Theme I: Timely and Efficient Transitions

Measure

Dimension: Timely

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Average ED Length of Stay for Admitted Patients (hours) at St. Michael's Hospital.	C	Hours / All acute patients	HSSO HCD, CIHI DAD, CIHI NACRS / April 2022 - Jan 2023	18.10	16.30	Timely access continues to be a critical focus for our organization. We have established an Access, Flow and Transitions Task Force to develop, implement, continually revise and monitor a plan to improve access to care for our patients, with a particular focus on emergency department and inpatient care. Through a data analysis review and the engagement of the Task Force and other key stakeholders, we are proposing an improvement target of 10% for 2023/24 and will re-assess contributing processes in our control to drive improvements.	

Change Ideas

No Data Available

Change Idea #1 Conduct a value stream mapping analysis at both SMH and SJHC in order to map out the time to inpatient bed process.

Methods	Process measures	Target for process measure	Comments
Stakeholder interviews and quantitative data will be used to map the current state process for Time to Inpatient Bed.	Value Stream Mapping (VSM) Event completed.	VSM completed by end of Q1 23/24 with action plans to address Time to Inpatient Bed.	This initiative will allow the development of a targeted improvement plan; identification of key measures of success and the development of a detailed action plan. Real change with standard work and visual management will be delivered.

Change Idea #2 Change Ideas following the value stream analysis.			
Methods	Process measures	Target for process measure	Comments
Plan-Do-Study-Act (PDSA) cycles.	Time to Inpatient Bed (and other sub processes – bed assignment time ready bed transfer time).	70% of the change ideas following the VSM implemented by end of Q2 23/24.	
Change Idea #3 Standardize ALC processes.			
Methods	Process measures	Target for process measure	Comments
Engage stakeholders to ensure there is consistency across sites and programs to identify and transition ALC patients.	Completion of standard work for ALC processes.	Processes standardized by the end of Q1 and will be reassessed for compliance.	
Change Idea #4 Develop a "Unity First" policy focused on pathways from acute care sites to Providence.			
Methods	Process measures	Target for process measure	Comments
Engage stakeholders and map out the process of transfer to include in the policy.	Policy developed and implemented (process measure targeting ALC rates).	Policy completed by beginning of Q1 (ALC target rate TBD).	
Change Idea #5 Development and deployment of AI enabled discharge prediction tools.			
Methods	Process measures	Target for process measure	Comments
Target high volume services (GIM) to pilot AI enabled discharge predication tools.	Average EDD % match on select pilot units.	To be determined (TBD).	
Change Idea #6 Continue to monitor and drive improvements through the Access, Flow and Transitions Task Force for our three pillars of focus: Safe Patient Placement, Staffing and Transition Planning.			
Methods	Process measures	Target for process measure	Comments
Quick wins and projects identified to address improvement opportunities through bi-weekly meetings.	To be determined (TBD).	To be determined (TBD).	

Measure

Dimension: Timely

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Average ED Length of Stay for Admitted Patients (hours) at St. Joseph's Health Centre Toronto.	C	Hours / All acute patients	HSSO HCD, CIHI DAD, CIHI NACRS / April 2022 - Jan 2023	33.80	30.40	Timely access continues to be a critical focus for our organization. We have established an Access, Flow and Transitions Task Force to develop, implement, continually revise and monitor a plan to improve access to care for our patients, with a particular focus on emergency department and inpatient care. Through a data analysis review and the engagement of the Task Force and other key stakeholders, we are proposing an improvement target of 10% for 2023/24 and will re-assess contributing processes in our control to drive improvements.	

Change Ideas

No Data Available

Change Idea #1 Conduct a value stream mapping analysis at both SMH and SJHC in order to map out the time to inpatient bed process.

Methods	Process measures	Target for process measure	Comments
Stakeholder interviews and quantitative data will be used to map the current state process for Time to Inpatient Bed.	Value Stream Mapping (VSM) Event completed.	VSM completed by end of Q1 23/24 with action plans to address Time to Inpatient Bed.	This initiative will allow the development of a targeted improvement plan; identification of key measures of success and the development of a detailed action plan. Real change with standard work and visual management will be delivered.

