Let's Make Healthy Change Happen.

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

For Approval

SOUTHLAKE REGIONAL HEALTH CENTRE

3/13/2018

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a Quality Improvement Plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein.

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 *excellent patient and staff 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 there. In addition, each of our programs has developed or is 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 results of the three corporate scorecards are fully analyzed and discussed at minimum, quarterly, at all of our Leadership and Board Committees and each of us is held accountable to achieve 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 (Joint Centres). The Joint Centres is a partnership between seven large community hospitals comprised of Humber River Hospital, Mackenzie Health, Markham Stouffville Hospital, Michael Garron Hospital, North York General Hospital, Southlake Regional Health Centre and St. Joseph's Health Centre. The objectives are to: seek and share innovative ideas that improve service delivery and / or value across the system, serve as a living laboratory to demonstrate innovation, provide a forum for the rapid execution of new ideas, technologies, products and processes to improve system performance and create opportunities for shared innovation, learning and knowledge transfer among the member organizations, their staff and physicians.

The Joint Centres hospitals have worked on a number of improvement initiatives that have focused on clinical and administrative process changes designed to improve care through collaboration and innovation. Past projects include reduction of C-*difficile* infections and reduction of Cesarean sections (C-Sections) which, as of 2017-18, have moved into a sustainability and monitoring phase at each hospital, supported by the Joint Centres communities of practice. In addition, Choosing Wisely, an Adopting Research to Improve Care (ARTIC) Program supported project, has targeted that the reduction of unnecessary tests will conclude at the end of March 2018.

Active projects that the member hospitals will continue to collaborate on in 2018-19 include:

- the prevention of workplace violence through development and implementation of a common approach to risk identification and care planning (alert for behavioural care protocols and processes)
- the reduction of harm classified as never events beginning with prevention and management of pressure injuries through awareness raising, reliable application and auditing of an agreed upon set of always events and patient and family engagement

These on-going projects continue to reflect the commitment of the Joint Centres hospitals to working together to develop, implement and spread leading practices and innovative solutions to improve care for the patients and families they 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 to speak up, and we commit to listening up and thanking you for taking the time to help us.

For the 2018/19 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 27 percent

(*Decrease from 0.3 to 0.22 per 1000 patient days*).

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. This decrease that we are targeting would mean that 9 less patients acquire CDI at Southlake this year. One of the strategies Southlake will pursue is enhanced cleaning and de-cluttering in high priority areas and performing scheduled vapor spray technology to further sanitize these areas. Additionally, the environmental services team will continue the quality assurance auditing using the Assure product to measure the effectiveness of our environmental cleaning and identify improvement opportunities.

B. Reduce the Number of Patients with Hospital Acquired Pressure Injury by 32%

(Reduce from 4.1 percent to 2.8 percent)

A pressure injury, sometimes called a bedsore, is an injury to the skin or underlying tissue caused by pressure, friction and moisture. These injuries often occur when patients have limited mobility and can't change position in bed on their own. When pressure injuries occur they must be treated quickly or they can damage the skin and underlying tissue, causing slow recovery, pain, infection and other

problems. Almost all pressure injuries are preventable and, in fact, hospital acquired pressure injuries (stage 3 or higher) are considered Never Events. At Southlake, all our providers are trained in pressure injury prevention. There are many interventions used to prevent this condition such as assessing individual patient risk, providing good skin care, regularly assisting patients to change their position and using pressure reducing cushions, mattresses, and heel boots. We were successful in reducing pressure injuries from 20% in 2012 to 3.1% in 2016. However, we have noticed that we did not meet the target performance of 2.8% in 2017/18 and want to achieve this goal in 2018/19. As a member of the Joint Centres for Transformative Health Innovation, our plan is to implement the strategies developed by the "Joint Centres Pressure Injuries" Working Group. Additionally, we will ensure appropriate education related to pressure injuries is in place for all clinical staff.

C. Improve Medication Reconciliation compliance for patients at admission by 3.7 percent

(*Increase from 86.7 percent to 90 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.

BPMH is the activity by which we ensure we ask you about your current medications and document the medications you took prior to coming to the hospital. We will review the data collection process to ensure our practice is standardized and will audit compliance appropriately. Another important strategy is to continue collaborative efforts to further improve the Med Rec process in the Mental Health department.

D. Improve Medication Reconciliation compliance for patients at discharge by 17.4 percent

(Improve from 57.8% to 70% compliance corporately)

When you are discharged from hospital often changes will have been made to your medication that you were taking prior to your admission. It is important that you know what medications you should be taking when you return home and we ensure this by performing medication reconciliation on discharge. We monitor this process by checking the number of patients who had a Best Possible Medication Discharge Plan (BPMDP) created. This is a multi-year plan to achieve 100% compliance by 2020. This year we will focus on rolling out the implementation plan across the organization and pilot a workflow based redesign to improve the documentation process.

E. Reduce ER Wait Times for Patients with Complex Conditions by 10% percent

(Reduce from 14.2 hours to 12.8 hours)

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 four 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 that even though there has been a significant amount of work to improve flow there are still things we can do to improve your wait time for a bed. We intend to understand more about these opportunities by conducting a LEAN event and striking a working group to improve ED consult time by physicians.

F. Improve Patient Satisfaction in the Emergency Department by 5 percent

(Improve from 55 percent to 58 percent)

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 we are performing well for Patient Satisfaction in our group of hospitals that see more than 75,000 patients a year – however, we recognize that you deserve better. You have previously told us that our volunteers at Southlake really make a difference in your stay. That is why we changed 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 ensure that you are kept informed during your stay through the use of White Boards and the introduction of bedside shift reporting. A real time ED feedback process was implemented in Q3 of 2017/18 and the goal is to continue this process to receive real time feedback and provide real-time service recovery.

