Excellent Care for All
Quality Improvement Plans (QIP): Progress Report for 2018/19 QIP

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ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
1	Number of workplace violence incidents (overall) reported by hospital workers within a 12 month period. Note: workplace violence incidents are reported via the incident reporting system. Note: Definitions for the terms "worker" and "workplace violence" will be those in the *Occupational Health and Safety Act* (OHSA, 2016).		773 (January – December 2017)	≤ 700 in calendar 2018	1212 (Calendar Year)	Calendar year reporting happens for this indicator as per HQO

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Change Ideas from Last Year's QIP (QIP 2018/19)	Was this change idea implemented as intended? (Y/N only)	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?
Provide on-line Code White [1]/ Workplace Violence Prevention training to all staff • Continue to monitor staff completion of the Code White/ Violence Prevention training and increase compliance among Active Staff by keeping leaders informed of progress. [1] Code White is an emergency code for staff to notify others of an incident that requires immediate action, in particular to assist staff when interacting with person who is or who may become violent.	Y	We believe that on-line training has increased staff awareness of how to identify and respond to violent situations. For example, we experienced an increase in the number of Code White calls; which anecdotally staff attributed to feeling more comfortable initiating, based on the learnings in the on-line training.

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		We also feel that making this a mandatory training (repeated every 3 years) helps to retain the key messages and actions and would recommend this for other organizations.
Provide Non-violent Crisis Intervention education with a focus on high-risk areas • Ensure regularly scheduled course offerings as needed April 2018 to March 2019. • Complete the roll-out and increase participation rate from 61% to 90% in high risk areas [2] and expand to staff in lower risk areas. • Continue to monitor staff attendance via the Learning Management System and share results with leaders. [2] High Risk Areas are the Emergency Department, Veterans Centre units (Dorothy Macham, LGSE, LGSW, LSSE, and LSSW, NRT, K3C, K3E) and acute care units C5, D5, F2 (Mental Health), Nursing Resource Teams (CNRT/ACRNT and Observers).	No	Achieving this target for some of the high risk areas has been challenging. High occupancy and other contributing factors have stretched our staff's ability to attend education and despite multiple sessions being offered, attendance has been low. Engagement of senior leadership to support individual strategies to enhance staff attendance in high risk areas is required.
Monitor that the *Framework for Responding to Reported Violent Incidents* (3 step process) is being followed. Step 1: Team huddle – Run by the team that responded immediately after any violent patient incident. Step 2: Unit Debrief and Patient Safety Care Plan – the Debrief is to be conducted after any repetitive incidents and/or actual/potential serious harm and – the Safety Care Plan is to be developed as necessary. Step 3: Serious Incident Investigation/System Review - this is completed for actual or potential violent situations involving serious injury or if a weapon was used. It is led by Risk Management and Occupational Health and Safety.	Yes	Occupational Health and Safety and Risk Management are involved, track and report on Step 2 and 3 of this Framework. A positive outcome from this change idea is an increase in the number of patient safety care plans being requested and initiated by clinical staff which speaks to the value of these care plans for staff as a tool to manage potential harm. Staff have shared also that they appreciate the collaboration with Occupational Health and Safety, Risk Management, Security (corporate support) and other clinical experts. Having the involvement of corporate support services has been received very positively.

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Continue to support practice changes to enhance violence prevention with staff.
 	
A. On two units engaged in pilot violence prevention work in 2017/18:
• Implement pilot Violence Assessment and Documentation Tool for admitted patients in the Emergency Department to identify
  ○ Those 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.
• For the identified patients, implement unit-based care planning processes to identify triggers/ contributors to the demonstrated behaviour and more intensive care interventions to continue prevent /mitigate it.
B. Apply the learnings from the Part A (above) to another priority high risk unit.
Develop learnings by December 2018 and implement by March 2019.
	No	The behavioural assessment tool was piloted in the Emergency Department (ED) as a separate documentation tool and the trial implementation period demonstrated the need for the tool to be integrated into the permanent documentation in order to support compliance. The implementation of this has been slower than expected and since this was the prerequisite step for the unit based care planning process, that process was also delayed.
		
		At this time one unit has begun regular behavioural care planning rounds to identify triggers and interventions to address concerns, independent of the assessment process planned for the ED.
		
		Despite not completing all requirements for this change idea, it is expected that by having the ED staff engaged in rapid cycle improvement cycles and developing a tool that meets their needs, this will increase their use of the behavioural assessment tool

Consult and collaborate with community partners to support practice changes to enhance violence prevention with staff. • At Toronto Academic Health Sciences Network- Senior Friendly Community of Practice meetings, discuss opportunity to collaborate and develop common strategies. • Explore risk identification and communication processes to inform the Sunnybrook electronic patient care record; • Explore electronic documentation solutions for flagging behaviours that put others at risk • Explore opportunities to develop common strategies to identify and	Yes	TAHSN community partners have begun to share strategies related to the management of high risk behaviours and violence prevention. Through discussions and sharing of processes and tools with other Toronto GTA hospitals, it is noted that there are common core elements related to risk identification and flagging across the system however, customization for each organization needs to be recognized.

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communicate risk among community partners Share progress with Screening and unit-based Care Planning processes with Michael Garron Hospital.		Committee members who will work on the development of a flagging process have been identified with this work slated to happen in 2019/20, as outlined in the QIP for next year.

Q3 Commentary (Workplace Violence reports on an annual basis, hence this commentary reflects the period Jan – Dec., 2018)

Status and Progress

- Throughout the year there was an increase in reporting. This increase is felt to be attributable to a number of factors including: greater awareness through training, increased incident reporting, effectiveness and uptake of the patient safety care plans, high occupancy and patients with responsive behaviours.
- The key focus continues to be on keeping lost time incidents (most severe incidents) below 7 per year. While the number of claims reported to the Workplace Safety and Insurance Board (WSIB) exceeded the threshold, at 14, to date 7 of these claims have been denied, 6 approved and 1 remains outstanding.
- Code White versus Staff Assist Calls have declined to date. Staff assists are pre-emptive calls when staff arrange security to be present as they work with patients who are known to display aggression. A Code White is an emergency code that is called in the moment when a situation has escalated and is deemed to require additional support. Of note, security have been assigned directly to higher risk units, hence this may be why our Code White numbers are lower.
- This year, there has been significant focus on violence prevention training and simulation. This included crisis prevention intervention (CPI) training. Discussions are underway to determine how to further support the higher risk areas and the staff who support those areas. Ongoing efforts are underway to improve attendance from low performing units.
- The violence assessment and documentation tool is being embedded in the Emergency Department clinical documentation electronic tool to promote consistent use.
- Discussions are underway with the Clinical Documentation team to add the Violence Assessment and Documentation Tool to the hospital electronic health record and to consider ways to adopt a flagging system for identifying high risk patients.

