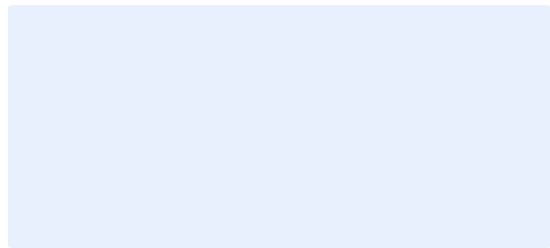


Let's Make Healthy  
Change Happen.



## Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario



**3/17/2017**

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a Quality Improvement Plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein.

[ontario.ca/excellentcare](http://ontario.ca/excellentcare)

# Overview

This Quality Improvement Plan (QIP) represents an exciting milestone and opportunity for Scarborough and Rouge Hospital (SRH) – a newly-merged organization still currently in a period of transition. This is the organization’s first QIP, and it sets the stage for establishing SRH as a high-performing, patient-centered provider of excellent quality care.

## Developing a quality agenda while in transition

SRH was established on December 1, 2016, bringing together the Birchmount and General sites of The Scarborough Hospital (TSH) and the Centenary site of Rouge Valley Health System (RVHS). All three sites brought with them strong quality improvement programs that have provided a firm foundation for SRH to develop this QIP.

As this first year is a transitional one, SRH’s approach to its new quality improvement agenda is to take this opportunity to learn and share among the three sites. Targets have been set that are meaningful and achievable. SRH will take this first year to better define and standardize quality improvement processes and measurements, and build on the momentum of initiatives that are driving positive change. Looking to the future, SRH envisions advancing the organization’s quality improvement agenda further through more widespread innovation and best practices. We have learned that it often takes years to implement change ideas and see their impact. This QIP is the first step on our improvement journey as a new organization. It is a key component of our overall approach to quality which is founded on the philosophy that quality is everyone’s responsibility.

## Addressing key quality issues

QIPs help us to address the issues that threaten a quality patient experience. Health Quality Ontario (HQO), the provincial advisor on quality in health care, has six dimensions of quality for which it has identified 11 key issues facing health care:

- Effective: Effective transitions, Coordinating care, Population health
- Patient-centred: Palliative care, Person experience
- Efficient: Access to the right level of care
- Safe: Safe care, Medication safety, Workplace safety
- Timely: Timely access to care/services
- Equitable: Equity

Although these issues have been identified at the provincial level, they match the priorities that our SRH has set. These key issues served as a framework for the development of SRH’s 2017/18 QIP.

## Addressing key quality issues

SRH is strongly committed to stakeholder engagement as we move forward with our new organization. In keeping with this commitment, our QIP was guided by input from a wide range of stakeholders. To better understand what these quality issues mean for SRH, a dialogue on quality of care was held with those experiencing patient care and those delivering services. **More than 500 internal and external stakeholders were engaged in our QIP** in many ways, including:

- Face-to-face interviews with 77 current patients and family members
- Focus groups, huddles and interviews with 366 staff
- A survey for management and physician leaders that yielded 51 responses

- Community focus groups with 22 participants
- A health provider partners meetings with 12 participants
- Change idea workshops that involved 30 leaders and physicians and 2 Patient/Family Advisors

These engagement activities focused on how stakeholders define quality and understanding their experience with care delivery at SRH. We learned that in many ways, the stories of patients, families, and community members echoed what was heard from staff and physicians, with many of the same themes emerging around the key quality issues. The chart below summarizes the key themes we heard in relation to the quality issues:

