THE HIROC CONNECTION

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HEALTHCARE INNOVATION AT THE FOREFRONT

HIROC Safety Grants in Action

Recognizing Past Recipients | Sharing and Scaling Learnings | Calling for 2020 Submissions

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Please visit our website at **HIROC.com** to see back issues of The HIROC Connection.

Supporting Healthcare Innovation through the HIROC Safety Grants Program

At HIROC we are always looking for opportunities to scale learnings from our valued Subscribers. Your work, coupled with HIROC's team and world-class tools and resources, come together to help us live our vision of partnering to create the safest healthcare system.

In recognition of the value of your work and its potential to be used across the system, the HIROC Foundation created the Safety Grants Program. This grants program is designed to support grassroots initiatives that further healthcare safety across Canada.

Now in its third cycle, the program has helped foster a number of truly innovative safety solutions. These projects are inspiring and we want to share them with you.

In this special issue of The HIROC Connection, we've captured stories on a few of the amazing projects we've helped to support thus far. We hope you will find them equally inspiring, and perhaps they'll serve to ignite additional patient safety initiatives at your organization.

We encourage all Subscribers to apply to the 2020 HIROC Safety Grants Program. With reference to topics identified as a priority from our claims database and in light of this year's pandemic, our areas of focus this year include:

- **Fetal health surveillance, intravenous oxytocin-related harm**
- **Patient deterioration**
- **Death by suicide while in care**
- **Property loss**
- **Emergency preparedness**

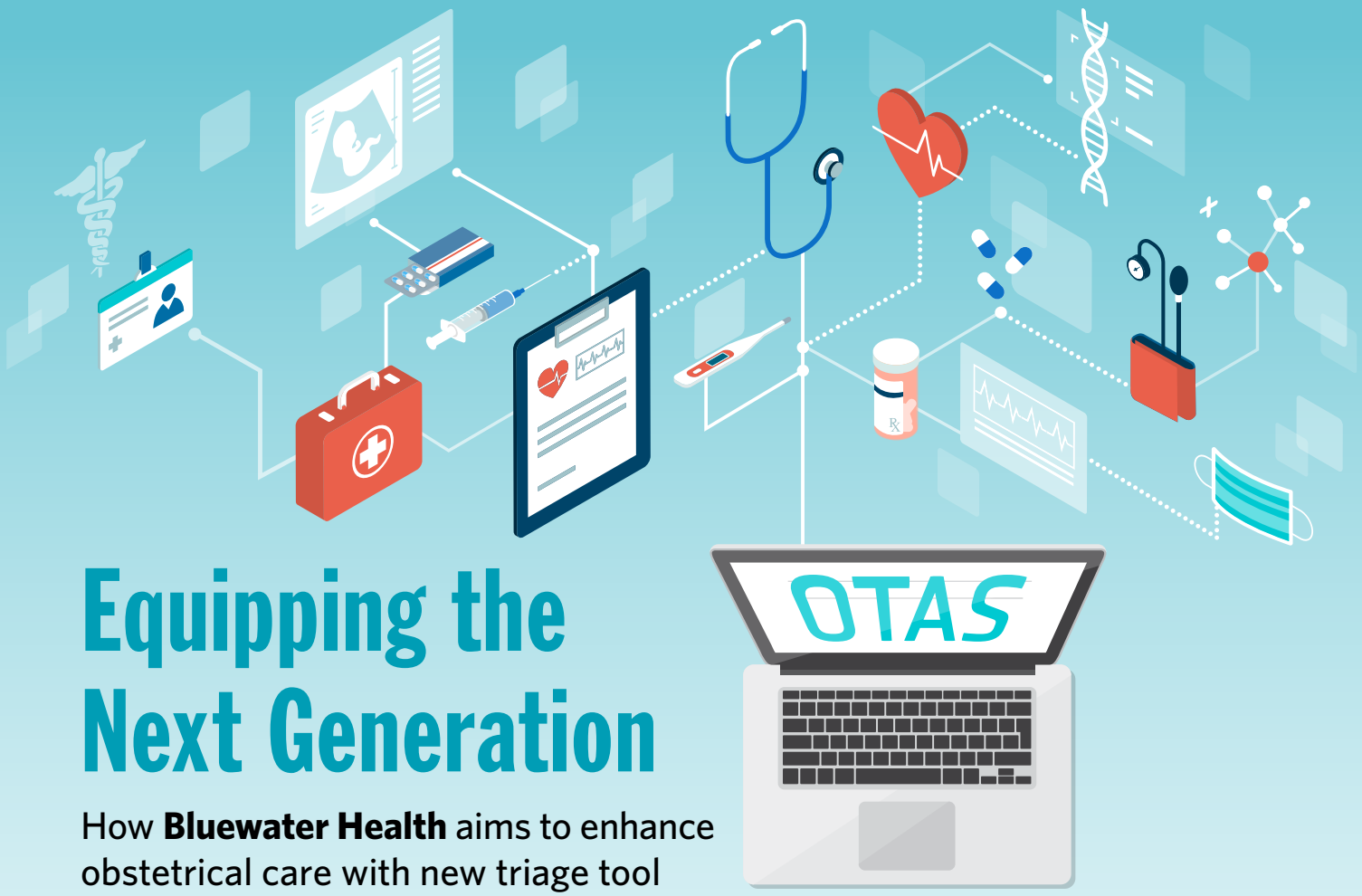
HIROC's Foundation is now accepting 2020 grant submissions.

Visit HIROC.com for submission deadlines and details.

Get more information on the Safety Grants Program and this year's application process under About Us on HIROC.com.

We look forward to seeing what you're up to!

Catherine Gaulton,
HIROC CEO



Equipping the Next Generation

How **Bluewater Health** aims to enhance obstetrical care with new triage tool

The team at Bluewater Health's Maternal Infant Child (MIC) department realized their obstetrical unit was not unlike emergency departments across the country, where unpredictable presentation patterns mean the potential for extended wait times and possible impact on patient outcomes.

Michelle Walsh, Professional Practice Supervisor and Krista Turner, Manager, saw an opportunity to bolster MIC staff education at Bluewater Health with an evidence-based obstetrical patient triage tool to direct decision-making.

