Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2019/2020

The Progress Report is a tool that will help organizations make linkages between change ideas and improvement, and gain insight into how their change ideas might be refined in the future.

Ontario Health (previously HQO) will use the updated Progress Reports to share effective change initiatives, spread successful change ideas, and inform robust curriculum for future educational sessions.

Workplace Violence

Measure/Indicator from 2019/20	Current Performance as stated on QIP2019/20	Target as stated on QIP 2019/20	Current Performance 2020	Comments
Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period. (Count; Worker; January - December 2018; Local data collection)	1212.00	1500.00	991	

Change Ideas from Last Year's QIP (QIP 2019/20)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
In our effort to address staff safety and ensuring appropriate clinical care post violent incident, we will continue to monitor that the Framework for Responding to Reported Violent Incidents is being followed. Standard violence interventions are initiated by the unit at the time of a first incident. This year's focus will be on ensuring the implementation of the patient safety care plan after all repetitive incidents and/or actual/potential serious harm incidents as per the hospital's Safety Report - Reporting & Learning from Safety Events policy.	Yes	Risk Management has partnered with Quality and Patient Safety to undertake a systematic review of aggressive and abusive patient incident reports to identify actionable themes.
Continued focus on Non-violent Crisis Intervention education to high risk areas and teams	Yes	Currently, 95% of full and part time staff have completed the On-line Violence Prevention training education program.

• Recertification is a biennial requirement; therefore, results will be reported on that basis with an interim report. • Review data to update the high risk areas • Re-evaluate the education format to enhance uptake of staff participation • Continue to monitor staff attendance via the Learning Management System and share results with leaders.		Non-violent crisis intervention training continues to be scheduled on a monthly basis with two classes offered each month. Attendance for the third quarter is quite a bit lower than our targeted number of 90% going into Q4.
Continue to support practice change to enhance violence prevention with staff. Admitted patients in the Emergency Department will continue to have an Observed Behavioural Assessment completed in the patient's health record. To increase compliance this tool has been included in the permanent patient care record in year 2019 and will continue to identify: • Patients who have a history of, or have demonstrated behaviour that puts others at risk and • De-escalation care strategies that can be used to address the behaviour On 2 units implement a unit-based care planning process for the identified behaviour and more intense care interventions for prevention / mitigation.	No	An observed Behavioural Assessment was created and inserted into the permanent nursing documentation in ER. Efforts to document patients admitted from the Emergency Department to the Units who have exhibited behaviours that puts others at risk has proved challenging, hence a shift in focus to the Transfer of Accountability (TOA) as the indicator to jump start care planning on 2 trial units. Unfortunately documentation in TOA was also found to be a barrier. It was decided to abandon this change idea and focus efforts on other change ideas such as developing a flagging protocol and electronic flagging system a to identify patients who pose a safety risk for staff with high risk behaviours that will be completed on admission.
Develop a flagging protocol to identify patients at high risk for violent behaviour. It is recognized that this is a sensitive ethical issue that will require significant consultation, inter-professional collaboration and leadership to establish the rigour for success. Occupational Health and Safety and Risk Management will co-lead the development of a committee including Ethics and Mental Health; develop a terms of reference and outline the scope of work to develop a patient-centred flagging protocol. This will be done in consultation and collaboration with community and family partners.	No	Initial meetings were held to commence work on developing a flagging protocol to identify patients at high risk for violent behaviour. This change idea has been carried forward to FY 20/21 QIP.

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Suicide Prevention

Measure/Indicator from 2019/20	Current Performance as stated on QIP2019/20	Target as stated on QIP 2019/20	Current Performance 2020	Comments
Percentage of patients screened for suicide risk in: 1. General Internal Medicine 2. Emergency Department – (focus: patients with substance abuse, overdose, withdrawal or mental health concerns) 3. Veterans Program 4. Psychiatry – F2 (N/A; N/A; N/A; N/A)	55.00	70.00	72.00	

Change Ideas from Last Year's QIP (QIP 2019/20)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
General Internal Medicine (GIM) Engaging teams to co-design screening and documentation tools to enhance suicide screening practices. Interventions such as the coping card will be implemented.	No	GIM teams did collaborate on designing a screening tool for the program which has received approval and has been shared with GIM leadership for implementation.
Emergency Department Expand current screening processes for mental health patients to ensure patients presenting to the Emergency Department with substance abuse, overdose, withdrawal and/or mental health conditions are screened for suicide.	No	Performance did not meet target however a new process was implemented to ensure patients presenting with ingestion, poisoning, and overdose have a documented suicide screen. A nurse champion was involved in education for suicide screening and engaged physicians and other nurses in documentation. This led to an increase in documented screens.
Veterans Program Monitor algorithm use to ensure suicide screening is completed for residents in the Veterans Centre. Palliative Care Consult Team to include suicide screening during consults.	Yes	A process was implemented to ensure residents who are flagged as at risk have a screen completed.
Psychiatry Monitor interventions such as coping card for those who screen positive for suicide. Collaboration with Mood Disorders Association of Ontario to implement Caring Contacts for patients presenting in the Emergency Department and assessed by Psychiatry. Caring Contacts is	Yes	An updated coping card has been developed in collaboration with the Mood Disorders Associations of Ontario and the Patient & Family Advisory Committee. The coping card has been translated into a variety of languages to support our patients' needed. The Coping Card is being programmed