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2	**Percentage of inpatients, Emergency Department patients (when indicated), and Veterans residents for whom suicide screening is completed** Screening includes completion of either: • Columbia Suicide Severity Rating Score (CSSRS) or • Documentation of equivalent suicide risk screen at one point during their care in hospital		Baseline data will be collected via sample chart audit in early 2018	Target will be set after baseline data collected	1. Veterans – Q3 64% 2. ED – substance abuse & Mental Health Assessment – Q3 47% 3. Baseline data is beginning to be collected in GIM in Q4	

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1. Staff Training on Suicide Prevention Awareness and Training Module "Preventing Suicide at Sunnybrook" • 12-minute Suicide Prevention e-learning training is on-line and registration occurs through Sunnybrook's Learning Management System (LMS) Implement broad communication strategies to improve leader and staff training rates	Y	To ensure completion of the modules, a key lesson learned is that it requires commitment from leaders to encourage completion. The module provides education to staff increasing awareness of tools and resources available for suicide prevention. Since the "Preventing Suicide at Sunnybrook" module was made available, 492 staff have completed the training.

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2. Initiate Discussions with Sunnycare team on the creation of an electronic process for documentation of screening and referrals for suicide prevention interventions	N	A form for suicide screening was implemented to screen patients for risk of suicide, however the form to refer patients to suicide prevention interventions has been delayed
3. Take the Quality Improvement Plan to the Department of Psychiatry Patient and Family Advisory committee for review.	Y	Review of quality improvement plan with all members is critical for engagement and accountability. A member of the Patient and Family Advisory Committee attends the Suicide Prevention Steering Committee and is involved in implementing interventions within the Quality Improvement Plan.
4. Increase external capacity and access to community services (psychotherapy and follow-up) A half-day educational event(s) on suicide screening and prevention strategies will be organized for community agencies, Local Health Integration Network and primary health care teams. Workshops will also enhance capacity for coordination with Sunnybrook services. Targeted invitations will be disseminated. Focus will be on psychotherapy services and follow-up support post-discharge from Emergency Department or inpatients.	N	The educational event will occur in June 2019, engagement with community partners initiated in 2018/19. Engagement has occurred with Primary Care Physicians at community events and rounds to build awareness in resources available. Feedback received that an educational event would be beneficial to bridge transitions from hospital to community.
5. Increase internal capacity for delivery of suicide-prevention strategies and treatments • Develop and disseminate information within Sunnybrook on key suicide prevention strategies for patients who screen positive for suicide risk • This specifically includes: - Using Columbia Suicide Severity Rating Score (CSSRS) to track change in suicidal thoughts - Use of the Sunnybrook Coping Card - Access to psychotherapy resources (Cognitive Behavioural	Y	A learning module on suicide screening and use of coping card as a resource has been implemented. Establishment of new ketamine and neuromodulation clinic is in progress. C-SSRS widely implemented in Psychiatry, future efforts are underway to spread additional suicide screening approaches to other areas outside of Psychiatry.

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Therapy (CBT), problem-based app) - Establishment of new ketamine and neuromodulation clinics - Access to Electroconvulsive therapy (ECT) services (inpatient and ambulatory) - Restricting access to lethal suicide methods Work with hospital resources (Communications, Sunnycare) and programs (Department of Psychiatry, Brain Sciences) to build internal resources and enhance communication / access across the organization.		The Coping Card has been implemented in focus areas as an intervention to support patients who have been identified as at risk for suicide. ECT resources have been expanded, with reduced wait times. There has been extensive collaboration by our team with policy makers to develop strategies to reduce opportunities for harm on bridges and the transit system. Collaboration with social media companies has occurred with respect to media guidelines to minimize risk on safe reporting of suicide.

Q3 Commentary

Status and Progress

- The Veterans Program continues to use the recently developed algorithm to enhance screening practices - all residents with a depression score greater than three (3) must have a suicide screening completed.
- The Emergency Department is currently updating nursing notes to include suicide screening. A draft version is currently up for approval.
- Within General Internal Medicine, C4 has implemented patient screening with a Kardex form. Weekly audits are conducted by Quality & Patient Safety and results discussed weekly via Quality Conversations.
- The Department of Psychiatry is collaborating with North Toronto Sub-Region Advisory Council to host a half day workshop on June 18, 2019. The event, "Community-Based Suicide Prevention: Resources and Services to Enhance Care," will highlight evidence-based, practical suicide prevention approaches for implementation. The target audience will be community-based Clinicians (Family Physicians, Psychologists, Social Workers, Nurses), Mental Health Workers at community agencies and others involved in suicide prevention. Planning and material review is currently underway.

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3	Rate of hand hygiene performance (hand hygiene events divided by hand hygiene opportunities measured via e-monitoring). Numerator (hand hygiene events): the number of times that healthcare providers (nurses, other health professionals, residents, physicians, Environmental Services Partners, and Patient Services Partners) clean their hands. Denominator (hand hygiene opportunities): a validated number of expected number of hand hygiene opportunities based on multiple variables.		47.9% Q1 17/18 (462,205 hand hygiene events divided by 964,935 hand hygiene opportunities. This is an aggregate of five pilot medical/surgical units D2, D3, D5, B4, C5).	≥ 60% average performance across all pilot medical/ surgical units by Q4 2018/19	61.2%	

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Implement provision of weekly E-monitoring Feedback Reports (contain hand hygiene compliance for the prior week) to front-line staff.	Yes	This practice has been raising awareness among staff about their hand hygiene rates more frequently. Staff are excited to receive feedback on their performance. Many staff requested the

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		reporting frequency to be changed to daily to measure progress every single day and use data as a motivator to fuel performance further. Random audits are performed in order to ensure e-monitoring feedback is being provided to front-line staff and issues are being resolved in a timely manner.
All units will set a 1-month and a 3-month goal for hand hygiene compliance. Goals will be set by the unit during Quality Improvement huddles and • posted on Quality boards • included in Feedback Reports • shared with the unit Infection Prevention & Control coordinator	Yes	All units have been successful at setting achievable 1 month and 3 month goals but some units have felt empowered by their consistent performance to set and achieve stretch goals as high as 75%. This results-driven improvement has generated additional staff engagement and accountability for their performance. Hand Hygiene compliance results posted on quality boards and public areas has raised awareness among all staff on the unit, including consultants, residents, medical students, patients, families and visitors about hand hygiene being a priority on the unit.

Monitor that a minimum of two weekly Quality Improvement huddles will occur on units to review and discuss E-monitoring Feedback Reports and identify opportunities for iterative changes* that promote better hand hygiene compliance. *Examples of iterative changes arising from huddles may include walk-arounds to identify specific physical locations where hand sanitizer location may be optimized to improve workflow, and reviewing hand hygiene data at specific times of day to correlate with patient care activities.	Yes	Units that are most successful at improving their hand hygiene are having quality improvement huddles daily (including weekends) reviewing previous day's compliance rate with their staff, assessing how staff feels about the result and what should be done differently each day. Through iterative process, staff have identified that keeping huddles short 3-5 minutes and integrating conversations about reduction in infection rates and hand hygiene into daily workflow as a reminder results in increased staff engagement. Keeping all staff involved through daily conversations (and not waiting till next quality conversation/huddle each week) coupled with sharing results frequently has allowed staff to address any dips in performance and celebrate successes. Opportunities for improvement identified by unit staff such as optimizing dispenser locations, creating new processes for re-filling dispensers, improving visual management (signs as reminders upon unit and room entry) and changing placement of glove boxes (which are frequently used as an inappropriate substitute for hand hygiene), are only a few examples of successful change ideas implemented to promote improved hand hygiene.
Empower patients and families to make hand hygiene an expectation of care by: 1) Providing point of care hand hygiene bottles for patients and families at the bedside 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.