Change Idea #2 Change Ideas following the value stream analysis.			
Methods	Process measures	Target for process measure	Comments
Plan-Do-Study-Act (PDSA) cycles.	Time to Inpatient Bed (and other sub processes – bed assignment time ready bed transfer time).	70% of the change ideas following the VSM implemented by end of Q2 23/24.	

Change Idea #3 Standardize ALC processes.			
Methods	Process measures	Target for process measure	Comments
Engage stakeholders to ensure there is consistency across sites and programs to identify and transition ALC patients.	Completion of standard work for ALC processes.	Processes standardized by the end of Q1 and will be reassessed for compliance.	

Change Idea #4 Develop a “Unity First” policy focused on pathways from acute care sites to Providence.			
Methods	Process measures	Target for process measure	Comments
Engage stakeholders and map out the process of transfer to include in the policy.	Policy developed and implemented (process measure targeting ALC rates).	Policy completed by beginning of Q1 (ALC target rate TBD).	

Change Idea #5 Development and deployment of AI enabled discharge prediction tools.			
Methods	Process measures	Target for process measure	Comments
Target high volume services (GIM) to pilot AI enabled discharge predication tools.	Average EDD % match on select pilot units.	To be determined (TBD).	

Change Idea #6 Continue to monitor and drive improvements through the Access, Flow and Transitions Task Force for our three pillars of focus: Safe Patient Placement, Staffing and Transition Planning.			
Methods	Process measures	Target for process measure	Comments
Quick wins and projects identified to address improvement opportunities through bi-weekly meetings.	To be determined (TBD).	To be determined (TBD).	

Theme II: Service Excellence

Measure

Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Top box response to "Did we involve you as much as you wanted in decisions about your care?" for Inpatients	C	% / All inpatients	In-house survey / Q1-Q3 2022/23	85.80	86.70	In FY 22/23 (Q1-Q3) we achieved a 5% increase in performance from 80.8% to 85.8% for inpatients responding "always" to the question: "Did we involve you as much as you wanted in decisions about your care?" This represents responses from 4868 patients and a response rate of 51%. In 2022/23 we collected feedback from outpatients on the same question within the Providence outpatient clinics beginning in Q1 and in the Ambulatory Care Clinics at St. Joseph's in Q3. We have purposefully separated the data for this question between inpatients and outpatients as the patient experience in these two settings is not comparable and requires different interventions. Additionally, we will begin using email as a new modality to administer the surveys and it is unclear how this will impact the data. Therefore, we will focus on understanding the differences between inpatient and outpatient experiences with being involved in decisions about their care and focus on achieving a modest improvement over the next year.	

Change Ideas

No Data Available

Change Idea #1	Implement pilot of Real-Time Care Experience Interviews with Inpatients to further understand what contributes to patients feeling involved in care decisions and inform improvement strategies.		
Methods	Process measures	Target for process measure	Comments
Data will be collected through monthly Real-Time Interviews with inpatients on 3 pilot units (1 per site). Data will be entered into Qualtrics and analyzed. A report will be generated within 48 hours post interviews and shared with unit leaders.	% Patients interviewed on unit (based on daily census). Increase in % of patients who answer “always” to the question “Did we involve you as much as you wanted in decisions about your care?”.	75% of patients who meet inclusion criteria complete the interview each month. Achieve 86.7% target for inpatient performance by March 31, 2024.	

Change Idea #2	Complete data analysis of shared decision making question to understand opportunities for improvement in inpatient settings		
Methods	Process measures	Target for process measure	Comments
Care experience data including shared decision making question will measure ongoing performance. Data will be reviewed on a monthly basis and reported to clinical programs through Qualtrics.	Analyze inpatient FY 2022-23 quantitative results from shared decision making question to inform improvement ideas. Analyze inpatient FY 2022-23 qualitative (free text) results reflective of shared decision making to inform improvement ideas. Use data analysis to identify one clinical area per site for targeted improvement strategies specific to shared decision making.	Quantitative and qualitative data analysis of completed by April 30, 2023. Inpatient areas for improvement opportunities identified and engaged by November 30, 2023.	Future thinking includes opportunities to leverage new Electronic Patient Record to support shared decision making tools.

