2019/20 Quality Improvement Plan
"Improvement Targets and Initiatives"

UNITY HEALTH TORONTO | PROVIDENCE Healthcare | ST JOSEPH'S HEALTHCARE TORONTO | St. Michael's Inspired Care. Inspiring Science.

AIM		Measure									Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification		Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
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Theme I: Timely and Efficient Transitions	**Timely**	**The time interval between the Disposition Date/Time (as determined by the main service provider) and the Date/Time Patient Left Emergency Department (ED) for admission to an inpatient bed or operating room.**	**MANDATORY**	**Hours / All patients**	**CIHI NACRS / October 2018 – December 2018**	**980***	**31.95**				**1)Work related to this indicator is provided by the respective sites. Please see site level work plans for more information.**	**Work related to this indicator is provided by the respective sites. Please see site level work plans for more information.**	**Work related to this indicator is provided by the respective sites. Please see site level work plans for more information.**	**Work related to this indicator is provided by the respective sites. Please see site level work plans for more information.**	**Work related to this indicator is provided by the respective sites. Please see site level work plans for more information.**
	Timely	**The time interval between the Disposition Date/Time (as determined by the main service provider) and the Date/Time Patient Left Emergency Department (ED) for admission to an inpatient bed or operating room.**	**MANDATORY**	**Hours / All patients**	**CIHI NACRS / October 2018 – December 2018**	**852***	**21.5**	**20.96**	**Over the past 3 years we have seen an increase in our overall 90P DTA to Bed performance from 17.7hrs to 21.2 hours. Additionally there has been an increase in DTA to bed with our GIM (23.82hrs to 25.5hrs) and Cardiology (19.93hrs to 20.35hrs). This target reflects a 2.5% reduction in the overall SMH 90P DTA to Bed and is reliant on the GIM and Cardiology inpatient units each achieving a 6.68% reduction in their individual 90P DTA to Bed performance. A 2.5% reduction will achieve a 32.4 min reduction in the overall corporate SMH DTA to Bed performance. The change ideas identified are focused on building processes and capacity to support more timely transferss of admitted patients from the ED to these two inpatient units.**	**1)Reduce time required to transfer patients from MSICU to GIM**	**1. Develop a standardized communication process to facilitate transfer of patients from MSICU to GIM 2. Implement standardized communication process through PDSA cycles to facilitate transfer of patients from MSICU to GIM 3. Develop and implement process to measure average length of time for transfer of patients from MSICU to GIM 4. Collect baseline data for average length of time**	**1. Standardized communication process developed 2. Standardized communication process implemented 3. Process to measure average length of time for transfer of patients from MSICU to GIM developed and implemented 4. Baseline data for average length of time for transfer from MSICU to GIM collected**	**1. Communication process developed by April 19, 2019. 2. Communication process implemented by May 1, 2019. 3. Measurement process implemented by April 19, 2019. 4. Baseline data collected by May 1, 2019.**	
											2)Reduce bed turn-around time on GIM	1. Complete current state process mapping to identify barriers to timely bed cleaning, TOA and portering to expedite transfers of GIM patients from ED 2. Map out future state to support timely bed cleaning, TOA and portering to expedite transfers of GIM patients from ED 3. Implement strategies through PDSA cycles to support timely bed cleaning, TOA and portering to expedite transfers of GIM patients from ED	1. Current state process mapping to identify barriers to timely bed cleaning, TOA and portering completed 2. Future state map to support timely bed cleaning, TOA and portering to expedite transfers of GIM patients from ED completed 3. Strategies to support timely bed cleaning, TOA and portering to expedite transfers of GIM patients from ED completed	1. Process mapping completed and opportunities identified by Mar 1, 2019. 2. Future state mapping completed by April 30, 2019. 3. Strategies implemented by August 2, 2019	
											3)Understand flow of patients to Cardiology inpatient unit	1. Complete Kaizen rapid improvement event on Cardiology unit to identify improvement opportunities to expedite transfers of Cardiology patients from ED 2. Develop strategies to reduce time to transfers Cardiology patients from ED to inpatient unit 3. Implement strategies through PDSA cycles to reduce time to transfers Cardiology patients from ED to inpatient unit current state	1. Kaizen rapid improvement event on Cardiology unit completed 2. Strategies to reduce time to transfers Cardiology patients from ED to inpatient unit developed 3. Strategies through rapid tests of change (PDSA) to reduce time to transfers Cardiology patients from ED to inpatient implemented.	1. Kaizen completed by Mar 1, 2019. 2. Strategies developed by Apr 1, 2019. 3. Strategies tested and implemented by Jul 31, 2019.	