Q3 Commentary
In Q3, hand hygiene compliance for the units was above the corporate target for 60% and significantly improved from previous Quarters. We will continue to track sustainability of this improvement in Q4. Units that have shifted their focus on doing short daily Quality Conversation huddles (less than 3-5 minutes) including weekends based on the prior day's Hand Hygiene performance – have achieved the greatest improvements, especially when these huddles are staff-initiated. During these huddles, interdisciplinary healthcare providers are contributing ideas and solutions to several unit-initiated interventions that address identified root causes of missed hand hygiene opportunities. Increasingly, the staff are taking ownership for their performance and feel comfortable providing peer to peer feedback to reduce number of missed opportunities. Unit specific data on Antibiotic-Resistant Organism transmissions particularly Methicillin-resistant Staphylococcus aureus (MRSA) infection and patient stories are shared with unit staff to highlight the link between improved hand hygiene compliance on these E-monitored units to the decrease in transmission to engage and motivate staff. The incremental hand hygiene improvements seen has further motivated staff to continue to make further changes in practice that lead to improved patient safety.

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4	Percentage of primary care physicians (PCP) who responded "yes" to the question, 'Was the content of the Discharge Summary relevant and concise?'		33% (9 PCPs) October 2017	≥ 75% Q4 2018/19	60%	140 PCPs surveyed: 35 responses in 2nd survey

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1. Implement changes to resident training on Discharge Summaries in line with Toronto Central Local Health Integration Network (TCLHIN) recommendations a. Implement University Heath Network tool kit which specifies best practices for Discharge Summaries b. Implement video education to support resident learning c. Corporate trainers to provide training to residents on units (units will be selected based on current performance data) d. Create Discharge Summary quick reference guide (based on University Health Network's) to inform residents on Discharge Summary best practices including Sunnybrook's	Y	A training module was developed for resident orientation which included a video. In addition a quick reference guide was developed and will be posted on our intranet site. Currently corporate trainers are being developed and will provide education. Need to evaluate impact of these strategies. Residents have a large number of learning modules and may be overwhelmed with information at orientation. We may possibly need to integrate learning into practice with feedback. This will be determined.

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focus on timeliness, completeness (required components) and clarity of follow up plan Modify orientation (December 2017 and further for July 2018)		
2. Modify Discharge Summary template to align with LHIN best practice template (also used by St. Michael's Hospital and University Heath Network). a. Base modifications on learnings from i. other hospitals that have implemented the template ii. 'high' performing physicians here at Sunnybrook iii. Quality audit – e.g. Length, sections left empty, quality of follow-up section b. Implement modifications to template if required: - Consult with Sunnycare - Obtain Medical Advisory Committee approval - Obtain Forms Committee approval	Y	The current e-discharge template aligns with the LHIN best practice template. There is opportunity to continue to learn about use of the template from high performers. Modification to the follow-up section has been recommended by community family physicians. This is awaiting formal approval by our internal committees and clinical information system.
3. Continue to increase timeliness (rate of Discharge Summary completion within 48 hours) a. Take new target completion rate of above 80% to Medical Advisory Committee for approval b. Conduct focus groups with those not meeting targets to determine barriers and how to improve rates using tools such as fishbone diagram. c. Seek and share insights and strategies to overcome barriers from high performers d. Continue physician education on Discharge Summary completion (e.g. through e-learning) e. Implement a quality improvement process to make Discharge Summary process efficient for providers (without impacting quality)	Y	There is a slight downward trend in compliance with timely discharge summaries (within 48 hours of admission) across the board. The reason for this is unclear. We continue to learn from high performers and seek to understand barriers from low performers.
4. Continue to improve fax success rate (the percentage of faxes to primary care that successfully go through (e.g. not rejected due	N	Fax success rate is > 75% if the PCP is indicated however there is an ongoing challenge when the PCP is not indicated. This is an

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to wrong number or primary care fax turned our etc. a. Improve accuracy of documentation of patient's family physician at time of registration b. Implement fax registry maintenance (using University Heath Network's process) c. Streamline discontinuation of faxing for primary care physicians who are on HRM (Hospital Report Manager) Note 1: HRM coming fall 2017 and this will cover many Family Practitioners Note 2: College of Physicians and Surgeons of Ontario (CPSO) moving to email in 2018, so will need to develop a plan to incorporate this change once it is available d. Implement Auto-fax e. Create a one page document to detail how Health Records department is trying to get Discharge Summaries out to physicians with tips to increase success rates – send out to primary care physicians with Discharge Summaries		ongoing challenge that will require Health Records & Patient Registration to work directly with the programs to improve the detail collected during the patient registration process. Accountability is required at the program level for ensuring primary care provider detail is accessed during registration.
5. Engage with patients and families to solicit and implement improvement ideas.	Y	A patient survey about the discharge summary and the discharge process was developed by LHIN Citizen's Panel with input from North Toronto Patient and Family Advisory Council. The details regarding piloting this survey with General Internal Medicine patients is pending.

Q3 Commentary

1. Ongoing work is required on timeliness of discharge summary completion (completion rates within 48 hours). This includes feedback to chiefs and individual physicians. There has been a slight trend downward recently which is concerning, with reporting as follows:
    a. Monthly reports on late offenders will continue to be followed up with emails/phone calls to understand causes and possible enablers.
    b. Monthly reporting of top performers continues at our Medical Advisory Committee.

2. Continued work is happening to improve our fax success rates – success rate is > 75% if the PCP is indicated. There is an ongoing challenge when Dr. "NA" is being entered. The following strategy is recommended:
    a. Require monthly reporting on number of patients with PCP 'NA' or blank
    b. Require senior leadership endorsement for Health Records & the Patient Registration Department to work directly with the programs to improve the patient registration process related to entering the primary care provider upon registration – accountability at the program level is required for this.
    c. Outstanding issues that are awaiting Information Management solutions include:
        i. Removing duplicate discharge summary requests
        ii. Removing requests for discharge summaries for those patients who do not require one (e.g. patients with only one overnight stay without complications)

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5	The proportion of patients repatriated to Markham-Stouffville Hospital (MSH) within 2.5 days of initiation of repatriation (Initiation of repatriation defined as when the Sunnybrook Repatriation Office is contacted by the Sunnybrook clinical team).		67% Q2 17/18	≥ 90% Quarterly	**67%** **(Q3 18/19)**	*See below*
	Comments: As acknowledged in the selection of the indicator for this QIP, the volume of repatriations is very small, which means the indicator is highly sensitive to small changes in repatriation case volumes. The Working Group (with membership from both Sunnybrook and MSH) implemented a case review process to understand the factors preventing repatriation within the 2.5 day target. This case review process highlighted the need to define exclusion criteria for atypical cases that do not follow the repatriation process between Sunnybrook and MSH that is the focus of improvement for this QIP. By applying these criteria, the data will better reflect the process it is measuring. The Working Group will define the criteria for atypical cases, and apply these criteria retroactively to re-analyze data previously reported from FY 18/19, and to the baseline data.					

