Quality Improvement Plan (QIP) Narrative
Health Care Organizations in Ontario
March 2022

SOUTHLAKE
REGIONAL HEALTH CENTRE
Leading edge care. By your side.

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Overview

Southlake Regional Health Centre (Southlake) is building healthy communities through outstanding care, innovative partnerships, and amazing people. We deliver a wide range of healthcare services to the communities of northern York Region and southern Simcoe County. Our advanced regional programs include Cancer Care and Cardiac Care and serve a broader population across the northern GTA and into Simcoe-Muskoka.

Our team of nearly 6,000 staff, physicians, volunteers, students and Patient and Family Advisors are committed to creating an environment where the best experiences happen. As a recognition of our commitment to quality and patient safety, we have received the highest distinction of Exemplary Standing from Accreditation Canada.
This is an open communication to the Patients and Families in our community who we exist to serve in fulfilling our four strategic goals to:

1. Forge a new path to meet the changing needs of our growing communities
2. Champion a culture of exemplary care and deliver clinical excellence
3. Create an environment where the best experiences happen
4. Own our role to improve the system

Reflections since our last QIP submission

Our intent is to share our QIP in an open and transparent declaration of our pursuit of Quality and Patient Safety for our patients, staff, and community. **Thank you** for taking the time to find and read our QIP. Every year, we create a new plan and post it publically; it is a part of our commitment to you. At Southlake, we are committed to continuously improving the quality and safety of the care we deliver to our patients and families and the work environment we provide to our staff, physicians, students, and volunteers.

Over the past 18 months, we have adapted greatly in response to COVID-19. Our teams have seen immense growth in embracing quality improvement cycles with the implementation of COVID-19 protocols, testing and vaccination clinics, and provision of care guidelines when resources are limited. To build on this, our teams started utilizing real-time COVID-19 data to inform needs of the organization including capacity, staffing, and supplies. With this new way of using data, we introduced a live electronic huddle board that provides clinical leaders real-time patient information related to safety indicators. Using this live report, leaders have enhanced the visibility and communication in daily huddles with their staff.

We continue to grow a culture that embraces change and quality improvement. For our patients, staff, and community, we continue to embrace continuous improvement in everything that we do.

Quality Improvement Achievements

New Application for Incident Reporting

In April 2021, Southlake launched a new application for incident reporting (including patient, visitor, and employee incidents) and tracking of patient relations issues (such as compliments and complaints). Despite being in the middle of a pandemic, there was a high level of engagement in the planning and design of this application. Rather than accepting the “out-of-the-box” design, Southlake chose to customize many aspects of the application to meet the unique needs of our organization and patients.

Since its launch, the following process improvements were seen: manual processes to ensure appropriate follow-ups were being completed have been incorporated into the new design; enhanced reporting capabilities have allowed us to extract data in different ways; and mechanisms to notify the right people about patient and staff concerns to address them in a timelier manner.

We will continue to leverage the features of this new system in 2022/23 and years to come, to drive quality improvement throughout the organization.

Collaborative Care Re-Design (CCR)

CCR is a model of care that provides total patient care within an enhanced team environment. Each team member has individual and shared responsibilities. Lessons learned from a previous model of care change implementation were acknowledged and leveraged to form the CCR project in May 2021. This renewed approach included an evaluation of the previous implementation (using tools to validate skills mix such as Patient Care Needs Assessments, Environmental Profile Tools, and staff surveys) and creation of a new project plan developed by staff.

This engagement saw managers, educators, front-line staff, and patients co-create the tools for their unit and encouraged quality improvement principles using small tests of change when implementing a CCR element.

Since its launch in May 2021, 4 of the 11 inpatient units are in the implementation or sustainability phase of CCR.

Quality Improvement Achievements

Southlake's QIP has been developed through a comprehensive process including an assessment of our previous priorities, engagement of our staff and patients, and benchmarking with other hospitals and Ontario Health measures. The 2022/2023 QIP defines our 8 priorities; 5 of which are part of Southlake's 5 Patient Safety Priorities (depicted in Image #1).