Change Idea #3 Identify and/or develop shared decision making tools for staff to support patients and caregivers in care decisions.

Methods	Process measures	Target for process measure	Comments
Care experience data including shared decision making question will measure ongoing performance. Data will be reviewed on a monthly basis and reported to clinical programs through Qualtrics.	Complete review of literature and best practices to identify shared decision making tools that best align with identified clinical areas. Develop tools for use in select outpatient settings to support staff, physicians and learners in involving patients/caregivers in care decisions. Create implementation plan for identified shared decision making tools. Develop and implement a communications campaign to raise awareness amongst staff, physicians and learners regarding shared decision making (what, how, why). Create evaluation plan to measure impact of shared decision making tools.	Identify shared decision making tools aligned with identified clinical areas by February 28, 2024. Tools identified and/or developed for use in select outpatient settings by March 31, 2024. Develop implementation plan of identified shared decision making tools for implementation in FY 24/25 by March 31, 2024. Communications campaign developed and implemented by October 31, 2023. Creation of evaluation plan completed by March 31, 2024.	

Change Idea #4 Continue implementation of care experience surveys in outpatient settings to develop robust baseline and identify opportunities for improvement.

Methods	Process measures	Target for process measure	Comments
Care experience data including shared decision making question will measure ongoing performance. Data will be reviewed on a monthly basis and reported to clinical programs through Qualtrics.	Implement care experience surveys in additional clinics within St. Michael's in alignment with Verto platform. Publish care experience survey results from outpatient areas in Qualtrics platform. Analyze quantitative results from outpatient care experience surveys to inform improvement ideas specific to shared decision making. Analyze qualitative (free text) results from outpatient care experience surveys to inform improvement ideas specific to shared decision making. Identify outpatient areas with opportunity for improvement at all 3 sites.	Care experience surveys implemented within St. Michael's outpatient clinics in alignment with Verto roll-out by December 31, 2023. Care Experience survey data available on Qualtrics by June 30, 2023. Quantitative and qualitative data analysis of completed by December 31, 2023. Outpatient areas for improvement opportunities for 2023/24 identified by February 28, 2024.	

Change Idea #5 Continue to participate and influence provincial discussions on patient experience benchmark data and the ability to use a net promoter score.

Methods	Process measures	Target for process measure	Comments
Data will be collected through the discharge phone calls and introduction of email.	Participate as an active member of the Ontario Hospital Association Patient Experience Steering Committee where development of an approach to benchmark data is underway. Complete research into utility of Net Promoter Score in healthcare context. Make recommendation to organization on participation in and use of provincial benchmark data. Make recommendation to organization on use of a NPS within Unity Health.	Active participation maintained throughout the fiscal year. Research into Net Promoter Score within the healthcare context completed by September 30, 2023. Recommendations made to Unity Executive Quality Council by December 30, 2023.	

Measure

Dimension: Patient-centred

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Top box response to “Did we involve you as much as you wanted in decisions about your care?” for Outpatients	C	% / Other	In-house survey / Q3 2022/23	80.50	81.50	In FY 22/23 (Q1-Q3) we achieved a 5% increase in performance from 80.8% to 85.8% for inpatients responding “always” to the question: “Did we involve you as much as you wanted in decisions about your care?” This represents responses from 4868 patients and a response rate of 51%. In 2022/23 we collected feedback from outpatients on the same question within the Providence outpatient clinics beginning in Q1 and in the Ambulatory Care Clinics at St. Joseph’s in Q3. We have purposefully separated the data for this question between inpatients and outpatients as the patient experience in these two settings is not comparable and requires different interventions. Additionally, we will begin using email as a new modality to administer the surveys and it is unclear how this will impact the data. Therefore, we will focus on understanding the differences between inpatient and outpatient experiences with being involved in decisions about their care and focus on achieving a modest improvement over the next year.	