G. Improve Patient Satisfaction in the Hospital (Inpatient Care) by 3% percent

(Improve from 72 percent to 74 percent)

Similar to our approach in the Emergency Department, we want to use your feedback in the inpatient care units to improve the care we provide. One of the Corporate Strategies for the upcoming years will be to focus on improving the fundamental elements of patient care: 1) Communication with patients; 2) Bedside Shift reporting; 3) Patient rounding. Additionally, we will revamp our real time survey plan to ensure point of care resolution is provided for patients.

H. Reduce Unnecessary Hospital Readmissions for Congestive Heart Failure (CHF) by 10 percent

(Reduce from 14.8 percent to 13.2 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 (CHF), we can make improvements to ensure your successful transition to home following your 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. Currently we strive to improve your ability to manage your condition in the community after discharge by the provision of a transitional care package to you which includes a referral to Health Link.

Health Link is a special program, sponsored by the Ministry of Health and Long Term Care, with the sole focus of working with you, your family and your health team (doctors, pharmacists, etc.) to make sure we are all working together to do everything we can to keep you healthy in the community. In addition to Health Link, you also may need some care in the community to be arranged quickly after your discharge from the hospital. We currently provide a referral to the Central LHIN Home and Community Care rapid response team, which provides you with early assistance in the community that you may need. Last year we engaged in a quality improvement project (value stream mapping) to identify gaps in your care journey. The focus this year will be to implement the identified opportunities in phases to ensure they are sustainable. We will also monitor the implementation of the "Transitions of Care Standards" that will ensure appropriate measures have been put in place for a successful journey home.

I. Reduction of Incidence of Workplace Violence that Result in Lost Time by 100 percent

(Reduce from 2 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 has added a new spread project related to workplace violence prevention that will be undertaken in collaboration with all seven 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 the development of a new prevention and investigation tool for incidents of violence. Overall, it is our desire to provide Our People and you, our patients and families, with the safest hospital possible.

J. Ensure Appropriate Information Is Given on Discharge – 3.4 percent improvement

(Improve from 56 percent to 58 percent)

When you are discharged from the hospital, we want to make sure that you have all the information you need to ensure a safe transition. One important element is knowing who to call should you become worried about your condition or have questions about your treatment. We intend to make sure you get this information by creating a safe discharge plan and implementing a bundle of items that we will standardize across the hospital. We will work on initiating key improvement projects to improve the discharge communication process.

K. Ensure Appropriate Supports in the Home for Palliative Patients – 6.8 percent improvement

(Improve from 86.7 percent to 93 percent)

In surveys of patients and caregivers in Ontario, most people say they would prefer to die at home, but we know that most patients in Ontario who receive palliative care, die in a hospital. Our goal is to ensure access to the best possible palliative care for all terminally ill patients when and where they need it. During consultation with our Corporate Patient and Family Advisory Committee (Corporate PFAC), it was made clear that improving on this indicator is a priority for our community. We heard there is a concern that supports in the home for palliative patients are, sometimes, not what is expected and we could do better to meet the needs of patients. We know when discharge planning happens for palliative patients the hospital Central LHIN Home and Community coordinator works with the hospital care team to define the supports required. Once the patient is returned to the community, the plan might be altered based on community services available and that this change in plans may not be communicated back to the hospital based care team. Working with our Corporate PFAC Committee, we agreed that this was an important area to improve. To improve our performance in this area: Creation of a team consisting of representatives from the hospital Central LHIN Home and Community Care Coordinator, community Central LHIN home and Community Care Coordinator a Patient and Family advisor (PFA), Medicine and Cancer Care Leadership and the Palliative Care Team to develop an understanding of the issues and to make recommendations to improve.

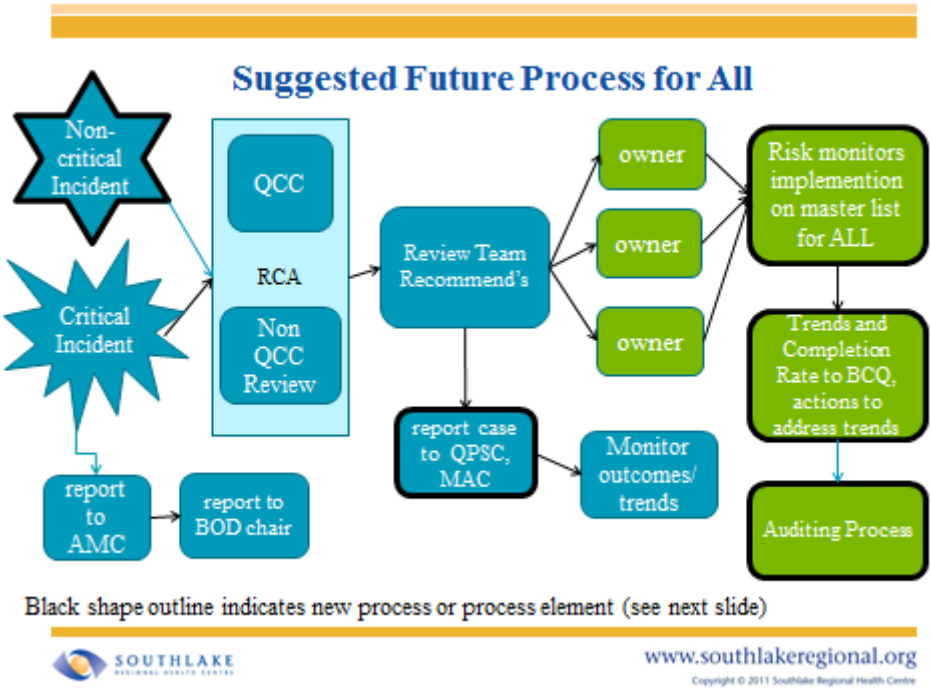
For this year, we will re-establish a working group to review this indicator's measurement process and identify specific improvement strategies. Additionally, we will to continue to partner with Central LHIN's Home and Community to ensure appropriate support is available for patients, when and if required.

