, Shankar Chowdhury, Jane Warner
(South East Regional Cancer Program)

**Aim/Objectives:** By March 1, 2016, the Hotel Dieu Hospital (HDH) Breast Assessment Program (BAP) will consistently exceed the provincial wait time target of 90% of women aged 50 and older referred through an Ontario Breast Screening Program (OBSP) will receive diagnosis or rule out of breast cancer with core tissue biopsy within 6 weeks of an abnormal screening mammogram.

This target is critical, as up to 10% of women in Ontario who participate in breast cancer screening require follow-up through a BAP. This is an anxious time for patients therefore, better integration across this journey will improve efficiency and patient centredness, and over a longer time period result in cost savings.

**Intervention/Change Ideas:** This work resulted in the development, testing and implementation of two interventions:

- **PDSA #1** – Decrease the time from screening mammogram to the time BAP receives the requisition that an abnormal screen was identified and an assessment is required.
- **PDSA #2** – Execute a diagnostic mammogram and ultrasound blitz to eliminate back log within the HDH diagnostic imaging department.

**Evaluation/Measures:** The following measures were tracked manually to measure the tests of change:

- Percent of OBSP clients who meet the following indicators:
  - Time from abnormal screen to the first assessment (3 weeks)
  - Diagnostic interval with core biopsy (6 weeks)
  - Time to third next assessment appointment at HDH BAP
  - Courier expense costs associated with physical transfer of charts from OBSP site to HDH BAP

**Spread/Sustainability:** Currently spread projects are in the development process; these are a component of this work and have stemmed from this project. These projects include:

- OBSP Dictation at a third site in the South East Region;
- Transition away from hard copy Breast Imaging Requisition Form (BIRF); and, Reducing the workload associated with physical folder use at OBSP Discovery.

**Key Lessons Learned:**
- Paperless documentation improves radiologist workflow.
- Reduction of days the patient has to wait for an initial assessment appointment reduces their wait to a tissue biopsy. - Linkages made during the IDEAs project between organizations have led to knowledge sharing.
- Staff are energized and engaged in change ideas and the development of subsequent quality improvement projects.
- Focusing efforts on one area of the process does not decrease the variability of wait times for the multiple, subsequent procedures for the patient.

C13) Safe Transitions Project
Anna Marie Smith. Dr. Rory McDonagh, Kate MacNamara
(St. Joseph’s Healthcare Hamilton)

**Aim/Objectives:** To reduce the length of stay for low risk postpartum women from 1.9 to 1.4 days by January 1st 2016.

**Intervention/Change Ideas:** Implemented the Baby assessment Clinic offering low risk vaginal deliveries an early discharge with newborn follow up in an outpatient clinic (BAC). Staff were educated on change in practice and community supports available to families after discharge.

**Evaluation/Measures:** Measures of outcome were Length of stay data, patient satisfaction, BAC visits, readmission rates and patient flow average census per month.

**Spread/Sustainability:** The project has spread to all obstetricians and family physicians offering an opportunity for early discharge including c-section patients. An expansion in BAC hours to meet the needs of the family. Expanding Public Health’s role in the antenatal period.

**Key Lessons Learned:** The importance of communication between health care providers. How education with staff influences the success of the project.

C14) Attendant Care Outreach Support for Clients at Transitions
Angie Tingren-Watkins, Jo-Ann Shotton, Keilly Lebelle, Marty Elliott
(Providence Care)

**Aim/Objectives:** In order to improve continuity and transitions of care by March 31, 2016, 100 % of consenting Attendant Care Outreach (ACOP) clients will continue to receive attendant services during hospitalization.

ACOP clients have stated they experienced an interruption in their client care needs, and identified a need for improved communication at transition to hospital.

**Intervention/Change Ideas:** Initial change ideas focused on:

- Defining the scope of services and or support that will be provided for clients by the ACOP Attendants during hospitalization and develop policy, procedure and guidelines.
- ACOP Attendants & Acute Care staff have received an overview on provision of attendant services while in acute care.
• Develop a communication plan for ACOP clients who may be eligible to receive ACOP services while in acute care.
• Monitor this transition initiative to evaluate client satisfaction and improved continuity of care at transition.

Evaluation/Measures:
For the purpose of this project we defined our key measures as:
• The number of ACOP clients that receive attendant services while in hospital.
• The number of clients admitted to acute care.
• The length of client stay in acute care.
• The client needs assessment data was evaluated to identify ACOP client requests while in acute care, within the scope of the current care plan.
• Pre/post hospital admission satisfaction data indicated this was a suitable project initiative.
• The Transition Scores obtained from the Pre/post hospital admission satisfaction data continue to be collected and reviewed on a regular basis.

Spread/Sustainability:
Spread of the project continues with information sharing within Providence Care: e-currents, Connections, Management Team forum presentations, and Community Program meeting presentations. The core team continues to meet on a regular basis to review client feedback and ongoing collection of data to support key measurements.

Key Lessons Learned:
• Working collaboratively between organizations is important to sustain change.
• Keeping staff, clients and partners actively engaged is a priority.
• The definition of a friendly visit is individualized on a per client basis.
• Focusing on relationships with acute care requires collaboration to refine processes and tools.
• Collection and interpretation of measurable data is relevant and ongoing.

C15) Wesway Medication Documentation Improvement Project
Connie Sakiyama, Suzanne Hart (Wesway)

Aim/Objectives: By March 2016, there will be a 50% reduction in the number of medication incidents at our Court St. Respite Home.

Improvement/Innovation/Change Ideas: The Respite Home secretary scheduled Intake appointments between 10a.m. and 6p.m. with families in order to stagger participant arrival times. Intakes were moved to another room to reduce interruptions and distractions during the Intake Process, which enabled staff to focus on an accurate completion of the MAR. Historically a staff member working the 8a.m. to 4p.m. shift was responsible for administering medications and completing intakes. Intake duties were removed from the 8a.m. to 4p.m. shift and assigned to the 10a.m. to 6p.m. shift.

Evaluation/ Measures:
Outcome Measure:
• Reduce medication errors
• # of medication errors

Process Measure:
• Stagger intake appointment times
• Scheduled intake appointment times vs actual times
• Interruptions during Intake process
• Number of interruptions during Intake process
• Quiet room used to complete
• Number of times quiet room used
• Intake process
• Staff follow-through with shift
• Number of times identified shift completed Intake responsibilities

Balancing Measure:
• Family satisfaction
• Formal and informal dialogue
• Staff Satisfaction Formal and informal dialogue

Spread/ Sustainability:
• Core changes have been implemented at the Court St. site
• New process to address Medication Incidents
• Reminders/check-ins have been necessary with staff to ensure the follow-through of change ideas
• Wesway has formally developed an internal QI committee
• Quality Assurance Facilitator presents QI In-service at monthly staff meetings
• QIP committee continues to evaluate next steps in prevention of medication incidents

Key Lessons Learned:
• Importance of gathering information from all stakeholders
• Make it easy for people to do the right thing
• Recognition of the commitment required to maintain momentum and enthusiasm

C16) Central West Early Palliative Identification Project
Margaret Paan, Trudy Mulder-Hall, Rita Khamis, Naomi Uy (CW Palliative Care Network)

Aim/ Objectives: Research shows that if patients were identified earlier in their illness they would benefit from well-coordinated and high quality palliative care and improve both quality of life and length of life. Early referral to palliative care not only facilitates the timely diagnosis and treatment of symptoms, but also minimizes care giver distress and aggressive measures at the end of life. Early referral to palliative care not only facilitates the timely diagnosis and treatment of symptoms, but also minimizes care giver distress and aggressive measures at the end of life. Early referral to palliative care not only facilitates the timely diagnosis and treatment of symptoms, but also minimizes care giver distress and aggressive measures at the end of life. Early referral to palliative care not only facilitates the timely diagnosis and treatment of symptoms, but also minimizes care giver distress and aggressive measures at the end of life. By September 30th 2016, Central West will increase its identification of patients with palliative care needs from 5.2 % to at least 10% to enable access to optimal palliative care and improve quality of life.

Intervention/Change Ideas:
• Increase knowledge/skills of health care providers in identifying patients with palliative care needs
• Optimize information systems
• Understand patient needs
**Evaluation/Measures:**

**Outcome Measure:** Reduced the number of unnecessary hospital admissions/readmissions by over 40% in patients identified as palliative from March to August 2016.

**Process Measure:** Increased the number of CW CCAC patients identified as palliative to 10% overall.

**Balancing Measure:** Reduced the number of inappropriate patient transfers to the Specialty Palliative caseloads from the general neighborhood caseloads from 19% in pilot sites compared to 81% in non-pilot site.

**Spread/Sustainability:** The project team focused on consistent engagement and information sharing with stakeholders including sharing of data for the staff involved in early identification.

The project transitioned to operations and transferred accountability to the CW Palliative Care Network, ensuring an enhanced systems approach and high profile within the region.

Internal Spread across the LHIN region from 2 neighbourhoods to 3 neighbourhood teams.

External spread included engagement of a Primary Care Family Health Team, a Health Links Community Partners Table and a targeted partnership with the Dufferin Community Paramedicine Program.

**Key Lessons Learned:**
- Skill sets and expertise along with commitment of the Core Project Team was critical to success.
- Engaging and reengaging the user in identifying the quality improvement opportunities and tools is fundamental at achieving the change.
- Identify and leverage existing synergies e.g. Health Links
- Do not underestimate the resources required to identify and create consistent processes for data collection.

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**C17) Improving Transitions of Care between Hospital and LTCH Facilities**

Mary Bayliss, Munira Thayani, Dr. Heather Currie, Jacqueline Tudor
(Markham Stouffville Hospital)

**Aim/Objectives:** By March 1, 2016 we will decrease avoidable transfers of Unionvilla and Woodhaven LTCH residents to MSH ED by 20% from baseline.

**Intervention/Change Ideas:** Nurse Practitioner (NP)-led education sessions to LTCH staff on the topics of foley catheters and G-tubes as we noted a pattern of transfers related to these issues.
- SBARD tools were developed and introduced for both LTCH and Markham Stouffville Hospital (MSH).
- Post discharge telephone calls were instituted from hospital to LTCH.
- To improve communication and build relationships a MSH/LTCH Joint Committee was created with the goal of addressing common issues and barriers to the care of LTCH residents.
- We developed a data sharing agreement permitting LTCH staff access to their residents chart when admitted to MSH.
- Increased adoption of Ontario Telemedicine Network (OTN) for general internal medicine clinic and Telewound.

**Evaluation/Measures:**
- Number of transfers from LTCH to MSH.
- Manually monitored the usage of the SBARD tools from both the hospital and LTCH.
- Pre/post survey of LTCH staff about the education topics provided and physicians experience of using OTN to provide consultations to LTCH.
- Did not see significant statistical change due to small sample sizes and limited time of the project but did observe a positive trend in terms of reducing avoidable transfers from two LTCH facilities who were part of our IDEAs project.

**Spread/Sustainability:**
- SBARD tools continue to be used by MSH and LTCHs.
- Continue to work on process improvements to increase adoption of OTN for our LTCH residents.
- MSH/LTCH Joint Committee continues to meet quarterly.
- Five of 7 LTCHs have signed DSA for access to Hospital's Meditech. The remaining two are expected to sign shortly.

**Key Lessons Learned:**
- Nurse-Led Outreach Team (NLOT) is a scarce resource in the Central LHIN
- Noted a pattern for avoidable transfers related to blocked foley catheters and G-tubes
- Several transfers from LTCH were related to restrictive diagnostic and lab services and resident/family wishes.
- Transportation costs significant barrier
- Working collaboratively between organizations is important to sustain meaningful change.
- Physician engagement is key.
- Challenging to promote change in large organizations beyond our control: eg. CCAC and IV starts

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**C18) Integrated Comprehensive Care 2.0: Hamilton Niagara Haldimand Brant (HNHB) LHIN wide COPD and CHF Program**

Laura Wheatley, Dilys Haughton (VP, CCAC), Heather Paterson (Director, NHS), Scott Secord (Health System Integration Lead, BCHS)
(St. Joseph’s Healthcare Hamilton)

**Aim/Objectives:** The Integrated Comprehensive Care (ICC) program is spread and scaled across HNHB to improve: transitions, patient experience, and health care resource utilization.

80% of patients admitted to Joseph Brant Hospital (JBH) with COPD/CHF requiring home care post discharge will be enrolled in the ICC program and follow the 60 day care path within 90 days of implementing the program (by January 1, 2016)
IDEAS Cohort 7, 8, 9 Poster Abstracts

SECTION H

Intervention/Change Ideas:
- Spread and scale of SJHC ICC program across the HNHB LHIN
- Current and Future State Mapping with key stakeholders (including patients/family)
- ICC screening and referral criteria to INSPIRE, Wellness House, Caring for My COPD program, Health Links, and CCAC services
- Improve patient experience

Evaluation/Measures:
- Tested method to identify potential ICC patients – Learned that we are casting a “broad net” (opportunity to refine method of identifying potential patients)
- Volume of patients enrolled, average total length of stay, unplanned ED visits (30 and 60 day for same and all cause) and unplanned readmissions (30 and 60 day for same and all cause)

Spread/Sustainability: The ICC program has spread across all HNHB acute care hospital sites since the initial project end cycle.
Robust governance structures and MOH, LHIN, and Executive Leads support and leadership has enabled the HNHB ICC 2.0 to hold these gains.

Key Lessons Learned:
- Strong commitment and support by senior leaders created momentum and stainability
- Governance structure with frequent meetings – focus on implementation and then shift to focus on outcomes
- Communication with key stakeholders
- Physician leadership and engagement important
- Patient engagement in planning, implementation and evaluation
- Soft launch – start small and scale up
- Rigor of improvement models, tools and e platforms that can enable process and achieve outcomes
- Collaboration and new partnerships to drive integration such as Health Links
- Knowledge transfer of implementation of the model to scale and spread the ICC program
- Engagement with primary care teams, indigenous health providers and other health system partners

C19) The Ontario Emergency Department Return Visit Quality Program: A Provincial Initiative to Promote Continuous Quality Improvement
Nisha Singh, Angie Burden, Sue Swartzack, Gord Canning (North West Mississauga and South West Mississauga Health Links)

Aim/Objectives: By March 2016, 70% of the Credit Valley Family Health Team Health Link patients will have a care conference where the patient, Primary Care Provider (PCP) and Care Coordinator develop a coordinated care plan with patient goals.

Intervention/Change Ideas:
1. Does a referral to Health Links from the PCP automatically result in a physician attended care conference? We discovered that this was not always the case due to numerous constraints.
2. Does prior communication of the care coordination plan (CCP) to the PCP result in a more enhanced care conference? Physicians felt that they were not contributing meaningfully or adding value to the care conference.
3. Does feedback from the PCP, Care Coordinator and patient/family improve understanding of the value of a care conference? All participants did not fully understand their roles or expectations and therefore feedback was obtained to enhance the quality of the conference.

Evaluation/Measures:
Outcome Measure:
- % of CVH FHT Health Link patients who received a care conference

Process Measures
- % of patients who were referred from a PCP who were then enrolled to Health Links
- % of PCPs who received communication within 72 hours of care conference
- % of PCPs, Care Coordinators and patient/family who said the care conference was of value

Sustainability:
1. The Credit Valley FHT developed a query report to identify high users of primary care for referral to Health Links.
2. A Clinical Practice Lead was resourced to determine reasons for non-enrolment and develop mitigation strategies.

Spread: Learnings will be spread to the wider NWM/SWM Health Link team and to the other MHLHIN Health Links.

Key Lessons Learned:
1. Approximately 50% of patients referred to Health Links were not enrolled.
2. PCPs need to be part of the development of goals to contribute meaningfully to the care conference.
3. Patients identified as complex by PCPs were not always high users of the hospital.
4. There were barriers identified to patient participation in the care conference (i.e. transportation, building location).
5. The Care Coordinator/physician relationship was a key driver to physician engagement and participation.
C20) Improving Resident Outcomes in Central West

Teresa Judd, Christine Pellegrino, Carla Braid, Liezel Trinidad
(Central West Community Care Access Centre)

**Aim/Objectives**: AIM Statement: 90% of Substitute Decision-Makers (SDMs) of residents with dementia admitted to Tall Pines LTCH by 60 days post admission, will demonstrate an awareness of dementia progression and available supports by March 31, 2016.