Change Ideas

No Data Available

Change Idea #1	Implement pilot of Real-Time Care Experience Interviews with Inpatients to further understand what contributes to patients feeling involved in care decisions and inform improvement strategies.		
Methods	Process measures	Target for process measure	Comments
Data will be collected through monthly Real-Time Interviews with inpatients on 3 pilot units (1 per site). Data will be entered into Qualtrics and analyzed. A report will be generated within 48 hours post interviews and shared with unit leaders.	% Patients interviewed on unit (based on daily census). Increase in % of patients who answer “always” to the question “Did we involve you as much as you wanted in decisions about your care?”.	75% of patients who meet inclusion criteria complete the interview each month. Achieve 86.7% target for inpatient performance by March 31, 2024.	

Change Idea #2	Complete data analysis of shared decision making question to understand opportunities for improvement in inpatient settings.		
Methods	Process measures	Target for process measure	Comments
Care experience data including shared decision making question will measure ongoing performance. Data will be reviewed on a monthly basis and reported to clinical programs through Qualtrics.	Analyze inpatient FY 2022-23 quantitative results from shared decision making question to inform improvement ideas. Analyze inpatient FY 2022-23 qualitative (free text) results reflective of shared decision making to inform improvement ideas. Use data analysis to identify one clinical area per site for targeted improvement strategies specific to shared decision making.	Quantitative and qualitative data analysis of completed by April 30, 2023. Inpatient areas for improvement opportunities identified and engaged by November 30, 2023.	Future thinking includes opportunities to leverage new Electronic Patient Record to support shared decision making tools.

Change Idea #3 Identify and/or develop shared decision making tools for staff to support patients and caregivers in care decisions.

Methods	Process measures	Target for process measure	Comments
Care experience data including shared decision making question will measure ongoing performance. Data will be reviewed on a monthly basis and reported to clinical programs through Qualtrics.	Complete review of literature and best practices to identify shared decision making tools that best align with identified clinical areas. Develop tools for use in select outpatient settings to support staff, physicians and learners in involving patients/caregivers in care decisions. Create implementation plan for identified shared decision making tools. Develop and implement a communications campaign to raise awareness amongst staff, physicians and learners regarding shared decision making (what, how, why). Create evaluation plan to measure impact of shared decision making tools.	Identify shared decision making tools aligned with identified clinical areas by February 28, 2024. Tools identified and/or developed for use in select outpatient settings by March 31, 2024. Develop implementation plan of identified shared decision making tools for implementation in FY 24/25 by March 31, 2024. Communications campaign developed and implemented by October 31, 2023. Creation of evaluation plan completed by March 31, 2024.	

Change Idea #4 Continue implementation of care experience surveys in outpatient settings to develop robust baseline and identify opportunities for improvement.			
Methods	Process measures	Target for process measure	Comments
Care experience data including shared decision making question will measure ongoing performance. Data will be reviewed on a monthly basis and reported to clinical programs through Qualtrics.	Implement care experience surveys in additional clinics within St. Michael's in alignment with Verto platform. Publish care experience survey results from outpatient areas in Qualtrics platform. Analyze quantitative results from outpatient care experience surveys to inform improvement ideas specific to shared decision making. Analyze qualitative (free text) results from outpatient care experience surveys to inform improvement ideas specific to shared decision making. Identify outpatient areas with opportunity for improvement at all 3 sites.	Care experience surveys implemented within St. Michael's outpatient clinics in alignment with Verto roll-out by December 31, 2023. Care Experience survey data available on Qualtrics by June 30, 2023. Quantitative and qualitative data analysis of completed by December 31, 2023. Outpatient areas for improvement opportunities for 2023/24 identified by February 28, 2024.	

Change Idea #5 Continue to participate and influence provincial discussions on patient experience benchmark data and the ability to use a net promoter score.			
Methods	Process measures	Target for process measure	Comments
Data will be collected through the discharge phone calls and introduction of email.	Participate as an active member of the Ontario Hospital Association Patient Experience Steering Committee where development of an approach to benchmark data is underway. Complete research into utility of Net Promoter Score in healthcare context. Make recommendation to organization on participation in and use of provincial benchmark data. Make recommendation to organization on use of a NPS within Unity Health.	Active participation maintained throughout the fiscal year. Research into Net Promoter Score within the healthcare context completed by September 30, 2023. Recommendations made to Unity Executive Quality Council by December 30, 2023.	

