23/24 Progress Report

Quality Improvement Plan Scorecard 2023/2024

Strategic Goal	Quality Dimension	Indicator	Definition/ Description	Desired Direction	FY23/24 Target	FY23/24 Performance				
						Q1	Q2	Q3	Q4	YTD
Own our role to improve the system	Timely	90th Percentile ED Wait Time to Inpatient Bed	90th percentile wait time (hours) for patients admitted from the ED to an inpatient bed or operating room, where wait time is from Disposition Date/Time until the Date/Time Patient Left Emergency Department for admission.	↓	31.5	41.0	31.7	42.5		39.5
	Efficient	Discharge Summaries within 2 Days	Percentage of patients (who have a Family Provider noted in their Health Record) discharged from hospital for which discharge summaries are sent to their primary care provider within 2 days of discharge.	↑	90%	88.0%	88.0%	89.0%		88.3%
Champion a culture of exemplary care and deliver clinical excellence	Patient Centred	Patient Experience	Percentage of respondents answering 9 or 10 when asked to rate their overall hospital experience, where 0 is very poor and 10 is very good.	↑	67%	N/A	N/A	68.3%		68.3%
Create an environment where the best experiences happen	Safe	Workplace Violence Incidents Resulting in Lost Time or Healthcare	Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period, that result in Lost Time or Healthcare	↓	6.5/qtr 26/yr	7	9	11		30
		Hospital Acquired Pressure Injuries at Prevalence	Percentage of patients with a new stage 2+ hospital acquired pressure injury (HAPI) identified during the quarterly pressure injury prevalence study.	↓	7.0%	6.4%	3.9%	3.6%		4.6%
		Inpatient Falls Resulting in Moderate+ Harm	Percentage of reported inpatient falls that result in moderate or higher harm (as a proportion of all inpatient falls and near-miss falls reported in SafePoint).	↓	1.6%	1.7%	1.6%	1.6%		1.6%

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Executive Summary

Indicator	Change Ideas	Indicator Lead(s)
90th Percentile ED Wait Time to Inpatient Bed	• Develop contingency plans • Standardize our admission and transfer process • Standardize our discharge process • Find and remove discharge bottlenecks relating to Diagnostic Imaging	Derek McNally, Katrina Scott
Discharge Summaries within 2 Days	• Find and remove bottlenecks relating to preparing Discharge Summaries within two days of discharge • Find and remove bottlenecks in identifying primary care providers	Dr. John Randle
Patient Experience	• Listen to the patient's voice by actively seeking their feedback. • Enhance the overall patient experience through focus on standard work and teamwork • Strategically recruit members for our Patient and Family Advisory Committees (PFACs) to be inclusive and represent the populations we serve • Enhance the patient experience for our Senior Population	Sarah Alisch
Workplace Violence Incidents Resulting in Lost Time or Healthcare	• New corporate training initiatives to include workplace violence, patient handling and supervisor competencies	Menka Anand
Hospital Acquired Pressure Injuries at Prevalence	• Synchronize quality improvement efforts through a coordinated and collaborative interprofessional approach • Invest more capital resources, to increase the use of Pressure Injury Prevention Interventions	Sarah Alisch
Inpatient Falls Resulting in Moderate+ Harm	• Improve the accuracy of Falls Risk Assessments • Invest more capital resources, to increase the use of Falls Prevention Interventions • Improve communication of falls risk during transfers of accountability	Sarah Alisch

90th Percentile ED Wait Time to Inpatient BED

Overall Comments: Through July – August 2023, the Patient Flow Strategy was implemented resulting in the addition of electronic estimated discharge date (EDD), Blaylock, a standardized welcome guide, form updates, pull to inpatient bed, and a new patient flow and surge policy. The 2023 Q1-3 saw increases in ED patient volumes, resulting in increases in acute admissions, driven by exacerbations of chronic illnesses and an aging population, acuity and complexity of patients presented challenges with discharge planning and community supports. In response to these challenges, the continued focus on patient flow improvements includes a targeted effort on reducing the time to inpatient bed, aiming to enhance overall efficiency and patient care.