Bluewater Health's implementation of a "just culture" enabled staff in the MIC department to identify barriers in triaging and an opportunity to incorporate consistent assessment tools to facilitate knowledge transfer. The solution they identified is a digital documentation process called the Obstetrical Triage Acuity Scale (OTAS), developed by a team from London, Ontario, to enable safe, effective and timely care for patients.

"Our intermediate and junior nurses want to ensure they continue to make the right decisions," says Turner. "They want to improve care and we feel OTAS will support them in that."

OTAS is now built right into Bluewater Health's computer system, Intellispace Perinatal (ISP). When a patient arrives at the obstetrical unit, nurses enter a triage examination on their computer. A pop-up window displays all the pertinent questions to ask the patient.

> **"Depending on a patient's answers, they'll be assigned a number from one to five," said Turner. "OTAS will suggest how quickly they'll need to be seen, with a score of 'one' requiring immediate assessment, including a practitioner."**

Turner expects this rapid assessment will enhance care and patient safety at Bluewater Health. "It will determine when our physicians need to arrive and how soon patients must be treated and thus improve the overall quality of care," she says.

At the outset of the project, Walsh discovered there were opportunities to improve triage training for nursing staff in a more structured way. She recalls asking them to identify where the gap in knowledge or education was.

"New staff learned how to become labour and delivery nurses, and to assess patients from more experienced nurses, with limited education specifically about triage for obstetrical patients," says Walsh.

"Receiving HIROC's Safety Grant has allowed us to go faster," says Walsh. "In healthcare, there are so many competing priorities and I'm thankful we've been able to get this support for our project."

Walsh first focused on getting OTAS fully built into the electronic documentation system and then on updating the accompanying learning package, to reflect Bluewater Health's standards of care.

"Receiving HIROC's Safety Grant has allowed us to go faster," says Walsh. "In healthcare, there are so many competing priorities and I'm thankful we've been able to get this support for our project."

The first rounds of educational training are scheduled for September. The department has close to 30 nurses to be trained on OTAS, including the experienced senior nurses. An educational poster with triage guidelines showing response times with OTAS is also in development.

Once the team finishes implementing OTAS, Turner wants to ensure they conduct a proper evaluation of the new process to see whether the tool does help with triaging in those crucial moments. Patients will be traced to ensure best practice standards are being met.

"We want to make sure both our nurses and physicians feel like it's a benefit to them," adds Turner. ●

By Marc Aiello, Communications & Marketing Coordinator, HIROC

Walking the Talk

Executive Patient Safety Rounds positively impact the culture at **William Osler Health System**

At William Osler Health System (Osler) conversations around safety are not defined as top-down or bottom-up. That's thanks to Osler's Executive Patient Safety Rounds (EPSRs) initiative launched in 2019.

EPSRs see leaders engage in candid conversations with staff about safety culture and discuss opportunities for improvement.

In support of this project, Osler received a 2018/19 HIROC Safety Grant.

In the early stages, senior leaders were fully briefed on this evidence-informed process that many organizations have used to drive critical change.

Through their work in patient safety education, Elaine Richards, Patient Safety and Quality Improvement Specialist says there was often a disconnect between what the leaders heard and what staff were experiencing on a day-to-day basis. They viewed EPSRs as an opportunity to open the lines of communication and get a bird's-eye view of organizational successes and the challenges frontline staff were facing.

"When it comes to patient and staff safety, you can't really have one without the other," says Richards. And a critical element of staff safety is culture, creating a safe space to have open conversations.

HOW EPSRS WORK AT WILLIAM OSLER

Each week, one senior leader, a patient safety lead, and anyone working in the unit gather together for a 30-minute conversation. Depending on the unit, the group could include nurses, physicians, housekeeping, allied health, pharmacy, and others. Unit managers are also present for transparency and staff comfort.

Senior leaders received training on EPSRs and the types of conversations that may arise. This was critical for the project's development, understanding that not all leaders have a clinical background. "The leaders that aren't in a clinical role have learned a lot in terms of what happens across the organization," shared Richards.

In advance, staff and leadership have a chance to review the questions that will guide the discussion that week. Because Richards and her team may receive a long list of suggested changes depending on the unit, they ask the teams to prioritize their top two during the rounds.

Since the first few rounds, Richards says they have revised the way they ask questions to help staff in the moment.

> **"So instead of asking, 'What is affecting your ability to provide safe care?' we might say, 'What has affected your ability to provide care in the last three days?'"**

DRIVING IMPROVEMENTS

Through the EPSRs to-date, 48 improvement opportunities have been identified.

For example, an EPSR revealed that Osler's ambulatory clinic sees many soon-to-be and new parents seeking care for mental health issues related to pregnancy and post-partum. The appointments are very one-to-one, with a clinician often alone with a patient and at times, the patient's family. The configuration of the rooms also added a challenge, with the clinician positioned at the back of the room. Clinicians felt that if there were instances of escalating behaviours, there was no way to let other team members know that support was needed. Code White buttons were identified as an improvement opportunity by the clinical team, and through the EPSR process the clinicians were supported in obtaining Code White buttons to address this safety concern.

Another EPSR success was the identification of a falls risk associated with a certain type of geriatric chair used specifically in Osler's seniors' population. "The Chief Nurse Executive was the senior leader on the round and was walked through the risk with the chairs," said Richards. "They immediately worked with the manager to look at what could be done."

FROM PROJECT TO PROGRAM

While the concept of EPSRs started as a project, Richards says it has evolved into more of a program for the organization. With some interruptions as a result of the COVID-19 pandemic, they will continue with EPSRs on an ongoing basis – in a virtual format if needed.

Findings from EPSRs are also aligned with corporate risks – adding to the organization's awareness of risk and the development of solutions. "We let the conversation flow organically, but we definitely compile our information and put it in buckets based on what we are hearing," said Richards.