Improvement Themes from Patient & Staff Engagement		
Themes	Patient/Families	Staff/Physicians
<b>Effective Transitions</b>	<i>Care plan coordination / Standardize Discharge planning processes</i>	<i>Improved Use of Technology / Care plan coordination / Standardize Discharge planning processes</i>
<b>Patient Centered</b>	<i>Compassion/Courtesy/Advanced clarity of care plans / Standardize communication processes / Patient involvement</i>	<i>Clarify Team roles / Standardize communication processes / Patient involvement</i>
<b>Efficient</b>	<i>Standardization / Consistency in care</i>	<i>Continue improvements in Clinical Utilization / Standardization (i.e. Order sets)</i>
<b>Safe</b>	<i>Cleanliness /Thorough investigation/Accurate diagnosis/ Keeping patients/family up to date</i>	<i>Sustain improvements in care / Promote Interdisciplinary Team Collaboration / Keeping patients/family up to date</i>
<b>Timely</b>	<i>Support in Managing expectations / Advanced Communication</i>	<i>Adequate resources / Recognition for Efforts</i>
<b>Equitable</b>	<i>Cultural Sensitivity / Consistency in care across continuum</i>	<i>Cultural Sensitivity</i>

*Purple = Aspects of Theme from Patients/Families Blue = Aspects of Theme from Staff/MDs  
Green = Aspects of Themes from both Patients/Families and Staff*

As part of the development of the 2017/18 QIP, SRH also conducted a retrospective analysis of both legacy organizations' internal data. The review included patient incident data, patient complaint/compliment data, findings from post-discharge phone calls to patients, results of staff engagement surveys, results of staff patient safety culture surveys and community input received through engagement activities during the merger process. In addition, both legacy organizations were recently surveyed by Accreditation Canada in September/October 2016. The accreditation reports provide useful insights into quality improvement opportunities.

As a result of our extensive analysis and stakeholder engagement efforts, sixteen priority indicators have been selected to enable the organization to measure how effectively it is addressing its key quality issues and moving ahead with its quality improvement agenda.

The selected indicators listed below reflect both our analysis and stakeholder input:

### Scarborough and Rouge Hospital 2017/18 QIP Issues and Indicators

Issue	Proposed SRH 2017/18 QIP Indicator
Timely Access	90 <sup>th</sup> percentile emergency department length of stay for complex patients
Safe Care	<i>Clostridium difficile</i> infection rate per 1,000 patient days
Safe Care	% Hand hygiene compliance before patient contact
Safe Care	% Hospital acquired inpatient pressure injuries (≥ Stage 2)
Safe Care	Inpatient falls rate per 1,000 patient days (moderate/severe harm)
Medication Safety	% Medication reconciliation at admission
Medication Safety	% Medication reconciliation at discharge
Access to Right Level of Care	Alternate level of care rate
Effective Transitions	30-day readmission rate to own facility – Congestive Heart Failure
Effective Transitions	30-day readmission rate to own facility – Chronic Obstructive Pulmonary Disease
Effective Transitions	Patient Survey: % Did you receive enough information when you left the hospital? (medical and surgical inpatients)
Palliative Care	% inpatients identified as palliative who are discharged home with support
Person Experience	% Patient satisfaction in the ED: Would you recommend emergency department?
Person Experience	% Patient satisfaction: Would you recommend inpatient care? (medical and surgical inpatients)
Workplace Safety	Ideas Implemented per full time equivalent (FTE)
Efficient	Net Margin

Our QIP outlines several change ideas that SRH will be implementing in order to address the key issues. Some examples of these change ideas are described in the table below. We are committed to involving patients/families in the implementation and evaluation of these change ideas.

## Examples of Change Ideas

Key Issue	Change Ideas
Timely Access	Create a virtual Short Stay Unit in ED; Fast track ED registration process; Reduce Wait time for diagnostic test(s) and consult(s)
Safe Care	Spread involvement of Patient and Family Advisors in supporting infection prevention and control; Standardized Review Process for Pressure Injuries Prevention and Patient Falls.
Medication Safety	Establish a joint Medication Safety oversight committee; Standardize Medication Reconciliation process at admission/discharge for Medicine patients admitted through the Emergency Department; Standardize Medication Reconciliation audit processes.
Access to the Right Level of Care	Complete and spread the ED Diversion project to all three Emergency departments; Develop and implement patient and family education for at risk patients including scripting, and other key messages; Escalation process for ALC designation.
Effective Transitions	Develop a standardized care pathway for CHF/COPD patients across all sites; Ensure timely communication to primary care providers of their patients' discharge information; Enhance patient access to education and discharge information.
Palliative Care	Early identification of patients who would benefit from palliative care assessment and intervention; Establish and sustain a Multidisciplinary Palliative Care Team to provide palliative care assessment, consultation and treatment planning across all sites.
Person Experience	Develop and implement a framework to gather real-time feedback from patients; Improve the patient experience by timely acknowledgement upon arrival to the ED; Implement a communication board in patient rooms across all 3 sites.
Workplace Safety	Create opportunities for patients and families to provide feedback for improvement; Implement routine evening/night/weekend shift idea board huddles in departments/units that have 24/7 shifts; Focus staff ideas on improved patient experience and staff satisfaction.
Efficient	Volume Management; Improve documentation and coding to maximize Resource Intensity Weighting (RIW) and Expected LOS.