a program that is used as an adjunct to treatment; an automatic message is sent to patients after they are discharged to remind them of available support and safety strategies. Method of communication to be determined and trialed as part of implementation.		electronically for patients to access online to complete at home. To support patients after discharge, a TASHN fellow worked with the department of Psychiatry to understand patient needs after discharge for caring contacts. Patients told us that they wanted to receive regular emails reminding them of available resources. The Program was trialled and will be implemented.
Increase internal capacity for delivery of suicide prevention strategies and treatments. Increase access to mental health / suicide prevention support services for those who have screened positive for suicide: • Coping Card and Hope Kit • Access to online and community-based psychotherapy resources • Access to Problem-based app	Yes	Patients have been encouraged to use online and community-based psychotherapy, an updated list has been circulated for use. The Coping card has been shared at the workshop as a resource.
Collaborative Change Idea with Community Partners to improve access to suicide prevention strategies Host two half day education event(s) on suicide screening and prevention strategies for Community Agencies, Primary Care Physicians, and North Toronto Region Advisory Council. Workshop(s) will enhance coordination with Sunnybrook services; provide resources to the community to support suicide screening, North Toronto Hope Campaign, and interventions such as the coping card. • First workshop to be hosted at Sunnybrook Health Sciences Centre Spring 2019. • A second workshop will be organized in Winter/Spring 2020 to share best practices across community organizations. • Lunch and Learn sessions to be held at various community sites to raise awareness of available resources	Yes	One workshop was hosted in June 2019 to connect community partners and Sunnybrook to enhance community partnership. Feedback from event was positive and well received. The second workshop was not organized due to resource availability although attendance target had been achieved.

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Hand Hygiene

Measure/Indicator from 2019/20	Current Performance as stated on QIP2019/20	Target as stated on QIP 2019/20	Current Performance 2020	Comments
Percentage of hand hygiene compliance measured using electronic monitoring across the 10 specified medical and surgical units for three consecutive months during 2019/20. Numerator: the number of times that healthcare providers (nurses, residents, physicians, allied health, environmental service partners, patient service partners) clean their hands Denominator: the expected number of hand hygiene opportunities (N/A; N/A; N/A; N/A)	52.30	62.50	62.60	Q4 March data showed that every unit at Sunnybrook achieved its goal and corporately we have achieved the highest hand hygiene performance since the start of electronic monitoring in 2017.

Change Ideas from Last Year's QIP (QIP 2019/20)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Implement provision of weekly E-monitoring Feedback Reports that provide hand hygiene compliance for the prior week to front-line staff. These reports will be sent electronically to leaders and champions of each inpatient unit. Hand hygiene performance will also be posted on large poster in the entrance of each unit.	Yes	Goals and current performance for the unit continue to be posted on the publicly displayed quality boards and all hand hygiene champions, team leaders, advanced practice nurses and patient care managers continue to receive automatically generated reports outlining weekly and daily hand hygiene compliance rates. Having this in place has significantly added to discussions about hand hygiene among staff on the unit at quality conversations.
Ensure that hand hygiene performance based on E-monitoring Feedback is discussed at a minimum of one weekly Quality Conversation for 5 minutes that empowers unit staff to identify opportunities for iterative changes that promote better hand hygiene compliance.	Yes	There has been consistent discussion about improvement strategies and hand hygiene practice at quality conversations on all units except for two. These two units do not have quality conversations in place as yet which makes it

		challenging to have discussions when there is no dedicated time to share updates with the unit staff.
Each unit will set a 1-month and 3-month goal for hand hygiene compliance.	Yes	Unit leadership was engaged and motivated early on for all 10 units. New units set their 1 month and 3 month hand hygiene improvement goals and old units revised their 1 month and 3 month goals in Q1.
Empower patients and families to make hand hygiene an expectation of care by: 1) Providing point of care hand hygiene bottles to improve accessibility for healthcare providers. 2) Formalizing empowerment of patients and families to assist with audit and feedback of healthcare provider hand hygiene	Yes	Some units have invited patients and families to attend daily Quality Conversation huddles to involve them in discussion. Some families have noted posted hand hygiene performance and have felt empowered to speak to their healthcare provider about this expectation. We continue to encourage family/patient involvement in this initiative and will continue this change idea into FY 20/21 QIP looking for additional ways to structure patient engagement.

