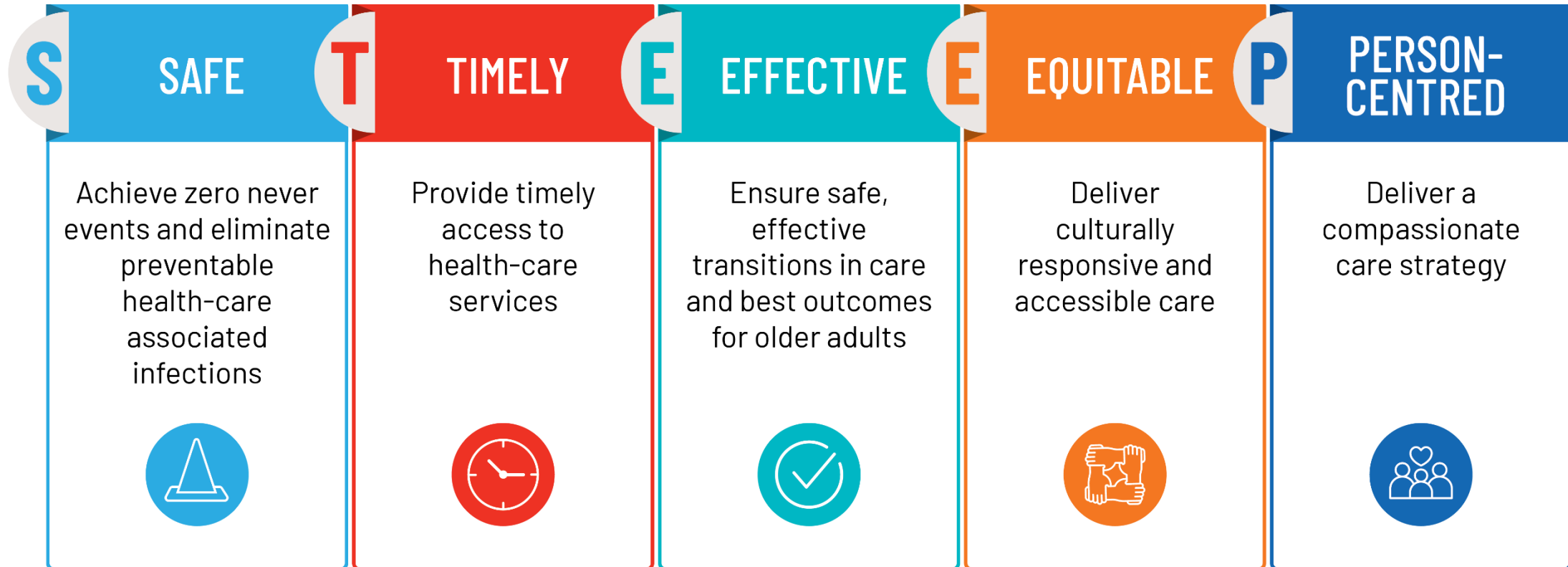


Quality Improvement Plan

# (QIP) 26/27 Workplan




# Quality Aims 2025-2028



## Quality Aim Domain – Workplan Page Navigation

Indicator	Unit Measure or Patient Population	Data Source	Baseline	Target for 25/26	Target Justification
				3 Year Stretch Target	
Measurable variable that tracks progress towards achieving a specific QI goal Quantifiable data <ul style="list-style-type: none"> <li>• Rate</li> <li>• Percent</li> <li>• Days In-between</li> <li>• Time</li> <li>• Experience score</li> </ul>	Describes the patient population the indicator will focus on <ul style="list-style-type: none"> <li>• Unit or program</li> <li>• Hospital or System</li> <li>• Specific patient population</li> </ul>	The methodology of collecting the data <ul style="list-style-type: none"> <li>• SAFER reports</li> <li>• Hospital Data</li> <li>• EPR report</li> <li>• Audits</li> <li>• Experience Survey</li> </ul>	Current state metrics	Improvement target to meet or exceed  <b>Aspirational 3 year stretch target</b>	Why and how the target was set <ul style="list-style-type: none"> <li>• Meeting benchmark performance</li> <li>• Aligning with provincial performance</li> <li>• Evidence based practice</li> </ul>

#	Change Idea	Methods	Process Measure	Target	Comments
1	<ul style="list-style-type: none"> <li>• Specific, practical strategies that focus on improving aspects of a system, process or behavior</li> </ul>	Process and tools to use and monitor progress How and by whom Specific “actionable” and “measurable”	<ul style="list-style-type: none"> <li>• How to measure and gauge the % uptake of the change idea</li> <li>• Quantifiable measure</li> </ul>	Set based on “uptake” of the best practice (% patients, or % staff where change idea embedded into practice)	These can include factors for success, partnerships, barriers, etc
2	<ul style="list-style-type: none"> <li>• Can be tested and measured</li> </ul>	 <b>Foundational</b> work that is required to lay the groundwork for a successful project, initiative or change effort and will not impact year one target.  Establishes a strong base to ensure the initiative is well-planned, evidence based and sustainable	Usually measured as “Project milestone” or “% completion”	100%	

**Ontario Health Priority:** A provincially identified quality focus area set by Ontario Health that hospitals are expected to address through their QIP

**Patient and Family Advisory (PFAC) Priority:** A quality improvement priority identified or prioritized through patient and family input and partnership

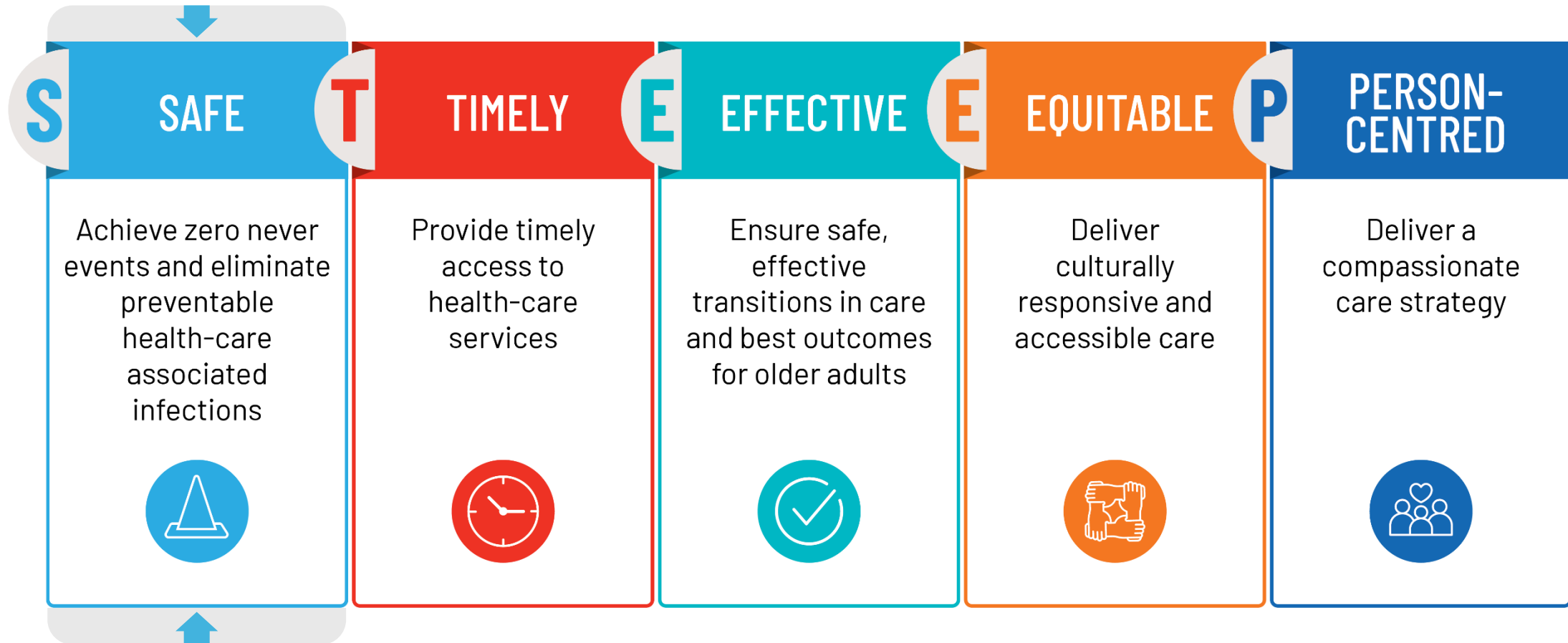
**Board Priority:** An area identified by the hospital’s Board of Directors as critical to patient safety, quality, and the achievement of the organization’s strategic objectives

