2017/18 Quality Improvement Plan
"Improvement Targets and Initiatives"

Scarborough and Rouge Hospital (Birchmount, General and Centenary Sites)

Quality Dimension	Objective	Site	Improvement Indicator	Baseline Oct. 2015 to Sept. 2016	SRH Target
Timely	**Reduce wait times in the ED**	**SRH**	**90th percentile emergency department length of stay for complex patients**	**9.9**	**9.0**

Change Idea # 1

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Implement a virtual short stay unit in order to reduce Length of Stay(LOS)	Establish a Business Case for a virtual Short Stay Unit at SRH-G and SRH-B.	Initiate data analysis regarding demand for Short Stay Unit that will improve ED wait times for admitted patients. SRH-C has established a plan to implement a Short Stay Unit within the ED. SRH-G and SRH-B to explore the opportunity of establishing a Short Stay Unit within each ED respectively.	Business Case for a Short Stay Unit at SRH-G and SRH-B established by September 2017.	Ambulatory Care Sensitive Conditions(ACSC) appropriate for a Short Stay Unit include: • Asthma • Heart Failure • Hypertension • Angina • Diabetes
	% of ED patients that require short stay admission accommodated within the Short Stay Unit at time of admission.	Establish process for early identification of diagnosis and treatment plan for patients with potential short LOS (UTI, TIA, Asthma exacerbation) Utilize Meditech and ED data management tool (EDIS) to track LOS.	80% of ED patients that require short stay admission are accommodated within the Short Stay Unit at time of admission by December 2017.	Dependent on the approval and timeline to implement a Short Stay Unit at SRH-G and SRH-B.
	% improvement in wait times for admitted patients in ED that are appropriate for transfer to the Short Stay Unit	Determine baseline wait time for Ambulatory Care Sensitive Conditions appropriate for a Short Stay Unit.	50% improvement in wait times for admitted patients in ED that are appropriate for transfer to the Short Stay Unit by March 31, 2018.	

Change Idea # 2

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Fast track registration process to decrease length of wait	% of CTAS IV and CTAS V will be registered in the area where they receive care	Registration process should be flexible and mobile to follow the patient	100% of identified CTAS IV and CTAS V patients will be registered utilizing mobile devices (i.e. kiosks, Workstation on Wheels) by December 31, 2017.	Current goal at SRH-C with opportunity to explore for SRH-G and SRH-B.

Change Idea # 3

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Reduce Wait time for diagnostic imaging test(s)	% of ED patients requiring ultrasound and CT scans who meet 2 hour turnaround time target	Defined as: Turnaround time for ultrasound and CT scans for ED patients from order to test completion Designated times and appointment slots in DI to fast track ED patients Expand after-hours access to DI for ultrasound and CT scans	70% of ED patients with ultrasound and CT scans will meet 2 hour turnaround time target by December 2017	SRH-G and SRH-B have recently extended ultrasound after-hours access and continued access to CT scan after hours. Explore opportunity for extended ultrasound after-hours at SRH-C.

Change Idea #4

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Expand geriatric management care for higher needs frail seniors in the ED	% of senior friendly care strategies implemented in ED	Senior friendly hospital initiatives (Care practices, environment, resources)	80% of senior friendly care strategies are implemented in EDs at all sites by end of March 31, 2018.	Senior friendly hospital initiatives for patients in acute zone (that are non-ambulatory and require functional care supports)

Quality Dimension	Objective	Site	Improvement Indicator	Baseline Oct. 2015 to Sept. 2016	SRH Target
Safe	**Reduce hospital acquired infection rates**	**SRH**	***Clostridium difficile*** **infection rate per 1,000 patient days**	**0.32**	**0.30**

Change Idea # 1

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Standardize the use of Ultraviolet (UV) Light no-touch technology where indicated across all three SRH sites to enhance environmental disinfection.	Develop a business case for the use of UV Light disinfection across all three SRH sites.	Business case development in collaboration with environmental services.	Business case for UV Light disinfection developed by April 30, 2017.	Centenary currently uses UV Light Disinfection following terminal Tier II cleaning of patient rooms.
	UV Light disinfection integrated into SRH standard work for environmental cleaning.		UV Light disinfection integrated into standard work for environmental cleaning by August 31, 2017.	Dependent upon acquisition of UV Light technology for the Birchmount and General Sites and staff training pre-requisite.

Change Idea # 2

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Explore and standardize sporicidal cleaning agents for everyday use across SRH.	Investigate and trial selected product(s) currently available on the market.	In partnership with environmental services.	Investigate and trial selected product(s) currently available on the market by November 2017.	