Today the team is focusing on circling back with the programs regarding the changes that have been made. "I think that's really key to the success," said Richards. They are also working to share learnings organizationally with all staff on their intranet, creating a more visible presence around safety culture. ●

By Michelle Holden, Lead, Communications & Marketing, HIROC

Implementing moreOB Across the Province of Saskatchewan

Standardized education for maternal services at the **Saskatchewan Health Authority**

In 2018, the Maternal and Children's Provincial Programs team conducted an environmental scan of 36 Saskatchewan Health Authority (SHA) sites. This was a valuable opportunity to hear from frontline physicians and staff, and to follow up with requests for standardized education around maternal services. That's where moreOB came in.

As part of a number of initiatives related to the returning and stabilizing birth strategy at the SHA, the goal was to onboard 17 sites to the moreOB program, ensuring a province-wide standard of care.

moreOB – run by Salus Global – is a program that helps teams provide the best care for mothers and their newborns. Salus Global works with healthcare organizations to empower team members, prioritizing safety and open communication.

In support of this work around patient safety, the SHA was one of five Subscribers to receive a HIROC Safety Grant in 2019/20.

SHA's birth sites include rural facilities as well as large hospitals – organizations which see varying numbers of births each year. "If you're a site doing less than 200 births a year, it could take years for a provider to get comfortable managing a laboring patient on their own," said Carrie Dornstauder, Executive Director of Maternal and Children's Provincial Programs. Nursing comfort, said Dornstauder, was an important focus.

Dornstauder and her colleagues knew that implementing moreOB was more than just a one-and-done. A provincial approach would build in benchmarks and lessons learned, linking to strategic priorities for the province.

In 2020 the team began orienting several sites with the moreOB program and re-orienting sites that had already been familiar. "The initial rollout was well received," said Leah Thorp, Perinatal Outreach Education Coordinator. Thorp says bringing everyone (including nursing, family medicine, obstetrics, and midwifery) to the table has made a difference and increased collaboration.

“We need common ground from which to build a true, collaborative, interprovincial framework that supports smaller centres, especially midwives and family physicians,” said Dr. Joanne Sivertson, Interim Provincial Department Head of Obstetrics and Gynecology.

Dornstauder says she received a call from a physician shortly after announcing the program. “It’s the first time that I finally felt heard,” the physician told her. This confirmed how important of a step forward this was for the organization.

Just as the project was gaining momentum, COVID-19 hit. While SHA’s main focus has been on managing the pandemic, they are now coming back to the table to continue rolling out moreOB across the province.

“The pandemic has been a great learning opportunity for us to come together in a very short amount of time and gain some knowledge about site challenges and struggles, while being able to do that in a virtual fashion,” said Thorp.

WORKING WITH PARTNERS

Developing the moreOB program for Saskatchewan has led to a strong partnership with Salus Global. Because sites like Saskatoon had done some work with moreOB in the past, Dornstauder says it was helpful to leverage those experiences when building out how the program and the partnership with Salus would look today.

Salus Global has also been incredibly supportive since the start of the pandemic in working with the SHA to develop a digital platform to help continue the rollout, functioning in conjunction with in-person education.

Because of previous experience in acute care with Heartland Health Region, Dornstauder learned a lot about risk factors for obstetrics and how HIROC can support as a valued partner in safety.

Another partner in launching moreOB across the province has been SHA’s leadership, who have been heavily invested in strengthening the provincial Moms and Kids Health Saskatchewan program. “We have had great support along the way from our senior leaders,” said Thorp.

ADVICE FOR OTHERS

Aside from working closely with partners, when asked what advice the SHA has for other organizations and health authorities looking to roll out a program like moreOB, Thorp spoke about point of care.

“The people who are on the ground doing the work are acutely aware of the safety risks and have great solutions,” said Thorp.

She added that ensuring provincial standards can be delivered in a local way that has meaning for patients and families is critical.

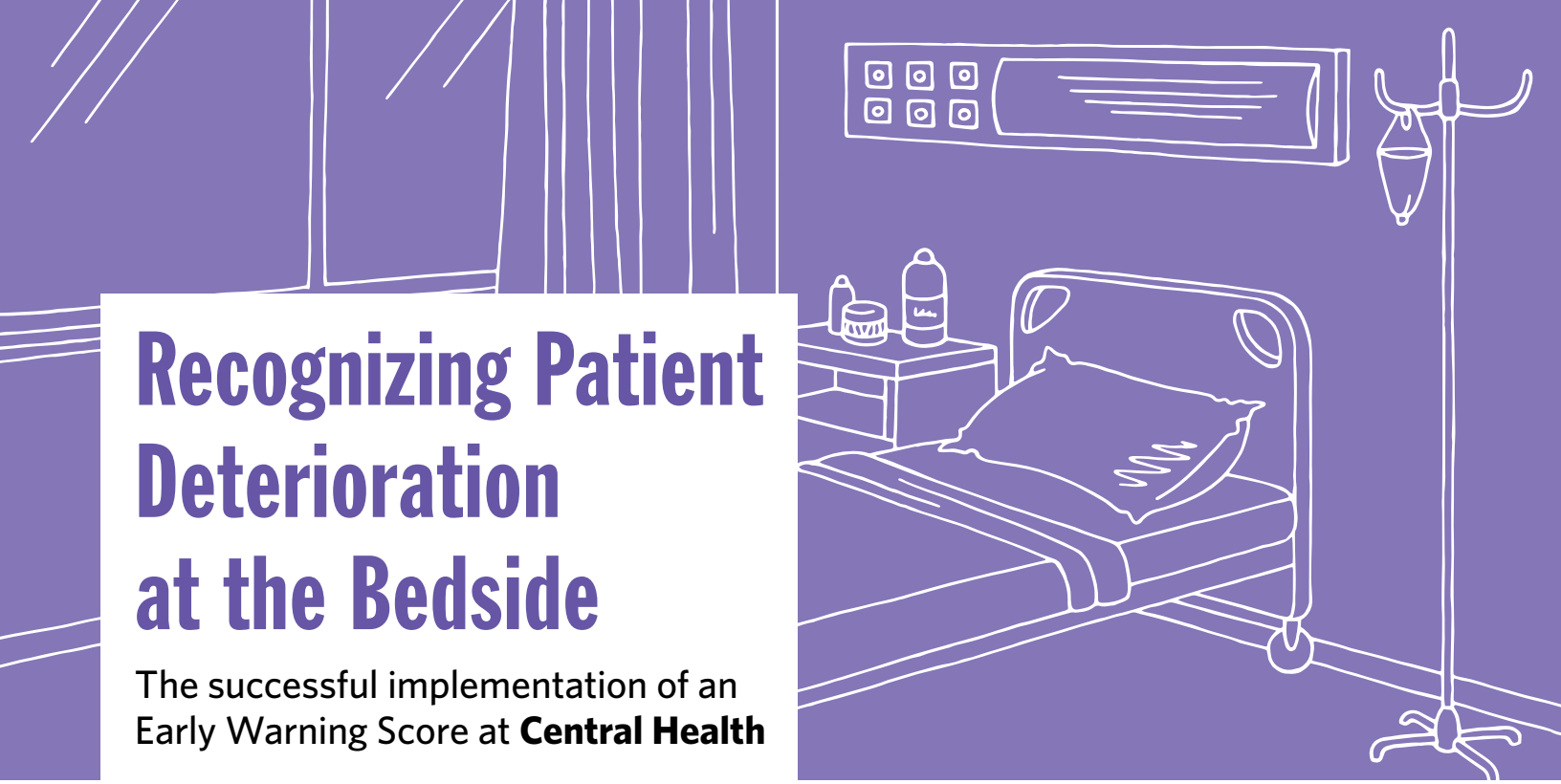
Building in family involvement is also important. SHA has done that through patient and family advisors at the local level, as well as through patient satisfaction surveys.