Change Idea	Methods	Process measures	Target for process measure	Implemented as intended?	LESSONS LEARNED
Develop contingency plans	Create a working group that will develop and implement an effective corporate surge plan that is process driven, transparent and standardized.	Working group project milestones	100% complete by June 2023	Yes	Southlake launched the Patient Flow Steering Committee to better serve patients, allocate resources more effectively, and manage the hospital's capacity. The significant success of the working group can be attributed to its inclusive approach, engaging a broad array of stakeholders from various disciplines and departments. This diverse representation ensured that a wide range of perspectives and expertise were brought to the table, fostering a comprehensive and well-rounded strategy. The blend of extensive stakeholder involvement was a key factor in the working group's ability to meet and exceed its objectives, reflecting a model of excellence in collaborative problem-solving and strategic planning. In light of the unprecedented increase in Emergency Department (ED) visits and acute admissions experienced in 2023, surpassing the volumes of the 2022 calendar year, it was imperative for us to update our Surge Plan. In the Fall of 2023, Southlake witnessed a region-wide surge in visits, a scenario not previously encountered. The working group has been reformed to make necessary edits, further integrate program surge plans, and re-evaluate triggers based on data from the Corporate Operational Dashboard.
Standardize our admission and transfer process	Create a working group that will develop standard documents with common language outlining expectations for the entire organization around admission and transfer.	Working group project milestones	100% complete by June 2023	Yes	The established working group was successful in creating standardized forms, a Patient and Family welcome guide, and implemented Blaylock to help standardize admission and discharge processes. Integral to the working group's effectiveness was its commitment to continuous education throughout the project. This educational component not only kept all members up-to-date with the latest developments and best practices facilitated a shared understanding and collaborative spirit across the team.

90th Percentile ED Wait Time to Inpatient BED (Cont'd)

Change Idea	Methods	Process measures	Target for process measure	Implemented as intended?	LESSONS LEARNED
Standardize our discharge process	Create a working group that will develop and implement an effective and efficient standardized discharge process that begins at admission.	Working group project milestones	100% complete by June 2023	Yes	The implementation of the electronic estimated discharge date (EDD), standardized bullet rounds, and Patient and Family Welcome Guide yielded effective results. Minor revisions are being completed to EDD to ensure accuracy of prediction of expected discharge date. Bullet rounds standardized and positive experience on units.
Find and remove discharge bottlenecks relating to Diagnostic Imaging	Increase predictability of inpatient scheduling of imaging and decrease variability of access based on time of day/week and addition of off-hours capacity.	Working group project milestones	100% complete by June 2023	No	Challenges in implementing this change idea due to transitions in the Diagnostic Imaging (DI) leadership structure, including the appointment of a new Director and vacancies in two DI manager positions. We anticipate a completion by Q4. Concurrently, we are collecting data to better understand and address discharge barriers. These steps are essential for a more effective and sustainable implementation of the change initiative.

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Discharge Summaries in 2 Days

Overall Comments: At the system level, the primary issue contributing to the inability to complete tasks within 48 hours stems from Most Responsible Physicians (MRPs) not receiving notifications when a patient is discharged. Compounding this problem, once discharged, patients are removed from the MRP's daily census list. Furthermore, the physical chart becomes inaccessible as it is transferred to health records. The time taken for health records to reconcile, upload, and then notify the MRP of a “deficiency” or a missing discharge summary often exceeds 48 hours. This delay is a key factor in not meeting the QIP indicator target.

Change Idea	Methods	Process measures	Target for process measure	Implemented as intended?	LESSONS LEARNED
Find and remove bottlenecks relating to preparing Discharge Summaries within two days of discharge	Through a Physician champion in our Surgical Program, investigate individual barriers to timely completion of the Discharge Summaries and develop improvement strategies to address.	Overall performance in our Surgical Program.	Increase performance in the Surgical Program from 55% to 76% within 2023/2024.	No	This fiscal year, a thorough assessment of the process revealed a systemic-level barrier. Key stakeholders were engaged and informed. Indicator leads will continue to work with internal stakeholders to identify appropriate solutions to address identified barrier.
Find and remove bottlenecks in identifying primary care providers	Review processes relating to collection and documentation of Primary Care Providers, to identify barriers to populating this field in patient health records.	% of inpatients who have a primary care provider listed in their health record.	Relative improvement of 5% by end of 2023/2024.	No	The strategy of direct intervention at the individual level was removed, with a decision to concentrate efforts on identifying systemic issues.