Tall Pines received high overall ratings from residents in 2015 on the annual Resident Satisfaction Survey with an overall satisfaction rate of 84%. Although there were very few complaints, of those, we found that many of the concerns stemmed from the lack of information and misconceptions about transitions into long term care, and a lack of awareness or supports related to the dementia journey of their loved one.

Recognizing this gap, we saw an opportunity to look at what supports we could provide to the caregivers and create an awareness of the dementia journey and their transition. This involved collaboration between both the community supports of the Central West Community Care Access Centre and the Alzheimer’s Society of Peel with the long term Care home Tall Pines.

**Intervention/Change Ideas**: There were several change ideas that we implemented over the course of our project which included the creation of a lived experience survey used at the time of admission and post admission at 60 days, BSO Dementia Support Screener, revised a social history assessment whereby the information gathered from this is populated onto the resident care plan/kardex. There is also a revised electronic care conference template, and Supervisor of Care “check-ins” with the SDMS of new admissions at designated intervals.

**Evaluation/Measures:**

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<tr>
<th>TOOLS</th>
<th>PURPOSE</th>
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<tr>
<td>Lived Experience Survey (interviews) for 5 recent admissions</td>
<td>Validated and provided resident-familycentered evidence and pressure points at pre-admission, admission and post care admission with evaluation follow-up</td>
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<tr>
<td>BSO Dementia Support Screener (PDSA)</td>
<td>Determined dementia supports already in place and identify needed referrals</td>
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<tr>
<td>New/revised social history assessment (2 PDSA’s)</td>
<td>No previous standardized tool to collect social history. Risk of it being lost in admission paperwork and not being carried over on to the resident’s electronic chart</td>
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<tr>
<td>Care Plan /Kardex includes detailed social history</td>
<td>Ongoing utilization and updating of social history. Access by all (HCP) Health Care Providers</td>
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**TOOLS** | **PURPOSE** |
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<tr>
<td>Revised Electronic Care Conference Template (PDSA)</td>
<td>Increase access by all Health Care Providers and allow them to gain a better understanding of the resident</td>
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<tr>
<td>Alzheimer Society Peel materials shared with Substitute Decision Makers</td>
<td>Connecting family with community resources outside of home to support grief and capacity awareness of disease.</td>
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<tr>
<td>Compassion Fatigue-Needs Resource guide for Informal Caregivers</td>
<td>To assist family members to recognize their own compassion fatigue and increase awareness of resources available</td>
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<td>Supervisors of care “check-in’s” with SDMs of new admissions (3 days, 7 days, 3 weeks, 6 week care conference)</td>
<td>Relationship building addressing clinical care issues. Proactive care planning and risk mitigation.</td>
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<tr>
<td>Lived Experience Survey (interviews) at 60 days post admission</td>
<td>Outcome based data collection to validate tools and approaches to care implementation.</td>
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**Spread/Sustainability**: Supervisors of Care are checking in with SDM’s and family on day 1, within the first 2 weeks and again at 6 week care conference.

The social history is now divided into 3 sections-social work, activation and BSO (this is done in house currently) but is going to peer groups of Directors of Care, Social Workers and Activation in September to get their approval to continue the spread across all five regional LTC homes. The social history is completed on all new admissions. It is populated into Point Click Care (PCC) and added to the care plan. At present is completed as an assessment in PCC. We are developing on where and how best to display for front line staff. This may include laminated versions in the resident rooms, clean utility or bathing areas ensuring privacy.

Care plan conference notes are being used in all five homes in different lay outs.

**Key Lessons Learned**: Some of the key lessons learned are broken down into 2 categories:

**Project Engagement**
- Three distinct organizations engaged in integrative thinking to achieve desired results
- Leadership support is essential
- Comprehensive communication with stakeholders would result in better program management
- Optimizing the resource team would allow for better identification of pitfalls

**Execution**
- PDSA’s were critical to help support/validate the creation of new tools and provided opportunities for sustainability
- Additional refining of PDSA’s are required to validate effectiveness of tools
• Residents and SDMs supported in the community, linked to agencies providing dementia education and support have better transition outcomes
• Gained momentum in bridging previously identified policy gaps and opportunities
• The change ideas would benefit all new admissions, not just the residents with dementia and their families.

C21) Consistency of Care Assignment
Mary Furlan RPN, Debi Cope RPN, Jill Youde (Afton Park Place/S&R Nursing Homes Ltd.)

Aim/Objectives: The Resident’s response from the satisfaction survey “The same staff is assigned to care for me over time” will improve from 28% to 85% by the date of the next general survey (April 2016)

Intervention/Change Ideas: update/change Resident Care assignments, Post names of care providers in each home area, Coordinate FT & PT PSWs into teams

Evaluation/Measures: Outcome (improving the results of the resident survey question), Process (average # of PSWs documenting for personal hygiene), Balance (change in publically reported quality indicators)

Spread/Sustainability: The project has been spread throughout our home for 60 PSWs and 128 residents. We will be suggesting changes to the collective bargaining agreement in order to support long term success of consistent care assignments (eg; maintaining minimum posting time frames, revising mutual/giveaway practices, extending summer/winter holiday windows)

Key Lessons Learned: Registered staff need to understand the value of positive change to spread awareness to PSWs, all staff (in a variety of roles) need to be involved with decision making, use visual reminders of success (eg; posters, photos), perspective is important during review of data, no singular QI method is adaptable to all contexts

C22) Kipling Acres Convalescent Care Length of Stay
Elizabeth Juraschka, Nelson Ribiero, Gina Filice (City of Toronto, Long-Term Care Homes & Services)

Aim/Objectives: To assess that Convalescent Care Program (CCP) resources at Kipling Acres are effectively utilized, meet the healthcare system requirements and enable clients to safely return to their home with appropriate supports to minimize hospital readmissions.

Aim Statement: To reduce the length of stay for 80% of convalescent care residents at Kipling Acres from 75 days to 65 days.

Intervention/Change Ideas:
• An electronic application approval process was tested with reduced signoffs to streamline the number of days to review and approve an application.
• Criteria Checklist ensuring that only applications that met the criteria for the program were approved.

Evaluation/Measures: Key Indicators Adopted to Measure Improvement:
• Length of Stay
• Number of Days to Review and Notify Community Care Access Centre of Application Outcome

Spread/Sustainability
• Internally presented the final presentation to our senior management team
• Spread of change ideas to other Convalescent Care Programs within our division

Key Lessons Learned: The major improvement opportunity existed more so in reducing the number of applications being rejected.

The high rejection rates of applications illustrates that there is an opportunity to establish a new program for those who do not meet the criteria for convalescent care.

C23) Reducing Medication Errors in Assisted Living for High Risk Seniors
Carol Page, Nancy Kula, Kalsang Phuntsok

Aim/Objectives: See a 20% reduction in the number of recorded medication errors at identified Assisted Living sites by March 31st, 2016.

Intervention/Change Ideas:
• Consistent Medication Education and Medication Regime review
• Red flags for medication changes & errors in Communication Book
• Revised Intake Process
• Standard Sequencing of medication tasks on Care Plan
• Visual Cueing; Medication Logs on bright coloured paper
• Alignment of Blister Package and Care Plan medication times
• Visual Consistency in Blister Packaging
• Meds Check at Intake and Annual Reviews

Evaluation/Measures:
• Incident Reporting Module
• Manual Care Plan Audits
• Manual Counts
• Impact was made but not demonstrated, however we hope to see statistically significant changes over time
Key Lessons Learned:
- Measurement as well as the ability to demonstrate statistically significant change is a challenge when you have a small number of incidents.
- Engagement of frontline staff/supervisors is invaluable; as is having broad perspective on the project team.
- The more we worked with the tools, the more comfortable staff got with using the tools
- Creating a culture of QI and a just culture is both time consuming and energizing
- Having a diversity of tools and being able to apply them at different times and with different audiences was very helpful.
- Publicly sharing the work of teams with their (PSW) peers is powerful!
- Reflecting on our AIM statement, with the additional knowledge we now have, we would, in the future, create a more specific statement related to one or more of the contributing factors.

C24) Emergency Mental Health Follow Up Clinic

John Prieto, MHM, Clinical Manager, Lawna Brotherston, NP, Clinical Manager, Roberto B. Sassi, MD PhD, Child Psychiatrist
(Hamilton Health Sciences, McMaster Children’s Hospital)

Aim/Objectives: By January 2016, the Mental Health Emergency Follow Up Clinic at McMaster Children’s Hospital will increase its capacity by four visits, on average, per week.

Intervention/Change Ideas: 1. Human resource management 2. Revised clinician schedule to allow increased capacity 3. Training and support to expanded human resources 4. Development of standardized referral form 5. Development of feedback mechanisms with ED stakeholders

Evaluation/Measures: Outcome-68% reduction in ED revisits. Process-29% reduction in ED wait times. Balancing-50% reduction in referrals to more intensive, urgent community services.

Spread/Sustainability: Regional providers have recognized the Mental Health Follow Up Clinic as a promising solution to challenges faced by partners. The model has sparked interest in regional collaboration towards multi-site adoption along with the pursuit of funding options.

Key Lessons Learned:
- All Interventions and Change Ideas were spread to all 9 Assisted Living Sites
- Project Team continues to meet on a regular basis
- Continued front line staff engagement to identify QI opportunities
- Ongoing and improved incident reporting with staff using consistent language to identify issues
- All changes imbedded in day to day business processes
- Continuation of front line staff engagement to identify QI
- Project Team continues to meet on a regular basis

C25) Contextualizing Learning to Improve Care Using Collaborative Communities of Practices

Marsha Bryan, Cathy Duivesteyn, Sarah Kipping, Nicole Parton
(Ontario Shores Centre for Mental Health Sciences)

Aim/Objectives: By February 29, 2016, completion rates for measuring waist circumference as part of the CPG for the treatment of schizophrenia, in three representative clinical units at Ontario Shores Centre for Mental Health Sciences, will have increased to a minimum of 90%.

Intervention/Change Ideas: Clinical team leaders in each participating unit were provided with access and training to the existing hospital CPG Adherence Reports. Changes were also made in the hospital’s Electronic Medical Record (EMR) system including changes to prevent orders for this intervention being cleared or set at the wrong frequency and reminders/links in the monthly conference report. One unit tested standardization of a monthly date for completion of the intervention. Monthly conference meetings with patients were leveraged to discuss metabolic monitoring results. Finally, simplified CPG Unit Reports pushed on a weekly basis to clinical leaders.

Evaluation/Measures: The following measures were monitored: % of waist circumference measurements completed within the specified intervals; reasons for measurements not being completed; % of interventions to measure waist circumference that are set to the correct frequency; % of patients with orders for this intervention; patient satisfaction and staff satisfaction. As of February 25, 2016, the overall adherence rate for completing waist circumference measurements within the specified timeframe was 84.5%. An audit confirmed that if patient refusals were removed, a 100% adherence rate was achieved.

Spread/Sustainability: EMR Changes have been implemented for the entire hospital and plans for spread of simplified CPG Unit Reports discussed and identified for development.

Key Lessons Learned: The following are some of the key lessons learned: complexity of changing clinical practice, evolving research base and overlay of competing priorities meant it was not a simple technical fix; pull access to information was not enough for helping to build understanding of the data; importance of using a statistical approach; moving too quickly through change tests may

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mask true impact of changes; and the importance in peer-to-peer dialogue, within in a trusted relationship, to promote constructive self-reflection around practices & accountability.

**C26) Improving Pediatric Experience of Pain during Vaccinations at the North Bay Nurse Practitioner-Led Clinic (NBNPLC)**

Terri MacDougall NP-PHC, Leann Whitney MAEd, BScN1, Mona Sawhney, NP(Adult), PhD2 (North Bay Nurse Practitioner-Led Clinic)

**Aim/Objectives:** We will reduce procedural pain in children aged 0-16 years attending the NBNPLC by 50% (pain score) at procedure (0 minutes) and post procedure (5 minutes) by March 4, 2016

**Intervention/Change Ideas:**
- Use of age appropriate assessment tool to score pain at procedure and 5 minutes afterward
  - Validated tools changed… stopped 5 min measure at 8 weeks
- Use Sucrose as a pain mitigation strategy
  - Standardized sucrose product is available to purchase
  - Increased staff knowledge/confidence in EMLA®, enhanced education of parents, costly to offer free patches to all parents. Encouraged parents to purchase own EMLA®, product monograph is inadequate… We created a easy to read handout
  - Implement as many pain mitigation strategies as indicated for age group
  - Educate staff about the guideline, visual reminder in well baby/child file and on Electronic Medical Record
  - Website update www.nbnplc.com
  - Obtain feedback from parents/patients about their experience
  - Help refine our techniques (EMLA®, Tootsweet®); inform our improvement plan

**Evaluation/Measures:**
- Outcome Measures: Pain Score, Parent/Patient Experience
  - Recovery from Pain
- Process Measures: Number of interventions used to mitigate pain > PDSAs
- Balancing measures: Staff satisfaction Cost of EMLA or sugar water (impact on budget)

**Spread/Sustainability:**
- Knowledge uptake regarding pain reduction strategies has spread to all clinical staff at the NBNPLC.
- Strategies to decrease pain during infant/child immunizations have been effective as demonstrated by staff and parental feedback. NP and RN students are utilizing strategies.
- Parent feedback has been incorporated into the project and parents are using information on our website to reduce immunization pain.
- Standardised charting has demonstrated more practitioner’s are documenting response to painful procedures.

**Key Lessons Learned:**
- Continue to utilize pain mitigation measures in clinic
- Embrace opportunities to share data (spread)
- Document use of interventions and recovery as standardized procedure
- Addressing attitudinal assumptions such as parents not believing addressing procedural pain as necessary is important

**C27) Chronic Disease Self-Management**

Christina Darlington, Nadia Hladin (VHA Home HealthCare)

**Aim/Objectives:** By March 31st, 2016, 80% of clients recruited to participate in the Central and Toronto Central pilot project will report having developed and utilized components of their diabetes self-management plan.

**Intervention/Change Ideas:** Change ideas included;
- developing and delivering education to our pilot group nurses on Chronic Disease Self-Management (CDSM), Stages of Change, Motivational Interviewing strategies, BPG 5A’s and Brief Action Planning as well as developing relevant resources to support the uptake of the change process in the community. Three PDSA cycles were completed.

**Evaluation/Measures:** Number of clients with a plan for self-management; number of nursing visits; completion of depression screen; uptake by nurses implementing CDSM strategies; % of clients assessed for depression; nurse’s satisfaction, client’s satisfaction and impact on workload.

**Spread/Sustainability:** A number of strategies have been implemented in an effort to sustain and gain momentum. They include: peer support for nurses with case reviews, support from the nursing supervisor on review of clinical records, identification of champions to support nurses and encourage use of CDSM strategies. We are planning to roll-out CDSM education to a large group of rehab service providers and will continue to education nurses on other teams.

**Key Lessons Learned:** Importance of data collection to understand the impact of changes; it takes a dedicated and committed team, from senior sponsor to managers, supervisors and point of care staff to get the desired outcome. Adoption of new practice or behaviour change takes time +++.
C28) Improving Transitions for Complex Patients

Agnes Tong, Leonardo Alfaro
(Sinai Health System – Bridgepoint Hospital)

Aim/Objectives: At Sinai Health System, we endeavor to provide seamless care for our patients, a smooth and safe transition from hospital to home. We recognize the importance of a robust transition planning process that is patient and family centered, and the continuity of care post discharge as keys to patient safety, improved patient outcomes, and exceptional patient satisfaction and experience. Our big dot aim was to improve Bridgepoint’s NRC Picker Patient Satisfaction score for continuity and transition from 76% to 80%. Specifically, our project aim was to improve the Neuro Program’s continuity and transition score from 80% to 85%.