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1. Improve transfer of accountability (TOA) between Sunnybrook and Markham-Stouffville Hospital *The Transfer of Accountability Leads at Sunnybrook and Markham-Stouffville*	Yes	Optimizing the process of transfer of accountability (TOA) is in progress. The Working Group identified an opportunity to enhance TOA between allied health teams. Taking feedback from the allied

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Hospital will jointly oversee the following: a. Optimize process for transfer of accountability for repatriation *The Flow Steering and Utilization Committee at Markham-Stouffville Hospital and The Shared Knowledge Working Group of the Sunnybrook Repatriation Taskforce will oversee the following:* b. Improve handover between sending and receiving physician i. Create guideline for Sunnybrook to determine correct receiving service at Markham-Stouffville Hospital when initiating repatriation ii. Increase understanding of repatriation principles and processes for Physicians at Sunnybrook and Markham-Stouffville Hospital. Create education package regarding repatriation for Resident orientation/education. c. Clarify roles and responsibilities. Develop a standard repatriation guide for staff that outlines the repatriation process, roles and responsibilities, and key contact information.		health team members, the Working Group sought strategies that were aligned with current processes and tools, and are exploring how existing sources of information, such as rehab applications, can be leveraged for TOA. The guideline for most appropriate receiving service at Markham-Stouffville Hospital (MSH) and corresponding discussions have been helpful, particularly for diagnoses that do not align clearly with one service at MSH. A plan for Resident education regarding repatriation is in progress. A standard repatriation guide for staff is in revision. The Working Group identified seeking stakeholder feedback as a key factor in development.
2. Improve communication regarding repatriation with patients and family *The Shared Knowledge Working Group of the Sunnybrook Repatriation Taskforce and the Flow Steering and Utilization Committee at Markham-Stouffville Hospital will jointly oversee the following:* a. Educational outreach to ensure staff are using consistent and appropriate terminology when discussing repatriation with patients and families b. Co-design with patients and family members a comprehensive repatriation information package for patients and families.	Yes	In progress. Educational materials are in development. A plan for educational rollout is in development to share the standard repatriation guide.
3. Understand patient and family experience of repatriation	Yes	A plan for measuring patient and family feedback through interviews was developed and

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The Shared Knowledge Working Group of the Sunnybrook Repatriation Taskforce will oversee the following: Create a plan for measuring patient and family experience of repatriation and assess patient and family satisfaction with the process of repatriation. Design quality improvement initiatives based on patient and family feedback.		implemented. A key learning was identifying the best timing to approach patients by balancing timeliness with acuity of care. Having the interviews conducted by a staff member with whom patients and family members had interacted with before was also found to be helpful. The feedback from the interviewees indicated that they were satisfied with their experience of repatriation from Sunnybrook overall, and that the identified change ideas in the QIP were in line with this feedback.

Q3 Commentary
Overall, the opportunity for dialogue between Sunnybrook and Markham-Stouffville Hospital created through this work has been a great tool for collaboration and shared learning! This partnership has provided a great opportunity to develop best practices for repatriation that can be utilized for repatriation with other hospitals.

Excellent Care for All
Quality Improvement Plans (QIP): Progress Report for 2018/19 QIP

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6	90th percentile Length of Stay for all Non-Admitted patients		9.0 hours Oct 17, 2017 YTD	≤ 7.7 hours by March 31 2019	9.98 hours FY 2018/19 Oct 20 YTD	

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Physician Initial Assessment[1] A number of initiatives will be reviewed, tested (if necessary) and introduced when appropriate to improve flow so that new patients can be seen by an Emergency Department physician sooner after arrival to the Emergency Department: - Increased nurse time in the Ambulatory area - Adjusted start time for the Triage nurse(s) - Process for CCL (Clinical Care Lead) to work more closely with Bed Flow staff - Flowing patients more proactively from triage into the department, and from the department to the ward - Improving bed "sign-over" times (including porter and environmental services processes) - Facilitating ambulatory patients waiting in the waiting room when	Y	2018 was a challenging year for the Emergency Department (ED) with record levels of high occupancy, admissions as well as acuity seen in increasing stroke and trauma patients as well as the number of ICU admissions boarded in the ED. This has impacted the ability to meet the target times. 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.

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appropriate - Moving appropriate stretcher patients into a chair [1] This indicator measures the time interval between the earlier of triage date/time or registration date/time and the date/time of physician initially assesses the patient in the emergency department.		
Consult Arrival 1. A. Report new consultation[2] time measures (from consultation request date/time to patient discharge home date/time) for the eight most frequent consulting services to the Department Chiefs 1. B. Solicit feedback from Department Chiefs [2]In the Emergency Department, a consultation is when an emergency medicine physician contacts another physician (specialist or otherwise) for advice or intervention regarding patient care. 2. A. Complete implementation of Phase 2 of HERMES[3] trial by April 30, 2018 with ability to: i. Track the following psychiatry consult time metrics - Consultation request - Bedside arrival - Staff physician contacted - Decision made, and - Disposition/discharge ii. Offer a new interactive interface between HERMES and the consultant; and iii. Implement a new peak hours FAST TRACK protocol. 2. B. Review and analyze the consultation data from Phase 2 and recommend changes to improve consultation times by June 30, 2018. [3]HERMES is a pilot project using a new iPhone application measuring very	N	We were not able to track consult arrival time despite our change efforts. We reviewed and identified a more accurate metric to measure consult times, specifically consult time to disposition time. Moving forward, we will be using this metric. In addition, we will be partnering with General Internal Medicine to help identify new opportunities for improving this time in the future.

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specific time intervals in the consultation process. The data can then be used to make improvements in time from consultation request to consultation. 3. Partner with Clinical Champions to implement improvement opportunities in other services.		
Diagnostic Imaging 1. Complete full establishment of the Emergency & Trauma Radiology Division (ETRD) with overnight reporting by hiring the last member of this ETRD staff radiologist team by January 2018. 2. Analyse the need to expand current on-site ultrasound technologist coverage (Monday - Friday 8:00 a.m. up to 12:00 a.m.) to Monday – Sunday 24 hours a day. Analyze if change would improve patient care and total length of stay for non-admitted Emergency Department patients. The key is to analyze number of ultrasound orders on off-hours (between midnight and 8 am and on weekends and statutory holidays). 3. Present business case and seek approval from Senior Leadership Team to increase CT (computerized tomography) technologist staffing to two staff per after-hour shift as part of initiative to improve turn-around time of Endovascular Treatment (EVT) in stroke management. 4. 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. 5. Explore and analyse patient transportation support for safe, timely and efficient movement of patients from Emergency Department to Diagnostic Imagining locations allowing patients for their tests and treatment procedures	N	The joint ED and Trauma Radiology team was established and this has improved collaboration. Analysis of after-hour ultrasound demand did support expansion of our on-site technologist which is targeted to be implemented in Q3/Q4 of fiscal year 2019/20. Improvements to reduce the 90th percentile of ED CT turn-around time were negatively impacted by higher ED CT volumes/ demands. Not all the change ideas could be implemented as the plan was highly ambitious and likely too large to accomplish within one year. Efforts will continue as part of a QIP in 2019/20.