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Patient Safety Culture

Measure/Indicator from 2019/20	Current Performance as stated on QIP2019/20	Target as stated on QIP 2019/20	Current Performance 2020	Comments
Percent positive response to Patient Safety Culture Survey Question: “Staff are usually given feedback about changes put into place based on incident reports” (%; N/A; N/A; N/A)	58.00	63.00	49%*	We changed Patient Safety Culture Survey tools from the Accreditation Canada version to the AHRQ tool. Although the question related to staff feedback was nearly identical, the likert scale for the responses were different from those used for the baseline. Baseline question used an “agree/neutral/disagree” 5 point scale. The new scale used a “never/sometimes/always” 5 point scale. As such, when taking the % positive response, the new likert scale excludes the middle response (‘sometimes’) which we do not consider to be ‘neutral’. This makes a positive response more challenging to achieve. If we include those who responded that they sometimes receive a response, the current performance is 83%.

Change Ideas from Last Year’s QIP (QIP 2019/20)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Modify Safety Reporting System	Yes	Modifications have been made to the online safety reporting system to allow read-only access to staff in order to enhance their awareness about follow up arising from reports they submit. Leaders can also directly respond to submitters via the safety reporting system with a note describing follow up or thanking them for submitting.

Safety Culture Pilot Project in CICU: Design and Implement a series of technical and adaptive exercises on the unit (CICU) to boost culture of safety	No	A draft framework was developed to support the unit leaders with key actions and language for investigating events reported on their unit and facilitating discussions at their Quality Conversations. The unit leadership changed over during this fiscal year, and the new manager is being engaged to integrate discussions about safety reports into Quality Conversations (weekly team huddles about quality)
Revise Patient Safety Specialist role profile	Yes	The Patient Safety Specialist role was revised to include two more specific components related to trending and follow up of safety reports, to complement the ongoing daily review of safety reports completed by the Risk Management team. 1. The Patient Safety team now does an in-depth analysis of all low / no harm safety events to identify trends both within and across event types. Trends are reviewed at the Patient Safety Leadership Team (PSLT) meetings (with Risk Management) and the detailed data are shared with relevant subject matter expert committees/departments (e.g. Medication Safety Subcommittee, Falls Prevention Committee, Interprofessional Practice, etc.). Trends without a clear or distinct subject matter expert / leader are discussed by the PSLT and triaged to be addressed by the department of Quality & Patient Safety (e.g. patient misidentification trends). To date, dozens of trends have been identified and shared with subject matter expert committees to better focus their quality and patient safety improvement efforts. 2. Feedback loop emails have been piloted with frontline staff to thank them for submitting safety reports and highlight their contributions to safety culture. Many staff have received direct and specific emails to clarify the role their leaders play in investigating events, identify what has been done with their report and thank them for speaking up. Positive feedback has been received to date. The Patient Safety Specialist team will continue to this going forward.
Revise Patient Safety trend oversight model	Yes	See above
Integrate safety questions for patients/families into Mock Tracer Program	Yes	This program is ongoing and patients are asked about safety, typically by our Patient Mock Surveyors.
Collaborative Change Idea: Toronto Serious Safety Event Collaborative	Yes	In partnership with UHN, Sick Kids, Sinai Health System, Unity Health and several others, Sunnybrook established and cohosted 4 meeting of the Patient Safety Collaborative (with 11 hospitals across the GTA & Hamilton) where we shared anonymized cases and simulated event classification with our partner hospitals to learn about common processes. The last meeting included

		development of a driver diagram of potential work to help move us as a collective towards the goal of reducing hospital acquired harms.

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Patient Oriented Discharge Summary

Measure/Indicator from 2019/20	Current Performance as stated on QIP2019/20	Target as stated on QIP 2019/20	Current Performance 2020	Comments
Percentage of respondents who responded “completely” to the following question: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital? (%; Survey respondents; Most recent consecutive 12-month period; CIHI CPES)	6.00	58.10	100.00	

Change Ideas from Last Year’s QIP (QIP 2019/20)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
IMPLEMENTING PATIENT ORIENTED DISCHARGE SUMMARIES (PODS) Develop, implement and evaluate PODS (Patient Oriented Discharge Summary) with three Quality Based Procedure populations (congestive heart failure, chronic obstructive pulmonary disease and pneumonia). Implementation of PODS will include simulation based education for staff on the core competencies of Health Literacy and Teach Back.	Yes	The PODS working group has successfully lead the implementation of PODS. PODS tools have been developed and implemented for Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD) and Pneumonia populations. Staff are providing the tools to patients upon discharge for those on the standardized Care Pathway for CHF and COPD on five units.
Staff education programming and evaluation will be completed in collaboration with Michael Garron Hospital to further advance system partnership and collaboration.	Yes	Sunnybrook has co-developed PODS staff training in collaboration with Michael Garron Hospital and Sunnybrook’s Canadian Simulation Centre. We have achieved our target for Staff training in Health Literacy via the Learning Management System Module and Teach-back. Teach-back is a communication confirmation method used by healthcare providers to confirm whether a patient (and/or their care takers) understands what is being explained to them. If a patient understands, they are able to "teach-back" the information accurately. Simulation based

