Access and Flow

Measure - Dimension: Timely

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Emergency department length of stay for admitted patients (mean) (St. Michael's Hospital)	C	Hours / Other	HSSO HCD, CIHI DAD, CIHI NACRS / April 2023-Jan 2024	19.10	17.20	A 10% absolute improvement is ambitious and may depend on system factors. We have also set a relative target – i.e., that each hospital should be in the top 1/3 of its peer group.	

Change Ideas

No Data Available

Change Idea #1 Standardize the Transfer of Accountability (TOA) and Bed Assignment processes to improve the time between the decision to admit and arrival in an inpatient bed.

Methods	Process measures	Target for process measure	Comments
Engage stakeholders to develop standard work for TOA and bed assignment processes to ensure consistency across sites and programs; provide education for use and implement I-PASS tool for TOA clinical information sharing.	Ready bed transfer time completed within less than 1 hours. Processes standardized.	80% of the time the 1 hour target time is met. Standardization completed by end of Q1.	

Change Idea #2 Multiple initiatives designed to improve wellness and turnover within the organization, especially in areas that are critical to inpatient flow.

Methods	Process measures	Target for process measure	Comments
Implement Federal Nursing Retention Toolkit. Continue funding programmatic elements focused on supporting wellness, mental health and leadership development.	Early Service (employees hired within 2 years). Turnover for Nurses (RNs and RPNs). Voluntary Turnover.	25.5% (15% improvement from baseline). 10% less than OHA Winter 2024 Survey.	

Change Idea #3 Multiple initiatives designed to improve transitions between hospital and the next setting, with a particular focus on patients with an ALC designation.

Methods	Process measures	Target for process measure	Comments
Establish integrated pathways to post-acute services. Standardize ALC process including rounds and documentation.	Alternate level of care (ALC) Rate.	15.3% (in line with provincial average Q1 -Q3 23/24).	

Measure - Dimension: Timely

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Emergency department length of stay for admitted patients (mean) (St. Joseph's Health Centre)	C	Hours / Other	HSSO HCD, CIHI DAD, CIHI NACRS / April 2023-Jan 2024	20.50	18.50	A 10% absolute improvement is ambitious and may depend on system factors. We have also set a relative target – i.e., that each hospital should be in the top 1/3 of its peer group.	

Change Ideas

No Data Available

Change Idea #1	Standardize the Transfer of Accountability (TOA) and Bed Assignment processes to improve the time between the decision to admit and arrival in an inpatient bed.		
Methods	Process measures	Target for process measure	Comments
Engage stakeholders to develop standard work for TOA and bed assignment processes to ensure consistency across sites and programs; provide education for use and implement I-PASS tool for TOA clinical information sharing.	Ready bed transfer time completed within less than 1 hours. Processes standardized.	80% of the time the 1 hour target time is met. Standardization completed by end of Q1.	

Change Idea #2	Multiple initiatives designed to improve wellness and turnover within the organization, especially in areas that are critical to inpatient flow.		
Methods	Process measures	Target for process measure	Comments
Implement Federal Nursing Retention Toolkit. Continue funding programmatic elements focused on supporting wellness, mental health and leadership development.	Early Service (employees hired within 2 years). Turnover for Nurses (RNs and RPNs). Voluntary Turnover.	25.5% (15% improvement from baseline). 10% less than OHA Winter 2024 Survey.	

Change Idea #3	Multiple initiatives designed to improve transitions between hospital and the next setting, with a particular focus on patients with an ALC designation.		
Methods	Process measures	Target for process measure	Comments
Establish integrated pathways to post-acute services. Standardize ALC process including rounds and documentation.	Alternate level of care (ALC) Rate.	15.3% (in line with provincial average Q1 -Q3 23/24).	