Image #1: Southlake's Five Patient Safety Priorities

ONE: Improve the compliance of Two Patient Identification to 95.2% or higher

To keep patients safe, we want to reduce the errors that could result when not properly identifying a patient's identity. Two-client identification has been determined as an evidence based method to reduce errors during medication administration, treatments, tests and procedures. This means that with every interaction we will use two pieces of information to ensure we have the right patient (e.g. full name and date of birth). Since January 2021, we have been asking patients about the frequency of their identity being checked, through a real-time survey. This approach provides the opportunity for patients to be involved in measuring our performance, and is a more sustainable approach and provides a larger sample size than manual audits. As one of our five Patient Safety Priorities, corporate results from this feedback will be shared broadly, and unit specific data will be posted on Quality and Safety huddle boards throughout the hospital.

TWO: Improve medication reconciliation compliance for patients at discharge to 91% or higher

It is important that patients know what medications to take when they leave the hospital or care setting. Often, changes to their medications will need to occur from what they were taking prior to their stay. We help to make this happen 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. In 2020/21, implementation roll-out across clinical units occurred. In 2022/23, we have increased our target to 91% following the success of previous years' improvements. This year, there will be a continued focus on units that are not meeting the target.

THREE: Reduce percentage of inpatient falls resulting in serious harm to 1.6% or lower

At Southlake, we recognize that mobilization is an important part of a successful recovery for many patients. Mobilizing also helps with preventing pressure injuries; another one of our five Patient Safety Priorities. With mobilizing though, the risk of falling increases. We know that falls can and will happen while patients are in hospital. We also have a least restraint policy; which means we do not restrain patients simply to prevent them from falling. However, injuries from falls can be minimized by implementing best practice falls prevention guidelines. This is why, this year we are changing our measurement to focus to minimize falls resulting in serious harm. As one of our five Patient Safety priorities, corporate results will be shared broadly, and unit specific data will be posted on Quality and Safety huddle boards throughout the hospital.

FOUR: Improve patient satisfaction related to information on discharge (inpatients) to 66% or higher

As part of our patient satisfaction survey after discharge, we measure the success of appropriate discharge communication with patients through the following question: "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?" (Four point scale). We analyze feedback provided by patients through this survey, to help us understand how well we communicate with patients at discharge. For 2022/23, we plan to develop a mechanism to understand our practices regarding standard discharge documentation, to help identify areas for improvement.

FIVE: Reduce rate of hospital acquired pressure injuries at prevalence to 10% or lower

A pressure injury, sometimes called a bedsore or pressure ulcer, 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 cannot 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. 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.

Southlake uses a prevalence and incidence study process to measure pressure injuries. On a single day each quarter, a large sample of our inpatients are assessed to determine if they have any pressure injuries. This is the prevalence study. Exactly one week later, the same patients are re-assessed (for pressure injuries) if they are still in the hospital. This is the incidence study. Any new pressure injuries that developed during that week are known to be hospital acquired.

In previous years, we used incidence to measure hospital acquired pressure injuries because it was a definitive way to identify new pressure injuries (acquired while in hospital). It was not as simple to identify at prevalence which ones were hospital acquired. We now have a better system in place to identify at prevalence, which pressure injuries are hospital acquired. Using prevalence not only doubles our sample size, it also captures hospital acquired pressure injuries that developed outside the timeframe of a specific week.

As such, for 2022/23, we will begin to use prevalence to measure our hospital acquired pressure injury indicator. With this change, we recognize that our rate will appear much higher than previous years, but instead it is just a more accurate reflection of pressure injuries acquired in hospital.

As one of our five Patient Safety priorities, corporate results will be shared broadly, and unit specific data will be posted on Quality and Safety huddle boards throughout the hospital.