**Strategic/Organizational Priority:** Prioritized on the Sinai Health 2023-2028 Strategic Plan and annual Operating Plan

**Emergency Department Return Visit Audit:** Identified trends in repeat visits, enabling targeted interventions to improve care quality, patient safety, and continuity of care



# Quality Aims 2025-2028 : SAFE



# Aim Statement

Achieve zero never events and eliminate preventable health-care associated infections



<b>#1 Sub Aim Statement:</b>	<b>Achieve ZERO Never Events</b>
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<b>VP Lead</b>	<b>Medical Lead</b>
Kara Ronald	Dr. Christine Soong

<b>#2 Sub Aim Statement:</b>	<b>Reduce Self Harm Events</b>
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<b>VP Lead</b>	<b>Medical Lead</b>
Kate Wilkinson	Dr. Bob Maunder

<b>#3 Sub Aim Statement:</b>	<b>Eliminate Preventable Healthcare Associated Infections (HAIs)</b>
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<b>VP Lead</b>	<b>Medical Lead</b>
Kate Wilkinson	Dr. Jennie Johnstone

# Achieve ZERO never events – Pressure Injury



Indicator	Unit Measure or Patient Population	Data Source	Baseline	Target for 26/27	Target Justification
				3 Year Stretch Target	
Average days in-between Pressure Injury <b>HBH</b> Stage 3 and 4 (Never Event criteria)	ALL HBH	SAFER Reports	<b>FY 25/26 YTD Nov:</b> 3 events or 97.3 days	107 days between events	
				<b>10% improvement year over year</b>	
Average days in-between Pressure Injury <b>MSH</b> Stage 3 and 4 (Never Event criteria)	ALL MSH	SAFER Reports	<b>FY 25/26 YTD Nov:</b> 2 events or 149.7 days	165 days between events (10% improvement)	
				<b>10% improvement year over year or Theoretical best 365 days</b>	

#	Change Idea	Methods	Process Measure	Target	Comments
1	Targeted Pressure Injury Prevention strategies	<b>MSH</b> - Implement an early PI detection scanner protocol for target populations in the ICU and audit (CAPITAL)	% Patients with usage of scanner / eligible patients	>85%	Audit care initiated within 24 hours of early identification
2		<b>HBH</b> - Complex Neurological care Unit (9th floor): Monitoring adherence / reinforcement of use of positioning, offloading and therapeutic surfaces best practices	% Patients with adherence to bundle / eligible patients	75%	
3	Early stage pressure injury identification and escalation	<b>MSH</b> - Develop and disseminate an early-stage pressure injury algorithm, including related products	% Patients with initiation of care/eligible patients	>85%	Audit care initiated within 24 hours of early identification
4		<b>Foundational</b> 📊 <b>HBH</b> - Develop a data visualization and/or report for 9 <sup>th</sup> floor Hospital Acquired Pressure Injuries (HAPI)	Project Milestone	100%	
5	Effective treatment of stage 2 pressure injuries and prevention of progression	<b>Foundational</b> 📊 <b>MSH</b> – Develop a standardized wound care product formulary for pressure injury prevention and management	Project Milestone	100%	

# Reduce Self Harm Events

PFAC / Organizational Priority



Indicator	Unit Measure or Patient Population	Data Source	Baseline	Target for 25/26	Target Justification
				3 Year Stretch Target	
# Self-harm events in “at risk” patients	9S (Mental Health) ED (Emergency Department)	SAFER Events  (using defined criteria)	FY 25/26 YTD Nov: ED – Zero 9S - Zero	Theoretical Best “ZERO”	FY 23/24 and 24/25  ED – 3 event 9S – 1 event
				<b>Theoretical Best “ZERO”</b>	

#	Change Idea	Methods	Process Measure	Target	Comments
1	Appropriate screening and identification of suicide risk	Improve staff compliance with completing the standardized suicide screening risk assessment tool on inpatient psychiatry (9S), the Emergency Department for those patients who are identified as high risk by the Psychiatry Consult Liaison team in all inpatient areas at MSH	C-SSRS completion rate	9S Inpatient 90% CL Inpatient 75% ED – increase to 90% completion by end of Q4	Any NEW admission screening completed by Consult Liaison (CL) Psychiatry Physicians
2	Appropriate interventions to prevent harm in-hospital	Expand and audit use of the suicide intervention bundle (therapeutic harm reduction) and documentation tool in ED for ALL patients who are identified as high risk for self harm (Collecting Baseline)	% of identified high risk patients with bundle completed	By Year End 75%	Checklist includes bundle of safety interventions
3		Implement the policy for effective patient searches (SH) and develop eLearning to be rolled out in ED/9S as mandatory	% Training Completed	ED and 9S Completion 80% by Year End	To be integrated with annual eLearning modules
4		Update hospital-wide Patient Observation Policy informed by external benchmarking which includes clear direction on nursing accountabilities and handover for UHCP	% high risk patients with completed RN-UCP handover tool (if assigned)	95% by Year End	

## Eliminate Preventable Healthcare Associated Infections (HAIs) – CLABSI



Indicator	Unit Measure or Patient Population	Data Source	Baseline	Target for 26/27	Target Justification
				3 Year Stretch Target	
Rate of Central Line Associated Blood Stream Infections (CLABSI) in NICU	<ul style="list-style-type: none"> <li>Rate of CLABSI per 1,000 line days in the NICU</li> </ul>	Hospital Collection Data	FY 25/26 YTD Nov is 6.2	Maintain FY 25/26 target of 5.8  Achieve Canadian Neonatal Network top 75%	

#	Change Idea	Methods	Process Measure	Target	Comments
1	Purposeful Central Line Audits	Develop and implement a standard work process for PICC Nurses and Nursing Clinical Coaches to conduct routine audits and support point of care feedback and track/audit	% Compliance with standard work process	75%	Audits to be reviewed quarterly
2	Consistent Skin and Line Care	Implement Hypochlorous Acid (PureCleanse™) as part of the Diaper Dermatitis Policy	Product Compliance Audit % patients / eligible patients	>80%	30 day audit
3		Formalize a CLABSI prevention bundle with inclusion of SecurePortIV and 3M Curoc Disinfecting Caps	Bundle Compliance Audit % patients / eligible patients	>80%	
4	Improving Hand Hygiene Compliance	Expand the staff hand hygiene improvement program	% compliance with HH Moment 1a/1b & Moment 4	95%	Quarterly aggregate

# Eliminate Preventable Healthcare Associated Infections (HAIs) – CAUTI



Indicator	Unit Measure or Patient Population	Data Source	Baseline	Target for 26/27	Target Justification
				3 Year Stretch Target	
Days in-between Catheter associated Urinary Tract Infection (CAUTI)	GIM and ICU	Hospital Collection Data	<b>FY 25/26 YTD Nov:</b> <b>GIM</b> average is 18.8 days in-between (FY 25/26 target was 17.9) <b>ICU</b> average is 48.3 days in-between (FY 25/26 target was 32.8)	10% improvement in GIM and ICU days in-between <b>GIM</b> target is 21 days <b>ICU</b> target is 53 days  <b>10% improvement year over year (average days in-between)</b>	