Experience

Measure - Dimension: Patient-centred

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% of residents who responded “usually” to the question “do you feel you are listened to by staff” (House of Providence)	C	% / LTC home residents	In house data, NHCAHPS survey / Q1-Q3 2024-25	70.00	75.00	Asking residents about their experiences about the care and service they receive is key to improving quality of care. When residents feel comfortable sharing their thoughts, it allows care providers to identify areas for enhancement and address concerns promptly. When residents feel their needs and preferences are being listened to, it empowers them to actively participate in their care decisions. The Houses of Providence wants to ensure that residents feel they are being listened to.	

Change Ideas

Change Idea #1 Seek additional detail from residents based on survey responses.

Methods	Process measures	Target for process measure	Comments
Conduct focus groups with 5-6 residents to obtain detail on areas identified as needing improvement in the quarterly survey. (Focus on communication comments).	Number of focus groups held.	Number of focus groups held.	Themes and areas of focus arising from the focus groups will be shared with the Resident Experience Committee to guide improvement plans.

Change Idea #2 Explore use of technology for residents whose first language is not English.

Methods	Process measures	Target for process measure	Comments
The Director of Care to meet with the hospital to determine feasibility of extending VOYCE licences in the Houses of Providence.	Number of VOYCE licenses sought for the Houses of Providence.	4 Voyce licenses obtained for the Houses of Providence by March 31, 2025.	

Change Idea #3 Raise awareness of information/communication sources.

Methods	Process measures	Target for process measure	Comments
The Operation Leads to set up key contact information posters at a standard location that is accessible to residents on each unit.	Number of key contact information posters being set up in a standard location accessible to residents.	100% of units have set up key contact information posters in a standard location accessible to residents on each unit by March 31, 2025.	

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of inpatients who respond “always” (top box score) to the question: “Did you feel listened to?”	C	% / All inpatients	Other / Q1-Q3 2023-24	77.00	80.00	When patients feel listened to they are more likely to perceive a positive overall experience and included in their care decisions. Current performance across all Unity Health inpatient units is variable with a decrease in performance between FY 2022-23 and Q1-Q3 2023-24 in over 60% of inpatient units. A targeted increase of 3% is reasonable and requires an improvement in all inpatient areas.	

Change Ideas

No Data Available

Change Idea #1 Develop an in-depth understanding of what contributes to patients feeling listened to.			
Methods	Process measures	Target for process measure	Comments
a) Conduct 3 focus group sessions with Patient Family Partners to understand what contributes to patients feeling listened to. b) Conduct survey through Virtual Patient Panel to seek input from patients on what contributes to patients feeling listened to. c) Complete literature review to uncover best practices to support how staff and physicians in supporting patients in feeling listened to.	a) % of focus groups completed. b) Completion of survey through Virtual Patient Panel. c) Completion of literature review and synthesis of findings.	a) 100% of focus groups completed by May 31, 2024. b) Survey administered through Virtual Patient Panel by May 31, 2024. c) Literature review on best practices and synthesis of findings completed by May 31, 2024.	

Change Idea #2 Implement a working group with representation from Patient Family Partners, leadership and patient experience to guide improvement strategies across all three hospital sites.			
Methods	Process measures	Target for process measure	Comments
a) Develop an action plan with metrics based on synthesis of feedback from patients on what contributes to feeling listened to. b) Review action plan and achievement of monthly milestones and provide quarterly report to Executive Quality Council.	a) Implementation of working group. b) Development of action plan by working group.	a) Working group implemented by April 30, 2024. b) Action plan developed by June 28, 2024.	

Change Idea #3 Drive unit specific improvements through timely data sharing and unit based huddles (QMS model).