A CONSISTENT APPROACH

In speaking about the project, Dornstauder, Thorp, and Dr. Sivertson spoke highly of the evidence around consistency to improve safety and quality.

“In having a common language, a common approach, and skills consistent throughout the province, I have no doubt that in adopting this, embracing it, and rolling it out well that we will see patient care, provider satisfaction, and quality improve,” said Dornstauder with pride. ●

By Michelle Holden, Lead, Communications & Marketing, HIROC



Recognizing Patient Deterioration at the Bedside

The successful implementation of an Early Warning Score at **Central Health**

When Michelle Hoffe and her team at Central Health in Newfoundland recognized a rise in patient deterioration, it became clear that issues were not being detected early enough.

Hoffe and her team immediately started thinking outside the box. In that way, they function like a startup – focusing on what they can change, and tapping into the expertise of partner organizations like HIROC and CIHI.

In 2016, as Clinical Patient Safety Coordinator, Hoffe jumped into research and created a plan to develop an early warning score and escalation system at Central Newfoundland Regional Health Centre's Medical Unit.

In 2018 Central Health was one of six healthcare organizations to receive a HIROC Safety Grant in its inaugural year. The grant assisted Central Health in integrating an Early Warning Score (EWS) with their Meditech Electronic Health Record system, purchasing equipment and developing education for unit staff.

TAPPING INTO PEER EXPERIENCE

Hoffe says one of the team's challenges was mimicking the UK's paper-based early warning score in their Meditech system – she knew there had to be a better way. Hoffe came across the work of Dr. Alison Fox-Robichaud, Director of Medical Education at Hamilton Health Sciences.

"We were almost building the exact same thing," said Hoffe, who connected early on with Dr. Fox-Robichaud.

Hamilton has since modified the national early warning score to suit their needs – creating the Hamilton Early Warning Score (HEWS). Hamilton has also implemented alarm triggering on mobile devices, alerting providers in real-time.

"I am pleased to see that early warning scores, such are HEWS, are being spread within Canada," said Dr. Fox-Robichaud. "The goal of reducing in-hospital cardiac arrests and improving early recognition of clinical deterioration should be standard of care."

Hoffe credits the ingenuity of Dr. Fox-Robichaud's team and their advanced technology with keeping Central Health on their toes. "It helps us to have a vision of where we need to get to and to keep fighting for it."

When our Subscribers lean on each other and share knowledge to advance patient safety in their own organizations, it is inspiring and speaks directly to HIROC's vision of partnering to create the safest healthcare system," said Catherine Gaulton, CEO of HIROC.

INNOVATIVE EDUCATION

Another barrier, says Hoffe, was staff education on early warning scores and deteriorating patients. Much of the training and education was happening on the sides of providers' desks. Hoffe and the team developed a creative solution, launching an escape room scenario on the early warning score and escalation pathway, where nursing staff received an hour of dedicated training in small groups.

Having their undivided attention and allowing staff to ask questions before implementation had a strong impact on the success of the project. Staff were able to provide feedback on the program in dedicated binders on the unit. "We are constantly iterating," said Hoffe, who added that it's important to clearly articulate the why when developing new programs that will change the way staff work.

Today, the program has been fully integrated in all nine acute care facilities at Central Health.

Hoffe says the next step is to develop a way for patients and families to escalate care concerns. "This came out of HIROC's Risk Assessment Checklists, with regard to deteriorating patient," said Hoffe.

While reflecting on the project, Hoffe appreciates the support of her manager, Melanie Hewlett, who was instrumental in this work as both a mentor and in providing great leadership in moving the work forward.

When asked what advice Hoffe has for other healthcare teams looking to tackle big projects like mitigating the risk of patient deterioration, she said it's about focusing on one project and sticking with it. Investing in staff, following quality improvement methodology, and getting key stakeholders on board is also critical for improving a project's success factor. ●

By Michelle Holden, Lead, Communications & Marketing, HIROC

Spot It. Prevent It!

Creating a positive safety culture at **VHA Home HealthCare**

For Personal Support Workers (PSWs) caring for clients in the home, the work can at times be isolating. Delivering care within the four walls of clients' homes can leave providers vulnerable in a number of ways – one of those ways is provider abuse.

In recent years, cases of abuse towards home care providers have been on the rise; and not all incidents are reported. The team at VHA Home HealthCare recognized their responsibility to step in and promote a safe work environment. "You need to build trust and say, 'It's okay. It happened. And, we know it's not your fault'," said Sandra McKay, Director of Research at VHA Home HealthCare.