#	Change Idea	Methods	Process Measure	Target	Comments
1	Prompt Discontinuation of Catheters	Sustain physician indwelling catheter reminders in rounds in GIM	Completion rate in GIM rounds (audit)	80%	
2	Best Practices for Catheter Maintenance & Care	Implement and monitor bi-monthly catheter care and maintenance practice audits in GIM and ICU	% Compliance of Key Practices	80% Compliance	
3	Restrictive Catheter Insertion	<b>Foundational</b> 📊 Conduct a review/root cause analysis of catheter insertion practices in the ED to identify potential opportunities for improvement	Project Milestone	100%	

## Eliminate Preventable Healthcare Associated Infections (HAIs) – VRE



Indicator	Unit Measure or Patient Population	Data Source	Baseline for Target Setting	Target for 26/27	Target Justification
				2 Year Stretch Target	
Vancomycin-Resistant Enterococcus (VRE) <i>nosocomial</i> colonization rate	Inpatient units at MSH and HBH	IPAC Surveillance Data	<b>HBH:</b> FY 24/25 rolling 4Q rate 0.056 per 1,000 patient days  <b>MSH:</b> FY 24/25 rolling 4Q rate 0.340 per 1,000 patient days	<b>HBH:</b> 0.05 per 1,000 patient days (10% decrease)  <b>MSH:</b> 0.30 per 1,000 patient days (10% decrease)	Internal Target for comparison
				<b>25% decrease from FY 24/25 in the 4Q rolling rate</b>	

#	Change Idea	Methods	Process Measure	Target	Comments
1	<b>HBH</b> Improve Human Waste Management Practices and Reduce Bioburden in Patient Care Environment	Optimize human waste management workflows in accordance with PIDAC Best Practices	Count of inpatient units who have adopted enhanced workflows / Total count of inpatient units (15)	>75%	
2		Implement quarterly cleans of high touch surfaces in all inpatient units to reduce bioburden of environmental organisms	Count of completed cleans / Count of scheduled cleans	>90%	
3					
4	<b>MSH</b> Enhance Clinical Practice to Reduce Horizontal Transmission Events	Assess pericare carts in inpatient units to identify deviations from best practices in IPAC (e.g. overstocking of supplies, expired inventory, shared personal items, water sources, etc.)	Number of carts adherence to best practice	100% compliance	
5		Expand scope of quarterly enhanced cleans to include decluttering of hallways and POC carts.	% project milestone	100%	
6		Expand Hand Hygiene Star Program to all GIM (General Internal Medicine) inpatient units (10N/S and 12N/S)	Number of Unit	4/4	

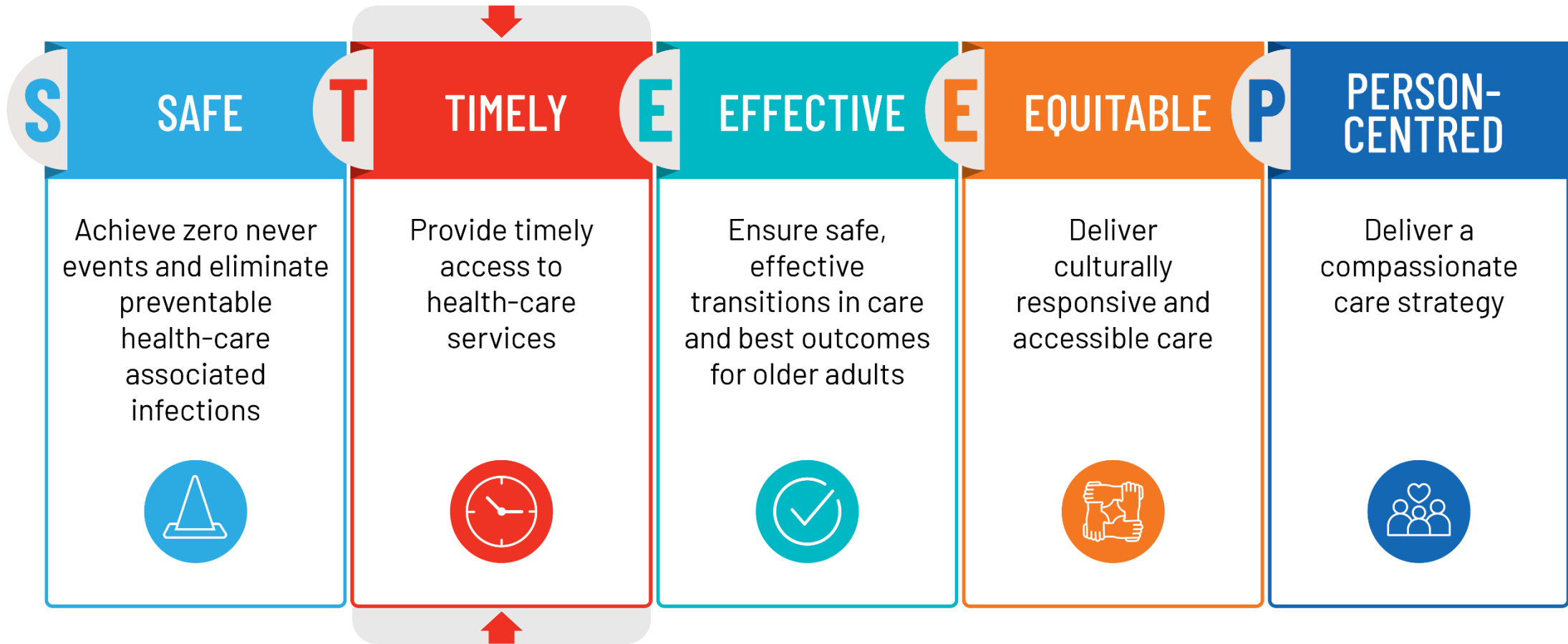
## Eliminate Preventable Healthcare Associated Infections (HAIs) – NEW Antimicrobial Use



Indicator	Unit Measure or Patient Population	Data Source	Baseline for Target Setting	Target for 26/27	Target Justification
				2 Year Stretch Target	
Percent of appropriate post-op antimicrobial use within 24hrs of surgery	MSH Adult Inpatients (Sub-set of Orthopedic Surgery)	ASP Antimicrobial Use Reports/Audits	FY 25/26 YTD Nov - 30% of prophylaxis discontinued within 24h of surgery	10% relative improvement (33% of prophylaxis discontinued within 24h of surgery)	Internal target, comparison to benchmark
				<b>10% year over year improvement</b>	

#	Change Idea	Methods	Process Measure	Target	Comments
1	Discontinuation of antimicrobials by 24hrs post-procedure	Expand audits of post-operative antimicrobial prophylaxis prescribing practices to additional orthopedic procedures	% of target procedures assessed	25%	Via NAPS
2		Feedback through individual clinical interaction and dashboard reporting	% of procedures with feedback to surgery	25%	Dashboard and feedback reports
3		<b>Foundational</b> 📊 Build a dedicated post-operative antimicrobial order set for post-operative prophylaxis	% Milestone (completion of the order set)	100%	
4		<b>Foundational</b> 📊 Creation of unified guidance process for post-operative prophylaxis duration	% Milestone (completion of guidance process)	100%	

# Quality Aims 2025-2028 : TIMELY



# Aim Statement

Ensure timely access to care in acute, complex continuing and rehabilitative care by reducing waits and harmful delays in care



## #1 Sub Aim Statement:

**Achieve Top Performance (90th percentile – P4R Rank, OH Regional) amongst academic organization focused on:**

- Ambulance off-load time (Ontario Health Priority)
- ED Time to inpatient bed (Ontario Health Priority)
- ALC rate and throughput

### VP Leads

Kate Wilkinson and Sandra Dietrich  
Kara Ronald (ALC)

### Medical Leads

Dr. Qassim Tejpar (ED)  
Dr. Jordan Pelc (HBH ALC)  
TBD (MSH ALC)

## #2 Sub Aim Statement:

**Achieve incremental year over year improvement in surgical capacity and efficiency to achieve wait time target by:**

- Increasing surgical volumes
- Increasing Cancer surgical volumes
- Improving % wait list priority targets for all surgeries (Long waiters)