											4)Measurement strategy to drive change	1. Develop process measures to support weekly DTA to bed improvement huddles on GIM and Cardiology 2. Implement weekly huddle process on GIM and Cardiology to review improvement initiatives and performance to date	1. Process measures to support weekly DTA to bed improvement huddles on GIM and Cardiology developed. 2. Weekly huddle process on GIM and Cardiology to review improvement initiatives and performance to date implemented	1. Process measures for all strategies developed by May 1, 2019. 2. Huddles are implemented by May 15th, 2019.	

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	Timely	**The time interval between the Disposition Date/Time (as determined by the main service provider) and the Date/Time Patient Left Emergency Department (ED) for admission to an inpatient bed or operating room.**	**M A N D A T O R Y**	**Hours / All patients**	**CIHI NACRS / October 2018 – December 2018**	**898***	**39.07**	**38.09**	**In May 2018, St. Joe's received a letter of commendation from the LHIN for achieving an 11% improvement in EDLOS in 2017. We had gone from 41.1 hours to 33.8 hours. The Time to inpatient bed had also improved by 18% from 2016 to 2017, going from 31 hours to 25.4 hours. 2018 has seen a significant decline in performance in Time to Inpatient Bed (DTA to Bed), with an increase of 12.3 hours (48% increase in wait time) – moving from 25.4 hours to 37.7 hours. The primary driver of the increase associated with medicine admits, where the 90th Percentile DTA to Bed increased by 11.6 hours (39%) moving from 29.7 hours to 41.3 hours. In addition, Mental Health has a significant DTA to Bed time of 67.3 hours, and although it improved by 2.5% this year, this wait significantly exceeds acceptable wait times. The improvement target for 2019 reflects a 2.5% (59min) reduction in the overall St. Joe's site 90P DTA to Bed and is reliant upon 2L achieving a 13% (5.6 hour) improvement and 4L Medicine inpatient unit achieving an 11% (4.92 hour) 5.60 hours improvement from baseline performance on Q3 2018-19. 7M MH would need to achieve an 11% (5.61 hour) improvement from baseline performance at Q3 2018/19.**	**1)Electronic solutions optimization**	**1) Operationalize Compass Tool for Access & Flow Steering Committee 2) Develop Daily Dashboard Data tool for Unit Performance Boards 3) Optimization of CareTRACK screens by role 4) Development of Standard Reports for Access and Flow in CareTRACK 5) Optimize VISTA tool for ED and corporate Leadership use**	**1) Compass Dashboard being used in Steering Committee Meetings 2) Daily Data pushed to managers 3) CareTRACK screen views implemented and in use by role 4) CareTRACK reports dashboard available and trained to Manager Access & Flow, Manager of Corporate Services & Decision Support 5) VISTA tool feeds and bed mapping corrected and system re-brand**	**1) May 1, 2019 2) June 1, 2019 3) June 1, 2019 4) July 1, 2019 5) July 1, 2019**	**Will require a lead from IS & Clinical Informatics**
											2)Surge/Overcapacity Policy revision	Policy Revision	Policy approved	Approved by July 1, 2019	
