Theme I: Timely and Efficient Transitions

Measure

Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of inpatient days where a physician (or designated other) has indicated that a patient occupying an acute care hospital bed has finished the acute care phase of his/her treatment.	C	% / All patients	CIHI DAD / 2021	20.50	20.40	Target has been set using the same approach as for our internal Corporate Performance Scorecard using the 2021 calendar year as the baseline (20.5). Any improvement over baseline will be seen as meeting our improvement goal.	

Change Ideas

Change Idea #1 TOH ALC Strategy

Methods	Process measures	Target for process measure	Comments
1. Regional Integration & Building Capacity: Continued expansion of discharge home with supports (Your Care @ Home). 2. Regional Integration: Implement regional referral strategy for geriatric patients in the ED to prevent admissions. 3. ALC Dashboard: To have robust, real-time data and tools to drive results and measure success through the development of an ALC Metrics and Dashboard. 4. Documentation: Improve documentation in EPIC by social work (SW), Discharge Planning Coordinator (DPC), Central Access team and providers.	1. # of eligible patients admitted to Your Care @ Home Program per month 2. # of patients accepted into the program 3. # of strategy initiatives implemented based on dashboard results. 4. Compliance based on audits	1. 40 per month (483 per year) 2. TBD 3. 1 initiative/month 4. 10% improvement in compliance	

Measure

Dimension: Timely

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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.	C	Hours / All patients	CIHI NACRS, CCO / 2021	23.68	23.67	Target has been set using the same approach as for our internal Corporate Performance Scorecard using the 2021 calendar year as the baseline (23.68). Any improvement over baseline will be seen as meeting our improvement goal.	

Change Ideas

Change Idea #1 Inpatient Discharge Rounding

Methods	Process measures	Target for process measure	Comments
1. Reeducate teams on requirements for discharge. 2. Analyze baseline performance on ALOS to ELOS to identify opportunities to enhance discharge process. 3. Implement compliance tracking and of rounding and accuracy of EDD at the unit level. 4. Evolve 7-day per week patient flow model spread to entire organization. 5. Track and measure ALC discharge delays.	KR1: 90% of patients with a documented estimated discharge date (EDD). KR2: Reduce median discharge time of day from 14:34 to 14:00 and sustain for 6 months. KR3: Order to discharge (Pulse). KR4: Establish Accuracy of Estimated Day of Discharge.	KR1: 90% KR2: Median discharge time of day of 14:00. KR3: Monitor and evaluate. KR4: Implement in Epic, monitor and evaluate by end of Q3.	

Theme II: Service Excellence

Measure

Dimension: Patient-centred

Indicator #	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
51417: Overall Rating of Care	C	% / All inpatients	CIHI CPES / Dec 2020 - Nov 2021	66.20	66.30	Target has been set using the same approach as for our internal Corporate Performance Scorecard using the 2021 calendar year as the baseline (66.2%). Any improvement over baseline will be seen as meeting our improvement goal.	

Change Ideas

Change Idea #1 What Matters to You Initiative

Methods	Process measures	Target for process measure	Comments
1. Develop and execute new corporate strategy to implement WMTY. 2. Educate and implement new Patient Care Boards incorporating WMTY. 3. Develop, test, and implement audit set on mobile app to support real time data collection and analysis. 4. Develop and utilize education package for Unit Leadership and staff. 5. Re-Implement Unit leadership rounding on patients using audit set. Identify and support low performers to improve performance.	% of patient care boards installed % of unit leadership attending an education/information session # of patients rounded on Monthly scores on identified CPES questions	Complete by March 31. 2023 100% of patient care boards installed by August 2022. (Total of 1300) June 2022 80% of inpatient unit leadership Target 20-30 patients per month	

Measure

Dimension: Patient-centred

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
51409: During this hospital stay, did you get all the information you needed about your condition and treatment?	C	% / All inpatients	CIHI CPES / Dec 2020 - Nov 2021	57.80	57.90	Target has been set using the same approach as for our internal Corporate Performance Scorecard using the 2021 calendar year as the baseline (57.8%). Any improvement over baseline will be seen as meeting our improvement goal.	