		education for staff on the core competencies of Health Literacy and Teach Back was held to reinforce the teachings and problem solve barriers to utilization in practice.
Post discharge calls to patients and families will be used to evaluate the effectiveness of PODS.	Yes	The PODS working group is currently evaluating the effectiveness of PODS. The Sunnybrook SCOPE Nurse Navigator continues to conduct post discharge phone calls to patients on pathways to enquire about receiving the PODS tool, if they found it helpful, and whether they had sufficient information about post-discharge follow up. We continue to look for opportunities for improvement to streamline the process, broaden our reach, and enhance the tool. Although PODS will not be included on the FY 20/21 QIP, we will continue with PODS on our pilot units with consideration being made to expand to additional populations.

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Wait Time to Inpatient Bed

Measure/Indicator from 2019/20	Current Performance as stated on QIP2019/20	Target as stated on QIP 2019/20	Current Performance 2020	Comments
The time interval between the Disposition Date/Time (as determined by the main service provider) and the Date/Time Patient Left Emergency Department (ED) for admission to an inpatient bed or operating room. (Hours; All patients; October 2018 – December 2018; CIHI NACRS, CCO)	38.78	35.00	35.2	

Change Ideas from Last Year's QIP (QIP 2019/20)	Was this change idea implemented as intended?	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Maximize referrals to transitional care beds and programs (e.g. at Pine Villa, Humber, Holland).	Yes	A number of change ideas have been implemented to optimize referrals to transitional care beds and programs: Weekly ALC meeting has been reviewed and refreshed to include an updated Terms of Reference which focuses activity and output of the interprofessional team. This includes enhanced integration of best practices for transition, inclusion of My Healthcare Navigator team members to support early risk identification, and implementation of a new tracking tool to support timely and efficient workflow. Referral criteria to transitional care beds and programs have been updated to create clarity for disposition. Additionally a process for a streamlined One Referral process has been implemented to support ease of referral for clinical teams. The leads for each program work collaboratively to make decisions about timing and transfer. A new community team member has been integrated to support care across the continuum and to facilitate transfer to Pine Villa, as well as coordinate multiple services for care. This role works collaboratively with the hospital, SPRINT Senior Care and LOFT.

		Enhanced collaboration with community service providers has created an improvement in continuity of care, and a sense of one team working together across a health system. Focusing on clarity of work flow and process is important enabling role clarity and clear expectations for care and service by all.
Performance monitoring	Yes	An electronic (Power BI) report of Emergency Department Pay for Results (P4R) Indicators was developed to monitor performance on P4R Indicators, which include the Wait Time for Inpatient Bed. This dashboard is updated weekly and is available to ED leadership, patient flow, the senior leadership team, decision support and several others for tracking. The EDP4R Ranking Report produced by Ontario Health (CCO) is also reviewed and summarized regularly and shared with the Emergency Department medical and operational leadership for awareness, discussion and follow up.
Reduce the time from patient discharge to their bed becoming available.	No	Daily patient flow and Environmental Services huddles take place on a daily basis. This change idea was developed within the context or Post Anesthesia Care Unit pressures and ED pressures which have been replaced by COVID pressures at present. Decision Support completed an analysis of Environmental Services turnaround times to identify opportunities for improvement. These are currently being explored (Q4). No further initiatives have been developed at this time.
Engage with the emergency department and inpatient wards to reduce the time taken to conduct transfer of accountability, as well as to complete transfer requests.	Yes	In Collaboration with Patient Flow, Quality & Patient Safety, the inpatient wards, Nursing Practice, Infection Prevention & Control and the Emergency Department, a Transfer of Accountability (TOA) Practice Change Memo was distributed in March 2020, outlining the revised practice of incorporating written TOA into the escalation process to expedite the transfer of patients after 2 attempts at verbal handover. This will be evaluated by close monitoring of safety reports related to gaps in communication. Further, plans are underway between Patient Flow and the vendor for the electronic Bed Management System to reconfigure existing Care Visibility Screens (electronic unit whiteboards) to identify patients waiting to be transferred from the Emergency Department or recovery room (PACU).
Prioritize operating room cases in the emergency department.	No	As of Q3, the development of a prioritization matrix has not been completed. In reflection, much of this work is led by the OR and flow does not have a great of an impact on this change idea.
Explore the patient perspective to understand and identify further opportunities for improvement in the processes and experience of transfer from the Emergency Department to inpatient wards.	No	The Emergency Department Community Partnership Initiative has not met in 2019/20 to date (as of Q3).