## QI Achievements From the Past Year

SRH is proud of the many quality improvement achievements at its three sites from the past year. Our progress reports show that each legacy organization implemented over 90% of the change ideas in their 2016/17 QIP.

While our sites were part of different organizations prior to December 1, 2016 those organizations shared a strong commitment to quality improvement. They also shared many common philosophies with respect to quality including patient and family-centered care and Lean Thinking. Our ability to leverage this common ground will be a key factor in the successful implementation of our 2017/18 QIP. Therefore, in this section, we have purposefully chosen to highlight examples that illustrate our similarities with respect to quality improvement.

**Person Experience.** One of our greatest quality improvement achievements is our success in the area of patient and family centered care (PFCC) across our three sites. There is a shared hospital-wide focus on the four pillars of PFCC - respect and dignity; information sharing, participation and collaboration. A Patient and Family Advisor structure is in place.

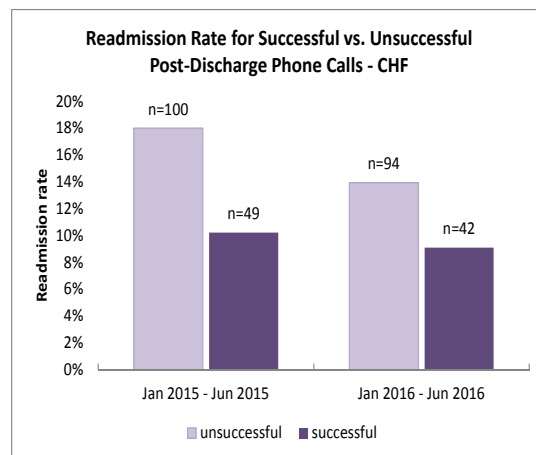
Our Birchmount and General sites have been extremely successful at embedding PFCC principles into frontline clinical practice. This was achieved by implementing the Best Practice Spotlight Organization (BPSO) Patient Centred and Interprofessional Health Care Guidelines developed by the Registered Nurses Association of Ontario. Implementation of PFCC Best Practice Guideline (BPG) to all clinical areas was accelerated through Q1 and Q2 in order to support Accreditation survey readiness. The uptake of PFCC foundational principles, implementation of a documented daily goal in the health record and standard work to track patient engagement in quality improvement have been key successes. As of December 2016, 88% of units/areas had implemented the Interprofessional model of care as measured using an evidence-based tool. Patient and Family Advisors have participated in:

- Co design of Psychiatric Intensive Observation Unit, Alternate Level of Care Units, Emergency Triage/Registration redesign, DI Concourse, e-therapy (iCBT), mobile technology solutions
- Two patient identification and surgical safety checklist safety videos
- Providing education to front line staff on the principles of person and family centered care, and setting daily goals

PFCC has also been a priority at our Centenary site over the past year. April 2016 saw the arrival of our Manager of PFCC whose hiring process included former patients and community members. We also hosted experts from the Institute for PFCC in Georgia who trained 172 people representing management, physician leaders, volunteers, frontline staff, our community advisory group and board members. The team from the Institute for PFCC helped us to complete a PFCC readiness assessment that was informed by direct observation and stakeholder surveys. Our multi-pronged approach to PFCC involves both hospital-wide practices and more in-depth interventions in early adopter areas. Early adopter clinical areas (ICU and Neonatal ICU) are working with Patient Family Advisors to improve care delivery through a unique model that combines PFCC principles, Lean Thinking and Unit-Based Safety methods based on CUSP – the Comprehensive Unit-Based Safety Program developed by Johns Hopkins Hospital in Baltimore. From a non-clinical perspective we have focused on recruitment. For example, we have incorporated PFCC principles into job postings and interview questions and a patient story is shared by a PFA at new staff orientation sessions.