Measure

Dimension: Patient-centred

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents in the Houses of Providence who receive palliative care for greater than one month prior to their passing (House of Providence)	C	% / Residents	Other / Q3 2022/23 YTD	38.00	46.00	The Houses of Providence have chosen to continue focusing on the palliative care program for the 2023/2024 QIP. Although the target was not met last year, we have seen improvement in this indicator over the course of the year. The SPICT (Supportive and Palliative Indicators Tool) tool has been successfully implemented and there is good momentum in providing education to staff and physicians. With a focus on improving goals of care conversations we believe a target of 20% improvement is realistic for this year.	

Change Ideas

Change Idea #1 Provide staff and physician education in Palliative care.

Methods	Process measures	Target for process measure	Comments
Attendance at education sessions will be tracked.	Number of staff who complete palliative education course.	40 staff having completed palliative education course by March 31, 2024.	

Change Idea #2	Implement process to ensure SPICT (Supportive and Palliative Indicators Tool) triggers goals of care conversation.		
Methods	Process measures	Target for process measure	Comments
Monthly report of GOC conversations initiated by SPICT Tool.	a. Number of staff who completed simulation exercise in goals of care (GOC) conversations b. Number of GOC conversations triggered by positive SPICT Tool.	a. 100% Full time RNs complete simulation for GOC conversations by March 31, 2024. b. 80% of identified residents by SPICT Tool will have GOC conversations documented in Point Click Care platform by March 31, 2024.	

Change Idea #3	a. Create brochure for Houses Palliative care program b. Create “A plan for my comfort” template to learn what is important to resident/caregiver in their life.		
Methods	Process measures	Target for process measure	Comments
Progress on the development of the Palliative Care Program brochure and “A plan for my comfort” template will be monitored by the Houses Palliative Care Committee.	a. % Completion of Houses Palliative Care Program brochure b. % Completion of “A plan for my comfort” template.	a. Palliative Care Program brochure completed and approved by relevant committees by Q3 2023/24. b. “A plan for my comfort” tool completed by March 31, 2024.	

Change Idea #4	Restart Palliative care committee with resident/family member representation.		
Methods	Process measures	Target for process measure	Comments
The work of the Palliative care committee will be reported to the Houses Performance Council on a quarterly basis.	Number of Palliative Care Committee meetings attended by resident/family member.	Four Palliative Care Committee meetings (with resident/family member attendance) completed by March 31, 2024.	

Theme III: Safe and Effective Care

Measure

Dimension: Safe

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of newly acquired stage II, III, IV, unstageable and deep tissue pressure injuries (PI) in the Cardinal Ambrozic Houses of Providence (House of Providence)	C	Count / Residents	Other / Jan - Dec 2022	31.00	28.00	The QIP 2022/2023 was not successful in reaching a target of reducing PI by 10%. Therefore, the Houses' team would like to continue working on improvements to the PI program. This year, the Houses team will be using their internal data which is more accurate and available in real time allowing clinical staff to be more responsive. As staff increase their understanding of pressure injury prevention, we believe our target of 10% reduction is realistic.	

Change Ideas

Change Idea #1 Identify a PI Management Lead to oversee the PI program together with the staff champion.

Methods	Process measures	Target for process measure	Comments
PI Management Lead and champion to review and track monthly data on newly acquired stage II, III, IV, unstageable and deep tissue pressure injuries in the KPI folder. PI data will monitored on the PI scorecard (i.e. trending, etc.).	PI Management Lead in place to oversee PI program by March 31, 2023.	Management Lead in place to oversee PI program by March 31, 2023.	

Change Idea #2 Educate front line staff in best practice skin health for the prevention of pressure injuries.			
Methods	Process measures	Target for process measure	Comments
PI data and staff training attendance (see Process Measures) will be monitored on Performance Boards; shared and discussed at staff meetings, huddles and monthly best practice meetings.	Number of staff that has attended the Skin Health for Prevention of Pressure Injuries training.	80% or higher of front line staff (nurses and PSWs) received Skin Health for Prevention of Pressure Injuries training by March 31, 2024.	