SIX: Maintain 90th percentile wait time to inpatient bed under 28.5 hours

As we look to the future and anticipate a period of post-pandemic recovery and rebuilding, we will face a series of challenges that will require our teams to continue to work collaboratively to address. First and foremost is access and flow, as we continue to see significant demand pressures, ALC challenges, and opportunities for improved coordination across the system. Early in 2022/23, Southlake will be realigning the organizational structure, and with this, a new Access and Patient Flow portfolio will be created. The focused and targeted efforts of this new portfolio will aim to improve flow in all areas of the organization, including from our emergency department to inpatient beds.

SEVEN: Improve reporting of incidents of workplace violence to 239

In April 2021, we introduced a new application for incident reporting. The change in process may have contributed to a decrease in reporting of workplace violence incidents. While the ultimate goal is to decrease incidents of workplace violence, for 2022/23 we want to see an increase in reporting of these incidents, to match historical reporting volumes. This is why our target is higher for 2022/23 than our current performance. Through improved reporting, we gain a better understanding of how often they occur, why they occur, and can develop strategies on how to prevent or mitigate them from occurring.

In effort to prevent these incidents from occurring in the first place, Southlake will continue to offer Workplace Violence Prevention training to staff in 2022/23, and strive to maximize participation in the classes. See more information in the Workplace Violence Prevention section below.

EIGHT: Improve overall patient satisfaction score to 67% or above

Throughout the pandemic, Southlake has had to make ongoing adjustments to our Visitor policy as pandemic directives from the Ministry have changed, and in effort to keep our patients and staff safe, by minimizing the potential spread of COVID. In 2022/23, Southlake will continue to support visitor access as much as possible, as well as virtual visits. Additionally, our goal is to continue the administration of our Real-Time Surveys (RTS), which help us understand how and where we can improve patient satisfaction.

Collaboration and Integration

The participating organizations in the Southlake Community Ontario Health Team (OHT) Best Practice Spotlight Organization (BPSO) desire to collectively provide care to our patient population working as a coordinated team. The BPSO OHT is committed to the implementation of Best Practice Guidelines (BPGs) to provide a consistent approach and coordination of care. The BPSO model enables the OHTs to respond to the quadruple aim of:

Improved Patient Experience	Better Outcomes	Cost Efficiency	Improved Team Experience

The initial work within the BPSO OHT has been focused on the Person and Family Centered Care BPG and an educational module has been co-created for implementation. Due to the nature of the pandemic, this work remains in progress. The second BPG identified for collective implementation is Engaging Clients who Use Substances. This work is in the initial stages.

Patient/Client/Resident Partnering and Relationships

As part of Southlake's 2022/23 Quality Improvement Plan development process, we have ensured that the QIP goals continue to align to the quality agenda and Southlake's strategic goals. Through our Corporate PFAC, we received feedback in the development of the 2022/23 QIP. In addition, our chair of the Corporate PFAC is a member of the Board Committee on Quality and the committee has been continuously involved with the development of our QIP. Our drive to achieve our Quality Improvement Plan goals for 2022/23 will be supported in collaboration between dedicated staff, physicians, volunteers and patients/family.

Workplace Violence Prevention

Southlake is committed to addressing safety concerns of staff, physicians and volunteers; reducing the risk of workplace violence; and creating a safe environment for all. We regularly monitor the number of incidents, security response time, and severity of incidents and our leadership team and our

safety officer regularly engage staff in safety dialogue to hear their perspectives.