Change Ideas from Last Year's QIP (QIP 2018/19)	Was this change idea implemented as intended? (Y/N only)	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?
Ambulance offload time (90th percentile Transfer of Care time baseline 82 minutes, overall goal = 45 minutes) *Phase 1/Input:* Improve the process for knowing when an Ambulance has arrived. Develop kiosk for Ambulance paramedics self-check-in. - On arrival, the Ambulance paramedics would check-in using the kiosk and their unique Trip Number. This would alert the triage nurses to the ambulance arrival and allow them to call the crew for triaging. Triaging is the first step for the patient to be identified by the Emergency Department system and allows them to be placed in appropriate areas based on their severity. - Steps for this change idea include: 1. Train Ambulance personnel on Check-in Kiosk 2. Implement Kiosk Trial Period – Nursing Education 3. Rapid PDSA (Plan-Do-Study-Act) cycles to improve process Timeframe: Ambulance Kiosk Live Date: Jan 1, 2018 Kiosk Trial Period: Jan – March, 2018 Time points measured: 1. Time from Ambulance Arrival to Kiosk Check-in 2. Time from Kiosk Check-in to Patient Triage Compliance measure: Percentage correctly inputting Trip Number *Phase 2/Throughput:* Improve the flow of Emergency Department patients to increase stretcher availability. Maximizing the stretcher availability will improve the ability to transfer ambulance patients into the Emergency department as well as general flow.	Y	A TAHSNp Fellowship to reduce 90th Percentile Ambulance Offload time by focusing one triage nurse on patients arriving by Ambulance, resulted in significantly improved offload times and a dedicated nurse who began in the role in June, 2018. The Transitional Zone was successful in that it was used effectively to increase capacity for physicians to see patients. However, because hospital occupancy was so high during this period, length of stay was not impacted but we hypothesize that it would have been even longer without the Transitional Zone. The Transfer of Care trial was successful in lowering the time from Inpatient Bed Ready to Patient Departure from the Emergency. However, due to competing initiatives, the improvement was not sustained. The next step is to analyze two time components, Bed Ready to Portering Called, and Portering Called to Patient Departure. This will enable interventions for each process to be developed, including the possibility of automating the Porter Call.

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A. Emergency Department Transitional Zone. Develop an area for ambulance patients waiting to be transitioned into the Emergency Department, so that they will not be held on offload delay*. During offload delay, a patient will remain with the ambulance paramedics and this delays both the patient's care and the time that the paramedics remain in the hospital. This area would also serve to help bed flow and would be for eligible patients already seen by a physician and awaiting tests. *Offload delay is defined as when a patient must remain with the Ambulance paramedic after being triaged because there is not yet an Emergency Department nurse available to complete the transfer. Phase 2/Throughput: (continued) B. Develop Transitional Protocol for nurses to help guide moving patients to the appropriate areas, including: - Ambulance patients to be moved to chair/waiting area - Ambulance patients to be moved to Transitional Zone - Emergency Department patients in a stretcher to be moved to a chair or the Transitional Zone C. Registration Flow: Registration occurs after triage and is necessary for the patient to be placed in the Emergency Department information system and obtain health record information. Perform flow mapping and time analysis of the current registration process. Implement PDSA (Plan-Do-Study-Act) cycles to improve the process. Phase 2/Throughput: (continued) D. Transfer of Care for Emergency Department Admitted Patients: For admitted patients, an Emergency Department nurse must give the unit ward nurse information through a process of Transfer of Care. The goal of this phase is to perform flow mapping and time analysis of the current transfer of care process. If admitted patients have a delay to being transferred to the ward, this impacts the general Emergency Department flow as the stretcher that the		

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admitted patient occupies is blocked for other use. Therefore there will be PDSA (Plan-Do-Study-Act) cycles implemented to improve the process and transfer of care time for admitted patients and increase the stretcher availability in the Emergency Department.		

Q3 Commentary

Q3 Status and Progress

- Sunnybrook continues to have high hospital occupancy, thus impacting the emergency department flow.
- Transitional Zone (TZ) and Transfer of Accountability (TOA) strategies continue to be effective in improving flow so that new patients can be seen by an ED physician sooner after arrival
- Ambulance Offload Time maintained its success in achieving better than the target with the additional triage nursing shift in the ED.

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7	% positive response* in the overall Respect and Dignity Dimension (made up of nine questions) from the Canadian Patient Experience Survey in the Women's & Babies, Trauma, Cancer, Community, Cardiac, and Holland programs. The Dimension is defined in four sectors: 1. **Communication with Nurses** - This measure is a composite measure of three questions measuring the patients' responses to whether they were treated by nurses with courtesy and respect, were listened to, and explained things in an understandable way. 2. **Communication with Doctors** – Three questions that describe how well doctors communicate with patients. 3. **Emotional Support** - One question that describes the emotional support provided for anxieties, fears or worries during their hospital stay. 4. **Involvement with Decision-making** – Two questions that describe how well patients and families are involved in decision-making. * The questions are all on a four point scale (never, sometimes, usually, always), and the % positive score is only used for the 'always' response.		67.9% Q1 17/18	≥ 72% By Q4 2018/19	66% Q3, 2018/19	

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The goal of the Compassion work on the hospital's quality strategic plan is to lead in valuing the humanity and vulnerability of our staff, patients and families through implementing innovative initiatives promoting the humane aspects of healthcare. We will accomplish this by: 1. Advance a culture of compassion 2. Support health care providers to deliver compassionate care 3. Support staff and physician wellness. **ADVANCE A CULTURE OF COMPASSION** Attract, recruit and retain a workforce committed to consistently approaching patients, residents, and family in a person centred way that demonstrates compassion for the emotional experiences of receiving health care services. It is recognized that every Sunnybrook staff person makes a difference in patient and family experiences of high quality care. **1.** Revise job descriptions to recruit talent committed to this values- based approach to care **2.** Revise behavioural-based interview guides to enable applicants to describe their strengths in this area **3.** Update performance appraisals with accompanying conversation guides to enable managers to review and discuss behaviours and accountabilities to continuously improve integration of compassion in daily care	Y	We have been consistently striving to ensure that new job postings add the value and behaviour of compassion to support recruitment of staff who have aligned values. Interview guides have been modified to ask applicants behavioural based questions about how they have used compassionate, person centred approaches in their care that made a difference. We are currently in the process of revising our Performance Appraisal Tool to fully embed compassionate, person centred care competencies.
STAFF ENGAGEMENT Engagement is described as a positive attitude held by employees towards the organization and its values. It is a two way relationship and organizations must work to develop and nurture engagement. One of the strongest drivers of engagement is a sense of feeling valued and involved. Engagement is heightened by compassion and commitment increases when staff have an opportunity to both experience and express compassion. As an organization, we wish to increase our understanding of our staff's level of engagement by measuring drivers of engagement, including compassion. Add questions measuring drivers of engagement to the current Staff & Physician Engagement Survey. Results from the Staff and Physician Engagement Survey inform the Wellness Strategy. Additionally each leader is provided with their own	Y	Our Staff Engagement Survey was modified to include the drivers of Wellness, as they relate to compassion for staff. This year's survey has been implemented and results are currently being collated, to be shared with respective leaders.