Intervention/Change Ideas: Patients transitioning home from hospital will receive a follow-up reminder telephone call within 72 hours of discharge home. Staff were also to educate and empower patients to make family doctor appointment within 7 days post discharge.

Evaluation/Measures: We had 49 patients discharged home over a 14 week period. 93% received follow-up phone calls within 72 hours of discharge. We also had 100% of patients discharged home with follow-up doctor appointments by the 9th PDSA cycle. Overall, our NRC patient satisfaction continuity and transition score increased to 89% by March 2016.

Spread/Sustainability: We continuously engaged staff and patients for their experience and feedback regarding the new processes, especially during the periods when we encountered challenges and barriers. We also created a board as visual management to help the team organize follow-up processes. The new processes will be incorporated into the standard discharge process and spread to other units across the hospital.

Key Lessons Learned: The success of any change initiative needs to be aligned with organizational priorities, in order to ensure senior leadership support and potentially support for resources. End user participation and involvement of patients and family advisors were vital to the success to our QI project. It was important to engage them early on in designing the new processes, to ensure they are highly adoptable and sustainability and spread.
1) Screening for Sexually Transmitted Infection in the Young Families Program
Nicholas Chadi*, Zahra Alebraheem, Megan Cooney, Katherine Hick, Mariano Macias, Allison Rodriguez, Cathleen Steineggert *(Hospital for Sick Children)

Background/Context: Young Families Program (YFP) is an inter-professional health care clinic for adolescent mothers and their children at the Hospital for Sick Children offering: comprehensive well baby care, sexual health, psychosocial support and parenting education. Adolescent mothers in YFP may engage in high risk sexual behaviours and are at increased risk for sexually transmitted infections (STIs). Despite the increased risks for STIs, screening opportunities were being missed related to multiple issues including: complexity of patients, lack of time in clinic, lack of screening protocol, multiple healthcare providers.

Aim/Objectives: To optimize STI screening in Young Families Program adolescent mothers, using Public Health Agency Canada (PHAC) STI Guidelines.

Measures: The specific goal of this project was to increase the offering of STI urine and serum screening from 80-85% to 100% and the completion of urine and serum screening from 85% to 100% and 5% to 65% respectively by May 20, 2016.

Improvement/Innovation/Change Ideas: Based on PHAC STI Guidelines recommendations, the project team created an STI screening algorithm as a timeline reference in collaboration with YFP healthcare providers. This algorithm helps capture adolescent mothers during their routine clinic visits within the recommended screening window (annual screening). The changes were implemented on January 18, 2016 after discussion with the YFP team. Audit after implementation was conducted by reviewing the timeline reference sheet included in each eligible patient’s chart.

Impact/Lessons Learned/Results: Team members felt the process was smooth and helpful. Offered screening rates during the project period were 92% for urine and serum screening. Completed screening rates were stable at approximately 85% for urine screening and increased from 5 to 21% for serum screening. This project has shown that a simple change measure implemented through a collaborative and consensual process can improve screening rates and quality of care in a complex multi-disciplinary clinical setting.

Discussion/Spread: Discussions will take place in the upcoming months to determine if the STI screening algorithm will be maintained and/or modified. Potential next steps include expanding the use of the STI screening algorithm to other clinics within the Adolescent Medicine Division.

2) ATTEND: A Two-pronged Trial to Eliminate No shows in Diagnostic Imaging
John Mikhail*, Erdit Celo, Jessica Shanahan, Brian Harvey, Bonnie Sipos, Jennifer Koetsier, Helen Wiley, Tom Roy, Shawn Fitzgerald *(Brock University)

Background/Context: Diagnostic Imaging (DI) at the Niagara Health System (NHS) experiences a considerable percentage of patients who do not attend their scheduled appointments, resulting in a ‘no show.’ Reducing no show rates presents an opportunity to exceed government benchmarks, and moreover, to improve upon wait lists within specific modalities like Magnetic Resonance Imaging (MRI).

Aim/Objectives: This project is aimed at reducing no shows in Diagnostic Imaging at the St. Catharines and Greater Niagara General hospital sites from 6.5 to 4.5 percent by January 2017.

Measures: For both changes, the outcome measure is the rate of no shows, which is recorded as a percent of no shows from the total appointments. The process measure for the first invention is the percent of letters received by patients in the mail. The process measure for the second intervention is a calculation of the percent of pamphlets distributed to patients from the physician’s office. The balancing measure for both interventions is in-patient wait times.

Improvement/Innovation/Change Ideas: Our two-pronged approach includes interventions at the NHS and at the primary care level. Our first approach is to mail out a letter to patients with their appointment time and other pertinent information, leading to an increase in the number of patients reminded about appointments, and ultimately resulting in lower no show rates. Our second approach consists of a patient information pamphlet, which outlines the benefits of showing up to the scheduled appointment, and aims to educate patients and improve the culture around attendance at DI.

Impact/Lessons Learned/Results: Our team conducted an extensive literature review that revealed various reasons why patients did not show up to Diagnostic Imaging appointments. This guided our team in developing interventions to address some of these factors, which resulted in the patient letter and information pamphlet. These interventions are still being trialed, but a run chart was produced with the most current data regarding the improvements.

Discussion/Spread: Once our PDSA cycles are completed, a manuscript will be submitted for publication. If these interventions are found to be effective, the reminder letters will continue, and the pamphlet will be scaled up to more physicians, and eventually across the Niagara region.
3) Improving 14 day follow up for patients with Heart Failure- a single unit experience

Toni Schofield*, Meredith Linghorne, NP, Dr J Duero, Dr H Ross, Dr C Alba * (Toronto General Hospital, University Health Network)

Background/Context: An internal audit showed that heart failure patients were being lost to follow up after discharge, being readmitted or not being seen in clinic in a timely manner. Canadian Cardiovascular Society (CCS) guidelines recommend patients admitted with heart failure should be seen in follow up within 14 days. To address this quality gap we focused on reducing time to follow up after hospital discharge. Our initial practice was to send a request to a centralized fax number and then to an email. There was no feedback to the medical team that the email or fax was received or acted upon or when the patient was booked. <50% were seen within 14 days. The purpose of this project is to meet current, recommended national standards according to CCS guidelines.

Aim/Objectives: 90% of eligible patients admitted to the inpatient heart failure team with decompensated heart failure will be seen in the outpatient clinic within 14 days of discharge.

Measures: Outcome measure: Proportion of patients seen within 14 days. Balancing measures: Proportion of patients eligible to attend our clinic, clinic saturation and additional workload are taken into consideration.

Improvement/Innovation/Change Ideas: Process Analysis and changes tested: Root cause analysis of current practice found that a lag in email receipt, accountability for checking email and acting on the email were problems. To address this problem, a dedicated clerk was assigned to book our patients prior to discharge.

Impact/Lessons Learned/Results: Improvement in patient follow up from <50% to an average of 80% (Figure A). With more data, we may be able to calculate a new median. We learned that we are able to make a small sustainable change in the way we transition patients from the inpatient to outpatient setting.

Discussion/Spread:

Next Steps: Roll out to all of the Peter Munk Cardiac Centre. Unit clerks to be trained in booking appointments. Assess outcomes such as patient satisfaction, length of stay and readmission rates.

4) A Quality Improvement Initiative to Decrease the Rate of Solitary Sets of Blood Cultures in the Emergency Department

Joseph Choi*, Sahand Ensafi, Lucas Chartier, Oliver Van Praet *(University Health Network)

Background/Context: Blood cultures (BCs) are commonly performed in the emergency department (ED). Proper collection is paramount for accurate and interpretable results, which includes obtaining at least two sets of BCs. At our tertiary care academic centre EDs, an unacceptably high proportion of patients have single (i.e. solitary) sets of BCs sent to the microbiology lab (40%).

Aim/Objectives: The aim of this project was to reduce the rate of solitary sets of BCs being sent to the lab on patients discharged from the ED.

Measures: The primary outcome was the bi-weekly percentage of patients for whom a solitary set of BCs was sent to the lab.

Improvement/Innovation/Change Ideas: This quality improvement initiative evaluated two sequential interventions, using PDSA cycles. The first intervention included didactic teaching sessions and informal reminders in staff huddles directed to providers in the ED. The second intervention added a forcing function (FF) at the point of computer order entry that automatically produced two sets of sticker labels (corresponding to two sets of BCs), instead of the single set that was the previous default. Providers could still deviate from sending two sets of cultures by discarding unused stickers. The results were analysed using statistical process control charts and segmented regression analyses.

Impact/Lessons Learned/Results: The baseline rate of solitary sets of BCs was 41.1%. The education intervention reduced this rate to 30.3%. The introduction of a FF further reduced the rate to 11.6%. This represents an absolute reduction of 29.5% from baseline (relative reduction of 71.8%). According to segmental regression analyses, the education intervention alone did not produce a statistically significant change when factoring possible background time-related trends (P = 0.071). However, the FF produced a statistically significant improvement (P < 0.0005), which was maintained for 6 months.

Figure A
Discussion/Spread: The combination of an education intervention and a computerized FF was more effective than education alone in reducing solitary BCs to an acceptable rate in our ED. FFs can be a powerful tool in modifying behaviours and processes in the clinical setting. We are continuing to evaluate our processes to improve adherence to best practices at our institution, including investigating differences identified between ED sites.

5) Prevention of Error-Based End-of-life Decision-making in Critical Care
Dr Paula Chidwick*, Dr Jill Oliver, Dr Andrew Cooper *(William Osler Health System)

Background: Our research on Form G decisions from Ontario’s Consent and Capacity Board identified six common errors in the consent process that have serious ramifications on patient safety and quality of care. Such errors include not identifying the legally correct decision maker, and not acting on the patient’s previously expressed capable wishes.

Objectives: To prevent these 6 errors we implemented a checklist (Checklist to Meet Ethical & Legal Obligations ChELO). Preventing these errors improves patient safety and quality of care because it reveals the patient's wishes, values, and beliefs and also ensures they receive wanted and beneficial treatment, and that they do not receive unwanted and potentially harmful treatment. Our aim statements included:
1. By April 2015, ChELO completion in Osler ICU’s has increased 5% for 100% of eligible patients
2. By April 2015, a trained nurse will initiate ChELO and document on Meditech for 98% of patients in Renal Program.

Measures: Our family of measures included:
(1) documentation of incapacity for decision making; (2) identifying the correct substitute decision maker; (3) recording the advanced care planning documents; (4) inquiry of personal values and beliefs; (5) treatment plans as per the patient’s wishes is being followed; and (6) # where family member or substitute decision maker were allowed to direct treatment plans. We measured completion of ChELO comparing T1 (Oct 15) – T2 (May 16).

Improvement: Post intervention measures showed improvement of:
• 22% in the documentation of Incapacity for decision making
• 24% in identifying the correct substitute decision maker
• 43% in recording the advanced care planning documents
• 36% in the inquiry of personal values and beliefs
• 100% in treatment plans aligned with patient’s wishes
• 100% no substitute decision maker directed treatment plans.

Lessons: We learned that having a dedicated person supporting ChELO completion makes teams aware of patient wishes, values, and beliefs, and integrating these into the care plans increased quality of care and prevented errors in decision-making.

Spread: We have spread this project to the Osler Renal Program, Palliative Care Outpatient Program, Medicine Program and Headwaters Health Care Centre.

6) Improving the quality of long-term care transfer reports to the emergency department
Joseph Carson*, Stephanie Gottheil, Alan Gob, Sherri Lawson *(University of Toronto)

Background/Context: In Ontario, about 25% of long-term care (LTC) residents are transferred to hospital emergency departments (ED) every six months. ED staff rely on accurate personal health information to provide safe, high quality care. However, many residents have difficulty describing such information, especially if they have impaired cognition. In the absence of accompanying caregivers or family members, ED staff look for essential details in the LTC transfer reports. Communication gaps between LTC and ED are common, and may lead to unnecessary diagnostic testing and treatments for LTC residents.

Aim/Objectives: The purpose of this quality improvement study was to establish a baseline understanding of the LTC-ED communication gap and test change ideas for sustained improvement. Our aim was for 90% of LTC emergency transfers to include the resident’s reason for transfer and baseline cognitive status by June 30, 2016.

Measures: Our outcome measures were the percentage of transfer reports documenting reason for transfer and baseline cognition. Our process measures were the percentage of transfers containing the MDS Kardex and all four standard forms. Our balance measures included the percentage of transfers documenting medications and advance directives, which the ED also rated as high priority information.

Improvement/Innovation/Change Ideas: London Health Sciences Centre, a tertiary care organization in Ontario, Canada, partnered with 10 LTC homes to improve documentation of the two most important items: ‘reason for transfer’ and ‘baseline cognitive status’. After the root cause analysis was performed, a series of PFDA cycles were conducted and results were analyzed using statistical process control charts. The final intervention included individual nurse education, a transfer guide posted at nursing stations, and a standardized minimum set of currently available transfer documents.

Impact/Lessons Learned/Results: After implementation, the documentation rate of ‘reason for transfer’ improved from 60% to 84%, and ‘baseline cognitive status’ improved from 4% to 56%.
Discussion/Spread: These results suggest that transfer communication can be improved by co-designing solutions with LTC nurses that build on current reporting practices, which are shared across multiple LTC organizations.

7) Advancing the Culture of Medical Quality: Linking Improvement and Safety Rounds to Hospital Credentialing
A. Yeung*, A. Ginzburg, R. Cooper, C. Weatherston, S. Bains, D. Morra *(Trillium Health Partners)

Background/Context: Privileging recommendations to a hospital’s Board of Directors are typically made without information on how individual professional staff are advancing the quality of care they provide to patients. Trillium Health Partners (THP), one of Canada’s largest academically-affiliated hospitals with over 1300 Professional Staff members, has sought to define medical quality of care and link it to the annual reappointment process. The Medical Quality of Care (MOC) Initiatives for Members of the Professional Staff Policy was created in 2015 to ensure professional staff have clear participation guidelines to advance medical quality of care. The first initiative was to create a common standard for Quality Improvement and Patient Safety Rounds (QIPS).

Objectives: Prior to this initiative, continuing medical education rounds were inconsistent in terms of expectations. The Medical Advisory Committee (MAC) developed criteria for QIPS (see attached criteria). As a requirement for reappointment, active and associate professional staff were required to attend 3 QIPS in Year 1 (2015) and 5 QIPS per year thereafter.

Measures: Professional staff attendance at QIPS was centrally recorded in a database managed by the Quality Department.

Innovation Ideas:
- Existing rounds were realigned and new rounds were introduced to meet criteria for QIPS.
- Quarterly hospital wide Quality Grand Rounds helped to provide professional staff with additional opportunities to meet attendance expectations.
- Professional Staff competence in patient safety culture and quality improvement can be improved by participation in QIPS.
- Mandatory participation in quality activities will be supported by professional staff.
- A corporate-wide initiative with professional staff can be sustained over time.

Results: After just one year since inception, professional staff participation in QIPS has become hardwired into practice and a learning culture around quality and safety has become embedded in the organization. In 2015, there were a total of 695 QIPS and cumulative attendance of 6679 non-unique active/associate professional staff members. 96% of 734 active/associate professional staff met their QIPS requirements. For the first six months of 2016, there were a total of 561 QIPS and cumulative attendance of 4728. 45.6% of active/associate professional staff have already met their requirement of attending five rounds this year.

8) Communicating critical results: positive blood culture Gram notification in the General Internal Medicine ward – identification of a quality improvement initiative opportunity
Lee Gonna*, Yan Chen, Ramzi Fattouh, Aaron Campigotto, Nancy Matic, Maan Hasso, Ana Cabrera, Manal Tadros, Larissa Matukas *(University of Toronto)

Background/Context: Delay in the initiation of appropriate antibiotic therapy is a significant risk factor for mortality in cases of bacteremia. Thus, communication of Gram stain results from positive blood cultures is a critical first step in early initiation of targeted therapy.