This became the focus of VHA's Spot it. Prevent it! awareness campaign, part of a larger project which received a 2018/19 HIROC Safety Grant.

PROVIDER ABUSE

McKay says abuse tends to stem from the number of individuals in home care with behavior issues related to cognitive impairments, known as responsive behaviours. The project was launched to reduce incidents of workplace violence in the home. It also aimed to decrease the perception of risk that comes with caring for clients with cognitive impairments who may exhibit responsive behaviours.

Responsive behaviours, such as hitting, cursing, and biting, are some of the challenges PSWs may

experience in the home. These behaviours are often a response to something in the personal, social or physical environment of a client with dementia, mental health, substance use and/or other neurological disorders.

McKay and her team also understand that VHA's PSW workforce is largely made up of racialized minorities. "We know from the literature that vulnerable minorities are reluctant to speak up when they believe there may be an impact to their employment, to their status within the organization, and if it's unclear what will happen."

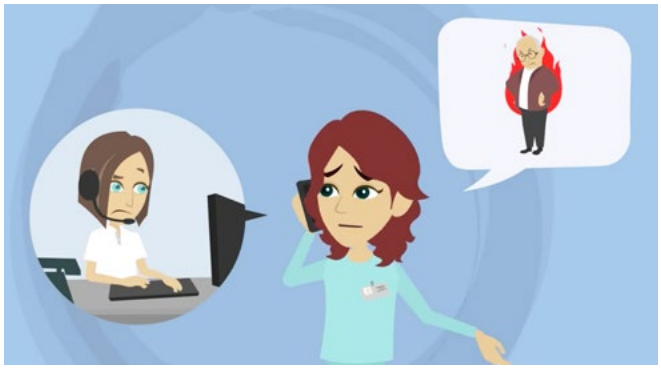
THE SPOT IT. PREVENT IT! CAMPAIGN

VHA's project was split into two parts, targeting PSWs and their supervisors. It integrated education on best practices and de-escalation strategies for mitigating risk. And for incidents that do take place, it provided tactics such as a rapid-response algorithm to visualize the reporting process, videos, posters, policy updates, ethics education sessions, and integration into new-hire orientation sessions.

The campaign by McKay and the team communicated the message that when PSWs and supervisors report an incident, these are the steps that you can expect the organization to take – it was about clarity.

"That clarity provides a level of comfort to people and it allows them to make decisions based on the available information."

VHA monitored the campaign through a survey to providers and supervisors. They saw an overwhelming response rate – an indication to the research team that they were speaking about something that is really important to PSWs.

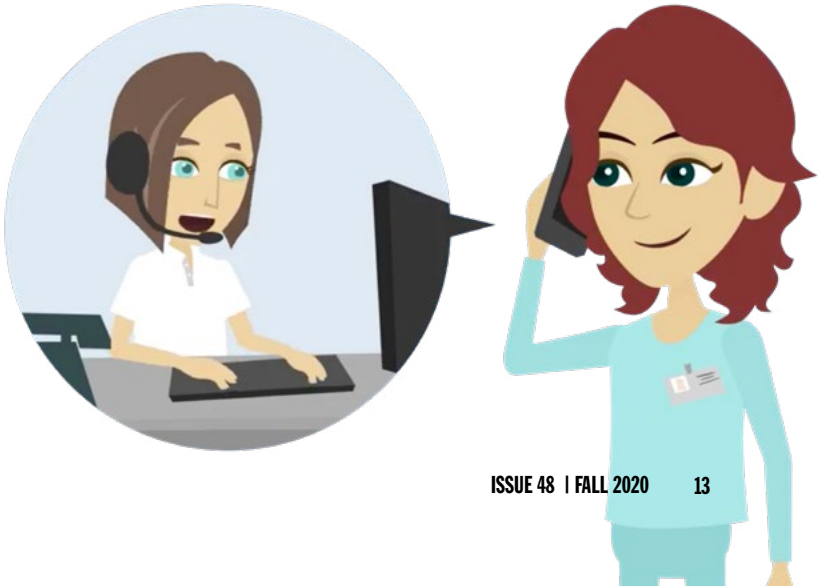


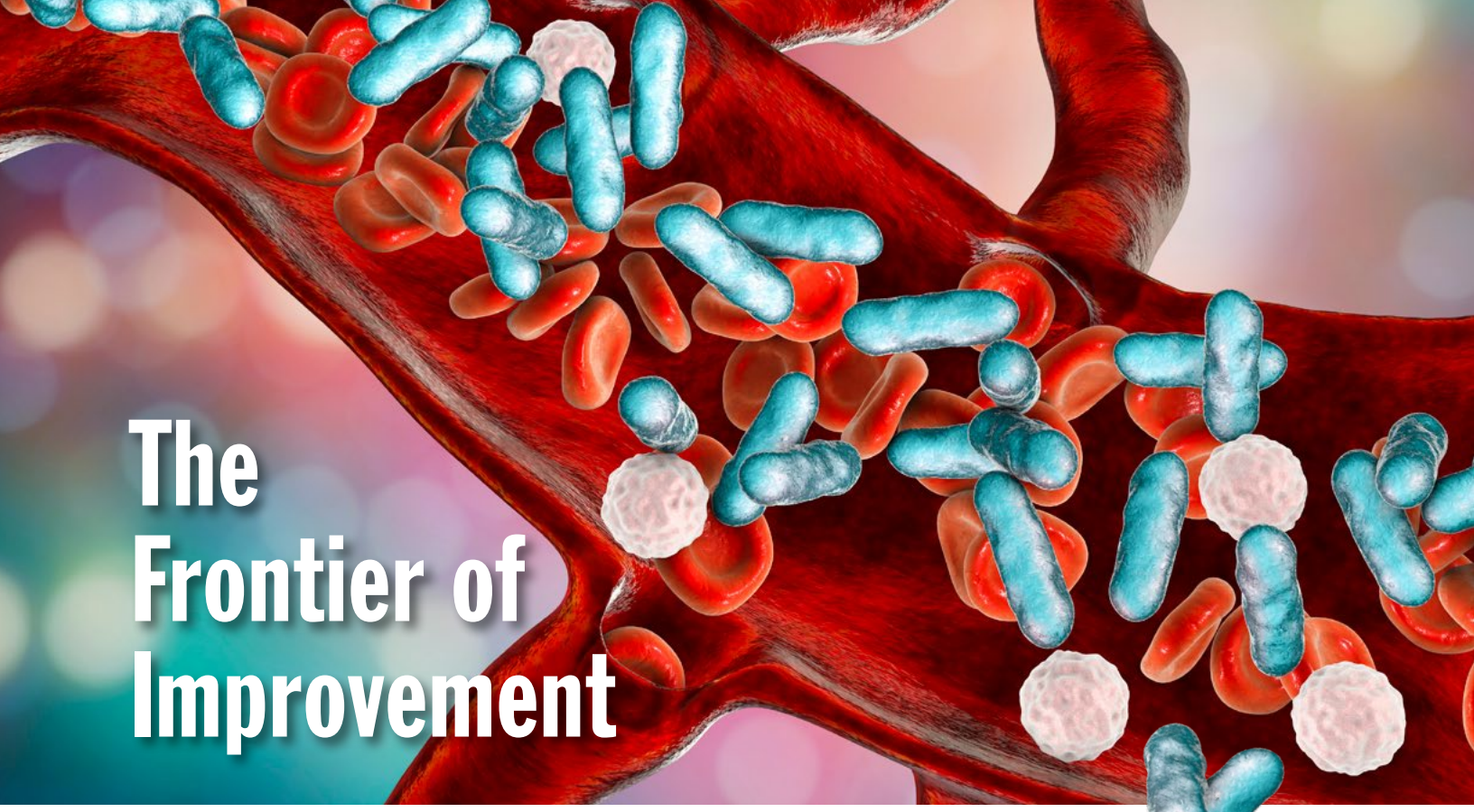
"We developed a much closer relationship with the teams," said McKay, who expressed the importance of creating a positive safety culture.