QI Achievements from the Past Year

At Southlake, we are proud of the evolution of our learning approach to patient safety incidents. Even prior to the inception of the Quality of Care Information Protection Act (QCIPA) in 2004, our approach to reporting, learning and sharing included a focus on critical incidents. Thankfully infrequent, these occurrences were disclosed and reported to the affected patient as well as to our Senior Team, Medical Advisory Committee and Board of Governors. With QCIPA legislation, we struck a Quality of Care Committee (QCC) which was a body responsible for the review of critical incidents and provided a solid foundation for learning. We did review several cases under the umbrella of QCIPA but we were not satisfied with the restrictions on the sharing of information with you, our patients and with our Southlake family. Our values of transparency, learning and sharing, and our Journey to High Reliability caused us to cease using QCIPA legislation to keep our reviews confidential. We have not invoked QCIPA since 2013.

Although QCIPA is not used, the QCC was a valuable team with solid processes that we leveraged to evolve our approach to learning from patient safety incidents. In 2013, the process in Figure 1 below was presented to the Board Committee for Quality and adopted. We do however report more than simply trends to BCQ – we also report on root causes, causal factors and recommendations for improvement.

Figure 1



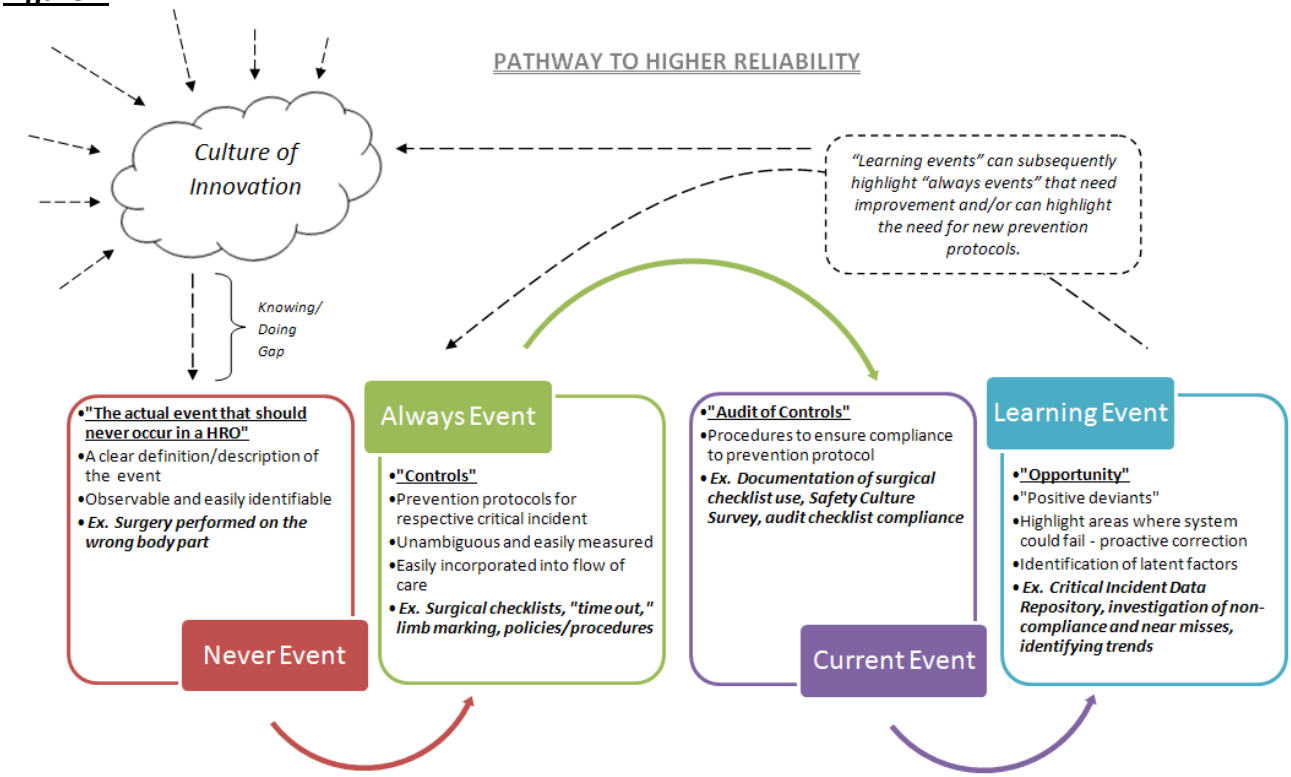
With this new process, non-critical incidents (Critical Near Miss Incidents) as well as critical incidents would be reviewed by the Quality of Care Committee (QCC), and reported throughout the hospital. This is a key turning point as we embrace the High Reliability concepts of Preoccupation with Failure, Reluctance to Simplify, Sensitivity to Operations, Commitment to Resilience, and Deference to Expertise. We know that most incidents are caused by flaws in our systems and that the goal of Safe Health Care could be achieved by understanding where these flaws existed and correcting them. Critical near miss incidents are considered a gift since, although no harm was done, flaws in our processes are revealed to us and made available for improvement. We also know that simply making a change in one area of the hospital and not translating this change across programs is a lost opportunity as most learnings in one program are of benefit to all. One of the mandates of our QCC is to ensure translation of learnings across the hospital. Through this attention at QCC, we have developed a Safety Alert approach to sharing urgent learnings and thus promoting situational awareness corporately and rapidly. The Safety Alert is disseminated to all members of the leadership team via e-mail with requirements to share at huddles and during rounding. Safety Alerts typically include a poster that can be shared at huddles and/or on communication boards. To ensure the Safety Alert is seen and acted upon, we utilize our electronic bed boards to flash a message to leaders to immediately access this important e-mail and information.

