2015/16 Quality Improvement Plan for Sunnybrook Health Sciences Centre

Measure				Change						
Indicator	**Baseline**	**Target**	**Result**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Goal for change ideas**	**Comments**	Was this change idea implemented as intended?	Lessons Learned: (Questions to Consider): - Did the change ideas make an impact? - What advice would you give to others?
Reduce # of occurrences of off-load times greater than 3 hours	560	280	115 (up to and including Q3)	1)Implement Toronto Paramedic Services (TPS) 6-week assistance program	Toronto Paramedic Services provides a Supervisor on a temporary basis (6 weeks) to assist with paramedic movement and documentation.	Toronto Paramedic Supervisor to meet weekly with Emergency Department Manager and Medical Director to discuss observations.	Emergency Department Manager and Medical Director to produce a brief report of observations and recommendations based on 6 week period.		yes	This built stronger relationships and was good for ambulance and hospital staff to see senior leaders on both sides engaged.
				2)Implement Green Zone chair model.	Create spaces for appropriate stable ambulance patients by moving that patient or another stable patient to a chair on a temporary basis to create stretcher capacity for a more acutely ill patient. Work with Nursing and Decision Support to develop tracking mechanism for these moves.	Establish tracking mechanism for these moves. # of ambulance patients that are able to be moved to a stretcher or chair in the Green Zone. Survey awareness of Green Zone chair model monthly.	Establish tracking mechanism by May 31, 2015. A minimum of 15 patients (total) are moved to Green Zone chairs per month. At least 75% of staff surveyed are aware of Green Zone chair model.		yes	It was important for staff to be engaged in this initiative as it impacted their work flow. Also data was important to be able to show the positive impact of this model and secure funding for nursing staff to be able to continue model of care.
				3)Clinical Care Leader (CCL), in collaboration with triage nurse, increases rate of ambulance patients being off loaded.	Emergency Department staff will use Sunnybrook's internal, real-time 2-hour tracking system to prioritize patients for offloading into the department and/or move patients who are waiting for a floor onto stretchers so that Ambulance patients can move into a bay.	Monthly tracking of internal 2 hour wait target. Tracking "streaks": number of days with "0" patients waiting longer than two hours.	Baseline (Jan-Dec 2014): 568 Target (April 1, 2015 – March 31, 2016): Improve monthly and annual rates by 50% to 284. Double the number of 3-day streaks from two to four within 6 months (September 30, 2015). And double the number of 5-day streaks by year-end (March 31, 2016) from four to eight.		yes	The electronic real time system was helpful to alert staff of timing and the need for action. Data was also important to bring back to staff for ongoing encouragement and engagement.
				4)Share monthly performance with staff in order to improve awareness and support staff in their efforts to address this priority.	Share monthly performance at weekly staff meetings and post where staff can see.	Ensure ED off-load performance on every staff meeting agenda.	ED off-load performance discussed at 100% of team meetings. Data posted monthly.		yes	The staff were very attuned to this goal. Processes for delivering monthly performance feedback were adjusted based on staff input.
				5)Conduct registration during ambulance patient wait time to reduce overall wait time.	Conduct bedside registration when bay available, instead of waiting for chart to be made up by Patient Administrative Associate (PAA) when appropriate.	Random audit of bedside registration (two per month)	Bedside registration being conducted 100% of the time for appropriate ambulance patients.		no	The practice was completed on a number of occasions however we did not have the resources to maintain regular audits of compliance and as such this practice has not sustained.
				6)Ongoing collaboration with ambulance staff on following criteria for double up. (Double-up is when one paramedic team takes responsibility for another team's patient in the ambulance bay, so that this second paramedic team can return to service.)	Post criteria for double-up in ambulance bay area so when reaching a critical ambulance volume trigger, ambulance staff can off load a patient in line with agreed upon protocol. Shift Manager and or Emergency Department Manager should be notified when this is done.	Track number of doubling-up instances.	Increase double-up instances by 50% from April 1, 2015 to March 31, 2016.		no	Though 'doubling up' is a paramedic practice, we do not have resources to maintain regular audits of compliance and as such it is not clear whether this practice is consistent.
				7)Analyze Emergency room physician performance.	Measure emergency physician data: • Rate of seeing patients • Consult rate • Rate of admissions of consults	Once the data collection is complete, performance will be analyzed.	Complete data collection and analysis and begin to identify any opportunities for improvement (if applicable) by August 31, 2015.		yes	This data is available and is shared with individual physicians by their chief. This information is used to guide performance improvements.
				8)Occupancy management initiatives	A substantial number of initiatives, tools and processes are underway aimed at improving occupancy in the hospital inpatient units in response to increasing patient volumes. These range from flow initiatives to system partnerships.	The progress of each initiative is overseen by the Occupancy Executive Committee which meets weekly.	Baseline: 99% (January - December 2014) Target: 95%		Yes	Many of the initiatives have occurred including expanded hallway protocols and more designated surge space and a focus on repatriation. These initiatives have still not been able to get the occupancy target to 95% but may have had an impact on decreasing crowding in the ED.

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									Overall Comments: • What was your experience with this indicator? • What were your key learnings?	We were able to achieve a 70% reduction in ambulance off loads (target was 50%). The success was due to staff effort and attention to this metric and a broader system focus.