Change Idea # 3

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Raise physician awareness and understanding of C. difficile risk factors through implementation of an online IPAC module for new physicians.	% new physicians who have completed the IPAC online training module.	Training module to be accessed through the SRH Learning Management System which allows for tracking of module completion.	100% new physicians complete the IPAC online training module as of September 2017.	Physicians will have one month to complete the IPAC online module from the date of hire.

Change Idea # 4

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Engage physicians in current IPAC matters of interest relevant to their programs during departmental meetings	IPAC updates provided to physicians within the department of medicine	Medical Director for Infection Prevention and Control or delegate to attend department of medicine meetings to provide updates on IPAC matters of interest.	IPAC updates provided to physicians within the department of medicine at a minimum quarterly or as needed.	Initiate updates with medicine program and spread to other relevant departments

Quality Dimension	Objective	Site	Improvement Indicator	Baseline Oct. 2015 to Sept 2016	SRH Target
Safe	**Reduce hospital acquired infection rates**	**SRH**	**% Hand hygiene compliance before patient contact**	**85%**	**90%**

Change Idea # 1

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Establish real-time hand hygiene performance reporting using a web-based hand hygiene auditing technology.	Implement the HandyAudit hand hygiene auditing system	Implement the HandyAudit hand hygiene auditing system Including the use of mobile hardware as audit tool.	Implement the HandyAudit hand hygiene auditing system by March 31, 2018 across all SRH units/departments that collect hand hygiene audits.	Goal dependent upon the acquisition of mobile devices (computer, iPad etc.) as well as pre-requisite staff education and training.

Change Idea # 2

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Increase transparency and thus local accountability for hand hygiene performance by making unit monthly hand hygiene results visible to all staff and visitors at all sites.	Public posting on each unit of unit-specific monthly hand hygiene performance for Moments 1 and 4.	Public posting of unit-specific hand hygiene monthly performance to be in a visible location on each unit.	Public posting on each unit of unit-specific monthly hand hygiene performance for Moments 1 and 4 as of September 15, 2017.	This change idea is currently in place at the Centenary Site and will be spread to the Birchmount and General Sites.

Change Idea # 3

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Engage and partner with patients and families to identify strategies to improve hand hygiene and reduce hospital acquired infections.	Awareness campaign established.	IPAC in partnership with Patient and Family Advisors and SRH Communications Team.	Awareness campaign established by August 31, 2017.	
	Recruit a patient and family advisor (PFA) for each site to work with the Infection Control Committee and IPAC Team.	Work with PFCC leads to recruit and orient PFAs.	Recruit a patient and family advisor (PFA) for each site to work with the Infection Control Committee and IPAC Team by June 1, 2017.	

Quality Dimension	Objective	Site	Improvement Indicator	Baseline Oct. 2015 to Sept 2016	SRH Target
Safe	**Avoid facility acquired pressure injuries**	**SRH**	**% Hospital acquired inpatient pressure injuries (≥ Stage 2)**	**0.38%**	**0.37%**

Change Idea # 1

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Create a corporate Scarborough and Rouge Hospital (SRH) Pressure Injury Prevention (PIP) Committee	SRH PIP committee established	Establish small working group with representation from all sites by Q2 Compare current work processes, policies and prevention strategies already in place by Q2 Establish the standardized committee structure & confirm terms of reference by Q2 Review current best practice guidelines and evidence on Pressure Injury prevention strategies	SRH PIP committee established across all sites by September 30, 2017.	Process to harmonize the SRH PIP committee will leverage learnings from the recent Order Set Committee harmonization process.

Change Idea # 2

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Standardized Review Process for Pressure Injuries Prevention	Standard work for purposeful rounding for pressure ulcer prevention developed	Develop auditing checklist and expectations for staff and leadership for unit rounding in relationship to pressure injury prevention. Create standardized questions to add to bullet rounds and/or quality improvement huddles. Engage and involve patients and families in review of current status and development of prevention strategies. Develop and implement unit specific PIP prevention strategies.	Standard work for purposeful rounding for pressure ulcer prevention developed by November 30, 2017.	Leverage standard work for falls to support purposeful rounding for pressure injuries

Change Idea # 3

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Establish Pressure Injury Prevention Champions to support implementation and adherence to best practices for pressure injury prevention.	PIP Champions for each pilot unit established.	Identify units at risk for higher pressure injury Capacity building at the local level for units identified at higher risk for pressure injury.	PIP Champions for each pilot unit established by December 2017.	

