Let's Make Healthy Change Happen.

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

March 27, 2015

SOUTHLAKE REGIONAL HEALTH CENTRE

3/27/2015

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 HQO (if required) in the format described herein.

Overview

At Southlake Regional Health Centre (Southlake), we are committed to continuously improving the quality and safety of the care we deliver to our patients and the work environment we provide to Our People—staff, physicians and volunteers. Our Quality Improvement Plan (QIP) is an important element in our commitment to deliver *Shockingly Excellent Experiences* and our ability to achieve quality outcomes and create value in Healthcare. The QIP provides the basis for our Corporate Quality Scorecard and every QIP indicator is included there. In addition, each of our programs have developed or are in the process of developing program scorecards whereby QIP elements for which they have an impact are included and monitored on a regular basis. We also have developed Corporate Scorecards for Our People and Our Financial Health and relevant indicators from the QIP are included there. These scorecards are reported on regularly at all of our Leadership and Board Committees.

In addition to regular reporting and in order to ensure that all of Our People have access to the most up to date information in real time, we rely on our Business Intelligence System. With this system, any of our staff has the ability to drill down into each report card element to monitor portfolio or unit-level performance against our QIP. At Southlake, we embrace our responsibility to ensure that each of us is aware of and actively pursuing our priorities.

As a starting point, Southlake must identify areas and processes in which we have the potential to achieve a substantial improvement in our work and care practices that will translate into quality outcomes and greater value. For the 2015/16 QIP, Southlake will focus our time and energy to achieving the following objectives:

A. **Reduce the rate of hospital acquired Clostridium Difficile Associated Infection (CDI) by 51%** (*decrease from 0.45 to 0.22 per 1000 patient days*). Southlake's current hand hygiene compliance is 90%. In 2015/16, Southlake will strive for a theoretical best practice of 100% organizational compliance. Strategies to reduce CDI will continue by expanding our Antimicrobial Stewardship Program. We will also review all new in-patients who have a history of C-Diff in order to prevent any C-Diff relapses. The focus will be on the need for antibiotics and a review of therapy and recommendations for treatment. In addition, Southlake will implement ATP (Adenosine Triphosphate) sampling to measure the effectiveness of our environmental cleaning and identify improvement opportunities. We have also embarked on a study to compare the relative efficacy of different cleaning protocols on 4 study units and will continue on this journey throughout the 2014/15 year. One arm of this study is to assess the impact of dedicated equipment on transmission rates. With sponsorship from our Foundation, dedicated equipment was installed on one of the study units. This two year study will provide valuable information for hospitals as decisions are made around the validity of full bleach cleaning hospital wide and the associated negative consequences (staff sensitivities, equipment damage). Southlake is also a member of the Joint Centres of Innovation. This group is a collaboration of 6 hospitals (Mackenzie Health, Markham Stouffville Hospital, North York General Hospital, Toronto East General Hospital, Southlake Regional Health Centre, and St. Joseph's Health Centre Toronto) with the intent of sharing learnings and creating innovative solutions related to quality and safety initiatives. One such example is the CDI collaborative which has informed some of the strategies in our QIP.

B. **Improve medication reconciliation compliance for patients at admission** (*increase from 63% to 70% received medication reconciliation*). Medication reconciliation is widely recognized as an important patient safety initiative and we know it can save lives. As such, Southlake is committed to exceeding the set target by ensuring the standardization of practice to attain Best Possible Medication History (BPMH), a precursor to effective medication reconciliation compliance. We will achieve this by establishing an interdisciplinary coordination team to lead and sustain medication reconciliation and to formalize policy and process, including the accurate use of the BPMH form. A key success factor in this approach will be reaching out to community pharmacists and partners to ensure that patients arrive to hospital with an updated BPMH whenever possible. Our Medicine Program has also proposed a focus on medication reconciliation on discharge and we will pursue this opportunity during 2015/16. We expect to add this element to our QIP in 2016/17.

C. **Reduce HYDROmorphone, Fentanyl and Morphine medication incidents by 50%** (*reduce the rate of related incidents per 10,000 dispenses from 4.6 to 2.3)*. Historically incidents related to these drugs represent 69% of all narcotic incidents at Southlake and have been identified by ISMP and Accreditation Canada as high alert medications. In addition to an awareness campaign, and in order to improve our performance, we intend to perform a monthly compliance audit of our 24 hour medication check process which is meant to capture any transcription or ordering discrepancies. We also intend to implement an independent double check for Morphine and continue with this initiative for HYDROmorphone units in order to prevent administration errors. With these two interventions, we target ZERO preventable errors that should have been caught by 24 hour check and independent double check.

