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# Quality & Patient Safety Plan

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2018-2021

# Our Quality Journey

At Michael Garron Hospital (MGH), we take pride in our ongoing journey for quality improvement and a shared desire to provide the safest care to the community we serve. Our rich history of partnering with patients and families is something we value as they share with us, their feedback and perspectives on what they value about their healthcare experience.

We are committed to building on this legacy as we launch the new Quality & Patient Safety Plan, 2018-2021. This plan is our commitment to prioritizing what our patients, families, staff and physicians believe is important, and we are proud to share the vision, purpose, goals and objectives of this plan with all those who will be taking part in this important work, from the boardroom to the bedside.

This plan will outline our vision to partner to create a culture of quality and patient safety to provide exemplary care through learning, collaboration and inquiry. We will discuss how the collective voices of our community helped us realize what is important to focus on, what behavior within a safety culture looks like, and how we can measure our progression toward our goals. This plan is closely linked to our Quality Improvement Plan and it will illustrate our efforts to close the gap between what we strive for and what we currently practice.

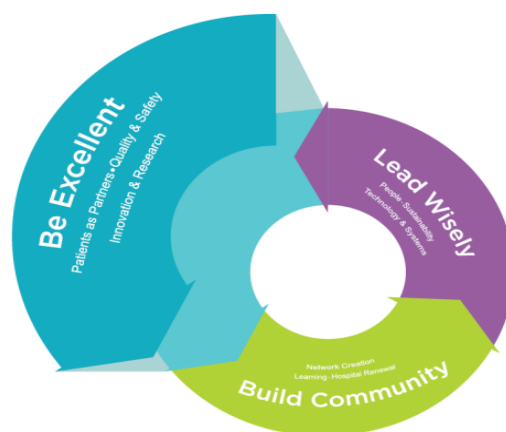
In 2017, MGH released its new five-year strategic plan. The strategic plan outlines how we will work towards achieving our vision to Create Health and Build Community through three strategic directions: Be Excellent, Lead Wisely and Build Community. Building on this strategy, and through this new Quality and Patient Safety Plan, we are committing to fundamentally changing how we do things at MGH. The alignment of this Quality and Patient Safety Plan with MGH's Strategic Plan is crucial to each of their success, as we will need to focus our resources on what is vitally important.

This plan originated out of the acknowledgement that quality improvement is limitless and we require essential partnerships to collectively raise the bar in quality and safety (HQO, 2012). HQO guides us in stating that, "A key objective of quality planning is to influence the culture of an organization such that quality and safety measures migrate away from being 'tasks' and become embedded in the psyche and routine of every staff and physician".

Through programs such as TeamSTEPPS and others that foster a culture of high performance, we will be investing in our staff and physicians to accelerate and hardwire changes that lead to a strong culture of quality and safety. Aligned with our corporate strategy, we believe execution of the new Quality & Patient Safety Plan will enable us to deliver high quality and safe care, reliably and consistently.

While this plan provides a framework for action as we chart the next chapter in our quality journey, we are committed to ongoing dialogue and co-creation of initiatives with patients and families.

Finally, we are confident that the priorities and commitments identified will provide clearer direction and further leverage our partnership with patients and their families to optimize quality and patient safety at MGH.



# Rich History of Accomplishments

The new Quality and Patient Safety Plan builds on our strong legacy of quality and our priority to provide safe, equitable and accessible patient care. This plan also complements our history of embedding the patient voice throughout everything we do. From storytelling at the frontlines of care to our award-winning Patient Video program, this patient-focused approach has been fundamental in many of our recent accolades.

## 2016 Accreditation Canada

*Exemplary Standing including 17 Leading Practice Awards*



## 2016 Canadian Patient Safety Institute (CPSI)

*Patient Safety Champion of the Year Award*



## 2014-2017 Canada Awards For Excellence

*Order of Excellence*

*Organizational Quality & Healthy Workplace*

## 2008-2010 Canada Awards for Excellence

*Gold Award of Excellence*

*Organizational Quality & Healthy Workplace*

## 2006-2008 Canada Awards for Excellence

*Silver Award of Excellence*

*Organizational Quality & Wellness: Health Care*



## 2016 Cleveland Clinic

*Patient Voice Award & Leading Practice*



## 2015 The Change Foundation

*20 Faces of Change Award*



# The new Quality & Patient Safety Plan aligns with our MGH Mission:

*Our community inspires us to deliver exemplary care, develop innovative partnerships and mentor the next generation of health care providers. Together we will make a difference and change the face of health in east Toronto and beyond.*

We all, patients, family members, staff and physicians, play a role in fostering a Culture of Safety & Exemplary Quality of Care and we are guided by the Quality & Patient Safety Plan's three priorities:

- High Performing Teams;
- Early Warning Systems; and
- Speak up for Safety.

It starts with building, strengthening and sustaining High Performing Teams. When all members of the team, which includes patients and their families, trust each other, have a clear picture of their role and understand how they fit into the larger picture, we are better able to work toward a common goal: proactively identifying potential safety hazards and quality of care issues (Early Warning Systems) and voicing their concern (Speak up for Safety).

Our safety culture encourages a positive patient experience and within this plan, patients and their families not only sit at the core, but also influence the commitments and success factors of the initiatives of each of the three priorities.

Fundamentally, our safety culture is one that supports a pro-active learning environment and enables patients, staff, leadership and physicians to work collaboratively together to achieve our plan's vision to "Partner to create a culture of patient safety & quality care through learning, collaboration and inquiry."




# Quality & Patient Safety Strategy 2018-2021

We are on a journey towards a stronger culture of quality and patient safety and we know it starts with a focus on our partnership with patients and families.



# What We Heard



“I wish there was more coordinated communication between team members and patients, so there are no mixed messages.”