### VP Leads

Kate Wilkinson and Sandra Dietrich

### Medical Lead

Dr. Ian Witterick

# Achieve Top Performance – ED Ambulance Offload Time

Organizational Priority



Indicator	Unit Measure or Patient Population	Data Source	Baseline	Target for 26/27	Target Justification
				3 Year Stretch Target	
Ambulance off-load time	EMS ED Patients	OH ED P4R Ranking Report	FY 25/26 YTD Nov: 61 min	Maintain FY 25/26 target of 44 min  <b>Meet or exceed P4R 30 min</b>	Provincial target is 30 min

#	Change Idea	Methods	Process Measure	Target	Comments
1	Tracking and monitoring of ED extended LOS	<b>Foundational</b> Implement a new FirstNet tracking shell for patients awaiting ambulance offload, with colour-coded alerts for extended stays	Milestone	100%	
2	Restricted ED throughput to support timely offload	Review and optimize the ED patient-to-care-location assignment model which includes evaluating and refining the ED offload escalation tool	% of EMS patients who transfer directly to a room instead of an offload stretcher	Relative Improvement of 10% once baseline collected	Collecting Baseline
3		Develop and implement a Standard Operating Procedure (SOP) for standardizing the implementation of additional ED offload locations and audit process	% of EMS patients who use alternate offload locations when available	Relative Improvement of 10% once baseline collected	Report to be built Collecting Baseline

**Achieve Top Performance – ED Time to Inpatient Bed** **Organizational Priority**



Indicator	Unit Measure or Patient Population	Data Source	Baseline	Target for 26/27	Target Justification
				3 Year Stretch Target	
ED Time to Inpatient Bed (90 <sup>th</sup> Percentile)	ED Decision to admit to time left unit (hours)	Hospital Data	FY 25/26 YTD Nov: 34.6 hours (Target is 27 hours)	Maintain FY 25/26 Target of 27 hours <b>10% improvement year over year</b>	

#	Change Idea	Methods	Process Measure	Target	Comments
1	Standardize Bed Assignment Process	<b>Foundational</b> 📄 Re-establish an SOP for IP transfer times	Project Milestone	100%	Inclusive of a process for escalation in delay of transfer, tracking and sharing bed assignment-to-transfer times and Cerner discharge delays data
2		Determine inclusion criteria and introduce routine mixed-gender cohorting as a standard practice	% of admissions placed into mixed-gender rooms	Collecting Baseline	
3		Audit the after-hours bed assignment with ED LOS prioritization	Staffed bed not filled overnight	Less than 10%	
4	Root Cause Analysis	Complete the multidisciplinary Root Cause Analysis (RCA) and identify key system-level barriers to timely admission	Project Milestone	Implement 2/2 prioritized flow interventions	

## Alternate Level of Care (ALC)

## Organizational Priority

T

TIMELY



Indicator	Unit Measure or Patient Population	Data Source	Baseline	Target for 26/27	Target Justification
				3 Year Stretch Target	
Alternate Level of Care (ALC) Rate (ALC days / Bed days)	All ALC patients at MSH and HBH	Hospital data	<b>Rate:</b> FY 25/26 Nov YTD: 15.2  <b>ALC – LTC:</b> Mean performance of FY 24-26 YTD Nov = 58%	<b>Rate:</b> Maintain 15% target  <b>ALC – LTC:</b> Maintain mean performance of FY 24-26 YTD Nov = 58%	Surpassed FY 25/26 target of 68.6  Dependent on LTC availability
% patients designated ALC – Long Term Care (open cases)				<b>Rate:</b> Maintain 15% <b>ALC – LTC:</b> 10% improvement year over year	

#	Change Idea	Methods	Process Measure	Target	Comments
1	Appropriate and timely identification of patients at risk of becoming ALC and who are ALC	<b>HBH</b> - Expand Clinical Frailty Score (CFS) screening tool and interventions and expand across applicable units/patient populations	# of units/populations expanded to	5/5	2N, 2S, 8N, 8S, and 9S
2		<b>MSH</b> – Develop standardized CFS interventions in response to CFS scores (TPRAS – Transition Planning Risk Assessment Tool). Audit for patients who score 5-7 (at risk for functional decline) and see what discharge options are explored and/or accessed	% of CFS interventions in use / eligible patients	10% Relative improvement once established	
3	Implement Sinai Health to Home (SHtoH) across SH to full maturity	Implement Sinai Health Hospital to Home (SHtoH) Program within the Emergency Department and continue to expand access for eligible inpatients.	# of patients in program	ED: 50 by YE once established  Overall Program: 300 patients by YE	
4 16	External partnerships to support patient transitions	Explore new or expanded external partnerships with organizations that support individuals with cognitive impairments and/or a mental health conditions	Partner with 1 external organization	1/1	

# Achieve Surgical Volumes and Surgical Bed Capacity

Organizational Priority



Indicator	Unit Measure or Patient Population	Data Source	Baseline	Target for 26/27	Target Justification
				3 Year Stretch Target	
Surgical Hours	All surgeries (Cancer and non-cancer)	Hospital measure  Perioperative Clinical Information System (PCIS)	FY 25/26 YTD Nov:  <b>Surgical Hours:</b> 17,550  <b>Surgical Volumes:</b> 5874 count (monitoring)  <b>Cancer Surgery Volume:</b> 1538 count (monitoring)	<b>Surgical Hours:</b> Maintain FY 25/26 target of 25,785	Both a capacity and efficiency metric to optimize surgical access. Surgical time is determined by demand, surgical specialty, case complexity and long waiters
Surgical Volumes (Elective)				<b>Surgical Volumes:</b> Maintain 25/26 volumes (monitoring)	
Cancer Surgical Volumes				<b>Volumes; year over year improvement</b>	

#	Change Idea	Methods	Process Measure	Target	Comments
1	Increase OR Efficiency through optimization patient workflow processes	Implement parallel turnaround time process strategies related to roles and responsibilities	% improvement in Turn Around Time (TAT)	10% improvement to 33 min	FY 25/26 Q2 TAT is 36 min
2		Collect information and data for first case start time utilizing OH SETP target (within 5 minutes) <b>and perform RCA</b> to identify areas for improvement and target a minimum of <b>ONE</b> improvement strategy	% of first cases started by 0805	10% improvement to 75%	Baseline YTD Nov is 68%