VHA also received buy-in from supervisors, who met once a month with the research team to provide an update on individual cases that had occurred and where they had used the algorithm to support staff. McKay emphasized the fact that the project wasn't inspired or developed in a vacuum. A great deal of support came from VHA's work with client partners – clients and their caregivers who work with VHA on a variety of initiatives and have first-hand experience with home care.

For McKay and her team, the campaign's message of trust and open communication was incredibly powerful and is something that carries through into their work today. The impact it has had on VHA's culture is a reminder for everyone involved of the responsibility to speak up and put safety first. ●

By Michelle Holden, Lead, Communications & Marketing, HIROC





The Frontier of Improvement

How the Surviving Sepsis Project aims to improve patient experience and safety at **Scarborough Health Network (SHN)**

Sepsis is one of the leading causes of death in hospitals primarily because its symptoms are difficult to recognize, especially in an environment with competing priorities.

"Sepsis was identified as one of the top clinical risks at Scarborough Health Network after we reviewed our patient safety incidents," said Syed Sarwar, Director, Quality, Patient Safety and Experience at SHN. "We noticed there were increasing incidents of patients deteriorating rapidly and suddenly in our Emergency Departments, medicine units, and ICUs, and we needed to understand why."

While breaking down the hospital standardized mortality ratio (HSMR) data, Dianne Tomarchio, Manager of Quality Improvement and Clinical Standardization at SHN, noted that the organization found sepsis was typically in the top five contributors to a higher HSMR value than was SHN's corporate goal. By trending the HSMR value over time, Tomarchio explained they were able to measure the impact of sepsis improvement strategies.

"We gathered patient profile information and did a deep dive into the data, including chart reviews," said Tomarchio. "We found that we could make improvements in the timeliness of sepsis recognition, early treatment and escalation of concerns."

In the fall of 2018, Tomarchio and Dr. Kevin Shore implemented three sepsis working groups focusing on preventing hospital acquired infections and optimizing care for septic patients. The working groups addressed care processes for patients that arrive septic to the emergency departments, those that become septic during their hospital stay, and documentation and coding of sepsis.

To increase awareness, Tomarchio connected with clinicians early in the project and asked them what performance data they needed to know whether sepsis should be a priority for the organization. Things like length of time to get antibiotics, amount of intravenous fluids and timeliness of obtaining blood cultures were concerns for the clinicians. Tomarchio supported chart reviews based on their parameters and shared the results to gain traction and identify improvement strategies for the working groups.

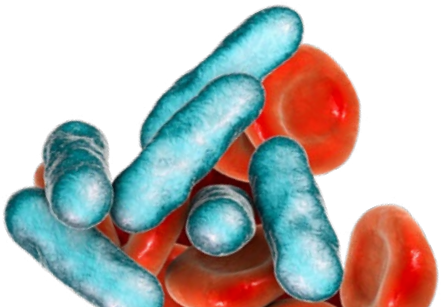
"It's about creating that burning platform, creating the need for change," said Tomarchio. "We're very excited to have the HIROC Safety Grant to support the work that needs to be done."

From a staff safety perspective, Tomarchio said the sepsis working group's focus on reducing hospital-acquired infections would make a big difference to staff because preventing adverse events ensures patients will not become more complex to care for.

"We'll be able to cut the length of stay and have a higher satisfaction rate as patients will be able to be discharged sooner," said Tomarchio.

The sepsis working groups have already developed a care pathway for sepsis, a workflow chart identifying what should be done in the first hour with a patient, and the ongoing reassessment of a patient. According to Tomarchio, the sepsis working groups plan on releasing the poster this fall as well as biannual mandatory e-learning modules currently in development by SHN's Organizational Development Team.

"The current focus over the summer is to recover all of the great work already done across the different programs and sites," said Sarwar. "We want sepsis not to be one of our top patient safety incidents anymore."



Sarwar and the sepsis working group continue to be focused on sepsis prevention and management. They aim to have all materials from the sepsis project hardwired into SHN's Clinical Information System so that physicians and staff members will be able to follow up on it.