											3)Bed Assignment Optimization	Kaizen – Bed Assignment process	a. % missed patient isolation b. Kaizen complete c. Schedule of Improvement Actions complete d. New Process implemented	a. Baseline benchmark Set by April 1st; 80% improvement from baseline benchmark b. Kaizen complete March 29, 2019 c. Improvement Action Plan Schedule with dates/timelines in place by April 8, 2019 d. Kaizen future state process implemented fully by June 7, 2019	
											4)Reduce Bed Turnaround Time	1) Kaizen – Decision to Admit to Patient in Bed Adult MH April 9-12, 2019 2) Kaizen – Transfer reporting from ED (TOA) – all inpatient units April 23-26, 2019 3) Implementation of New Inpatient Functional Centre & Process for MH 4) Trial of Corporate Access Coordinator with focus on Medicine 5) Kaizen – Bed Empty Bed Filled (7M, 2LM, 4LM) May 21-23, 2019 6) Kaizen – Discharge Planning – 2L & 4L June 18-21, 2019	a. Kaizen complete b. Schedule of Improvement Actions complete c. New Process implemented d. MH Consult request to complete time e. Time from MHESU Inpat bed assigned to Patient in 7M bed a. Kaizen Complete b. Schedule of Improvement Actions complete c. New Process implemented d. Time from Bed Clean Start to Transport Request a. Functional Centre in operation b. ED LOS for Admitted Mental Health Patients a. Secure funding for position b. Recruitment complete c. Pilot evaluation / ROI complete d. Decision re making position permanent a. Kaizen complete b. Schedule of Improvement Actions complete c. New Process implemented d. 90P Time from Bed Empty to Clean Start e. 90P Bed Clean to Bed Filled f. 90P Time from Bed Empty to Bed Filled a. Kaizen complete b. Schedule of Improvement Actions complete c. New Process implemented d. % Potential Discharge Dates entered e. % Discharge Compliance	a. Kaizen event complete by April 12, 2019 b. Improvement Action Plan Schedule with dates/timelines in place by April 22, 2019 c. Kaizen future state process implemented fully by July 22, 2019 d. 10% improvement on baseline Q4 2018/19 e. 11% improvement on baseline "time to inpatient bed" Q4 2018/19 a. Kaizen complete by April 26, 2019 b. Improvement Action Plan Schedule with dates/timelines in place by May 6, 2019 c. Kaizen future state process implemented fully by August 5, 2019 d. 45 min target a. Functional Centre in operation by April 30, 2019 b. 11% improvement from baseline Q4 2018/19 a. May 1, 2019 b. July 30, 2019 c. Jan 30, 2019 d. Jan 30, 2019 a. Kaizen Complete by June 6, 2019 b. Improvement Action Plan Schedule with dates/timelines in place by June 23, 2019 c. Kaizen future state process implemented fully by Sept 23, 2019 d. 15 mins e. 30 mins f. 45 mins a. Kaizen complete by June 23, 2019 b. Improvement Action Plan Schedule with dates/timelines in place by June 23, 2019 c. Kaizen future state process implemented fully by Sept 23, 2019 d. 50% improvement from baseline Q4 2018/19 e. 50% improvement from baseline Q4 2018/19	
Theme II: Service Excellence	**Patient-centred**	% Respondents who respond positively (top-box) to the following question: "Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?"	C	% / Specific units	Discharge phone calls / FY 18/19 Q3	980*					1)				Please see site level work plans for more information.