“When my dad comes to MGH for care, I wish the transitions from one department to another were seamless and timely.”

“I wish my professional voice and identity was more visible and respected.”

# High Performing Teams



***“We’re in this together.”***

At MGH, a high performing team is one that shares a common vision, and who collaborates in holding each other accountable for outstanding results. Its members have a clear vision about what they want to achieve and what goals and behaviours are needed to improve. Trusting all members of the team including patients and families, staff and physicians means that we value one another’s opinions and knowledge and communicate effectively when sharing information, especially at handovers and transitions of care. Being ever mindful that “We’re in this together.” keeps us focused on a culture of service and excellence, which will continue to thrive at MGH.

## Our commitments

1

Recognition and appreciation of the various roles, skill sets, and scope of the team

Role, skill set and scope for each member of a team is recognized, with an appreciation for situational-dependent contributions to a patient’s care

2

Collaboration within and across teams using standardized communication tools

Individuals help, support and work together within and between teams to ensure clear communication

3

Information transfer across transitions

Information is shared clearly at all transitions across a patient’s journey

### Safety behaviours

- We will share information clearly
- We will use structured communication during transitions/handovers
- We will work with others to form a unified team

### Patient role

Patients can actively participate in their own care and treatment by:


- Sharing information
- Asking questions

### How will we know we have improved?

- Increased positive score in communication openness
- Reduced number of incidents where communication is a contributing factor



# What We Heard



"Please don't wait until something bad happens before action is taken."

"Frontline staff and management need frequent check-ins about safety issues."

"We need incidents to be shared with teams as a learning opportunity."



## Early Warning Systems



***“I wish my care providers made more proactive decisions together to ensure that I’m getting the best care.”***

Our patients voiced the importance of ensuring that their care providers make proactive decisions together to ensure patients receive safe, high quality care. Establishing early warning systems gives the team situational awareness to proactively identify and resolve issues that may put patients at risk.

### Our commitments

- |   |  |  |
|---|--|--|
| 1 | Check in for safety to identify and mitigate safety risks                                | Identify potential concerns proactively through a Daily Safety Check that occurs 7 days a week |
| 2 | Encourage escalation of safety concerns when needed and inform the team about next steps | Monitor, identify and respond to safety concerns in a timely way                               |
| 3 | Close the loop by sharing learning and improvement internally and externally             | Learn and share from safety events by discussing lessons learned                               |

#### Safety behaviours

- We will be on the lookout for potential safety issues
- We will step up to keep patients safe

#### Patient role


Patients can share:

- Information
- Concerns
- Suggestions in the moment

#### How will we know we have improved?

- Increased Good Catches
- Measure related to the Daily Safety Check
- Measure related to spread of info (“learning from incidents”)
- MEWs, Rescue Index

# What We Heard



“I wish patients could feel safe to discuss quality/safety issues with staff...and staff were more receptive.”

“Problems are not identified because staff are afraid to approach management, and they voice their concerns amongst each other.”

“I wish for more open communication between staff and management.”

## Quality Priority Three

# Speak Up for Safety



### ***“Stop the line.”***

An environment where each team member can “Speak up for Safety” fosters transparency, trust and resilience which gives our patients and their families confidence that they are receiving high quality, safe care. Our patients and staff told us that, “Everyone must be comfortable enough to voice their concerns and stop the line before problems occur.” We are committed to supporting our team to “Ask, Listen and Talk”, and supporting them to act when they feel quality and safety could be compromised.

### **Our commitments**

**1**

**Raise and listen to safety concerns**

All staff are supported to ask questions about safety concerns and will feel comfortable in sharing their concerns

**2**

**Review safety events through fair and transparent processes**

Patients, staff and physicians can trust that safety events are reviewed to support learning and improvement

**3**

**Ask and encourage questions**

Everyone is encouraged to ask questions, be inquisitive and trust that their concerns will be heard

### **Safety behaviours**

- I will always ASK questions
- I will always Speak Up (TALK)
- I will always LISTEN

### **Patient role**

Patients can:

- Feel open to communicate with their health care team
- Feel safe to seek clarification

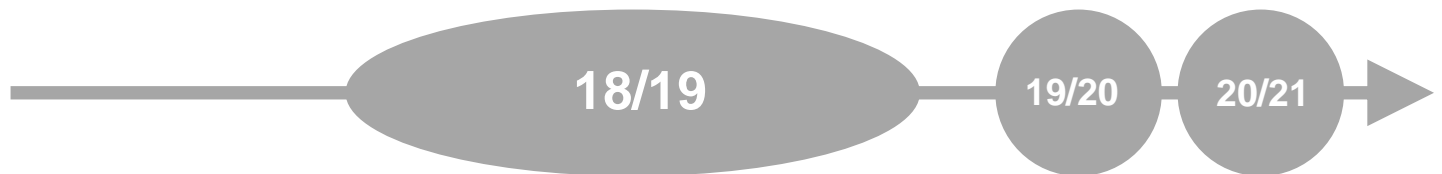
### **How will we know we have improved?**

- Increased incident reporting
- Increased escalation to rapid response teams



# Workplan: Year 1

## Quality & Patient Safety Strategy



### Priority

### Initiatives



High  
Performing  
Teams

- Update **Team Agreements**
- Adopt standardized teamwork and communication tools (TeamSTEPPS):  
Phase 1 – **I-PASS**
- Strengthen **Positive Patient Identification** Process



Early Warning  
Systems

- Enhance **Daily Safety Check**
- Develop the **Good Catch Program**
- Formalize **Learning from Incidents** Processes



Speak Up  
for Safety

- Implementation of **CUS Feedback Tool**
- Integrate **Just Culture** principles through standardized practices
- Refresh **Leadership Safety Walkarounds**

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