# Surgical Long Waiters

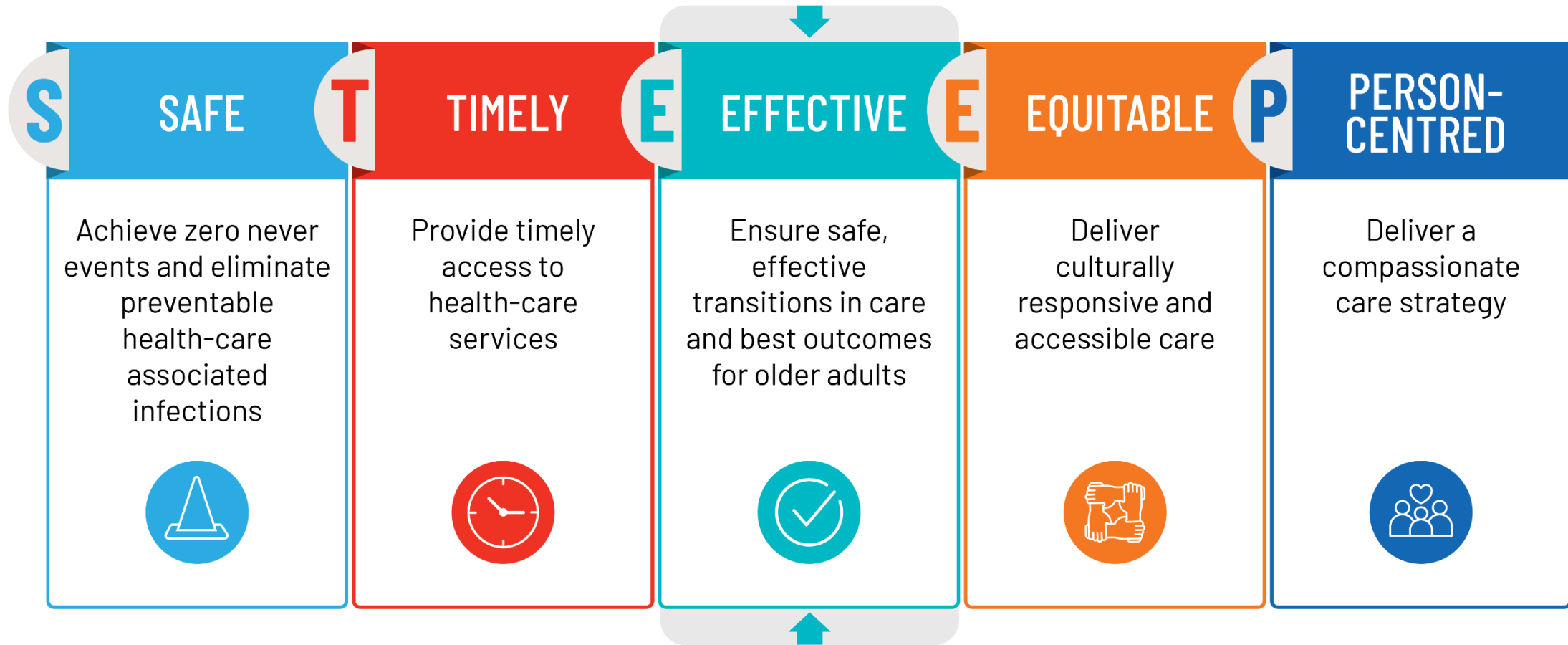
## Organizational Priority



Indicator	Unit Measure or Patient Population	Data Source	Baseline	Target for 26/27	Target Justification
				3 Year Stretch Target	
% Wait list over priority targets for all surgeries (long waiters)	% of open cases who exceed recommended wait times	Hospital measure NOVARI WTIS	FY 25/26 YTD Nov: <b>All Surgeries:</b> 24.2% <b>Oncology:</b> 16.9% <b>Non-Oncology:</b> 24.9%	<b>All Surgeries:</b> 22% (10% improvement)	Oncology open Long Waiter target set by CCO is $\leq 10\%$  All surgeries OH target 20%
				<b>Year over year improvement 10%</b>  <b>To achieve &lt;20% for all surgeries at end of 3 years</b>	

#	Change Idea	Methods	Process Measure	Target	Comments
1	Optimize OR Capacity to maintain % wait list priority targets for all surgeries (long waiters)	Adherence to protocols for identification and scheduling <b>all elective surgical cases</b> within their priority wait time targets	% cases completed within priority wait time target	80% for P3/P4 cases	Dependent on accuracy data entry into NOVARI  Baseline approx. 65%
2		Continue to dedicate additional OR time focused solely on long waiters	% OR blocks dedicated to LW that are utilized by LW cases	LW rooms 75% utilization of LW surgeries	

# Quality Aims 2025-2028 : EFFECTIVE



# Aim Statement

Ensure safe and effective transitions in care



## #1 Sub Aim Statement:

Ensure safe and effective **transitions in care** by reliably delivering targeted HQO Transition Between Hospital and Home standards including optimizing a Mental Health and Addictions care pathway.

## #2 Sub Aim Statement:

Achieve the highest quality of life and health outcomes for older adults by meeting their fundamental care needs and optimizing transitions in care by focusing on the 4M's in alignment with IHI Age Friendly Health Systems and other leading practices.

VP Lead	Medical Leads
Kara Ronald	Dr. Christine Soong – Transitions in Care
	Dr. Nathan Stall – Best Outcomes for Older Adults
Kate Wilkinson	Dr. Robert Maunder - Mental Health and Addictions Pathway

## Transitions in Care: Mental Health and Addictions Pathway – Access



Indicator	Unit Measure or Patient Population	Data Source	Baseline	Target for 26/27	Target Justification
				3 Year Stretch Target	
Visits (access) to emergency psychiatric care and addictions services  • <b># of ED to CAMH Avoidable Transfers</b> (when appropriate 9S bed available)  • <b>HBH/ACS Volumes # visits</b> (including eConsults)	All patients across SH (MSH and HBH)	Hospital Data collection	2025 Jan – October: <b># of ED to CAMH Avoidable Transfers = 113</b>  FY25/26 YTD Nov: <b>HBH ACS Baseline = 130</b>	<b>ED transfer to CAMH: 56</b> (50% reduction)  <b>HBH ACS: 195</b> (50% increase)  <b>25% year over year improvement to theoretical best of zero</b>	Excluding PICU level patients (MSH does not have PICU beds)  Emergency Department Return Visit Audit

#	Change Idea	Methods	Process Measure	Target	Comments
1	Optimize on-site psychiatric emergency services (PES)	<b>Foundational</b> 📊 Operationalize weekend Mental Health Nurse Practitioner at MSH to support Mental Health workflow	% project milestone	100%	Emergency Department Return Visit Audit
2		<b>Foundational</b> 📊 Complete evaluation of the psychiatric emergency medical model of care and make recommendations for improved coverage and access	% project milestone	100%	Emergency Department Return Visit Audit
3		Implement proactive PES behavioral and safety interventions for high-risk ED patients	patients who received high risk interventions / eligible patients	50% by year end	Baseline is zero (collecting baseline). Need to establish new process
4		<b>Foundational</b> 📊 Operationalize new low barrier post-discharge addictions clinic for ED referrals (STAMP Clinic: Sinai Transition Addiction Medicine Program)	% project milestone	100%	Emergency Department Return Visit Audit
5	Optimize & Expand Addictions Services to Meet Patient Needs	Launch new Meditech referral process for Addictions Services at HBH	Initial assessment within 7 days of referral	80%	

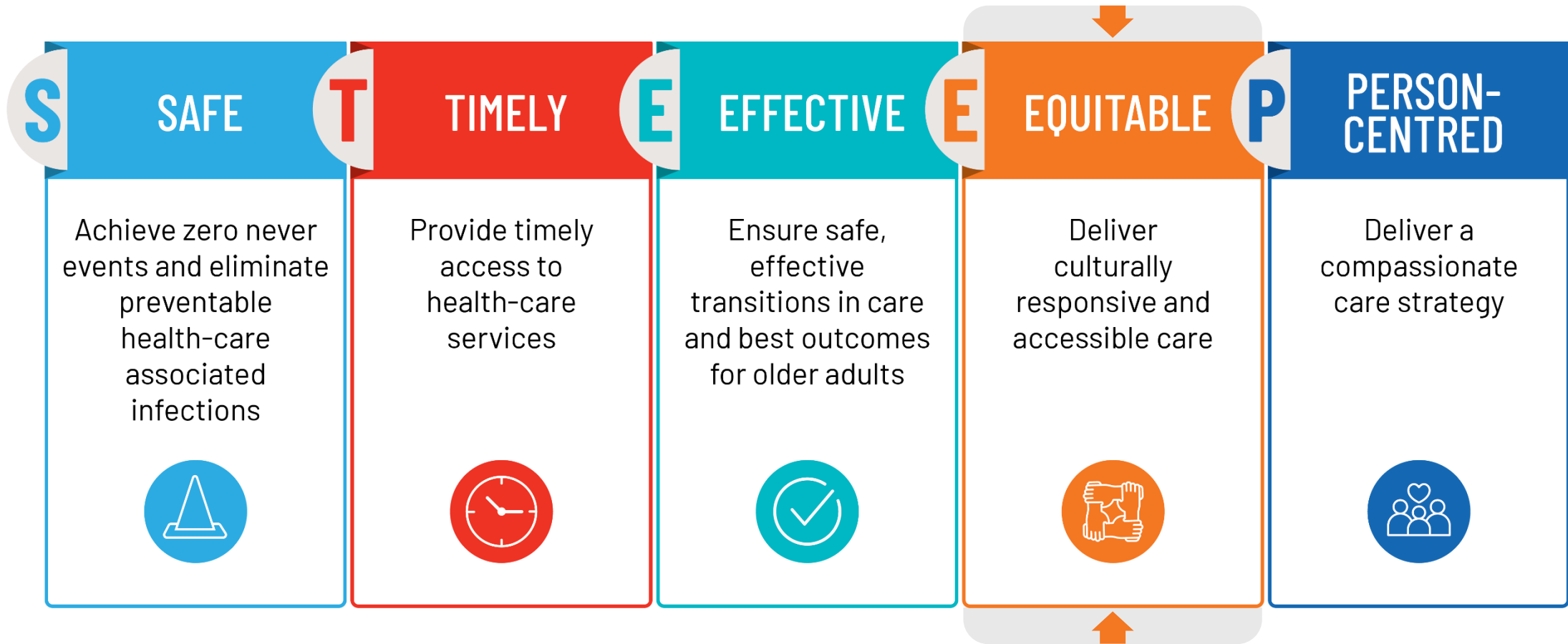
## Transitions in Care: Age-Friendly : Appropriate Prescribing of Medication



