QIP: 2024-2025 Progress Report

SouthlakeHealth

2024-2024 QIP Scorecard

Strategic Goal	Quality Dimension	Indicator	Description	FY24/25 Target	FY24/25 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.	38.0	43.2	40.9	41.0	43.5	42.1
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 hospital experience/care/ stay, where 0 is the worst and 10 is the best.	67%	71.0%	73.4%	73.2%		71%
	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	26	4	13	7	8	32
		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.	5.0%	5.4%	5.1%	7.1%	5.3%	5.7%
		In patient 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).	1.4%	0.06%	0.9%	1.6%	2.4%	1.5%
Create an Environment where the best experiences happen	Equitable	Equity	Percentage of leaders who completed relevant equity, diversity, inclusion, and antiracism education	100%	N/A	4%	50%	100%	100%

QIP: 2024-2025 Progress Report

SouthlakeHealth

Executive Summary

Indicator	Change Ideas	Indicator Lead(s)
90th Percentile ED Wait Time to Inpatient Bed	• Implement an electronic transfer of Accountability (TOA)	Clint Atendido
Patient Experience	• Establish an Essential Care Partner (ECP) Program • Dashboard will be implemented in 2024-25 for standardized analysis • Leadership Rounding	Sarah Alisch
Workplace Violence Incidents Resulting in Lost Time or Healthcare	• Develop a Workplace Violence Prevention awareness campaign	Menka Anand
Hospital Acquired Pressure Injuries at Prevalence	• Improve patient safety by optimizing current and new capital resources • Provide education to Essential Care Partners • Seek opportunities to improve documentations through education to staff	Sarah Alisch
Inpatient Falls Resulting in Moderate+ Harm	• Provide education to Essential Care Partners • Implement improvements to information shared related to falls risk during Transfer of Accountability (TOA)	Sarah Alisch
Equity	• Provide training and education opportunities for leaders to build foundational knowledge in Diversity, Equity and Inclusion (DEI) • Provide an unconscious bias training module to all leaders	Chantelle Vernon

QIP: 2024-2025 Progress Report

SouthlakeHealth

Indicator 1: 90th Percentile ED Wait Time to Inpatient Bed

Definition: *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 (ED) for admission.*

Overall Lessons Learned: *Timely bed updates and TOA completion are challenging because McKesson Performance Visibility (MPV) doesn't have automatic alerts, leading to missed updates and unexpected patient arrivals. Switching to Meditech adds complexity since its housekeeping and messaging tools are not fully developed, so staff still rely on MPV. To improve TOA consistency and address staff concerns, better training, system improvements and leadership accountability are needed, along with exploring automated messaging, dashboards and real-time feedback.*

Change Idea	Methods	Process Measures	Target for Process Measure	Implemented as Intended?
Implement an electronic Transfer of Accountability (TOA) to streamline patient handoffs while minimizing or eliminating the need for multiple phone calls. By implementing an electronic TOA system, the hospital can significantly enhance the safety and efficiency of patient transfers from the ED to inpatient units. This method focuses on creating a standardized, integrated, and user-friendly system, supported by thorough training and continuous monitoring, thereby reducing the reliance on phone calls while ensuring a high standard of patient care.	• Implement steps to ensure a smooth, reliable, and efficient transfer of information. • Integrate the electronic TOA process into the existing workflows of both the ED and inpatient units to ensure it complements and enhances current practices. • Automate notifications within Meditech to alert inpatient staff when a patient is ready for transfer and when the TOA is complete.	Percentage of steps taken to implement the electronic TOA	Percentage of steps taken to implement the electronic TOA	Partially – full roll out April 2025

Lessons Learned

- Timely notification of bed availability and TOA completion remains a challenge due to reliance on MPV color changes without automated alerts. Inconsistent staff monitoring of MPV results in missed notifications and unexpected patient arrivals. Stronger accountability is needed to ensure bed status updates and TOA completion before transfers.
- The transition from MPV to Meditech adds complexity, requiring dual-system usage as Meditech's housekeeping module and messaging functionality remain underdeveloped. This limits automated communication and prolongs reliance on MPV.
- Inconsistent adherence to TOA protocols has led to staff dissatisfaction, union concerns, and patient handoff issues. Addressing these concerns requires improved training, clearer expectations, and system enhancements.
- Potential Solutions & Next Steps:
- Explore activating Meditech's messaging system for automated bed status notifications.

- Develop an ED-facing dashboard to display bed status and prompt timely TOA completion.
- Maintain verbal TOA as an optional but available clarification tool.
- Implement regular audits and real-time feedback to improve compliance.
- Investigate communication tools (Hypercare, Teams, Meditech messaging) for TOA efficiency.
- Strengthen leadership accountability measures to address non-compliance.

