Quality Improvement Plans 23/24 (QIP): **Progress Report** on the 2022/23 QIP

Measure/Indicator	22/23 Target	Current Performance	Overall Comments (22/23)	Change Idea	Methods	Process measures	Target for process measure	Implemented as intended?	LESSONS LEARNED
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.	≤ 28.5	33.0	In 2022/23, Southlake saw unprecedented volumes in our Emergency Department, significant health human resource challenges, and other barriers and bottlenecks throughout the health system. A significant driver of this surge was the residual impact of the peak of the COVID pandemic. As patients avoided health visits over the previous two years, chronic health conditions were not being controlled, and as a result we are seeing more acute visits now. Challenges with infection prevention protocols limited our abilities to co-locate patients, putting even further restrictions on patient flow movement. We are maintaining focused efforts on improving patient access and flow, and over the next fiscal year will continue to look for ways to optimize. As we see improvement in these areas, we will see reduced wait times in our Emergency Department. Date range for "Current Performance": 2022/23 Q1-Q3	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%	Y	Resources were redirected to focus on the processes and outcomes for Patient Access and Flow including people, process and technology. A new position, Director of Access and Patient Flow, was created and filled in early 2022. In Q3, we launched a Patient Flow Steering Committee (PFSC). This committee's focus is to develop, promote and support quality improvement strategies, strengthen system capacity through collaboration, and partner with system leaders to improve organizational access, patient flow, utilization. This position is also supporting the Bed Optimization project, which is ongoing and should be completed by September 2023. We continue to implement Standard Work for all patient care areas to standardize systems and processes and to streamline patient flow across the organization. With respect to our Collaborative Care Redesign (CCR), due to other competing corporate priorities related to staff safety, we revised our targeted number of inpatient units for implementation in 2022/23 from 11 units to five. To date, it has been fully rolled out on two, and the other targeted units are in progress.
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?	≥ 66%	N/A	On April 1, 2022, the Patient Satisfaction survey contract with NRC Health ended. Along with most hospitals, Southlake decided to wait for the formal RFP process through the Ontario Hospital Association (OHA), to select a new vendor. Unfortunately, in July, OHA announced that they were unable to achieve acceptable terms with the lead proponent, and negotiations were terminated. They also announced that other RFP bid options would meet the expectations of the sector, leading to the cancellation of the RFP. This impacted data for two indicators on our QIP. Work is ongoing at Southlake to procure a new vendor. In the interim, we continue to monitor patient satisfaction through our real-time surveys. Date range for "Current Performance": 2022/23 Q1-Q3	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	Y	As work on this change idea evolved, and we understood barriers more, work was aimed at providing clearer discharge instructions by improving and developing a standard discharge process at the bedside level through the use of a “discharge package/envelope” in the surgical program. This would include a discharge summary (if available), prescriptions, follow-up appointment information, and relevant discharge teaching material. This was standardized through the program and the charge nurses continue to optimize and work on this.

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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%	89.3%	Overall, our performance on this indicator is right around 90%, which is excellent, despite not quite reaching target. We saw a bit of a drop in performance in Q1, but improved each quarter as the year progressed. Our process for Medication Reconciliation is very manual and time inefficient. As a corporate initiative, Southlake is working toward assessing and planning for the implementation of the Computerized Provider Order Entry (CPOE). Once completed, this will transition our organization from using written orders to electronic order entry within Meditech, which will help us gain efficiencies and have a positive impact on Medication Reconciliation. Date range for "Current Performance": 2022/23 Q1-Q3	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.	N	Given that we have been performing at near-90% compliance on this indicator, it has been a difficult safety initiative for programs to focus on with competing priorities. The programs not meeting target were those most under significant pressures throughout the fiscal year; Maternal Child, Mental Health, and Emergency. In 2022/23, we saw significant patient volume surges in these areas, and in combination with our health human resource challenges and our overall near-target performance on this indicator, resources were not asked to prioritize improvement efforts here. Entire program engagement is required for any success in changes, so unfortunately this specific change idea was not implemented as intended.
				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.	Y	This initiative was implemented in a modest way with limited pharmacies. There have been challenges with respect to electronic/patient information exchange programs that were not anticipated. The pace has been slower than expected, given the hurdles along the way, which were successfully surmounted. We continue to engage and await next steps from Ontario Health.
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.	≥ 67%	N/A	On April 1, 2022, the Patient Satisfaction survey contract with NRC Health ended. Along with most hospitals, Southlake decided to wait for the formal RFP process through the Ontario Hospital Association (OHA), to select a new vendor. Unfortunately, in July, OHA announced that they were unable to achieve acceptable terms with the lead proponent, and negotiations were terminated. They also announced that other RFP bid options would meet the expectations of the sector, leading to the cancellation of the RFP. This impacted data for two indicators on our QIP. Work is ongoing at Southlake to procure a new vendor. In the interim, we continue to monitor patient satisfaction through our real-time surveys. Date range for "Current Performance": 2022/23 Q1-Q3	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	Y	The change idea was achieved through a different method than planned. We had hoped to use data from external surveys to identify most pressing patient experience concerns, however due to the unfortunate delayed procurement process with a new vendor, we did not have the extensive data available to drill down based on correlation coefficients. As an alternative approach in the interim, we continued to monitor and respond to patient experience identified concerns through the use of our real-time surveys. In addition to providing units with real-time information to address concerns in-the-moment, summary data is shared with our Senior Leadership Team, Board Committee on Quality, our Patient and Family Advisory Councils (PFACs), Interprofessional Practice and Education Council (IPEC), Nursing Council, our surveyors, other committees and councils as required.