2017/18 will see SRH build upon this solid foundation and blend the excellent PFCC strategies that have been so effective to-date. We are pleased that the very first education session presented to the new board of directors of SRH was on PFCC, within weeks of our amalgamation we were able to engage close to 80 patients/families in the development of this QIP and we have formed a working group to explore how our new organization can celebrate Patient Experience Week in April 2017.

**Effective Transitions:** All three sites are committed to following up with patients after discharge to facilitate effective transitions and coordination of care. Over the past year, our Birchmount and General sites have continued to explore ways to expand the innovative *Virtual Ward* program that provides intensive restorative care enabling safe transitions home from the hospital for geriatric patients.



Plans are underway to expand Virtual Ward into the EDs. Surgery and other programs are currently assessing how the Virtual Ward may complement their existing post discharge transition initiatives. Similarly, our Centenary site has a post-discharge telephone call program staffed by an RN who contacts medicine and surgery patients as a key means of helping to create a smooth transition for patients back to the community. Customized telephone scripts for specific conditions have been developed and the nurse making the calls checks to see that patients have been able to connect to the primary care, home care, and community services that they need. An evaluation of the program that compared readmission rates for patients that received a phone call with patients experiencing similar conditions who we were unable to reach by phone demonstrated that our post discharge phone calls have been successful at reducing hospital readmissions for patients with congestive heart failure, chronic obstructive pulmonary disease and other conditions.

**Access:** Our new organization will build on the success of two regional programs that provide timely access to high quality specialized services for patients across our region – Nephrology and Cardiac Care. Although these are long-standing programs, there is a commitment to continuous quality improvement. Examples of improvements in the past year are noted below:

*Regional Nephrology Program* - SRH has one of the largest regional nephrology programs in North America with more than 6,000 patients, and has one of the largest home dialysis programs in the province. Now, we are looking to redesign home-based dialysis and ensure that it's delivered to many more patients. This includes expanding our network of partners. Also, in order to address the needs of high-risk geriatric patients, we enhanced our ongoing partnership with Carefirst Seniors and Community Services Association through a partnership with Carefirst's new Transitional Care Centre. The Transitional Care Centre began to receive patients from two of our sites in May 2016.

*Central East Regional Cardiovascular Rehabilitation Service*- This service offers individually-customized education and exercise training across the Central East LHIN. The service is led by SRH in collaboration with hospital and community partners. The regional service was launched in 2012, and with the Central East LHIN's support, has expanded to serve 4,000 patients annually at 14 community sites across the region. In last year, Bobcaygeon was added as a new site and the service has expanded with enhanced support for patients with congestive heart failure. Today, almost 95% of patients have had access to community-based sites less than 30 minutes from their home, and over 90% have waited less than four weeks to join the service.

**Palliative Care:** Another fulfilling quality improvement achievement from the past year was the enhancement of services and supports for our patients and families experiencing the end-of-life journey. Within SRH, a range of services are available for patients with palliative care needs. At our General site, we offer a well-established palliative care inpatient unit. At our other sites, inpatient consultation models and outpatient clinics exist. For our Centenary site, a gap in this model was identified. Following an extensive community consultation process led by our Community Advisory Group in 2014-15, several ideas for improvement were brought forward and have now been implemented. A steering committee, with patient representation, was formed to oversee the implementation of these ideas, including assessing different models and best practices. In 2016, a multi-disciplinary palliative care team was launched to provide consultation and support to inpatients with a life-limiting illness. In addition to this inpatient service, a new palliative care outpatient clinic offering symptom management and psychosocial support has also been implemented.