In 2015, the Canadian Patient Safety Institute (CPSI) published a list of Never Events. At this time, Never Events were added to the QCC process and are now reported on across the hospital. Also in 2015, we developed the Southlake Patient Incident Management System (PIMS) and Toolkit that supports our Integrated Quality Management Framework. The PIMS and Toolkit will be revamped in 2018/19 to ensure an appropriate framework and process is in place to support the individuals who report, manage, and analyze patient safety incidents.

In the event of a critical incident, a near miss critical incident or a never event, disclosure is made to the patient and family immediately. Support is provided to both the patient and the care team who are seen as the second victim. An immediate muddle (in the moment huddle) is convened to provide immediate support. The root cause analysis team is created and, when it is appropriate, the patient perspective is collected to inform the work of the team and an invitation is made to the patient and/or family to participate in the review to the extent they are comfortable. We assign a contact person that will continue to communicate with the patient and close the loop once we understand what caused the incident and what we are doing to correct our systems. Recommendations are assigned to a most responsible person (MRP) to implement and at the same time, a most responsible Vice President is assigned to ensure completion of the recommendation and to assist with removing any barriers. We track recommendations which are completed, on track and past due, on our Corporate Quality Scorecard. The MRP and the most responsible Vice President are held accountable to the Board for timely completion.

The value of learning from Never Events is of such importance at Southlake that we have developed a Southlake Never Event Elimination Initiative (Figure 2).

Figure 2



In this model we have adopted the CPSI list of Never Events and propose "Always Events" or controls that are prevention protocols for the respective Never Event. "Current Events" are the audit of these controls – these are procedures to ensure compliance with the "Always Events". The opportunity for learning from Never Events has been coined "Learning Events" and these highlight proactive correction and identification of latent factors. These "Learning Events" should be shared broadly. At this time, these learnings are communicated within Southlake but we strongly believe in the value of them for safety beyond our walls. To this end, we have shared this model with the Joint Centres as a suggested and it will be utilized in the Reducing Harm from Pressure Injury initiative.

Transparency, accountability, transferability and shared learning are embraced at Southlake and have underpinned our drive to achieve High Reliability and to provide excellent patient and staff experiences.

Resident, Patient, Client Engagement and relations

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 2018/19 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".* As Southlake embarks on developing a new Strategic Plan, the QIP will continue be aligned to the corporate goals and quality agenda. 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 impact 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 Ultimate Patient Experience Real Time Surveys provide a valuable source of information as we strive to embed your voice in our improvement efforts. Patient and Family Advisors currently sit on six Clinical service teams at the program level where goals, objectives and program scorecards are developed. In addition to our Corporate Patient and Family Advisory Committee (Corporate PFAC) we have many other formal Committees where patients are engaged upon their admission, by setting goals in collaboration with the health care team.

At Southlake, your voice is heard through the Corporate PFAC, which serves as a forum for patients and families to partner with Our People to provide input and influence on how to improve the patient experience. The Corporate PFAC reports to our Ultimate Patient Experience Steering Committee (UPESC), whose purpose is to support Southlake in honoring its core commitments, strategic goals and objectives for creating the Ultimate Hospital Experience. The UPESC fosters a culture where our Value of "Putting Patients First" is recognized in everything we do, and from the patient's perspective there is "Nothing about me without me". Our drive to achieve our Quality Improvement Plan goals for 2018/19 will be supported by these important groups of dedicated staff and patients/family.

Collaboration and Integration

Southlake's 2018/19 Quality Improvement Plan (QIP) 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 demonstrates Southlake's

commitment to work with our system partners to achieve improved quality, both within and beyond hospital walls. Feedback from our patients and data from our staff satisfaction surveys have helped us develop our QIP and identify our priorities.

Here are some examples:

We have forged a strong partnership with the Central LHIN's Home and Community Care 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 also, a strategic initiative in partnership with the Central LHIN's Home and Community Care, to conduct LEAN transitions to community, and reduce unnecessary hospital admissions through our Health Link commitments.

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 facilitates a coordinated, integrated care delivery model for our complex patients. Our Health Link, as part of the provincial wide project testing an electronic version of the coordinated care plan, worked with all of our Health Service Providers, our Patient Advisory Council and our Steering Committee to co-design processes around the tool to improve collaboration and communication. SSNYRHL has over 500 coordinated care plans entered into the electronic tool, with the majority completed by the Central LHIN Home and Community Care, as well as those completed by CMHA, LOFT, CHATS, and the Alzheimer Society of Canada. We also worked collaboratively with the other Central LHIN Health Link's to standardize patient identification, care transitions, patient/provider engagement and care coordination. There is a continual focus on quality improvement and our Health Link works closely with Health Quality Ontario (HQO) to develop and support emerging best practices. SSNYRHL, in partnership with three community partners, York Region EMS, CMHA and LOFT, are participating in an IDEAS project.