Quality Dimension	Objective	Site	Improvement Indicator	Baseline Oct. 2015 to Sept 2016	SRH Target
Safe	**Reduce patient falls**	**SRH**	**Inpatient falls rate per 1,000 patient days (moderate/severe harm)**	**0.15**	**0.14**

Change Idea # 1

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Harmonize to a corporate Scarborough and Rouge Hospital (SRH) Falls Committee	SRH Falls Committee in place.	Establish small working group with representation from all sites. Compare terms of reference, membership, and current focus of existing committees Review best practice guidelines and evidence on falls prevention and injury reduction strategies to identify priorities and annual work plan. Monitor corporate and unit falls rates on a monthly basis at the Falls Committee	SRH Falls Committee in place by April 30, 2017.	The process to harmonize the SRH Falls Committee will leverage learnings from the recent Order Set Committee harmonization process.

Change Idea # 2

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Standardized Review Process for Patient Falls	Harmonize SRH falls prevention policy across all sites.	Falls Committee reviews and harmonizes the various falls policies to one corporate policy.	SRH falls prevention policy harmonized across all sites by June 30, 2017.	Policy to include a systematic approach to review falls causing adverse results.
	% of staff on identified pilot units completing falls training.		80% of the staff on identified pilot units complete falls training by September 30, 2017.	

	Standardized falls debriefing tool established.	Pilot unit(s) identified at each site to test the tool and process. Develop communications and education/training plan for the pilot units	Standardized falls debriefing tool established by June 30, 2017.	Plan for spread to other units.
	% falls on the pilot units with debriefing tool completed post fall.		100% falls on the pilot units with debriefing tool completed post fall by September 30, 2017.	
	Explore an automatic electronic solution to alert leaders of patients having repeat falls.	Work with incident reporting system company to identify an automatic electronic solution to alert leaders of patients having repeat falls.	Explore an automatic electronic solution by May 30, 2017 to alert leaders of patients having repeat falls.	
	Standard work for purposeful rounding for falls prevention developed.	Develop expectations for nursing and leadership unit rounding in relationship to falls	Standard work for purposeful rounding for falls prevention developed by April 30, 2017.	To facilitate accountability for patient safety

Change Idea # 3

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Develop and implement unit specific falls prevention and injury reduction strategies	Specific unit falls prevention strategies in place for pilot units.	Identify units with high falls rates Recruit falls champion(s) for the unit and leverage Unit Councils. Complete targeted education on unit specific falls risks for clinical & nonclinical staff Engage and involve patients and families in review of current status of falls and development of prevention strategies	Specific unit falls prevention strategies in place for pilot units by September 30, 2017.	

Quality Dimension	Objective	Site	Improvement Indicator	Current Performance	Target
Safe	**Enhance medication safety for patients**	**SRH**	**% Medication reconciliation at admission**	**85**	**89**

Change Idea # 1

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Establish oversight committee (i.e. SRH Safe Medication Practice Committee) - Corporate wide - Physician rep from each site - Exec sponsorship - Reporting to the Quality of Care Committee	Creation of SRH Safe Medication Practices Committee	Develop corporate terms of reference Select members Meet every 2 months for the year Ensure that Medication Reconciliation is a shared interprofessional responsibility involving the nurse, physician and pharmacist which includes the patient/family input in the process.	Creation of SRH Safe Medication Practices Committee by May 2017.	The project will be a multiple year plan with the initial focus on patients admitted via the ED to the Medicine units at all 3 sites and then discharged home. This will be followed with a plan to spread across all units in a sequential manner.

Change Idea # 2

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Standardize auditing process of Medication Reconciliation at Admission within Medicine units across all 3 sites	% of Medicine units with MedRec audits completed using new standard work.	Review current state auditing processes and develop standard work for best practice future state to ensure local ownership of processes and sustainability	75% of Medicine units with MedRec audits completed using new standard work by December 2017.	This will be piloted on a specific unit at each site and spread out to all the medicine units on the respective sites.