Change Ideas

Change Idea #1 What Matters to You Initiative

Methods	Process measures	Target for process measure	Comments
1. Develop and execute new corporate strategy to implement WMTY. 2. Educate and implement new Patient Care Boards incorporating WMTY. 3. Develop, test, and implement audit set on mobile app to support real time data collection and analysis. 4. Develop and utilize education package for Unit Leadership and staff. 5. Re-Implement Unit leadership rounding on patients using audit set. Identify and support low performers to improve performance.	% of patient care boards installed % of unit leadership attending an education/information session # of patients rounded on Monthly scores on identified CPES questions	Complete by March 31. 2023 100% of patient care boards installed by August 2022. (Total of 1300) June 2022 80% of inpatient unit leadership Target 20-30 patients per month	

Measure

Dimension: Patient-centred

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
51410: Did you get the support you needed to help you with any anxieties, fears or worries you had during this hospital stay?	C	% / All inpatients	CIHI CPES / Dec 2020 - Nov 2021	62.70	62.80	Target has been set using the same approach as for our internal Corporate Performance Scorecard using the 2021 calendar year as the baseline (62.7%). Any improvement over baseline will be seen as meeting our improvement goal.	

Change Ideas

Change Idea #1 What Matters to You Initiative

Methods	Process measures	Target for process measure	Comments
1. Develop and execute new corporate strategy to implement WMTY. 2. Educate and implement new Patient Care Boards incorporating WMTY. 3. Develop, test, and implement audit set on mobile app to support real time data collection and analysis. 4. Develop and utilize education package for Unit Leadership and staff. 5. Re-Implement Unit leadership rounding on patients using audit set. Identify and support low performers to improve performance.	% of patient care boards installed % of unit leadership attending an education/information session # of patients rounded on Monthly scores on identified CPES questions	Complete by March 31. 2023 100% of patient care boards installed by August 2022. (Total of 1300) June 2022 80% of inpatient unit leadership Target 20-30 patients per month	

Measure

Dimension: Patient-centred

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
51406: Do you feel that there was good communication about your care between doctors, nurses and other hospital staff?	C	% / All inpatients	CIHI CPES / Dec 2020 - Nov 2021	59.60	59.70	Target has been set using the same approach as for our internal Corporate Performance Scorecard using the 2021 calendar year as the baseline (59.6%). Any improvement over baseline will be seen as meeting our improvement goal.	

Change Ideas

Change Idea #1 What Matters to You Initiative

Methods	Process measures	Target for process measure	Comments
1. Develop and execute new corporate strategy to implement WMTY. 2. Educate and implement new Patient Care Boards incorporating WMTY. 3. Develop, test, and implement audit set on mobile app to support real time data collection and analysis. 4. Develop and utilize education package for Unit Leadership and staff. 5. Re-Implement Unit leadership rounding on patients using audit set. Identify and support low performers to improve performance.	% of patient care boards installed % of unit leadership attending an education/information session # of patients rounded on Monthly scores on identified CPES questions	Complete by March 31. 2023 100% of patient care boards installed by August 2022. (Total of 1300) June 2022 80% of inpatient unit leadership Target 20-30 patients per month	

Theme III: Safe and Effective Care

Measure

Dimension: Effective

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged.	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / October 2021– December 2021	93.49	93.50	Target has been set using the same approach as for our internal Corporate Performance Scorecard using the 2021 calendar year as the baseline (93.5%). Any improvement over baseline will be seen as meeting our improvement goal.	