We have also collaborated with Health Link and Telehomecare in the prevention of readmission for patients with Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF). 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 Link, as

appropriate. We have also collaborated with the Central LHIN Home and Community Care to ensure appropriate referral to the Central LHIN Home and Community Care rapid response team. An example of this is the CHF working group that meets monthly with community partners (Telehomecare, the Central LHIN Home and Community Care Rapid Response, Health Link) to share information to ensure continuity of follow-up for CHF patients. The LACE readmission risk tool (length of stay, acuity of admission, Charlson comorbidity index, CCI, and number of emergency department visits in the preceding 6 months) was implemented for this patient group, on Cardiology (CAM), together with a follow up with our community partners (Telehomecare / the Central LHIN Home and Community Care Rapid Response / Health Link) is encouraged daily, at Joint Inter-professional Discharge rounds. We are currently reviewing the Central Local Health Integrated Network (Central LHIN) best practices for transition from hospital to home to ensure our practices are aligned in the Cardiac and Medicine Programs, as well as the Heart Function Clinic. In the near future, we will host a LEAN event in partnership with the Heart Function Clinic patients and families.

To ensure continuity of care, we partnered with the Georgina Health Centre to create our Diagnostic Imaging Satellite office which provides primary care physicians and patients in the community with seamless access to accredited hospital imaging services and IT systems, closer to home. Our Radiologist reporting turnaround times are second to none, meaning you will have answers from your primary care physician sooner than any other community clinic. In cases where you are referred to the hospital, your images are already part of your patient record, meaning you do not have to be re-imaged, saving the system money, and for you, unnecessary radiation.

The Mental Health Department conducts 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 Clinicians, Leadership & 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 (MAC), the Administrative Management Committee (AMC), our Quality Utilization and Resource Management Committee (QURM), the Patient Care Leadership Committee (PCLC), the Board Committee on Quality (BCQ) and our Corporate Patient and Family Advisory Committee(Corporate PFAC).

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 Horizon Business Intelligence (HBI) tool 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 who continually updates information, 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.

Population Health and Equity

Our hospital's Community Awareness Committee (CAC) includes a mandate to review community demographics and health statistics annually in an effort to help inform the discussion of services provided by Southlake. An environmental scan is also completed as part of the annual operating plan process and individual programs are responsible for collecting data on patient needs. Through this work, we know that 2 unique populations require intensive focus in our community: Mental Health and our growing senior group.

Our Mental Health team notes the growing need for acute and crisis mental health services in the region has put tremendous pressure on Southlake, as it works to meet the needs of patients whose gateway to care is, too frequently, the emergency department. One factor that may help explain the increase in demand is the region's rapidly growing population. Another is that we have eight group homes in walking distance of Southlake.

Southlake's inpatient beds are part of the region's mental health bed registry, launched in December 2015, which aims to quickly identify available beds to improve timely admissions. The hospital also works with other acute facilities, some as far away as Kitchener-Waterloo, Hamilton and Cornwall when a patient urgently needs hospitalization and there are no available beds at Southlake or a nearby hospital.

The significant growth in volumes and acuity puts pressure on the hospital and, due to scarcity of available inpatient beds, patients can face long waits in the emergency department for assessment and admission. In an effort to ease some of the pressures of escalating need, innovative solutions are being created across programs to better address.

We see similar high volumes within our senior group of patients. Between 2011 and 2031, we expect to see an increase of 148% in the 65+ age group in York Region. We know that responding to the needs of an aging population will be the single most difficult challenge facing our health system as demand continues to grow. ALC is a problem as the number of medical patients continues to increase. There are several hospital strategies to address these challenges including improved partnerships, transitions and coordination of services in our community. We are also implementing best practice protocols for certain groups, for example, patients with strokes. There are several initiatives aimed at improving clinical efficiency, for example, shifting some inpatient procedures to day surgery.

At Southlake, our staff complete an annual training requirement (core curriculum) and for the past 3 years, we have achieved 100% compliance with its completion. One of the modules within the curriculum is called Accessibility: Customer Service Standard and Ontario Human Rights Code. Included in here is information on our polices, assistive devices and services, information on how to communicate with persons with disabilities, the use of service animals, the inclusion of support persons and the requirement to provide notice when facilities or services that people with disabilities usually use to access our service are temporarily disrupted. Through this training, we ensure that all of Our People are aware of the ways in which we can each ensure equity for all in our community.

One specific example of this is the South Simcoe Northern York Region (SSNYR) Health Link, as it aims to improve equitable access to care as one key priority aligning with the Central Local Health Integration Network (CLHIN) Integrated Health Service Plan (IHSP) 2016-2019 core mandate. We are in the midst of implementing an electronic Coordinated Care Plan (CCP) that involves community Health Service Providers across sectors to support our targeted population, and address Social Determinants of Health, Mental Health and Additions.

This electronic version of the CCP is allowing us to build and further solidify partnerships and improve collaboration across sectors and therefore improving equitability. With this tool, the SSNYR Health Link is able to develop a standardized process and integrated system of care that will result in improved patient centered outcomes based on your identified goals. Also, Health Links is committed to ensuring that you have a primary care physician and community services as you may require according to your action plan. Through our work with our partner Health Service Providers we have been able to identify and voice inequities in service delivery between rural and urban areas and economic status.

Our partners include the following:

The Regional Municipality of York Emergency Medical Services (York Region EMS), York Regional Police (YRP), York Support Services Network, Addiction Services York Region, Canadian Mental Health Association (CMHA), Behavioural Support Organizations (LOFT: housing, employment), Family Health Teams (FHTs), Community & Home Assistance to Seniors (CHATS), Alzheimer Society of Canada, Geriatric Outreach Team, and Psychogeriatric Community Treatment Team (PACTT).