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Cancer Surgery Wait Time

Measure/Indicator from 2019/20	Current Performance as stated on QIP2019/20	Target as stated on QIP 2019/20	Current Performance 2020	Comments
Percent of Priority 2, 3 & 4 cases completed within target time Priority 2 target = 14 days Priority 3 target = 28 days Priority 4 target = 84 days (%; N/A; N/A; N/A)	78.00	90.00	85.60	

Change Ideas from Last Year's QIP (QIP 2019/20)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Improve access to urgent / off-hours care for cancer patients (to prevent unnecessary ED visits, reduce admissions from ED, reduce readmissions and alleviate occupancy pressures)	No	We have limited to just medical oncology patients due to space constraints it will be expanded to include surgical patients once space is renovated in the Fall 2020.
Align with corporate OR Cancellation Initiatives, to reduce surgical cancellations that contribute to longer wait times	Yes	The hospital has increased the access to critical care beds allowing for more patients to be transferred vs completing their stay in Post Anesthesia Care Unit.

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Palliative Care Access

Measure/Indicator from 2019/20	Current Performance as stated on QIP2019/20	Target as stated on QIP 2019/20	Current Performance 2020	Comments
Proportion of hospitalizations where patients with a progressive, life-limiting illness, are identified to benefit from palliative care, and subsequently (within the episode of care) have their palliative care needs assessed using a comprehensive and holistic assessment. (Proportion; All patients; Most recent 6 month period; Local data collection)	0.12	0.13	14.40	Results exceeded target in Q2 and Q3. In Q1-Q3 19/20, 401 hospitalizations had an ACP/GOC conversation documented, as compared to 284 during the same period in FY 18/19.

Change Ideas from Last Year's QIP (QIP 2019/20)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
1. System Partnership Establish a North Toronto Sub-Regional Palliative Care collaborative comprised of provincial, LHIN, community and hospital provider stakeholders to develop a three-year Palliative Care Action Plan. Three interventions will be identified, based on provincial, regional and local priorities and directions.	Yes	In Q1 19/20, the North Toronto Palliative Care Journey Committee engaged in a collaborative quality improvement exercise to improve timely access to palliative care in North Toronto (NT). From this exercise, 4 change ideas were identified: standardizing and sharing ACP/GOC information across the system, creating a system pathway to identify changing palliative needs, create a NT "Code Palliative" for urgent needs, and educate the public. Standardizing ACP/GOC information is supported by a template that was collaboratively created by system partners, and is being implemented at various organizations. Throughout the year, working groups for each change idea were established, and identified measures to track progress, and developed interventions and implementation plans. Implementation of the change ideas will continue throughout FY 20/21.

2. Build Capacity in Health Care Teams for Advance Care Planning (ACP), Goals of Care, and End of Life Conversations * Develop a formalized education program to build capacity for “Essential Approaches to Care” in collaboration with Organizational Development and Leadership and the Simulation Centre for staff and system partners focusing on: • Person Centred Approaches to Care • Advance Care Planning and Goals of Care Conversations • Patient Oriented Discharge (PODS) and Transitions • Warm Handovers • End of Life Conversation	Yes	Interprofessional simulation-based Advance Care Planning Workshops were held throughout FY 19/20. To date, 38 clinicians from various professions have been trained. Identification of key groups to engage for training is ongoing with plans for additional training ongoing. The NTSR Palliative Care Journey Committee has created a survey for an environmental scan of practices for ACP/GOC conversations that includes questions regarding training for ACP/GOC conversations – survey responses will inform alignment of education programs and potential collaboration.
3. Implement Technology Based Solutions to Support and Measure Integration of Palliative Care a. Centralize consult request, response and outcome process. b. Use BetterCare platform as a mechanism to share ACP information to support improved continuity in care	Yes	The creation of a new palliative care dashboard to support monitoring of key indicators is in progress. Key stakeholders have collaborated to identify key measures of our internal processes, as well as measures that align with external partners to reflect collaboration at the regional level.
4. Timely Access to Palliative Care Support within Sunnybrook: a. Enable emergency departments/hospital ward to discharge palliative care patients back home (if desired) with symptom relief kits and care resources matched to need (i.e. First 48 hours Program) b. Ensure level of care offered is matched to palliative patient needs e.g. patients with low Palliative Performance Scale (PPS) scores to be redirected to appropriate settings (hospice, home), Palliative Care Unit admission for patients with high PPS scores or other care complexities.	Yes	The new Emergency Department Pain and Symptom Management for Patients with a Palliative Focus of Care order set was approved in Q3. A home symptom relief kit with an option for expedient home oxygen was created – workflows to support implementation are in development, leveraging support from teams that support care from the Emergency Department to the community. Requests for Palliative Care Consult Team consults in the Emergency Department were made available electronically, to support access to the team, and measurement of demand. Workflows are being developed to facilitate access to palliative care support for patients presenting to the Emergency Department who do not require admission.
5. Establishing Palliative Urgent Care Models The newly established Odette Palliative Care Advisory Council will establish what urgent care models and interventions are required to address acute palliative needs earlier in the palliative patient journey.	Yes	Odette Palliative Care Advisory Council is analyzing results of a chart review on details of cancer patients dying in acute care, and of a survey regarding patient and family preferences for ACP/GOC discussions. A resident-led QI initiative to increase ACP/GOC documented notes using the ACP template focusing on gastrointestinal and lung cancer patients is in progress.