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Year 1: % of patients on 4 units who are assessed for delirium twice daily (units in Medicine, Oncology, Trauma Emergency Critical Care & Cardiology) A significant focus of the work through this year will also be on ensuring assessment accuracy as we know the process of making this determination can be tremendously complex – in year 2, assessment accuracy will be the primary indicator.	60	90	Q1-73 Q2-85 Q3-93	1)Establish delirium screening as expected practice, focusing on accuracy & the implementation of interventions to prevent & to manage delirium on 7 units (4 measurement + 3 others)	1. Conduct Knowledge to Practice, in the moment learning sessions on the units 2. Engage staff in case reviews focusing on delirium identification accuracy 3. Promote interprofessional team dialogue to enhance implementation and range of interventions in use to mitigate delirium 4. Expand Champion role to support delirium intervention 5. Determine fit for delirium work with Veterans Centre & Holland Centre	1. % of staff engaged in education sessions & reporting knowledge uptake 2. Chart audits of patients suspected of delirium for accuracy of identification 3. % of interventions / range of interventions in use 4. Champion alignment with the delirium work 5. Dialogue re: opportunity to streamline work with other sites/programs	1. 80% of staff on 7 units engaged in education & report knowledge uptake 2. 80% alignment between chart information & accuracy of delirium identification 3. 80% identification of interventions in place to prevent / manage delirium 4. One Champion aligned to delirium work on each of the 7 units 5. Delirium strategy articulated for Veterans Centre / Holland Centre		Yes	1. 80% of staff on **8** units engaged in formal education sessions and in knowledge-to-practice patient specific case reviews, in addition staff on 3 of these units have had intensive weekly delirium quality improvement programming, by virtue of involvement in the Regional Geriatric Program led ACTION Program initiative 2. **59%** delirium accuracy across 8 units was achieved (less than the 80% target) 3. **63%** identification of interventions to prevent / manage delirium was realized (less than the targeted 80%) 4. Champions are supporting the work across units 5. Needs assessmennt in progress at Veterans Centre and work with Holland Centre is focused on supporting management of patients displaying high risk behaviors as this is a new patient population for this site
				2)Continue emphasis on patient mobilization across 31 units at Bayview, Veterans & Holland sites. (While mobility does not contribute to the year 1 goal of delirium assessment, mobility contributes significantly to mitigating delirium (the ultimate goal of this multi-year plan)).	Continue audit & feedback with respect to: 1. Established mobility level 2. 3 times daily mobilization 3. Out of bed audits	1. % of patients with established mobility level 2. % of patients mobilized 3 times daily 3. % of patients out of bed	1. 90% of patients have established mobility level in charts monthly 2. 70% patients in acute care and 85% patients in Veterans & Holland Centres are mobilized 3 times daily 3. 55% of patients in acute care and 85% patients in Veterans & Holland Centre are out of bed during quarterly visual audits		Yes	1. **96%** of patients across 31 units have an established mobility level 2. **75%** of patients in acute care were mobilized 3 times daily (higher than the target of 70%), and **92%** of patients in Veterans & Holland Centre (higher than the 85% target) 3. **65%** of patients were out of bed in acute care and 94% in Veterans & Holland Centre, higher than the respective targets of 55% & 85%
				3)Engage stakeholders in developing the components of the 3 to 5 year Senior Friendly (SF) Plan	1. Determine key stakeholders 2. Develop 3 to 5 year plan	Retreat to be held in Spring 2015	3 to 5 year comprehensive plan addressing a hospital-wide senior friendly strategy articulated with concrete goals and measures for each year of the plan		Yes	A retreat was held in the spring of 2015. As a result a Working Group formed, with specific action ongoing to partner with TPS (Toronto Paramedic Services) to impact delirium detection across the continuum of care, as well as work to standardize care protocols related to sleep and agitation within the hospital. In addition, the SF Team continues to focus on patient mobilization, enhancing delirium management, influencing the appropriate use of antipsychotics, influencing high risk behavior management and observer use. Goals and objectives have been articulated for these pieces of work. These goals will continue to raise awareness about delirium screening and continue to engage others in understanding the need for accurate assessment as part of a broader delirium prevention strategy.
									Overall Comments: • What was your experience with this indicator? • What were your key learnings?	The experience over this year has been extremely positive in terms of accomplishments. Plans and achievements have been on track, apart from the targets related to delirium. Influencing the accurate detection of delirium takes time and significant effort as this condition is not determined at a point in time, conversely it necessitates an understanding of the patient's status at baseline and over time. It is also key for communication and dialogue to occur soliciting input from members of the interprofessional team – in many instances a challenging thing to achieve. Our work is on track to influence the management of delirium across our hospital with additional time and as such, delirium will continue to be on next year's QIP to maintain focused efforts on this important priority.

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90th percentile Length of Stay Non- Admitted patients	8.08	7.08	Q1-8.8 Q2-8.1 Q3-7.9	1)Expedite initial assessment of all patients (thereby also including those that are not admitted).	Targeted positioning of Physician Assistant on busier times to address spikes in CTAS* 4-5 activity. "Green zone chair" initiatives to get patients out of waiting room and into care area faster. Weekly audit, assessment and feedback and analysis by Department Chief and interprofessional team on length of stay metric for non-admitted group. *The Canadian Triage & Acuity Scale (CTAS) is a tool that enables Emergency Departments to prioritize patient care requirements. Patients with a lower acuity score have a CTAS of IV or V and do not need to be seen as quickly by a physician as patients with a CTAS of I through III.	90th percentile time to Physician Initial Assessment (the time that 90% of patients waited in the Emergency Department for a physician initial assessment after triage or registration (whichever was done earlier))	Reduce Physician Initial Assessment time by 5% by March 31, 2016.		Yes	The Green Zone chair project has been fully implemented. Detailed data analysis has shown that this model has had a significantly positive effect on patient flow in this part of the Emergency Department without negatively impacting stretcher patients or having a negative effect on patient safety. Length of stay performance for non-admitted patients is monitored and reported weekly. This metric is further sub-divided into LOS for patients seen only by ED staff and those seen by both ED staff and consulting services prior to discharge. ED alone patients have shown consistent improvement with a lesser degree of progress with consulting services. Initiatives are under way with consulting services. Would advise others that increasing flexibility for making patients ambulatory has flow benefits in an overcrowded ED but that quality and safety must be monitored and interprofessional team must all be committed to change.
				2)Expedite imaging for non-admitted patients, especially CT (computed tomography) scans	Multiple initiatives with Diagnostic Imaging to improve turn-around times with auditing and reporting. Push reporting of all imaging results to Emergency Physician iPhones.	Monitoring, audit and feedback of Diagnostic Imaging "turn-around time" together with Diagnostic Imaging and Emergency Department team.	90th percentile CT turn-around: 2 hours by March 31, 2016. All imaging results to Emergency Physician iPhones by March 31, 2016.		Yes	Multiple meetings have taken place with Diagnostic Imaging and monthly metrics related to CT turn around times are now reported. A Division of Emergency and Trauma imaging is being created. Would advise others that departments with high need for imaging studies (especially cross-sectional) that a close working relationship with Diagnostic Imaging and reporting of shared metrics is essential.
				3)Optimize the connection between the Emergency Department team and consultants so there is less prolongation of patient journey waiting for transitions between the Emergency Department and consultant.	Audit and feedback for doctors and teams at Medical Advisory Committee and the Implementation and Integration Committee	Establish credible data for consult arrival times for the top 5 services by volume.	25% reduction in consultant arrival time interval for the top 5 services by volume by March 31, 2016.		No	Actions taken to improve data qualtiy included (1) posting signage throughout the Department reminding consultants to chart arrival time and (2) emphasizing the need for accurate data and efficient performance from consultants each Medical Advisory Committee meeting. Success has been limited. Would advise others that gaining consultant buy-in for improving this metric is challenging and requires constant encouragement and monitoring. An electronic solution for tracking arrival time may improve this data.
									Overall Comments: • What was your experience with this indicator? • What were your key learnings?	This indicator measures the efficiency of the ED in caring for patients who are discharged and is an important quality metric. In order to improve performance, both internal ED processes (such as using ambulatory zones) and external processes such as crowding, DI performance and consultant performance must move together.

