Let's Make Healthy Change Happen.

Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

March 22, 2016

SOUTHLAKE
REGIONAL HEALTH CENTRE

Ontario

Overview

This is an open communication to the Patients and Families in our community who we exist to serve in keeping with our philosophy to create the Ultimate Hospital Experience. Our intent is to share our Quality Improvement Plan (QIP) in an open and transparent declaration of our pursuit of Quality. Thank you for taking the time to find and read our QIP.

Every year we create a new plan and post it publically which is a part of our commitment to you. At Southlake Regional Health Centre (Southlake), we are committed to continuously improving the quality and safety of the care we deliver to Our Patients and the work environment we provide to Our People—staff, physicians and volunteers. Our QIP is an important element in our commitment to deliver *Shockingly Excellent Experiences* and our ability to achieve quality outcomes and create value in Healthcare.

The QIP provides the basis for our Corporate Quality Scorecard and every QIP indicator is included in our more comprehensive Corporate Quality Scorecard. In addition, each of our programs have developed or are in the process of developing, program scorecards whereby QIP elements for which they have an impact are included and monitored on a regular basis. We have also developed Corporate Scorecards for Our People and Our Financial Health and relevant indicators from the QIP are included within these corporate scorecards. Together, the three corporate scorecard results are full analyzed and discussed at minimum quarterly at all of our Leadership and Board Committees and each of us is held accountable to achieving the QIP outcomes through our personal Management Performance Plan process.

In addition to regular reporting and in order to ensure that all of Our People have access to the most up to date information in real time, we rely on our Business Intelligence System. With this system, our staff has the ability to drill down into each report card element to monitor portfolio or unit-level real time performance against our goals. At Southlake, we embrace our responsibility to ensure that each of us is aware of and actively pursuing our priorities.

Southlake will continue to work with its partners in the Joint Centres for Transformative Health Care Innovation (The Joint Centres) to share and adapt leading practices of direct relevance to large community hospitals to improve quality, patient safety, value and accountability in health care. The current spread projects that involve staff and physicians from the six member organizations including Markham Stouffville Hospital, Mackenzie Health, North York General Hospital, Southlake Regional Health Centre, St. Joseph's Health Centre and Michael Garron Hospital (formerly Toronto East General Hospital) will be strengthened based on monitoring and reporting on progress. Strategies to drive further improvement in Previous Joint Centres initiatives which will be continued include **reducing C-*difficile* infections, reducing C-Sections and reducing unnecessary tests through Choosing Wisely** and strategies to drive further improvement will continued to be identified and shared. In addition this year, a new spread project related to workplace violence prevention (WVP) will be undertaken in collaboration with all six hospitals. This initiative represents a commitment to creating secure, safe and healthy work environments for staff by leveraging the expertise of the member hospitals within the Joint Centres. Inclusion in each hospital's QIP signifies that the prevention of workplace violence is recognized as a key dimension of quality that directly impacts you, the patients and families we serve.

We are proud of the work we do, and we know that we can always do better. We would like to invite you to tell us about your experience with us, good or bad. Please share your thoughts on where we can improve and challenge us to do better because your voice is essential to our ongoing journey. As we encourage Our People to speak up, so do we encourage you and we commit to listening up and thanking your for taking the time to help us.

For the 2016/17 QIP, Southlake will focus our time and energy to achieving the following objectives:

A. **Reduce the rate of hospital acquired Clostridium Difficile Associated Infection (CDI) by 39 percent** (*decrease from 0.36 to 0.22 per 1000 patient days*).

As a community member who uses our services, you may not know about CDI and the importance of preventing this illness. We want you to be as safe as possible and to know that Hospital acquired CDI is caused by many different variables and is not always preventable, but there are some steps we can take to decrease CDI at your hospital. To you, the patient, this decrease that we are targeting would mean that seven less patients acquire CDI at Southlake this year. Please click on this link to learn more about CDI and what we can do together to keep you safe.

The reduction of CDI is also a Joint Centres initiative. Strategies to reduce CDI will continue by supporting our Antimicrobial Stewardship Program (AMSP) and by the use of a vapor spray technology to sanitize isolation rooms. In addition, Southlake will implement cleanliness auditing with the use of a tool called *Glogerm* to measure the effectiveness of our environmental cleaning and identify improvement opportunities.

CDI can spread on items that move between patient rooms including shared equipment. If you ever require isolation, the best practice is to dedicate equipment to your room. If sharing of this equipment is ever required, the hospital staff is required to disinfect it with a hospital grade disinfectant. Our goal is to minimize the movement of equipment in and out of these isolation rooms. We will achieve this goal by the use of a tracking system (asset tracking) and a daily review of reports which will allow us to better understand when equipment is being shared in order to make improvements as they become apparent.