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Workplace Violence Incidents with Loss Time and Health Care

Overall Comments: During this period, Southlake has diligently addressed workplace violence in compliance with OSHA guidelines. Despite facing challenges, we continue to uphold a high standard in occupational health and safety with a commitment to health, safety, and wellness. Our strategies have been adapted to meet these challenges, drawing valuable lessons from past incidents. This commitment is pivotal in mitigating risks and ensuring that our workplace is a safe environment where all staff can contribute effectively. Looking forward, we are focused on refining our strategies, further enhancing safety measures, and improving hazard identification processes.

Change Idea	Methods	Process measures	Target for process measure	Implemented as intended?	LESSONS LEARNED
New corporate training initiatives to include workplace violence, patient handling and supervisor competencies	Extending SMG training to all areas through the new hybrid model and collaboration with allied health to deliver the new safe patient handling training to all clinical areas.	% of staff completing/attending the training will be measured through internal reporting mechanisms.	Frontline staff for all clinical areas to achieve 100% compliance in these training initiatives before Dec 31, 2023.	YES	Our approach to this change idea included engaging with leaders to gain by in and support to deliver Safety Management training (ie. SMG), to all frontline staff. This method effectively addressed workplace violence, emphasizing the need for ongoing preventative actions. Discussions continue with relevant stakeholders about the possibility of making workplace violence training mandatory for all front-line, patient-facing staff to ensure sustainability.

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Patient Experience

Overall Comments: As the population grows, the strain on healthcare capacity has become increasingly evident. This fiscal year, Southlake has experienced a significant surge in patient volumes. Despite these challenges, we have remained steadfast in our commitment to providing people-centered care.

Change Idea	Methods	Process measures	Target for process measure	Implemented as intended?	LESSONS LEARNED
Listen to the patient's voice by actively seeking their feedback.	Use patient experience surveys to hear the concerns of the customer, and target improvement efforts accordingly.	Complete the procurement process of selecting a new external vendor to perform patient experience surveys, and begin collecting data.	Have a process in place to seek, collate, and analyze patient experience data in 2023/2024.	Yes	In accordance with the OHA recommendations, Southlake procured Qualtrics to measure patient experience. Qualtrics surveys went live in July 2023. We have received over 3000 survey responses since going live. A dedicated working group was formed to develop and pilot surveys. The inclusion of a Patient and Family Advisor significantly contributed to the group's success. Program-level engagement is underway for customized Qulatrics Dashboards.
Enhance the overall patient experience through focus on standard work and teamwork	Increase number of units implementing the standardized approach to Collaborative Care Redesign (CCR)	% of inpatient units with CCR implemented.	100% of inpatient units within scope of CCR, implementing CCR by fiscal year end	Yes	Some key learnings include early engagement of unit leaders and staff in the rollout. A staggered rollout worked well for this project identifying unit champions to support rollout was key and allowing each unit to co-design the rollout of each CCR element.

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Patient Experience (Cont’d)