Access to the Right Level of Care - Addressing ALC Issues

Alternate Level of Care (ALC) refers to patients who no longer need treatment in a hospital, but who continue to occupy acute care hospital beds as they wait to be discharged or transferred to another care environment. ALC patients tend to need help with activities of daily living, which can range from house cleaning or cooking, to people who need round-the-clock care. ALC patients, who remain in hospital, do so because the supports they require outside of the hospital are not available. There is a shortage of options in the community. High numbers of ALC patients in acute care beds represents a challenge because these beds are not available for you, if you were to become acutely ill and come to the emergency department for care. High numbers of ALC patients are an important cause of emergency department overcrowding. We have been able to develop key partnerships with community partners to help move our patients out of hospital sooner, when appropriate. As part of a Central LHIN strategy, Southlake is one of the hospitals that opened 30 beds in the “Reactivation Care Centre” on December 2017. The purpose of the “Reactivation Care Centre” is to enable our ALC patients to continue to receive high quality care focused on addressing their specific needs and better manage patient flow throughout the hospital. It’s all about the right service, the right time, in the right place.

Additionally, what we have found is that these community issues require solutions that hospitals have very little control over. There are issues that are internal that hospitals can solve. At Southlake, some reasons for ALC days were caused by us! In fact, in 2010, 26% of ALC days were caused by hospital reasons such as delays in arranging a Physiotherapy referral. Today, and since 2014, 0% of ALC days are caused by hospital reasons. We did this through leveraging a tool called Medworxx.

Medworxx is a tool that our organization uses daily in our acute areas which includes the Medicine Department, the Surgical Department, the Cardiology department and the Mental Health Department. With engaged physicians and clinical leadership, we have tied utilization management to our daily work. We have used Medworxx to help us early identify patients and their needs and barriers to discharge. By being able to identify patient’s earlier that may have barriers to discharge, we have been able to reduce the hospital reasons for ALC. Discharge Planners or Patient Flow Navigators (PFN’s) work to spend time up front, to help you and your families make decisions about the best options after your stay in hospital.

We are continuously working with the people who enter the data to better help us identify patients ready for discharge or transfer and those who are here and waiting on a service delay. Utilization Management has also implemented the use of RM+R (Resource Matching and Referral) in the inpatient areas. The teams must complete a RM+R referral for inpatient general rehabilitation, inpatient neuro rehabilitation and complex continuing care. This is to help us place the right patient in the right bed.

Opioid Prescribing for the Treatment of Pain and Opioid Use Disorder

Prescription opioids include a broad range of medicines related to morphine, which are frequently prescribed to relieve pain. While prescription opioids are an important therapeutic tool for select patients, they carry inherent risks when prescribed and used inappropriately. Harms associated with opioids include addiction, potentially deadly overdoses, breathing problems during sleep, depression, chronic constipation, osteoporosis and an increased risk of death. Patients taking opioids also experience physical dependence, which means they experience withdrawal symptoms if they stop taking the drug or reduce the dose.

Southlake continues to take steps to review opioid prescribing practices and promote alternatives to opioids. The Emergency Department and the Mental Health program have partnered with Addiction Services of York Region (ASYR) to establish a Rapid Access Addiction Medicine (RAAM) clinic to ensure appropriate harm reduction support is available for patients. The pharmacy and psychiatry programs are making concerted efforts to increase their services for addiction support and management of opioids appropriately.

A few other key initiatives include:

1) Implement the Institute for Safe Medication Practices (ISMP) Canada Education tool for Opioid Stewardship for patients and families
2) Revise the acute pain service order sets to ensure the appropriate prescription protocol is in place
3) Implement a recently developed post op standardized discharge script to limit the medication choices and promote multimodal alternative choices
4) Develop a framework for PRN or “as needed” medication orders and incorporate best practices/standards on nursing decision making for appropriate dosing

Workplace Violence Prevention

Southlake's Corporate Workplace Violence Prevention Committee is committed to addressing concerns in relation to the safety of Our People, reducing the risk of workplace violence, and creation of a safe environment for everyone who walks through our doors. As a leader in promoting safety in healthcare, awareness and embracing the evolution of safety legislation, this continues to be a significant priority to Southlake, as we strive to establish a culture of safety throughout our Hospital.

There are 5 essential components of a comprehensive workplace violence and prevention program including Governance and Leadership, policies and procedures, training and knowledge transfer, physical environment design, and tools and technology. At Southlake, we have structured our program with attention to all of these components. Our Leadership have articulated a zero tolerance for workplace violence and we have corporate level reporting and monitoring of incidents via our corporate workplace violence scorecard. This is a tool that tracks and trends performance related to workplace violence through reporting at a corporate level. It includes metrics such as the number of incidents, security response time to violence, and severity of incidents.

Our Executive team also engages in regular walkabouts with key questions for senior leadership being asked during visits to the units. This promotes discussion of issues related to safety with staff and allows front-line perspectives to be heard and demonstrates leadership commitment to action.
We have developed aggressive behavior alerts (a flagging process), a care plan strategy individualized to the patient that is based on the assessment of violence risk and strategies for managing those risks while providing safe, effective care to the patient. It is important to learn from the types of incidents we are seeing, which requires a robust incident investigation and analysis strategy. Our staff are very engaged in careful and inclusive incident reporting, investigation and analysis and our Joint Health and Safety Committee (JHSC) is very involved in this work.

We know that training of our staff is of key importance as it imbeds the necessary prevention skills as well as the skills and judgement to prevent, mitigate or deal with incidents of violence. We raise skills and awareness through our annual core curriculum which is completed by 100% of our staff every year. Many of our staff, and all of our most at-risk staff, have completed Crisis Prevention Intervention (CPI) training. We have also engaged in simulation exercises with staff including York Region EMS and York Regional Police, followed by a debrief, which has been an excellent source of learning.

The design of our physical environment is also an important consideration for safety. We have signage visibly displayed throughout the hospital describing zero tolerance for workplace violence. Whenever there is a change in use of an area and annually across the hospital, an environmental risk assessment is performed. Access to the Emergency Department is also controlled; all patients and visitors must enter through a security controlled entry.

