2022/23 Quality Improvement Plan (QIP)

Quality Aims	Goals	Measure												
			YE 2020/21		Current Performance YTD Q3 2021/22		2022/23 Target							
		Outcome Indicator	MSH	BH	MSH	BH	MSH	MSH Target Rationale	BH	BH Target Rationale	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for 2022/23
Safe	Make care safer by eliminating preventable healthcare associated infections (HAI)	Rate of nosocomial C.Difficile Infection (CDI) per 1,000 patient days Number of nosocomial CDI Cases	0.25 N=23	--	0.20 N=14	--	<0.20	Below Provincial Average	Maintain Indicator to be monitored through Infection Prevention & Control Committee		Enable environmental services cleaning audit feedback (MSH)	Operationalize the quality control program that includes regular audits of cleaning and feedback of results to front line staff and other stakeholders with education and training	% of adherence to standardized cleaning procedures	>80% adherence (inpatient and outpatient clinical areas)
											Antimicrobial Stewardship (SH)	Conduct 1 hospital wide audit of antimicrobial prescribing appropriateness using the NAPS (National Antimicrobial Prescribing Survey) tool and share audit results with prescribers	% Antimicrobial prescribing appropriateness	10% improvement from 66% (last audit)
		Rate of Catheter associated Urinary Tract Infection (CAUTI) per 1,000 catheter days in Surgery Number of CAUTIs	2.5 N=11	--	2.05 N=7	--	1.8	10% Improvement	--		Urinary Tract Infection Campaign	Implement the consensus-based decision tool to guide appropriate indications for catheter use and standardize processes of care in each surgical POD (Gyne, ENT, Ortho, Gen Surg)	% of adherence to decision tool # of surgical PODs spread	90% adherence 4/4
		Rate of Central Line Associated Blood Stream Infections (CLABSI) per 1,000 line days in the ICU Number of CLABSIs in ICU	2.97 N=32	--	2.13 N=21	--	1.9	10% Improvement	--		Evidence-based CLABSI prevention bundle	Implementation of evidence-based CLABSI prevention bundle, process monitoring by direct observation and feedback to the team	% of adherence to standard process	100% adherence
		Rate of Central Line Associated Blood Stream Infections (CLABSI) per 1,000 line days in the NICU Number of CLABSIs in NICU	7.3 N=29	--	5 N=14	--	<=5	Maintain Best Achieved	--		Adopt new practices to reduce skin bacterial burden in neonates	Implement new bathing practices and products to reduce skin bacterial burden for CLABSI prevention	% of adherence to bathing protocol	100% adherence
		Number of COVID-19 outbreaks	5	1	0	1	0 Theoretical Best				Prevent nosocomial spread of COVID-19 in inpatients	Adhere to PIDAC best practices for prevention of COVID-19	Adherence to provincial guidance and best practices	100%
											Adhere to provincial or local guidelines, directives, standards and best practices in the prevention of COVID-19 and outbreak management	Surveillance and awareness of new standards/guidelines/directives/best practices. Adoption and evaluation of effectiveness. Examples include: ECP (visitor) guidance, vaccination, masking, physical space.	Adherence to provincial guidance and best practices	100%

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	Advance our system focus on throughput to ensure timely access to care in acute, complex continuing and rehabilitative care	**Pandemic Response**												
		Time to Inpatient Bed from Emergency Department (90th Percentile)	18.1 hours	--	11.5 hours	--	10.4 hours	10% Improvement	--	--	Redesigning the system to enhance hospital **flow**	Emergency Department	Current P4R Rank = 7	Top 10
												Collaborate with Ontario Health and external partners to support the ED working group to develop and action on short-term and long-term solutions for ambulance offload time (AOT)	90 percentile ambulance offload time	30mins
												Fully operationalize new ED spaces (Phase 3A) to optimize AOT and patient flow in the ED	Project milestone	100%
												Explore and optimize the Bed Information System and Porter solution to support patient flow	Project milestone	100%
												Explore partnership opportunities with non-emergency patient transport services to facilitate discharge	Project milestone	100%
												ALC	Current Throughput MSH=0.97; HBH=1.08	>=1
												Expand and optimize utilization of the conditional discharge order with physician engagement	% Physicians engaged	80%
												Enhance collaboration and strategic partnerships to improve the effectiveness and timeliness of complex patient transitions to the community	% Project milestone	100%