These enhancements contributed to a significant increase in the percentage of palliative care patients discharged home with support services-- an important QIP indicator. Efforts have been made to strengthen, promote, and align our acute palliative services to pull patients from hospital to community to receive end-of-life care at home, supported by resources within the broader system of palliative services in Scarborough. Where a palliative care unit does not exist and inpatients are dispersed, having a formal palliative care team has helped to identify patients and link them to home support services.

**Safe Care:** A significant quality achievement for both legacy organizations in the past year was the completion of onsite surveys by Accreditation Canada. Both organizations have been accredited and legacy TSH received accreditation with Commendation! Both organizations met all but one Required Organizational Practice and over 97% of criteria upon which we were evaluated. The surveyors' reports commended our teams on many levels, including embracing a culture of patient- and family-centred care, quality, and safety despite the significant organizational changes underway.

## Population Health

To better understand and meet the needs of the people served by SRH, a comprehensive profile of the Scarborough community has been created. It includes five areas: population, health behaviours, health status, health system characteristics, and health system performance. The results provide critical insight into the health of the community, and the factors influencing it.

Here is just some of what we have learned about our population:

- **Population growth will keep spurring demand** – Scarborough has 686,300 residents, and the hospital's catchment area is expected to grow to 716,000 by 2022. This calls for ongoing improvements to health services to deliver positive patient outcomes.
- **Our population is aging** – Right now, 14% of the population is age 65 and older. Another 26% is between 45 and 64 years old. The largest growth rates are expected in the 60 to 80-plus age group. This will place an even greater focus on initiatives to support the needs of seniors.
- **Cultural diversity and socio-economic factors affect service delivery** – Scarborough is known for its rich diversity. Approximately 59% of residents are foreign-born, 8% have no knowledge of either official language, and over half speak another primary language. The top 10 home languages (in order) are: English, Tamil, Cantonese, Chinese (not otherwise specified), Mandarin, Tagalog, Urdu, Gujarati, Bengali, and Farsi. Additionally, 20% of the population is low income, and 27.5% of children live in low income families. Scarborough's unemployment rate (11%) and proportion of single-parent families (21%) exceed the provincial average. Research on the determinants of health indicates that these factors affect health status and health care needs.
- **High population density affects healthy lifestyles** – Many aspects of the nature of our community directly affect the health of residents, from urban lifestyles (less physical activity) to health issues stemming from traffic accidents and violence.



- **There is an opportunity to improve on key health risk factors** – Many risk factors that are prevalent in our community have implications for chronic diseases. Scarborough residents report less physical activity and have lower screening rates for some cancers (e.g. colorectal and breast) than the provincial average. SRH will need to find more ways to engage our community, promote disease prevention and facilitate early intervention. This includes improving access to well-coordinated primary care and community resources.

## Equity

At SRH, an equity lens is embedded into every aspect of the hospital's work, from planning to implementation. SRH is fortunate to be able to build on the well-rounded and comprehensive approach to equity at its legacy organizations, which stretches well beyond the typical boundaries of culture, ethnicity, and language.

Our hospital has a patient navigation centre, called the Global Community Resource Centre (GCRC). The collaborative model for the GCRC includes partnerships with fourteen community agencies that provide information and referrals to patients and visitors seeking to access services in the Scarborough community. Patient education sessions and workshops are also conducted in the GCRC to provide patients with holistic support in navigating the health care system.

Another recent initiative started at two of our sites, is the collection of additional patient demographic data so that the hospital can better understand its patient population and identify health inequities and access barriers, with the aim of improving patient health outcomes and experiences.

SRH employs a number of strategies to improve communication with our patients who speak many different languages. For example, our Birchmount and General sites have full-time interpreters who provide interpretation services to the Chinese and Tamil populations. All three of our sites have access to 24/7 telephone interpretation services available in more than 200 languages. There is also a service for American Sign Language (ASL), allowing hearing-impaired patients to communicate with physicians and staff while at the hospital by using iPads to connect to interpreters in a similar fashion as Skype or FaceTime. The patient uses ASL to communicate with the interpreter, who can then speak to the health care provider, and vice versa.