B. Improve Hand Hygiene Compliance Before Patient Contact by 25 percent
(increase from 80percent to 100 percent)

You might not know that infections, including CDI, can spread on the hands of health care providers. It is important that we protect you by practicing excellent hand hygiene. Here is some information for you to read about the importance of hand hygiene and the role you can take in this important safety practice. Southlake's current hand hygiene compliance is 80 percent. In 2016/17, Southlake will again strive for a theoretical best practice of 100 percent organizational compliance. We will continue to report weekly on performance from both anonymous auditors and unit based auditors and target improvements based on this data. We would like you, our patients and family members to play an important role in improving out hand hygiene performance. We will develop a strategy to encourage "speaking up" by you, our patients and families to remind Our People to wash their hands prior to providing care. An important element of this strategy will be to work with Our People to invite you to play this role and to say "thank you," when you do remind us or ask us about our hand hygiene compliance before we provide care to you.

C. **Improve Medication Reconciliation compliance for patients at admission by 17.5 percent** (*increase from 68.1 percent to 80 percent received Medication Reconciliation*).

It is important that your health care providers know exactly what medications you are taking and to ensure any changes are accurately made. Accuracy in hospitals is facilitated by a process we call Medication Reconciliation. Medication Reconciliation is widely recognized as an important patient safety initiative and we know it can save lives. As such, Southlake is committed to exceeding the set target by ensuring the standardization of practice to attain Best Possible Medication History (BPMH), a precursor to effective Medication Reconciliation compliance. Best Practice Medication History is the activity by which we ensure that we ask you about your current

medications and we document the medications that you took prior to coming to the hospital. We will implement the use of a specially-designed form to ensure our practice is standardized and will audit compliance with these BPMH forms. Another important strategy is the introduction of Pharmacy resources into our peri-operative areas to educate and focus on the Medication Reconciliation process and will include the introduction of a new tool, the Best Possible Medication Discharge Plan to our care team.

D. Reduce HYDROmorphone, Fentanyl and Morphine medication incidents by 77 percent
(reduce the rate of related incidents per 10,000 dispenses from 2.1 (20 incidents) to 0.48 (5)).

HYDROmorphone, Fentanyl and Morphine are narcotics used in the hospital. They are very potent drugs that must be delivered to you exactly as ordered. Because they are so potent, the Institute for Safe Medication Practice and Accreditation Canada has both identified these drugs as "high alert medications". Although we have a very low rate of medication incidents at Southlake (those incidents that we have had cause either no or mild harm), historically, incidents related to these three high risk drugs represent 69 percent of all reported narcotic incidents. It is important that you know that for us, an "incident" includes all the activities including things like comparing the time the drug was given with the time the drug was ordered to be given. We have been on a three-year journey to make our practices safer and the indicator that we have been tracking has been improved along the way. Our journey began when the Board of Governors at Southlake requested that we include an initiative relative to the safety of these high alert medications. We began by monitoring one drug HYDROmorphone and we instituted the practice of an independent double check every time this medication was given. An independent double check means that two professional staff independently checks it is your exact order and your exact dose. If you are ordered any of these three high alert medications, we will ensure we complete an independent double check before we give you're your medication in the hospital. Other improvements included the investment in Accudose dispensers that automate part of the medication administration process. Technology helps our team ensure your medications are accurately given. This year we monitor all three high-risk medications and, in addition to an awareness campaign, and in order to improve our performance, we intend to perform a monthly compliance audit of our 24 hour medication check process. This means that your medications will be checked against what is ordered every 24 hours. With these interventions, we target ZERO preventable errors.

E. Maintain/Reduce ER Wait Times (For Inpatient Bed)
(maintain current performance 30 hrs.)

It is important to us that you are seen in the Emergency Department in a timely manner and that your time to transition to an inpatient bed upon admission is as short as possible. We are pleased to report to you that, for the last three years in a row, we have been recognized in the Province as the best performer for how quickly patients are seen by a physician upon arrival; although less than 10 percent of our more than 100,000 visits to the Emergency Department every year require admission. However, we do recognize that if you need to be admitted, the time to get you or your loved one to an inpatient bed is too long. We know that all the things that contribute to the availability of beds in a hospital is complex and often being able to move patients out of the hospital contributes to your bed being made available. However, at Southlake, we know there are things we can do to improve your wait time for a bed too. Sometimes, waiting for laboratory and other results can contribute to delays. To reduce your wait time for results, we will implement bedside testing for some laboratory tests. This is called point of care (POC) testing. We will target a rate of 100 percent of eligible tests completed at the bedside in our ED. By shortening the time you wait for test results, this initiative will decrease the time you stay in the emergency room until your bed is ready.