By embedding what they've learned and continue to learn about sepsis into their Clinical Information Systems journey, SHN hopes to automate certain aspects with a built-in sepsis indicator, tracking and highlighting all best practices and making the process smoother. Currently, SHN is upgrading to a new system called EPIC along with all of the hospitals in the Central East LHIN, which is used to access, organize, store and share electronic medical records.

"The more we automate things and build in triggers and forced functions, the more it takes away from the human factors inundated with all the different things they're doing," said Sarwar.

According to Sarwar, what's next in SHN's sepsis project is finding the right governance structure to lead the working groups and strategies from both the nursing and physician perspective. The project is scheduled to be relaunched this fall. Until then, the sepsis group will be focusing on all the items that have already been finalized to ensure people are aware of the new sepsis materials and are utilizing them.

"We eventually want to get to a point where this isn't a project anymore," said Sarwar. "We want it to be something that's embedded within practice." ●

By Marc Aiello, Communications & Marketing Coordinator, HIROC

An Algorithm to Ensure the Best Start to Life

A successful reduction of newborn CPAP rates at **Hôpital Montfort**

When asked what makes France Morin proud of her work at Hôpital Montfort, she says without hesitation, "The team is very collaborative in our unit and when you have that collaboration... that's when the results come."

Morin, one of the Clinical Managers of the Family Birthing Centre at Montfort, was speaking specifically about the impressive results they've seen around the goal to reduce Continuous Positive Airway Pressure (CPAP) rates for newborns at the organization.

Prior to this initiative, BORN Ontario data showed that CPAP rates for newborns born at Hôpital Montfort's Family Birthing Center were 3.5 times higher (13.4 per cent) compared to other level 2a Family Birthing Units in Ontario (3.8 per cent) (BORN Ontario, 2018-2019).

The Montfort team acknowledged that their CPAP rates were too high and that they had to rectify their current practices in order to prevent adverse neonatal outcomes associated with complications of CPAP, which include pneumothorax, decreased cardiac output, gastric distension, feeding intolerance, skin irritation, etc. (Claassen, C.C., Strand, M. L., 2019).

In addition to being exposed to medical complications, these babies are being separated from their parents at birth which has been shown in the literature to negatively affect bonding and breastfeeding success (Safari, K., Saeed, A. A., Hasan, S. S., Moghaddam, L., 2018). These babies often require an admission to the Special Care Nursery, resulting in less skin-to-skin contact with parents, more mother-infant dyad separation and more interventions.

"We knew we had some work to do to decrease our CPAP rates," Morin said. "So, our plan was to review our current practices and policies, and provide training to healthcare professionals (pediatricians, nurses and respiratory therapists) in order to improve their knowledge, skills or abilities."

At the same time, work was underway on developing a CPAP algorithm to guide all healthcare professionals in the delivery room in order to reduce the rates of CPAP and increase immediate skin-to-skin and rooming-in rates.

During the fall, virtual in-service education regarding the CPAP algorithm was provided, combined with interdisciplinary workshops for respiratory therapists and nurses.

"Embracing simulation ensured there was as much hands-on as possible to practice various scenarios as a team," said Morin. "It's important for us to foster a safe environment for the team with open and honest feedback."

THE NUMBERS TELL A STORY OF SUCCESS

The interim report completed as part of the 2019/20 HIROC Safety Grant showed promising results.

The team saw an incredible 50 per cent decrease in infants receiving any amount of CPAP. Not only that, rates for infants receiving CPAP for less than 30 minutes after birth decreased by 25 per cent, and rates of longer than 30 minutes after birth saw a reduction of 33 per cent. Reducing the rates of CPAP also reduced the rates of inborn infants brought to the Special Care Nursery, resulting in a decrease in mother-infant dyad separation.

WHAT'S NEXT FOR THE ALGORITHM

The team is focused on ensuring competencies are maintained and that they are continuing with monthly reviews.

They also plan to review and revise Montfort's formal CPAP policy while developing strategies to maintain skills. First up is making sure all new procedures are added to the Special Care Nursery orientation.

Sharing the results of the initiative is also a top priority, "We'd love to see what we've done at Montfort scaled at other healthcare organizations across the country," said Morin.

When asked what advice she has for HIROC Subscribers who are on their patient safety journey, Morin suggests starting here:

1) Identify a knowledge-practice gap by using a quality improvement process and data.
2) Be sure that when your quality improvement project is initiated, you land on SMART goals and have a clear action plan.
3) Involvement of stakeholders is key throughout the quality improvement process – you'll see success with an interdisciplinary approach.
4) Having a dedicated person such as a project lead or change agent is important to the successful implementation of a quality improvement initiative by ensuring that momentum is maintained and planned activities are completed.

Finally, Morin stresses that evaluation is key. "We're all so good at creating new projects, but it's important to monitor knowledge use and evaluate outcomes. It is actually the evaluation process that signals ways to improve and ensures you are on the right track – you must sustain this process."

THE SECRET SAUCE

"We're so fortunate at Montfort to have leadership that encourages and values thinking outside the box," said Morin. "Our leaders are always promoting best practice which translates into the best possible care for baby, mom and families... it's instilled in our mission and vision," she added.

Digging a bit deeper, we may have uncovered the secret sauce at Montfort. "I didn't hesitate to seize the opportunity to come work at Montfort when the opportunity presented itself – I wanted to be a part of the team because they make things happen here."

Special thanks to Vanessa Rouleau, project lead for this initiative. ●

By Philip De Souza, Director, Communications & Marketing, HIROC

Mobilizing to Mitigate Risk and Improve Communication

How **Trillium Health Partners** mapped out a new obstetrics process while improving patient experience

Expectant parents may already be feeling a variety of emotions. If you couple that with the uncertainty that at times comes with navigating the healthcare system, you'll likely see some trends in patient satisfaction.

That's exactly what the team at Trillium Health Partners (THP) saw in the feedback from new parents with respect to admission and communication around the process itself.

THP provides obstetrical care at both the Credit Valley and Mississauga hospital sites. "We saw an opportunity to optimize obstetrical safety and patient flow through implementation of an obstetrical triage acuity scale and quality improvement methodologies to improve care in Birthing Services across our sites," said Cathy Walker, Interim Program Director, Women's and Children's at THP.