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Patient Experience

Measure/Indicator from 2019/20	Current Performance as stated on QIP2019/20	Target as stated on QIP 2019/20	Current Performance 2020	Comments
% of patients who respond always to the question 'How often did staff act on what was important to you' Numerator: Number of always responses Denominator: Total number of responses (%; N/A; N/A; N/A)	61.00	64.05	65.75	(Current Performance 2020 contains early reports from Q4) Conversations with Patients is a unique approach to understanding what is important to a patient at a particular moment in time. As such it is treated as a snapshot of experience.

Change Ideas from Last Year's QIP (QIP 2019/20)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Increase the number and frequency of conversations with patients	Yes	We are meeting our overall volume targets, and have finalized Program and unit monthly targets.
Review Conversations with Patients' feedback on units and care areas and profile action taken on a bi-monthly basis.	Yes	A small number of units are sharing data from Conversations with Patients during committee meetings and other venues. Conversations with Patients data now available to clinical middle leaders via Power BI platform. Nursing Council membership and engagement with Conversations with Patients continues to be our primary source of data collection and stories activities. Staff are finding that hearing patient feedback through stories is a useful way of reflective learning on both clinical practice and quality improvement. Identifying themes in the qualitative data is the next step in using the data for local improvement. In the coming months units will be encouraged to share this data regularly at their Quality Conversations Boards. Further storytelling tools and learning are being integrated into other corporate committees and settings.

Develop and pilot a new tool to measure patient experience. The tool would include subjective feedback from patients and objective measures indicating an optimal patient experience designed specifically for each patient care area.	Yes	One unit has launched the use of a new Digital Tool (with Office of the Patient Experience) for capturing patient experience, with another in development and one more on the way.

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Total Margin

Measure/Indicator from 2019/20	Current Performance as stated on QIP2019/20	Target as stated on QIP 2019/20	Current Performance 2020	Comments
Total Margin (consolidated): 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. (%; N/A; N/A; N/A)	2.11	0.00	3.00	Sunnybrook's performance has exceeded target this quarter (and YTD) due to one-time opportunities such as in-year vacancies as well as patient revenues.

Change Ideas from Last Year's QIP (QIP 2019/20)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Improve the patient experience, and increase revenue from patients accessing Hearing Services at Sunnybrook by: • Improving the Hearing Services clinic accessibility • Improving the rate of hearing aid sales to patients • Increase the new patient volumes accessing products and services	Yes	We continue to investigate opportunities to increase retail revenues by scaling of existing services, delivery of new services and re-assessing current pricing strategies and costs to increase net revenue to the organization. Hearing Services is one of the opportunities we are currently working on. As of Q4 we have now implemented new pricing levels with three vendors as part of a Preferred Partnership program. Upcoming work will include development and implementation of merchandising programs, patient education and communication. We continue to implement additional initiatives to achieve revenue increases year over year.
Optimize implementation of bundle care model to ensure financial sustainability	Yes	Sunnybrook is participating in 8 Ministry-led bundles, three of which are now deferred to F21/22 – Coronary artery bypass grafting (CABG) and Stroke (Hemorrhagic & Ischemic). Program continues to refine patient pathways to reduce length of stay (LOS), change in-patient referral patterns and overall optimize care with our community partners. The most

		advanced pathway is unilateral hip & knees where we are working to further reduce current Acute LOS which is already improved from prior year (i.e. 2.1 from current 2.4). Work is ongoing but all efforts to date have confirmed that there is unlikely to be any material detrimental financial impact to Sunnybrook.
Reduce wastage of commonly used point-of-care supplies (for example gloves and wipes) by introducing new policies and procedures for stocking supplies in patient rooms	No	This initiative is intended to reduce wastage of point-of-care supplies through the development and implementation of a phased, multi-pronged approach across inpatient care units (a) Products, (b) Storage, (c) Policy & Practice. This initiative was halted but re-started in October 2019, but will not result in any savings in F19/20. The plan is to have 2 vendors do an assessment in March / April 2020 to review practices and recommend savings opportunities for the hospital. A business case will be developed to ensure any investments can be justified. However, this timeline can potentially be delayed given our current situation with COVID-19.