We have a robust incident investigation and analysis strategy. Processes are in place to manage the risk of violence while ensuring safety for patients and staff. Our staff and our Joint Health and Safety Committee (JHSC) are very engaged in careful and inclusive reporting, investigation and analysis of incidents. Our annual core curriculum is completed by 100% of our eligible staff every year. In the most immediate past, many staff, and all of our most at-risk staff, have completed Crisis Prevention Intervention (CPI). We are actively transitions to a two day SMG Workplace Violence Training where the same priority groups are slated to receive training. We have also engaged in simulation exercises with York Region EMS and York Regional Police followed by debriefing exercises. Signage is displayed throughout the hospital describing zero tolerance for workplace violence. An annual environmental risk assessment is performed corporately and repeated when there is a change in use of a specific area. Access to the Emergency Department for all patients and visitors is through a security controlled entry. Patients are assessed at registration for a history of or risk of violence using a violence assessment tool and a purple identification arm band is applied to those positively identified; our patient tracking board displays if there is a risk for violence. All staff wear a safety pendant that will provide an immediate alert to security identifying the location and staff at risk; this strategy also includes a process for maintenance of the pendant (i.e. checking battery status). We know that by working together to keep everyone safe, we can “create an environment where the best experiences happen”.

Alternate Level of Care

New in 2022/23, the Southlake Ontario Health Team (OHT) will have its own Quality Improvement Plan (QIP), referred to as the Collaborative QIP (cQIP). Within the cQIP, there will be a mandatory indicator on Alternative Level of Care (ALC). Working with our partners, the goal will be to reduce ALC days for patients in our health system. Please refer to the cQIP for more information.

Virtual Care

Southlake has embraced a shift towards the increase use of virtual technologies for both the objectives of Southlake and in collaboration with our Southlake Community Ontario Health Team (OHT). Our progress to maturity is to leverage existing virtual services and explore opportunities is anchored in addressing population priorities, community needs, while ensuring flexibility to adapt.

We continue to work around the following initiatives:

- Maturity Virtual Care Connectivity: Building of successes with MEDITECH Virtual Visits, Microsoft Teams, OTN Consultations
- Remote Patient Monitoring: Expand services to priorities beyond COPD, CHF and GDM (gestational diabetes) COVID@Home
- Digital Process Transparency: Enable direct patient updates as electronic referrals move between care providers and provide opportunities for patients to see status of their referrals
- Remote Appointment Check-in: Allow patients to validate and update their Southlake appointment information and enable mobile check-in for clinics and services
- Patient Digital Identify: Expand the number of services that can seamlessly access virtual care services through a provincial endorsed identity, authentication, and authorization (IAA) service
- Digital Service Front Door: Evolve the current Southlake Navigator App to accommodate regional services that are needed by our community and is reflective of how they access services
- Personal Information Access: Southlake continues to champion improved access to patient results to increase health literacy and enable patients to be true partners in their care.

Executive Compensation

Southlake’s executive team’s compensation is linked to the performance of the QIP in order to ensure a change in focus from compliance to performance improvement.

Manner in and extent to which compensation of our executives is tied to achievement of targets

For Senior Executives and Directors at Southlake:

1. There is total envelope of funds set aside by Finance for Senior Executives and Director Compensation. Total variable pay linked to performance based compensation aligning to requirements in ECFAA plus the Management Performance Plans will vary in percentage.
2. Twenty percent of the total variable pay will be linked specifically to achievement of the QIP component of the overall Management Performance Plan.
3. Eighty 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. The allocation linked to the QIP will be calculated utilizing the following terms:
   - All Corporate Priority QIP indicators will be linked to variable pay
   - Achievement will be based on the percentage complete based on the formula below:

Corporate Priority Indicators	Baseline FY 21/22 YTD (Q1-Q3)	Target (2022/23)
Two Client Identification Compliance	95.2%	95.2%
Medication Reconciliation on Discharge	90.4%	91%
Inpatient Falls Resulting in Serious Harm	1.6%	1.6%
Enough Information on Discharge	66%	66%
Hospital Acquired Pressure Injuries at Prevalence	8.2%	10%

Approach/Formula

For selected QIP 2022/23 indicators, the score would be calculated based on outcome indicator performance and progress of project milestone completion (includes review of process measures)