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Number of workplace violence incidents reported by hospital workers within a 12 month period.	**239**	273	Overall during 22/23, the change in the workplace violence prevention training model, in terms of accountability, helped boost participation and led to increased compliance. This model will continue to be monitored as will be the mechanism for increased reporting of workplace violence incidents throughout the organization. Date range for "Current Performance": 2022 calendar year (Jan. 1 - Dec. 31, 2022)	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	Y	A mechanism to identify miscategorized incidents was in place for 2022/23. Our Occupational Health and Safety team was able to identify incidents categorized incorrectly, and engage management in appropriate follow ups. As a result, we were able to increase the reporting of workplace violence incidents that previously may have been missed. A key learning is that the process is very manual. As such, there is ongoing work occurring to improve the mechanism, to gain further efficiencies and accuracies in 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%	Y	During the pandemic, workplace violence prevention training sessions were held virtually. Accountability sat with individual staff members to sign up and participate in the training. There were challenges identified with this accountability model, so in 2022/23, the sessions were moved back to in-person and accountability was shifted to managers for ensuring their staff were enrolled and participating. This ultimately did increase participation and training compliance.
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%	Our goal was to complete 500 real-time surveys each quarter. Due to challenges with health human resources this fiscal year, we were only able to hit 81% of this target. Despite the lower than desired number of responses, the data gathered was still useful and provided information to the unit levels on individual performances for this indicator. Date range for "Current Performance": 2022/23 Q1-Q3	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%	Y	Unit-level data is provided to each inpatient area, and posted on their Quality and Safety Huddle Boards. As units huddle, this is one of the indicators that is regularly reviewed. Anecdotally, we do know that conversations occur at the unit level regarding patient safety errors, including specific examples and patient stories about those resulting from improper patient identification. However, we were not able to standardize a mechanism to track these conversations. With the performance hitting target, this work was not prioritized amongst other competing priorities.

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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).	≤ 10%	7.5%	This year we used prevalence data, instead of incidence data, to measure this indicator. This allowed us to have a larger sample size for our measurement and have a better picture of hospital acquired pressure injuries. In 2022/23, we surpassed the target for all three quarters measured so far. For the upcoming year, we will continue measuring this indicator via prevalence, and will aim to drive further improvements by lowering the target. Date range for "Current Performance": 2022/23 Q1-Q3	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	N	Information about the importance of decreasing brief use and uneccesary layers is included in the orientation presentation and the Pressure Injury Education Day. Work continues on development of the linen algorithm. The tool has not yet been developed, but through discussion relating to the tool, barriers have been identified and work is underway to address. Examples of barriers include products currently in use at Southlake, such as brown pads and condom catheters. During the upcoming Q4 prevalence study, the team will gather more information about the number of layers under every patient assessed, which will help further inform the development of the algorithm.
				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%	Y	In 2021, 14 staff attended the Pressure Injury Education Day. In 2022, 44 staff attended the Pressure Injury Education Day. The Pressure Injury Prevention toolkits are available on all inpatient units, and the therapeutic surface selection tool is a part of this toolkit. It is also available on the Southlake Intranet, with links embedded in the *Skin - Prevention of Skin Breakdown* and *Skin - Management of Skin Breakdown* Standards of Care. Unit specific Pressure Injury Prevalence results are shared with managers and educators to share with their staff. After the Q4 study (which is a more comprehensive prevalence study than Q1-Q3), we will have the data to compare brief usage to determine if a decrease has occurred.
				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%	Y	The implementation of the Meditech Quality and Safety Board has made it easy for clinical managers and educators to quickly see which patients on their units have a low Braden score indicating risk of skin injury as well as existing pressure injuries with location and stage. Unit-specific data from the Pressure Injury Prevalence study is provided to clinical leaders, for the information to be posted on their Huddle boards. Anecdotally, we do know that conversations occur at the unit level regarding pressure injuries, however, we were not able to develop an established mechanism to track these conversations. With the performance hitting target, this work was not prioritized amongst other competing priorities.
				NEW: Invest more human resources	Increase the nursing capacity in wound care specialization	Hire an additional FTE Wound Care Nurse Specialist	1 FTE hired by end of Q3	Y	Previously, our wound care specalists were not able to see every patient that required their service, in a timely manner. In order to better align capacity with demand, we added an additioanl 1.0 FTE (full time equivalent) to the wound care team. The position was filled in Q2 2022/23. This additional FTE also allowed us to provide additional education to unit staff regarding pressure injury prevention and management.

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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%	1.7%	In 2022/23, Southlake saw unprecedented volumes in our hospital. Between Q1-Q3, the total number of admits was greater than any other three consecutive quarters over the past four years. In addition, we had significant health human resource challenges in the organization. Despite all of this, our performance on this indicator improved since the previous year. Unfortunately, we have not quite yet meet our annual target. We will continue our improvement efforts through Q4 and into 2023/24. Date range for "Current Performance": 2022/23 Q1-Q3	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%	Y	Increasing compliance to falls risk assessment requirements was a multi-pronged approach, including education and data quality monitoring. In July 2022, education related to falls risk assessments and falls prevention interventions were included in new staff Clinical Orientation. All new clinical staff who join Southlake now receive this education. Data from the electronic health record was analyzed to measure compliance. Several units achieved 100% of falls risk assessments completed within 24 hours of admission, notably Medical Complex Care and the Reactivation Centre units. The hospital overall average from April 2022-January 2023 was 75.8%. We continue efforts to monitor and improve this percentage.
				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%	Y	The implementation of the Meditech Quality and Safety Board has made it easy for clinical managers and educators to quickly see which patients on their units have a high risk of falls. In July 2022 education related to falls risk assessments and falls prevention interventions were included in new staff Clinical Orientation. All new clinical staff who join Southlake now receive this education. We were not able to decrease total falls by 10%.