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Rate of falls with harm: Number of inpatient and resident falls with harm classified as moderate or greater (severity score of 3-6) / 1,000 patient and resident days	0.22	0.19	Q1-0.13 Q2-0.21	1)Promote broad awareness of the falls experience in each of the five identified clinical areas (includes 60 patient / resident units)	1. Develop and standardize data reports by clinical area/unit 2. Clinical areas/units establish report review process	1. Report distribution 2. Established report review process, e.g. falls data is reviewed quarterly in program council, huddles, etc.	1. Data reports disseminated to five identified clinical areas (60 units) each quarter beginning in Q1 2. Process is established to share falls data regularly across at least 30 units by March 31, 2016		Yes	A two pronged process has been established across the hospital: 1. A chart / visual audit immediately following a fall to ascertain process fidelity, e.g. falls risk identified / intervention(s) in place and 2. A request for post fall staff debrief / report back regarding the event, action(s) taken, learning. Focus in this year for sharing reports has been to do so with the units with greater numbers of falls over time.
				2)Engage Falls iLead Champions to promote falls risk reduction best practice implementation at the unit level	1. Identify champions in clinical areas/ units 2. Champions receive & share data with colleagues at the unit level	1. Champion identification 2. Champions attend iLead Connects meetings / engage with Work Groups Leads / Change Coordinators to receive and learn re: overall / unit level data	1. Champions are aligned to falls work specifically in at least 30 units 2. Champions are recognized on at least 30 units as leaders with respect to falls best practice and articulate the falls risk reduction strategy for their patient population		No	A hospital wide event was well attended by champions in Nov., 2015 - two of our sites with robust process (Veterans Centre & St. John's Rehab) shared the rigor of their programming and a Patient Partner shared his falls story - the feedback from this event was entirely positive and the learning described as significantly impactful. A Champion Activity Report engaged Champions at large in 2015. While efforts have been made throughout the year to reach more Falls Champions specifically, engaging them in the work and engaging units generally in appraising their falls review process has been challenging due to champion workload. A survey was sent to units early in the year with limited response. For this reason a decision was made to focus on the areas with greater numbers of falls over time, as outlined above.
				3)Continue corporate-wide education enhancing awareness of the critical aspects of the falls risk reduction strategy	1. Falls risk assessment are completed with patients at admission 2. Impart general knowledge to new staff via general orientation 3. Existing staff participate in e-learning module 4. Promote continued transparency in falls reporting	1. Compliance with falls risk assessment in workload load measurement system. The workload measurement system is used in approximately 2/3 of the 60 units. Current compliance is approximately 40% since inception (fall of 2014). 2. Number of participants in general orientation 3. Number of staff completing the e-learning module 4. Number of e-safety reports	1. Enhance workload reporting by 20% (to 48%) in Year 1 (2015/16) 2. Approximately 360 new staff over the year (~30 / month) participate in general orientation 3. 644 existing staff complete the e-learning module (10% increase from 2014/15) 4. Potentially realize an increase in all falls reporting		Yes	The following are statistics for 2015 / 16: 1. Workload reporting data was not yet available at time of internal submission, but will be updated when available. 2. 865 new staff participated in general orientation, where falls work was shared (work is currently happening to enhance the information shared in orientation and to bundle falls and mobility strategies) 3. 373 existing staff completed the e-learning module 4. Falls with harm rates have not risen - the experience in this year has been to achieve a truer reflection of our falls experience, by virtue of establishing a level of harm review process.
									Overall Comments: • What was your experience with this indicator? • What were your key learnings?	Transitioning to monitoring falls across the entire hospital takes time. Learning is required to understand the data and ensure the data accurately reflects current state; audits / debriefs are becoming very important. In addition understanding process across patient populations is necessary as is establishing point people in common areas where a large proportion of falls occur.

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Sunnybrook's indicator for Hand Hygiene: The number of times that hand hygiene was performed during all 4 moments for proper hand hygiene, divided by the total number of observed hand hygiene moments, multiplied by 100.	84	87	Q1-85 Q2-86 Q1-85	1)Visible senior leadership support: Chief Executive Officer as well as Senior Leadership Team to be role models for hand hygiene.	Senior leader self reporting	Senior leaders perform all 4 moments for proper hand hygiene, as applicable, when on the patient care units.	100% compliance		Yes	Visible, committed senior leadership is essential to a successful program. Advice: engage senior leadership from beginning as champions and advocates for improvement.
				2)Hand hygiene “observer” role	Observer reporting	Immediate feedback to those observed with emphasis on education through feedback.	100% of those observed receive feedback.		Yes	Immediate feedback is an essential educational component of the program. Advice: include immediate feedback regarding hand hygiene practices at the point of care, as part of the "observer" role.
				3)Ensure accurate placement of point-of-care alcohol-based hand rub (ABHR) product	Conduct standardized quarterly Walkabouts	• Alcohol Based Hand Rub products accessible to clinical staff • # of completed walkabouts • # of recommendations implemented post walkabout	• 100% of bottles that had a product in them at the time of random audit • 100% of walkabouts completed as per standardized schedule • 100% of recommendations implemented post walkabout		Yes	Point-of-care product is essential for staff to perform hand hygiene at the appropriate times. Advice: ensure that product is at point-of-care in all patient care locations, processes are in place to ensure it is always full/available and review periodically.
				4)Education	Education in Orientation, for all students, and as an e-learning module	Demonstrated use of all educational modalities	100% compliance		Yes	Feedback after orientation sessions is provided and is positive. Advice: include hand hygiene education in orientation, preferably interactive, with periodic re-certification, e.g., every 2 years on-line, interactive, various modalities.
				5)Enhance communication and awareness of Hand Hygiene activities	• Post quarterly results on Sunnynet (internal website) with programs/units listed best to worst • Quarterly results and videos accessible on physician page of Sunnynet • Pictures of front-line staff “caught clean handed” on Sunnynet.	• # of hits on results and video pages • # Hand Hygiene champions (physicians and unit based) surveyed who could identify at least two Hand Hygiene awareness strategies	100% Hand Hygiene champions surveyed are aware of least two Hand Hygiene awareness strategies		No	Components not implemented in entirety - in progress.
				6)Hand Hygiene Champions	• Enhance the engagement of Hand Hygiene Champions • Expand the role of Hand Hygiene Champions	# of champions retained at the end of 2015/2016	100% Champions in place and retained for each unit		No	There are 70 hand hygiene champions across all 3 Sunnybrook campuses; only 4 units do not have a champion. Advice: be aware of challenges in maintaining communication with a group of frontline champions (due to schedule differences, limited availability for in-person meetings and irregular email acccess). Ensure that champions have sufficient time assigned for the role.
				7)Patient and family engagement • “it’s OK to ask” for in-patients • “Patient as observer” for out-patients	• In-patient unit focus groups completed; pilot units identified; pilot to roll out in Q4 2014-15; expand to other units through 2015-16 • Out-patient observer expand to other ambulatory areas	• # of in-patient units engaged in program • # of ambulatory areas engaged in program	• 100% in-patient units introduced to idea of patient empowerment • Continue to increase # of engaged ambulatory areas		Yes	All in-patient units have adopted the program. Critical care units are currently implementing. The 4 largest ambulatory areas (Emergency Department, Family Practice, Odette Cancer Centre and Diagnostic Imaging) have implemented. Advice: this approach to patient empowerment requires adaptation for various care settings, e.g., table cards for in-patients, signage in waiting areas for ambulatory care. Anecdotally we heard that that patients were most comfortable asking staff who were wearing buttons.
									Overall Comments: • What was your experience with this indicator? • What were your key learnings?	Hand hygiene is an extremely important patient safety indicator. Sustainable improvement requires continuous review and refresh to keep staff engaged. Multi-modal approach is key. Human factors including behavioural influences need to be addressed on an ongoing basis.