Aim/Objectives: The microbiology laboratory aims to communicate 100% of Gram stain results from positive blood cultures to physicians within 15 minutes of discovery.

Measures: The notification process was mapped after doing observations for ten positive blood cultures from General Internal Medicine (GIM) patients at three academic hospitals in Toronto (Table 1). The primary process measure was the time from microbiology laboratory Gram stain result to communication to MRP.

Improvement/Innovation/Change Ideas: In 6 out of 10 observations, communication of results to physicians was greater than 15 minutes; in two cases, the physician was not contacted at all. The reporting of critical results for most institutions was found to be inefficient, involving initial communication to the unit clerk, who would relay the result to a nurse, who would then forward to the MRP.

Process change was implemented in the microbiology laboratory of one institution as a pilot study. A Plan, Do, Study, Act (PDSA) cycle was initiated after meeting with the GIM staff, unit manager, and nurse educator. The implemented process instructed laboratory technologists to contact locating who would then page the appropriate GIM resident directly.

Impact/Lessons Learned/Results: In 4/7 cases, residents responded promptly (within ten minutes) to laboratory pages relayed through locating. However, the remaining cases required a second page before responding, delaying communication by as much as 90 minutes. A second PDSA cycle has now commenced which aims to utilize the web-based paging system WebEx to permit communication of critical results from technologist directly to the MRP. This should remove delays associated with the ‘relay’ system currently in place.
Discussion/Spread: This study highlights significant delays in the communication of, and therefore response to, critical blood culture results. We suspect that many of these issues will be addressed by implementing WebEx reporting, with the added benefit of introducing accountability to staff of responding to pages promptly.

Table 1: Gram stain notification process observations

<table>
<thead>
<tr>
<th>Observation ID</th>
<th>Gram stain result</th>
<th>Time of notification 1 – clerk / nurse (minutes)</th>
<th>Time of notification 2 – patient's nurse (minutes)</th>
<th>Time of notification 3 – physician (minutes)</th>
<th>TAT (minutes)</th>
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<tbody>
<tr>
<td>A1</td>
<td>GPC clusters</td>
<td>14:36</td>
<td>15:21</td>
<td>15:36</td>
<td>60</td>
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<tr>
<td>A2</td>
<td>GPC chains</td>
<td>09:18</td>
<td>09:18</td>
<td>09:24</td>
<td>6</td>
</tr>
<tr>
<td>A3</td>
<td>GNB</td>
<td>14:03</td>
<td>14:18</td>
<td>14:18</td>
<td>15</td>
</tr>
<tr>
<td>A4</td>
<td>GNB</td>
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<td>10:34</td>
<td>ND1</td>
<td>&gt;60</td>
</tr>
<tr>
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<td>GPC chains</td>
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<td>5</td>
</tr>
<tr>
<td>B1</td>
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<td>09:56</td>
<td>10:00</td>
<td>6</td>
</tr>
<tr>
<td>B2</td>
<td>GNB</td>
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<td>ND2</td>
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<td>58</td>
</tr>
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<td>11:30</td>
<td>ND1</td>
<td>&gt;60</td>
</tr>
</tbody>
</table>

GPC gram positive cocci, GNB gram negative bacilli, TAT turn-around-time
¹Not possible to determine time, nurse did not report to MRP even after intervention
²Not determined, nurse was contacted with Gram stain result after 45 min delay at ward clerk
³Report to physician was done only after intervention

9) Code Resus – Using a Quality Improvement Approach to Improve Health Care Provider Response During Resuscitations

Edward Xie*, Shandi Hansen, Dawn Lim, Soojin Yi, Barb McGovern, Deb Davies, Kevin Beane, Nicole Harada, Lucas Chartier *(University Health Network and University of Toronto)

Background/Context: Achieving the best possible outcome for patients requiring resuscitation (PRRs) in the emergency department (ED) requires efficient, multi-disciplinary and coordinated responses from healthcare providers (HCPs).

Aim/Objectives: The objective of this quality improvement (QI) initiative was to improve HCP response to PRRs at two tertiary care hospital EDs in Toronto.

Measures: We conducted a pre-implementation mixed-method survey to evaluate the perception of the adequacy of HCP response and clarity of HCP role when responding to PRRs. Qualitative responses were used to develop the project’s change ideas. Six months after implementation, a second survey was conducted to evaluate the sustained effects of the intervention. Results were compared using Chi-square test.

Improvement/Innovation/Change Ideas: Through interviews of key stakeholders and with continuous input from HCPs, a multi-disciplinary team modified the ED resuscitation protocol. Innovations included standardized pre-hospital paramedic communication forms, ED-wide announcement of ‘Code Resus’, dedicated HCPs assigned to respond to PRRs, and specific duties assigned to each responder. Change initiatives were reinforced through education and posters in the ED.

Impact/Lessons Learned/Results: Baseline measures indicated that 16 of 52 (30.8%) nurses surveyed believed their role was often or always apparent to themselves and others when they attended to a PRR (on a 5-point rating scale). This proportion increased to 35 of 55 (63.6%) nurses in the post-implementation survey (p < 0.001). Regarding adequacy of the number of HCPs responding to PRRs, 17 of 39 (43.6%) physicians and 23 of 53 (43.4%) nurses surveyed thought the appropriate number of HCPs responded to PRRs; the remainder thought that there were too few or too many HCPs. In the post-implementation survey, 34 of 41 (82.9%) physicians (p < 0.001) and 36 of 56 (64.3%) nurses (p = 0.029) surveyed felt that the appropriate number of HCPs attended to PRRs.

Discussion/Spread: Using a quality improvement approach, we identified and quantified perceived deficiencies in HCP response to PRRs in the ED. Through feedback-based modifications of the ED resuscitation protocol and by engaging HCP stakeholders, change initiatives were implemented to improve HCP response. As a result, this project achieved significant and sustained improvements in HCPs’ perceived response to PRRs, and we continue to elicit feedback and improve on our response to PRRs.

10) Improving Inpatient Advanced Care Planning (ACP) with a Medical Order for Scope of Treatment: A Quality Improvement Study

Samuel Kohen BSc, MD FRCP, MSc*, Rajesh Nair BSc, MD *(St Joseph’s General Hospital, Comox, British Columbia)

Background/Context: Research suggests hospital based health care providers (HCP) infrequently engage patients and families in end-of-life (EOL) planning conversations. This care gap can lead to unwanted under or over treatment, conflict, family distress, and clinician burnout. The Vancouver Island Health Authority implemented a standard Medical Order for Scope of Treatment (MOST) placed at the front of admitted patients’ charts outlining their code status in order to improve inpatient documentation of patient health care wishes. To date, the MOST has not been proven to be more effective at documenting goals of care than the standard “DNR” order.
Aim/Objectives: Our objective is to track and optimize MOST implementation at St. Joseph’s General Hospital and see if it improves: 1) Inpatient ACP Documentation, 2) Concordance between ACP documentation, patients’ wishes and care delivery, 3) Patient and caregiver satisfaction, 4) HCP understanding of key ACP concepts, and 5) Use of acute care resources.

Measures: The primary outcome was ACP documentation (% of admitted patients who had the MOST complete by the third day of hospitalization or before discharge). Secondary outcomes were: 1) Concordance between patient wishes and what is documented in the chart, 2) HCP ACP knowledge (HCP quiz), 3) Intensity of care, 4) Life expectancy, and 5) Patient and caregiver satisfaction (CanHelp Lite).

Improvement/Innovation/Change Ideas: Between May and August 2016, the proportion of patients with a completed MOST increased from 0 to 77%. This was associated with 1) A 47% improvement in ACP documentation, 2) 51% improvement in concordance, 3) 14% improvement in HCP ACP knowledge, and 4) 11% improvement in patient and caregiver satisfaction. We are still awaiting 90-day follow up data to measure intensity of care.

Impact/Lessons Learned/Results: Documenting ACP patient wishes with a standard tool (MOST) is associated with improvements in ACP documentation, concordance and satisfaction with care.

Discussion/Spread: This supports the hypothesis that the MOST improves inpatient documentation of patient wishes when compared to the standard “DNR”.

11) Improving Critical Care Intubation at a Community Hospital Through Process Standardization: A Prospective Quality Improvement Study

Samuel Kohen BSc, MD FRCPC, MSc
(St Joseph’s General Hospital, Comox, British Columbia)

Background/Context: Critical Care Intubation (CCI) is a resource intensive emergency lifesaving procedure performed intermittently, often without notice in physiologically unstable patients, under suboptimal conditions by physicians with limited airway training or experience. These challenges are major contributors to poor documentation, processes inefficiencies, procedural complications and health care practitioner (HCP) stress.

Aim/Objectives: This multidisciplinary quasi-experimental CCI quality improvement project was developed and implemented at St Joseph’s General Hospital (SJGH) over one year to: 1) Improve documentation by 25%, 2) Reduce the relative risk of procedural complications by 50%, 3) Improve procedural efficiency by 50% and 4) Reduce HCP stress related to intubation by 50%.

Measures: This prospective study with historical controls outlines includes 20 pre-intervention (2014) and by 26 peri-intervention CCIIs (2015). Outcome measures included 1) Procedural documentation (key information recorded in chart), 2) Procedural efficiency (time from decision to intubate to CXR), 3) Procedural complications (new desaturation, hypotension, esophageal intubation, aspiration or cardiac arrest) and 4) HCP stress (self-assessment tool).

Improvement/Innovation/Change Ideas: The CCI worksheet was used in 81% (21/26) of the procedures. Use of the CCI sheet was associated with: 1) 17% improvement in CCI documentation (score 5.2/7 to 6.5/7), 2) 73% relative risk reduction in life threatening procedural complications (6/20 to 3/26) and 3) 52% improvement in procedural efficiency (59 to 27 minutes). We were unable to measure HCP stress.

Impact/Lessons Learned/Results: All improvements reached statistical significance and most attained the stretch goals. We were unable to measure HCP stress because the initial tool was too complicated, staff time pressure and a fear of retribution.

Discussion/Spread: This CCI project drew upon several QI methodologies. Strengths include reliance on current evidence, concordance with previously published complication rates, local administrative support, rigorous data collection and clinical significance. A control group would help to better attribute the observed improvements as due to the intervention rather than baseline improvements over time. This intervention may be easily generalized to other centres.

12) Beyond compliance: An ethnography of OR safety cultures

Sherry Espin*, Rachel Grant, Roxanne Ziman, Simon Kitto *(Ryerson University)

Background/Context: The surgical safety checklist (SSC) has been implemented for use in operating rooms (OR) worldwide to optimize patient safety and improve interprofessional communication. While compliance rates have been reported as high, reductions in post-operative mortality and complications have not improved significantly.

Aim/Objectives: The aim of this ethnographic study was to examine the factors which may be impacting the uptake of the SSC.

Measures: Through direct observation and semi-structured interviews with staff, this study looked beyond what “ought” to be happening in the OR to what is actually happening.

Improvement/Innovation/Change Ideas: Qualitative methods uncovered the challenges and complexities of surgical culture in which the SSC is being implemented.
Impact/Lessons Learned/Results: Key findings emerging from this study included the perceived (un)importance of specific checklist components, lack of patient involvement, and workflow barriers that hamper effective communication and use of the SSC.

Discussion/Spread: Study findings have been submitted for publication, and the knowledge and recommendations for improvement have been disseminated locally and nationally.

13) Code Hip: Evaluating Time to Surgery Prior to and After the Implementation of a Multidisciplinary Hip Fracture Care Pathway
Sarah Ward, MD FRCSC*, Lisa Wild, RN(ECT), MN, Michelle Biehl, BHRSc(c), Rosane Nisenbaum, PhD, Genny Micallef, RN, MN, Jeremy Hall, MD, FRCSC, M.Ed *(St. Michael’s Hospital)

Background/Context: Hip fracture is a common orthopaedic injury most frequently affecting people aged 65 years or older, resulting in the need for hospitalization and surgery. Hip fractures carry significant risk of mortality, morbidity and loss of functional independence. Early diagnosis and access to surgery within 48 hours have been shown to improve these outcomes.

Aim/Objectives: To improve the percentage of hip fracture patients receiving surgery within 48 hours to over 90% by August 2013 through the development of the Code Hip clinical pathway for hip fracture patients.

Measures: The primary outcomes were average time from ED admission to surgery and percentage of patients achieving surgery within 48 hours.

Improvement/Innovation/Change Ideas: The Code Hip clinical pathway was developed by a multidisciplinary team to improve and streamline care of hip fracture patients. The pathway comprised a bundle of interventions including rapid ED assessment and admission and expedited surgical booking. Retrospective chart reviews were conducted on 202 patients with hip fracture during the study period. The Pre-Code Hip cohort included 97 hip fracture patients admitted between June 2011 and May 2012. The Post-Code Hip cohort included 105 patients admitted between September 2012 and August 2013. The three-months between cohorts allowed for introduction and incorporation of the Code Hip pathway into clinical practice.

Impact/Lessons Learned/Results: Implementation of the Code Hip clinical pathway resulted in a sustained improvement, with the percentage of hip fracture patients achieving surgery within 48 hours increasing from 77% to 92%. Average time from admission to surgery was below 48 hours in the Pre-Code Hip cohort (mean 35.3 hours, SD 23.9) but there was nonetheless a reduction of 19.2% (p=0.0159) in time from admission to surgery (mean 28.6 hours, SD 17.9) Post-Code Hip. Time from admission to surgical booking was significantly reduced, but time from surgical booking to surgery remained unchanged.

Discussion/Spread: Future efforts will focus on sustaining this improvement, optimizing wait time from surgical booking to surgery, and improving other aspects of hip fracture care, such as nutrition and early post-operative mobilization.

14) Improving the post-operative mobilization protocol following Total Knee Arthroplasty at St. Michael’s Hospital
Dr. Sarah Ward, MD*, Leah Schwartz, PT, Merle Uglow, RN, Tara Raine, RN, Dr. Nick Lo, MD *(St. Michael’s Hospital and University of Toronto)

Background/Context: St. Michael’s Hospital is a high-volume arthroplasty centre. Prior to July 2015, various different surgeon-specific post-operative protocols were in use, which were not evidence-based. The lack of a single clear protocol caused confusion for trainees and members of the allied health disciplines and also prevented rapid post-operative mobilization, prolonging length of stay.

Aim/Objectives: To develop a standardized post-operative mobilization protocol for total knee arthroplasty patients at St. Michael’s Hospital and thereby to decrease knee immobilizer use by 50% by April 1, 2016.

Measures: Length of stay (LOS) was evaluated as an outcome measure. Knee immobilizer use was used as a process measure. Balancing measures included the occurrence of falls and knee range of motion (to ensure this was not compromised by the new protocol).

Improvement/Innovation/Change Ideas: First we adopted a standardized post-operative protocol for use by all surgeons. Subsequently, we engaged the physiotherapy team to decrease knee immobilizer use. We then engaged the Acute Pain Service (APS) and anaesthesia teams to discontinue femoral nerve catheters earlier to permit return of quadriceps function and promote improved independence with mobilization.

Impact/Lessons Learned/Results: Through the development of a unified post-operative protocol, we reduced knee immobilizer use by ~90%. There was no increase in falls and range of motion at hospital discharge increased under the new protocol. We also increased the proportion of patients being discharged home on post-operative day 2.

Discussion/Spread: Engaging stake-holders, especially the physiotherapy and APS teams, was crucial to the success of this initiative. The physiotherapy team identified persistent knee buckling that limited mobilization while femoral nerve catheters were in place. Engaging the APS team to remove the catheters earlier and delaying the decision regarding knee immobilizer use helped to address this issue. We also identified other areas for further improvement and
we are now embarking on a larger project to create a more comprehensive standardized clinical pathway for total knee arthroplasty patients. This pathway will involve further enhancements to early post-operative mobilization as well as improvements and standardization of the pain management protocol.