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	Patient-centred	% Respondents who respond positively (top-box) to the following question: "Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?"	C	% / Specific units	Discharge phone calls / FY 18/19 Q3	773*	54.7	58.60	Historically we have utilized NRCC survey results to measure our performance with this specific question. The lag time in receiving our results has made it challenging to monitor the impact of previous change ideas in a timely manner. Data from discharge phone calls conducted within 48-72 hours of discharge will be used going forward. At St. Michael's and Providence our performance has been stable over the past year with little variation. At St. Joseph's we are currently collecting baseline data with discharge phone calls. The sample size is small due to this which will require additional monitoring to ensure that the sample size continues to increase and provides meaningful data. The change ideas developed for this indicator is directly targeted at ensuring patients understand who to call if they have concerns about their health post discharge. Targets have been set for the individual units involved in this initiative and range from a 2% to a 5% increase.	1)Optimize existing phases of discharge on B4 and B5 at Providence to ensure patients receive and understand discharge information.	1. Create a process map of the existing discharge processes on B4 and B5 with representation from interprofessional team, current and past patients to identify opportunities to improve provision of discharge information. 2. Review existing discharge tools and information to identify the best location for sharing who the patient should contact after discharge if they are concerned or have questions. 3. Opportunities to improve provision of discharge information including who to contact after discharge developed 4. Opportunities to improve provision of discharge information including who to contact after discharge implemented	1. Process map of existing discharge processes on B4 and B5 with representation from interprofessional team, current and past patients completed 2. Review existing discharge tools and information completed 3. Opportunities to improve provision of discharge information developed 4. Opportunities to improve provision of discharge information implemented	• Process map completed by May 3, 2019 • Review completed by May 3, 2019 • Opportunities developed by May 31, 2019 • Opportunities implemented by August 2, 2019	
										2)Provide regular feedback to inpatient units on progress with achieving target	1. Develop and implement weekly performance reports for each unit on progress from previous week with ensuring patients knew who to call after discharge 2. Implement process for teams to have weekly huddles on units to discuss performance, have rapid review of change ideas and course correct as required.	1. Weekly performance reports for each unit on progress from previous week completed 2. Process for teams to have weekly huddles on units to discuss performance implemented	• Weekly performance reports generated for each unit by May 31st, 2019 • Weekly huddles implanted by May 31st, 2019	
	Patient-centred	% Respondents who respond positively (top-box) to the following question: "Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?"	C	% / Specific units	Discharge phone calls / FY 18/19 Q3	852*	81.6	84.50	Historically we have utilized NRCC survey results to measure our performance with this specific question. The lag time in receiving our results has made it challenging to monitor the impact of previous change ideas in a timely manner. Data from discharge phone calls conducted within 48-72 hours of discharge will be used going forward. At St. Michael's and Providence our performance has been stable over the past year with little variation. At St. Joseph's we are currently collecting baseline data with discharge phone calls. The sample size is small due to this which will require additional monitoring to ensure that the sample size continues to increase and provides meaningful data. The change ideas developed for this indicator is directly targeted at ensuring patients understand who to call if they have concerns about their health post discharge. Targets have been set for the individual units involved in this initiative and range from a 2% to a 5% increase. All targets will have an impact on the overall corporate performance. 16CC and 4B/9CS	1)Optimize existing discharge tools and resources to ensure patients have the best information to care for themselves after discharge	1. Review existing Patient Orientated Discharge Summary (PODS) templates to identify where information about "who to call" if a patient is concerned about their condition post discharge should be placed 2. Seek input from patients (present and past) on where the best location for "who to call" is on the PODS template 3. Adjust existing PODS template to reflect best location of "who to call" information 4. Create process map of existing discharge processes to identify opportunities to have earlier conversations with patients about discharge and encourage patients to ask questions and prepare for their discharge 5. Implement strategies to have earlier conversations with patients about discharge and encourage them to ask questions and prepare for their discharge	1. The best location to place "who to call" information on the PODS is identified 2. Input from patients on where the best location to place information about "who to call" on the PODS template sought 3. Changes to PODS templates to best locate "who to call" information implemented 4. Process map of existing discharge processes completed and opportunities for earlier discharge conversations with patients identified 5. Strategies to support have earlier conversations with patients about discharge implemented	• Location for "who to call" information on PODS identified by May 1st, 2019. • Input from patients on where to locate "who to call" information on PODS sought May 1st, 2019. • PODS templates updated based on feedback from patients completed by May 17, 2019 • Workflow of existing discharge processes completed by May 31, 2019 • Strategies to support earlier discharge conversations with patient implemented by August 2, 2019	