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ED Length of Stay for non-admitted patients

Measure/Indicator from 2019/20	Current Performance as stated on QIP2019/20	Target as stated on QIP 2019/20	Current Performance 2020	Comments
90th percentile Length of Stay for all Non-Admitted patients (Hours; N/A; N/A; N/A)	9.98	7.70	10.30	

Change Ideas from Last Year's QIP (QIP 2019/20)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Patient Engagement 1. Bring ED QIP initiatives to the ED Community Partner Initiative (CPI) Committee CPI assists the Emergency Department in enhancing experiences of patients and those accompanying them by promoting awareness and understanding within the community of the services provided by the Emergency Department, and by suggesting ways in which those services may be improved.	Yes	At the Community Partner Initiative (CPI) meetings, the ED One Team and reduction in admissions to help with the lengthy LOS have been discussed. March meeting was to have an official overview of this QIP however the meeting has been cancelled due to the pandemic.
Physician Initial Assessment (PIA) The main challenge to achieve the Physician Initial Assessment target (PIA) is related to stretcher availability in the Emergency Department (ED) and overall hospital occupancy. Therefore, three strategies are presented to reduce the impact occupancy has on the ED to improve flow so that new patients can be seen by an ED physician sooner after arrival: Transitional Zone (TZ) Strategy Transfer of Accountability (TOA) Strategy Surge Plan Policy Development	Yes	Achieving the PIA target continues to be complicated by stretcher availability in the ED as well as overall hospital occupancy pressures. In an effort to combat these contributing factors, a new draft ED Gridlock Policy has been developed with corporate-wide responses, along with new initiatives such as the ED One Team approach and a new Ambulatory Zone (AZ) Trial The ED One Team initiative has shown to decrease admissions from the ED by utilizing an interdisciplinary team of health professionals available 8AM to 11PM 7 days per week, who seek to improve safe discharges back to the community. By reducing admissions, we hope to reduce ED overcrowding, to improve our PIA time. The most successful initiative was the proactive flow of patients from the waiting room into the department using a virtual transition zone. This created capacity to see new patients.

		The new AZ Trial is now improving PIA through more effectively facilitating flow of patients within the ED by having patients waiting for tests and treatments in chairs instead of remaining in stretchers throughout their stay in the ED. Showing promising results to date, the AZ trial builds off of key learnings from the Transitional Zone (TZ) strategy explored through ED QIP 2019/20.
Consult Interval Following the development of individual service performance measurement in 2018/19, the team will report new consultation time measures (from consultation request date/time to patient's ED discharge date/time) for the eight most frequent consulting services to the monthly ED QIP meeting. Actively engage General Internal Medicine consulting services as pilot to look for opportunities to improve consult interval times and launch a quality improvement plan. This pilot will build upon previous learnings with Psychiatry as a pilot service (completed in 2018/19). (An ED consultation is when an emergency medicine physician contacts/requests from another physician (specialist or otherwise) for advice or intervention regarding patient care)	Yes	In 2018/19 we were not able to track consult arrival time despite our change efforts. A more accurate metric to measure consult times was needed, specifically consult time to disposition time In 2019/20, the team began reporting new consultation time measures for the eight most frequent consulting services to the monthly ED QIP meeting. Efforts in 2020/21 will continue to focus on actively partnering with the General Internal Medicine consulting service to identify new initiatives to improve consult interval times. External to the ED QIP, a consult committee has been formed to look at CI from a Medical Advisory Council perspective. Relevant insights and initiatives from these discussions will be brought forward to the ED QIP meeting where applicable for consideration.
Medical Imaging Expand current on-site ultrasound (US) technologist coverage (Monday - Friday 8:00 a.m. up to 12:00 a.m.) to Monday – Sunday 24 hours a day. Expanded imaging services were determined based on analyses completed on the 2018/19 QIP plan.	No	Due to staffing levels and day time non-ED demands, it will take more time and planning to have this fully implemented. The intermediate step is to ensure that an ultrasound technologist is on site on all STAT holidays (from 8 am to 4 pm). Note that a U/S tech is on site on weekend days (from 8 am – 4 pm).
Based on analyses completed on the 2018/19 QIP, a Business Case was developed and will be presented for approval from Senior Leadership Team to increase CT (computerized tomography) technologist staffing to two staff per after-hour shift. This change idea is part of the initiative to improve turn-around time of Endovascular Treatment (EVT) in stroke management. Internal reporting will include 50th, 75th and 90th percentile performance measures.	No	SLT has approved the investment to add two full time CT technologists. As of July 2019, a second CT tech was added for each of evening and night shifts during the week, i.e., Mondays through Fridays. It is expected that the second shift will be added to the evening and night shifts on the weekends as of beginning of June, 2020.
Implement the Senior Leadership Team approved construction project of building a point-of-care radiology reading room in Emergency Department to improve radiologist support in an acute clinical setting.	No	The project is integrated into the CT fleet replacement project. The construction part of the project is expected to be tendered with the target date of completion of the reading room and the ED CT replacement to be Jan 2021.