Change Ideas

Change Idea #1 Medication Reconciliation in Epic

Methods	Process measures	Target for process measure	Comments
1. Participant in review of Ambulatory care accreditation standards for med rec requirements by end of Q1. 2. Identify and implement solutions to address gaps. 3. Continue to advance technical enhancements to EMR to support clinical staff. 4. Consider resource model for BPMH.	1. Complete by end of Q1. 2. Complete by end of Q2. 3. Number of updates provided to RCOC throughout the year. 4. Complete by end of Q2.	1. End of Q1 2. End of Q2 3. At least 3 4. End of Q2.	

Measure

Dimension: Safe

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.	P	Count / Worker	Local data collection / January - December 2021	621.00	622.00	Target has been set using the same approach as for our internal Corporate Performance Scorecard using the 2021 calendar year as the baseline (621). Any improvement over baseline will be seen as meeting our improvement goal. Improvement is defined as an increase because we continue to focus on increasing the percentage of events that are reported.	

Change Ideas

Change Idea #1 Workplace Violence Strategy

Methods	Process measures	Target for process measure	Comments
1a: Evaluate TIDES training program by Q4 FY22-23. 2a: Provide 20 in-services on requirement and mechanisms for incident reporting by Q4 FY22-23. 2b: Launch and promote 'Good Catch' recognition campaign for SLS reporting and recognize 2 reporters by Q2 FY22-23. 2c: Release 4 Safety Lessons posters. 3: Promote on TOH's Violence Prevention Program Toolkit. 4: Analyze reported incidents data based on new classification system to inform strategy by FYQ4 22/23.	# of in-services on requirement and mechanisms for incident reporting. # Safety Lessons posters published (What's Happening, Huddle Updates). # of 'Good Catch' reports. # of Unique users per month.	20 in-services on requirement and mechanisms for incident reporting by Q4 FY22-23. Publish 4 safety lessons by Q4 FY22-23. More than 171 Good Catch reports. Average of 30 unique monthly visits to Violence Prevention Program Toolkit.	FTE=12576

Measure

Dimension: Safe

Indicator #9	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Hand hygiene rates (moment 1 and 4 combined)	C	Proportion / Worker	Hospital collected data / 2021	80.50	80.60	Target has been set using the same approach as for our internal Corporate Performance Scorecard using the 2021 calendar year as the baseline (80.5%). Any improvement over baseline will be seen as meeting our improvement goal.	

Change Ideas

Change Idea #1 IPAC Safety Strategy

Methods	Process measures	Target for process measure	Comments
1. Pilot enhanced IPAC audit & feedback tool by end of Q1. 2. Build comprehensive IPAC screening reports leveraging EPIC. 3. Integrate IPAC Safety Champion roles within unit teams. 4. Design and implement comprehensive unit-based IPAC performance dashboard by end of Q3 incorporating preventive screening activities, HH, IPAC practice audit data and outbreak data.	% of units with safety champion role identified by end of Q3	Complete by Q1 Complete by Q1 50% of units Complete by Q3	

Measure

Dimension: Safe

Indicator #10	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Fall Rate per 1000 patient days on units conducting a standardized post-fall huddle.	C	Rate / All patients	Hospital collected data / 2021	6.13	6.12	Target has been set using the same approach as for our internal Corporate Performance Scorecard using the 2021 calendar year as the baseline (23.68). Any improvement over baseline will be seen as meeting our improvement goal.	

Change Ideas

Change Idea #1 Falls Prevention Strategy

Methods	Process measures	Target for process measure	Comments
1: Review/Revise Standardized Post Fall huddle process with stakeholder input. (June 2022) 2: Explore and streamline data collection points (September 2022) 3: Develop and implement enhanced auditing of the patient environment fall risk factors using mobile app. (June 2022) 4: Spread post fall huddles to other service lines (Subacute service line, and Inpatient Medicine Units). March 2023	# of units using standardized post-fall huddle form % of falls with completed post-fall huddles on implemented units. # of audit sets completed	100% of Sub Acute Service Line will use post fall huddle form. (Currently 50%) 60% of falls will have PFH completed 20 completed audits per month	