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results, and is required to develop a shared team action plan based on the review of the results.		
NEW COMPASSION AWARD Develop and implement a new annual team Compassion Recognition Award which will be open to everyone. Specific criteria that recognize compassion for patients, families and staff will be developed. The new award will be aligned to the Schwartz Centre Rounds and will be celebrated at the new Human Resources Day in 2019. **MEASURE IMPACT OF SCHWARTZ ROUNDS*** Implement measurement tool to evaluate the impact of Schwartz Centre Rounds on participants' overall wellness. The enhanced evaluation will measure the impact of participating in the rounds over time. An Ethics approved multi-methods study will explore the impact on the individual and organization as it relates to compassion, meaning of work and burnout. *Schwartz Centre Rounds provide staff with an interprofessional forum and space to reflect and discuss the social, emotional and ethical impact of working in the health care system.	N	A new Team Compassion Award was conceptualized to be recognized during Schwartz Rounds, however, has not been implemented to date. There is aligned work to ensure that compassion is integrated into all awards, and there has not yet been a final decision as to whether the Compassion Award will be implemented as planned. Schwartz Rounds evaluation is completed following each event to evaluate the experience of the participants. Very positive feedback has been provided with 89% of participants stating that the rounds enable them to discuss the emotional, social and ethical aspects of care, 85% stated they gained new insights into the perspectives of their colleagues and 69% stated that they felt less isolated in their work.
COMPASSIONATE PERSON CENTRED CARE Utilize unit-based discussions to enable interprofessional teams to collectively review and act on patient-reported data, with a goal to improve patients' experiences of compassionate care. Teams will be supported to develop and implement local improvements ideas. Unit-based improvement activity is informed by numerous sources including: 1. iLead data 2. Themes found in comments from Canadian Patient Experience Survey 3. Data from quarterly "Conversations with Patients" audits 4. Improvement ideas from a new question to be added to "Conversations with Patients."	Y	The Canadian Patient Experience Survey is automatically shared, on a regular cycle with Program Directors. The results are reviewed regularly in Program/Practice Councils and Staff Meetings. Data from the survey and associated themes are being used to create local quality improvement ideas and initiatives that are being acted on by local teams, such as decreasing noise during the night. Additionally, teams are engaging in

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		Conversations with Patients, an evaluation method to ask patients about their experience in real-time, to collect stories of impact. These stories are being shared in interprofessional committees and team meetings. Patients have reported 73% positive satisfaction with experiencing compassion and kindness in their care. This new question has seen a positive trend over the last three quarters.
PATIENTS AS EDUCATORS: ADVANCING COMPASSIONATE CARE Create a website with written and video content to share the individual experience of five Sunnybrook patients who experience bipolar illness. This website will be designed to help enhance the compassion of medical students and residents at the University of Toronto towards people with mental illness. The website will also be shared with patients, family members and the general public in order to help viewers better understand these patients' experiences and to reduce stigma. A health reporter will interview five Sunnybrook patients about their life experience with bipolar illness and a film company will create a video for the website. We will measure views of the website and patient and family and student learner satisfaction.	Y	A high quality video series was created and implemented. A hospital wide launch was held to share the stories with interprofessional team members from across the organization. The video series is highly impactful, meaningful, and has generated very positive learning about the patient experience of living with mental illness. This videos series is now being explored for integration in resident teaching programs.
STAFF AND PHYSICIAN WELLNESS AND RESILIENCE Implement and evaluate programs to foster compassion and overall wellness: 1. Mindfully Working with Stress Program for Health Professionals and Physicians (2018 – 2019) 2. Building Mental & Emotional Wellness Workshop (2018) 3. Emotional Wellbeing & Mental Health Keynote (2018) 4. Narrative Medicine in Palliative Care 5. Lavender Alert Pilot in General Internal Medicine 6. Improving Wellness through Improvisation	Y	A number of new programs have been created and implemented with a focus on staff wellness. Staff are very interested to attend and express how important this focus of programming is for their overall support and wellbeing. The programs include those that staff register for participation, as well as those that they can access just in time, when they identify the need for support (e.g. Lavender Alert)

Q3 Commentary

- Q3 results reflect October and November data (December not yet available).
- Through the fall 2018, the hospital continued to experience high levels of occupancy requiring patients to be cared for in nontraditional care settings, such as the hallway. During this time the interprofessional staff and teams strived to use Three Vital Behaviours to provide compassionate, person-centred care.
- Qualitative responses from patients in the Canadian Patient Experience Survey note dissatisfaction with their care experience when cared for in the hallway, noting noise and light as negative impacts.
- During Q3, Sunnybrook actively worked towards an operational plan to eliminate hallway medicine. Through a partnership with the Ministry of Health and Humber River Hospital, 60 alternate level of care beds opened at the Reactivation Care Setting on December 16th. As of that day, Hallway Medicine at Sunnybrook was eliminated. We anticipate this will be reflected in the Q4 results for this indicator.
- Sunnybrook is very pleased with the accomplishment to ensure that patients are cared for in the best possible setting, supporting a compassionate experience of care.

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8	Percentage of respondents who responded positively 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? (The Canadian Patient Experience Survey (CPES) question #37)		54.4% Q1-Q2 2017/18	≥59.8% By Q4 2018/19	57.2 Q3 2018/19	

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IDENTIFYING ESTIMATED DATES OF DISCHARGE An Estimated Dates of Discharge is important as it gives the patient, their family and the health care team a time line during which they can strive to provide the information patients need prior to discharge. On a monthly basis, disseminate the Estimated Discharge Date (EDD) Dashboard (contains compliance and accuracy data) to the following teams to enable improvement strategies to be developed and implemented where appropriate: • Clinical teams (including resident physicians)	Y	Clinical teams continue to identify Estimated Dates of Discharge (EDD) that are communicated daily to the Patient Flow Team to support flow and transition across the hospital. EDD has been integrated into to the Electronic Health Record so all clinicians can visually see who is planned to be discharged on the day or the next day. This aggregate data is shared monthly through the Discharge Dashboard.

