2023/24 Quality Improvement Plan (QIP)

Quality Aims	Goals	Measure	YE 2021/22		Current Performance YTD Q3 2022/23		2023/24 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 2023/24
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	0.23 N=11	--	0.18 N=14	--	<0.20	Better than Provincial Average	Maintain Indicator to be monitored through Infection Prevention & Control Committee		CDI Cleaning Protocol Enhancement (MSH)	Implement the use of sporicidal wipes for clinical users to enhance the CDI cleaning protocol for CDI patients on 2 medicine units	Number of units implemented	2/2
											Hand Hygiene compliance monitoring tool (SH)	Complete RFP and planning for phased implementation approach for a new hand hygiene compliance monitoring tool	% Project Milestone	100%
											Antimicrobial Stewardship (SH)	Refresh the strategy and work plan for Sinai Health's Antimicrobial Stewardship Program Enhance surgical prophylaxis by optimizing agent choice and re-dosing practices according to best practice in surgery (BPS) guidelines Conduct quarterly audits and provide feedback to the surgical divisions (General, Orthopedic, ENT, Gynecology)	% Project Milestone % adherence to BPS guidelines Audits and feedback provided per quarter	100% >90% 3/3
		Rate of Catheter associated Urinary Tract Infection (CAUTI) per 1,000 catheter days in Surgery Number of CAUTIs	1.9 N=9	--	3.0 N=12	--	1.9	Best Achieved	--		Point prevalence study of in-dwelling catheters	Participate in the "Zero-In" point prevalence program for in-dwelling catheters. Engage with Unit Council and Champions to develop a quarterly point prevalence process to assess catheter use and provide feedback to unit staff	# of point prevalence studies completed	4/4
		Rate of Central Line Associated Blood Stream Infections (CLABSI) per 1,000 line days in the ICU Number of CLABSIs in ICU	2.36 N=11	--	0.28 N=1	--	0.28	Best Achieved	--		Evidence-based CLABSI prevention bundle	Ongoing implementation and reinforcement of evidence-based CLABSI prevention bundle, process monitoring by direct observation and feedback to the team as ICU team transitions into the new ICU space	% 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	5.8 N=22	--	6.8 N=19	--	5.8	Best Achieved	--		Evidence-based CLABSI prevention bundle in neonates	Ongoing reinforcement of evidence-based CLABSI prevention bundle, audit and feedback through safety huddles Implementation of new bundle practices as determined by the EPIC Nosocomial Infections Taskforce (Feb 2023)	% of adherence to prevention bundle best practices	100% adherence
		Number of Transmissions Beyond 1 Incubation Period	NA		NA		0 Transmissions				Prevent nosocomial spread of respiratory viruses in inpatients	Adhere to PIDAC best practices for prevention of respiratory viruses	Adherence to provincial guidance and best practices	100%
											Adhere to provincial or local guidelines, directives, standards and best practices in the prevention of respiratory 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.	% of outbreaks controlled within 1 incubation period	>90%

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Timely	Advance our system focus on throughput to ensure timely access to care in acute, complex continuing and rehabilitative care	**Pandemic Response**												
		Emergency Department Pay for Performance Rank		--	Ranked 1st among Academic Teaching Hospital	--	Top 3 Ranked Academic Teaching Hospital		--	--	Redesigning the system to enhance hospital **flow**	Emergency Department	Time to Inpatient Bed (37.4Hrs)	Top 3 among academic hospitals
												Fully operationalize new ED East spaces (Phase 3A) and interim/final state processes to enhance patient flow in the ED	% Project Milestone	100%
												Fully operationalize the new diagnostic ultrasound suite	% Project Milestone	100%
												Plan and commence implementation on defined priority action items associated with Psychiatric Emergency Services	% Project Milestone	100%
												Complete a comprehensive ED analytics report to support ED program planning	% Project Milestone	100%
												Optimize the Bed Information System to support patient flow	% Project Milestone	100%
												ALC	Current Throughput MSH=0.96; HBH=0.94	>=1
												Optimize processes to support sustainability of the More Bed, Better Care Act, with implementation of the inpatient discharge policy	% Project Milestone	100%
												Explore enhanced partnership opportunities with Circle of Care for transition planning	% Project Milestone	100%
												Maintain and maximize expanded capacity for ICU, medical and surgical beds	# of ICU, medical and surgical beds maintained	ICU: 21 --> 24 beds Medicine: 84 --> 92 beds Surgery: 100 --> 116 beds
													# of COVID funded Med/Surg beds maintained	53 beds
												Fully operationalize new ICU space (Phase 3A)	% Project milestone	100%
		Pandemic Recovery												
		Pre-pandemic Surgical Volume & Cancer Care Recovery	Surgical Volume 2018/19 7,960 2021/22 5,242	--	4,875	--	8,500	2018/19 Pre-pandemic volume + 25% Improvement (last 2 quarters)	--	--	Recover hospital **capacity** to prepandemic clinical volume activity and address backlog of cases	Operating Rooms (ORs) Fully operationalize ORs to address backlog for surgical patients through continued workforce stabilization. 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
			Cancer Surgical Volume 2018/19 2,227 2021/22 1,873	--	1,464	--	2,450	2018/19 Pre-pandemic volume + 10% Improvement	--	--		Enroll Sinai Health Nurses in the Peri-operative Nursing Program	# of nursing cohorts trained	3 cohorts annually
												Implementation of a new waitlist management and surgery scheduling system to address surgical backlog, identify prioritized patients through a health equity approach, and support a regional view of the demand for surgical services	% Project Milestone	100%
												Operationalize the new pathology lab space to meet provincial pathology turn around time	% Project Milestone	100%