15) Reducing unnecessary inpatient routine blood work
Margaret Siyu Wu*, Dr. Christine Soong *(University of Toronto)

Background/Context: Literature estimates that between 10 to 67% of laboratory testing are inappropriate. Inappropriate laboratory testing is associated with adverse health consequences for inpatients, such as iatrogenic anaemia, false positive test results, and pain. Reducing unnecessary repetitive phlebotomy can improve patient experience, patient safety, and better resource utilization.

Aim/Objectives: To reduce “routine” blood testing (CBC, electrolytes, and creatinine) testing by 20% among internal medical inpatients at an academic tertiary hospital in a 1-year period.

Measures: The primary outcome measure is the total volume of blood drawn for routine blood testing (CBC, electrolytes, and creatinine) per inpatient days on internal medicine units compared to baseline of 6 months before intervention. The process measure includes the proportion of patients with completed consecutive 3-day routine blood testing ordered from admission as part of an order set. The balancing measure is the number of processed STAT routine blood work per inpatient day. Surgical services are used as control group.

Improvement/Innovation/Change Ideas: We achieved consensus on appropriate indications for routine blood testing. We modified existing admission order sets to reduce the default setting of daily blood testing among internal medicine patients and built in decision support.

Impact/Lessons Learned/Results: Compared to baseline, there was a 17.2% reduction in the total number of routine blood work per inpatient days in internal medical services the month after intervention. In comparison, the surgical control group had no significant reduction in routine blood work. A chart audit of 60 medical inpatients demonstrated a 7.9% reduction in the number of processed daily 3-day admission routine blood work orderset. There was also a 3.6% decrease in the number of processed STAT routine blood work per inpatient day.

16) Evaluation of a novel surgical safety checklist process to improve checklist item completion in a tertiary pediatric hospital: A quality improvement project
Mehr Jain*, Andrea Sepa, Unni Narayanan, James D. O’Leary *(Hospital for Sick Children)

Background: Surgical safety checklists have become a standard of care for safe operating room practice, but their use in Ontario pediatric hospitals has not been associated with reductions in perioperative complications. Poor checklist completion has been observed in our local practice setting, which may contribute to this lack of effect.

Aim: To evaluate a novel surgical safety checklist process designed to improve checklist item completion.

Measures: Surgical safety checklist completion was independently observed in the operating room before and during the intervention. The primary outcome measure was overall checklist item completion. Differences in item completion in pre-intervention and intervention groups were compared using Fischer’s exact test.

Improvement: With Quality and Risk Management approval, a novel surgical safety checklist process and content –developed by the local Perioperative Services Surgical Safety Checklist Committee– was evaluated in Orthopaedic operating rooms at our institution during July and August 2016. The novel checklist consisted of a wall-mounted physical checklist intended to aid item recall and increase ownership of checklist phases with questions and responses provided by designated team members. Team training was provided, operating room team leaders were identified to promote the intervention, and revisions to the checklist content were implemented in short cycles based on feedback from operating room team members on the feasibility and clinical sensibility of the intervention.

Results: We observed 45 and 59 children who underwent orthopaedic surgery in pre-intervention and intervention groups respectively. 86.8% (1,354/1,560) of all checklist items were observed overall. Checklist item completion was significantly increased in the intervention group (76.7% [615/802]) compared with the pre-intervention group (27.2% [150/522]) (P<0.001).
Discussion: These findings suggest that this novel surgical safety checklist process employing a physical memory aid can significantly improve checklist item completion in our local practice setting. It is planned to use the lessons learned during this project to implement strategies to improve surgical safety checklist completion in other operating rooms at our institution.


17) The Ontario Emergency Department Return Visit Quality Program: A Provincial Initiative to Promote Continuous Quality Improvement

**Declaration of conflict of interest: Authors are employed by Health Quality Ontario, which manages the program discussed, or by Cancer Care Ontario, which provides analytical capabilities.

Background/Context: Analysis of charts of patients who have a return visit to an emergency department (ED) requiring hospital admission (termed ‘RV’) is an efficient way to identify possible adverse events (AEs). Subsequent investigation of AEs can then be used to improve the quality and safety of the care being delivered in the ED.

Aim/Objectives: The ED RV Quality Program is a new provincial program launched on April 1st, 2016. It aims to promote a culture of continuous quality improvement through routine audit and investigation of ED RVs. It is supported by the Ministry of Health and Long-Term Care of Ontario and managed by Health Quality Ontario.

Measures: Participating EDs must review data on their 72-hour RVs, and on all 7-day RVs with a ‘sentinel diagnosis’ of subarachnoid haemorrhage (SAH), acute myocardial infarction (AMI), or paediatric sepsis (PS).

Improvement/Innovation/Change Ideas: The program is mandatory for all EDs participating in the Pay-for-Results (P4R) program and voluntary for others. EDs must conduct audits to identify the root causes of the RVs and identify steps to address these causes. Reviews are performed using a standardized audit template, which includes a breakdown of the type and severity of AEs, the underlying causes, and potential actions for quality improvement.

Impact/Lessons Learned/Results: 73 P4R EDs and 14 voluntary non-P4R EDs are participating in the program. Collectively, these EDs receive 87.6% of ED visits in the province. Six months’ worth of data has been released to date, which encompasses 21,956 patients with an RV (1.03% of all ED visits). Of these, 150 visits (0.037%) resulted in an RV for a sentinel diagnosis (7 for SAH, 123 for AMI, and 20 for PS). 17.7% of patients returned to a different hospital than the one on their index visit. The most common presenting complaint of the index visit was abdominal pain (17.8%), and the most common discharge diagnosis of the RV admission was acute appendicitis (3.8%).

Discussion/Spread: The ED RV Quality Program is focused on continuously improving the quality of care delivered in Ontario EDs through routine audits of RVs and identification of potential AEs. 87 hospitals that have seen a combined 2,125,823 patient visits over six months are currently participating in the program, with hundreds of patient chart audits already completed to date.

18) Development of a Province-Wide Audit Program for Return Visits to the Emergency Department

**Declaration of conflict of interest: Authors are employed by Health Quality Ontario, which manages the program discussed, or by Cancer Care Ontario, which provides analytical capabilities.

Background/Context: Routine auditing of charts of patients with an emergency department (ED) return visit (RV) resulting in hospital admission can uncover quality and safety gaps in care. This feedback can be helpful to clinicians, administrators, and leaders working to improve clinical outcomes, increase patient satisfaction, and promote high-value care.

Aim/Objectives: Health Quality Ontario (HQO) has been tasked by Ontario’s Ministry of Health and Long-Term Care (MOHLTC) to manage the newly created ED RV Quality Program (RVQP), which mandates EDs participating in the Pay-for-Results (P4R) program to audit a minimum of 25-50 RVs/year. The goal is to promote a culture of quality improvement (QI) that will lead to improved patient care.

Measures: Participating hospitals receive quarterly confidential reports from Access to Care (ATC) that show their and other hospitals’ rates of RVs, as well as identifying information for patients meeting RV inclusion criteria at their ED (within 72hrs of index visit, or within 7 days with specific diagnoses). HQO is tracking program uptake and number of audits completed.

Improvement/Innovation/Change Ideas: HQO has partnered with QI experts and ED physician-leaders to develop guidance materials, including a website, Frequently Asked Questions (FAQs), an audit template with step-by-step instructions on conducting the audits, and an interim Check-In form. These materials have been disseminated through various media (print, electronic, webcast) – see supporting documents for examples. Hospitals are conducting audits to identify underlying quality issues, take steps to address the underlying causes, and submit reports to HQO. A taskforce will then analyze clinical observations, summarize key findings and lessons learned, and share improvements at a provincial level through an annual report.
Impact/Lessons Learned/Results: Since its launch in April 2016, 73 P4R and 14 voluntarily enrolled non-P4R hospitals (which collectively receive approximately 88% of ED visits in the province) are participating in the RVQP. ED leaders have engaged their hospital’s leadership to leverage interest and resources to improve patient care in the ED. To date, hospitals have conducted hundreds of audits and have identified quality and safety gaps to address.

Discussion/Spread: The ED RVQP aims to create a culture of continuous QI in the Ontario health care system, which provides care to over 13.8 million people. Other jurisdictions can replicate this model to promote high-quality care.

19) Developing a sustainable deprescribing program at the Michael Garron Hospital

John Abrahamson, MD*, Mark Daubaras, Ana Florescu, MD, Christopher Smith, MD, Jennifer Jayakar, MD, Ankeeta Tadkase, MD, Andrew Liu, DPharm *(Michael Garron Hospital)

Background/Context: Numerous studies have shown that, in elderly patients, certain classes of medications may have reduced therapeutic benefit or harmful drug interactions and side effects. Deprescribing is the systematic discontinuing of drugs whose potential for harm outweighs their benefits within the context of an individual’s care goals, level of functioning, and life expectancy.

Aims/Objectives: To develop a workflow and business model which demonstrate the feasibility of a sustainable deprescribing program at the Michael Garron Hospital (MGH).

Measures: All admissions to the General Medicine Service at the MGH over a 30 day period were enrolled. A review of home medications was conducted on participants with more than five prescriptions and over 65 years. The total numbers of deprescribing recommendations were recorded and estimated savings were calculated. Hospital physicians were assessed qualitatively for their acceptability of this deprescribing pilot. Readmissions within 30 days were reviewed to determine if this was a consequence of the deprescribing recommendations. Compliance to suggested medication changes will be tracked through the Ontario Drug Database.

Improvement/Innovation/Change Ideas: Improving the health care system by reducing adverse drug reactions and pharmaceuticals spending through the implementation of a deprescribing program at MGH.

Impact/Lessons Learned/Results: From 272 admissions, 72 participants underwent full review of their home prescriptions with 255 deprescribing recommendations made in total. Commonly targeted classes of medications included analgesics (20%), anti-hypertensive (20%), proton pump inhibitors (16%), and sleeping medications (15%). Hospital physicians were accepting and supportive of this pilot project. Less than one in ten readmissions within 30 days was attributed to a deprescribing recommendation. Estimated annual savings to the hospital as a result of this deprescribing pilot was $20,000.

Discussion/Spread: Approximately 25% of Hospitalists patients at MGH could benefit from a deprescribing review. We have verified that an accepting culture for a deprescribing program exists at MGH. Additionally, readmissions within 30 days were rarely linked to a deprescribing recommendation. The proposed business model for hospitals to develop a sustainable deprescribing program can be funded through pharmaceutical cost savings.

20) Low Risk Rule: High QI Reward – Application of the Low Risk Ankle Rule (LRAR) in the SickKids Emergency Department

Dr. Greg Harvey*, Dr. Faisal Al-Sani, Dr. Maxim Ben-Yakov, Dr. Jessica Gantz, Dr. Daniel Rosenfield, Dr. Kathy Boutis, Dr. Olivia Ostrow, Dr. Tania Principi *(Hospital for Sick Children)

Background/Context: At baseline within the Hospital for Sick Children ED, acute ankle injuries have been imaged using x-rays approximately 90% of the time. An evidence-based decision rule, The Low Risk Ankle Rule (LRAR) by Boutis et al. has been developed and validated for minor ankle injuries for the purposes of determining which ankle injuries do not necessitate radiography. The rule is 100% sensitive for capturing clinically important ankle injuries and has been shown to reduce ankle x-ray imaging by 30% when applied.

Aim/Objectives: Our Aim Statement was as follows: “Achieve a 30% reduction in ankle x-rays for acute ankle injuries ordered by June 30th, 2016”.

Measures:
Outcome:
- X-rays ordered for ankle injuries
- ED Length of Stay (PIA to discharge)

Process:
- Documentation of LRAR in medical record
- Use of developed ankle x-ray form

Balancing:
- Return to ED visits within 72H for same reason
- Orthopaedic clinic referrals
Improvement/Innovation/Change Ideas: Project implementation was approved by the local Quality Management Board. The project was prioritized by the local Choosing Wisely campaign initiative. Relevant patient data was obtained by reviewing the electronic medical record.

Major change ideas implemented included 1) Staff (medical, nursing) education surrounding the LRAR, 2) LRAR reference posters within the ED, and 3) Development of a new mandatory diagnostic requisition for ankle injuries in collaboration with the Division of Radiology that encourages use of the LRAR.

Impact/Lessons Learned/Results: Ankle X-ray ordering rates decreased significantly following implementation of changes (~90% to ~56%, run chart included in additional figure) and ED length of stay decreased in patients with ankle injuries. Increased documentation of LRAR was seen as was use of the developed radiology requisition form. Return visits to the ED and Orthopedic clinic referrals did not increase.

Discussion/Spread: To date, the results have not been replicated outside of the original setting, however our intention is to publish results once sustained gains have been clearly established. We intend to sustain gains by having implemented a hard-stop radiology requisition for all ankle injuries, creating a new electronic documentation template for ankle injuries, continuing regular monitoring of x-ray rates, and handing over of key project roles for long-term maintenance.

21) Evaluation of a quality improvement education program in Obstetrics and Gynaecology for final year medical students
Michelle R. Wise*, Bridget Kool, Roshini Peris-John, Lynn Sadler, Susan Wells *(University of Auckland)

Background/Context: Since 2003, medical students at University of Auckland learn improvement science theory and skills in Year 5, and put this into practice by doing a Quality Improvement (QI) project during their Obstetrics and Gynaecology (O&G) clinical attachment in Year 6. In 2015, a reinvigorated curriculum resulted in a reduction of the O&G attachment from five weeks to four, necessitating revision of the QI program.

Aim/Objectives: To evaluate the Year 6 QI educational program in O&G.

Measures: Based on a CIPP (Context/Input/Process/Product) evaluation model, the study was conducted in several stages to get a sense of the context whilst planning the new program (Context evaluation), the feasibility of an alternative approach to meet educational needs (Input evaluation), the implementation of the revised program (Process evaluation) and the program outcomes (Product evaluation). We used multiple data sources (medical students, QI project clinical supervisors, academic administrators, and hospital QI staff) and data collection methods (questionnaires, semi-structured focus group discussions, and individual interviews; consultative workshop; and formal evaluation of student project reports and oral presentations).

Improvement/Innovation/Change Ideas: Students were encouraged to work in small groups, limit the audit to only one standard, and have the proposal signed off within the first week, including feedback from the supervisor. Several resources were developed, such as an orientation video, a report template, and a ‘tips’n’hints’ student webpage.

Impact/Lessons Learned/Results: Context evaluation: the program was valuable and contributed to O&G service improvements; however, concerns were: time to complete the project, timely topic selection and access to data, recognition of student achievement, and staff workload. Product evaluation: there was improvement in most of the previously identified challenging areas, and in QI knowledge, skills and attitudes, despite the shortened time frame.

Discussion/Spread: Applying the CIPP model to our revised QI program enabled streamlining of procedures to achieve greater efficiency, without compromising the quality of the learning experience or increasing burden on staff. Our program is feasible within a four week clinical rotation, and is sustainable

22) Reducing post-caesarean endometritis using the audit cycle
Michelle R Wise*, Kaveshan Naidoo *(University of Auckland)

Background/Context: Reducing harm from surgical site infections is a Health Quality & Safety Commission New Zealand target. Post-partum endometritis is an infection of the urogenital tract necessitating early re-admission to hospital. It is more common after caesarean section (CS) and 32% of women at our hospital delivered by CS in 2012. A Cochrane review has shown that pre-operative vaginal cleansing can reduce the risk of endometritis in women undergoing CS; however, this is not performed at our hospital, nor is post-partum endometritis rate measured.

Aim/Objectives: To determine the rate of endometritis by pre-set diagnostic criteria in women following CS; to evaluate if the rate could be reduced by implementing a quality improvement initiative.

Measures: Audit: baseline (1 December 2012 to 28 February 2013) and post-intervention (1 January to 9 February 2014) case note review of consecutive block sample of women undergoing CS at Auckland Hospital; repeat audit also performed (10 February to 31 December 2014), survey of theatre nurses on knowledge, skill and attitudes.
Improvement/Innovation/Change Ideas: Presented to multidisciplinary Theatre Management Committee; developed nursing and medical education and protocols around routine pre-operative vaginal cleansing; added question on vaginal cleansing to Surgical Safety Checklist.