D. **Reduce the Percent of patients with new pressure ulcers stage 2 or higher by 39%** *(decrease from 6.4% to 3.9%).* In our multi-year journey we have achieved an impressive improvement of 68% in our rate of new pressure ulcer incidence (from 20% to 6.4%). We did not reach our 14/15 target of 3.9% and we realize that this may not be achievable however we recognize the importance of this safety initiative. Our 13/14 performance of 5.2% was our best annual performance and included 3 quarters at 4% (Q1), 4.5% (Q2), and 4.3% (Q3) which is very close to target. In 14/15, our result was 6.4% (Q1), 6.7% (Q2) and 6.2% (Q3). Southlake will continue to pursue a stretch target of a 39% reduction over current performance and we are taking the year to fully understand our performance by fully investigating our data and positive deviance in our high performing units during this time. Our change ideas include a focus on hourly rounding and increasing the number of nurses who have completed the Nurse Certificate Program in Pressure Ulcer Staging. We will also implement a chart audit for all patients who develop a pressure ulcer (stage 2 or greater) in order to identify trends and system improvement opportunities and to target interventions based on findings. Another opportunity that we will pursue recognizes the lack of a Canadian acute care benchmark and involves engagement with peer hospitals to share our quarterly incidence methodology and to share and compare incidence data in order to benefit from identified improvement opportunities. In 2013, we implemented the use of heel boots for patients at risk for heel ulcers. With this intervention, we achieved ZERO heel ulcers and we will continue to stress their importance in 2015/16.

E. **Improve awareness of people changes and optimize knowledge retention through analysis of turnover** *(our maximum target is 8.2%).* Our People are a formidable team and we strive to create an environment where healthcare professionals are inspired and empowered to work, practice and learn together as inter-professional teams. Diversity of thought feeds a culture of innovation and excellence which drives improvement. Our best way forward is to understand our turnover experience and implement targeted improvement to optimize this important element of our culture. A turnover rate of 8.2% would place us at the 75th OHA percentile. In order to achieve this result, we will implement a 6 month engagement of new hires to optimize organizational commitment and will conduct exit interviews for individuals in groups experiencing turnover greater than target. We will track the percentage of new staff who remains Southlake employees for a minimum of 12 months.

F. **Improve Hand Hygiene % compliance before patient contact** *(increase rate from 90% to 100%).* In 2011, the Hand Hygiene scores at Southlake were 69% and by 2014, a score of 90% against a target of 100% was achieved and we have completed 41,611 audits in 2013/14. We will continue our efforts to target improvements by the implementation of a cross auditing methodology. We will complete a minimum of 1920 cross audits (10 audits/unit/month) per year and report results to the unit staff. Our Hand Hygiene audit tool also allows us to mine the data by level of program, unit and provide to further target improvement opportunities.

Southlake's 2015/16 quality improvement objectives reflect our strategic plan and our goal to be recognized as a performance leader in the delivery of safe, quality healthcare services, embracing the principles of High Reliability Healthcare. Our chosen QIP indicators are aligned with our Hospital Services Accountability Agreement (H-SAA), obligations under the Ministry's Pay-For-Results program, the Health System Funding Reform (HSFR), Accreditation Canada's ROPs, and reflect Southlake's vision to deliver "Shockingly Excellent Experiences".

Integration & Continuity of Care

Southlake's 2015/16 Quality Improvement Plan is aligned with Southlake's strategic directions, *"Create the Ultimate Hospital Experience, Transform Healthcare Relationships and Seek and Share Better Solutions".* Southlake has incorporated the Ministry of Health and Long Term Care priorities of integration and continuity, by designing improvement strategies which demonstrate Southlake's commitment to work with our system partners to achieve improved quality, both within and beyond hospital walls. Examples include: a strong partnership with CCAC to reduce the number of ALC days and a strategic initiative in partnership with CCAC to LEAN transitions to community, a reduction in unnecessary hospital admissions through our Health Links commitment, and Medication Reconciliation involving community pharmacies. Feedback from our patients and data from our staff satisfaction surveys have helped us to develop our QIP and identify our priorities.