Change Idea # 3

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Standardize Medication Reconciliation process at admission across 3 sites, for Medicine patients admitted through the Emergency Department.	Value stream map developed for each site.	Value stream mapping, rapid improvement event. Ensure the value stream map is a shared interprofessional model involving the nurse, physician and pharmacist and patient/family along with other staff as deemed appropriate.	Value stream map developed for each site by September 2017.	The project will be a multiple year plan with the initial focus on patients admitted via the ED to the Medicine units at all 3 sites and then discharged home. This will be followed with a plan to spread across all units in a sequential manner.
	% prospective MedRec completed (in ED, before admission)		50% prospective MedRec completed (in ED, before admission) by March 31, 2018.	To determine resource allocation i.e. how many are done in the ED versus on the units
	% patients within Medicine who were asked by a staff member for a medication history (part of "Best Possible Medication History")	Reinforce patient engagement – staff education, orientation	75% patients within Medicine who were asked by a staff member for a medication history (part of "Best Possible Medication History") by March 31, 2018.	This is a quality measure to evaluate the content of the medication reconciliation
	% of Medication Reconciliation amended by Pharmacy staff when initially performed by physician/nurse.	Collect the number of medication reconciliations that have been revised by the pharmacist when initially done by the physician/nurse	50% of Medication Reconciliation amended by Pharmacy staff when initially performed by physician/nurse as of March 31, 2018.	This is a quality measure to evaluate the content of the medication reconciliation and to assist in allocation of staffing for these more complex patients

Quality Dimension	Objective	Site	Improvement Indicator	Current Performance	Target
Safe	**Enhance medication safety for patients**	**SRH**	**% Medication reconciliation at discharge**	**75**	**79**

Change Idea # 1

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Establish oversight committee (i.e. SRH Safe Medication Practice Committee) - Corporate wide - Physician rep - Exec sponsorship	Creation of SRH Safe Medication Practices Committee	Develop corporate terms of reference Select members Meet every 2 months for the year Ensure that Medication Reconciliation is a shared interprofessional responsibility involving the nurse, physician and pharmacist which includes the patient/family input in the process.	Creation of SRH Safe Medication Practices Committee by May 2017.	The project will be a multiple year plan with the initial focus on patients admitted via the ED to the Medicine units at all 3 sites and then discharged home. This will be followed with a plan to spread across all units in a sequential manner.

Change Idea # 2

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Standardize Medication Reconciliation process at discharge across 3 sites, within Medicine Units	Value stream map developed for each site.	Value stream mapping, rapid improvement event. Understand the current process at each site and standardize and simply processes using Meditech generated forms/prescriptions.	Value stream map developed for each site by September 2017.	The project will be a multiple year plan with the initial focus on patients admitted via the ED to the Medicine units at all 3 sites and then discharged home. This will be followed with a plan to spread across all units in a sequential manner.

Change Idea # 3

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Standardize Medication Reconciliation audit process at discharge across 3 sites, within Medicine Units	% of Medicine units with audits completed	Review current state auditing processes and develop standard work for best practice future state to ensure ownership at local level and sustainability	75% of Medicine units with audits completed by December 2017.	This will be piloted on a specific unit at each site and spread out to all the medicine units on the respective sites. This will be followed with a plan to spread across all Medicine units in a sequential manner.

Quality Dimension	Objective	Site	Improvement Indicator	Baseline Oct. 2015 to Sept 2016	SRH Target
Efficient	**Reduce unnecessary time spent in acute care**	**SRH**	**Alternate level of care rate**	**18.8**	**21.2**

Change Idea #1

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Complete and spread the ED Non-Acute Admission Diversion project recommendations to all three Emergency departments	% of Non-Acute Admitted patients that become ALC for LTC	Medworxx Patient Throughput Review (PTR) tool that identifies non acute admissions	10% decrease of Non-Acute Admitted patients that become ALC for LTC by September 31, 2017.	Currently a project in partnership with CCAC, Seniors Care Network, GAIN and SRH-Birchmount/ General
	% of Non-Acute Admission Diversion project recommendations implemented in all 3 EDs	PTR tool	75% of Non-Acute Admission Diversion project recommendations implemented in all 3 EDs by December 31, 2017	

Change Idea #2

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Ensure best practices to divert ALC are optimized and sustained across inpatient units at all sites	Complete ALC Avoidance self-assessment at all 3 sites	ALC Avoidance self-assessment tool	ALC Avoidance self-assessment at all 3 sites completed by June 1, 2017.	
	% of ALC Avoidance best practices selected will be met	Establish an ALC strategy to address and implement best practices	80% of ALC Avoidance best practices selected will be met by March 31, 2018	ALC Avoidance best practices will be selected from the Toronto Central CCAC ALC Avoidance Toolkit. .