Impact/Lessons Learned/Results: Endometritis rate decreased by 44%, from 41/631 (6.5%) at baseline to 9/245 (3.7%) post-intervention, and sustained for the rest of the year (14/383). There was no difference between groups by age, ethnicity, body mass index, CS type or ruptured membranes. Vaginal cleansing was performed in 81% of cases, not performed in 9% of cases, and not documented on the Checklist in 10%. Fifteen nurses completed the survey; most felt that reducing infection was important and supported its continuation, most felt competent at it but that doctors should do it; concerns raised included: invasive nature of cleansing, extra time taken in a ‘crash’ CS.

Discussion/Spread: Despite only 81% of women having the cleansing prior to undergoing CS, there was a significant reduction in endometritis rate consistent with that found in the trial literature. We suggest that embedding a new element into an already well-established pre-operative nursing practice was the key to the success of this quality improvement initiative.

23) Contextualizing Learning to Improve Care Using Collaborative Communities of Practices

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Background/Context: The use of interorganizational, collaborative approaches to build capacity in quality improvement (QI) in health care is showing promise as a useful model for scaling up and accelerating the implementation of interventions that bridge the “know-do” gap to improve clinical care and provider outcomes.

Aim/Objectives: This learning approach aims to create the conditions for collaborative, reflective, and innovative experiential systems that enable collective discussions regarding daily practice issues and finding solutions for improvement.

Improvement/Innovation/Change Ideas: The concepts associated with interorganizational learning and deliberate learning activities within a collaborative ‘Communities-of-practice’ (CoP) approach formed the foundation of the of an interactive QI knowledge translation initiative entitled PERFORM KT. Nine teams participated including seven teams from two acute care hospitals, one from a long term care center, and one from a mental health sciences center. Six monthly CoP learning sessions were held and teams, with the support of an assigned mentor, implemented a QI project and monitored their results that were presented at an end of project symposium.

Measures: 47 individuals participated in either a focus group or a personal interview. Interviews were transcribed and analyzed using an iterative content analysis.

Impact/Lessons Learned/Results: Four key themes emerged from the narrative dataset around experiences and perceptions associated with the PERFORM KT initiative: 1) being successful and taking it to other levels by being systematic, structured, and mentored; 2) taking it outside the comfort zone by being exposed to new concepts and learning together; 3) hearing feedback, exchanging stories, and getting new ideas; and 4) having a pragmatic and accommodating approach to apply new learnings in local contexts.

Discussion/Spread: Study findings offer insights into collaborative, inter-organizational CoP learning approaches to build QI capabilities amongst clinicians, staff, and managers and the need to contextualize QI learning by using deliberate learning activities to balance systematic and structured approaches alongside pragmatic and accommodating approaches with expert mentors. A toolkit has been developed to assist other health care organizations in their efforts to build QI capabilities with clinical and staff to improve work processes and patient care.

24) Automation of Follow-up Microbiology Culture Results in Patients Discharged from the Emergency Department

Paul Sinclair*, Dominick Shelton, Darren Hefferon, Zlata Janicijevic *(Sunnybrook Health Sciences Centre)

Background: Timely reporting of microbiology culture results is crucial to ensuring that patients receive optimum quality of care. At Sunnybrook Health Science Centre’s emergency department (ED) delays occurred in reporting positive culture results of patients discharged from the ED. Follow up of culture results was driven by a manual paper based process that was inefficient and resulted in a 1-3 day delay in reporting results. We aimed to minimize the delay in follow up of culture results by eliminating the manual process and replacing it with an automated process.

Aim: By May 31, 2016, 80% of positive microbiology culture results of patients discharged from Sunnybrook Health Sciences Centre ED will be followed up within 24 hours of results being available from the lab.

Measures:
Outcome Measure – Percentage of positive culture results followed up within 24 hours
Process Measure – Time interval: Availability of culture results from microbiology department to completion of patient follow-up
Balancing Measure – Number of positive results not displayed in an ED web based program
Innovation: An electronic interface was created to capture results from the microbiology department in real time. Parameters set by our microbiology department were used to accept only positive culture results and block results with no growth. These flagged results were automatically pushed into an ED web based follow up program.

<table>
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<th>Data collected</th>
<th>n</th>
<th>Median (hours)</th>
<th>Interquartile Range (hours)</th>
<th>Mean (hours)</th>
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<td>27.07</td>
<td>58.79</td>
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<tr>
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<tr>
<td>Post-intervention</td>
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<td>4.30</td>
<td>1.87 – 11.08</td>
<td>13.95</td>
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<td>(2 months)</td>
<td></td>
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A significant reduction of 23 hours to complete a patient’s follow-up of culture results was achieved by eliminating the manual process used in relaying results from the microbiology department to ED.

Impact:
1. Earlier initiation or change in antibiotics to patients with culture proven infections
2. Enhanced patient safety due to elimination of human error in relaying results
3. Improved work flow due to elimination of batching results and data entry
4. Reduction in manual processing time of 7 hours per week
5. Entire process is streamlined, since only positive culture results are displayed for follow-up.

25) Pediatric ED Return Visits: A Proactive Approach to Quality Improvement
Olivia Ostrow, MD, FAAP*, Andrea Shim RN, BScN, HBSc, Syed Azmat, Lucas Chartier, MD, MPH, FRCPC *(Hospital for Sick Children)

Background/Context: Emergency Department (ED) return visits leading to admission (RVs) are a well-recognized quality metric that can potentially signal quality gaps in patient care. Routine capture, investigation and monitoring of monthly ED RVs provides a better understanding of specific patient and visit-level factors associated with RVs, future improvement initiatives can be targeted that will ultimately promote higher quality patient care.

Results:

- **Post-intervention RVs**: 4.30 hours
- **Pre-intervention RVs**: 27.07 hours

A significant reduction of 23 hours to complete a patient’s follow-up of culture results was achieved by eliminating the manual process used in relaying results from the microbiology department to ED.

Impact:

1. Earlier initiation or change in antibiotics to patients with culture proven infections
2. Enhanced patient safety due to elimination of human error in relaying results
3. Improved work flow due to elimination of batching results and data entry
4. Reduction in manual processing time of 7 hours per week
5. Entire process is streamlined, since only positive culture results are displayed for follow-up.

26) Choosing Wisely at SickKids: A Children’s Hospital’s Experience Promoting Value at the Bedside
Olivia Ostrow, MD FAAP*, Carolyn Beck, Kathy Boutis, Sanjay Mahant, Deena Savlov, Jeremy N Friedman *(Hospital for Sick Children)

Background/Context: It is estimated that 20-30% of the annual Canadian healthcare budget may be wasted on unnecessary tests and treatments. Choosing Wisely is an initiative dedicated to addressing this problem. In Canada it has focused primarily on adult healthcare.

Aim/Objectives: To describe the development, implementation and initial impact of a departmental Choosing Wisely ‘top 5’ list on paediatric care at a Canadian children’s hospital.

Measures: After key stakeholder input and review of current specialty society lists, an inventory of potential paediatric recommendations relevant to hospital care was generated. A survey was developed and broadly administered to rank items. Two hospitalist leaders independently scored top ranking items based on ease of implementation, measurement, alignment, and value. Five final items were chosen. Baseline measurement was achieved through various hospital databases, chart review or audit where appropriate.
Improvement/Innovation/Change Ideas: After appointing a physician lead and developing an implementation strategy for each recommendation, the Choosing Wisely ‘top 5’ list was launched in January 2016. Recommendations were implemented using various improvement methodologies.

Impact/Lessons Learned/Results: Early results 6 months into the initiative show large improvements in reducing unnecessary care. For example: by not automatically giving IVIG as first-line treatment for children with typical newly diagnosed ITP, usage of IVIG has decreased from an initial baseline of 85% to 20%. In the emergency department, nasopharyngeal testing for respiratory viruses has decreased by more than 80% and routine radiography for children with low risk acute ankle injuries has decreased from 86% to 57%.

Discussion/Spread: Developing and implementing a Choosing Wisely ‘top 5’ list at a children’s hospital aims to promote a culture of quality, evidence-based and high-value care. We have plans for further improvements in the current project, sustaining the gains already achieved, and to expand the initiative to other areas in our institution. This model, along with lessons learned, is being shared with paediatric healthcare providers across the country through presentation at meetings and rounds, as well as publication in various media and high impact journals.

27) Nursing Practice Changes to help Prevent Workplace Violence in SUCD
Billie Pryer*, Director of Nursing, Dan Vetesnik, RN in SUCD *(Royal Ottawa Health Care Group (“the Royal”))

Background/Context: The Nursing Advisory Council (NAC) at the Royal changed its meeting structure to become more action oriented rather than information sharing and to align output with our organization’s Strategic Plan. Workplace Violence was one of the first topics discussed. Members were trained in techniques to identify key issues and the PDSA method.

Aim/Objectives: One key initiative prioritized by the group focused on implementation of Hourly Rounding as a way to address both client needs and client focused independent goals. Hourly rounding is an evidence based approach to nursing rounds performed with the intent to evaluate and meet a patient’s comfort and needs.

Measures: A baseline of scores on the Aggressive Incidents Scale (AIS) was established on the unit prior to initiation of the rounding. Compliance with the new technique of Hourly Rounding and follow up AIS scores measured success.

Improvement/Innovation/Change Ideas: The PDSA approach was driven in the Addictions unit, by a staff nurse member. The practice change centered on the unit staff trying and growing the practice through education, discussion at team meetings, and peer involvement.

Impact/Lessons Learned/Results: Initial feedback indicated that this practice led to more inclusive documentation about patient progress, improved goal-focus with the use of whiteboards, and nurses expressed that they knew their patients better. Another advantage was more time for planning and patients spending less time at the nursing station. Mixed reviews emerged about documentation duplication, and staffing resource challenges.

The approach showed that implementing practice change can be done quickly and locally, with a unit champion coupled with sound evidence based practice. Staged preparation allowed teams to accept new routines, with time and space for analysis of the new practice. The qualitative improvement will also be further measured with AIS scores.

Discussion/Spread: This is an example of taking an established practice from a medical setting and adapting it to addiction/mental health setting successfully. Further improvement and spread will include providing resource materials for training casual staff, easing the load of documentation through application of the electronic medical record, and providing more protected time to the staff nurse when making a practice change.

28) Developing an Algorithm to Reduce Inappropriate Orthopedic On-Call Pages
Dr. Ryan Perlus*, Dr. Ian Whatley, Dr. Sarah Ward *(University of Toronto)

Background/Context: In Orthopedics, residents are assigned to care for the patients under a specific staff. As such, each resident knows the clinical information relative to a small subset of the in-patient population. At level 1-trauma centers, there is an abundance of pages for the on-call Orthopedic resident, most of which would be better managed by the specific resident taking care of that patient. This results in delayed treatment decisions and prevents allied health professionals from performing directed care in a timely manner. Currently, there are no mechanisms to identify which resident to call for a given patient related issue.

Aim/Objectives: Our aim was to reduce inappropriate pages to the on-call orthopedic residents at St Michael’s Hospital by 80% over a 3-month period.

Measures: The primary outcome was amount of inappropriate pages. This was defined as a page that should have been directed to the most responsible resident but instead went immediately to the on-call resident. Paging patterns were measured over 3 call shifts. Once current behaviours were recorded, a system was implemented whereby detailed lists were posted on Orthopedic wards including resident staff coverage and location of residents throughout daytime hours. Once implemented, paging patterns were again measured over 3 call shifts.
Improvement/Innovation/Change Ideas: There was a 50% reduction in unnecessary pages after implementation of the new system. Multiple change ideas became evident including paging options for residents in the operating room, after hours paging, pages regarding urgent issues, and paging protocol for discharge limiting issues. We then created a daytime hour algorithm to be used by the interdisciplinary team in an effort to further streamline the system.

Impact/Lessons Learned/Results: The implementation of the algorithm resulted in improvement communication and efficiency for the Orthopedic team during daytime hours. Qualitative feedback suggests the algorithm clarifies ambiguities regarding proper resident paging.

Discussion/Spread: These results have improved the overall efficiency and performance of the Orthopedic in-hospital service. An additional strategy exists to establish a specific model to not only continue to improve accurate resident paging but communication between medical residents and the rest of the interprofessional team to continue to optimize patient care and efficiency.

29) Effectiveness of a Co-Learning Model to Teach Quality Improvement at an Academic Centre With Limited Quality Improvement Expertise

Alan Gob (London Health Sciences Centre)

Background/Context: CanMEDS 2015 emphasizes teaching quality improvement and patient safety (QIPS) concepts to residents; academic institutions have found it challenging to incorporate these concepts into existing programs. Utilizing a co-learning model, Wong and colleagues have developed a successful QIPS curriculum for residents/faculty at the University of Toronto. Major enabling factors included 1) a centralized body of QIPS expertise (C-QuIPS) and 2) multiple faculty with advanced degrees in QIPS. Without these two factors, it is not known whether the co-learning model can be successfully implemented to teach QIPS concepts to residents.

Aim/Objectives: To evaluate the effectiveness of the co-learning model at London Health Sciences Centre (LHSC), as evidenced by completed QIPS projects and changes to clinical processes.

Measures: Over a two-year period, we logged the number of projects presented at our local research day or at national/international conferences. We tracked self-reported comfort with participation in QIPS-related activities.

Improvement/Innovation/Change Ideas: The co-learning model at LHSC included one lecturer with advanced QIPS training who designed and delivered QIPS content. The delivery included three large group half days that were didactic/interactive, and a year-long team QIPS project. Four divisions from the Department of Medicine participated.

Each division was represented by one faculty lead, and at least one PGY5 trainee. None of the faculty leads had advanced training in QIPS.

Impact/Lessons Learned/Results: In year one, one poster was presented at our local resident research day, one at a national subspecialty conference, and one at the Institute of Healthcare Improvement’s national forum. In year two, one poster was presented at resident research day, and one clinical process was modified. The majority of participants reported increased comfort with participation in QIPS activities.

Discussion/Spread: The results demonstrate that the co-learning model can be successfully implemented despite neither centralized QIPS expertise nor an abundance of faculty highly trained in QIPS. The third iteration of the curriculum includes six divisions. Unexpected benefits included increased interest in QIPS project participation outside of the curriculum by junior residents. This year, QIPS will have its own category at our local research day. These developments synergize with the curriculum to stimulate QIPS interest at our centre.

30) Transitioning the Colonoscopy Preparation Process to Home

Simon Ling*, Amanda Ricciuto, Eileen Crowley, Marta Carneiro de Moura, Mar Miserachs, Eberhard Lurz, Catharine Walsh *(University of Toronto)

Background/Context: SickKids patients complete the second half of their pre-colonoscopy Picosalax bowel preparation (BP) in hospital under nurse supervision. Transitioning BP entirely to home represents an important quality improvement goal given its potential to liberate bed spaces and enhance patient/family satisfaction.

Aim/Objectives: To reduce the number of in-hospital BPs by 50% by October 2016 among English-speaking children ≥10 years old, without compromising BP quality.

Measures: Outcome measures included number of BPs performed at home and user satisfaction on a Likert scale. The percentage of eligible children who completed home BP was monitored as a process measure. Balance measures included home BP quality, rated using the Ottawa BP score (OBS) (lower is better and OBS >6 considered “unacceptable”), and “rescue” enemas.

Improvement/Innovation/Change Ideas: An Ishikawa diagram and process map were constructed. The interventions implemented centered on the change idea that children and their families have the capacity to independently prepare for colonoscopy, without the need of in-hospital nursing supervision. Improved educational materials were developed. Changes were tested in Plan-Do-Study-Act (PDSA) cycles.
Impact/Lessons Learned/Results: In a pre-intervention audit, among 37 in-hospital BPs over 1 month, the mean OBS was 3.8 and 6/37 (18%) had scores >6, with 0 rescue enemas. In a first PDSA cycle, among 14 children who completed home BP (48% of those eligible), the mean OBS was 5.8 (SD 3.3) and 5/14 (36%) had scores >6. Six patients received enemas. Given the decline in BP quality, the home BP process was modified (recommended fluid intake increased, PEG3350 added for 3 days) and the educational materials updated and simplified. In a second PDSA cycle including 11 children (50% of those eligible), mean OBS was 5 (SD 3.5), similar to previous, but only 2/11 (18%) scored >6 and only one enema was required. User satisfaction with home BP was high (4/4.5).