As noted earlier, more than 59% of residents in Scarborough are foreign-born and in order to address the needs of this population, a number of partnerships with newcomer agencies have been established to undertake outreach and education, including health fairs hosted in the hospital. Most recently, the sites have been working with community partners to help Syrian refugees navigate the health care system. A community resource guide has been developed to help patients and staff access various multilingual services in Scarborough.

As part of the 2016 employee and physician opinion survey administered by our Birchmount and General sites, additional demographic information was collected to determine whether staff and physicians reflect the diverse population that the hospital serves. SRH provides a number of initiatives to support our staff in delivering care to a diverse and vulnerable population, including equity training on serving a global population, leadership development on leading a diverse workforce, and an Accessibility and Inclusion Committee.

# Integration and Continuity of Care

A key part of how the quality of health care is defined is its seamlessness, or ease by which patients can transition from one health care setting or provider to another. Our new organization aims to deliver better, integrated, and connected care within the Scarborough community and the region. SRH is actively continuing the work of its legacy organizations to build stronger relationships within the health system.

On February 15 and March 7, SRH hosted roundtable meetings entitled “**Connecting for Quality**” that were attended by representatives of eight of our local health system partners. The organizations represented at these meetings included:

- Scarborough Centre for Healthy Communities (a community health centre)
- East GTA Family Health Team
- Yee Hong Centre for Geriatric Care
- TransCare Community Support Services
- Hong Fook Mental Health Association
- Toronto Paramedic Service
- March of Dimes
- The Wexford, Long-Term Care and Apartments for Seniors

Some of these organizations also submit annual QIPs so this forum was an opportunity to share our respective quality improvement priorities, common challenges and identify areas where we can work together. The following are the common quality issues discussed:

- Reduction of unnecessary Emergency Department visits
- Better access to primary care
- Meaningful measurement of patient satisfaction
- Employee engagement
- Communication between hospitals and other providers regarding shared patients
- System-wide issues and effective transitions

The amount of input provided was so rich that a second meeting is being scheduled to continue the discussion.

The format for the Connecting for Quality meeting leveraged the process that legacy Rouge Valley had used for development of its 2016/17 QIP. Health partner forums were held in March and June 2016 to discuss common issues and build strategic alliances.

Other examples that demonstrate our efforts to improve integration and coordination of care are:

- We utilize the Resource Matching and Referral software solution to improve coordination and access to complex continuing care beds, rehabilitation beds, and palliative care beds.
- We are collaborating with other providers within the Central East LHIN to develop a coordinated care plan for Scarborough’s two Health Links.
- All SRH sites have Community Care Access Centre staff working on-site, joining in daily “bullet rounds” on various units, and helping to support patients in their timely discharge.
- Physicians and staff utilize Connecting GTA (cGTA) – a hub for electronic health information - to

access patients' data from other acute care hospitals, community support services, and long-term care and primary care providers.

- At our Centenary site, a working group has engaged the Central East Community Access Care Centre (CCAC), Ontario Telemedicine Network (OTN) and the long-term care sector in collaborative work on strategies to ensure a smooth transition of residents/patients between long-term care homes and hospitals. This has included looking more closely at ways to prevent the need for residents to be transferred to the hospital and better sharing of discharge information. This work stems from our analysis of data on the number of transfers from long-term care homes to the hospital, the nature of the admissions and patient outcomes. The long-term care homes that have participated in our meetings include: Seven Oaks, Extencicare Rouge Valley and Ballycliffe. Plans are in progress to broaden this working group to include all of our hospital sites.

## Access to the Right Level of Care - Addressing ALC Issues

Alternative level of care (ALC) refers to beds occupied by patients who are no longer acutely ill, but require transfer to a long-term care facility or other appropriate setting. Meanwhile, they continue to occupy a bed meant for an acute-care patient. This situation is common and presents significant capacity issues for SRH and other hospitals in the province. The percentage of patients that are considered ALC is a quality indicator that was in the 2016/17 QIP for both legacy organizations and is once again part of the 2017/18 QIP for SRH.

In 2016, a Central East LHIN-wide study on ALC challenges and potential mitigating strategies was completed and shared with the Ministry of Health.