Indicator	Unit Measure or Patient Population	Data Source	Baseline	Target for 26/27	Target Justification
				3 Year Stretch Target	
Number of prescriptions (count) of Potentially Inappropriate Medications (PIMS) (targeted list) initiated during hospital admission	Adults over 65 across SH	Hospital Data (from EPR)	zero	Collecting Baseline in first 2 quarters	Collecting Baseline. Best Possible Medication History needs to be excluded.
				10% decrease of baseline	

#	Change Idea	Methods	Process Measure	Target	Comments
1	Acquire baseline data	<b>Foundational</b> 📊 Pull MSH and HBH data, to inform which medications are being used in excess, and would be an appropriate target for deprescribing initiatives	% milestone	100%	
2	Clinician tools	Develop clinician practice guidance for 1) pharmacist/physician (drug +/- symptom focus) and 2) nurses (symptom focused – alternatives to prescriptions) for 2 high priority PIMS identified	Practice guidance	2/2	Developed based on PIMS baseline collection
3	Structured intervention on rounds	Deprescribing on rounds with Pharmacy (develop process and audit); aim to embed process into new EPR	Data to be collected	% 20 improvement of baseline by Q4	
4	Develop Report	<b>Foundational</b> 📊 Explore audit and feedback report opportunities identifying high priority PIMS for ordering clinicians	% milestone	100%	
5	Review of Order Sets	<b>Foundational</b> 📊 Structured review of standardized order sets to remove high priority PIMS	% milestone	100%	

# Quality Aims 2025-2028 : **EQUITABLE**



# Aim Statement

Deliver Culturally Responsive and Accessible Care



## #1 Sub Aim Statement:

Advance the maturity of Sinai Health’s Equity program to ensure culturally responsive and accessible patient care

## #2 Sub Aim Statement:

Reduce disparities in **access** to care, **patient experience** and **clinical outcomes** for equity deserving populations in targeted program areas.

VP Lead	Medical Lead
Nely Amaral (Michael Palomo)	Lesley Wiesenfeld

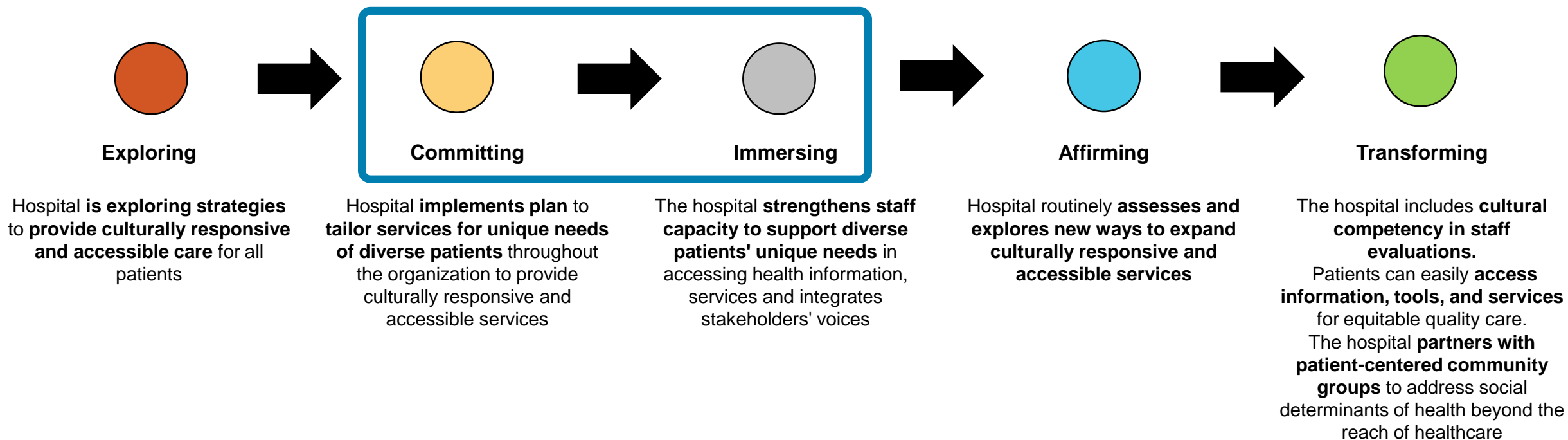


Indicator	Unit Measure or Patient Population	Data Source	Baseline	Target for 26/27	Target Justification
				3 Year Stretch Target	
Progression on organizational Maturity Scale from Exploring to Transforming	Across SH	Hospital Measurement using AHA Health Equity Road Map (see next slide for details)	Exploring	Committing	
				Affirming/Transforming	

#	Change Idea	Methods	Process Measure	Target	Comments
1	Universally Accessible & Inclusive Care	Implement the prioritized accessibility enhancements identified by the RFH at HBH to achieve GOLD certification by 2027–2028.	% Project Milestone	100%	<ul style="list-style-type: none"> <li>Tactile stairwell flooring</li> <li>Accessibility hearing assistive devices to be installed in key public areas (e.g., Ground Floor Security Desk, Information Desk on Main and Nursing Stations TBD)</li> <li>Request for RHF reassessment of HBH in 2027/28 for HBH with target of GOLD</li> </ul>
2		Complete the Rick Hansen Foundation (RHF) assessment for the Mount Sinai Hospital buildings (600 University)	% Project Milestone	100%	<ul style="list-style-type: none"> <li>This will inform development of accessibility enhancement roadmap</li> </ul>
3		Expand implementation of the revised accessibility training (eLearning)	% Competency Achievement % module issued	>90% (all managers and above) ONE TIME ONLY 100% (Issued to New Hires)	<ul style="list-style-type: none"> <li><b>Providing Access for People with Disabilities Policy</b></li> <li>2 year goal of 90% for <b>all</b> nursing and Health Disciplines</li> <li>Legislative requirement</li> </ul>
4		<b>HBH:</b> Strengthen wayfinding systems to ensure clear, accessible navigation to the auditorium for patients and community members	% Project Milestone	100%	<ul style="list-style-type: none"> <li>PFAC Priority</li> </ul>

# Health Equity Organizational Maturity Continuum

DELIVER CULTURALLY RESPONSIVE and ACCESSIBLE CARE





Indicator	Unit Measure or Patient Population	Data Source	Baseline	Target for 26/27	Target Justification
				3 Year Stretch Target	
Progression on organizational Maturity Scale from Exploring to Transforming	Across SH	Hospital Measurement using AHA Health Equity Road Map (see next slide for details)	Exploring	Committing	
				Affirming/Transforming	