F. Improve Patient Satisfaction in the Emergency Department
(baseline to be determined)

We are passionate about the feedback we receive from you and make it a priority to use this feedback to improve the care we provide. We are proud that your feedback indicates that we are the third best performer for Patient Satisfaction in our group of hospitals that see more than 75,000 patients a year – however, we recognize that you deserve better. That is why we plan to continue to provide you with *Shockingly Excellent Experiences* and strive to further improve. You have told us that our volunteers at Southlake really make a difference in your stay. That is why we will change our model of care in the Emergency Department to include dedicated volunteers alongside our nursing staff to assist in meeting your needs in real time. We will also ensure that we keep you informed through the use of White Boards and the introduction of bedside shift reporting.

G. Reduce Unnecessary Hospital Readmissions for Congestive Heart Failure (CHF) by 10 percent
(reduce from 18.9 percent to 17.0 percent)

We want to make sure that your needs are taken care of in a way that will allow you to safely remain in the community and prevent unnecessary (preventable) readmission to the hospital after you go home. A review of all of our data shows us that if you are a patient with Congestive Heart Failure, we can do better to ensure your successful transition to home following a stay at the hospital. We know that sometimes, as your health changes it is important that you are readmitted to the hospital but we also know that sometimes, we could do a better job working with you and your health team in the community to keep you safely out of the hospital. Our focus will be on reducing readmission to Southlake. Our plan is to improve your ability to manage your condition in the community after discharge by the provision of a transitional care package to you which will include a referral to Health Links. Health Links is a special program sponsored by the Ministry of Health with the sole focus of working with you, your family and your health team (doctors, pharmacists etc.) to make sure we are working all together to do everything we can to keep you healthy in the community. In addition to Health Links, you also may need some care in the community to be arranged quickly after your discharge from the hospital. Thus, we will improve our referral rate to the Community Care Access Committee (CCAC) rapid response team which will provide you with the early assistance in the community that you need.

H. Reduction of Incidence of Workplace Violence that Result in Lost Time by 100 percent
(reduce from 4 incidents to 0)

Southlake has been on a three-year journey to become the safest hospital globally. As a recognized leader in providing a safe workplace Southlake will share our learnings so far with our Joint Centres partners all the while continuing to improve on our quest to become the safest hospital. Southlake, through its work with its partners in the Joint Centres for Transformative Health Care Innovation (The Joint Centres) has added a new spread project related to workplace violence prevention that will be undertaken in collaboration with all 6 hospitals. This initiative represents a commitment to creating secure, safe and healthy work environments for all Our People by leveraging the expertise of the member hospitals within the Joint Centres. Inclusion in each hospital's QIP signifies that the prevention of workplace violence is recognized as a key dimension of quality that directly impacts patients and families. Our strategies for improvement include a focus on improving our staff completion rate of Non-violent crisis intervention training as well as improving the rate of completion of violence risk assessment checklists. Overall, it is our desire to provide Our People and you, our patients and families with the safest hospital possible.

In conclusion, it is our desire to continue to identify, develop and deliver quality initiatives which will improve the care we deliver to you. Southlake's 2015/16 quality improvement objectives reflect our strategic plan and our goal to be recognized as a performance leader in the delivery of safe, quality healthcare services, embracing the principles of High Reliability Healthcare. Our chosen QIP indicators are aligned with our Hospital Services Accountability Agreement (H-SAA), obligations under the Ministry's Pay-For-Results program, the Health System Funding Reform (HSFR), and Accreditation Canada's standards. Ultimately, our quality improvement objectives are set in order to keep our promise to you and our community to deliver "Shockingly Excellent Experiences."

QI Achievements from the Past Year

Southlake has four-Corporate Scorecards: Corporate Quality, Finance, Our People and Capital Projects. The Quality Improvement Plan is a subset of the more comprehensive Corporate Scorecard. Although we have made many achievements on our scorecard metrics, Health Quality Ontario has requested that we highlight one on our QIP. We have chosen to highlight, and are proud of, our Prevention of Pressure Ulcers (bed sores) Journey.

Last year, one of our priorities was to reduce the percent of patients with new pressure ulcers stage two or higher by 39 percent
(Decrease from 6.4 percent to 3.9 percent).

We have achieved an impressive improvement of 52 percent in our rate of new pressure ulcer incidence and we were able to exceed our target with a rate of 3.1percent last year. This means that since 2013, we have improved from a rate of 8.1 percent (42 patients) to an impressive 3.1percent (13 patients). What this means to you is that we potentially prevented 29 patients from developing a pressure ulcer in the last year alone. Although we were worried that our target for 15/16 (3.9 percent) was perhaps not achievable, we decided on this aggressive goal because we recognized the importance of this safety initiative and the negative impact of this complication on your health and wellbeing.