												Re-education of key stakeholders using Ontario Health's ALC Reference Manual to ensure consistent use of ALC definition and designation	% of key stakeholders educated	>80%
												Maintain and maximize expanded capacity for ICU, medical and surgical beds	# of new ICU, medical and surgical beds maintained	ICU - 7 (5 level 3, 2 level 2); medicine - 12; surgery - 13
												Fully operationalize new ICU space (Phase 3A)	% Project milestone	100%
		Pandemic Recovery												
		Pre-pandemic Surgical Volume	2018/19 Volume 7,304 2020/21 Volume 4,756	--	3,367	--	7,854	--	2018/19 Pre-pandemic volume + 15% for last 6 months	--	Recover hospital **capacity** to prepandemic clinical volume activity and address backlog of cases	Operating Rooms (ORs) Fully operationalize new ORs to address backlog for surgical patients through workforce stabilization, infrastructure, and assurance of surgical instrument availability. Support sustainability and maintenance of new processes and continuous improvement of core peri-operative processes through the Perioperative Business Unit	# of Operating rooms in operation	14/14 by Sept 2022 16/16 by March 2023
		Cancer Care Recovery	2018/19 Volume 2,155 2020/21 Volume 1,586	--	1,119	--	2,322	--	2018/19 Pre-pandemic volume + 15% for last 6 months	--	Return to cancer surgery volumes to pre-pandemic levels	Fully operationalize new ORs to address backlog for surgical patients through workforce stabilization, infrastructure, and assurance of surgical instrument availability. Support sustainability and maintenance of new processes and continuous improvement of core peri-operative processes through the Perioperative Business Unit	# of Operating rooms in operation	14/14 by Sept 2022 16/16 by March 2023
			CB	--	CB	--	90% PICC < 10 days PORT < 20 days	CCO Target	--	--	Increase access to PICC and PORT insertions for systemic therapy initiation	(i) Escalation process in Diagnostic Imaging (ii) Operationalize second angiography suite	% milestone	100%
			8,487 Volume	--	6869 Volume	--	9087 Volume	Prepandemic + 600	--	--	Address cancer screening backlog for breast imaging	Implement "blitz shifts" to support additional capacity on the weekends to increase appointment availability	# weekends (1 day) with expanded capacity	20
			CB	--	CB	--	>85% within CCO wait target	CCO Target	--	--	Address cancer screening backlog for colonoscopy	Maintain additional capacity and implement MSH Family Health Team follow up call process	% of patients requiring follow up reached	>85%

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	Be a top performer among academic hospitals in delivering care outcomes by reliably embedding core care standards based in evidence to meet fundamental patient care needs.	Escalation of Care: Number of serious incidents involving escalation of care (3, 4, 5)	8		5		0 Theoretical Best				Foundational Activities	Establish governance structure and finalize policy. Implement TeamStepps - 1 team per program.	# of teams with TeamStepps implementation	4/4
											New high acuity WIH inpatient unit	Develop a funding proposal and implementation strategy for a high acuity WIH inpatient unit to address escalation of care	% Project milestone	100%
											Secondary alarms	Expansion and full implementation of the vital sign strategy (Masimo technology) across the organization including GIM and Post-partum inpatient units and fully integrate the secondary alert functionality	% of patients who meet the high risk criteria receiving the technology (surgical area)	>85%
											Remote video monitoring	Expand remote monitoring program to increase monitoring capacity by implementing a third monitoring station Expand clinical criteria for remote monitoring and spread to the Emergency and Psychiatry Departments	% reduction in reported falls and other safety incidents deemed appropriate for remote monitoring	30%
		Medication: Number of medication incidents (3,4,5)	1		2		0 Theoretical Best				Automation/Closed Loop Mediation Systems	Implement ADCs in ED, Peri-op and ICU Implement workstation on wheels on 6 medical and surgical units Reduce frequency of overrides	# of areas with ADC implementation # of units with workstation on wheels implementation % reduction in overrides	3/3 6/6 20%
											Medication Reconciliation	Optimize BPMH and medication reconciliation process in ICU, ED, Medicine, Palliative Care, and Cancer Care areas; Determine and begin implementation of appropriate Cerner software for med rec	% BPMH and med rec completed % Project milestone	>80% 100%