Change Idea #3

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Develop and implement patient and family education about discharge planning expectations	% of identified staff that complete discharge planning education	Online tutorial that includes rationale and script about discharge planning	60% of identified staff complete the discharge planning education by March 31, 2018	Consider exemption to maternal newborn/paediatric Inclusive of physicians
	Develop a standardized communication tool for patients and families about discharge planning expectations from acute care	Review existing SRH communications tools about discharge planning. Engage a PFA.	Standardized communication tool for patients and families about discharge planning expectations from acute care developed by December 31, 2017	

Change Idea #4

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Develop and reinforce an escalation process to ensure all steps have been taken to divert ALC and determine ALC designation	Standardize ALC policy and escalation process between all sites	Review existing site specific escalation policies.	ALC policy and escalation process standardized between all sites by September 2017.	
	% of ALC potential patients escalated to determine ALC designation.	Align ALC policy and escalation process between all sites Standardized corporate "ALC rounds and escalation process"	90% of ALC potential patients escalated to determine ALC designation by January 31, 2018.	Includes escalation for alternate discharge options as well as application process for alternate facilities (i.e. LTC, rehab, etc.)

Quality Dimension	Objective	Site	Improvement Indicator	Baseline Oct. 2015 to Sept 2016	SRH Target
Effective	**Reduce readmission rates for patients with CHF**	**SRH**	**30-day readmission rate to own facility – Chronic Heart Failure (CHF)**	**16.8**	**16.5**

Change Idea # 1

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Standardized care pathway for CHF patients across all Scarborough and Rouge Hospital	Creation of standardized Care Pathway for CHF across all 3 sites	Conduct a Value Stream Mapping exercise to identify opportunities to streamline and strengthen CHF care pathways • Identified commonalities and differences in existing states at all three sites • Educating interprofessional team caring for CHF patients on the CHF Pathway • Determine best practice approach to define consistent practice and process • Identify process of roll out and education • Create timelines for phases of roll out and implementation (PDSA) • Conduct audits at various points in the map that measures consistency to establish baseline and track improvements • Feedback and sharing of adherence data to front line team members	Creation of standardized Care Pathway for CHF across all 3 sites by June 2017.	

Change Idea # 2

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Implement and increase utilization of CHF order sets (including medication reconciliation)	CHF Order Sets standardized across all 3 sites	Stakeholder engagement to develop and create a consistent CHF order set Establish PDSA process for education, awareness, and roll out of CHF order set	CHF Order Set standardized across all three sites by June 2017.	
	% admitted CHF patients that are on the established CHF Order Set.	Conduct Audits Ongoing communication regarding CHF Order Set utilization.	80% of admitted CHF patients are on the established CHF Order Set by March 31st, 2018.	

Change Idea # 3

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Provide physicians with their CHF readmission rate	Physician reports on readmission rates for CHF	Collaborate with Decision Support on this initiative. Review metrics that currently exist on existing MD scorecards Establish agreement among MDs as to indicators measures on common scorecard Collaborate regularly with physicians to identify opportunities to reduce unnecessary readmissions Review use of evidenced based practice and guidelines for CHF.	Physician reports on readmission rates for CHF developed by September 2017.	

Change Idea # 4

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Develop an integrated and coordinated plan of care for patients upon discharge.	% of high risk CHF patients discharged with the appropriate follow up appointment/services in place % of high risk CHF patients contacted post discharge who access their discharge follow up service	Establish baseline current state measure Track number of patients admitted with CHF Establish process of measuring # of admitted CHF pts discharged with appropriate follow up plans Conduct post discharge audits Review appropriateness of set goal/measure and adjust as needed to better reflect feasible goal Follow up phone calls to discharged patients Track readmission rates of CHF patients	100% of high risk CHF patients (stage 4 and stage 5) will be discharged with the appropriate follow up appointments/services by September 2017. 80% of high risk CHF patients contacted post discharge who access their discharge follow up services by March 31, 2018.	Community resources include: • Health links • Telehomecare-CHF module • Central East LHIN enhanced regional cardiovascular rehabilitation for CHF • CHF Clinic • MD (either primary care or cardiologist) office. • % patients accessing their discharge follow up services may need to be adjusted depending on baseline measurement of current state.
	Creation of a standardized toolkit to support CHF patients in the community setting. % of discharged CHF patients who are provided with the CHF toolkit.	Establish awareness of standardized tools and resources for CHF patients, families and their caregivers • Creation of a standardized toolkit to support CHF patients in the community setting • Conduct focus groups for CHF patients and LTC Homes. • Establish links on hospital websites to enable access to tools • Establish means of measuring patient access to CHF toolkit	Standardized toolkit to support CHF patients in the community setting created by September 2017. 80% of discharged CHF patients are provided with the CHF toolkit by March 31, 2018.	