We took the time to fully understand our performance by investigating our data and high performing units during this time. Our change ideas included a focus on hourly rounding and increasing the number of nurses who have completed the Nurse Certificate Program in Pressure Ulcer Staging. We also implemented a chart audit for all patients who develop a pressure ulcer (stage 2 or greater) in order to identify trends and system improvement opportunities and to target interventions based on findings. Another opportunity recognizes the lack of a Canadian acute care benchmark. We engaged with peer hospitals to share our quarterly incidence methodology and to share and compare incidence data in order to benefit from identified improvement opportunities. In 2013, we implemented the use of heel boots for patients at risk for heel ulcers. With this intervention, we achieved ZERO heel ulcers and we continue to stress this important strategy.

Even though we had achieved such success, we continued to look for opportunities. Our Board and Governance structure actively uses information about the quality performance of the hospital to make resource allocation decisions and to set priorities. Because we set the reduction of pressure ulcers as a priority at Southlake and we were passionate about reaching our target of 3.9 percent, our Board made the decision to invest in bed surfaces and new beds to help address pressure ulcer reduction targets. With this most recent improvement we will further improve the quality of care we provide to you, our patients.

Integration & Continuity of Care

Southlake's 2016/17 Quality Improvement Plan is aligned with Southlake's strategic directions, *"Create the Ultimate Hospital Experience, Transform Healthcare Relationships and Seek and Share Better Solutions".* Southlake has incorporated the Ministry of Health and Long Term Care priorities of integration and continuity, by designing improvement strategies which demonstrate Southlake's commitment to work with our system partners to achieve improved quality, both within and beyond hospital walls. Examples include: a strong partnership with CCAC to reduce the number of Alternate Level of Care (ALC) days (days spent in acute care beds that no longer require acute care resources) and a strategic initiative in partnership with CCAC to LEAN transitions to community, a reduction in unnecessary hospital admissions through our Health Links commitment, and Medication Reconciliation involving community pharmacies. Feedback from our patients and data from our staff satisfaction surveys have helped us to develop our QIP and identify our priorities.

Southlake supports a philosophy called "There Is No Place Like Home" targeted at providing ALC patients, often with complex conditions and multiple comorbidities, with the supports they need to go home and stay well at home. Creative individualized care plans are often required to enable these patients to stay at home, challenging our teams to work closely with our community partners and agencies to support these patients and their families. When you do require hospitalization our goal is to have a length of stay at the 25th percentile and a comprehensive plan in place to enable a successful transition home. Readmission rates are our countermeasure metric which ensure we are safely transitioning our patients to home. A key to our success is a solid plan, established in partnership with you and your family, truly demonstrating our commitment to patient centered care.

As the lead organization for South Simcoe Northern York Region Health Link (SSNYRHL), Southlake Regional Health Centre, facilitates a coordinated, integrated care delivery model for our complex patients. The advanced Health Link population includes the top 5 percent high cost users, patients with four or more chronic / high cost conditions, with an additional focus on mental health, addictions, palliative, frail elderly and the social determinants of health.

Working with over 20 community partners that include health service providers, other community partners and the Central Community Care Access Centre, the goal is to improve timely, coordinated access to care, the development of coordinated care plans that include patient goals, access to primary care and to reduce both Emergency Room visits and hospital stays. As of January 2016, 206 patients have been enrolled with the South Simcoe and Northern York Region Health Links program since April 1, 2015. Currently the SSNYRHL is participating in a pilot project using an electronic version of the Coordinated Care Plan that has the ability for Health Service Providers involved in your care to either author or view the patient's plan. An active Patient Advisory Council with CCAC has been established comprised of both patients and caregivers; working to advise and co-design coordinated care plans and a patient experience survey. Our goal is to ensure 20 patients have coordinated care plans per month.

We have also collaborated with Health-links for prevention of readmission for patients. Discharged patients are provided with an education package to improve self-management in the community and to ensure appropriate community support, including a referral to Health-links as appropriate. We have also collaborated with CCAC to ensure appropriate referral to the CCAC rapid response team.

The Mental Health Department conducts Plan/Do/Study/Act (PDSA) rounds daily – patient rounds with community partners present to expedite transitions to community services and systems. All potential community partners have been identified to assist with the "high users" of the Emergency Department in order to participate in the transition planning and connect them with appropriate community services to support autonomy and optimize at home recovery. In addition, a rapid response working group with community partner services, including the police, will be starting soon to focus on patients with high mental health needs.

Engagement of Leadership, Clinicians and Staff

In the creation of our 2013 – 2018 Strategic Plan, we engaged with thousands of internal and external partners via surveys, focus groups, workshops, planning summits, and face-to-face interviews to better understand their visions for healthcare. We also mined through satisfaction results and feedback reports. Through this engagement process, we have been able to create a document that we believe truly reflects the needs, opinions, feedback, and ideas of the many individuals that we are privileged to serve: Our Patients, Our People, Our Partners. In the development of our Individual Management Performance Plans, our leaders come together to openly discuss our hospital priorities, including QIP priorities, and ensure that our annual goals are aligned in achieving our targets. During the development of this year's QIP, we engaged multiple groups including the various program teams; the Medical Advisory Committee, the Administrative Management Committee, our Quality Utilization Resource Management Committee, the Patient Care Leadership Committee, the Board Committee on Quality and our Corporate Patient and Family Advisor Committee.