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Average acute care length of stay for patients designated palliative ALC (Alternate Level of Care).	6.10%	4.90	Q1-4.4 Q2-3.6 Q3-4.0	1)Enhance processes related to the transition of patients from acute care to Palliative Care	Formalize communication and processes of transfer between the acute care units and the Palliative Care Unit. Use unit-specific data to identify high and low performing acute care units to share best practices and target improvement efforts. Create a process for early identification of palliative care patients. Pilot a process to ensure that Sunnybrook's palliative care unit is always included as a referral option.	Wait time from when patient application is received by Palliative Care Unit to patient arrival to Palliative care unit. % of acute patients designated ALC palliative care • referred to Palliative Care Unit* • transferred to Palliative Care Unit*	Goal: Reduce by 1.0 day. Data collection and analysis begins October 1, 2015. • ≥ 80% of acute patients designated ALC palliative care referred to Palliative Care Unit. • ≥ 75% of acute patients designated ALC palliative care transferred to Palliative Care Unit.		Yes	Bayview campus improved the overall ALC length of stay of palliative patients in the last three quarters. Data is being presented and monitored through Occupancy Executive Committee on a weekly basis.
				2)Enhance processes to increase number of patients transferred directly from home to Sunnybrook's Palliative Care Unit.	Educate medical and other staff (inpatient and ambulatory units) in the Cancer and Community Program regarding improved processes. Enhance community collaborations: - Work with CCAC (Community Care Access Centre) to facilitate direct admission to the Palliative Care Unit. - Look for opportunities to standardize aspects of the transfer process for patients with a common disease/condition. - Consider ways to work more closely with the home palliative care physicians regarding decisions to transfer to hospitals. - Investigate ways for community-based palliative care patients to go straight to the palliative care unit and bypass the Emergency Department when in crisis.	Number of direct patient* transfers from home to Palliative Care Unit. *Definition: patients with previous visit(s) in Odette Cancer Centre.	Maintain 12.5% of palliative care unit occupancy as admissions direct from home. Patient pathways reviewed and any appropriate recommendations developed by December 31, 2015.		Yes	In an effort to alleviate occupancy pressures, the main priority for admissions at the Palliative Care Unit (PCU) is acute inpatient referrals. This reduces the palliative unit's ability to bring in patients from the community. However, if there is a patient that is requires palliative admission, the PCU makes every effort to accommodate them in order to reduce the likelihood of them coming through Emergency. In addition, we consistently assess the home-based patients who come to Emergency and reprioritize them to admit directly to the PCU whenever possible. Ambulatory Odette Cancer Centre Social Workers have also held several education sessions regarding back-up papers and applications to the palliative unit so that this process is smoother.
				3)Analyze transfer patterns to better understand patient need, patient groups and factors related to transfer.	Review data to analyze: - Patient types and needs - Unit (and/or team) transfer volumes and practices (high performers, low performers)	- Data collected and reviewed and analyzed	- Data collected by May 31, 2015 - Data review completed by June 30 - Any relevant recommended actions developed by August 31, 2015	The reasons for delays in transfers from acute to PCU. For Q1-Q3 they are: long term applications when we have no long term PCU beds available (35); Patient requires isolation (10); Patient declines the bed (7); Patient came to PCU and then went back to acute (3); Incomplete applications (2)	Yes	Palliative unit performed an analysis related to the reasons for delay in transfer from acute to PCU. Learnings included that additional alternatives to the long term palliative care beds should be considered, the ratio between short and long term palliative should be constantly evaluated and that additional study should be performed and acted upon for the potential of transferring out from palliative unit to home.
				4)Reduce time between 'Palliative Care ALC designation' and 'Referral Sent' in Resource Matching &Referral (RM&R) system.	Review data identifying dates for: - ALC designation - RM&R initiation - RM&R completion - RM&R sent Identify barriers and facilitators for entry into RM&R system.	Audit of all patients per quarter. Review barriers and facilitators.	- Data collection and analysis begins Oct 1, 2015. - Minimum quarter over quarter (Q3 to Q4) improvement of 20%. - Barriers and facilitators identified, reviewed and action plan development scheduled by March 31, 2016.		No	Process efficiency was not analyzed, however, the discharge coordinator for the cancer units suggested that the overall referral process and overall time are excellent. Please note that not all applications are received through the Resource Matching and Referral (RM&R referral database) because it is only accessed by providers located in the Toronto Central LHIN (Local Health Integration Network). The Palliative unit also receives applications from outside of the Toronto central LHIN i.e. North York, Scarborough, home etc.
									Overall Comments: • What was your experience with this indicator? • What were your key learnings?	Engagement and coordination between Acute Care, Cancer Program, Community Program, Occupancy Executive Committee and Palliative unit leadership can drive improvements in the timelines relevant to Palliative Care transitions from acute and home to palliative settings. <u>Key Learnings:</u> This work improved the culture of connection as well as the efficiency between acute and palliative units. This indicator was a good foundation and a starting point for our next evolution of the palliative strategy which will define the next required steps and quality improvement goals. Lots of work related to palliative has been performed in the last year. Better collaboration between all parties as well as a more defined meetings schedule could benefit this improvement work in the future.

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From NRC Canada: "Overall, how would you rate the care and services you received at the hospital (inpatient care)?" (add together % of those who responded "Excellent, Very Good and Good").	93.97	95.00	Q1-94.0 Q2-93.3 Q3-94.2	1)Across Sunnybrook's three campuses, continue broad implementation of the Person-Centred Care Best Practice through the "Seeking and Embedding the Voice of the Patient" strategy which consists of 3 vital behaviours: 1. Start with NODS to make a connection (say Name/ Occupation/ what is to be Done with the patient, with an attitude of Support, Sincerity and with a Smile) 2. Always Seek the Voice of the Patient (Ask First what is most important) 3. Always Embed the Voice of the Patient (Share and Act on what matters most)	a. Across the organization, continue raising awareness about "Seeking and Embedding the Voice of the Patient" via staff and leader meetings as well as a survey to establish the expectation for consistent demonstration of the 3 vital behaviours for all staff. b. Use the Dashboard data infrastructure for quarterly communication of patient satisfaction results, to enable care teams to discuss how to consistently meet the 95% overall satisfaction target. c. In the last 2+ years, more than 500 iLead (quality improvement) Champions have been identified across programs & units. As Champions advance "Seeking and Embedding the Voice of the Patient" within the work of each best practice, they will be supported by middle leaders on the units in sharing information & planning quality improvement initiatives with colleagues. Leading initiatives will be profiled in organization wide forums. d. Engage staff in "Conversations with Patients". "Conversations with Patients" is protected time, provided quarterly for approximately 35 staff, to each talk with 2 to 5 patients in patient care units across the hospital. These conversations enable and promote dialogue related to patients' experience of staff 'Seeking and Embedding the Voice of the Patient, with respect to the 3 vital behaviours: staff introduction, always asking and always acting on what is important to the patient	a. Administration of 'The Voice of the Patient' Survey b. Dashboard dissemination c. Updated Champion Role Profile Champion Satisfaction Survey results. d. Number of "Conversations with Patients". "Conversation" results.	a. Survey will be administered to select non-clinical stakeholder groups (e.g. Environmental Services, Dietary Services, Patient Transport, etc.) by March 31, 2016. b. Dashboard dissemination quarterly beginning in Q1. c. Champion Role Profile updated and aligned to strategy by September 30, 2015. Champion survey to yield 50% growth from baseline (fall 2014) results in satisfaction in the identified areas: • Process • Resources • Team Support • Role Clarity d. Conduct "Conversations with Patients" with 500-700 patients in 15/16. "Conversations with Patients" quarterly data targets: • 90% of patients said staff always introduced themselves (baseline 67%); • 66% of patients said staff always asked what was important to them (baseline 38%); • 66% of patients said staff always acted on what was important to them (baseline 44%)		Yes	The approach of Person-Centred Care is being operationalized at SHSC through consistent actions of "Three Vital Behaviors" to Seek and Embed the Voice of the Patient. As planned, work in this year has focused on further engagement of champions & leaders, sharing data and promoting team conversations about the data and the practice, action planning based on feedback received and profiling champions who have made a difference. Surveys were adminstered to both Champions and Leaders this year, with overall role satisfaction at ~ 65%. 361 conversations with patients occured this year. On average, 90% of patients said staff introduced themselves, between 60 - 70% of patients reported they were being asked what was important to them, and 70 - 80% said staff were acting on that information. A 'Dream Team' initiative began last year, developed by staff, as a way to recognize colleagues. This resonated throughout the organization and recognized all members of the team, clinical and non-clinical staff.
				2)Continue targeted implementation of the Person-Centred Care Best Practice through the "Seeking and Embedding the Voice of the Patient" strategy (see details of components above). Sustain implementation at the Holland Centre and implement in two additional programs.	a. A 16 week plan guides Person-Centred Care implementation facilitating the integration of two aspects of the work: 1. The required components (policy, documentation requirements, etc) 2. The customizable components - integrating the Person-Centred Care dialogue in unit care planning processes, identifying opportunities for interprofessional collaboration, venues to share data / dialogue re: the experience, etc.) b. The Person-Centred Care strategy will be sustained post implementation. c. The experience in implementing the 16 week plan will be captured as a toolkit which will be used to guide future implementations.	a. Various measures will be used: • Completion rates for 16-week cycle • Education rates • Survey results b. Post implementation data will be collected. c.'Lessons learned' from each implementation to be captured in the Tool Kit.	a. Goals: • the targeted areas will have completed the 16 week implementation cycle • 80% of staff within targeted areas will receive education re: the Person-Centred Care strategy • A 25% increase from baseline will be achieved by the team over 12 weeks in the following survey questions: 1) What is most important to the patient is discussed by the team 2) What is most important is documented 3) A plan to address what is most important is captured b. An additional 25% increase (to results achieved at 12 weeks, see above) will be achieved by the team in a 6 month post implementation audit 1) What is most important to the patient is discussed by the team 2) What is most important is documented 3) A plan to address what is most important is captured c. Person-Centred Care Implementation Toolkit captures lessons learned and is completed by March 31, 2016.		Yes	The Person-Centred Working Group includes patients and family member partners. In 2015, the Working Group received a patient engagement grant from the Canadian Foundation for Healthcare Improvement and deveoped three videos about Person-Centred Care. The stories of Sunnybrook's own patients and staff formed the videos; "Seeking & Embedding the Voice of the Patient", "Partnering with Patients" and "Quality Dying". These videos form the basis for interprofessional education sessions which occur within the 16 week implementation plan. Facilitated sessions, co-led by staff and patient and family partners as well as the use of the videos provide frontline staff with information about the 3 Vital Behaviors to Seek and Embed the Voice of the Patient, and demonstrates how the approach is integrated into daily practice. The education bundle was rolled out in our cardiology and critical care areas, with post evaluation ongoing. Planning is now underway for implementation in the Odette Cancer Centre. A toolkit is in development as is a 3 to 5 year sustainability plan.
									Overall Comments: • What was your experience with this indicator? • What were your key learnings?	Our experience in this year has been entirely favourable. True engagement and partnership with patient and family partners has been a key enabler to evolving this work meaningfully. In addition, engaging experienced Champions to coach new Champions is an invaluable approach to success in implementation.