Quality Dimension	Objective	Site	Improvement Indicator	Baseline Oct. 2015 to Sept 2016	SRH Target
Effective	**Reduce readmission rates for patients with COPD**	**SRH**	**30-day readmission rate to own facility – Chronic Obstructive Pulmonary Disease (COPD)**	**14.6**	**15.9**

Change Idea # 1

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Develop a standardized care pathway for COPD patients across all sites	Creation of standardized Care Pathway for COPD across all 3 sites	Conduct a Value Stream Mapping exercise to identify opportunities to streamline and strengthen COPD care pathways	Standardized COPD Care pathway is completed for all sites by September 2017	Build upon learnings and processes with CHF team partners

Change Idea # 2

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Develop an integrated and coordinated plan of care for patients upon discharge.	% of COPD patients discharged with the appropriate follow up appointment (i.e. family physician, family health care team/services (i.e. CCAC, GAIN, GIM, OTN, Central East LHIN Regional Cardiovascular services) in place	Conduct post discharge audits Follow up phone calls to discharged patients	80% of COPD patients will receive COPD follow up appointments upon discharge by September 2017	Community resources; • Health links • Telehomecare-COPD module • CCAC-Rapid response nursing team
	% of COPD patients that received standardized discharge toolkits	Develop standardized toolkit for COPD patients, families and their caregivers Conduct focus groups for COPD patients, families and caregivers	80% of COPD patients will receive standardized discharge toolkit upon discharge by December 2017	Hospital to home strategy Smoking cessation program

Change Idea # 3

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Provide physicians with their COPD readmission rate.	Physician reports on readmission rates for COPD.	Collaborate with Decision Support on this initiative. Review metrics that currently exist on existing MD scorecards Establish agreement among MDs as to indicators measures on common scorecard Collaborate regularly with physicians to identify opportunities to reduce unnecessary readmissions Review use of evidenced based practice and guidelines for COPD management	Physician reports on readmission rates for COPD developed by September 2017.	

Change Idea # 4

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Implement and increase utilization of COPD order sets and care pathways (including medication reconciliation)	Develop COPD order set that is standardized across all 3 sites	Using evidence based practices enabled through order set committee	Standardized COPD order set will be completed across all 3 sites by September 2017.	
	% of COPD order sets utilized for COPD admitted patients	Tracking COPD order set utilization through health records bar code	70% of all COPD patients will have COPD order set used by December 2017.	

Quality Dimension	Objective	Site	Improvement Indicator	Baseline Oct. 2015 to Sept 2016	SRH Target
Patient-centred	**Improve patient satisfaction**	**SRH**	**% Patient satisfaction: Did you receive enough information when you left the hospital? (medical and surgical inpatients)**	**48.5**	**53.3**

Change Idea # 1

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Enhance communication with patients and families that helps navigate hospital processes and patient experience.	Develop Patient Information Handbook.	Review existing patient communication brochures and tools across all sites to standardize into one handbook Handbooks available at designated points of entry for patients and their families Available to download via hospital internet/intranet	Patient Handbook is standardized across all 3 sites by December 31, 2017.	

Change Idea # 2

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Ensure timely and complete communication to primary care providers and LTC Homes of their patients' discharge information	% of discharge summaries competed	Automated chart audit Retraining and education of physicians and staff for completion of discharge summaries.	As of March 31, 2018, 80% of known primary care providers listed on patient charts will receive discharge information within one week of patient discharge.	Use findings from audits to implement process improvements.
	% patients discharged back to LTCH with standardized discharge package	Pilot standardized discharge package with Seven Oaks and Yee Hong LTC Homes.	100% patients discharged back to LTCH with standardized discharge package by March 31, 2018.	

Change Idea # 3

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Implement real time patient feedback process across all sites	% of discharge telephone calls across three sites made within 48 hours of discharge.	Review patient feedback tools used at each site to explore opportunities for spread and standardization.	70% of discharge telephone calls across three sites are made within 48 hours of discharge.	

Quality Dimension	Objective	Site	Improvement Indicator	Baseline Oct. 2015 to Sept 2016	SRH Target
Effective Transitions	**Improve Home Support for Palliative Patients**	**SRH**	**% inpatients identified as palliative who are discharged home with support**	**93.4**	**95**

Change Idea # 1

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Standardize referral criteria and process for patients referred to the Palliative Care Team.	Palliative care referral criteria standardized across all three sites.	Review palliative care referral criteria currently in place across all three sites. Explore best practices for Palliative Care Teams and referral processes.	Palliative care referral criteria standardized across all three sites by November 30, 2017.	
	Automate the referral process to PCT in Meditech, through Order Entry (OE).	In partnership with health informatics.	Automate the referral process to PCT in Meditech, through Order Entry (OE) by December 31, 2017.	Currently in place at SRH-G and SRH-B with spread plan for SRH-C.