QIP: 2024-2025 Progress Report

SouthlakeHealth

Indicator 2: Patient Experience

Definition: *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.*

Overall Lessons Learned: *The Essential Care Partner (ECP) Program successfully established a strong framework with regional and external support, reinforced by leadership engagement and positive patient advisor feedback. Increased leadership presence on units improved patient and staff engagement, while enhanced data analytics strengthened decision-making, though differences in data literacy created challenges in applying insights. Broader system-level integration, competing priorities, and varying engagement required targeted coaching, standardized tools, and leadership commitment to sustain improvements.*

Change Idea	Methods	Process Measures	Target for Process Measure	Implemented as Intended?
Initiate and implement an Essential Care Partner (ECP) Program	• Integrate and enhance ECPs role in the patients care team, allowing them to participate in care planning of their loved ones to support decision-making, and daily care activities with the guidance of healthcare professionals. • Establish clear communication channels and protocols between ECPs, patients, and healthcare teams to ensure coordinated care and shared decision-making. • Provide resources and support to ECPs, including educational materials, access to care plans, and guidance on best practices in patient support.	% of ECP initiatives identified that are implemented Regularly collect and analyze feedback from staff, patients and families, caregivers, and physicians to assess satisfaction with the ECP Program and identify areas of improvement.	100% of ECP initiatives by end of fiscal 2024/25.	No – In progress

Lessons Learned
The implementation of the Essential Care Partner (ECP) Program led to key successes, including the establishment of a dedicated working group to develop the program framework and strong support from regional programs and external organizations such as the Ontario Caregiver Organization

(OCO). Leadership and frontline staff engagement, alignment with the Quintuple Aim framework, and positive feedback from patient advisors further reinforced the program's value. However, implementation required broader system-level integration rather than solely an organizational approach, making alignment across multiple stakeholders more complex and challenging.

Change Idea	Methods	Process Measures	Target for Process Measure	Implemented as Intended?
Improving patient experience through increased access to real time data to inform improvement strategies.	Engage with decision support and clinical programs, to understand how to extract data from Qualtrics to help inform strategies for patient experience improvement. Establish mechanisms to share real time data at all levels of the organization.	% of clinical leaders to have access to real time data from Qualtrics.	100% of all leaders to have access to their own Qualtrics dashboards by the end of Q2.	Yes

Lessons Learned

Gained strong executive and departmental leadership support, allowing for data-driven decision-making at all levels. The Decision Support Team played a key role in refining data analytics and reporting targets for process. What aided in enabling this process was leveraging expertise in data analysis and visualization improved the quality and usability of patient experience insights. Barriers existed in the form of differences in data literacy among staff which created challenges in effectively interpreting insights and driving meaningful changes. Moreover, engagement in utilizing data for improvement varied across departments, requiring targeted coaching and reinforcement.

Change Idea	Methods	Process Measures	Target for Process Measure	Implemented as Intended?
Improve patient experience with leader rounding.	Implement a standardized leadership rounding program. Patient Experience Office to conduct regular check-ins with leaders to support any concerns.	% of clinical leaders rounding daily (Inpatient) Completion date of standardized toolkit	100% of clinical leaders rounding daily Develop Tool kit by end of Q1	Yes

	Patient Relation Office to create a standardized toolkit to support the sustainability of rounding.			

Lessons Learned
Successes were seen in increased leadership presence on units, fostering direct engagement with patients and staff. And improved patient feedback collection, leading to quicker issue resolution. Enablers were a strong commitment from leadership to make rounding a priority, standardized tools and scripts to guide leader-patient interactions. And positive reception from both staff and patients, reinforcing the value of the initiative. A barrier was seen in the form of competing priorities made it challenging for some leaders to round consistently.

QIP: 2024-2025 Progress Report

SouthlakeHealth

Indicator 3: Workplace Violence Incidents Resulting in Lost Time or Healthcare

Definition: *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*

Overall Lessons Learned: *Collaboration with key stakeholders successfully restructured the Workplace Violence Prevention (WPVP) committee, but limited resource allocation and competing organizational priorities delayed the awareness campaign to May 2025. Strong executive leadership support enabled engagement in Public Services Health and Safety Association (PSHSA) risk assessments, leading to 100% completion of unit-level assessments. However, competing priorities for unit leadership posed challenges in maintaining focus on proactive risk assessment training and implementation*