		Pressure Injuries: Rate of Hospital Acquired Pressure Injuries > stage 2	8.2% (ICU)	11%	22.2% (ICU)	6.9%	17.8% ICU	20% Improvement	6.2%	10% Improvement	Targeted Pressure Injury Prevention Strategies	Optimize and monitor ICU bed devices and accessories to enable appropriate use of therapeutic surfaces (turn assist and microclimate management). Implement criteria for using the Turn-Assist function (MSH) Optimize and monitor the use of the COVID-19 Prone protocol (MSH) Review roles and responsibilities for PT, OT, and Dietitian related to PI prevention and management (MSH) Pilot and evaluate an innovative scanning device to assess and identify increased risk of pressure injury development (MSH) Develop and implement a medical directive to initiate wound care therapies (MSH) Create and implement a physician order set for PI prevention Enhance base therapeutic mattresses for 6N/S	% of patients receiving pressure injuries education materials % of COVID-19 patients put on the prone protocol % Project Milestone Reduction in pressure injury incidence % wound care therapies initiated for the appropriate patients % of physician order set initiated for the appropriate patients % Project Milestone	>90% 100% 100% 30% >80% >80% 100%

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People Centred	Eliminate serious employee and physician harm in the workplace	Number of Serious Incidents of Workplace Violence (moderate to severe) in the Emergency Department	CB		12		0 Theoretical Best				Complete External Reviews and Implement Priority Recommendations	Complete external review recommendations of (1) psychiatric emergency services and (2) ED safety and security and implement priority recommendations from both reviews	% Project milestone	100%
												Operationalize ED mental health assessment rooms	% appropriate patients triaged into the mental health assessment rooms	>90%
											Implement solutions that enable security response	Implement and fully operationalize the duress system in the ED and on the psychiatry inpatient unit.	% Project milestone	100% milestone
												Implement an organizational wide violence assessment tool and enact a behavioural/safety flag in the patient's health record for staff awareness and care planning	% Project milestone	100% milestone
	Be a top performer in engaging and informing patients and their families in the design and delivery of care	Information Sharing (CPES - Top Box) Rehab/CCC		50.9%		46.1%			50.9%	Best Achieved	MyChart	Spread MyChart in rehab/ccc. Co-design a patient and caregiver facing summary progress report to be included in MyChart; leverage MyChart to directly address domains of information sharing areas within CPES e.g. info re: admission process, care planning, medications	% of admitted patients enrolled	>80%
												Build new functionality including OLIS integration and expand the availability of clinical reports	% Project milestone	100%
			Note: New Patient Experience Survey Methodology Roll Out. Results may not be available in Q1 & 2. Process measures will be reported during these quarters.								Caregiver Resource Centre (HBH)	Operationalize caregiver resource centre - Ensure the physical environment is a welcoming space - Co-design with patients and family caregivers programming to access support, education and opportunities for practical skill building to increase resilience and wellness	% milestone	100%
													%Caregiver satisfaction with resource centre	>80%
		Engaged (CPES - Top Box) Urgent Critical Care (10N, 10S, 12S) Results	56.1%		58.2%		61.9%	5% Improvement (IP Academic Hosp Avg)			Organizational partnership through program level patient and family advisory councils (PFACs)	Create 5 program level PFACs: - UCC - Inflammatory Bowel Disease (IBD) PFAC - Dementia Caregivers Family Advisory - Surgery & Oncology - Oncology PFAC - CCC - CCC & Palliative Care PFAC	# of PFACs launched	5/5
			Note: New Patient Experience Survey Methodology Roll Out. Results may not be available in Q1 & 2. Process measures will be reported during these quarters.								Ensure Accreditation standards are met where patient and family engagement are required ("with input from or in partnership with") in year 3 survey areas	Review standards and implement co-designed changes as needed to ensure standards requiring engagement are met fully	% of standards within each standard set met	>=95%