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Timely	Advance our system focus on throughput to ensure timely access to care in acute, complex continuing and rehabilitative care	Post Partum Length of Stay	39.6 hours	--	39.2 hours	--	35.3 hours	10% Improvement	--	--	Staff Education	Implement mandatory (2 day) breastfeeding training for WIH staff	# of WIH staff trained Exclusive chest feeding /breastfeeding rate at time of discharge	140 per year for next 3 years (418 staff total) 66% --> 75% (10% Improvement)
									--	--	Evidence-Based Best Practice Guideline	Implement the SOGC guidelines on the prevention and management of postpartum hemorrhage	% staff trained Rate of post partum hemorrhage	>80% <3-6%
		MRI Wait Times for P3 Cases	P3 = 120 days	--	P3=148 days	--	P3 = 118 days	20% Improvement	--	--	Divert Research MRI for patient care	Operationalize the Research MRI for patient care to address MRI backlog and reduce wait times for P3/4 cases	# of shifts/hours for blitz shifts worked per week	3/5 weekday blitz shifts worked per week / 18 hours per week
Effective	*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)	5		2		0 Theoretical Best				Real Time Physician Communication (MSH)	Pilot secure texting technology in 1 clinical area	% Project Milestone	100%
											Optimization of On-Call Physician Communication (HBH)	Pilot the Physician Messaging technology to enhance communication between the clinical teams and on-call physicians	% Project Milestone	100%
											Alarm Management	Complete the vital sign (Masimo technology) implementation across the organization fully integrate the secondary alert functionality. Finalize the standard work processes and policy	% Project Milestone	100%
											Remote video monitoring	Complete the expansion of the 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)	2		0		0 Theoretical Best				Automation/Closed Loop Medication Systems	Implement ADCs in ED, ICU, and Endoscopy Planning and implementation of the pharmacy inventory system	# of areas with ADC implementation % Project Milestone	3/3 100%
											Medication Reconciliation	Optimize BPMH and medication reconciliation process in ICU, ED, Medicine, Palliative Care, Surgery, Cancer Care, Rehab, CCC, and Ambulatory Care (HBH)	% BPMH and med rec completed	>80%
		Low-Value Lab Tests per 1,000 Patient Days	289	--	269	--	215	20% Improvement	--	--	Reduce low-value laboratory testing (Choosing Labs Wisely)	Revamp/revise order sets, specifically targeting AST, urea and aPTT in instances where they are not adding clinical value. Enroll Sinai Health in CPSO QI Partnership for Hospitals Program using this laboratory utilization initiative and disseminate to SH physicians Develop feedback mechanism for ordering practices for inpatient physicians	# of order sets to be updated % of inpatient wards/clinical areas formally participating in CPSO QI partnership program # of physicians formally participating in CPSO QI partnership program % of participating MDs receiving a performance report (individual or aggregate) % of participating physicians completing the CPSO QI requirements	74 100% 100% (200/200) 100% 100%

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Effective	*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.*	Pressure Injuries: Rate of Hospital Acquired Pressure Injuries > stage 2	18.2% (ICU)	7.5%	9.4% (ICU)	7.8%	8.5%	10% Improvement	6.8%	10% Improvement	Targeted Pressure Injury Prevention Strategies	Review roles and responsibilities for PT, OT, and Dietitian related to PI prevention and management (MSH/HBH) Pilot and evaluate an innovative scanning device to assess and identify increased risk of pressure injury development (MSH) Implement moisture management strategies as part of the PI plan of care including: reduction of layers between the patient's skin and therapeutic surface in beds and chairs (HBH)	% Project Milestone Reduction in pressure injury incidence % of high risk HAPI patients with appropriate moisture management strategies in care plan	>90% 100% >90%
People Centred	Eliminate serious employee and physician harm in the workplace	Number of Workplace Violence Serious Incidents	NA		14		0 Theoretical Best				Workplace Safety Strategies	Deliver on priority work streams as set out in the Workplace Safety Steering Committee work plan.	% Project milestone	100%
	Be a top performer in engaging and informing patients and their families in the design and delivery of care	Number of patient/family advisors involved in the Patient/Family Partnership Program	47		63		100 60% Improvement				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%
											Patient Experience Surveys (SH)	Fully implement and improve the enterprise patient experience survey strategy - Implement Qualtrics and optimize processes for all Sinai Health priority populations, aligned with Accreditation and Magnet designation requirements - Co-design and launch a survey focused on patient reported measure of compassion - Create dashboards for regular reviews of patient experience data	% milestone	100%
											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 - Palliative Care PFAC	# of PFACs launched	5/5
											Ensure Accreditation standards are met where patient and family engagement are required ("with input from or in partnership with") in year 3 & 4 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%
	Health Equity	Reduce Health Disparities in Surgical Patient Reported Outcomes (1) Wait Time to Surgery (2) PROMs (pre and post surgery) - Oxford Hip / Knee Scores - ED-5D-5L Score	NA	--	NA	--	Collecting Baseline (CB) 0 Disparity in Wait Times and PROMs				Equitable management of surgical backlog to optimize access to surgical care	Identify and prioritize patient populations through a systematic health equity approach for surgical care access	% Project Milestone	100%
											Demographic data collection	Implement the OH Measuring Health Equity in Toronto Region Work Plan to support demographic data collection and use	% of patients with demographic data collected	>80%
											Enhance access to interpreter services	Implement on-demand interpreter services technology to improve health equity and access to care. Pilot in the emergency department and Palliative Care	% of patients with limited English proficiency offered access to the real time interpreters	>80%