Change Idea # 2

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Discussion in daily bullet rounds across all units where patients can be identified as benefiting from palliative supports to safely transition home.	Develop standard work for bullet rounds to support identification of patients that would benefit from a referral to the SRH Palliative Care Team.	Pilot standard work within one medicine unit at each site with the intent to spread to other units as feasible this fiscal year.	Standard work for bullet rounds to support identification of patients that would benefit from a referral to the SRH Palliative Care Team established by September 30, 2017.	

Change Idea # 3

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Enhance staff awareness of palliative care.	% of health care providers who complete the online palliative care education module	Complete classroom and online palliative care education utilizing the Learning Management System (LMS) for staff Provide education around the common tools to assess and intervene with patients and families; including, but not limited to: • PPS • Advance Care Planning Toolkit for Providers • ESAS Encourage participation in LEAP training	50% of health care providers complete the online palliative care education module by March 31, 2018.	Embed a patient and family-centred, evidence based approach in palliative care education and training. Healthcare providers include FT and PT RNs, RPNs, Social Work, Spiritual Care within the Medicine program.

Change Idea # 4

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Define a Multidisciplinary Palliative Care Team approach to support the palliative care assessment, consultation and treatment planning across all sites.	Multidisciplinary Palliative Care Team approach established for each SRH site.		Multidisciplinary Palliative Care Team approach established for each SRH site by January 31, 2018.	

Quality Dimension	Objective	Site	Improvement Indicator	Baseline Oct. 2015 to Sept 2016	SRH Target
Patient-centred	**Improve patient satisfaction**	**SRH**	**% Patient satisfaction in the ED: Would you recommend emergency department?**	**45.6**	**50.2**

Change Idea # 1

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Implement a framework to gather real-time feedback from patients	% patients and/or their families asked to participate who provide real-time feedback while in the ED	Use of I-Pillar or other electronic methods to capture real time feedback from patients and families. Consider how volunteers can support the process.	70% patients and/or their families that are asked to participate will provide real-time feedback while in the ED by December 31, 2017.	

Change Idea # 2

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Conduct a Kano analysis to understand patient expectations and identify factors influencing patient satisfaction and dissatisfaction	Kano analysis is completed across all 3 sites	Conduct a patient satisfaction analysis using Kano model. Involve patient and family advisors. Develop implementation plan for top 3 attributes identified to improve patient satisfaction by December 2017	Kano analysis is completed across all 3 sites by September 2017.	Kano is an approach to analysis of customer satisfaction, which classifies customer preferences into five categories. Service attributes could be physical layout, staff interactions, professionalism, and outcome of the service provided.

Change Idea # 3

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Improve clarity and frequency of wait time information in collaboration with patients/families	Wait times displayed in the ED across all 3 sites for all CTAS I to CTAS V cases.	Review current state of signage used at other hospitals. Share wait time performance on website	Wait times displayed in the ED across all 3 sites for all CTAS I to CTAS V cases by September 2017.	SRH-G and SRH-B has wait time data shared in ED.

Change Idea # 4

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Improve the patient experience by timely acknowledgement upon arrival to the ED	% of ED staff who complete customer service training	Retrain staff in customer service utilizing the “Hospitality” model (such as Communicate with H.E.A.R.T training) Consider “received” tracker as a tool that acknowledges and tracks patients as they arrive in the ED for immediate access to team member	80% of ED staff across all 3 sites complete customer service training by March 31, 2018.	

Quality Dimension	Objective	Site	Improvement Indicator	Baseline Oct. 2015 to Sept 2016	SRH Target
Patient-centred	**Improve patient satisfaction**	**SRH**	**% Patient satisfaction: Would you recommend inpatient care? (medical and surgical inpatients)**	**50.7**	**55.7**

Change Idea # 1

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Enhance communication with patients and families that helps them to navigate hospital processes and patient experience	Develop/revise Patient Information Handbook	Review existing patient communication brochures and tools across all sites to standardize into one handbook Handbooks available at designated points of entry for patients and their families Available to download via hospital internet/intranet	Patient Handbook is standardized across all 3 sites by December 2017	

Change Idea # 2

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Implement communication board in all patient rooms across all 3 sites	Communication board implemented across all 3 sites	Review existing white boards in place across all 3 sites. Focus group with key stakeholders including patient and family advisor(s) to identify needed information on white boards.	80% of patient rooms on designated units across all three sites will have a communication board by March 31, 2018.	Determine designated units for this project – medicine, surgery, post-acute care.