Change Idea #3 Nurses to attend the Practice Enrichment Workshop- Wound Prevention & Management education provided by CNS team.			
Methods	Process measures	Target for process measure	Comments
Monitor attendance at Practice Enrichment Workshop: Wound Prevention & Management.	Number of nurses that has attended the Practice Enrichment Workshop- Wound Prevention & Management education provided by the CNS team.	100% of FT and PT nurses attended the Practice Enrichment Workshop Wound Prevention & Management Education by March 31, 2024.	

Change Idea #4 Train staff on referral process for CNS consultation for PIs stage 3 and higher.			
Methods	Process measures	Target for process measure	Comments
Monitor staff training attendance on referral process for CNS consultation for PIs stage 3 and higher.	Number of nurses that receive training on referral process for CNS consultation for PIs stage 3 and higher.	100% of FT and PT nurses received training on referral process for CNS consultation for PIs stage 3 and higher by March 31, 2024.	

Measure

Dimension: Safe

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% of high priority action items from critical incident reviews implemented by target date	C	% / Other	Other / Q1-Q3 2022-23	76.00	85.00	High priority actions items arising from critical incident reviews are those actions deemed to be the most likely to prevent or mitigate future similar critical incidents. Timeframes for implementation of high priority actions items factor in potential delays. However, there are instances where an appropriate delay may occur and this is accounted for in the target.	

Change Ideas

No Data Available

Change Idea #1 Formally implement new high priority action item tracking tool within Safety First.

Methods	Process measures	Target for process measure	Comments
Utilization of tracking tool by leaders will be tracked through Safety First. Reports on utilization of report by program with critical incidents will be completed on a monthly basis. A corporate report on indicator performance will occur quarterly.	All clinical program leaders provided with access to and education on the high priority action item tracking tool. Quarterly reminders sent to clinical leaders with completion of actions.	All clinical program leaders receive access to and education on high priority action item tracking tool by June 1, 2023. Quarterly reminders to clinical leaders on completion of high priority actions sent 1 week after each quarter starting July 2023.	

Measure

Dimension: Safe

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Stage 4 Pressure Injuries Acquired After Admission to Hospital	C	Count / All inpatients	Other / Q1-Q3 2022/23	2.00	0.00	Never events are patient safety incidents resulting in serious patient harm or death and deemed preventable with appropriate organizational checks and balances in place. There are 15 types of never events we monitor as outlined in the Canadian Patient Safety Institute's Pan-Canadian Never Event report. Stage 3 and 4 pressure injuries are included as a type of never event. However, we will focus on stage 4 hospital acquired pressure injuries as they align with the critical incident definition and represent the most significant type of pressure injury. Given the level of harm associated with stage 4 hospital acquired pressure injuries and the fact that these are designated as "never events" we have set a target of zero.	

Change Ideas

No Data Available

Change Idea #1 Continue to complete formal patient safety incident reviews of all Stage 4 pressure injuries.

Methods	Process measures	Target for process measure	Comments
Stage 4 hospital acquired pressure injuries are captured in the Safety First System. Stage 4 hospital acquired pressure injuries data pulled from Safety First on a monthly basis and reported to Unity Health Pressure Injury Steering Committee, Executive Quality Committee, Board Quality Committee and the Medical Advisory Council. Findings from reviews of Stage 4 hospital acquired pressure injuries are documented in the Safety First System.	All identified stage 4 hospital acquired pressure injuries have a documented review. All action items resulting from the review of a stage 4 hospital acquired pressure injury are documented within Safety First and shared broadly as applicable.	100% of stage 4 hospital acquired pressure injury reviews are completed within the targeted 90-day timeframe. 100% of all action items resulting from a stage 4 hospital acquired pressure injury review are documented in the Safety First system.	

Change Idea #2 Develop and implement a standardized approach to systemically measuring and reporting pressure injuries across Unity Health.