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• Discharge and Transition Planning Committee • Occupancy Executive Committee Interprofessional Quality Committee (biannually)		
IMPLEMENTING AND SUSTAINING DISCHARGE BEST PRACTICES Improve patient experience with preparing for discharge and the transition home. Implement and sustain Discharge Best Practices and Tools to support discharge planning process and patient education. Discharge Best Practices and Tools include: 1. Standardized questions in Discharge Planning Rounds * 2. Discharge Poster * 3. Discharge Video 4. Patient Engagement Whiteboards * 5. Unit Discharge Pamphlet * 6. PODS (Patient Oriented Discharge Summary) NEW * = Sustain Clinical Teams will be provided with a Self-Assessment Tool to evaluate how well the Discharge tools are integrated into practice and to identify opportunities for improvement.	Y	The focus of the improvement was on the new initiative of Patient Oriented Discharge Summary (PODS). Sunnybrook worked in collaboration with Michael Garron Hospital to create a staff learning program about Health Literacy, Teach Back and Using PODS. The focus of implementation is on Quality Based Procedures (QBP) populations, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD) and Community Acquired Pneumonia (CAP). Staff training is currently underway, and in the areas that have achieved 80% completion of staff training, the PODS tool has now been implemented. This work is underway and will continue in a 2019/20 Quality Improvement Plan focused on improving transitions in care.
IMPLEMENTING PATIENT ORIENTED DISCHARGE SUMMARIES Develop, implement and evaluate PODS (Patient Oriented Discharge Summary [1]) on three units. Implementation of PODS will include simulation based education for staff on the core competencies of Health Literacy [2] and Teach Back [3]. Staff education programming and evaluation will be completed in collaboration with Michael Garron Hospital to further advance system partnership and collaboration. Post discharge calls to patients and families will be used to evaluate the	Y	Implementation of PODS is actively underway. The tools are now available on the patient care units where the staff training has been completed. Additionally, a physician based video has been created and will be launched very shortly. Analysis of workflow has been created to additionally integrate Teach Back using the PODS tools, patient friendly medication list, and the Discharge Summary. Best Practices for Discharge and Transition remain in place. This includes the use of

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effectiveness of PODS. [1] A written summary provided to patients typically with five key pieces of information they need to know in order to effectively manage their health after a hospital discharge: • Signs and symptoms to watch out for • Medication instructions • Appointments • Routine and lifestyle changes • Telephone numbers and information to have available [2] Health Literacy is the degree to which patients have the capacity to obtain, process, and understand health information needed to make appropriate health decisions. [3] The teach-back method, also called the "show-me" method, 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.		key questions in team rounds to support planning, use of white boards for patient and family communication and unit based discharge posters.
DEVELOP EFFICIENT STRATEGIES TO SHARE INFORMATION AMONG HOSPITALS, PRIMARY CARE AND PATIENTS. Pilot "Notification and Warm Handovers" between the Sunnybrook Family Health Team and Sunnybrook Internal Medicine teams at/near admission and prior to discharge. This initiative will encompass: • Identifying the information needs of primary care, internal medicine and complex patients.	N	The focus of this years' work transitioned to focus on the development and implementation of PODS. This work was time intensive and required collaboration between two organizations, clinical teams and the Canadian Simulation Centre.

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• Involving the Family Health Team nurse navigator to facilitate information sharing, "Warm Handovers", and completion of Patient Orientated Discharge Summaries • Identifying best practices to communicate with primary care • Using feedback from the Family Health Team Nurse Navigator on various communication strategies. **Background:** Primary care is an essential partner for optimal and efficient care throughout each patient's health journey. While the Sunnybrook Family Heath Team patient admissions only comprise 1% of the total admissions, the Family Health Team serves many patients with complex health conditions and would be a good pilot model for developing communication strategies that can work for these patients and other patients in the future. Information received by primary care providers from hospitals is often considered inadequate, inaccessible and/or untimely. Primary Care providers are often unaware their patients have been admitted. Internal Medicine physicians in the hospital can also feel there is a lack of accessible information about the patient's care prior to admission.		

Q3 Commentary

- Q3 results reflect October and November data (December not yet available).
- It is noted that during this quarter the hospital was experiencing very high occupancy, impacting care and workflow processes.
- Active work continues to improve the Discharge and Transition Planning process with a focus is on patient populations including congestive heart failure, chronic obstructive pulmonary disease and pneumonia.
- Patient Oriented Discharge Summary (PODS) tools have been created in plain, easy to understand language in collaboration with Michael Garron Hospital. Staff education is currently underway and the new tools will be implemented in February 2019.

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9	% of patients who respond positively to the Canadian Patient Experience Survey question "During this hospital stay, how often was the area around your room quiet at night?" Numerator: Number of positive responses within selected units Denominator: Total Number of responses within selected units		34.6 % - revised 31.5% Hospital average (2016/2017) Individual unit levels vary.	A 10% relative increase from baseline on the selected pilot units by March 2019. Pilot units have been identified in collaboration with program and unit leadership.	Pilot units have surpassed the 10% relative increase.	All pilot units have surpassed the 10% relative increase set out as the target, and continue to work towards sustainable gains with quiet at night. The hospital average has not shifted, and has been impacted by occupancy pressures. The baseline for Sunnybrook was adjusted to 31.5%, to ensure reflective of the acute care units; removed Woman and Babies program results.

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Conduct assessments of noise levels and factors contributing to noise on selected units. Observations as well as patient and staff surveys and interviews will be included in the assessments.	Y	We identified three theme areas for noise reduction that apply broadly across the organization. These include: • Quiet etiquette to create a healing

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Based on assessments, develop a broader understanding of the challenges that lead to noise on the units and identify unit specific strategies that can be implemented to reduce noise.		environment • Individualized and adjusted alarms • Environment and equipment noise assessment and adjustments These above themes are consistent with the literature, and are informing individual unit discussions on how to enhance quiet. The Quiet Campaign educational material and quiet posters, which were launched on January 31, 2019, integrated the above themes to ensure content relevance.
Implement sustainable strategies to reduce noise levels on a minimum of three selected pilot units.	Y	The three selected units have met their target noise reduction and continue to explore additional strategies to enhance quiet on the unit. The units struggled in Q2 due to significant occupancy pressures and construction noise. Sleep bundles with ear plugs and masks are now being distributed on the units to address hospital noises that are unpreventable.
Implement a One Month Quiet Education Campaign across all Sunnybrook Campuses and Programs to raise awareness of the impact of noise on patients and share data and strategies.	N	The Quiet Campaign has begun with all materials and tools shared organizationally on our intranet site for the month of February 2019. The organization's Communication Team and Patient Experience office are supporting this process.
Implement a Three Month Team Quiet Challenge that follows the Quiet Campaign. A toolkit with strategies to support noise reduction will be available on the intranet and teams will be able to select the most appropriate strategies for implementation.	N	The tool kit is available for the Quiet Challenge and final steps in planning are underway.

Q3 Commentary
The three pilot units have made significant strides toward achieving a culture of quiet, where the team members hold each other accountable for shifting behaviour. The focus for the shift in culture has been led by front line staff, including nurses and support staff. This is an essential component of the pilot units meeting the QIP targets, and also in ensuring the results are sustainable. The Quiet Campaign has rolled out in Q3.

Excellent Care for All
Quality Improvement Plans (QIP): Progress Report for 2018/19 QIP

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ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
10	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.		2.48% Q2 2017/18	≥ 0%	3.20%	

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Change Ideas from Last Year's QIP (QIP 2018/19)	Was this change idea implemented as intended? (Y/N only)	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 revenue from patients selecting Preferred Accommodations - Improve work-flow processes to enable more patients to be interviewed for their preferences and increase the likelihood of successfully placing patients in their preferred rooms despite high occupancy.	Y	Reducing administrative workload with process improvements and technology reduced the burden of work that was not value-add, and gave staff more time to interview patients. Further, reaching patients earlier in their journey by going to the Emergency Department to interview admitted patients led to greater rates of contact with patients and improved likelihood of preferred placement given the additional notice period to the Patient Flow department for bed preference.
Identify increased revenue opportunities from retail services	Y	Assessing barriers to providing new or expanded services was crucial in developing the scope of retail offerings.