Southlake supports a philosophy called "There Is No Place Like Home" targeted at providing ALC patients, often with complex conditions and multiple comorbidities, with the supports they need to go home and stay well at home. Creative individualized care plans are often required to enable these patients to stay at home, challenging our teams to work closely with our community partners and agencies to support these patients and their families. Our aim for those patients that do require hospitalization is to have a length of stay at the 25th percentile and a comprehensive plan for the patient to successfully transition home. Readmission rates are our countermeasure metric which ensure we are safely transitioning our patients to home. A key to our success is a solid plan, established in partnership with the patient and their family, truly demonstrating our commitment to patient centered care.

Through the provincial Health Links program, Southlake was selected to take a coordinating role in the development of a specialized healthcare program for complex patients in South Simcoe and Northern York Region. Working with over 20 community partners including hospitals, primary care providers and the Central Community Care Access Centre, the goal is to improve timely access to care and ensure the development of coordinated care plans and to reduce both Emergency Room visits and hospital stays for patients with complex conditions. Patients include frail, older adults, those with multiple chronic conditions, and people with mental health and addictions. As of January 2014, 208 patients have been enrolled with the South Simcoe and Northern York Region Health Links program. An active Patient Advisory Council has been established comprised of both patients and caregivers; working to advise and co-design coordinated care plans and a patient experience survey. Our goal is to ensure 20 patients have coordinated care plans per month.

Challenges, Risks & Mitigation Strategies

Southlake is an acute care hospital offering regional tertiary and quaternary services. Southlake is also situated in a high population growth area and has a higher than provincial average of the "65+" age segment of the population within our services area. Southlake's Emergency Department has also seen a 33% increase in volumes over the last five years. The following objectives have additional specific risks that may limit our success in 2015/16.

Clostridium Difficile Associated Infection (CDI) reduction:
Risks: Most CDI cases at Southlake occur on the Medicine in-patient unit. Environmental cleaning is essential in the reduction of CDI. We plan to optimize environmental cleaning with the purchase of a portable disinfection system and this purchase depends on available resources.

Mitigation: Investigation of technology such as the use of ATP to measure environmental bio-burden will help to mitigate risks associated with lack of resources to purchase portable disinfection systems and will allow education and environmental cleaning to be focused in the areas with high bio-burden as per ATP testing.

Improve Medication Reconciliation on Admission:
Risks: Activities identified to meet this objective continue to depend on human resources and are subject to unpredictable events associated with significant patient flow issues.

Mitigation: Certain programs have struggled with achieving success. Pharmacy will work with these programs and key areas within the hospital to review processes, identify barriers and make/suggest changes as needed.

Rate of Narcotic Incidents Related to HYDROmorphone, Morphine and Fentanyl:
Risks: The Medication Safety Committee will provide interdisciplinary coordination to support the implementation of this initiative and will require significant time investment of the Manager of Pharmacy, committee members and nursing staff. The determination of incident rate relies on information obtained from the Acudose roll-out which will continue during 2015/16.

Mitigation: Southlake anticipates that investments in technology enablers such as Acudose and implementation of practices resulting from LEAN system transformations will allow the redistribution of resources to support this initiative.

Information Management

Southlake Information Communication and Technology (ICT) program supports this year's QIP priorities as follows:

Safe: One key initiative is the use of Performance Visibility (MPV) boards for which we recently became the first international recipient to receive the Distinguished Achievement Award for Clinical Excellence. This system provides real time safety and flow information to our clinicians at a single glance. Information provided includes the location of patients, estimated date of discharge, a patient's risk of falling, and whether or not a patient has been placed on precautionary measures to avoid the risks associated with infectious disease. The corporate Hand Hygiene compliance rate is displayed YTD, previous month and previous week. High performing units are also congratulated on our MPV boards. MPV also provides a visual queue when medication reconciliation is required and when it is completed. Through MPV, Braden Scale (risk for skin breakdown) that is charted electronically is linked to provide a visual cue to the inter-professional team. This use of information will impact our Pressure Ulcer rate. Of note are our achievements in Violence Prevention and the use of MPV to flag patients who have had an individualized care plan developed so that staff can be alerted to the plan and take steps to protect both the patient and the inter-professional team.

Southlake has also developed and implemented a hand-hygiene audit collection tool to assist in the auditing of hand hygiene compliance, which is expected to decrease our CDI rate.