The priorities of our patients and our partners — as defined through our engagement process — are the cornerstone of our strategic vision and Southlake's QIP. To achieve success, we regularly engage Our People in monitoring and acting upon the related metrics. For example, time from each weekly leadership meeting is devoted to understanding and evaluating each metric. All of our QIP priorities are tracked on the Quarterly Corporate Performance Scorecard, which is regularly monitored and reported on. Our Business Intelligence Tool (HBI) is available to all and makes visible real time performance metrics for ongoing referral and action and is regularly monitored and reported on. Southlake's top priorities are also displayed on every computer home screen as a visual reminder about our current performance and targets. Each of these priorities has a lead assigned that continually updates information and works with stakeholders to carry out improvement plans and to constantly seek new solutions. These priorities are cascaded throughout all levels of our leadership team through our Management Performance Plan methodology which ensures that each of our annual goals is aligned in achieving our targets.

Patient/Resident/Client Engagement

Through our engagement strategy in the development of our 2013 – 2018 Strategic Plan, we were able to identify your priorities. We spoke to thousands of our community members via surveys, focus groups, workshops, planning summits, and face-to-face interviews. We also combed through satisfaction results and feedback reports. As already noted, Southlake's 2016/17 Quality Improvement Plan is aligned to Southlake's three strategic directions created through this engagement process; *"Create the Ultimate Hospital Experience, Transform Healthcare Relationships and Seek and Share Better Solutions".*

Our Board Committee on Quality has been involved since early October with the development of our QIP and the community membership ensures the patient perspective is embedded in the final result. For example, your feedback and experience around the impacts of developing a pressure ulcer have driven us to pursue an aggressive performance target and campaign to reduce their incidence.

Our patient satisfaction surveys and discharge phone calls provide a valuable source of information as we strive to embed your voice in our improvement efforts. One important opportunity we heard from you is that "time really counts". In the Emergency Department (ED) in particular, wait times are reflected as important to satisfaction. Because of this, ED wait times are a regular feature in our daily/monthly reporting and are even monitored in real time. Against our peer hospitals of similar volumes, we rank at the 90th percentile for percent positive score in the overall rating of care and believe this is largely the result of our very short time to physician initial assessment.

At Southlake, your voice is heard through the Corporate Patient and Family Advisory Council (PFAC) which serves as a forum for patients and family to partner with Our People to provide input and influence on how to improve the patient experience. This Council reports to our Ultimate Patient Experience Steering Committee whose purpose is to support Southlake in honoring its core commitments, strategic goals and objectives for creating the Ultimate Hospital Experience. This committee fosters a culture where our Value of "Putting Patients First" is recognized in everything we do, and that from the patient's perspective there is "Nothing about me without me". Our drive to achieve our Quality Improvement Plan goals for 2016/17 will be supported by these important groups of dedicated staff and patients/family. A good example of this approach is our Inter-professional Model of Care project which will involve patient and family councils.

The Corporate PFAC had significant input into the change idea for the Hand Hygiene indicator. They wanted to find a way to influence the ability of the patients in speaking up when a staff member had forgotten to perform hand hygiene. This will result in the creation and roll out of a corporate strategy, building on our Speak Up Value, to encourage and invite reminders and to thank patients and families when they are received.

Performance Based Compensation [part of Accountability Management]

For Executives and all Management Staff at Southlake:

1. Total variable pay linked to performance based compensation aligning to requirements in the *Excellent Care For All Act* (ECFAA) plus the Management Performance Plans to be 10 percent of base salary.

2. Forty percent of the total variable pay will be linked specifically to achievement of the QIP component of the overall Management Performance Plan.

3. Forty percent of the total variable pay will be linked to achievement of the additional operational objectives aligned to Southlake's strategic goals and identified in each individual's Management Performance Plan.

4. Twenty percent of the total variable pay will be linked to achievement of personal development objectives as outlined in each person's Management Performance Plan.

5. The forty percent allocation linked to the QIP will be calculated utilizing the following terms:

    - All QIP indicators will be linked to variable pay
    - Achievement will be based on the percentage completed toward the targeted goal
    - Under-achievement from 'current' will result in a negative percentage achievement.
    - Over-achievement from targeted goal will result in a score greater than 100 percent
    - The QIP indicators are ranked as Improve or Maintain in the 16/17 QIP
        - The QIP indicators to be improved will be weighted x 2
        - The QIP indicators to be maintained will be weighted x 1
        - The calculation of all QIP indicator with the weightings will provide for a percent achievement of 100 percent
        - The percent achievement will be used to determine the percent of the performance-based pay related to the QIP component of each individual's Management Performance Plan.