										2)Provide regular feedback to inpatient units on progress with achieving target	1. Develop and implement weekly performance reports for each unit on progress from previous week with ensuring patients knew who to call after discharge 2. Implement process for teams to have weekly huddles on units to discuss performance, have rapid review of change ideas and course correct as required.	1. Weekly performance reports for each unit on progress from previous week completed 2. Process for teams to have weekly huddles on units to discuss performance implemented	• Weekly performance reports generated for each unit by May 31st, 2019 • Weekly huddles implanted by May 31st, 2019	
	Patient-centred	% Respondents who respond positively (top-box) to the following question: "Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?"	C	% / Specific units	Discharge phone calls / FY 18/19 Q3	898*	54.7	58.60	Historically we have utilized NRCC survey results to measure our performance with this specific question. The lag time in receiving our results has made it challenging to monitor the impact of previous change ideas in a timely manner. Data from discharge phone calls conducted within 48-72 hours of discharge will be used going forward. At St. Michael's and Providence our performance has been stable over the past year with little variation. At St. Joseph's we are currently collecting baseline data with discharge phone calls. The sample size is small due to this which will require additional monitoring to ensure that the sample size continues to increase and provides meaningful data.	1)Optimize information shared with patients on discharge through implementation of Patient Orientated Discharge Summaries	1. Evaluate impact of implementing PODS on 2LS, 2M and 6M to inform further spread of PODS. 2. Develop plan to implement PODS in other inpatient areas based on evaluation of implementation on 2LS, 2M and 6M. 3. Complete baseline collection of performance with this indicator prior to implementing PODS on other inpatient units.	1. Impact of implementing PODS on 2LS, 2M and 6M evaluated 2. Plan to spread PODS to other inpatient areas developed 3. Baseline collection of indicator performance prior to further implementation of PODS completed	• Evaluation completed by June 30th, 2019 • Plan developed by May 31, 2019 • Baseline collected for 100% of all new units where PODS is being implemented	
										2)Provide regular feedback to inpatient units on progress with achieving target	1. Develop and implement weekly performance reports for each unit on progress from previous week with ensuring patients knew who to call after discharge 2. Implement process for teams to have weekly huddles on units to discuss performance, have rapid review of change ideas and course correct as required.	1. Weekly performance reports for each unit on progress from previous week completed 2. Process for teams to have weekly huddles on units to discuss performance implemented	• Weekly performance reports generated for each unit by May 31st, 2019 • Weekly huddles implanted by May 31st, 2019	
	Patient-centred	% of residents who respond positively (always & usually) to the following question: "I am aware of the process for initiating a concern or complaint."	C	% / LTC home residents	Annual Resident Experience Survey / 2018	54863*	28	30.00	The data for this indicator is currently collected annually. This is the first time this data has been used specifically for quality improvement purposes. An increase of 5% is achievable with the improvement initiatives outlined below directly focused on the survey question. A new process for measuring this question in greater frequency throughout the year will be implemented to provide more timely information on progress with improving our performance.	1)Optimize the use of existing tools and resources developed to share the process for initiating concerns and complaints with residents.	1. Review existing tools and resources that are used to communicate to residents regarding the complaints process and identify improvements 2. Develop revised tools and resources to communicate to residents the process for initiating a concern or complaint 3. Develop a robust communication plan to support the implementation of the new tools and resources 4. Implement new tools and resources.	1. Existing tools and resources are reviewed and opportunities for improvement identified 2. Tools and resources are revised based on review and input from residents and family members 3. Communication and awareness campaign developed 4. 100% of residents receive new communication on the process for initiating a concern or complaint	• Existing tools and resources are reviewed and opportunities for improvement identified by May 31st, 2019 • Tools and resources revised by July 12, 2019 • Communication and awareness campaign developed by July 31, 2019 • 100% by August 30, 2019	