Illustrative Example:

Quality Improvement Plan			- MPP Link to Compensation - Q4 FINAL Results			
Indicator	Baseline Performance Used for QIP Development	Targeted Performance on QIP	Current Performance	Performance Improvement	Weighting	Total Score
Improve Indicators - Double Weighting						
CDI Rate	0.45	0.22	0.29	83%	2	166
Hand Hygiene (Before)	90%	100%	83%	-70%	2	-140
Incidence of Pressure Ulcers	6.4%	3.9%	2.8%	144%	2	288
Medication	63%	70%	69.0%	86%	2	172
Narcotic Incidence	4.6	2.3	2.1	109%	2	218
Staff Turnover	6.8%	8.2%	5.00%	229%	2	400
ER Wait Times	32.0	29.0	29.4	87%	2	174
Maintain Indicators - Single Weighting - Met/Not Met						
ER Patient Satisfaction	87.2%	87.2%	86.0%	No	1	0
Readmission Within 30 Days	10.5%	10.5%	3.9%	Yes	1	100
Percent ALC	13.1%	13.1%	12.9%	Yes	1	100
Hospital-Related ALC	0%	0%	0%	Yes	1	100
Total Margin	3.3	2.0	5.10%	Yes	1	100
				Total Possible Points If Achieved All Targets		1900
				Total Points Achieved		1678
Overall Percentage Achievement						88%

Sign-off

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

Board Chair

Quality Committee Chair

Chief Executive Officer

2018/19 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

AIM		MEASURE				CHANGE				
Quality Dimension	**Issue**	**Measure/Indicator**	**Current Performance**	**Target for 2018/19**	**Target Justification**	**Planned Improvement Initiatives (Change Ideas)**	**Methods**	**Process Measures**	**Process Measure Target**	**Comments**
	Reduce CDI	**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 FY 2917/18 YTD Q3	0.30	0.22	Last year target not met. Continue with last year's target.	Enhanced cleaning in high priority areas	▪ Quarterly “enhanced cleaning” and de-cluttering in high priority areas ▪ Perform scheduled Nocospray cleans in units with highest CDI burden ▪ Pilot tracking of patients to better understand “infection touchpoints” in high priority areas	▪Hand Hygiene Compliance ▪# of enhanced cleans and nocospray cleans ▪ Quality of cleans	▪91%HH Compliance ▪90% score from quality audits	The "Assure System" audit determines if a surface was cleaned properly.
	Hand Hygiene	**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 - urrent Performance FY 2917/18 YTD Q3	91%	91%	Sustain at a high performance while focusing on increasing the number of observations	Improve the communication to department leaders and staff regarding the importance of hand hygiene	▪ Conduct tracers on identifying gaps related to Hand Hygiene ▪ Explore opportunities to support staff to conduct more observations/clinical area ▪ Provide ongoing education to staff related to Hand Hygiene based on Accreditation Canada's Infection Control Standards	▪ # of tracers completed ▪ % of all clinical areas meeting the minimum number of 80 observations/clinical area	▪ 10 tracers completed ▪ 80% of all clinical areas	

AIM		MEASURE				CHANGE				
Quality Dimension	Issue	Measure/Indicator	Current Performance	Target for 2018/19	Target Justification	Planned Improvement Initiatives (Change Ideas)	Methods	Process Measures	Process Measure Target	Comments
Safe	Workplace Violence	**Number of Workplace Violence Incidents:** New Mandatory Indicator	CB	CB	As this is a new mandatory indicator, year 1 will focus on better understanding the data	Data monitoring and quarterly evaluation	Trend data and suggest improvements at the Workplace Violence Prevention Committee	Indicators monitored by the "Workplace Violence Prevention Committee"	Meet the targets of the inidicators set by the "Workplace Violence Prevention Committee"	Southlake Is one of the leading hospitals in adopting Workplace Violence Prevention strategies
		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 FY17/18 YTD Q3	2	0	Theoretical best practice of zero	Maintain and implement key initiatives based on the recommendations of the hospital's "Workplace Violence Prevention Committee"	▪ Maintain appropriate identification of high risk patients ▪ Implement the Non-Violent Crisis Intervention training in high priority areas ▪ Improve the auditing of the Violence Assessment Checklist			
	Hospital Acquired Pressure Injury	**Percent of patients with new pressure injury (stage 2 or higher)**. Current Performance FY 17/18 YTD Nov. Include adult acute care, complex care and rehab patients.	4.1%	2.8%	Last year target not met. Continue with last year's target.	Appropriate staff education	▪ Explore funding to continue pressure injuries prevention and management education days ▪ Include pressure injury staging certification as a mandatory component for clinical staff during orientation	▪ Education Day Evaluation Scores ▪ % of staff completion for mandatory components	▪ Collect Baseline for Education Day Evaluation Scores ▪ 100 % of staff completion for mandatory components	This is one of the Joint Centres initiatives
						Implement Joint Centres Pressure Injuries Working Group strategies	Develop a project schedule to roll out the strategies identified by the Joint Centres Working Group for pressure injuries	% of completion of Joint Centres Project Milestones	100% Project Milestone Completion	