Methods	Process measures	Target for process measure	Comments
a) Launch new CX performance dashboards and provide access to all unit and program leaders. b) Add a clarifying question to existing care experience survey tool to collect qualitative feedback on patient responses to the question “Did you feel listened to?” c) Develop process to support staff in reviewing CX data and developing improvement ideas through unit based huddles. d) Utilize the patient experience real time program to seek ongoing feedback from inpatients who are currently in our care on how listened to they felt and what contributes to this.	a) Launch of new CX performance dashboards. b) Clarifying question added to survey. c) Unit based huddles incorporate review and discussions on CX data specific to the question “Did you feel listened to?” d) Patient experience real time program incorporates questions to further understand current inpatients perspectives on if they felt listened to and what contributed to this.	a) New CX performance dashboards launched by April 30, 2024. b) Clarifying question added to CX survey by April 30, 2024. c) Process to support review of CX data specific to the question “Did you feel listened to?” at unit huddles in place by September 30, 2024. d) Questions to further understand if current inpatients feel they are listened to implemented by May 31, 2024.	

Safety

Measure - Dimension: Safe

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of Stage IV Hospital Acquired Pressure Injuries (never event)	C	Count / All inpatients	Other / Q1-Q3 2023-24	2.00	0.00	Never events are patient safety incidents that result in serious patient harm or death and that are preventable using organizational checks and balances. Stage IV hospital acquired pressure injuries are viewed as never events. The target of zero reflects the notion that these type of pressure injuries are generally viewed as preventable.	

Change Ideas

No Data Available

Change Idea #1 Complete formal patient safety incident reviews of all Stage 4 pressure injuries using common cause analysis.

Methods	Process measures	Target for process measure	Comments
a) Using the common cause analysis framework review all stage IV hospital acquired pressure injuries over past two fiscal years and identify. b) Identify common gaps from common cause analysis and improvement strategies to address gaps.	a) Completion of common cause analysis. b) Completion of gap identification and corresponding improvement strategies.	a) Common cause analysis framework applied to review of all stage IV hospital acquired pressure injuries over past two fiscal years completed by June 30, 2024. b) Gap identification and corresponding improvement strategies completed by July 30, 2024.	

Change Idea #2	Introduce a UHT wide pressure injury prevention care plan and unique visual identifier for individuals at risk of developing pressure injuries in the new electronic patient record.		
Methods	Process measures	Target for process measure	Comments
a) Build within the new EPR a standard Unity pressure injury prevention care plan. b) Implement new Unity pressure injury prevention care plan through Project Connect go-live. c) Monitor usage of new Unity pressure injury prevention care plan post go live to optimize functionality and utilization. d) Track completion of Braden scale completion on admission through new EPR dashboard.	a) Build of standard Unity pressure injury prevention care plan within new EPR. b) Implementation of standard Unity pressure injury prevention care plan within new EPR. c) Determine audit functionality to monitor usage of Unity pressure injury prevention care plan post EPIC go live. d) Include metric to monitor completion of Braden scale completion on admission on Epic dashboard	a) Standard Unity pressure injury prevention care plan built within new EPR by November 30, 2024. b) Standard Unity pressure injury prevention care implemented as part of Project Connect go-live by November 30, 2024. c) Audit care plan completion rates for patients with a Braden Score less then or equal to 18 by March 2024. d) Metric to monitor completion of Braden scale completion on admission on Epic dashboard by November 30, 2024.	

Change Idea #3	Standardize measurement and reporting of Hospital Acquired Pressure Injuries (HAPIs).		
Methods	Process measures	Target for process measure	Comments
a) Provide education on reporting HAPIs through Safety First and the verification of staging. b) Use Safety First as the standard approach for the measurement of HAPIs across Unity. c) Develop standard reports to share HAPIs data across Unity.	a) Develop and implement required education on staging and reporting of HAPIs. b) Optimize Safety First fields to facilitate the collection of reliable staging data. c) Development of standard reports on HAPIs across Unity.	a)Education on staging and reporting of HAPIs completed by March 30, 2024. b) Optimizations to Safety First fields to facilitate the collection of reliable data completed by June 1, 2024. c) Standard reports on HAPIs across Unity implemented by February 28, 2024.	

Change Idea #4 Improve access to therapeutic surfaces for patients identified as at risk for pressure injuries.