Accessible: Accessibility will be improved by a continued focus on Emergency Department (ED) wait times by improving flow of patients admitted into inpatient wards. MPV boards in ED assist with flow management by providing visual cues of inpatient wards, status of patient discharges, and current clean state of available rooms and beds. With the visual cues from MPV at their fingertips, ED can expedite the flow of patients to in-patient rooms and reduce the wait times in ED. Another tracking board used in ED is our Emergency Tracking Board, which provides additional visual cues to the staff regarding patient status, allowing for prioritization of care and urgency. The Emergency Department will also be trialing a Point of Care testing trial which is hoped to facilitate patient flow.

Patient Centered: Providing patient centered care is a priority at Southlake. We are dedicated to organizing care around the patient by a number of current initiatives. These initiatives include our patient appointment management system, an automated way-finding system, and automated discharge call follow-up system—all which will be important to guide our improvement initiatives.

Integrated: Southlake is continuing to improve transitions by sharing information with community-based physicians via automated faxing and implementing Hospital Report Manager (HRM), which sends Electronic Medical Record patient information to family physicians. Southlake is also working with the University of Toronto to develop a simulation of the Emergency to ALC transition, which will help to optimize how patients are handled and streamed within the organization.

Effective: Southlake leverages the MPV boards to facilitate finance in ensuring patients have appropriate and correct accommodations, insurance, and notification of pending discharge and room clean requirements. With our Business Intelligence solution also working at the system data integration level, we are able to gather information from different systems such as ADT, Patient flow, Charting, hand hygiene auditing, etc., to generate performance scorecards that allow us to drill down into our data in different ways. This allows us to better understand our performance trend and composition, and take appropriate actions needed for making quality improvements.

Engagement of Clinicians & Leadership

In the creation of our 2013 – 2018 Strategic Plan, we engaged with thousands of internal and external partners via surveys, focus groups, workshops, planning summits, and face-to-face interviews to better understand their visions for healthcare. We also mined through satisfaction results and feedback reports. Through this engagement process, we have been able to create a document that we believe truly reflects the needs, opinions, feedback, and ideas of the many individuals that we are privileged to serve: Our Patients, Our People, Our Partners. Southlake's 2015/16 Quality Improvement Plan is aligned to Southlake's three strategic directions created through this engagement process; *"Create the Ultimate Hospital Experience, Transform Healthcare Relationships and Seek and Share Better Solutions".* In the development of our Individual Management Performance Plans, our leaders come together to openly discuss our hospital priorities, including QIP priorities, and ensure that our annual goals are aligned in achieving our targets. During the development of this year's QIP, we engaged multiple groups including the Medical Advisory Committee, the Administrative Management Committee, our Quality Utilization Resource Management Committee, Patient Care Leadership Committee and the Board Committee on Quality.

The priorities of our patients and our partners — as defined through our engagement process — are the cornerstone of our strategic vision and Southlake's QIP. To achieve success, we regularly engage Our People in monitoring and acting upon the related metrics. For example, time from each weekly leadership meeting is devoted to understanding and evaluating each metric. All of our QIP priorities are tracked on the Quarterly Corporate Performance Scorecard, which is regularly monitored and reported on. Our Business Intelligence Tool (HBI) is available to all and makes visible real time performance metrics for ongoing referral and action and is regularly monitored and reported on. Southlake's top priorities are also displayed on every computer home screen as a visual reminder about our current performance and targets. Each of these priorities has a lead assigned who continually updates information and works with stakeholders to carry out improvement plans and to constantly seek new solutions. These priorities are cascaded throughout all levels of our leadership team through our Management Performance Plan methodology which ensures that each of our annual goals is aligned in achieving our targets.

Patient/Resident/Client Engagement

Through our engagement strategy in the development of our 2013 – 2018 Strategic Plan, we were able to identify the priorities of our patients and families. We spoke to thousands of our community members via surveys, focus groups, workshops, planning summits, and face-to-face interviews. We also combed through satisfaction results and feedback reports. As already noted, Southlake's 2015/16 Quality Improvement Plan is aligned to Southlake's three strategic directions created through this engagement process; *"Create the Ultimate Hospital Experience, Transform Healthcare Relationships and Seek and Share Better Solutions".*

Our Board Committee on Quality has been involved since early October with the development of our QIP and the community membership ensures the patient perspective is embedded in the final result. For example, patient feedback and experience around the impacts of developing a pressure ulcer have driven us to pursue an aggressive performance target and campaign to reduce their incidence.