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Number of surgical site infections among patients (having neurosurgery craniotomies) submitted to NSQIP (National Surgical Quality Improvement Program of the American College of Surgeons)	7.94	2.75	Q1 0.0 Q2 2.3	1)Re-establish the sterile environment within the operating room	1. Awareness related to breaches in sterile technique: equipment (Regional Processing Centre) and personnel 2. Decrease Operating Room traffic (specific interventions to be determined following analysis of reasons for Operating Room entry) 3. Purchase single use iodine bottles/ sticks to prevent multiple open bottles in the Operating Room	1. Random Operating Room audits to evaluate breaches in sterile technique 2. Count of door openings (Engineering to develop means of "counting" door openings during case) 3. Cease use of multi-use vials of iodine to prevent cross contamination	1. Reduce number of breaches in sterile technique as determined by audit (target % reduction for both equipment and personnel-related breaches to be selected following collection of baseline data) 2. Reduce door openings by 20% 3. Cease use of multiuse iodine vials in the Operating Room by March 31, 2016	Decreasing Operating Room traffic is an ongoing effort.	Yes	The positive difference that these changes have made as a bundle are mirrored in our data. Controlling traffic in the operating room, however, is mainly a cultural change and therefore requires constant attention. Cultural changes often take time in order to become part of the team's daily behaviour.
				2)Change practice for applying dressing in the Operating Room	Develop guideline for the application of dressings at the end of procedure (gauze with Chlorhexidine, leaving iodine in place).	Percent compliance with new dressing technique in eligible patients (per guideline)	100% utilization of new dressing technique by March 31, 2016	Full Head dressings to be applied on all craniotomy patients.	No	Rapid PDSAs (Plan-Do-Study-Act) were tested. Some changes had to be made in order to standardize head dressings. Full head dressing will be applied on all craniotomies as of March 1st, 2016 by all Neuro surgeons. All changes had to be communicated to Operating Room, Post-Anaesthetic Care Unit and D5 (surgical ward). An audit will be conducted as of March 1st to ensure full compliance.
				3)Introduce pre-op hair wash solution for elective cases	Instructions will be given to patients to wash their hair with an antimicrobial shampoo prior to surgery	Measuring compliance through questionnaire administered in preoperative Same Day Surgery or inpatient units (for inpatients awaiting surgery)	100% compliance with pre-op hair wash by March 31, 2016		Yes	Instructions are given to elective patients. Sample survey of patients indicated 100% compliance with hair washing prior to surgery. We also introduced the hair wash solution for inpatients (some of which are elective) however implementation was delayed because the process change required pre-op order set revisions which are yet to be approved. Lessons learned: consider extra time required to make changes in order sets and forms due to approval required by all stakeholders including the approval committee.
									Overall Comments: • What was your experience with this indicator? • What were your key learnings?	Overall, we achieved success with many of our change ideas, and were able to adjust others when needed. This ongoing and regular review along with all stakeholders engagement are key success factors to ensure adjustments can be made in a timely manner and that change ideas are successful. As mentioned, for cultural changes, this is particularly important.

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Proportion of patients undergoing pancreatic surgery who develop a Surgical Site Infection	24	17.5	Q1-31.3 Q2-21.1	1)Screening and intervention for high glucose, HbA1c*. *HbA1c is a marker for high glucose in patients with diabetes. Uncontrolled glucose during surgery can increase the risk of developing an infection after surgery.	1. Add HbA1c screen to list of lab tests on preoperative pre-printed order sets for the Hepatobiliary population. 2. Perioperative tight glucose control among patients with preoperative high HbA1c.	1) HbA1C screening rate in eligible patients 2) Proportion of patients on post-operative day 1 with highest glucose in normal range	1) 100% of eligible patients screened 2) Increase in proportion of patients on post operative day 1 with highest glucose in normal range by >25%	Currently, the team is investigating the current processes for and feasibility of pre-op blood glucose control in collaboration with endocrinology team.	No	
				2)Use of wound protectors on all open pancreatic cases.	Implement use of wound protectors for pancreas surgical cases	Measure the use of wound protectors in eligible / appropriate pancreas surgical cases	100% of eligible / appropriate pancreas cases use wound protector		Yes	This change idea had decreased our superficial and deep SSIs in instances where it was used. However, lesson was learned that our compliance was not being measured. New processes were put in place to measure the compliance with wound protectors.
				3)Improve compliance with antimicrobial re-dosing.	1. Feedback to anesthesiologists and surgeons 2. Addition of dedicated timers in the Operating Room for reminders to re-dose 3. Update anesthesia record to add antibiotic re-dosing as a new field for documentation 4. Raising awareness in the Operating Room by discussing antibiotic re-dosing in briefing/ debriefing	1. Number of patients undergoing procedures >4 hours that receive antibiotic re-dosing in the Operating Room. 2. Measuring and reporting the compliance with re-dosing on a monthly basis.	Goal is to increase the average of antibiotic re-dosing from 70% (last year) to 100%.		Yes	Antibiotic re-dosing feedback has been communicated to all staff in order to raise awareness. We learned that patients with previous ERCP* also had bacteria resistant to standard antibiotics, so we changed the protocol and pre-op order sets (being reviwed by Form Commtitee) for these patients. This change idea will be closely monitored through NSQIP** to measure the effect on SSI rates. *Endoscopic retrograde cholangiopancreatography, or ERCP, is a specialized technique used to study the bile ducts, pancreatic duct and gallbladder. (http://www.asge.org/patients/patients.aspx?id=386) **American College of Surgeons National Surgical Quality Improvement Program
									Overall Comments: • What was your experience with this indicator? • What were your key learnings?	Pancreatic SSI has recently formed a multidisciplinary task force to implement an SSI bundle. Many new changes are on the way in hope of decreasing SSI in patients undergoing pancreatectomies.