Change Idea	Methods	Process Measures	Target for Process Measure	Implemented as Intended?
Develop a Workplace Violence Prevention awareness campaign	• Review and revamp the WPVP program in collaboration with key stakeholders to increase engagement. • Engage with the WPVP committee and corporate communications to develop an awareness campaign to communicate key elements and resources of the WPVP. • Actively involve hospital leadership in promoting and participating in WPVP program activities to support buy-in. • Ensure that all resources related to the WPVP are easily accessible to staff. This can include digital resources, printed materials, and direct contacts for immediate assistance.	% Completion of the awareness campaign	100% completion of the campaign by Q4 2024/2	Successfully revamped membership and terms of reference of the WPVP committee. Awareness Campaign deferred to May 2025 (H&S week) as per Corp Comms due to optics. Efforts continue to push leaders to complete SPOT checks.

Lessons Learned				
Successes for this change idea included collaboration with key stakeholders to re-structure the WPVP committee. However, barriers to this change idea were that resources were not allocated to the campaign / alternate priorities as an organization.				
Change Idea	**Methods**	**Process Measures**	**Target for Process Measure**	**Implemented as Intended?**
Increase the frequency of Public Services Health and Safety Association (PSHSA) Risk Assessments	• Engage with leaders to gain strong support and endorsement for the completion of proactive risk assessments • Provide comprehensive training on how to conduct risk assessments at Clinical Services Huddle. • Use the PSHSA Risk Assessment Tool to complete proactive risk assessments for all clinical units. • Incorporate risk assessments into regular workflows and protocols to enable annual completion of risk assessment and following any changes to the use of the physical workspace. • Develop measuring and monitoring methodology	Number of units requiring risk assessments % of leaders who have completed the necessary training Number of programs with up-to-date risk assessment Number of units/programs that complete the risk assessments per month. % of completion month by month	100% of units or clinical units that complete at least one risk assessment in fiscal 24/25 100% completion of risk assessment training for clinical leaders.	100% completion attained for unit level risk assessments. PSHA online platform allows for monitoring of initial completion.

Lessons Learned
Successes for this change idea included stakeholder active engagement in both the training and the completion of their risk assessments. What enabled this was having support from ELT. However, a barrier to this change idea was competing priorities for unit level leadership

QIP: 2024-2025 Progress Report

Indicator 4: Hospital Acquired Pressure Injuries at Prevalence

Definition: *Percentage of patients with a new stage 2+ hospital acquired pressure injury (HAPI) identified during the quarterly pressure injury prevalence study.*

Overall Lessons Learned: *A key success was the development and approval of a patient brochure by the corporate PFAC committee, which is now in the final approval stages through Corporate Communications. Students in PP worked closely with wound care nurses to create the brochure, and strong engagement from the PFAC committee facilitated its progress. However, a barrier remains as the initiative relies on individual staff members to initiate patient education.*

Change Idea	Methods	Process Measures	Target for Process Measure	Implemented as Intended?
Improve patient safety by optimizing current and new capital resources.	Optimize equipment to enhance patient care as it relates to pressure injury prevention.	Monitor the availability of pressure injury prevention equipment in patient care areas and allocate appropriately.	100% of patients with pressure injuries or at high risk for pressure injuries.	Yes

Lessons Learned

Successes included the purchase of several new air surfaces so that the majority of beds in the hospital are now powered air surfaces and now heel boots are available on all inpatient units. What enabled these successes was buy-in from Senior Leadership for budget approval, however a barrier is that we still do not have powered air surfaces for 100% of our beds.

Change Idea	Methods	Process Measures	Target for Process Measure	Implemented as Intended?
Provide education to Essential Care Partners (ECPs)	Develop and provide education to ECPs on their role in preventing pressure injuries.	Create formal education materials. Provide	Formal education	Partially

		education to interested ECPs.	materials created by Q3 100% by end of fiscal 24/25	

Lessons Learned
A point of success was that a patient brochure was developed and approved by the corporate PFAC committee. The pamphlet is in the final stages of approval through Corporate Communications and will then be available for units to order and provide for patients and families. What assisted in enabling success was students in PP worked with the wound care nurses to develop the brochure. The PFAC committee was very engaged. A barrier to this indicator was that it relies on individual staff members to initiate this education.

Change Idea	Methods	Process Measures	Target for Process Measure	Implemented as Intended?
Seek opportunities to improve documentation through education for staff.	Improve the quality and thoroughness of pressure injury documentation by educating healthcare staff on best practices. This includes recognizing the stages of pressure injuries, accurately charting their progression, and noting preventive measures taken.	Education materials were created and available to nurse educators by the beginning of Q3, with education provided by the end of Q3.	100% of project completion by Q3	Yes

Lessons Learned
A success related to this indicator was that the wound care nurses took the lead in obtaining feedback on the current documentation screens within Meditech and made improvements based on that feedback and their own expertise. This has made the Meditech screens more streamlined and less cumbersome to use. What enabled the success of this initiative was that wound care nurses and some nurse educators were very engaged. The changes are also discussed at the PI Prevention and Management education day. This documentation will be included in the overall documentation improvement recommendations from the Nursing Documentation Working Group.