Our patient satisfaction surveys and discharge phone calls provide a valuable source of information as we strive to embed the voice of the patient in our improvement efforts. One important opportunity from the patient perspective is that "time really counts". In the Emergency Department (ED) in particular, wait times are reflected as important to satisfaction. Because of this, ED wait times are a regular feature in our daily/monthly reporting and are even monitored in real time. Against our peer hospitals of similar volumes, we rank at the 90th percentile for percent positive score in the overall rating of care and believe this is largely as the result of our very short time to physician initial assessment.

At Southlake, we are further evolving our Patient and Family Advisory Council which will serve as a forum for patients and family to partner with Our People to provide input and influence on how to improve the patient experience. This Council will report to our new Ultimate Patient Experience Steering Committee whose purpose is to support Southlake in honoring its core commitments, strategic goals and objectives for creating the Ultimate Hospital Experience. This committee will foster a culture where our Value of "Putting Patients First" is recognized in everything we do, and that from the patient's perspective there is "Nothing about me without me". Our drive to achieve our Quality Improvement Plan goals for 2015/16 will be supported by these important groups of dedicated staff and patients/family. A good example of this approach is our Inter-professional Model of Care project which will involve patient and family councils. In addition, Patient and Family Advisors will be linked to all of our strategic initiatives and teams.

Accountability Management

For Executives and all Management Staff at Southlake:

1. Total variable pay linked to performance based compensation aligning to requirements in ECFAA plus the Management Performance Plans to be 10% of base salary.
2. Forty percent of the total variable pay will be linked specifically to achievement of the QIP component of the overall Management Performance Plan.
3. Forty percent of the total variable pay will be linked to achievement of the additional operational objectives aligned to Southlake's strategic goals and identified in each individual's Management Performance Plan.
4. Twenty percent of the total variable pay will be linked to achievement of personal development objectives as outlined in each person's Management Performance Plan.
5. The forty percent allocation linked to the QIP will be calculated utilizing the following terms:
    - All QIP indicators will be linked to variable pay
    - Achievement will be based on the percentage completed toward the targeted goal
    - Under-achievement from 'current' will result in a negative percentage achievement.
    - Over-achievement from targeted goal will result in a score greater than 100%
    - The QIP indicators are ranked as Improve or Maintain in the 15/16 QIP
        - The QIP indicators to be improved will be weighted x 2
        - The QIP indicators to be maintained will be weighted x 1
        - The calculation of all QIP indicator with the weightings will provide for a % achievement of 100%
        - The % achievement will be used to determine the % of the performance-based pay related to the QIP component of each individual's Management Performance Plan.

Health System Funding Reform (HSFR)

A series of initiatives have been launched at Southlake in response to the Ministry's funding model on hospital operations. These include:

• Continued work by the HSFR Working Group, to guide data analysis, develop recommendations on proposed strategies, identify data quality issues, and draft implementation strategies

• Multiple education sessions for Board members, the Administrative Management Committee (AMC), Program Directors and Medical Advisory Committee (MAC) on impact of the funding model

• Hospital Quality Based Practice (QBP) cost comparisons against Ministry of Health and Long Term Care (MOHLTC) funding rates to inform strategies, workflow improvements and supply cost reductions that will

decrease the case cost
• Development of HBAM/QBP reporting framework to track facility performance on a monthly/quarterly basis
• Quarterly reporting on QBP LOS metrics to hospital Quality Resource and Utilization Management (QRUM) committee, which doctor specific information
• Establishment of QBP Working Group to review QBP accountability process and development of standardized quality metrics and reporting framework for each QBP

The hospital is also a vital partner to the HSFR related activities occurring at various Central LHIN forums. Hospital representatives participate fully in the LHIN established QBP working groups which have been tasked to develop comprehensive care pathways for each QBP.

Intensive performance analysis has occurred in relation to the implementation of Year 2 QBPs. Highlights include:

• Chronic Heart Failure – implementation of Standard Order Sets and Care Pathways
• COPD and CHF – OTN Tele homecare Program commenced November 2013. The program allows patients in Northern York Region and South Simcoe to monitor their health conditions at home, with the support of a healthcare team remotely. Patients Accessing OTN has increased dramatically due to the introduction of OTN Clinical Education Events where we have been able to work with approximately 30 patients per event.

Patient data is monitored by a nurse and RT to help patients with their self-management. Supporting our patients to stay healthy and manage their chronic diseases in their home is our goal.