Measure

Dimension: Safe

Indicator #11	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Current state assessment of Just Culture at TOH	C	Proportion / Survey respondents	In house data collection / TBD	CB	CB	Collecting baseline	

Change Ideas

Change Idea #1 Patient Culture Survey & Just Culture Safety Assessment

Methods	Process measures	Target for process measure	Comments
1. Develop safety culture assessment method by end of Q1. 2. Conduct Just Culture scenario-based surveys and focus group discussions with Surgery service line by end of Q1. 3. Identify and plan patient safety pulse survey method – by end of Q2. 4. Launch patient safety pulse survey method by end of Q3.	Response rate on surveys. Complete 3 focus groups. Response rate on surveys.	Minimum 30% response rate on all surveys.	

Measure

Dimension: Safe

Indicator #12	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% staff and patient safety events closed within 30 days.	C	% / N/a	Hospital collected data / 2021	55.10	55.20	Target has been set using the same approach as for our internal Corporate Performance Scorecard using the 2021 calendar year as the baseline (55.1%). Any improvement over baseline will be seen as meeting our improvement goal.	

Change Ideas

Change Idea #1 Enhancing our learning systems for patient and staff safety

Methods	Process measures	Target for process measure	Comments
1. Rollout of communication and engagement strategy for the QPS Navigator and SLS Dashboard. 2. Identify and support low performers to improve performance. 3. Identification and implementation of Corrective and Preventative Actions based on incident review. 4. Share lessons learned from incident reviews with all TOH staff	1. # of views per week 2. # of unique users per week 3. # of overdue Corrective and Preventative Actions for critical and serious events 4. Lessons learned shared	1. 50 unique users by Dec 31 2. Maintain a minimum of 50 views per month. 3. 0 4. 4 per year	

Measure

Dimension: Safe

Indicator #13	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Repeat critical patient safety incidents (SLS) within 3 year period	C	Count / N/a	Hospital collected data / FY 2018/2019 to 2021/2022	0.00	0.00	Target is maintain a baseline of zero repeat critical safety incidents.	

Change Ideas

Change Idea #1 Enhancing our learning systems for patient and staff safety

Methods	Process measures	Target for process measure	Comments
1. Rollout of communication and engagement strategy for the QPS Navigator and SLS Dashboard. 2. Identify and support low performers to improve performance. 3. Identification and implementation of Corrective and Preventative Actions based on incident review. 4. Share lessons learned from incident reviews with all TOH staff	1. # of views per week 2. # of unique users per week 3. # of overdue Corrective and Preventative Actions for critical and serious events 4. Lessons learned shared	1. 50 unique users by Dec 31 2. Maintain a minimum of 50 views per month. 3. 0 4. 4 per year	

Equity

Measure

Dimension: Equitable

Indicator #14	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Understand culture of equity diversity and inclusion at TOH	C	Proportion / Worker	Local data collection / TBD	CB	CB	The objective is to explore measurement options to understand the culture of equity diversity and inclusion at TOH.	

Change Ideas

Change Idea #1 Equity, Diversity and inclusion strategy

Methods	Process measures	Target for process measure	Comments
1. Complete environmental scan for EDI at TOH 2. Execute 4 design jams in English and French by March 31, 2022, to understand current perceptions of diversity and inclusion amongst TOH stakeholder groups. 3. Analyze results of design jams by June 2022 and build an annual plan based on stakeholder feedback. 4. Select and initiate 1 initiative for each of the 5 pillars of focus based on the analysis of the design jams by June 2022.	1. Complete interviews and analysis of environmental scan. 2. Complete 4 design jams 3. Complete analysis of results and create action plan for 22/23 4. Hire EDI coordinator 5. Review outcomes of each initiative of the action plan.	1-4. End of Q1 4. End of Q4	