Efforts in place at SRH to reduce the ALC rate include preventing ED visits, promoting alternatives to inpatient admissions when possible (e.g. ambulatory clinics), getting acute care patients to begin moving and becoming active earlier in their recovery so that they are more likely to return to previous levels of independence, improving daily flow processes using Lean, bed reconfiguration and patient/family education.

From a system perspective, we are working collaboratively with our partners in long-term care and at the Community Care Access Centre to minimize transfers from long-term care homes to the hospital and to optimize communication at discharge so that patients are less likely to require readmission. Our hospital also uses the Resources Matching and Referral (RM&R) system to support post-acute admissions and improve patient flow.

# Engagement of Clinicians, Leadership & Staff

Quality improvement starts with a dedicated team of staff and clinicians who are engaged in developing and carrying out QI plans and initiatives. QIP indicators and issues concerning quality of care are regularly tracked and reviewed by staff and physicians. Within weeks of our amalgamation, an interim joint quality scorecard was developed. Our new Board of Directors has established a Quality Committee that engages clinicians, leadership and staff through monthly program presentations. A new, consolidated Quality of Care Committee will soon be launched. Various quality committees across all three SRH sites involve hundreds of staff, leaders, and physicians in rich quality discussions and collaborative problem-solving to improve the patient experience.

Committee work is reinforced by formalized structures on patient units at all three sites. These structures range from daily huddles to unit councils that meet regularly. They are also tied to Lean management processes. Engaging, educating, and empowering front-line staff to play a greater role in quality improvement on their unit is critical to locally managing the issues underlying QIP indicators. This is emphasized through our robust idea generation program (an initiative that was in existence in both legacy organizations). Our 2017/18 QIP includes the number of staff ideas implemented as a key indicator of staff engagement. Staff are also encouraged to collect ideas from patients and families. Ideas/improvement opportunities are tracked in each department and our leaders are trained to involve staff in huddles to discuss ideas and decide which ones to implement. Regular celebrations are held to acknowledge innovative improvements suggested by staff. This year one of our change ideas will ensure that staff that work nights and weekends also have opportunities to be engaged in this way.

As noted earlier, 366 staff were engaged in the development of this QIP in addition to administrative and medical leadership.

## Resident, Patient, Client Engagement

Quality improvement at a hospital is about ensuring the best care and experience for patients and their families. As such, it is critical that the approach to quality improvement also involve the perspectives of patients and family members.

In developing this QIP, SRH carried out several engagement activities with patients, family members, and the broader community to support the development of its 2017/18 QIP. We interviewed 77 patients/families across our three sites and heard from 22 community members. Two PFAs joined members of our leadership team in two workshops to develop change ideas.

A key component of patient and family centered care at our hospital is partnerships with Patient/Family Advisors (PFAs). They play an important role in many different ways, including working closely with frontline teams and unit councils, sharing stories at new staff orientation and serving on committees where they share their insights to improve the quality of the patient experience.

Our hospital values patient stories. Every meeting of the Quality Committee of the Board includes a patient story. We have also offered storytelling training to our PFAs.

Both legacy organizations have benefitted from having active and vocal community- and patient-based advisory groups that are made up of local residents, who are former patients or caregivers and community members. Over the years they helped to provide input on quality of care issues faced by each legacy organization, including those tied to the respective QIPs. Terms of reference for a new Community and Patient Advisory Council for SRH have been drafted with community input.

## Staff Safety & Workplace Violence

SRH is committed to creating a safe, healthy, and professional work environment, which includes reducing the risks and incidents of workplace violence and harassment. The workplace violence prevention policy was one of the first new harmonized policies created following the merger of the legacy organizations. Staff safety and workplace violence prevention is another area where SRH can build on the many initiatives already in place across the three sites. A number of examples are below.