										2)Seek direct input from residents in order to enhance the process and ensure they are more aware of how to initiate a complaint/concern and the process followed in its resolution	1. Hold two focus groups with residents to understand their current knowledge of the process for initiating a concern or complaint and their ideas on how to improve awareness of the process 2. Attend the Houses Family Council to gain input from family members how best to share information about complaint process with residents	1. Two focus groups with residents held to understand their current knowledge of the process for initiating a concern or complaint and their ideas on how to improve awareness of the process completed 2. Input from Houses Family Council sought on how best to share information about complaint process with residents completed	• Focus groups completed May 31st, 2019 • Input from Houses Family Council sought May 31, 2019 (suggest removing)	

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										3)Implement a strategy to measure performance on a regular basis	1. Develop a strategy to support monthly data collection for this indicator 2. Implement strategy for monthly data collection for this indicator 3. Develop and implement report to disseminate data	1. Strategy to support monthly data collection for this indicator completed 2. Strategy to collect monthly data on this indicator implemented 3. Monthly reports created to disseminate data for this indicator	• Strategy developed May 1, 2019 • Strategy implemented May 31, 2019 • First monthly report disseminated June 28, 2019	
Theme III: Safe and Effective Care	**Safe**	**Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.**	**MANDATORY**	**Count / Worker**	**Local data collection / January - December 2018**	**773***	**46**	**48.00**	**Reporting of workplace violence incidents is projecting to be above the QIP target for Unity Health this fiscal year. While as a corporation we are on target, at the Providence and SJHC sites, reporting has actually leveled off. It is difficult to determine if this is a trend or just a few months of low reporting but in choosing a target for this QIP, the steering group chose a conservative 5% increase over calendar year 2018 performance.**	**1)Work related to this indicator is provided as a whole organization. Please see Unity Health Toronto work plan for more information.**	**Work related to this indicator is provided as a whole organization. Please see Unity Health Toronto work plan for more information.**	**Work related to this indicator is provided as a whole organization. Please see Unity Health Toronto work plan for more information.**	**Work related to this indicator is provided as a whole organization. Please see Unity Health Toronto work plan for more information.**	**FTE=1718**
	Safe	**Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.**	**MANDATORY**	**Count / Worker**	**Local data collection / January - December 2018**	**852***	**345**	**362.00**	**Reporting of workplace violence incidents is projecting to be above the QIP target for Unity Health this fiscal year. While as a corporation we are on target, at the Providence and SJHC sites, reporting has actually leveled off. It is difficult to determine if this is a trend or just a few months of low reporting but in choosing a target for this QIP, the steering group chose a conservative 5% increase over calendar year 2018 performance.**	**1)Work related to this indicator is provided as a whole organization. Please see Unity Health Toronto work plan for more information.**	**Work related to this indicator is provided as a whole organization. Please see Unity Health Toronto work plan for more information.**	**Work related to this indicator is provided as a whole organization. Please see Unity Health Toronto work plan for more information.**	**Work related to this indicator is provided as a whole organization. Please see Unity Health Toronto work plan for more information.**	**FTE=4569**
	Safe	**Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.**	**MANDATORY**	**Count / Worker**	**Local data collection / January - December 2018**	**898***	**104**	**141.00**	**Reporting of workplace violence incidents is projecting to be above the QIP target for Unity Health this fiscal year. While as a corporation we are on target, at the Providence and SJHC sites, reporting has actually leveled off. It is difficult to determine if this is a trend or just a few months of low reporting but in choosing a target for this QIP, the steering group chose a conservative 5% increase over calendar year 2018 performance.**	**1)Work related to this indicator is provided as a whole organization. Please see Unity Health Toronto work plan for more information.**	**Work related to this indicator is provided as a whole organization. Please see Unity Health Toronto work plan for more information.**	**Work related to this indicator is provided as a whole organization. Please see Unity Health Toronto work plan for more information.**	**Work related to this indicator is provided as a whole organization. Please see Unity Health Toronto work plan for more information.**	**FTE=1718**