Change Idea	Methods	Process measures	Target for process measure	Implemented as intended?	LESSONS LEARNED
Strategically recruit members for our Patient and Family Advisory Committees (PFACs) to be inclusive and represent the populations we serve	Address the gaps identified during an environmental scan, to increase the proportion of our diverse participants on our PFACs	Increase the number of diverse patient and family advisors on our PFACs	Double our participation on PFACs for underrepresented groups	Yes	Following a demographic survey sent to active Patient and Family Advisors (PFAs), education and engagement sessions were held to support programs recruiting PFAs from their respective patient populations. In 2023/24 there was an increase in applications and recruitment. A second demographic survey will be required in the next fiscal year to determine the success of the strategies implemented in 2023/24.
Enhance the patient experience for our Senior Population	Develop and implement a senior-friendly strategy	% of senior-friendly initiatives identified that are implemented	100% by end of fiscal 2023/24	Yes	There is a significant demand to address and improve senior care. Through analysis of our admission data, we have identified that seniors (defined as patients 65+ years of age) account for 51.2% of our ED admissions, of which, half are presenting with four or more comorbidities. We also identified that, on average, seniors have an average length of stay (LOS) of 9.22 days. These metrics provides us guidance on where we might best target additional interventions to enhance the patient experience for this population, including the introduction of a specialty Acute Care of the Elderly Unit and the Hospital Elder Life Program. Both the unit and the program will provide senior specific care, to help reduced the incidence of delirium, falls, and functional decline within this population. The formation of a steering and working committee played a crucial role in identifying and implementing key projects.

Hospital Acquired Pressure Injuries (HAPI) at Prevalence

Overall comments: The increased access to specialty surfaces and transfer devices has helped staff to efficiently provide appropriate care and equipment to patients at risk for pressure injuries. Our continued vigilance with pressure injury prevalence assessments and staff education for a variety of health care providers (e.g. nurses, PSPs, allied health) has helped us to exceed our 23/24 target.

Change Idea	Methods	Process measures	Target for process measure	Implemented as intended?	LESSONS LEARNED
Synchronize quality improvement efforts through a coordinated and collaborative interprofessional approach	Re-launch the Skin and Wound Committee to generate and guide improvement strategies	Form committee and meet regularly	Committee will meet a minimum of 10 times within the 2023/24 fiscal year	Yes	The committee was formed and is meeting regularly. We are seeing a positive downward trend in pressure injuries and continue to monitor this trend on a quarterly basis. There has been a recommendation to decrease the meeting frequency to quarterly to evaluate each prevalence day results, with the option to increase the number or add ad hoc meetings if trends are seen in incident reports between quarterly meetings.
Invest more capital resources, to increase the use of Pressure Injury Prevention Interventions	Procure equipment to enhance patient care as it relates to pressure injury prevention.	Obtain additional beds with air surfaces, mechanical lifts, and patient transfer devices	Receive at least 80% of requested equipment.	Yes	Equipment was received over the 23/24 fiscal year which had made it easier for staff to find required equipment in a timely manner, and therefore provide more patient-specific care.

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Inpatient Falls Resulting in Serious Harm

Overall Comments: Although we have not yet met this target, the move to the validated Johns Hopkins Falls Risk Assessment has improved the accuracy of our risk assessments. The total number of falls has decreased from the 22/23 fiscal year. It is currently at 0.62 falls per 1000 patient days compared to 0.70 in 22/23.

Change Idea	Methods	Process measures	Target for process measure	Implemented as intended?	LESSONS LEARNED
Improve the accuracy of Falls Risk Assessments	Roll out the Johns Hopkins Falls Risk Assessment Tool	Tool will be embedded into the electronic medical record (EMR) and education will be provided to clinical staff related to how to use the tool.	The new tool will be used in all adult inpatient medical & surgical units in the hospital.	Yes	This validated tool was introduced for all inpatient medical and surgical units and is now the standard falls risk assessment tool. As part of the roll out a comprehensive education toolkit was created and used and is available for all staff as reference material.
Invest more capital resources, to increase the use of Falls Prevention Interventions	Procure equipment to enhance patient care as it relates to falls prevention.	Obtain additional beds with bed exit alarms, mechanical lifts, and patient transfer devices	Receive at least 80% of requested equipment.	Yes	Equipment was received over the 23/24 fiscal year which had made it easier for staff to find required equipment in a timely manner, and therefore provide more patient-specific care.
Improve communication of falls risk during transfers of accountability	Include falls risk in transfer of accountability at shift change	Roll out the Electronic Handover Report to inpatient units	Roll out the Electronic Handover Report to all adult inpatient Medical/Surgical units by end of 2023/24	No	This change idea is currently underway and has not been implemented. A report was created within Meditech, but requires additional revisions before being fully implemented. As part of the falls prevention education tool kit, the importance of falls risk communication was emphasized.