Change Idea # 3

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Develop and implement real-time patient feedback tools to enhance the patient experience.	Standard work established for leadership rounding to capture real-time patient feedback.	Purposeful rounds initiated by unit leaders with intent to seek patient/family feedback Includes target and clear process questions to be initiated by unit leaders.	Standard work established for leadership rounding to capture real-time patient feedback by March 31, 2018.	Real time feedback will allow staff to make appropriate changes.
	% of discharge telephone calls across three sites made within 48 hours of discharge.	Review patient feedback tools used at each site to explore opportunities for spread and standardization.	70% of discharge telephone calls across three sites are made within 48 hours of discharge	
	In collaboration with PFAs, develop standard work for volunteers to initiate real time feedback from patients and families	Review existing examples of how volunteers facilitate timely capture of patient feedback across all 3 sites	In collaboration with PFAs, standard work is developed and implemented for volunteers to initiate real time feedback from patients/families in designated programs across all 3 sites by March 31, 2018.	

Quality Dimension	Objective	Site	Improvement Indicator	Baseline Oct. 2015 to Sept 2016	SRH Target
Effective	**Foster a culture of creativity and innovation that enables timely adoption of leading practices, concepts and ideas and drives quality improvement**	**SRH**	**Ideas Implemented per Full Time Equivalent (FTE)**	**1**	**1**

Change Idea # 1

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Increase visibility/awareness of idea generation as innovation opportunities; Focus staff ideas on improved patient experience and staff satisfaction.	# of celebrations held organization wide to recognize ideas.	Standing item at Town Halls. Recognition of those submitting winning ideas. Local level celebrations to be reported monthly through standardized reporting tool.	One celebration per month at the organizational level to recognize ideas (Leadership Forum) as of June 2017.	
	% of standard internal organizational communications includes stories about idea generation.	Standing item in organizational e-newsletter. Spotlight on those submitting ideas and on recognition awards for winning ideas in internal communications following Town Halls.	75% of standard internal organizational communications includes stories about idea generation, measured at March 31, 2018.	

Change Idea # 2

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Create opportunities for patients and families to provide feedback re improvement opportunities or ideas and a portal to share their feedback with members of the SRH workforce.	% of total ideas implemented from direct patient and family feedback.	Patient/family idea boxes to be placed in common areas at all sites. We are working on a process for direct engagement from Patient ideas to be included on unit-based idea boards. Results to be self-reported by units.	10% of total ideas implemented from patient and family feedback by March 31, 2018.	

Change Idea # 3

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Implement routine evening/night/weekend shift idea board huddles in departments/units that have 24/7 shifts.	% of 24/7 departments that have held at least one idea board huddle per month on an evening/night or weekend shift	Data to be self-reported monthly by each department using shared reporting tool	80% of departments will complete at least one off-shift idea board huddle per month, by March 31/2018	

Quality Dimension	Objective	Site	Improvement Indicator	Baseline Oct. 2015 to Sept 2016	SRH Target
Effective	**Fiscal responsibility to support patient care delivery**	**SRH**	**Net Margin**	**0**	**0**

Change Idea # 1

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Volume Management (ongoing monitoring & oversight of volume performance that are incrementally funded)	% unfunded volumes	Track volume performance in monthly operating results package and meet regularly with clinical teams to discuss	0% unfunded volumes by March 31, 2018 (where volume restrictions pose no risk to patient safety)	Performing unfunded volumes (i.e. QBP's, Cardiac Priority and/or Wait-time) creates a financial exposure. Additional costs may be incurred without the guarantee of incremental funding.

Change Idea # 2

Change Idea	Process Measures	Methods	Goal for Change Idea	Comments
Improve documentation and coding to maximize Resource Intensity Weighting (RIW) and Expected LOS	% of deficiencies (incomplete charts) on a monthly basis	Raise awareness and improve processes and controls to enhance the completeness and accuracy of documentation with the Chief of Staff, nurses and Health Records.	0 % of deficiencies (incomplete charts)	Included in legacy RVHS 2016/17 Operating and Capital Plan "Blue Book". On-going efforts need to continue through 2017-18