Improve Indicators	
Criteria	Score
If Current Performance: < Baseline + All Activities Not Completed	0
If Current Performance: < Baseline + All Activities Completed	2.5
IF Current Performance: ≥ Baseline < Target + All Activities Not Completed	2.5
IF Current Performance: ≥ Baseline < Target + All Activities Completed	5
If Current Performance: ≥Target + All Activities Not Completed	7.5
If Current Performance: ≥Target + All Activities Completed	10
Maintain Indicators	
If Current Performance: < Baseline + All Activities Not Completed	0
If Current Performance: < Baseline + All Activities Completed	2.5
If Current Performance: ≥ Baseline/Target + All Activities Not Completed	2.5
If Current Performance: ≥ Baseline/Target + All Activities Completed	5

Sign Off

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

Patrick K. Horgan, Board Chair _____

Ansar Ahmed, Board Quality Committee Chair _____

Arden Krystal, Chief Executive Officer _____

2022/23 Quality Improvement Plan
"Improvement Targets and Initiatives"

Southlake Regional Health Centre 596 Davis Drive, Newmarket , ON, L3Y2P9

Lower is Better
Higher is Better

AIM	Measure				Change				
Quality Dimension	**Measure/Indicator**	**Current performance**	**22/23 Target**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**	**Comments**
Timely	The time interval between the Disposition Date/Time (as determined by the main service provider) and the Date/Time Patient Left Emergency Department (ED) for admission to an inpatient bed or operating room.	25.1	≤ 28.5	Lowest annual performance in the past three years prior to COVID was 29.9 hours. During COVID, this 90th percentile wait time greatly fluctuated, from 8.5 to 28.5 hours. The 22/23 target is being stretched from the pre-COVID target (31), to maintain lower but achievable wait times seen during COVID. Current performance study period (defined by OH): 21/22 Q3 (Oct. 1 - Dec. 31, 2021)	Improve patient flow, using new dedicated resources, through a targeted focus on discharge planning.	Dedicate resources to lead bed optimization and ALC strategy. Increase number of units implementing the standardized approach to bullet rounds through the Collaborative Care Redesign (CCR).	Resource(s) in place and mechanism to track program-level data. % of inpatient units with CCR implemented.	Yes 100%	Annual performance 2018/19 was 34.5 hours, while both 2017/18 and 2019/20 were 29.9. There is a strong relationship between wait times and inpatient census (which has also greatly fluctuated during the pandemic). Southlake continues to focus on improving flow, which will in turn improve wait times.
Patient-Centred	Percentage of respondents who responded “completely” to the following question: 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?	65.4%	≥ 66%	21/22 target not consistently met in 21/22, but current YTD is above target. Increase target for 22/23 to maintain current YTD (Q1-Q3). Current performance study period (defined by OH): Last 12 consecutive months (Jan. 1 - Dec. 31, 2021)	Improve adherence to providing written documentation to patients on their discharge.	Establish a mechanism to monitor whether a Discharge Summary (or equivalent) document was created and is in MediTech at discharge. Engage Decision Support and clinical programs to understand how to extract data from MediTech to monitor and track usage, to inform future strategies for improvement.	Mechanism to measure is in place	Yes	Information on Discharge has been identified as one of our five patient safety priorities. Southlake continues to aim for theoretical best target of 100%, while setting a realistic and achievable target for 22/23.
Effective	Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged.	91.0%	≥ 91%	Increase target for 22/23 to sustain improvements to date, and maintain best quarterly performance from 21/22 YTD (Q1-Q3). Q1: 89.3% Q2: 90.6% Q3: 91.0% Current performance study period (defined by OH): 21/22 Q3 (Oct. 1 - Dec. 31, 2021)	Continue to improve and refine processes and measures that were previously introduced with a focus on programs that are not meeting target.	Work with any Programs not meeting target to determine root cause and improvement strategies for completing medication reconciliation at discharge. Sustain improvements in Programs meeting target.	Engage clinical teams to help develop improvement strategies, including process adherence (including admission process re: BPMH), documentation and scanning of the form.	Teams not meeting target are engaged, and strategies developed.	Medication Reconciliation has been identified as one of our five patient safety priorities. Southlake continues to aim for theoretical best target of 100%, while setting a realistic and achievable target for 22/23.
					Explore and leverage electronic processes to gain efficiencies in Medication Reconciliation process.	Partner with Doctor First to develop and implement a process at Southlake to import the external medication history from both the community Pharmacy and the DHDR (ODB info) directly into the MediTech Home Meds module at registration for a Southlake visit.	Decreased time: 1. At gathering the history 2. At entering the history	30% decrease in time required for each of the 2 stages.	While the QIP patient safety focus remains on discharge, the reality is that an accurate and efficient discharge reconciliation is only possible if an accurate BPMH has been completed. If we are able to increase our BPMH throughput, there will be opportunities to improve and streamline our discharge processes.