	Safe	**Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.**	**MANDATORY**	**Count / Worker**	**Local data collection / January - December 2018**	**980***	**525**	**551.00**	**Reporting of workplace violence incidents is projecting to be above the QIP target for Unity Health this fiscal year. While as a corporation we are on target, at the Providence and SJHC sites, reporting has actually leveled off. It is difficult to determine if this is a trend or just a few months of low reporting but in choosing a target for this QIP, the steering group chose a conservative 5% increase over calendar year 2018 performance.**	**1)Better understand employee perceptions of workplace violence**	**Conduct focus groups in targeted areas to better understand our people's perceptions and experience related to workplace violence. This data will be integrated into other planned work in this QIP. Continue with implementation of "staff safety huddles." Develop an analytics dashboard to heighten utility and visibility of data related to workplace violence for managers and staff.**	**Focus groups will be held at each site in welcoming everyone but focusing on identified "high risk" areas. 1) In Q1, we will conduct focus groups at each site. Staff will be invited to attend from across the organization. Consider shift work and timing of groups. 2) Data from these focus groups will inform patient, provider and system solutions to follow. The organization has a number of different safety huddle processes. This work stream will try to understand current activity and drive reporting by engaging front line staff in safety. 1) Conduct environmental scan across sites on who is doing safety huddles, what is the content and who is leading them. (Q1) 2) Introduce workplace violence reporting information into huddles. Staff safety specialists to join huddles in ten areas at each site. (Q2) 3) Provide managers with tools to use in their huddles related to workplace violence reporting. (Q2) Currently use RL6 and Parklane systems for databases. Within RL6 for reporting, staffs have multiple options to report "events" they are part of. 1) Patient safety and occupational health teams to partner on developing consistent guidelines on what and how to report. 2) Educate staff and managers on appropriate reporting once defined. 3) Standard report built once guidelines for reporting are created.**	**2 sessions at each site in Q1. Occupational health safety specialist presence expanded to ten or more areas at each site. Dashboard is built – yes/no**	**FTE=6976**

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										2)Raise awareness and compliance with incident reporting process through education and training	Develop an education and training plan for managers to level set understanding of the incident reporting, investigation and follow-up processes. Continue focus on communication strategies to educate staff, physicians, students and the public on the importance of reporting workplace violence incidents.	Managers require further training to ensure a smooth process of reporting and follow up on workplace violence events. We will focus on: 1) Managers to be taught accountabilities under legislation. 2) Reporting and follow up process to be focus of education initiatives. 3) LMS (e-module) to be considered for use. 4) Onboarding process to include workplace violence reporting process. 5) In person director training to be followed by manager level training. 6) Focus on identifying patterns of patient, provider and system factors and building solutions to decrease risk of violence We want to continue visibility on workplace violence reporting processes across the organization. 1) Build communication plan for workplace violence for the year. 2) External posters to be posted in Q1	70% of managers in "high risk" areas are trained in the incident reporting/follow up process. Y/N	
	Safe	Number of falls with serious injury (moderate harm, severe harm, death)	C	Count / Hospital & Long-Term Care	In house data collection / Q4 2017-18 – Q3 2018-19	980*	97	89.00	Based on trending and variability over the past two fiscal years, a reduction of 2 falls with serious injuries per site (~5-10 % reduction) is considered a reasonable target. Confounding factors such as complexity of patient population and balance of risk/autonomy choice make this a challenging area to target set.	1)[Unity Health Toronto] Partnering with patients/residents and their caregivers around safety and falls prevention	Develop and define: - Provider roles - Caregiver roles - Education materials - Scripts for care planning (e.g. "what can be done to help keep you safe whilst at UHT?")	New communication tools developed and user tested	New communication tools piloted at each site for evaluation	
										2)[Unity Health Toronto] Standardize post-fall debrief and huddles process at all sites	Conduct current state assessment to better understand the strengths and opportunities at each site Increase reliability of the current process	Collect baseline data in Safety 1st system Attach an output/goal to the debrief and huddle process (e.g. updated care plan)	Data collection/current state to be completed by June 2019 TBD (based on current state findings)	
										3)[St. Michael's] Implement Intentional Rounding on remaining inpatient units	-Establish/confirm expectations with unit leadership - Each implementing unit to identify unit-based implementation working group (eg. CLM, Clinical RN Educator , RN, CA, and health discipline representation) with goal of establishing method of implementing IR on their unit - Share good strategies/enablers from other units	1)Remaining units develop unit-specific plan for IR (Yes/No) 2)% of time Intentional rounding done nightly per unit	1) Yes 2) 70% 1) Yes: remaining units to develop unit-specific plan 2) 70% of time Intentional rounding done nightly per unit	