• Stroke – flow of patients to an integrated stroke unit and conducting quarterly patient engagement sessions
• Target of 25th Percentile LOS for QBP procedures with positive results in decreasing LOS – A front line team focusing on improving quality has seen LOS for Hemorrhagic Stroke fall from 10.5 days in 2012/13 to 7.1 days year to date December 2014/15. Similarly, COPD has been a corporate quality improvement focus since 2010/11 resulting in sustained improvements dropping from a LOS of 7.8 days in 2009/10 to 4.9 days year-to-date December 2014/5.
• Front Line team has worked to reducing readmissions for QBP cases –COPD QBP 30-Day Readmissions were reduced from 8.7% returning for COPD-related diagnoses in FY2012/13 to 4.5% 2014/15 YTD (Dec)
• Systemic Therapy – actively engaging in Regional Cancer Centres' review of un-modeled bundle activity within the QBP framework, to further refine costs related to delivery of supportive care cancer services.

For QBPs being introduced in 2015/16, we await the outcomes of the Clinical Expert Advisory Groups and release of pricing frameworks to further establish planning parameters with respect to these procedures. Southlake also looks forward to receiving additional information regarding the introduction of new QBPs and will approach achievement of associated quality targets in the same manner as that detailed in the 2014/15 QIP.
Southlake has undertaken a tremendous amount of work this year to achieve QBP targets. Building upon current successes, Southlake has identified and is implementing best practice clinical protocols for Year 3 QBP targets. The implementation of new models of care will allow Southlake to meet the QBP price targets for future QBPs.

Sign-off

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's 2015/16 Quality Improvement Plan

Board Chair: Mr. Jonathan Harris Jonathan Harris

Quality Committee Chair: Ms. Colette Nemni Colette Nemni

Chief Executive Officer: Dr. Dave Williams

Instructions: Enter the person's name. Once the QIP is complete, please export the QIP from Navigator and have each participant sign on the line. Organizations are not required to submit the signed QIP to HQO. Upon submission of the QIP, organizations will be asked to confirm that they have signed their QIP, and the signed QIP will be posted publically.

2015/16 Quality Improvement Plans for Ontario Hospitals

Improvement Targets and Initiatives

Southlake Regional Health Centre, 596 Davis Drive, Newmarket, ON L3Y 2P9

Lower is Better
Higher is Better

2-Mar-15

AIM		MEASURE					CHANGE				
Quality dimension	Objective	Measure/Indicator	Current performance	Target for 2015/16	Target justification	Priority level	Planned improvement initiatives (Change Ideas)	Methods	Process Measures	Goal	Comments
Safety	Reduce hospital acquired infection rates	**CDI rate per 1,000 patient days:** Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1,000 - Current Performance Jan-Dec. 2014, consistent with publicly reportable patient safety data	0.45	0.22	We are not meeting 14/15 target. Currently 0.45 (Jan-Nov). Our peer group (>7,500 monthly patient days) includes 18 large community hospitals. The 90P FY13/14 was 0.23 with SRHC ranked 36P and in 14/15 (Apr-Nov) 90p is 0.14 with SRHC ranked 28P (higher percentile is better).Based on these results we recommend 0.22 for 15/16 QIP.	Improve	1. Implement an ATP (Adenosine Triphosphate) sanitation monitoring system to detect and measure ATP on surfaces and equipment. By measuring the effectiveness of our facilities' sanitation efforts, we can reduce transmission by re-cleaning a surface or device if ATP is detected. Adenosine Triphosphate (ATP) is an enzyme that is present in all living cells.	Record "positive" and "negative" results. Record surface location and equipment identification. Provide "in-the-moment" feedback to staff.	Measure the number of negative tests (passes) as a % of total tests	85% pass results	
							2. Purchase a NOCO Spray machine. (Noco spray is a proven and trusted disinfection system used in hospitals, long-term care & schools to sterilize & protect against C. diff, MRSA & Norovirus).	Monitor cases from rooms with and without use of Noco machine	% of CDI discharged rooms disinfected with NOCO Spray	100%	
							3. Twice weekly review of all inpatients present on review day who have tested positive in the past 3 years at Southlake for C Diff toxin. Focus will be on the need for antibiotics in the context of current or past C Diff - review of therapy and recommendations for treatment.	Review and compare nosocomial CDI rate and recurrent CDI rate.	(Nosocomial - SRHC) + (Recurrent C diff) rate. Current performance = 0.73	0.58	Decrease by 20% the last 12 month average
							4. Planned visits to RVH, William Osler and North Bay Regional to learn how they maintain annual rates below 0.22			Before July 2015	
	Improve provider hand hygiene compliance	**Hand hygiene compliance before patient contact:** The number of times that hand hygiene was performed before initial patient contact divided by the number of observed hand hygiene indications multiplied by 100 - Current performance Jan-Dec. 2013, consistent with publicly reportable patient safety data.	90%	100%	Although we have achieved very positive results we have not met target. We will continue to target the theoretical best of 100%	Improve	1. Further development and implementation of anonymous auditing method on selected units. (auditor discreetly conducts an unannounced audit) The minimum expectation is 10 audits/unit per month)	Use same methodology as standard audit. (with data available daily)	Number of anonymous audits completed	Min. 1920 annual audits	
	Reduce incidence of new pressure ulcers	**Percent of patients with new pressure ulcer (stage 2 or higher)**. Current Performance = FY 14/15 YTD Q3. Include adult acute care, complex care and rehab patients.	6.4%	3.9%	Our 13/14 best performance was 5.2%. We are currently not meeting the current 3.9% target. We recommend keeping the 3.9% target. We realize this may not be achievable and we will fully investigate positive deviance & our data this fiscal	Improve	1. Implement year 1 of 5 year corporate bed plan	Purchase process.	Number of beds/mattresses delivered and in use ending year 1	per Corporate Bed Plan	
							2. Implement a chart audit for all patients who develop a stage 2 or greater pressure ulcer identified during quarterly incidence study. Identify trends and system improvement opportunities and target interventions based on findings.	Quarterly analysis of audit	The % of patients who develop pressure ulcer stage 2 or greater who have a chart audit completed	100%	
							3. Engage with peer hospitals to share and compare incidence data	Establish a quarterly exchange of data and information	Measure differences processes	Benchmarking for improvement opportunities	