AIM	Measure				Change				
Quality Dimension	**Measure/Indicator**	**Current performance**	**22/23 Target**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**	**Comments**
Effective	Patient Satisfaction, as measured by percentage of respondents answering 9 or 10 when asked to rate their hospital experience/care/ stay, where 0 is the worst and 10 is the best.	66.0%	≥ 67%	21/22 target not consistently met in 21/22, and current YTD is lower than target. Continue with 21/22 target for 22/23. Current performance study period: Last 12 consecutive months (Jan. 1 - Dec. 31, 2021)	Enhance the patient experience by listening to, and addressing, their identified concerns.	Drill down into survey data to determine most influential patient satisfaction area, based on correlation coefficient, impacting overall patient satisfaction, and develop strategies to address in collaboration with our patient and family advisory groups.	Determination of a survey question(s) to focus on	Area identified	Southlake's Patient Satisfaction indicator is a customized and amalgamated indicator from six different patient satisfaction surveys. The surveys included are Emergency Department Patient Experience of Care Survey (EDPEC), Canadian Patient Experience Survey (CPES) for Inpatient Care and Maternity Module (CPES + Mat), Pediatric Patient Experience of Care Survey (PPES), Ontario Outpatient Experience Survey (OP Clinic), and Ontario Day Surgery Experience Survey (OP Surg).
Safe	Number of workplace violence incidents reported by hospital workers within a 12 month period.	**197**	**239**	In April 2021, we introduced a new application for incident reporting. The change in process may have contributed to a decrease in reporting of workplace violence incidents. The ultimate goal is to decrease incidents, while simultaneously improving reporting to match the historical reporting. This is why our target will be based on our most recent fiscal year prior to the new system being implemented (FY 20/21). Current performance study period (defined by OH): 2021 Calendar Year (Jan. 1 - Dec. 31, 2021)	Increase reporting of workplace violence incidents	Develop a mechanism to identify incidents not reported or reported but categorized incorrectly, and ensure accurate reporting is completed.	Mechanism to measure is in place	Yes	This continues to be a monitoring indicator internally, with a soft target. We are not aiming to increase incidents; instead we are aiming to increase reporting of them. This change idea is focused on increasing reporting.
					Decrease workplace violence incidents by expanding our Workplace Violence (WPV) prevention training.	Optimize class enrollment in WPV training sessions.	Number of people participating in the classes divided by the number of spots available.	90%	This continues to be a monitoring indicator internally, with a soft target. We are not aiming to increase incidents; instead we are aiming to increase reporting of them. This change idea is focused on preventing incidents from occurring.
	Patient Identification, as measured by percent positive responses ("Always" or "Most of the Time") to the real-time survey question "Before giving you medication or performing a test, such as an x-ray or drawing blood, how often do staff ask your full name AND date of birth, or check your ID bracelet?" (as a proportion of all responses to this question).	95.2%	≥ 95.2%	21/22 target not consistently met in 21/22, but current YTD is above target. Increase target for 22/23 to maintain current YTD (as of Q1-Q3). Current performance study period: Apr. 2021 - Dec. 31, 2021.	Leadership engagement at the unit level.	Conversations at huddle board, including patient stories and performance results on patient identification compliance, leadership rounding with patients.	Percentage of programs that have an established mechanism for tracking leadership engagement for patient identification as part of the Five Patient Safety Priorities.	100%	This indicator is an Accreditation Canada Required Organizational Practice and has been determined as an evidence based patient identification method to reduce errors during medication administration, treatments, tests and procedures. Southlake continues to aim for theoretical best target of 100%, while setting a realistic and achievable target for 22/23.