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Rate of urinary tract infections among patients (General Surgery, Orthopaedic Surgery (hip fractures), Neurosurgery and Vascular Surgery) submitted to NSQIP (National Surgical Quality Improvement Program of the	3.33	1.7	Q1- 2.7 Q2-1.3	1)Reduce rates of perioperative bladder catheterization through reducing utilization of Foley catheters among highest using services (General Surgery, Neurosurgery and Vascular Surgery).	Dissemination of and education around evidence-based guidelines on indications for catheter insertion.	Measure catheter insertion rates via data available through PICIS (the operating room information system).	Current: 30% of cases Goal: 24% of cases (20% relative reduction in utilization)		Yes	Catheter insertion measurement in the operating room (OR) demonstrated less urinary catheter utilization among targeted services. Remaining catheter utilization in the OR was appropriate. However, the biggest impact of this change idea has been seen on number on catheters being removed at the end of the procedure in the OR or PACU (post anaesthetic care unit) when appropriate.
				2)Improved compliance with sterile technique upon insertion.	Video and educational package to all Operating Room staff and house staff to reinforce sterile and “two person technique”.	Random audits of Foley insertion practice.	≥20% improved compliance with evidence-based practices pertaining to insertion by March 31, 2016.		Yes	This practice has been raising awareness among all OR teams, including our fellows, residents and medical students. Random OR audits are being performed in order to measure the effectiveness of this change idea.
				3)Earlier removal of Foley catheters	1. Development of guidelines for catheter removal in Post Anaesthetic Care Unit enabled by integration into the transfer process from the Operating Room 2. Expand use of algorithm for indications for catheter maintenance and removal used by nurses on General Internal Medicine units into Post Anaesthetic Care Unit.	Overall reduction in catheter-days.	Baseline catheter-days on surgical wards to be measured prior to March 31, 2015. Goal is to reduce baseline by ≥20% by March 31, 2016.		Yes	This change idea has made a great impact on appropriate catheter use post-op and early removal of catheters where appropriate. Data shows reduced catheter days per patient days in surgical units. Lessons learned: differences exist between medical and surgical wards that need to be considered when applying this change idea. Staff engagement is a key in implementing this change idea. Measuring compliance and presenting data to frontline played an important role in the success of this initiative.
									Overall Comments: • What was your experience with this indicator? • What were your key learnings?	Overall, excellent work was done through collaboration with all surgical units, OR and interprofessional staff and much was accomplished in 16/17 as outlined above. The initiative is coming off the QIP next year as it will be monitored/ maintained under a new interprofessional committee looking at catheter use and UTI rates across the entire organization. Key lessons for large scale QI initiatives such as UTI, were resource allocation, availability of measurable data and small fund availability.

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Measure				Change						
Indicator	**Baseline**	**Target**	**Result (from HQO)**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Goal for change ideas**	**Comments**	Was this change idea implemented as intended?	Lessons Learned: (Questions to Consider): - Did the change ideas make an impact? - What advice would you give to others?
Number of times the hospital uses a Virtual Engagement Consultation on Sunnybrook.ca to engage in conversations with patients and the community related to relevant hospital operations or policy. Given about 65% of patients who access Sunnybrook's services are from outside of the Toronto Central LHIN, Virtual Engagement Consultations on sunnybrook.ca provide people from anywhere in the Greater Toronto Area or the province with a voice and a path	1	4	2 (Q1/Q2)	1)Create awareness and provide education and support for use of Virtual Engagement Consultations to hospital leaders, staff and physicians to inform policy or practice changes.	Introduce the tool and encourage Senior Leaders, Clinical and Operational leaders as well as staff and physicians to use this on-line method of engagement when considering change initiatives in the hospital or developing policy that could impact patients and the community.	• Use of internal communications channels (e.g. Snapshot etc.) and present in venues such as committees, etc. to increase awareness • Number of completed education/ support sessions held specifically with those that have decided to use a Virtual Engagement Consultation.	• At least 2 communication channels implemented per quarter. • At least 4 by March 31, 2016.		Yes	There have been eight virtual consultations held in this timeframe. People have been invited to provide opinions on everything from the design of the entranceway to the hospital and or visiting hours, to whether or not music should be played in the ED waiting room and if staff uniforms should be colour coded. Areas throughout the hospital were canvassed for ideas and feedback was provided to them for consideration in their decision making. Results of each survey were also displayed online to close the loop for those who participated in the consultation. It is important to do key things in our view. The first is to set reasonable expectations with patients from the outset for what their input will actually do. It's not prescriptive advice and the outcome may not be exactly aligned with what they provided to you in the form of suggestions. The second is to ensure you close the loop and show people the results of their feedback and how it may (or may not) have been included in policy direction or some other decision in the hospital.
				2)Increase traffic to each Virtual Engagement Consultation for relevant external stakeholders.	Sunnybrook's Virtual Engagement Consultations are located in a dynamic webpage that provides user-friendly and accessible videos, slideshow, infographics and other content to allow people to engage in a discussion and provide feedback about the current topic. Public and patient engagement will also be solicited through the hospital's social media channels.	Although Consultations will be open to all members of the public, in instances where there are stakeholder groups that would be particularly interested in or impacted by a topic, these groups will be sought out and invited to comment in order to increase relevant feedback.	At least 4 stakeholders groups will be identified and invited to comment on each of the four Consultations conducted in 2015/16.		Yes	The benefit of conducting this online and promoting it through social media (such as Twitter) is the ease with which you can invite and include various groups in a consultation effort, even though they might share opposing views on an issue. A good example of this was the consultation on whether or not the hospital should build smoking huts for those who want to smoke while onsite. Obviously, a group such as a the Canadian Cancer Society would be opposed to such an initiative but someone like the Toronto Fire Service would see the safety benefits of such an initiative. When inviting groups to participate in a consultation process such as this, it is important to switch them up based on the topic and don't assume everyone will be interested in what you are asking. Avoid over saturating people with too many invites to provide feedback. Pick and choose stakeholder groups carefully and invite those who would find it most meaningful.
									Overall Comments: • What was your experience with this indicator? • What were your key learnings?	This was a great idea. It is a quick and in some cases more upbeat way to engage people in issues pertaining to care and other aspects of the hospital. Having a virtual tool allows you to take the temperature of people on a given issue and makes it easy for them to provide you with feedback.