Labour Assessment Units (LAU) have seen increasing volumes and acuity while the physical space remains limited, resulting in extended lengths of stay for both admitted and non-admitted patients.

Increased triage times create potential safety risks and treatment delays while contributing to a poor patient experience.

"Some days we'd come in and see that we might have 15 inductions scheduled and then the next day, there would only be three – so we knew that we had to work on level setting to reduce risk while improving communication," added Walker.

The team was routinely fielding calls from patients who felt they were waiting a long time to come in.

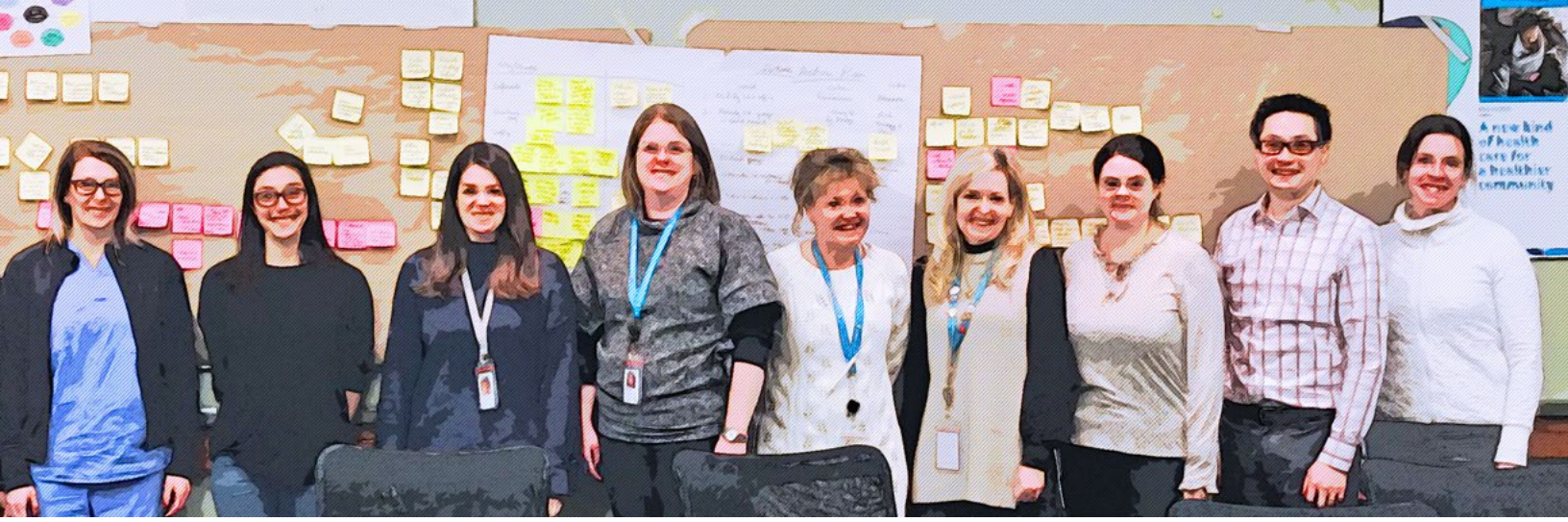
Additionally, they were seeing patterns where patient inductions were being delayed due to capacity constraints.

PROCESS MAPPING AN IDEAL FUTURE STATE

Receiving the 2019/20 HIROC Safety Grant allowed THP to reimagine the system, ensuring consistent communication while maintaining efficient flow. They were able to train staff on a new triage acuity scale that they plan to implement with their soon-to-be-launched new electronic health record system.

"We also completed a process mapping exercise with key stakeholders that came together to envision a patient-centred approach to improve safety, communication and the patient experience. We invited obstetricians, a family physician, a midwife, and nursing and registration staff," said Walker. "Their task was to map out the current process and then a future ideal state – that's how we came up with the solutions."

This work has had a positive impact on safety by decreasing the length of time between booking the induction of labour, initiation of the induction, and delivery. With this change in process there has been a decrease in the number of patients that have come to the LAU while waiting for the initiation of their induction.



The team has seen a 16.5 per cent decrease in the length of time in the LAU waiting for initiation of their induction and a 12 per cent decrease in the patient's total length of time in the LAU. Time from initiation of labour induction until delivery also decreased by 20 per cent when compared to data prior to this change.

Instead of limiting patient inductions to a single fixed date, the antenatal care provider now sends the clinical leader a date range.

The clinical leader takes all the necessary information, including the induction booking form, creating a complete package for the nursing team and the on-call obstetrician. "By having all of the information together in one package, it helps ensure there are no gaps or risks when booking the induction date," said Walker. "From there, we look at the planned care for an entire week and map out the schedule accordingly, ensuring there are no induction peaks and valleys and that patient inductions are scheduled considering their individual clinical needs/indications."

Now THP calls the patient to provide additional information prior to their scheduled induction, answer any questions, and clarify if there is any missing information.

"Initiating a call to patients and reviewing their plan of care helps us ensure the patient experience is positive," added Walker.

"Since implementing this new process we haven't had the same high-volume days; we're planning better and we're not having patients wait or be delayed because there are too many booked in one day."

Patient feedback from both the Maternity NRC Picker patient experience scores along with THP Birthing Services real-time surveying, and Leadership Rounding with patients has been utilized to improve the LAU triage and patient-flow processes.

CATHY WALKER'S ADVICE FOR OTHER ORGANIZATIONS:

1) Incorporate the patient experience through leadership rounding and patient surveying to identify what would be helpful from their perspective. But don't forget about your internal stakeholders too! Ask all staff involved what they see as opportunities.

2) Engage with your quality and process improvement teams as they likely have a number of tools or resources to help when developing solutions. At THP, the process mapping exercise was a huge win, bringing together various voices to uncover the future ideal state.

Walker stressed that driving improvement is also about sharing knowledge. "We are so grateful to HIROC for the grant program and we're happy to chat with other Subscribers as they think about applying for a future grant or want to initiate a quality improvement or patient experience project to improve care." ●

By Philip De Souza, Director, Communications & Marketing, HIROC

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