Methods	Process measures	Target for process measure	Comments
a) Monitor the implementation of site-specific strategies for clinical equipment workflows identified during 23/24 clinical equipment workflow review. b) Identify opportunities to standardize clinical workflows specific to accessing therapeutic surfaces for patients at risk for pressure injuries.	a) Completion of workflow review. b) Identification of opportunities to standardize clinical workflows specific to accessing therapeutic surfaces.	a) Review workflows specific to accessing therapeutic surfaces across Unity completed by February 28, 2024. b) Identify opportunities to standardize clinical workflows specific to accessing therapeutic surfaces completed by February 28, 2024.	

Measure - Dimension: Safe

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of never events excluding stage IV hospital acquired pressure injuries	C	Count / All inpatients	Other / Q1-Q3 2023-24	1.00	0.00	Never events are patient safety incidents that result in serious patient harm or death and that are preventable using organizational checks and balances. The target of zero reflects the notion that never events are generally viewed as preventable.	

Change Ideas

No Data Available

Change Idea #1 Develop process to share unit/program specific learnings and action items from reviews of all never event reviews.

Methods	Process measures	Target for process measure	Comments
a) Develop a standard report template to share unit/program specific learnings and action items from review of all never event reviews. b) Implement a standard report template to share unit/program specific learnings and action items from review of all never event reviews.	a) Development of standard report to share unit/program specific learnings and action items from review of all never event reviews. b) Implementation of standard report to share unit/program specific learnings and action items from review of all never event reviews.	a) Standard report template to share unit/program specific learnings and action items from review of all never event reviews developed by May 30, 2024. b) Standard report template to share unit/program specific learnings and action items from review of all never event reviews implemented by June 30, 2024.	

Measure - Dimension: Safe

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of newly acquired Stage 2, 3,4 unstageable and deep tissue pressure injuries in the Cardinal Ambrozic Houses of Providence (House of Providence)	C	Count / LTC home residents	In house data collection / Q1-Q3 2024-25	25.00	25.00	Although the QIP 2023-24 target was met, the Houses team would like to continue working on improvements in the Pressure Injury Program to maintain current performance. 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.	

Change Ideas

Change Idea #1 Raise Registered staff awareness of wound staging.

Methods	Process measures	Target for process measure	Comments
Clinical Lead to conduct education on wound staging including hands on training.	Number of Full Time/Part Time registered staff attending an education session on wound staging.	80% of Full Time/Part Time Registered staff attended an education session on wound staging by April 30, 2024.	

Change Idea #2 Improve the confirmation of wound staging.

Methods	Process measures	Target for process measure	Comments
Director of Care/designate to conduct focus groups with registered staff to obtain input on a process for confirmation of wound staging.	a) % of Full Time/Part Time Registered staff attending the focus groups provided by the Director of Care. b) Number of units implementing the trial approved wound staging process.	a) 80% of Full Time/Part Time Registered staff attended a focus group by October 30, 2024. b) 100% of units have trialed the staging process by March 31, 2025.	

Change Idea #3 Explore technology/tools to facilitate skin and wound healing.			
Methods	Process measures	Target for process measure	Comments
a. The Skin and Wound Champion contact LTC homes in the Alliance to collect information on their use of technology in their skin and wound program. b. Seek Foundation funding for the purchase of wound treatment carts with laptops for each floor.	a) Number of LTC Alliance homes contacted regarding their use of technology in their skin and wound program. b) Number of wound treatment carts approved for floors.	a) 5 LTC homes contacted regarding their use of technology in their skin and wound program by December 31, 2025. b) 50% of floors have a wound treatment cart on their floor.	

Change Idea #4 Conduct an inventory of pressure/relief/air mattress.			
Methods	Process measures	Target for process measure	Comments
The clinical lead Identify mattresses requiring replacement though an audit process.	% of mattress replaced as indicated by the audit by March 31, 2025.	80% of mattresses were replaced as indicated by the audit by March 31, 2025.	