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Eliminate the number of critical patient safety incidents with the root cause related to an ineffective escalation process	1	0	0	1)Qualitative evaluation to understand and enhance implementation of key interventions.	Primary observation (shadowing) of frontline staff regarding interventions & escalation of care policy feedback.	Number of observations completed in 2015/16	Target: • 2 nursing primary observations • 2 general surgery resident observations	2 nursing primary observations and 1 interview with resident physician.	yes	Nursing observations provided further insight on the influence team leaders have in enhancing unit processes and culture. The resident interview identified further opportunities for nursing to improve the information provided when paging, to help the resident prioritize. This information is being used to identify further areas for improvement.
				2)Enhance communication within and between teams: Intervention #: 1 paging algorithm.	Implement and maintain a paging algorithm* for each medical division (using escalation ladder format). *Paging algorithms are lists of team members the clinician can call when escalation is needed.	Paging algorithms updated appropriately and maintained on-line within Sunnybrook (random time point audits)	Target: 100% of medical divisions have paging algorithm updated appropriately and maintained.	100% of medical divisions have escalation ladders in place	yes	Challenges identified include increased number of pages to the incorrect physician due to unlabelled physician status and off-call members on the ladders. The EOC (Escalation of Care) committee is in the process of meeting with key stakeholders to address this.
				3)Enhance communication within and between teams: Intervention #2: use of alpha numeric pagers.	Increase use of alpha numeric pagers (versus numeric pagers) and implement SBAR (situation – background – assessment - recommendation) communication format for pages.	Proportion of alphanumeric pages with information (i.e. more than just the call back number)	Target: 70% of total pages from alphanumeric pagers have accurate SBAR information (versus only a call back number).	50% of staff physicians have an alphanumeric pager. 30% of pages are Smart Web and 75% use SBAR	yes	Cost of text pagers has created a barrier to increasing the number of users who can receive text information. The committee is exploring other solutions. When text paging is available and used, nurses are providing information 75% of the time.
				4)Enhance communication within and between teams. Intervention #3: daily safety huddles and low priority “to do” lists.	Spread use of daily safety huddles and low priority “to do” lists across all units to reduce non-urgent pages (expand from 6 pilot units from 2014/15).	Number of units conducting daily huddles re: at-risk patients (random audit + self-report) Number of units with a low priority communication strategy in place.	Target: 100% (50/50) units complying with both safety strategies.	Safety huddles and low priority to do lists are inconsistently done	no	Safety huddles and low priority work lists are inconsistently completed and many units have not found them to be an appropriate solution. The EOC committee will focus on surgical areas where they have been effective.
				5)Enhance awareness of the importance of timely and effective escalation of care, and overall goals of this initiative.	Corporate awareness campaign run in fiscal year 15/16.	Campaign implemented and completed. Staff awareness of key interventions of the initiative (random sample audit).	Target: Campaign completed by March 31, 2016 100% of audited staff are aware of key interventions from the escalation of care initiative.	There is a general awareness of EOC and the policy	yes	While there is understanding of the policy and best practices, a deeper understanding of the system issues (such as communication, teamwork and documentation) is needed.
									Overall Comments: • What was your experience with this indicator? • What were your key learnings?	While we have demonstrated significant improvement on this indicator, EOC is a complicated process that requires further investigation of the root causes in order to develop enhanced interventions.

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Percentage of ischemic stroke patients meeting the recommended 5 day length of stay target.	51.85%	62.00	Q1-70.6 Q2-67.0	1)Early identification of Alternate Level of Care (ALC) designation.	1. Identify potential ALC patients in stroke rounds daily. 2. Use ALC icon on the Bed Management System (BMS) electronic whiteboard for all appropriate patients on the day they have been designated. 3. Increase number of persons authorized to change ALC designation in BMS.	1. Random audit of compliance with daily identification process. 2. Random audit of compliance with use of icon and timing of posting ALC designation. 3. Increase in the number of authorizers.	1. 90% of potential ALC patients identified during daily rounds. 2. 100% of identified ALC patients will have the ALC icon posted on BMS electronic white board the day they are designated ALC. 3. Increase number of authorizers from 1 to 5, to include: team lead, and clinical nurse specialists.		Yes	ALC identification generated thoughtful discussion of patient progression amongst the team. Daily prompts for ALC designation did occur in the electronic ALC documentation system (e-ALC), however access to e-ALC for additional staff was not possible.
				2)Initiation of Rehab referral by day 3.	1. Identification of rehab candidates in daily rounds. 2. Completion of AlphaFIM® on day 3 of admission. 3. Utilization of a referral completion tracking board.	1. Random audit of compliance with daily identification process. 2. Percentage of stroke patients with AlphaFIM® completed by day 3 of admission (data source is Canadian Institute for Health Information). 3. Percentage of rehab referrals initiated by day 3 (data source is E-Stroke data, the on-line referral system).	1. 5/7 days per week potential rehab candidates will be identified during rounds. 2. 90% of all AlphaFIM® assessments will be completed by day 3 of admission. 3. 75% of all stroke rehab referrals are initiated on day 3 of admission.		Yes	Feedback from the Stroke Team indicated the referral tracking board was a good visual tool to prompt referral completion, and offered a useful way to communicate with residents with whom it may not be possible to meet on a daily basis to communicate updates. Delayed transfer to the Stroke Unit was found to be a limiting factor to early initiation of rehab referrals.
				3)Completion of appropriate stroke investigations within 72 hours of admission for ischemic stroke patients.	1. Initiation of stroke order sets and completion of associated forms by the neurology residents in the emergency department. 2. Communication of patient and timing prioritization for necessary diagnostics (specifically: brain imaging, echocardiogram, and holter). 3. Implement use of 2 holter monitors on the stroke unit.	1. &2. Random chart audit of compliance of completion of ordered stroke investigations (brain imaging, echocardiogram, and holter, when appropriate) within 72 hours of admission. 3. Holters implemented on the unit	1. and 2. 60% of patients will have their ordered stroke investigations completed within 72 hours of admission. 3. Holters on the unit by April 30, 2015.		Yes	Ongoing exploration of fast access to diagnostic investigations, especially CT/CTA tests is underway. Analysis of time to Holter application revealed need to revise Holter requisition form - involvment of multiple stakeholders resulted in a vastly improved requisition form. Translation of order sets and requisition forms into online ordering system to streamline ordering is currently in progress which we believe will assist in reducing the turnaround time for this test.
									Overall Comments: • What was your experience with this indicator? • What were your key learnings?	A cohesive team and strong cooperative culture on the Stroke Unit were enablers of these initiatives, in addition to organizational interest in improving length of stay for ischemic stroke patients. Patients admitted directly to the stroke unit were more likely to be positively affected by these initiatives and so getting patients to the stroke unit for this and other important initiatives continues to require organizational support.