AIM	Measure				Change				
Quality Dimension	**Measure/Indicator**	**Current performance**	**22/23 Target**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**	**Comments**
Safe	Pressure Injuries, as measured by percentage of patients with a new stage 2+ hospital acquired pressure injury identified at prevalence during the prevalence and incidence study (excludes any identified during previous prevalence studies).	8.2%*	≤ 10%	In 21/22 Q3, a more precise method for data capture was introduced, which identified additional patients with pressure injuries not identified during initial assessment, though chart reviews. This method will continue into 22/23, which indicates previous historical data is not representative of future measurement. Had this new method been used in Q1 and Q2, our current YTD would be 9.95% (10% rounded), which is what the target for 22/23 will be based on. Current performance study period: Apr. 2021 - Dec. 31, 2021.	Reduce layers beneath patients	Investigate the development of a linen algorithm, that helps to reduce the number of layers between patients and their bed surfaces	Algorithm in place	Yes	Pressure injuries has been identified as one of our five patient safety priorities. Southlake continues to aim for theoretical best target of 0%, while setting a realistic and achievable target for 22/23.
					Increase knowledge of pressure injury prevention for staff	Ensure pressure injury prevention is completed in orientation revamp. Promotion (consider assigning staff with appropriate back fill on units) of quarterly wound care education days. Decrease brief usage through initiative focused on a pilot on one inpatient unit. Clinical Operations work with Professional Practice on engaging educators and front line staff on the utilization of existing tools (pressure injury toolkit, therapeutic surface selection tool and guide, PI studies, etc.)	Number of people participating in the classes divided by the number of spots available. Decrease number of briefs used	Increase by 50% Decrease brief usage by 10%	
					Leadership engagement at the unit level.	Conversations at huddle board, leveraging the electronic huddle boards, and unit performance results on documentation requirement compliance. Leadership rounding with staff to promote pressure injury awareness to support the reduction in pressure injuries and back to basics.	Percentage of programs that have an established mechanism for tracking leadership engagement for pressure injuries	100%	
	Inpatient Falls resulting in Serious Harm, as measured by percentage of reported inpatient falls that result in moderate or higher harm (as a proportion of all inpatient falls and near-miss falls reported).	1.6%	≤ 1.6%	The measure for this indicator is new. Historical performance over last 3 years is 1.9%. Target for 22/23 will be based on the 21/22 YTD, which is 1.6%. This is a stretch target, given that Q2 21/22 was considered an anomaly at 0%. Current performance study period: Apr. 1 - Dec. 31, 2021	Increase compliance to falls risk assessment requirements.	Use data from the electronic health record (EHR) regarding falls risk assessments, to measure compliance of daily falls risk assessments. Drive improvements in data quality to ensure accuracy of compliance measure, and proper documentation location of falls risk assessments. Educate on standards of care and documentation requirements.	% of falls risk assessments completed with 24 hours of admission, and daily thereafter.	100%	Falls has been identified as one of our five patient safety priorities. Southlake continues to aim for theoretical best target of 0%, while setting a realistic and achievable target for 22/23.
					Improve universal and individual patient fall prevention interventions through education and leadership engagement.	With the use of electronic huddle boards and daily huddles, identify patients at risk for falls and implement patient specific interventions. Through education, enhance the development of routine practices in falls prevention.	Total number of falls, showing breakdown by serious/not	Decrease total falls by 10%	