Discussion/Spread: Results obtained to date indicate successful reduction of in-hospital BP with acceptable BP quality. Additional data are to be collected until October and the home BP process further modified as needed. If results remain favourable, home BP will be implemented as a standard of care.

31) Reducing unnecessary nasopharyngeal virus testing at a tertiary care paediatric centre – A Choosing Wisely initiative

Deena Savlov*, Olivia Ostrow, Astrid Petrich, Susan E Richardson, Jeremy N Friedman *(Hospital for Sick Children)

Background: Viral respiratory testing in paediatric patients is commonly performed, however results often do not impact care and the procedure is uncomfortable. At SickKids Hospital in Toronto, nearly 6000 nasopharyngeal (NP) swabs for direct fluorescent antibody (DFA) testing (8 viruses) were ordered in 2014; 61% in the Emergency Department (ED) or Paediatric Medicine wards. Approximately 63% ED swabs were on children discharged home. Since results were not immediately available and no formal follow-up was in place, the test frequently did not affect patient management.

Aim: To decrease the number of unnecessary NP swabs performed on children in the ED and Paediatric Medicine wards.

Measures: The main outcome measure is the total number of swabs performed, relative to total patient volumes, in the ED and Paediatric Medicine. Process measures include the reported indication for testing, ED and hospital length of stays, admission rates, antibiotic and antiviral usage. Balancing measures include total cost of respiratory testing and rates of nosocomial respiratory virus infection.

Innovation: A multidivisional expert panel reviewed published guidelines and formulated a pathway listing indications for viral respiratory testing. Two more effective tests were introduced to replace the older DFA test: 1) rapid influenza isothermal amplification that can provide results within 15 minutes and direct timely use of antiviral therapy, and 2) multiplex PCR (15 viruses). As a force function, the electronic order set was modified requiring users to select an appropriate indication. As a hard-stop, the rapid influenza test could only be ordered for inpatients with Microbiologist approval. A multi-faceted educational campaign was launched throughout the hospital.

Results: Early results indicate that total respiratory virus testing decreased by 38.5% and 32.4% in the ED and Paediatric Medicine respectively, compared with 2014. Testing rates reduced by 14.3% and 28.2% from 2015 rates. Excluding the new rapid influenza test, NP testing dramatically decreased by over 80% in the ED.

Spread: Reducing unnecessary viral testing promotes high-value care, decreases patient discomfort and allows for more effective resource allocation of tests that truly impact care. Planning is underway to disseminate this initiative to other hospital areas including outpatient clinics, subspecialty and surgical wards.

32) The Spread of the Better Coordinated Cross-Sectoral Medication Reconciliation (BOOMR) for Residential Care - A Quality Improvement Initiative

Denis O’Donnell*, Carla Beaton, Hrishikesh Navare, Vincent Vuong, Jennifer Simpson, Olivia Schmitz, Connie Sheridan, Lori Anderson *(Medical Pharmacies Group Limited)

Background: Poor communication across care settings frequently contribute to the preponderance of medication errors during transitions to LTC. Building on a novel inter-professional MedRec program initially piloted in a 15-bed LTC unit as an IDEAS Cohort 6 project, the Better Coordinated Cross-Sectoral Medication Reconciliation (BOOMR) quality improvement initiative was expanded to include 4 LTC homes, representing 540 beds.

Aim: To improve the quality of admission MedRec by at least 30% compared to baseline at six months postimplementation.

Measures:

Outcome: modified ISMP MedRec quality audit score

Process: number of discrepancies and clinical concerns

Balance: number of hospital visits due to medication issues/concerns.

Change Ideas: Application of Lean principles generated key change ideas which included: initiating the MedRec process 48 hours prior to resident admission, streamlining CCAC documentation to facilitate MedRec, connecting the LTC pharmacist with resident/family to complete a medication history, and utilizing a three-way "Trio call" between the LTC pharmacist, nurse and prescriber to finalize admission orders and discuss admission-related medication issues/concerns.
Results: With integration of care at the center of this practice design, BOOMR has demonstrated value in driving creative solutions in order to provide quality care. A collaborative, inter-professional approach was able to identify and address discrepancies and clinical concerns that were previously undetected. A mean of 2.3 discrepancies and 5.5 clinical concerns were identified per MedRec. No hospital visits were due to medications since the BOOMR intervention. The average modified MedRec quality score upon admission improved from 51% (January 2016) to 89% (May 2016). 92% of surveyed residents/ family were satisfied that their medication needs were met. The BOOMR process freed up 3 hours of nursing time and 1 hour of physician time while increasing 1.5 hours of pharmacist time per admission. System workflow efficiencies and polypharmacy reduction resulted in projected cost savings of $1000 per resident over 3 months.

Spread: Additional homes throughout the province will be included in the further spread of BOOMR. Processes for sustaining success include: clarity of the goal with recognized advantages to all sectors, team alignment meetings, ongoing data monitoring and sharing success stories, making quality improvement “the work” and not “extra work”.

33) Health Literacy; Development and implementation of a framework in chronic disease population
Darlene Bowman*, Delanya Podgers *(Kingston General Hospital)

Background: Health literacy refers to a broad set of skills that help patients and their families understand health information, participate in self-management, and navigate the complex health care system. In south eastern Ontario up to 84% of the population has low or very low levels of health literacy. Low health literacy is associated with higher health care costs, greater use of the health care system, higher rates of hospitalization and readmission, and is a significant barrier to safe transitions. It plays a critical role in patient outcomes.

An organizational health literacy scan was conducted at Kingston General Hospital (KGH) to determine current state. This scan identified knowledge and practice opportunities. Results from staff, physician and learner surveys indicated that although 45% of respondents answered that they were familiar with the term health literacy, only 7% could correctly define it. Eighty-two percent of those surveyed had received no formal health literacy education. Further 62% of respondents could not describe the most widely used, strategy aimed at addressing health literacy through patient-centred communication, known as Teach-back.

Objectives: Increase awareness of health literacy and provide the workforce with evidence based health literacy tools and strategies. Specifically increase provider competency in the use of the Teach-back method in the chronic kidney disease (CKD) population.

Process Measures:
• Program specific pre and post provider health literacy surveys and self-competency assessments
• Pre and post patient interviews (patient refers to patient/ family/ key learners)
• Percentage of providers participating in education program
• Post implementation chart reviews to determine Teach-back utilization.

Change Ideas: Develop and implement a framework for health literacy and the Teach-back method in the CKD program to address identified knowledge and practice opportunities.

Lessons Learned/Impact:
Health literacy areas for growth:
• Awareness across all disciplines
• Education and training
• Inclusion in healthcare curriculums

Anticipated impact includes:
• Improved patient-provider communication during discussions regarding therapeutic choices for treatment modalities
• Improved patient ability to fully participate in shared decision making, self-management and navigation of complex pathways and partnerships
• Improved organizational efficiencies

Spread: Future plans include spread to the chronic obstructive pulmonary disease population.

34) Safe Patient Handling Training in a Mental Health Facility
Melanie Taylor*, Lorraine Doucet, Emily Deacon *(Royal Ottawa Health Care Group)

Background/Context: There is a higher risk of falls and responsive behaviors with our patients due to their multiple medical and psychiatric co-morbidities. As a result, employees are at higher risk of injury with the increase in provision of physical care to patients.

Aim/Objectives: The goal of developing the Safe Patient Handling (SPH) training at the Royal Ottawa Mental Health Center was to decrease patient and staff injuries related to patient transfers/behaviours.

Measures: The number of staff trained in SPH has increased from 40 in 2007-2008 to 56 staff completing the 4 hour initial hands on SPH training and 353 staff completing the online modules in 2013-2014. In 2007 there were 16 staff members injured as a result of patient transfers. In 2015, 5 staff were injured. Furthermore, none of those staff members lost any time due to their injury as all of the injuries were minor.

Improvement/Innovation/Change Ideas: Strategies to address responsive behaviors when providing SPH were embedded within the mandatory SPH training.
Impact/Lessons Learned/Results: There has been a decrease in the severity of injuries to patients related to falls and to staff involved in SPH activities. Better education results in better patient handling practices which improves patient and staff safety within the organization.

Discussion/Spread: An increase in mentoring and development of “champions” on in-patient units is recommended.

35) Walk in My Shoes
Catherine Clarke (University Health Network and OCAD University)

Background/Context: Incivility among nurses, and in particular, directed towards novice nurses is a significant problem in hospitals. Uncivil behaviour erodes the quality of patient care and contributes to errors and adverse events. Absent from most organizational interventions are two key prerequisites for change: personal recognition of the need to change and sufficient motivation to alter and sustain new behaviour. This graduate student research project explored the use of arts-based approaches, specifically a shoes and personas exhibition as possible solutions because of their potential to promote self-reflection, perspective taking and meaning making to change the existing mental models that underlie incivility. Shoes were also used as a metaphor in the exhibit to represent the age-old challenge: before you judge a person, walk a mile in his–or her–shoes.

Aim/Objectives: This exploratory project was intended as a starting point for future study of the impact of using arts-based techniques in combination with other learning approaches, to promote positive change in workplace relationships and improved teamwork.

Measures: Two interactive techniques enabled the researcher to understand the emotional responses to the characters’ stories and a brief exit survey was used to assess if the exhibit had promoted self-reflection, perspective taking and meaning making to change the existing mental models that underlie incivility. The drop-in nature of the exhibit meant nurses could come by on their break and did not have to be scheduled.

Improvement/Innovation/Change Ideas: Fifteen - twenty minutes was needed to read the character stories, notice all the artefacts and participate in the activities. The drop-in nature of the exhibit meant nurses could come by on their break and did not have to be scheduled.

Impact/Lessons Learned/Results: Fifty-one participants completed the exit survey. Responses suggest that the methods evoked emotional reactions, increased the participants’ capacity to see nurse-to-nurse incivility from other perspectives and encouraged them to evaluate their personal behaviour and its impact on colleagues and student nurses.

Discussion/Spread: The exhibit’s simple design, low cost and adaptability make it an attractive option for hospitals with limited budgets and resources. The format can be adapted to include characters from the inter-professional team to promote greater understanding, respect and collaboration among teammates.

36) Addressing the quality gap: an order set and checklist to improve red blood cell transfusion ordering practices on the internal medicine ward
Katie Govereau*, Alison Battistuzzi *(University Health Network)

Background/Context: Falls in hospital are one of the most prevalent inpatient adverse events, with one third resulting in injury. 1 Falls rates on inpatient psychiatric units are estimated to be three to four times higher than on general hospital units. 2 As admitted patients become increasingly psychiatrically and medically complex, an increase in falls on an inpatient psychiatric unit was noted, with an average of 25 falls in a 6-month period. To address this increase, a falls prevention program was developed and implemented by two unit-based occupational therapists.

Aim/Objectives: To develop and implement a falls prevention program to reduce the incidence of falls in a 6 month period on an acute psychiatric unit.

Measures: Hospital incident reports were used to establish a baseline rate of falls 6 months prior to program initiation. Incidence reports were reviewed 6 months post initiation to determine outcomes.

Improvement/Innovation/Change Ideas: Education on falls and safety was provided during 3 nursing curriculum blocks by the occupational therapists. Falls signs with personalized safety measures were posted for patients. A falls debrief form was created, which was completed immediately post-fall and stored in the patient’s paper chart. An “Activity” section was added to the nursing Kardex to outline recommended safety interventions to promote communication during nursing transfer of accountability. A database was also created to collect information for each fall incident and to aid in analysis of unit falls patterns.

Impact/Lessons Learned/Results: Falls declined by 52% from 4.16 falls/month to 2.08 fall/month. Project outcomes also included improved inter-professional collaboration and communication, a population-specific understanding of falls risks and interventions, and enhanced patient safety.

Discussion/Spread: The commitment to ongoing patient and staff education by team occupational therapists and the acceptance of discipline-specific accountabilities to maintain and sustain the project were central to its success. Continued education sessions for all staff, monthly review of incident reports, and pattern analysis will be completed to optimize sustainability.

References:
37) Emergency Room Safer Transfers by On-Purpose Pauses (ER-STOP)
Savannah Norman*, Jennifer Sampson, Frank DeCicco, Ian M. Fraser *(Michael Garron Hospital and University of Toronto)

**Background/Context:** Prompted by incident report and CCRT (Critical Care Response Team) audit analysis, reducing risk of deterioration of adult ward patients within 24 hours of ER (Emergency Room) admission was targeted as part of an organizational rescue from danger redesign. A locally validated checklist (Modified Early Warning Score-MEWS + urinary catheter in-situ + nurse concern) with an intentional pause and explicit management options was deployed as a modification of an existing ward transfer of accountability fax report in a 400-bed urban community teaching hospital ER for all admitted adult medical-surgical patients between Jan 1st to June 30, 2016.

**Aim/Objectives:** Our aim was to improve patient safety by optimizing matching of patient need to provided care following ER admission with:
1. Decreased unexpected on-ward deterioration requiring CCRT activation within 24 hours of admission
2. Unchanged special care unit (CIU, ICU) admissions (vs. 2015)
3. Unchanged timely access to in-patient beds without increasing waiting time in ER to ward admission (vs. 2015)

**Measures:** Using an unblinded before/after design,

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<th>Total Med-Surg ER Admits (n)</th>
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<th>CIU Admission rate (%)</th>
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<th>ICU Admission rate (%)</th>
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<th>Mean time to ward admit (hours)</th>
<th>5.91+1.85</th>
<th>4.74 +1.44</th>
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<th>Medical Short Stay Unit (MSSU) Rate</th>
<th>31% (n=1370)</th>
<th>32% (n=1455)</th>
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# Control May 2014 to Dec 2015, *Control Jan to June 2015

**Improvement/Innovation/Change Ideas:** ER-STOP, a simple 3-component intervention, significantly reduced the risk of deterioration within 24 hours of ward admission to medical-surgical services without increased special care unit use or waiting time to ward admission. Qualitative observations suggest that the MSSU adjacent to the ER developed a close observation function for more severely ill admitted patients.

**Discussion/Spread:** The beneficial effect of this intervention was greater than the modest predictive value of the early warning score (MEWS) component suggesting that the major effect of ER-STOP was related to increased situational awareness and empowering a culture of patient safety. Local adaptation within existing processes is essential to successful outcomes.

38) Interprofessional and interdisciplinary collaborative approach for pre-anesthetic evaluations: successes and challenges
Elaine Ng*, Natasha Mills, Silvana Oppedisano, Pamela Sehdev, James Robertson *(Hospital for Sick Children)

**Background/Context:** Pre-anesthetic evaluations allow for preoperative planning and education of patients and families. In our current process, the referring service identifies inpatients who require an evaluation and informs the on-duty anesthesia resident who completes it. The process for inpatients for placement of gastrostomy tubes (G-tube) is of interest. The timeliness of the evaluations may not be a key factor contributing to the length of stay (LOS) by preventing timely G-tube bookings, however, the optimal process for pre-anesthesia evaluation is not entirely clear. A novel collaborative approach between advance practice nurses (APNs) and residents in anesthesia is proposed to provide support and structure to this process.

**Aim/Objectives:**
- To understand the pre-anesthesia evaluation process.
- To establish a collaborative model between the APNs and residents in anesthesia for pre-anesthesia evaluation.

**Measures:** All the residents and APNs in anesthesia in October 2015 were approached individually and as a group to discuss the current process for pre-anesthetic evaluations, desired state and challenges. Qualitative themes were identified from this meeting and subsequent focus groups to determine ongoing needs. Data on LOS at different intervals was collected.

**Improvement/Innovation/Change Ideas:** A logic model was created to identify processes and outcomes which was reviewed by and promoted to the primary stakeholders in anesthesia. In addition, a collaborative approach between APNs in anesthesia and G-tube clinic was established.