In collaboration with the Sustainability Program Office (SPO), Environmental Support Services and the Emergency Department, continue to improve flow of patient transportations from the Emergency Department to Medical Imaging for tests and treatment procedures from 2018/19 QIP. Actively engage Environmental Support Services to provide regular data monitoring reports to the Emergency Department regarding transportation of patients from the Emergency Department to the Medical Imaging Department, and ultimately to set improvement targets and look for opportunities to improve flow of patient transportations.	No	This project is on hold for further analysis before a decision is to be made.
Ambulance offload time Continue to improve the time from ambulance arrival to ambulance offload. The focus will be on sustainability for FY 2019/20 and build upon the learnings and successes from the previous year. Transfer of Care Time (EMS Offload time) Evaluate effectiveness and impact of EMS Intake nurse starting at 10:30am (funded June 2018-June 2019) and seeking permanent/extended funding if pilot is successful. Kiosk for Ambulance paramedics self-check-in. • On arrival, the paramedics will check-in using the kiosk and their unique Trip Number. This will alert the triage nurses that the ambulance has arrived and allowed them to call the crew for triaging. Triage is the first step for the patients to be identified by the Emergency Department system and allows them to be placed in appropriate areas based on their severity. • Timeframe: Ambulance: 1) Kiosk Live Date: Q3 2018/2019 2) Kiosk Trial Period: 3 months between Q3/Q4. • Time points measured: 1) Time from Ambulance Arrival to Kiosk Check-in 2)Time from Kiosk Check-in to Patient Triage • This will add the ambulance patients to the triage nurses' worklist, rather than having a separate queening system for EMS and walk-in patients.	Yes	Ambulance offload targets have been met and the workflow and staffing for this assignment are now routine practice in the ED

Quality Improvement Plans (QIP): Progress Report for 2019/2020

Staff Training

Measure/Indicator from 2019/20	Current Performance as stated on QIP2019/20	Target as stated on QIP 2019/20	Current Performance 2020	Comments
Develop a course-based Diversity & Inclusion program. Incorporate the Program into Sunnybrook Leadership Institute and Certificate programs for roll out beginning in Q4 2019/20 (%; All patients; The comprehensive research, design and implementation of an educational program that includes input from patients and marginalized communities will require the entire fiscal year to develop.; The comprehensive research, design and implementation of an educational program that includes input from patients and marginalized communities will require the entire fiscal year to develop.)	0.00	100.00	100.00	

Change Ideas from Last Year's QIP (QIP 2019/20)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Research core content for Diversity & Inclusion curriculum.	Yes	One of Sunnybrook's Strategic Directions is building High Performing Teams; and partnering with the Canadian Centre for Diversity & Inclusion provided the foundation needed to build a program reflective of the community we serve, and the teams we are all a part of at Sunnybrook. We also partnered with the Office of Patient Experience to hear and learn from our patients, families and visitors experience to add value to the experiential and didactic classroom learning. We have learnt together that Diversity & Inclusion is not visual representation, it is the deliberate act to include everyone in the discussion and/or conversation. D & I is not something we do in isolation, it's the behavior we practice together.

Understand the staff experience and recommendations for program development	Yes	One of the goals of the workshop is for participants to identify opportunities within their work setting for the promotion of Diversity & Inclusion and to develop informed decisions that create such a culture. In this facilitated portion, our aim is to not tell but to provide the tools and encourage the mindset needed to explore opportunities. Staff felt that more time is needed to unpack the topic of D&I, and the necessary adjustments will be made. A few comments are captured in the commentary section.
Develop the program	Yes	The Diversity & Inclusion (D&I) program was implemented in its entirety starting this September. Training will be offered 5 times per calendar year; 3 times as stand-alone workshops and twice in Leadership Programs. Diversity & Inclusion could also be offered in our customized programs as per departmental and/or team requests. The D&I program is comprised of an eLearning module, in partnership with the Canadian Centre for Diversity & Inclusion, and an in-class facilitated workshop (the eLearning module is a prerequisite to the workshop). This will also provide the team with 2 sets of data: 1. # completed D&I eLearning module 2. # D&I Certificate program graduates
Develop a plan for the required organizational supports to embed diversity and inclusion at SHSC	Yes	Diversity & Inclusion has been presented to the Sunnybrook Education Advisory Council (SEAC), the Nursing Council and the Implementation & Integration Committee (IIC) to create awareness about its availability.