Once again, thank you for reading our QIP. We are proud of the work we do, and we know that together we can always do better. Please don't hesitate to tell us about your experience with us, good and bad. We embrace the opportunity that your feedback represents.

Sign-off

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan

Jonathan Harris
Board Chair

Colette Nemni
Quality Committee Chair

Dr. Dave Williams
Chief Executive Officer

2016/17 Quality Improvement Plans for Ontario Hospitals

Improvement Targets and Initiatives

SOUTHLAKE REGIONAL HEALTH CENTRE

Southlake Regional Health Centre, 596 Davis Drive, Newmarket, ON L3Y 2P9

Lower is Better
Higher is Better

30-Mar-16

AIM		MEASURE					CHANGE				
Quality Dimension	Objective	Measure/Indicator	Current Performance	Target for 2016/17	Target Justification	Priority	Planned improvement initiatives (Change Ideas)	Methods	Process Measures	Goal	Comments
	Reduce hospital acquired infection rates	**CDI rate per 1,000 patient days:** Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1,000 - Current Performance Jan-Dec. 2015, consistent with publicly reportable patient safety data	0.36	0.22	We are not meeting 15/16 target. Currently 0.36 (Jan-Dec). Our peer group (>7,500 monthly patient days) includes 18 large community hospitals with an average of 0.31 April - Aug.	Improve	Minimize the unplanned movement of shared equipment in and out CDI isolation rooms	Daily review of asset tracking reports	Number of unplanned equipment moves	0	Anytime a CDI patient leaves a room (example – for a medically required diagnostic test), there should be IPAC notification and planning. Tracking this indicator will help us to close gaps in a focused manner as they become apparent.
							Monitor environmental cleanliness	Introduction of Glogerm audit process	Percent positive results	95%	
							The reduction of Cdiff rate is a Joint Centres of Innovation Initiative				
	Improve provider hand hygiene compliance	**Hand hygiene compliance before patient contact:** The number of times that hand hygiene was performed before initial patient contact divided by the number of observed hand hygiene indications multiplied by 100 - Current performance Jan-Dec. 2015, consistent with publicly reportable patient safety data.	80%	100%	Not meeting target. In 15/16 we introduced anonymous auditors. 5203 audits were done by unit champions and 4560 by anonymous volunteers.	Improve	Improve the frequency with which patients and families are encourage to "Speak Up" and remind staff to wash their hands prior to providing care.	Using the "Ultimate Patient Experience Survey" question: "Were you invited to remind staff to wash their hands if they forgot?"	Percent positive score	90% minimum	We do not currently have a baseline.
							Anonymous volunteer (secret shopper) audits commenced on Cardiac, Medicine and Surgery with differential between secret shopper and unit-based auditor ranging from 15-27%. Impact of introducing secret shopper resulted in a 5% compliance rate reduction and for the 3 areas where secret shopper introduced the impact was a 12% reduction. Continue to target theoretical best.				