Methods	Process measures	Target for process measure	Comments
Hospital acquired pressure injury data pulled from Safety First on a monthly basis and reported to Executive Quality Council.	Pressure Injury Prevention Steering Committee in collaboration with Patient Safety and Decision Support to determine and support a standard approach to defining, collecting and reporting hospital acquired pressure injury metrics across sites. Continue expansion of current education and decision support tools to facilitate accurate identification of pressure injuries at the point of care.	A standardized approach to defining, collecting and reporting hospital acquired pressure injury metrics is in place by January 30, 2024. Expansion of current education and decision support tools for accurate identification of pressure injuries by February 29, 2024.	All 3 sites have existing and well established processes in place to measure hospital acquired pressure injuries. Aligning existing measurement processes will strengthen the overall Unity hospital acquired pressure injury prevention program.

Change Idea #3	Align existing pressure injury prevention practices across the three sites to support the foundation for a structured and multi-faceted pressure injury prevention program across Unity Health.

Methods	Process measures	Target for process measure	Comments
Pressure injury data is reviewed by the Pressure Injury Prevention Steering Committee which is a cross-site committee that provides oversight and direction on pressure injury prevention with a goal to reduce HAI Pressure Injuries across UHT. A network wide needs assessment on Pressure Injury Prevention Practices will be used to provide initial data to inform improvement opportunities in 2023/24.	Complete a needs assessment to identify areas of success and gaps between current state and established best practices for pressure injury prevention based on international clinical guidelines. Validate findings from needs assessment through the Unity Health Pressure Injury Prevention Steering committee. Identify through the network wide needs assessment on Pressure Injury Prevention Practices quality improvement activities for 23/24. Establish cross-site work streams for high priority areas of focus aligning with International Clinical Best Practice Guidelines on Pressure Injury Prevention.	Cross-site needs assessment completed by April 1, 2023. Findings from cross-site needs assessment validated by the Pressure Injury Steering Committee by April 30, 2023. Identify improvement opportunities by May 31, 2023. Establish cross-site workstreams for high priority areas of focus by June 30, 2023.	All 3 sites have existing and well established processes and practices in place to prevent hospital acquired pressure injuries. Aligning existing practices and processes will strengthen the overall Unity hospital acquired pressure injury prevention program.

Measure

Dimension: Safe

Indicator #9	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Never Events (excluding stage 4 hospital acquired pressure injuries)	C	Count / All inpatients	Other / Q1-Q3 2022/23	3.00	0.00	Never events are patient safety incidents resulting in serious patient harm or death and deemed preventable with appropriate organizational checks and balances in place. There are 15 types of never events we monitor as outlined in the Canadian Patient Safety Institute's Pan-Canadian Never Event report. Given the level of harm associated with the never events a target of zero is reasonable and prudent.	

Change Ideas

No Data Available

Change Idea #1 Continue to complete a formal review of all identified never events to identify opportunities to prevent future similar events.

Methods	Process measures	Target for process measure	Comments
Never event data is captured in the Safety First System. Never event data pulled from Safety First on a monthly basis and reported to Executive Quality Council, Board Quality Council and the Medical Advisory Council. Findings from reviews of never events are documented in the Safety First System.	All identified never events have a documented review. All action items resulting from a review are documented within Safety First and shared broadly as applicable.	100% of never event reviews are completed within the targeted 90-day timeframe. 100% of all action items resulting from a never event review are documented in the Safety First system.	

Change Idea #2 Where applicable increase the number of medium to high leverage action items developed during reviews of never events.

Methods	Process measures	Target for process measure	Comments
Data on action items from critical incident reviews tracked through Safety First. Data to be reviewed on a monthly basis by Patient Safety Team.	All high priority action items from never events reviews documented in Safety First as high, medium and low leverage. Teams encouraged to develop high priority action items that are medium to high leverage as part of the critical incident review process. Quarterly report on high priority action items by high, medium and leverage created and reviewed by programs, patient safety team and EQC.	100% of high priority action items documented in Safety First as high, medium and low leverage each month. 60% or more of high priority action items are medium or high leverage at the end of each critical incident review. A report on high priority action items by high, medium and low leverage is developed and distributed at the end of each quarter.	