AIM		MEASURE					CHANGE				
Quality dimension	**Objective**	**Measure/Indicator**	**Current performance**	**Target for 2015/16**	**Target justification**	**Priority level**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process Measures**	**Goal**	**Comments**
	Increase proportion of patients receiving medication reconciliation upon admission hospital wide	**Medication reconciliation at admission:** The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital. Current Performance = 14/15 baseline	63%	70%	We used sampling methodology to select random charts (retrospectively). Baseline: Q3 admitted through ED compliance was 69%. Sept - Oct 2014 direct admits was 44%. The combined total baseline is 63%. We have targeted a 10% improvement to baseline.	Improve	1. Compliance campaign for the use of BPMH blue form. (including Physicians and Staff)	Establish this as a regular agenda item for MAC, QURM, AMC & Program Leadership Teams	Review minutes of meetings	Once per quarter	
							2. Conduct a formal Process Mapping (flowchart) review.	Gather a team of stakeholders.	Provide a list of improvement opportunities as a result of this review	Complete by Aug 2015	
	Reduce Narcotic medication incidents	**Rate of related medication incidents (excluding near-miss) per 10,000 Narcotic dispenses (HYDROmorphone, Morphine, Fentanyl) measured monthly:** Current Performance = Baseline Oct-Dec 2014	4.6	2.3	The 3 medications are our top 3 involved in narcotic incidents. Target is based on a 50% reduction in related incidents.	Improve	1. Monthly audit of the 24 HR medication check	Compliance Audit	% of preventable errors (that should have been caught)	0% preventable errors	
							Implement IDC (Independent Double Check) of Morphine & HYDROmorphone on targeted units	Quarterly random audits	% of IDC preventable errors	0% preventable errors	
Access	Reduce wait times in the ED	**ER Wait times:** 90th Percentile ER length of stay for Admitted patients. Q4 2013/14 – Q3 2014/15, iPort	32.0	29.0	Target to sustain.	Maintain	We have maintained performance outside of target. Q1 (30.3) Q2 (33.4) Q3 (32.1). Our past performance is as follows: FY11/12 (30.2) FY12/13 (26.3) FY13/14 (28.6) The 14/15 LHIN target is 30.0 hours. The 14/15 H-SAA target is 26.6 plus a 10% performance window therefore 29 .0 hours. We recommend this target pending approval of the 14/15 H-SAA. SL P4R rank is 51/74 hospitals as of November and we rank 3/7 for Very High Volume EDs (Credit Valley 30.1 and Lakeridge 30.7).				
Patient-centred	Improve patient satisfaction	**Percent positive score:** "Overall, how would you rate the care you received in the Emergency Department?" (question from NRC Picker) Current Performance = Oct 2013 - Sept 2014. (12 months baseline per HQO guideline)	87.2%	87.2%	Target to sustain.	Maintain	We have maintained performance within normal variation to target. Current benchmark averages as follows: GTA (82.5%) Community Hospital (85.5%) Ontario (86.8%) 90P (95.5%). Recommend current performance as target. Benchmarking to 15 hospitals ED Dept.'s (17 ED's) similar volume ED's: 12/13 avg 79.7%, 13/14 avg 80%. SRHC 85% & 87%. Amongst these hospitals in 13/14 we ranked at the 90P, only North Bay & Peterborough scored higher. A target of 87.2% to sustain will ensure we remain above 90P.				