**Impact/Lessons Learned/Results:** The proposed interprofessional model between residents and APN in anesthesia was not utilized; there was lack of understanding of the APN role and lack of resources. On the other hand, there was clear communication regarding patient readiness and preoperative concerns between the APNs in anesthesia and G-tube clinic. Several other processes were established at the same time which all contributed to a decreased LOS by four days.
Discussion/Spread: The streamlined interdisciplinary process with clear communication between APNs in anesthesia and G-tube clinic can be modelled for other services to promote collaboration and potentially decrease LOS. Interprofessional collaboration between residents and APNs in anesthesia could not be established and alternative pathways are being considered for pre-anesthesia evaluation.

39) REDUCED: Reducing Unnecessary Coagulation Testing in the Emergency Department
Nicola Goldberg*, Michael Fralick, Hina Chaudhry, Alun Ackery, Rosane Nisenbaum, Lisa Hicks, Michelle Sholzberg *(University of Toronto)

Background/Context: The aPTT (activated partial thromboplastin time) and PT/INR (prothrombin time/ international normalized ratio) coagulation tests are validated for use in specific circumstances, and rarely are both clinically indicated. Despite this, they are considered “routine” in medical practice. In fact, in 2015 nearly every coagulation test order at St. Michael’s Hospital (SMH) included both the aPTT and PT/INR. This suggests gross overuse.

Aim/Objectives: To determine whether a multimodal intervention could diminish excessive coagulation test ordering in the emergency department (ED) our institution, where test volumes were particularly high.

Measures: We compared the rate of coagulation tests ordered before and after the intervention was implemented. As a control measure we assessed creatinine testing rates during the same time periods. As a balance measure and proxy for major bleeding, we evaluated rate of red blood cell (RBC) transfusions. Results were analyzed using Poisson regression and interrupted time series analysis.

Improvement/Innovation/Change Ideas: We met with numerous stakeholders who identified two major barriers to appropriate coagulation testing: ordering processes and clinician understanding.

Prior to our intervention, aPTT and PT/INR were part of nearly all ED blood work panels, meaning these tests were ordered routinely for the majority of ED patients. Once we removed these tests from panels where they were deemed inappropriate, these coagulation tests were only performed if actively hand-written on an order sheet. We educated ED practitioners by presenting at their rounds and by posting targeted educational prompts.

Impact/Lessons Learned/Results: Following the intervention, weekly rates of PT/INR and aPTT testing decreased by over 50% (PT/INR: 17.2 vs 38.4, rate ratio=0.45 (95% CI 0.43-0.47), p<0.001; aPTT 16.6 vs 37.8, rate ratio=0.44 (95% CI 0.42-0.46), p<0.001, respectively). This resulted in $6,490 CAD in direct cost savings per month (projected annual savings: $77,880 CAD). The rate of creatinine testing remained unchanged. RBC transfusion rate fell slightly post-intervention - therefore there was no signal of harm.

Discussion/Spread: Our intervention has significantly reduced coagulation testing rates, unnecessary costs and enhanced awareness of appropriate testing at our institution. We attribute our success to stakeholder support and interventional focus on process change. We are now expanding our project to other departments at SMH.

40) Implementation of Routine Two-Person Care in the Neonatal Intensive Care Unit at Sunnybrook Health Sciences Centre
Virginia McLaughlin*, Dr. Asaph Rolnitsky, Elizabeth MacMillan-York RN, Lisa Sampson RN, Carli Hubbard RN, Laura Borges RN, Sarah Pelton RN, APN, Jo-Ann Alfred RN, Kate Robson, Karen Bong, Dr. Eugene Ng, Dr. Michael Dunn *(Sunnybrook Health Sciences Centre)

Background/Context: Sunnybrook Health Sciences Centre’s (SHSC) NICU is a 45 bed, single patient room, non-surgical unit within a perinatal center. In 2015 there were 296 VLBW (<1.5kg); also 57 micropremature infants were admitted into our NICU. Age appropriate, developmentally supportive care, including two-person care, is recognized as essential to reduce toxic stress and foster appropriate brain growth in order to reduce morbidity in this population. Two-person care has yet to be successfully implemented in our NICU. Potential barriers include:

- Workload
- Lack of unit wide consensus on developmentally supportive care
- Unit culture
- Unit layout
- Inconsistent documentation

Aim/Objectives: Increase the frequency of two-person care of micropremature infants for stressful procedures from less than 10% to 80% by December 2016.

Measures:
1. Staff questionnaire
2. Frequency of two-person care for stressful procedures
3. Family questionnaire.

Balancing measures
1. Staff Workload
2. Negative staff perception

Outcome Measures
1. IVH rates, growth <10th %ile at discharge
2. NCAST scoring (possible outcome measure).

Improvement/Innovation/Change Ideas:
We ran 3 PDSA cycles on two-person care:
1. One baby for one handling time.
2. An entire pod (approximately 4 eligible infants) for a shift.
3. An entire pod (3 eligible infants) for a day
Workload, staff perception and adherence to two-person care were examined in all three and parental perception was assessed in the third cycle. The purpose was to examine two-person care in the context of our unit.

**Impact/Lessons Learned/Results:** A modest increase of two-person care to 12.5% from 8.7% has been noticed so far within the pod where the PDSA cycles took place. Staff reported workload to be an issue but that it does appear to reduce the infant’s stress levels.

**Discussion/Spread:** Next steps include unit wide education around the benefit of two-person care, as well as how to do it, and to possibly use two-person care in a proposed Small Baby Team (specialized team to care for those infants born <26 weeks). Trying to address workload is another crucial step, as well as encouraging better use of parents as a second set of hands.

41) Improving Bariatric Surgery Appointment Attendance Using a Patient Centred Approach: Sustaining Change

**Dr. Sanjeev Sockalingam, MD, MHPE, FRCP, FAPM**, Vincent A. Santiago, BSc, Sandra Robinson, RN, Katie Warwick, RD, Shanthini Ratnakumarasuriyar, BSc *(University Health Network Centre for Mental Health)*

**Background/Context:** The Toronto Western Hospital Bariatric Surgery Program (TWH-BSP) routinely follows up with post-bariatric surgery patients for up to 5 years with an interdisciplinary team.

**Aim/Objectives:** We aimed to increase post-op attendance rates by 30% by July 2015.

**Measures:** The outcome measures included the percentage of patients attending, no showing, and cancelling their appointments in advance each week. The process measures were the number of patients receiving the advanced care calls, visiting the online bariatric aftercare app. The balance measures included patient satisfaction and number of pre-surgical visits per week. We analysed weekly appointment data and used ChartRunner software to detect Special Cause Variation (SCV).

**Improvement/Innovation/Change Ideas:** 1) Care planning calls/e-mails made by a clinic volunteer one-month in advance of appointments to personalize care; 2) Dissemination of a family physician “hand-off” letter of care; 3) Dissemination of an online mobile site for patients to access information regarding their aftercare; 3) Creation of a cancellation list to facilitate refilling of open slots.

**Impact/Lessons Learned/Results:** Based on patient and clinician feedback, the call script underwent PDSA cycles in order to encourage patients to attend their appointments, while still allowing patient-centred flexibility. From April 1, 2014-May 29, 2015, attendance and no-show rates remained stable from pre- to post-intervention at 87% and 13%, respectively. Cancellations increased with SCV from 13% to 19%. The increase in cancellations freed up appointments slots for pre-operative and urgent post-operative appointments. This refilling of slots led to average weekly savings of $513.50 that would have otherwise been wasted. For the first 41 weeks of the project, total savings were $21,053.50. After two years (102 weeks), the projected savings are $52,377.

**Discussion/Spread:** To sustain the project, a patient volunteer was trained and has supplemented calls since January 2015. This patient has provided invaluable peer-to-peer support and knowledge for other patients. We also developed a 19 page training manual detailing the processes required for care planning calls/e-mails. Two additional research volunteers have since been trained using this manual. Drafting of a publication for an international quality improvement journal is underway.

42) Gemba Time: Shifting Culture to Support Continuous Improvement at JBH

Cheryl Williams*, Susan Wannamaker, Erin Swindall, Denise Cusson, Nancy Casselman, Steve Metham, Dr. Wes Stephen *(Joseph Brant Hospital)*

**Background/Context:** In August 2015, Joseph Brant Hospital launched “Gemba Time” and team idea boards to involve staff and physicians in improvements to quality, safety and the Patient experience. As a component of our Lean Management System, Gemba Time is meeting-free time from 9-11 am, weekdays, for leaders to go to the Gemba (where value is created for Patients) and to engage staff and Patients using the principles “Go See, Ask Why, Show Respect”.

**Aim/Objectives:** Support quality, safety, patient experience, and a culture of continuous improvement by increasing engagement of staff and teams in innovations to the way we deliver care.

**Measures:**
- Process Measures:
  - # staff/team ideas implemented.
  - # Gemba Time visits by Senior Leaders.
  - # idea boards launched.
  - # ideas recognized through “Gemba Time in Action” program.

**Impact themes:** As of June 2016, over 430 staff/departmental ideas have been implemented across the hospital to improve quality, safety and Patient experience. General impact themes include improved communication, coordination across departments, reduced waiting and transportation waste, SS of workspaces, and reduction of defects/errors.
**Improvement/Innovation/Change Ideas:**
1. Gemba Time – meeting-free time, 9-11 weekdays.
2. Scheduled Senior Team/Board of Governors Gemba Time visits.
3. Departmental Idea Board huddles.
4. Gemba Time recognition through “Gemba Time in Action”.

**Impact/Lessons Learned/Results:**
As of June, 2016:
- 430 team ideas implemented.
- 41 different departments visited.
- 42 ideas recognized through “Gemba Time in Action” at Quality Wall.
- Action learning, leadership development, culture of continuous improvement.

**Specific Gemba Time/Idea Board impacts (Examples):**
- **Quality and Safety:** Improved Newborn Screening Card submission timeliness from 41% to 95% on-time.
- **Patient Experience:** ICU added triple lumen PICC line option to order set to improve safety and patient experience.
- **Leading Performance:** Used 5S to reorganize main stores area. Inventory took 25% less time with re-counts reduced by half.

**Discussion/Spread:** ‘Gemba Time’ is a grassroots approach that does not require extensive consultant expertise or ‘belt’ training, minimizes jargon, supports culture change, and serves as a platform for future introduction of quality tools and concepts.

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**43) EyeCare: A Project for Reduction of Severe Retinopathy of Prematurity in Very Low Birth Weight Infants in the NICU at Sunnybrook Health Sciences Centre**

Jean Chow*, Virginia McLaughlin, Asaph Rolnitsky, Elizabeth Asztalos, Marilyn Hyndman *(Sunnybrook Health Sciences Centre)

**Background/Context:** 48-bed, Level III, non-surgical, perinatal centre NICU, caring for ~300 very low birth weight (VLBW) infants yearly (~15% outborn) located in Toronto. A significant increase in advanced-stage Retinopathy of Prematurity (ROP) (≥ Stage 3) was identified with rates up to 13% in VLBW infants.

**Aim/Objectives:** To reduce Stage ≥3 ROP in VLBW infants from 13% to 7% by December 2016 in the NICU at Sunnybrook.

**Measures:**
- **Process measures:**
  - Reduction of incorrect oxygen saturation alarm settings
  - Reduction of incorrect oxygen saturation high alarm limits
  - Reduction of exposure to oxygen saturations >95%
  - Reduction of non-actionable desaturation alarms from baseline frequency

**Impact/Lessons Learned/Results:** The Pre-Intervention knowledge questionnaire had a 77% return rate, with an average of 62% correct responses. This resulted in education targeted at widespread knowledge gaps. The post-intervention questionnaire will be distributed September 2016.

After 3 months of implementing education about retinopathy of prematurity and oxygen awareness program, use of bedside oxygen saturation histograms, and implementing a 20 second alarm delay for oxygen saturations, we saw a reduction of time spent saturating >95% from 31% to 14%. The 20 second alarm delay was trialed through a PDSA cycle in one NICU patient care pod. The results revealed similar histogram findings and a decrease in the number of desaturations by approximately 25%.

**Discussion/Spread:** Upcoming activities include a post-intervention knowledge questionnaire with intended distribution in September 2016 to assess retention of knowledge and knowledge translation. Updates will be provided to staff in the NICU monthly newsletter to promote continued awareness and positive attitudes regarding the use of oxygen therapy in the NICU. We will be implementing a dashboard to highlight target saturations and performance. The 20 second alarm delay will be implemented as a unit-wide practice change by September 2016. As retinopathy develops late in the infants NICU stay, the key clinical outcomes (ROP incidence) will be reviewed by end of 2016.
SECTION I
Alumni Presentations and Receptions

Time: 4.30pm – 6.00pm
Location: Level 700, Room 718
Emcee: Dr. Joshua Tepper
President and Chief Executive Officer
Health Quality Ontario
Opening Remarks by: Nancy Naylor
Associate Deputy Minister, Delivery and Implementation
Ministry of Health and Long-Term Care

Join us for a series of exciting presentations delivered by the 2015 IDEAS Alumni Achievement Award winners! At this reception, IDEAS alumni will discuss how they have launched, sustained and spread quality improvement initiatives within their organizations, local health system and beyond.

Each group will have 7 minutes to present Pecha Kucha style. (Teams will present a set of 20 slides and each slide will be displayed for 20 seconds.) The format will keep presentations concise, fast-paced and engaging!

Following these presentations, the QIPSF 2016 poster winners will be announced. Prizes will be awarded based on the following categories:

- Outstanding Poster Award
- Outstanding Trainee Poster Award
- Honourable Mention Poster Award
IDEAS 2015 Alumni Achievement Award Presentations

IDEAS Project: Falls Prevention in Primary Care – Assessment to Intervention

Team Members:
Phase 1 (IDEAS Project: Implemented within GNFHT):
Shirley Watchorn, Dr. Jean Corbin, Dawn Olsen, Fern Belanger-Poirier

Phase 2 (Expansion across partners):
Shirley Watchorn, Wendy Carew, Ellen Ibey, Lorna Desmarais, Meghan Peters

Executive Sponsor(s):
Dr. Glen Corneil – Board Chair/Physician Lead – Great Northern Family Health Team

Organization(s):
- Great Northern Family Health Team
- Temagami Family Health Team
- NE Local Health Integration Network
- Timiskaming Health Unit
- City of Lakes Family Health Team
- Powassan & Area Family Health Team
- Timmins East End Family Health Team
- Espanola & Area Family Health Team
IDEAS Project: PoET (Prevention of Error-based Transfers)
Ethics Quality Improvement Project

Team Members:
Jill Oliver (Community Ethicist), Paula Chidwick (Director Research and Corporate Ethics)

Executive Sponsor(s):
Joanna Flewelling (Executive VP. Clinical Services & Chief Nursing Executive)

Organization(s):
• William Osler Health System

IDEAS Project: Improving Transitions from Acute Care to Rehab:
Spreading Change Across GTA Hospital Sites for Patients Post-Hip Fracture

Team Members:
Charissa Levy, Sharon Ocampo-Chan, Donna Renzetti

Executive Sponsor(s):
Charissa Levy, Donna Renzetti

Organization(s):
• GTA Rehab Network
IDEAS Project: Optimizing the Transitions of Care from Hospital to Community

Team Members:
Nicole Robinson,
Christine Thompson,
Tania Pinheiro,
Emily Sheridan

Executive Sponsor(s):
Dr. Nancy Whitmore,
Karen Davies

Organization(s):
• St. Thomas Elgin General Hospital (STEGH)

IDEAS Project: BOOMR (Better Coordinated Cross Sectoral MedRec)

Team Members:
Michal Racki,
Sheila Burton,
Carla Beaton

Executive Sponsor(s):
Debra Merrill,
Philippa Welsh,
Ed Jamieson

Organization(s):
• Royal Victoria Regional Health Centre
• Woods Park Care Centre of Sienna Senior Living
• Medical Pharmacies Group Limited