- Corporate and departmental risk assessments
- Electronic incident reporting systems
- Accessible information on workplace violence and harassment
- Workplace violence training for staff including, crisis prevention intervention and Gentle Persuasive Approach training for staff in high-risk areas. This training has proven to reduce both the number and severity of violent events in hospitals across North America
- A variety of physical safety features such as alarms, panic buttons, parking lot lighting, security cameras and a 24/7 security presence
- Patient assessment tools
- Code White procedures and regular drills
- Debriefs after violent incidents and every Code White event
- Exercises with community partners such as Toronto Police to ensure that the hospital is prepared for violent situations and to anticipate future risks; a Code Silver policy is under development.
- Patients and families also help to ensure that both their loved ones and staff are treated in a fair, safe, and respectful manner. Family members are encouraged to work with staff in reducing incidents of violence, such as by providing information about specific triggers.

Our hospital believes that a healthy workplace is not just about the absence of violence, it is also about staff morale, engagement and a culture of safety. As noted earlier, our 2017/18 QIP includes employee idea generation as an important indicator of engagement.

## Performance Based Compensation

ECFAA requires that the compensation of the CEO and executives reporting to the CEO be linked to the achievement of performance improvement targets laid out in our QIP. The purpose of performance based compensation related to ECFAA is to drive accountability for the delivery of QIPs, enhance transparency and motivate executives. ECFAA mandates that hospital QIPs must include information about the manner in and extent to which executive compensation is linked to achievement of QIP targets.

The executives who will participate in the QIP executive compensation program for 2017/18 are:

1. Chief Executive Officer
2. Chief of Staff
3. Executive Vice President, Corporate Services
4. Executive Vice President, Human Resources
5. Vice President, Quality, Strategic Planning & Performance
6. Vice President, Capital Planning & Facilities Operations
7. Vice President, Patient Services & CNE
8. Vice President, Patient Services
9. Vice President, Patient Services
10. Vice President, Patient Services
11. Executive Director, Communications & Government Relations

The calculation model for executive compensation in 2017/18 is summarized below:

<p>Number of Indicators</p>	<ul style="list-style-type: none"> <li>• Include all 16 QIP performance indicators.</li> <li>• 5 indicators receive a higher weighting; these 5 hold significant opportunity for improvement and are high priority indicators, they are:             <ul style="list-style-type: none"> <li>• Inpatient Falls Rate</li> <li>• 30 day Readmission Rate for Chronic Obstructive Pulmonary Disease (COPD)</li> <li>• Patient Satisfaction in the ED</li> <li>• Number of Ideas Implemented per Full Time Equivalent (FTE)</li> <li>• Net Margin</li> </ul> </li> </ul>
<p>% of Compensation At-Risk</p>	<p>3%</p> <ul style="list-style-type: none"> <li>• To be deducted from base salary over the first half of fiscal year based on current executive compensation plan;</li> <li>• For second half of fiscal year, subject to new executive compensation plan to be posted based on Ontario Broader Public Sector Executive Compensation Framework;</li> <li>• To be paid out by June 30, 2018.</li> </ul>
<p>Calculation Model</p>	<ul style="list-style-type: none"> <li>• Maximum score is 1000 points</li> <li>• Total of 780 points (78%) associated with 5 priority indicators at 156 points each:             <ul style="list-style-type: none"> <li>• Achievement of QIP target = 156 points</li> <li>• Within 10% of QIP target = 80 points</li> <li>• Non-achievement of QIP target by more than 10% = 0 points</li> </ul> </li> <li>• Total of 200 (22%) points associated with the other 11 non-priority indicators at 20 points each:             <ul style="list-style-type: none"> <li>• Achievement of QIP target = 20 points</li> <li>• Within 10% of QIP target = 10 points</li> <li>• Non-achievement of QIP target by more than 10% = 0 points</li> </ul> </li> </ul>

## Other

This first QIP for SRH reflects an important step towards shaping the future of health care in Scarborough. Throughout this transitional period, staff at all three SRH sites remain focused on providing quality care and putting the patient and family experience first.

## Contact

If you would like to learn more about the activities described in the Scarborough and Rouge Hospital 2017/18 QIP, please contact us at [communications@tsh.to](mailto:communications@tsh.to) or [communityrelations@rougevalley.ca](mailto:communityrelations@rougevalley.ca).

## Sign-off

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

Maureen Adamson, Chair, Board of Directors

Valerie Carter, Chair, Quality Committee

Andrée G. Robichaud, Interim President and Chief Executive Officer