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- Expand retail opportunities by scaling existing services, delivering new services, and assessing unsustainable offerings. - Ensure staff, visitors and patient preferences are taken into account by conducting initial surveys on preferences and assessing satisfaction once new retail initiatives are implemented.		Solutions to the barriers were developed through collaborative efforts between clinical pharmacists and administrative staff. Key learnings would be to create a partnership between clinical and administrative experts to understand barriers and collectively brainstorm creative solutions.
Ensure that the data submitted to the Ministry of Health that is used for funding purposes more accurately represents the services provided to patients. - Implement a comprehensive Data Quality Program to ensure that reported activity aligns with services provided and enhances Sunnybrook's funding position.	Y	Audit and feedback is an important part of a Data Quality program for coded data. We have learnt that the feedback must be customized to the service so that specific documentation practices can change.

Q3 Commentary

Sunnybrook's performance has exceeded target this quarter (and YTD) due to a number of focused efforts on optimizing expenses and increasing revenues, in particular:

Preferred Accommodation:

- Even though the number of semi-private and private beds available were impacted by the Complex Malignant Hematology renovations and ongoing occupancy pressures, there continues to be an increase in the number of patients placed in preferred accommodations in the targeted areas. All impacted areas have reopened as of late December.
- Process improvements made at St. John's Rehab in Q3 have also positively impacted the number of rehab patients placed in preferred beds.

Retail Services:

- To enhance patient experience, MyPayments was launched in November 2018, allowing patients to pay for their hospital invoices online.
- Sunnybrook has partnered with Canadian Tire Corporation, in efforts to introduce a new retail concept and enhance patient and staff experience. As part of a three month pilot, Mark's Work Warehouse opened a pop-up shop in December 2018, with all proceeds going back to the hospital.
- In spite of challenges with margins earlier in the year, efforts have been made to reverse the trend. The successful negotiation of a new RFP should lead to improved margins in 2019. In addition, dedicated staff for providing professional services in the Outpatient Pharmacy is planned to start in February 2019. We anticipate the following services to be provided: specialized education and fitting, home health care

device training, home care service referrals, medication reviews and patient consultations/education.

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ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
11	Alternate Level of Care [1] Rate Overall (%) for Acute & Post-Acute patients located at all Sunnybrook sites (Bayview, Holland & St. John's Rehabilitation). [1] Alternate level of care (ALC) refers to a patient who is occupying a bed in a hospital but does not require the intensity of resources or services provided in this setting (source: Health Quality Ontario: qualitycompass.hqontario.ca/ portal/plans-hospital/Alternate-Level-of-Care?extra=pdf)		9.20% Q1 2017/18	≤ 8.74% By Q4 2018/19	**11.66%** (YTD Oct 2018)	

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1. Consistent use of best practices - Complete Alternate Level of Care Self-Assessment Tool developed by the Toronto Central Local Health Integration Network - Incorporate patient and family feedback where possible - Address gaps as required	Y	We developed a Best Practices Tool Kit to ensure there was a consistent message around the ALC process. There is more work to do with engaging physicians in the use of the toolkit and sustaining our focus on best practices.

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2. Maximize the number of rehabilitation facilities selected by patients to enable them to receive rehabilitation in as timely a manner as possible - Ensure Sunnybrook's new Tool Kit processes are implemented so that referrals to multiple rehabilitation facilities are maximized (when appropriate) and that a first bed available policy is utilized whenever possible	Y	We did see some months with an increased average number of referrals. Visits to units to share results and discuss processes with staff were helpful. We are also strengthening linkages with rehabilitation facilities and this has been helpful in understanding their perspectives on the referral process and the patients they can best serve.
3. Maximize the number of Long-Term Care homes selected by patients to enable them to be in a home setting in as timely a manner as possible - Ensure patients have received communication and/or counseling related to the benefits of making five Long-Term Care home choices. - Follow tool kit processes to ensure choices are maximized (include all team members to support patient and family as required).	Y	Bi-weekly review meetings ensure cases are followed-up on as needed.
4. Maximize referrals to new transitional care beds and programs (e.g. at Pine Villa, St. Hilda's and Hillcrest). - Implement processes to support assessment and referral of patients who meet eligibility criteria.	Y	Having access to transitional care beds has been a benefit to patients formerly waiting in acute care as it is a better environment in which the transition planning can continue. In addition, Sunnybrook has opened a Reactivation Care Centre (RCC) at a new site designed to support patients in continuing their care when they no longer require specialized, acute hospital services. The centre is designed for patients who are waiting to move to another care facility in the community, and will help ensure the best care in the most appropriate setting.

Q3 Commentary

Status and Progress

- The Reintegration Unit beds at Pine Villa, opened in Q4 of 2018/19 have eased ALC pressures for a subset of qualifying patients – patient days accrued at Pine Villa Q3 YTD are equivalent to 23 acute beds. Referral volumes to Pine Villa are 5.7 / month (Q3 YTD) exceeding the target of 2 per month.
- Sunnybrook's ALC Task Force has implemented a number of strategies to address the challenges, including the launch of an ALC Tool Kit to help educate patients and families on their roles and responsibilities in the post-acute care application process
- A target of ≥2.1 rehab referrals per patient for 3 consecutive months has been achieved
- Strategies to reduce Requests for Information from post-acute facilities are being explored to decrease ALC days
- 60 beds at Humber Church St. site for ALC patients opened on December 16th, 2018 to help ease pressures on acute care beds at our Bayview site.

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12	Develop "Package of Care" [1] for Accessible Care Pregnancy Clinic. [1] This "Package of Care" will specify key best practices that a pregnant woman with a physical disability should receive prenatally.		"Package of Care" is under consideration	"Package of Care" developed by March 31, 2019		

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1. Collaborate on the development of the "Package of Care" for the Accessible Care Pregnancy Clinic. This will involve clinical stakeholders such as other staff and physicians in the Women's and Babies program and family physicians. Examples of best practices might include: - ultrasound appointments that accommodate extra time if needed - anesthesia consult if needed - exploration of need for community resources/ nurturing attendant if needed	Y	It was very important to include patient representatives as well as the clinician representatives. As a result of input from patients and clinicians, we ensured that appropriate consults were included in the timeline.

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2. Hold a focus group and/or conduct a survey with current and/or former patients and families regarding the draft "Package of Care" in order to co-create the final "Package of Care".	Y	A very useful meeting. An important change was an identified need from patients to discuss mode of delivery earlier in the pregnancy.
3. Increase awareness of the Accessible Care Pregnancy Clinic and its "Package of Care" to referring physicians in the Greater Toronto Area via - Web page - Letters - Outreach to groups that represent the interests of women with physical disabilities, for example, the Spina Bifida and Hydrocephalus Association of Ontario.	N	We are currently working on a web page, anticipated to be available by the summer, 2019/20.

Q3 Commentary

Status and Progress

In Q3, an inter-professional meeting occurred with patient representatives to go over the Package of Care and gather feedback. Changes have been incorporated into the Accessible Care Pregnancy Clinic (ACPC) Package of Care, including information regarding delivery mode and breastfeeding as well as the potential to test for diabetes earlier in the pregnancy. The Package of Care is now available for patients.