AIM		MEASURE					CHANGE				
Quality dimension	Objective	Measure/Indicator	Current performance	Target for 2015/16	Target justification	Priority level	Planned improvement initiatives (Change Ideas)	Methods	Process Measures	Goal	Comments
Integrated	Reduce unnecessary hospital readmission	**Readmission within 30 days for selected CMGs to Southlake only:** The number of patients with select CMGs readmitted for **any reason** to Southlake for non-elective inpatient care within 30 days of discharge. Current performance = FY14/15 Sept YTD	10.5%	10.5%	Target to sustain.	Maintain	In order to monitor the impact of changes and review of more timely data, we monitor readmissions to Southlake only. We have maintained 14/15 performance within overall target. Past performance: 13/14 to 14/15Oct Diabetes 7.7% to 17.8%, Cardiac 7.4% to 11.1%, COPD 14.2% to 8.4%. Only Diabetes is statistically significant difference. Recommend CP as target and Investigation focusing in the Medicine Program. (NOTE: Diabetes "same reason" indicator increased 3.1% to 13.7%)				
		Readmission within 30 days for selected CMGs to any hospital: the number of patients with select CMGs readmitted for any reason for non-elective inpatient care within 30 days of discharge. Current performance = Q2 12/13 - Q1 2013/14	14.30%	15.50%	Target to sustain.		We have maintained 14/15 performance within target and the Ministry "expected" ratio to this HQO Priority Indicator . (The "expected" is customized to each hospital's data by the Ministry, SRHC expected rate is 15.5% Q4 FY2013/14). By targeting the "expected" rate of 15.5%, we will sustain a "better than expected" performance.				
	Reduce unnecessary time spent in acute care	**Percentage ALC days:** Total number of patient days designated as ALC, divided by the total number of inpatient days. Current performance = FY Q312/13 - Q213/14	13.10%	13.10%	Target to sustain.	Maintain	We have maintained performance to this HQO Priority Indicator slightly outside of the 14/15 target (11.8%) The LIHN recommended 14/15 target for Southlake is 13.7%, our current performance is 13.1%.				
		Percentage ALC days: Total number of acute inpatient days designated as ALC in acute care beds due to "Hospital Reasons" divided by the total number of inpatient days. Current performance = FY13/14 December 31.	0.0%	0.0%	Target to sustain.		Because performance of the Ministry indicator is largely affected due to "Community" reasons that are beyond the Hospitals control, we monitor our performance of the "Hospital reasons" that influence ALC days as a separate performance indicator. We have reduced Hospital reasons to 0% and our goal is to sustain this performance.				
Effectiveness	Improve awareness of people changes & optimize knowledge retention through analysis of Turnover	**Staff Annual Voluntary & Involuntary Turnover Rate:** The number of employees (ONA, SEIU, OPSEU, Non-Union, Management) leaving Southlake during the period divided by the total workforce annualized. Includes both voluntary and involuntary resignations and retirements. OHA definition and bench marking criteria used. Current Performance = FY 13/14	6.8	8.2	Our maximum target is 8.2% based on the OHA 75th percentile (Feb 2015).	Improve	1. Implement 6 month engagement of new hires to optimize organizational commitment by conducting exit interviews for individuals in groups experiencing turnover greater than target	Focus Group interview	Number of exit interviews offered/conducted	100% of identified/offered exit interviews completed	
	Improve organizational financial health	**Total Margin:** Percent by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expenses, excluding the impact of facility amortization, in a given year. YTD Q3 2014/15, OHRS, MOH	3.3%	2.0%	Target aligned to our 14/15 H-SAA performance standard	Maintain	Our current performance is 3.3% and better than target. Our goal is to meet target at fiscal year end.				