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Indicator	**Baseline**	**Target**	**Result**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Goal for change ideas**	**Comments**	Was this change idea implemented as intended?	Lessons Learned: (Questions to Consider): - Did the change ideas make an impact? - What advice would you give to others?
Total Margin (consolidated): % by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expense, excluding the impact of facility amortization, in a given year.	3.6	0.00	Q3 3.14%	1) Reduce average acute care length of stay for populations targeted by the Toronto Central Local Health Integration Network (LHIN) for earlier transfers to inpatient rehab or outpatient rehab to achieve LHIN LOS (length of stay) targets. Specific populations include stroke patients and hip fracture patients.	1. Additional project resources will be added to the Performance Improvement team to enable focused effort on this initiative. Methods will include: - Identifying and obtaining consensus on clinical best practice - Lead PDSA (Plan-Do-Study-Act) cycles of proposed practice changes 2. Standardize communication with eligible stroke patients to support early discussion re: repatriation (i.e. discharge from inpatient unit to local hospital when appropriate) in the Emergency Department. 3. For stroke patients, improve access to the stroke unit by providing centralized stroke documentation (about the stroke unit) to the care team in the Emergency Department and include the sharing of the documentation with patients in the stroke admission Order Set.		Plan is to achieve the Local Health Integration Network average Length of Stay targets as follows: Hemorrhagic Stroke: 7 days Ischemic Stroke: 5 days TIA (Transient Ischemic Attack): 3 days Hip Fracture: 6.5 days Based on 2013/14 data, achieving these targets could reduce inpatient utilization by approximately 2,500 patient days. 1. Secure two full-time performance improvement resources by Q2 of 2015-16 and implement or assess all identified practice changes articulated in the work plan. 2. By the end of fiscal year 2015-16, 100% of eligible stroke patients will receive information about repatriation in the Emergency Department. 3. By the end of fiscal year 2015-16, achieve 80% utilization of the new stroke packages in the Emergency Department for patients admitted with primary diagnosis of stroke or TIA (Transient Ischemic Attack).	1. Two resources secured, and the following practice changes were implemented: Hip Fracture (13 items on QBP Project Plan) - Implemented: 4 - In progress: 7 - To be reassessed: 2 Stroke (12 items on QBP Project Plan) - Implemented: 4 - In Progress: 6 - To be reassessed: 2 2. Patients with a stroke are given a brochure explaining repatriation from the Toronto Stroke Networks. The brochure was finalized in FY15/16. The Code Stroke Consult also includes a prompt for discussion of repatriation. 3. After feedback from the Stroke Team and ED Staff, the stroke packages were discontinued in Fall 2014. However the Stroke Order Sets are currently in use, and a small audit sample taken in 2015 indicated 95% utilization. Further, stroke order sets for patients admitted to Critical Care are currently in development and integration of paper order sets into SunnyCare is underway.	Yes	Progress was made towards the LHIN QBP (Quality Based Procedures) length of stay (LOS) targets for Ischemic Stroke and TIA, but not for Hemorrhagic Stroke and Hip Fracture, due to atypical patients (an atypical patient follows an unusual pattern in their stay due to any number of factors, resulting in unusual or atypical resource use). The QBP LOS calculation includes both atypical and typical populations; if only typical patients are considered in the LOS calculation we are within target for both populations. Hemorrhagic Stroke LOS can experience variability due to low volumes, however a working group has been implemented to standardize care pathways.
				2)Maximize Revenue Stream for the Marketed Services	1. Marketed Services – Working Conditions Program (WCP) & Retail Pharmacy - Monitor volumes, revenue and margin and meet with operations personnel to ensure planned revenues achieved / optimized. 2. Preferred Accommodation: A resource has been added to focus on the process of admissions and the development of new reports and tools to help front line operations identify opportunities to improve this revenue stream	1. Marketed Services - Working Conditions Program: Quarterly review of activity to ensure that all potential cases are appropriately directed to the program. - Pharmacy: Monthly review of cost and revenues with the program to ensure net planned profitability optimized / attained. Reviews will include inventory levels. 2. Preferred Accommodation: - New report development & circulation. - Monthly monitoring of revenues achieved.	Achievement of improved revenue / margin for 2015/16 • Working Conditions Program: increase in margin over 2014/15 budget by $400K • Retail Pharmacy: increase in margin over 2014/15 budget by $500K • Preferred Accommodation: at least maintain 2014/15 performance		Yes	Progress has been made in achieving the goals of improved revenue / margin for 2015/16. • Working Conditions Program: Results are being closely monitored (both revenue and margin) and we are tracking to achieve the goal of increased margin over 2014/15 budget by $400K. • Retail Pharmacy: Margin has increased over 2014/15 budget but due to a new Ontario Drug Benefit change, that came into effect in Q3, the goal of $500K increase in margin over 2014/15 will not be fully achieved. • Preferred Accommodation: Some fluctuation has been experienced due to occupancy and other factors, but overall revenue is close to the 2014/15 level. Establishing an achievable (but somewhat stretch) budget was a good mechanism for tracking and monitoring progress towards increased net revenues. However, regular-progress monitoring is crucial to overall success.
									Overall Comments: • What was your experience with this indicator? • What were your key learnings?	To effect change on an overall corporate indicator like total margin many initiatives must be considered. Therefore, while there may be positive outcomes associated with the the change ideas outlined in this plan, work must continue on many fronts to ensure sustainability in the total margin outcome.

2015/16 Quality Improvement Plan for Sunnybrook Health Sciences Centre

Measure				Change						
Indicator	**Baseline**	**Target**	**Result**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Goal for change ideas**	**Comments**	Was this change idea implemented as intended?	Lessons Learned: (Questions to Consider): - Did the change ideas make an impact? - What advice would you give to others?
Unplanned, 30-day Readmission rates (%) for patients with COPD	25.5	24	Q1-14.1 Q2-11.1	1)Enhance awareness of staff about the TCCCAC (Toronto Central Community Care Access Centre)/OTN (Ontario Telemedicine Network) Telehomecare Program for COPD	Knowledge translation (KT) session with Unit Quality Councils, led by TCCCAC	Attendance at KT session	• 70% of the Unit based Quality Council members attend the KT session • 100% of General Internal Medicine social workers attend KT session		yes	Yes, this made an impact, as seen by the increase in the number of referrals made to telehome care. Lessons learned: Holding repeated educational sessions on the topic helps to reinforce the knowlegde and answer staff questions especially as they were implementing the referral process in the first few months.
				2)Make referral to TCCCAC for telehomecare the default on Order Set	Audit referral rate data	Random audits of referral rates for telehomecare program.	Referral rates to TCCCAC telehomecare program >80% of eligible patients		yes	We audited every patient who was on a care pathway on a monthly basis and tracked the results. The results were shared with the Program Council on a monthly basis to discuss improvement opportunities. As of today, we achieved 90% of all patients on a COPD pathway was referred to Tele-Homecare.
				3)Work with TCCCAC to increase patient awareness of program	Review education materials with TCCCAC, and ensure that the program is being discussed with eligible patients	Patient enrolment in the telehomecare program (TCCCAC data).	Enrolment in telehomecare program >40% of eligible patients		yes	We worked with TCCCAC to include a patient educational brochure in the Quality Based Procedure COPD Patient Education package provided to the patient. Enrolment improved as reported by TCCCAC.
				4)Track readmissions of patients on TCCCAC telehomecare program	Establish process for working with TCCCAC telehomecare program to get patient names to match against Sunnybrook readmission names and establish an	Readmission rate for patients on telehomecare (to be specified prior to April 1, 2015)	Reduce readmission rate by 5%		yes	Yes, this made an impact, as seen through the Re-admission rate improvement. Advice: It is important to monitor data monthly and provide data back to the inpatient team.
				5)Increase referrals to Health Links	Increase (appropriate) referrals of patients with COPD to Health Links	% of eligible (appropriate) COPD patients referred to Health Links	Increase % eligible patients referred to Health Links by 10%		**Overall Comments:** •The number of Health Links patients identified with COPD was greatly reduced over last year, due in part to better utilization of the Telehomecare program	Partnerships are one of the keys to helping reduce readmissions for complex patients.