AIM		MEASURE				CHANGE				
Quality Dimension	**Issue**	**Measure/Indicator**	**Current Performance**	**Target for 2018/19**	**Target Justification**	**Planned Improvement Initiatives (Change Ideas)**	**Methods**	**Process Measures**	**Process Measure Target**	**Comments**
Timely	Medication Safety	**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 17/18 Q3 YTD.	86.7%	90%	Last year target not met. Continue with last year's target.	Continue collaborative efforts to further improve the Medication Reconciliation process in the Mental Health Department	Monthly unit audit of patient documentation for BPMH and medication reconciliation completion	Unit % compliance of admitted patients receiving a completed med rec.	90% minimum Adult MH unit 85% minimum Child MH unit	Switchover to a new EHR system may delay the timelines
						Data Evaluation	Evaluate the data collection process and ensure there is a robust method to collect accurate data	Quarterly audits of the data quality	95% accuracy	
		Medication reconciliation at discharge: Total number of patients for whom a BPMDP (Best Possible Medication Discharge Plan) was created as a proportion of the total number of patients discharged. Current Performance: 17/18 Q3 YTD	57.8%	70%	On progress to meet 90% + for 2020	Continuing our implementation plan across the organization	Monitoring of plan roll-out from Pharmacy administration	Unit and Program % compliance	70% minimum unit compliance	Switchover to a new EHR system may delay the timelines
						Pilot a workflow based redesign to improve the documentation	Establish a team and identify a pilot unti to trial this opportunity	% of Project Milestone completion	100% Project Milestone Completion	
	Timely access to care/services	**ER Wait times:** 90th Percentile ER length of stay or visit for patients with complex conditions. Jan - Dec 2017 CIHI NACRS	14.2 Hrs	12.8 Hrs	This is a stretch target	Identify improvement opportunities	▪ Conduct a LEAN event ▪ Tie in progress from the corporate bed optimization initiative ▪ Strike a working group to improve ED consult time by physicians	▪ % of patient admitted ▪ ED Consult Time by physicians	▪Sustain at 10 % of patients admitted ▪ Improve ED Consult Time by physicians by 5%	

AIM		MEASURE				CHANGE				
Quality Dimension	**Issue**	**Measure/Indicator**	**Current Performance**	**Target for 2018/19**	**Target Justification**	**Planned Improvement Initiatives (Change Ideas)**	**Methods**	**Process Measures**	**Process Measure Target**	**Comments**
Patient-centred	Person experience	**"Would you recommend this Emergency Department to your friends and family?"** Percent positive score. (question from EDPEC) Current Performance FY17/18 YTD Nov	55%	58%	Last year target not met. Continue with last year's target.	Continue the real time ED feedback process	A real time ED feedback process was implemented in Q3 of 2017/18 and the goal is to continue this process to receive real time feedback and provide real-time service recovery	▪ # of "feedbacks" received ▪ # of "feedbacks" addressed within 30 days	Collect Baseline	NOTE: we will be tracking the "negative" responses as a balancing measure
		"Would you recommend this Hospital to your friends and family?" Percent positive score. (question from CPES-IP) Current Performance FY 17/18 YTD Nov	72%	74%	Peer Benchmark not yet available for this year. However, the achievement of the target for 2018/19 places us on the 90th P based on 2016/17 data	One of the Corporate Strategies for the upcoming years will be to focus on improving the fundamental elements of patient care: 1) Communication with patients 2) Bedside Shift reporting 3) Patient rounding	Establish a team and develop a Multi-Year project plan	▪ % of Project Milestones completed for Year 1 ▪ Monitor Process Measures established for the corporate initiative	100% of Project Milestones completed for Year 1	NOTE: we will be tracking the "negative" responses as a balancing measure
						Revamp the real time survey plan to ensure point of care resolution is provided for patients	Re-establish a team and process to conduct appropriate number of surveys	Positive Score on Surveys	Collect Baseline in Q1 and Q2; Improve by 10% in Q3 and Q4	

AIM		MEASURE				CHANGE				
Quality Dimension	**Issue**	**Measure/Indicator**	**Current Performance**	**Target for 2018/19**	**Target Justification**	**Planned Improvement Initiatives (Change Ideas)**	**Methods**	**Process Measures**	**Process Measure Target**	**Comments**
	Palliative care	**Percent of palliative care patients** discharges from hospital with the discharge status "Home with Support" Current performance FY 15/16	86.7%	93.0%	Last year target not met. Continue with last year's target.	Data Evaluation	Re-establish a Working Group to review this indicator's measurement process and identify specific improvement strategies	Action items percent completion	100% implementation by Q2 2018/19	Strategies include collaboration with C-LHIN Home and Community
Effective	Effective transitions	**"Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?"** Percent positive score.	56%	58%	This will meet the National Average	Initiate key improvement projects to improve discharge communication process	Establish teams and a project plan to implement the initiatives and track progress	Project Milestone % Completion	100% Project Milestone Completion	NOTE: we will be tracking the "negative" responses as a balancing measure
		Rate of psychiatric (mental health and addiction) discharges (LOS > 3 days; Ages 18+) that are followed within 30 days by another mental health and addiction admission (Southlake Only): Current performance Jan - Dec 2017	12.1%	12.1%	Sustain improvements made over the past 2 years	Alignment with corporate initiatives	Align with corporate strategies related to this indicator and develop a mental health specific plan for the following year (2019/20)	% Project Plan Completion	100% Project Plan Completion	We have customized this indicator to use real time data to impact improvements within the QIP timelines, if required
		Discharge Summaries Sent within 48 hours: Discharge Summaries with a Family Provider noted on Patient Record; LOS > 2 days; Ages 65 +; includes death	CB	CB	New indicator	Data Evaluation	Collect baseline, review the data to better understand the measurement and suggest improvement opportunities for the following year	Data Quality	Data review quarterly	Before establishing improvement strategies, we must understand the appropriate measurement logic

AIM		MEASURE				CHANGE				
Quality Dimension	Issue	Measure/Indicator	Current Performance	Target for 2018/19	Target Justification	Planned Improvement Initiatives (Change Ideas)	Methods	Process Measures	Process Measure Target	Comments
Efficient	Access to right level of 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 FY17/18 YTD Q3	16.41%		This indicator is not a hospital indicator. 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 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 FY17/18 Q3YTD	0.0%	0.0%						