AIM		MEASURE					CHANGE				
Quality Dimension	**Objective**	**Measure/Indicator**	**Current Performance**	**Target for 2016/17**	**Target Justification**	**Priority**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process Measures**	**Goal**	**Comments**
Safe	Reduce incidence of new pressure ulcers	**Percent of patients with new pressure ulcer (stage 2 or higher)**. Current Performance FY 15/16 YTD Q3. Include adult acute care, complex care and rehab patients.	3.1%	3.1%	We are currently meeting target and have steadily improved from 8.1% FY2013 to current performance 3.1%. Our plan is to maintain performance	Maintain	Continue implementation of corporate bed plan	Purchase process	Number of beds/mattresses delivered and in use ending fiscal year	Roll out per Corporate Bed Plan	
							Continued compliance with use of heel boots	Use of heel boots	Number of heel ulcers	0	
							Canada wide study of pressure ulcer prevalence from a leading medical supplier of beds in 2014 with 58 care facilities in Canada of which, 77% were from Ontario and included a total 6,059 patients indicated 6.8% of patients with a facility acquired pressure ulcer (excluding stage 1 and within a census size group of 300-399 patients) which is more than double our current and targeted performance.				
	Increase proportion of patients receiving medication reconciliation upon admission hospital wide	**Medication reconciliation at admission:** The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital. Current Performance 15/16 Q3 YTD.	68.1%	80%	Current target not met. We have made an investment in the Peri-op program related to Med Rec at discharge (target 100% roll-out across the organization within 4 years).	Improve	Optimize BPMH for Mental Health (MH) patients in the new ED renovated space in order to increase % of patients with Med Rec initiated though the BPMH	Compliance audit focus MH patients	Percent BPMH completion	100%	MH is recognized as an with the greatest opportunity for improvement
							Investment of Pharmacy resources in the peri-operative areas to facilitate education and focus on the med rec process	Recruitment and adoption of new tools (BPMDP) Best Possible Medication Discharge Plan.	Implementation and adoption of new tools	100% staff and Physicians	See below
							We believe this will positively impact our performance on Med Rec on admission across the hospital. The surgical program is 34% of admissions. It was determined that Periop with achieving 100%, the hospital would achieve 80%.				
	Reduce Narcotic medication incidents	**Rate of related reported medication incidents (excluding near-miss) per 10,000 Narcotic dispenses (HYDROmorphone, Morphine, Fentanyl) measured monthly:** Current Performance Q3 YTD15/16	2.1	0.48	Majority of reported incidents occurred on one unit. Our rate excluding this unit is 0.48. Our improvement strategy would focus on this unit. This rate, translates into 5 incidents corporately and we are currently at 20, represents an aggressive target.	Improve	Monthly audit of the 24 hour chart check	Compliance audit	Percent of that should have been caught by 24 hour chart check	0% preventable errors	The 24 hour chart check is a recognized safeguard measure to ensure early detection of errors and omission of orders.
							This indicator reflects the rate of reporting. The overall intent of this indicator is to focus the institution on high-alert medication safety. The indicator itself has undergone a CQI process over three years. (e.g. the first indicator measured compliance with Independent Double Check for HYDROmorphone). We are committed to medication safety and further refining measures.				
Timely	Reduce wait times in the ED	**ER Wait times:** 90th Percentile ER length of stay for Admitted patients. Jan - Dec 2015, iPort	30 Hrs	30 Hrs	The 16/17 H-SAA is not available till June 2016. Target is based on maintaining current performance.	Maintain	Implementation of Point of Care testing to reduce wait time for results and overall reduction in LOS	Implementation of bedside testing for select investigations	Percent of completed Point of Care tests	100% of eligible POC tests	
							For Ontario ER's classified as "very high volume" (greater than 85,000 annual visits) there are 7 facilities in this group. Southlake ranks 2nd at 30.2 hrs (Jan-Oct 2015), with the top ranked facility @ 28.7. The range for all 7 is 28.7 to 51.1 hours. (Jan-Oct 2015 P4R ranking report)				

AIM		MEASURE					CHANGE				
Quality Dimension	Objective	Measure/Indicator	Current Performance	Target for 2016/17	Target Justification	Priority	Planned improvement initiatives (Change Ideas)	Methods	Process Measures	Goal	Comments
Patient-centred	Improve patient satisfaction	**Percent positive score:** "Overall, how would you rate the care you received in the Emergency Department?" (question from NRC Picker) Current Performance Oct 2014 - Sept 2015. (12 months baseline per HQO guideline)	85.1%	CB	Our current performance does not meet 15/16 target (87.2%). We are transitioning to a new survey scoring format for 16/17 and will develop a target after collecting baseline data.	Improve	Improve our ability to enhance the patient experience in real time	Change in model of care to include dedicated volunteers alongside the nursing staff to assist in the patients needs	Number of volunteer hours dedicated to this service	TBD (based on available hours)	
							Provide appropriate experience enhancing information to the patient (Via White Board) and bedside shift report in acute and subacute	Audit of bedside shift report and use of white boards	% of time white board utilized & % of time bedside shift report is utilized	100%	Need to gather baseline
							Southlake is at 88th Percentile and ranks 3rd out of our 15 peer community hospitals. Only two hospitals North Bay at 100P (score 89.3%) and Peterborough at 94P (score 88.7%) are within the 90 percentile.				
Effective	Reduce unnecessary hospital readmission	**Readmission within 30 days for selected HBAM Inpatient Grouper (HIG) to Southlake only**: Percentage of acute hospital inpatients discharged that are readmitted for non-elective patient care within 30 days of the discharge for index admission. Current Performance FY14/15	12.8%	12.8%	Target to sustain.	Maintain	Currently meeting target with performance of 9.9% (based on CMG). This is a newly defined indicator based on HIG. Actual performance based on HIG is 12.76%. In order to monitor the impact of changes and to review more timely data, we monitor readmissions to Southlake only.				
		Readmission within 30 days for selected HBAM Inpatient Grouper (HIG) to any acute hospital: Percentage of acute hospital inpatients discharged that are readmitted for non-elective patient care within 30 days of the discharge for index admission. Current Performance Ju l2014-Jun 2015	15.0%	15.0%	Target to sustain.		We have maintained 14/15 performance within target and below the Ministry "expected" ratio for this new HQO Priority Indicator . (The "expected" is customized to each hospital's data by the Ministry, SRHC expected rate is 16.56%).				
		Risk-Adjusted 30-Day All-Cause Readmission Rate: (any Acute hospital) for CHF: As defined for quality-based procedure (QBP) Current performance Jan - Dec 2014	24.4%	22.0%	Incremental improvement of 10%	Maintain	We do not receive timely information (8-10 months lag) therefore this is not data that we can impact within the QIP timeline. The principals of a quality indicator should include the use of real time data. As a high reliability organization, we have adopted this principle and have developed the custom indicator "to Southlake only". "Expected" readmission rate is 23.19% and is suggested as target by the Ministry. We have achieved better than 10% on other CMG's therefore we will target a 10% improvement. We will explore the potential impact of the regional system and planned readmissions.				
		Risk-Adjusted 30-Day All-Cause Readmission Rate (Southlake only) for CHF: As defined for quality-based procedure (QBP) Current performance Apr-Oct 2015	18.9% Non-risk adjusted	17.0%	Used the incremental improvement rate (above) to determine target.	Improve	Education of CHF patient to improve self management of condition and to ensure appropriate community support including referrals to Health-links programs as appropriate.	Provision of "transitional care package" to patient and referrals to CCAC	Percent eligible patients receiving package	100%	Note: this indicator is <u>not</u> risk-adjusted (the methodology is not provided). This means that the Southlake target which is <u>not</u> risk-adjusted is more aggressive than the 'expected rate' provided by the MOHTLC.
							Referral rate for patients meeting criteria for CCAC response	Referral rate	% of eligible patients that received referral	100%	

