2019-2020 Quality Improvement Plan Workplan

Initiative	Indicator	Current Performance	Target	Methods
Improve patient flow on the Wards	1) The time interval between the Disposition Date/Time and the Date/Time Patient Left Emergency Department (ED) for admission to an inpatient bed or operating room. 2) Average number of inpatients receiving care in unconventional spaces or ER stretchers per day within a given time period.	1) 23.38 2) 37.33	1) 23.6 2) 37.6	1) Continue efforts to address discharge barriers collaboratively with post-discharge destinations, LTC, retirement homes, etc. 2) Continue to enhance a) daily flow structures (i.e. 'morning bed meetings') by: a) Including supporting service line leaders – and b) Shared accountability for patient flow by aligning leader performance metrics to include flow. 3) Revisit system level barriers by a) gap analysis of previous VSM efforts, b) prioritize and select top system level barrier to tackle, c) leverage PDSAs to affect.
Improve patient flow in the ED	The time interval between the Disposition Date/Time and the Date/Time Patient Left Emergency Department (ED) for admission to an inpatient bed or operating room.	23.38	23.6	1) Complete workshop to identify and prioritize solutions based on an analysis of problems identified through a large-scale survey and data extraction\analysis. 2) Design and implement a program and communication plan executed through PDSA cycles to decrease ambulance offload time at the Civic and General Campus by: a) Address the data gap between TOH and OPS data reporting and move towards utilization of a single source of data for measuring system performance.

				b) Define the process including roles and responsibilities. 3) Develop standard work and Key Performance Indicators for clinicians and leaders. Measure impact of initiative on flow metrics related to ED. 4) Explore city wide ambulance distribution rules to impact\smooth inbound demand. 5)Optimize service line accountability for pulling admitted patients from the ED.
Streamline triage process for subacute transitions	1) Average number of inpatients receiving care in unconventional spaces or ER stretchers per day within a given time period. 2) Total number of alternate level of care (ALC) days.	1) 37.33 2) 14.98	1) 37.6 2) 15.1	Streamline triage process for subacute transitions focusing on referrals for: 1. Hip fracture 2. Stroke 3. Flow from Geriatrics medicine to geriatrics rehab
Continued implementation of the Patient and Family Engagement Framework	Overall Rating of Experience - Inpatient surveys (% top box)	68.7	68.8	1) Systematic implementation of the patient and family engagement framework focused on development, implementation and evaluation of: a) Patients as Educators program (approval pending) b) Patients as Researcher Partners program (approval pending) 2) Continued engagement of patient advisors in decision-making related to strategic direction, patient and family education material and clinical and non-clinical processes.
Systematic Improvement of	Percentage of respondents who responded positively to the following question: Did you receive	64.7	64.8	1) Continue to standardize and streamline processes for creating or revising patient education materials.

Patient Education Information	enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?			2) Ensure health literacy best practices (patient feedback, clear language, clear design, adult learning principles, AODA compliance) are followed for each document or media type. 3) Train staff on health literacy best practices and on the process for creating/revising patient education materials. 4) Determine the best way to make documents available to patients.
Continued implementation of a Just Culture	Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.	429	479	Enhancements to safety learning system through: 1) Design and implementation of a 'shared lessons learned' approach around patient safety incidents. 2) Continue to educate leaders on our TOH method of Incident Investigation.
Continued implementation of violence in the workplace initiatives	Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.	429	479	1) Refining and spreading violence and prevention training strategy and delivery. 2) Continued promotion of reporting for frontline staff.
Enhancement of Patient Safety Monitoring Strategy	Hospital Standardized Mortality Ratio (HSMR – 2015)	82.4	82.3	1) Utilize EPIC's Patient Safety Monitoring dashboard to ensure hardwiring and compliance with new workflow processes and to collaborate with service line leadership and the fusion team to address gaps and challenges. 2) Design and implement a new nursing prevalence survey leveraging EPIC dashboards and reports to complement the bi-annual on unit surveys, and new nursing best practice and quality measure such as barcode compliance.

				3) Leverage new data, reports and dashboards available through EPIC to design and implement proactive learning processes and tools to improve quality of care and patient safety. 4) Engage stakeholders to determine and implement enhanced oversight and redesigned senior management committee for ongoing patient monitoring.
Implementation of Huddle Boards infrastructure and process	Hospital Standardized Mortality Ratio (HSMR – 2015)	82.4	82.3	Design and implement huddle boards and a daily quality safety huddle process that supports a culture of continuous improvement using a multiphase approach: 1) Basic infrastructure to provide support to TOH with Project Fusion as needed for go-live. 2) Transition design to support a Patient and Staff Safety and Quality Improvement huddle. 3) Incremental rollout.
Continued rollout of Operating Room Black box initiative	Hospital Standardized Mortality Ratio (HSMR – 2015)	82.4	82.3	Develop and pilot a comprehensive, standardized, structured and actionable set of teamwork behaviours to improve teamwork in the operating room (OR) and optimize surgical patient outcomes: (1) Identify an optimal set of specific OR teamwork behaviours that should be systematically applied. (2) develop a standardized set of actionable teamwork behaviours for the OR and combine these to create Team Improvement Project (TIP).

				(3) pilot TIP and test its acceptability among surgical patients, healthcare providers, and hospital decision-makers.
Optimization of process for identifying and assessing Palliative Needs	Proportion of hospitalizations where patients with a progressive, life-threatening illness have their palliative care needs identified early through a comprehensive and holistic assessment.	Collecting Baseline	Collecting Baseline	1) Establish a common understanding across partners of the tools used for identification of patients with a progressive, life-threatening illness and for assessment of their palliative care needs. 2) Identify opportunities to optimize patient flow and establish shared patient flow triage protocol across partners. 3) Gather baseline data across partners.