#	Change Idea	Methods	Process Measure	Target	Comments
1	Cultural Safety and Humility	Ontario Health Indigenous Relationships and Cultural Awareness Courses (4 modules in a phased rollout). <b>Modules 1 and 2</b> to be completed by NEW clinical operations and support function Mangers.	% Competency Achievement	>70%	
2		Ontario Health Indigenous Relationships and Cultural Awareness Courses. <b>Modules 3 and 4</b> to be completed by CURRENT clinical operations and support function Mangers who have completed modules 1 & 2.	% Competency Achievement	>70%	
3		Mandate Anti-Black Racism Training (Developed by WCH) for Advanced Clinical Group (Nursing) and all MSH Health Disciplines and RCC and ALL New hired staff	% Competency Achievement	>70%	
4		<i>NEW!</i> Providing Inclusive Care: Understanding Gender, Sexual Diversity and Affirming Practices eLearning. Launch new training for nursing staff in Emergency Department and Mount Sinai Fertility	% Competency Achievement	>70%	
5 27	Community Partnership	<b>Foundational</b> 🏢 In partnership with Toronto Academic Health Science Network (TAHSN) establish a standardized regional anti-Semitism training and develop a sustained training plan across SH	% Milestone	100%	Sinai Health



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Inpatient Experience Compassionate Care Survey  (Linguistic Accessibility)	<b>MSH:</b> Surgical In-Patient Program (11N/S, 14N/S)  <b>HBH:</b> Complex Continuing Care In-Patient (6 N/S, 7 N/S, 9 N/S)	<b>Compassionate Care:</b> Share information in a way that is understandable	FY 25/26 YTD Nov:  <b>MSH:</b> 51% <b>HBH:</b> 50 %  Top Box (Always)	5 % increase	
				<b>MSH:</b> 54 % <b>HBH:</b> 53 %	
				<b>Top performer on Compassionate Care survey</b>	

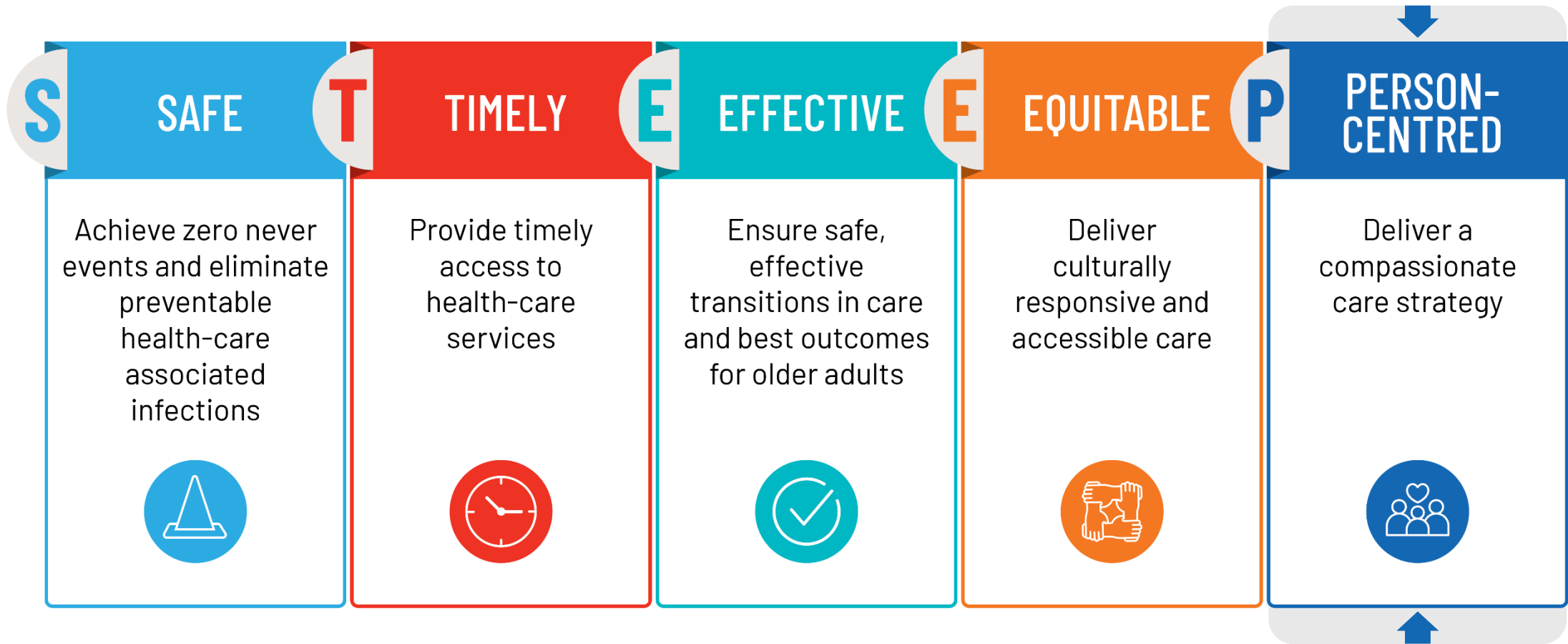
#	Change Idea	Methods	Process Measure	Target	Comments
1	Linguistically Accessible	Implement Phase Two of Spread of On-Demand Interpreter Services based on High Priority Area at <b>MSH:</b> <ul style="list-style-type: none"> <li>• <b>11 North and 11 South Surgical Unit</b></li> <li>• <b>14 North and 14 South Surgical Unit</b> <ul style="list-style-type: none"> <li>▪ Post-Anesthesia Care Unit / PAU</li> <li>▪ 600 University 4<sup>th</sup> floor Outpatient clinics</li> <li>▪ 600 University 5<sup>th</sup> Medical imaging</li> <li>▪ 600 University 6<sup>th</sup> floor Outpatient Oncology</li> </ul> </li> </ul>	Interpreter Services Utilization Rate	10% increase across SH	Units selected based on current interpreter usage (in person or line)
2		Implement Phase Two of Spread of On-Demand Interpreter Services based on High Priority Area at <b>HBH:</b> <ul style="list-style-type: none"> <li>• Complex Continuing Care (<b>6th Floor, 7th Floor, 9th Floor</b>) <ul style="list-style-type: none"> <li>▪ Rehabilitation (Ambulatory Care)</li> </ul> </li> </ul>	Interpreter Services Utilization Rate	<ul style="list-style-type: none"> <li>• 10% increase across SH</li> </ul>	Units selected based on current interpreter usage (in person or line)



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Progression on organizational Maturity Scale from Exploring to Transforming	Across SH	Hospital Measurement using AHA Health Equity Road Map (see next slide for details)	Exploring	Committing	
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#	Change Idea	Methods	Process Measure	Target	Comments
1	Advance Infrastructure to support Health Equity	Each program to identify an equity-focused quality improvement equity-focused initiative addressing either access to care, patient experience, or outcomes; informed by evidence, Ontario Health equity priorities, and available internal performance and demographic data.	# of programs that have identified and scoped a health equity-focused quality improvement initiative	7/7  GIM, Surgery, Mental Health, Women's and Infants Health, Rehab, Complex Care, and Pharmacy	<p><b>Examples:</b></p> <ul style="list-style-type: none"> <li>• Translate commonly used patient facing materials in top spoken languages</li> <li>• Use Demographic Data dashboard to identify QI priorities</li> <li>• Enhancement physical environment to support diverse physical/sensory needs</li> </ul>