Definition: *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).*
Overall Lessons Learned: ***T****he Falls Brochures for inpatients and outpatients were successfully reviewed and made available across hospital areas, with staff encouraged to provide them to patients and their ECPs. The brochures were already created, requiring only review, but a barrier was that individual staff members needed to initiate the education. Meanwhile, an electronic TOA (eTOA) tool was developed to streamline the transfer of falls risk documentation between the ED and inpatient units, ensuring accuracy and accessibility; however, the full hospital-wide rollout has been delayed due to needed adjustments in communication processes, with plans for launch in early spring 2025.*

Change Idea	Methods	Process Measures	Target for Process Measure	Implemented as Intended?
Provide education to Essential Care Partners (ECPs)	Develop and provide education to ECPs on their role in preventing inpatient falls Investigate flexible and accessible training Formats.	Create formal education materials. Provide education to interested ECPs.	Formal education materials created by Q3 100% by end of fiscal 24/25	Yes
Lessons Learned				
A point of success was seen in the form of the Falls Brochures for both inpatients and outpatients. These were reviewed and are available to all inpatient and outpatient areas for staff to provide to patients and their ECPs. What enabled this was that brochures were already created and only required review. However, a barrier to this change idea was that this relies on individual staff members initiating this education.				
Change Idea	**Methods**	**Process Measures**	**Target for Process Measure**	**Implemented as Intended?**
Implement improvements to information shared related to falls risk during Transfer of Accountability (TOA)	Create a standardized process for TOA from ED to inpatient units	Create the standardized process for TOA and establish necessary tools for support by end of Q2 and	100%	Partially

		implement process and tool by the end of Q3.		

Lessons Learned
An electronic TOA (eTOA) tool was created that pulls documentation, including falls risk, from the ED nurse documentation into a "snapshot" that is viewable by the receiving inpatient nurse. This ensures that the information is accurate and easily accessible. What enabled this was that the ED and CAM agreed to pilot this process and Clinical Informatics has been an important partner in building the applications within Meditech. However, because some adjustments were required to improve communication about when the ED should complete the process, we have not been able to roll this out hospital wide yet. The plan is to start that roll out as soon as the process is running smoothly on the pilot unit. This is anticipated to be early spring 2025

Definition: *Percentage of leaders who completed relevant equity, diversity, inclusion, and antiracism education*
Overall Lessons Learned: *The Organizational Development department successfully enrolled all leaders and provided reminders to complete training on time, with targeted emails and hospital rounding to encourage participation. While the initiative benefited from strong communication and support from the Organizational Development team, competing priorities between departmental and organizational goals posed a barrier.*

Change Idea	Methods	Process Measures	Target for Process Measure	Implemented as Intended?
Provide training and education opportunities for leaders to build foundational knowledge in Diversity, Equity and Inclusion (DEI).	Utilized various communication methods (i.e. corporate newsletters, leaders meeting, posters and rounding etc.) to promote the purpose and encourage completion of modules.	Utilize existing TAHSN e-learning Introduction to Anti-Black Racism Communication strategy to promote completion of the TAHSN Anti-Black racism eLearning module	100% of all Leaders (Managers, Directors and ELT) by the end of fiscal year 2024/25	Yes
Provide implicit bias in health care eLearning training module to all leaders.	Engage in a procurement process to identify a vendor for the implementation of an unconscious training module. Integrate the unconscious training module into SOLS. Utilized various forms of communication to Leaders.	Procurement and integration of the implicit bias eLearning module in SOLS platform.	100 % of all Leaders (Managers, Directors and ELT) by end of fiscal year 2024/25.	Yes

Lessons Learned

The Organizational Development department enrolled all leaders to ensure they would receive reminders to complete by the designated end dates. Targeted emails were sent to remind leaders who had not completed the training, offering support as needed. Hospital rounding was conducted to

inform staff that the training is optional but encouraged. Consistent communication was maintained through the corporate newsletter and monthly DEI newsletter, and posters were displayed around the hospital. Enablers for this initiative included the communication strategy and the support of the Organizational Development team, who handled the uploading and tracking through the SOLS platform. However, barriers included competing priorities between departmental and organizational goals.