AIM		MEASURE					CHANGE				
Quality Dimension	Objective	Measure/Indicator	Current Performance	Target for 2016/17	Target Justification	Priority	Planned improvement initiatives (Change Ideas)	Methods	Process Measures	Goal	Comments
Efficient	Reduce unnecessary time spent in acute care	**Percent ALC acute days:** Total number of ALC inpatient days contributed by ALC patients within the specific reporting period (open, discharged and discontinued cases), divided by the total number of patient days for open, discharged and discontinued cases (Bed Census Summary) in the same period. Current performance FY15/16YTD Feb.	12.48%	12.20%	The CLIHN proposed 16/17 target is 12.2%, provincial performance is 13.91%	Maintain	In 2010, Southlake invested in a daily utilization tool that separates out community versus hospital reasons for ALC. In 2010/11, 26% of all ALC days at Southlake were attributable to 'hospital reason'. Southlake initiated a quality improvement initiative to decrease ALCs for 'hospital reasons'. Southlake achieved 0% ALC rate for hospital related reasons in fiscal 13/14 and has sustained a 0% hospital related ALC rate since that time. Southlake tracks the hospital related reasons daily with a target to maintain the 0% rate. Southlake continues to work with the CLHIN and the CCAC to identify and implement initiatives which can decrease the ALC days related to community wait reasons.				
		Percent ALC days: Total number of acute inpatient days designated as ALC in acute care beds due to "Hospital Reasons" divided by the total number of inpatient days. Current performance FY15/16 Q3YTD	0.0%	0.0%	Target to sustain.	Maintain					
Equitable	Improve awareness of people changes & optimize knowledge retention through analysis of Turnover	**Staff Annual Voluntary & Involuntary Turnover Rate:** The number of employees (ONA, SEIU, OPSEU, Non-Union, Management) leaving Southlake during the period divided by the total workforce annualized. Includes both voluntary and involuntary resignations and retirements. OHA definition and bench marking criteria used. Current Performance FY 13/14	5.7%	8.6%	OHA 75th percentile	Maintain	Although our current performance is 5.7% we are comfortable with a rate of 8.6% which is the OHA 75P 16/17. We understand that turnover is a healthy indicator of a High Reliability organization.				
	Reduction in incidents of workplace violence	**The number of workplace violence incidents that result in lost days** is a count of the number of violent incidents in which an employee has lost more than the day of the actual incident (also known as a lost time incident). Current Performance FY15/16 Q1-Q3	4	0	Theoretical best practice of zero	Improve	Staff Training - Non-Violent Crises Intervention Training in high risk designated areas.	Mandatory Training	Percent of staff completion	100%	
							Patient identification and assessment	Completion of Workplace Violence Risk Assessment checklist	Percent completion of violence risk assessment checklist	100%	
	Timely completion of recommendations	**The percent of completed or on target** recommendations of Incident Management/ (Quality Care Committee) QCC reviews	98%	100%	Target 100% recommendations complete or on target as designated by QCC.	Improve	Quarterly review of recommendations past due by the QCC	Ensure that when there are any recommendations past due date that there is a consultation with the QCC to acknowledge and approve any extension – extensions to include action plans	% of recommendations with revised due dates that have QCC approval and action plan	100%	