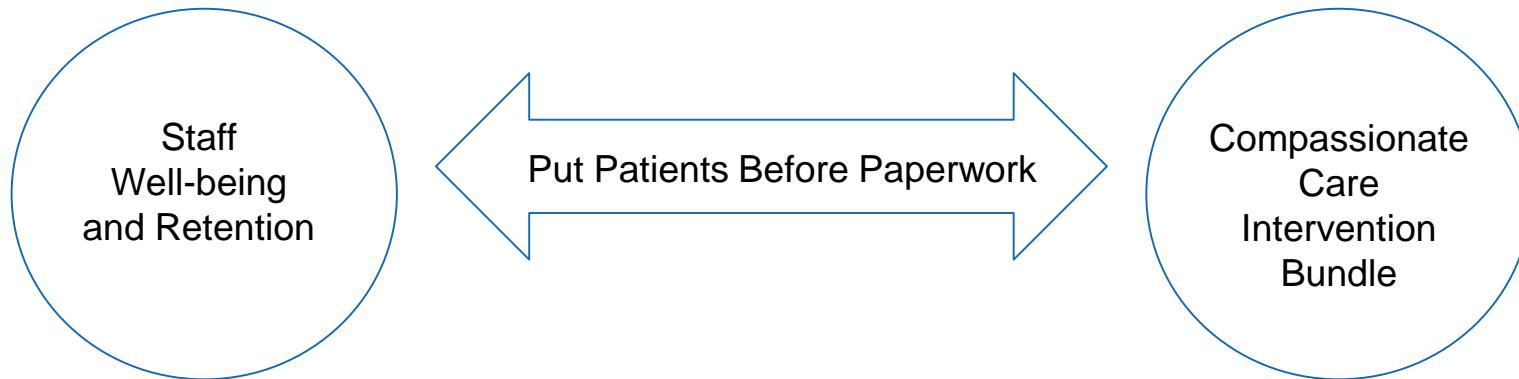
# Quality Aims 2025-2028 : PERSON CENTERED



**Aim Statement** Deliver a Compassionate Care strategy by implementing an evidence-based compassionate care intervention bundle, supporting staff well-being and prioritizing patient needs over paperwork



VP Leads	Sub-Aim	Medical Lead
Nely Amaral and Lianne Jeffs	Compassionate Care Intervention Bundle	Lesley Wiesenfeld
Barb Griffin Ian McDermott	Staff Well-being and Retention	TBD (Physician wellness)
Lily Yang	Put Patients Before Paperwork	Dr. Yenge Diambomba



# Compassionate Care Strategy – Compassionate Care Strategy

BOARD PRIORITY



Indicator	Unit Measure or Patient Population	Data Source	Baseline	Target for 25/26	Target Justification
				3 Year Stretch Target	
Compassionate Care (Patient)	<b>HBH: 9S</b> Neuro/Medical Complex Care -Year I <b>4S</b> Acquired Brain Injury - Year II  <b>MSH: 14N</b> General Surgery - Year I <b>12N</b> General Internal Medicine – Year II <b>9S</b> Psychiatry – Year II <b>WIH Antenatal</b> – Year II	Compassionate Care Survey (Patient)  <b>Question #1:</b> “Involve you in decisions about your treatment”  <b>Question #2:</b> “Treat you as a person not just as a patient or caregiver”	FY 25/26 YTD Nov Compassionate Care Survey Strongly Agree (Top Box)  <b>HBH 9S:</b> 44% Question #2 <b>4S:</b> 68% Question #1  <b>MSH 14N:</b> 63% Question #2 <b>12S:</b> 39% Question #1 * <b>9S Psych:</b> 67 % Question #1 <b>Antenatal:</b> 65% Question #1	5 % improvement  <b>HBH 9S:</b> 46 % <b>4S:</b> 71 %  <b>MSH 14N:</b> 66 % <b>12S:</b> 41 % <b>9S Psych:</b> 70 % <b>Antenatal:</b> 68 %  Top Performer Compassionate Care Survey	* <b>9S</b> data based on “all time” survey results (December 1, 2024 to November 30, 2025)

#	Change Idea	Methods	Process Measure	Target	Comments
1	Compassionate care Intervention bundle	Launch PHASE TWO of the Compassionate Care (CC) Intervention Bundle on pilot units: <b>MSH:</b> WIH Antenatal Unit, 12S General Medicine and 9S Psychiatry <b>HBH:</b> 4S Acquired Brain Injury	4/4	100%	
2		<b>Foundational</b> Compassionate Care Intervention Bundle funding proposal (includes Project Manager)	% Project Milestone	100%	
3		Select and operationalize Clinical and Physician Leads for implementation and ongoing sustainability	Selection of Leads	2/2	
4		Partner with Homewood Health to pilot “staff wellness” and physiological support sessions	4 Staff Wellness Sessions	4/4	
5	Engagement Survey	Complete <b>staff</b> facing Compassionate Care Survey	Completion Number	> 897	Number of surveys FY 24/25 780 (15% Improvement)



Indicator	Unit Measure or Patient Population	Data Source	Baseline	Target for 26/27	Target Justification
				3 Year Stretch Target	
Time in-between Serious Workplace Violence incidents resulting in harm	All staff and physicians across SH	SAFER	25/26 YTD Nov: 88.3 days between events (3 events)	15% improvement Time in-between events is 102 days	Did not meet target FY25/26 of 280 days in-between events
				Year over year improvement Theoretical best to zero	

#	Change Idea	Methods	Process Measure	Target	Comments
1	Enhanced Management of High Risk Behaviors	<b>HBH</b> – Implement and achieve consistent use of the VAT tool hospital-wide <b>MSH</b> – Implement and achieve consistent use of the VAT tool across WIH inpatient units	% Compliance of VAT Completion	60%	
2		<b>Foundational</b> 📊 Develop and implement a standardized process for unit leaders and certified trainers to reinforce and sustain the skills learned in Safe Management Group (SMG) training (high risk areas at SH)	% Milestone	100%	Example: Mock Codes, Tips of the month (Lead by Org. Development and Education)
3		Implement a standardized training plan to ensure all newly hired staff on high-risk units (ED and 9S at MSH) receive SMG training within 3–6 months of hire	% of Newly Hired Staff Who Receive Training	100%	Aligned with MOL requirement
4		Implement the aggression visual indicator across Sinai Health, integrating it into documentation, workflows, and staff education	# of programs	6/6	MOL requirement
5	Support for Staff involved in incidence of violence	<b>Foundational</b> 📊 Conduct a comprehensive options analysis of multiple technological solutions (E.g., RTLS system) at MSH to support elopement prevention and staff duress management (also RFID tracking of equipment)	% Milestone	100%	

## 26/27 Compassionate Care Strategy – Well Being: Voluntary Departure < 2years




Indicator	Unit Measure or Patient Population	Data Source	Baseline	Target for 26/27	Target Justification
				3 Year Stretch Target	
% Nursing turnover (voluntary) within two years of hire	Nursing at MSH and HBH	SH Human Resources Data	25/26 YTD Nov Nursing: 16.3%	Nursing: 14.8% (10% improvement)	
				Year over year improvement Theoretical best to zero	

#	Change Idea	Methods	Process Measure	Target	Comments
1	Exit Survey/Interview	<b>Foundational</b> 🏗️ Develop and implement a standard management report to support the dissemination of unit level data on Nursing Turnover in first 2 years of hire	% Milestone	100%	
2	REDI (Reconciliation, Equity, Diversity and Inclusion)	<b>Foundational</b> 🏗️ Develop People Equity Report to share REDI accomplishments at Sinai Health with our people	% Milestone	100%	
3		<b>Foundational</b> 🏗️ Develop and launch SH People Equity Strategy (using Vital Voices survey data)	% Milestone	100%	
4	Wellness and Retention	Implement 1 high-priority/high impact recommendation based on Vital Voices survey results	Impact recommendation	1/1	
5		<b>Foundational</b> 🏗️ Implement SH Wellness and Retention Strategy	% Milestone	100%	



Indicator	Unit Measure or Patient Population	Data Source	Baseline	Target for 25/26	Target Justification
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Board Resource and Planning Project Approved Milestones	% Milestone Completion	Minutes Board Resource and Planning	NA	90% milestones	Project based initiative
EPR Renewal Priority Indicators <ul style="list-style-type: none"> <li>HIMSS Level/Digital Maturity</li> <li>Patient Experience - Patient Portal</li> <li>Clinician Burnout (mini-Z)</li> <li>Priority Workflow Assessment</li> <li>Adoption of Evidence Based Practices</li> </ul>		EPR Renewal Evaluation	Available for Q2 2025/26	Collecting Baseline Targets to be Set with Benefits Realization framework	HIS Renewal is anticipated to be completed in FY 2027/28

#	Change Idea	Methods	Target	Comments
1	Begin implementation of New EPR	Foundational  EPR Renewal Preparation	90% Milestone Completion	