										4)[St. Joseph's] Incorporate Falls prevention care planning into daily Safety huddles on inpatient units to create/update individualized Falls care plans for at risk patients.	Review patients who are deemed high risk for falls based on STRATIFY risk assessment daily at safety huddles. Create/update care plans for patients and communicate with team, patient and family. Document plan on patient white boards and at shift to shift handover. Audit care plans and provide and receive feedback; respond to barriers and needs for Care plan improvements	Compliance with STRATIFY falls risk assessment documentation in chart % of patients with updated falls care plan documented on patient white board and in chart	70% of patients with updated falls care plan documented on patient white board and in chart	
										5)[Providence Houses] Reduce call bell wait time by relocating Point of Care documentation stations for each unit to the end of the hallway. This will enable shorter response times by bringing care providers closer to residents.	Relocation of point of care documentation stations for each unit in collaboration with environmental services.	Relocation completed (yes/no)	All units to have point of care stations relocated by end of Q2	
										6)[Providence Houses] offer Residents identified as high risk, appropriate harm reduction interventions	Utilizing the Fracture Risk Scale (FRS) identify which residents would benefit from harm reduction interventions. Create a process to assure that residents who score who score 4 or above on the FRS are offered the appropriate harm reduction interventions.	% of residents offered appropriate harm reduction interventions (e.g. Hip protectors, osteoporosis meds)	80% of residents offered appropriate harm reduction interventions (e.g. Hip protectors, osteoporosis meds)	
										7)[Providence Hospital] Falls risk re-assessment process developed and implemented for ALC (Alternative Level of Care) patients who have an extended length of stay	Develop a process and tools to standardize re-assessment of ALC patients for falls risk on a weekly basis (or with change in status. Implement new process on all 6 rehabilitation units	Process and tools developed with clinicians, patient advisors and clinical leadership staff % of ALC patients who have weekly falls risk review completed via chart audit	Process and tools Developed by Q2 70% of ALC patients have weekly falls risk assessment by end of Q4	

AIM		Measure								Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) C = custom (add any other indicators you are working on)														
	Safe	The data set used will be the Safety First system. The indicator will consist of a count of stage II, III, IV and unstageable pressure injuries acquired while in the Houses. Performance for 2018 was 42 incidents of pressure injuries. Our goal is to reduce that incidence by 4 to 38	C	Residents in the Houses of Providence / Residents in the Houses of Providence	Safety First system / January-December 2018	54863*	42	38.00	The 2018/19 QIP began focused work on reducing pressure injuries for the residents of the Houses of Providence. A number of initiatives were rolled out including creating new medical directives for pressure injuries, appointing a Change Champion, initiating a High Risk Rounding process, and providing education to staff and physicians around wound identification and management. Despite this great work the target for this year's QIP will not be reached. In the coming year, the goal will remain to reduce the occurrence of new stage 2-4 pressure injuries after admission. The indicator will focus on measuring the number of new pressure injuries that occur in the Houses rather than the percentage. This real time measurement is more responsive for clinical staff and easier to understand for all stakeholders.	1)Modify the Wound Program Audit Tool to evaluate uptake of the process developed in 2018-19.	Wound Care Specialist, Director of Care and Wound Program Change Champion to modify the Audit Tool to capture new processes developed in 2018-19.	New Wound Program Audit Tool developed.	New Wound Program Audit Tool developed by end of Q1 2019-20	
										2)Residents at high risk (PURS score of 4 or above and/or Braden score of 12 or lower) will have an individualized Pressure Injury Prevention Care Plan. To be proactive in the prevention of pressure injuries *PURS Pressure Ulcer Risk Score	Wound Care Specialist to develop a Pressure Injury Prevention Care Plan template using Best Practice Guidelines that can be individualized in conjunction with staff, residents and family members.	% of residents with PURS score of 4 or above and/or Braden score 12 or lower that have individualized pressure injury prevention care plan recommendations listed in their EMR.	80% of residents with PURS score of 4 or above and/or Braden score 12 or lower have individualized pressure injury prevention care plan recommendations listed on their care plans by end of Q3 2019-20	
										3)Educate front line staff in best practice skin health for the prevention of pressure injuries.	Mixed education strategies to cover areas: skin health, preventing deteriorating skin, day-to-day skin management.	% of front line staff that have completed education.	85% of front line staff educated by end of Q3 2019-20	
										4)Educate residents and family members around what pressure injuries are and how to reduce risk.	Use mixed educational methods to deliver this education to residents identified as high risk and family members.	% of identified high risk residents/families educated.	80% of identified high risk residents/families will have had education	