Let's Make Healthy Change Happen.

2021-2022 Quality Improvement Plan (QIP) for St. Joseph's Health Care London

03/23/2021

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a Quality Improvement Plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein.

Overview

We are pleased to introduce St. Joseph's Health Care London's (St. Joseph's) 2021-22 Quality Improvement Plan (QIP), with a focus on effective transitions, patient and staff safety and building patient partnerships. The 2020-21 fiscal year brought unprecedented challenges and the impact was felt across the organization. Our strength in collaboration and adapting quickly to rapid changes supported critical initiatives to keep patients, residents, staff and physicians safe, while also prioritizing return to service as soon as possible and finding solutions to provide care in innovative ways. St. Joseph's was able to reach 2020-21 QIP targets in key areas:

- Effective initiatives to enhance transitions in care included greater efficiency in discharge summaries being sent from hospital to health care providers responsible for post-discharge care
- For the safety of mental health care patients, completion of the Columbia Suicide Severity Rating Scale Lifetime Assessments within three days of inpatient admission has been achieved.
- A medication safety goal for time-specific completion of a team debrief reached our target of 100 percent
- In long-term care, an effective care goal was reached to ensure documented assessment of palliative care needs among residents who may benefit from palliative care.
- The reporting of workplace violence events met target in 2020 (January through December)

In addition to the targets for specific QIP indicators in our 2020-21 QIP, two key strategic initiatives impacting patient care in 2020-21 were:

- Achievement of milestones for implementation of an electronic health record (OneChart)
- Rapid adoption and expansion of virtual care appointments

Both of these initiatives include significant collaboration among multiple organizations. OneChart is a regional project to advance how care is provided across 11 regional hospitals with set milestones and collaborative work to develop standardized documentation. Expansion of virtual care is based on an integrated project with London Health Sciences Centre.

St. Joseph's strategic plan includes a key principle to purposefully partner with patients, residents and family caregivers. Over the past year, pandemic-related restrictions impacted our QIP target related to recruitment and on-boarding of patient partners. This initiative has now been re-started and will be a priority in 2021-22. Despite the challenges and restrictions in 2020-21, we were able to complete our annual surveys for residents at Mount Hope Centre for Long Term Care, as well as residents of the Veterans Care Program at Parkwood Institute. This was accomplished by changing the survey process from in-person to virtual. Family surveys were also completed. Feedback from patients, residents and families in patient populations across St. Joseph's continues to be a critical process for identifying where we are doing well, as well as opportunities for quality improvement. Both the hospital and long-term care workplans continue to include targets for specific survey questions in 2021-22.

Describe your organization's greatest QI achievement from the past year:

- The Zero Suicide steering committee set an ambitious target to reach 75 per cent completion of the Columbia-Suicide Severity Rating Scale (C-SSRS) Lifetime/Recent for mental health inpatients within three days of admission. We have collectively worked very hard to learn and improve over the last several quarters, to achieve this target. Work is ongoing to support targeted and timely follow-up with staff, and provide opportunities for coaching by program champions. The target will increase in 2021-22.

- Timely completion of discharge summaries supports effective care transitions. There was significant improvement from 24% to 55% of discharge summaries completed within 48 hours, and the target will increase to 65% in 2021-22. A reduction in transcription time, as well as development of reports to enable each service to monitor their own performance, benchmark to peers, and review individual patient cases has supported improvement. A key success factor for these efforts was review of outliers and operational/ process deviations requiring standardization.

- A defined process including Professional Practice support and sharing resources to help with the debrief has been well received and has helped achievement of 100% completion of medication safety event debriefs within 10 business days. In 2021-22 our goal to sustain 100% completion will include further hard-wiring of processes in clinical areas without a prompt from Professional Practice. Leader documentation of debrief completion in the Patient Safety Reporting System has also supported improvement and provides a process for capturing lessons learned from the debrief.

- Goals for workplace violence reporting, including near-miss reporting, align with our strategic targets related to staff safety. Following successful achievement of increased reporting, in 2020-21 further analysis of near-miss data, trends, and post-event processes such as debriefs and daily huddles will support development of specific goals.

- Our target for completion of comprehensive palliative care needs assessments at Mount Hope Centre for Long Term Care was achieved, while managing priorities to ensure resident and staff safety

In addition to QIP goals, our greatest achievements include initiatives to ensure patient, resident and staff safety during the pandemic, as well as the safe re-opening of services, including Perioperative Services (operating rooms and Cataract Suite) with return to 100 percent pre-pandemic levels. St. Joseph's also achieved goals for two key initiatives involving significant collaboration to support patient safety and quality care.

Collaboration and Integration

OneChart Electronic Health Record

St. Joseph's has continued extensive collaboration with London Health Sciences Centre (LHSC) and regional partners to standardize allied health / health discipline and nursing electronic documentation forms. While the pandemic pulled on resources, committed staff continued to prepare, which would contribute to remarkably smooth implementation. Staff redeveloped education and training plans to train in a safe way that would still support clinicians in adopting this transformative change to their work.

On January 26, 2021, health discipline staff with the B6 inpatient unit at St. Joseph's Hospital moved forward with electronic clinical documentation. This was a significant milestone given the complexities, scope, changes to clinical workflow and the number of health disciplines involved in this clinical and digital transformation, which includes physiotherapists, social workers, spiritual care practitioners, registered dietitians and occupational therapists.

These allied health clinicians were the first group of health disciplines to move forward with electronic clinical documentation at St. Joseph's.

On March 2, 2021, the inpatient and the ambulatory care programs at Parkwood Institute Mental Health Care Building went live with nursing and health discipline electronic documentation. One inpatient unit was slightly delayed due to COVID-19 but followed soon after, on March 8.
This go live marks an exciting and significant milestone in our electronic clinical transformation journey. To date, there are very few mental health hospitals in Canada using Cerner's Behavioural Health Module to the full extent. This speaks to the dedication and commitment of the project team and leadership to deploy technology that will better support our clinicians and patients. Highly engaged mental health care staff contributed to the immediate uptake of the new system and early feedback from the implementation team and end users is validating that optimization of the electronic patient record will enhance quality care.

On March 23, 2021, physicians will move forward with electronic documentation in both the inpatient units and ambulatory care programs at Parkwood Institute Mental Health Care.

Currently, St. Joseph's and LHSC are two of the most advanced Cerner sites in Canada using electronic clinical documentation for health disciplines.

Virtual Care Adoption

The COVID-19 pandemic was a catalyst for rapid uptake and utilization of virtual care globally and at St. Joseph's Health Care London. Since mid-March 2020, St. Joseph's has supported a range of 3,000 to 5,000 virtual care appointments (telephone and videoconference) per week compared to approximately 1000 virtual care appointments per week pre-pandemic. This rapid adoption has surfaced a number of challenges and opportunities related to virtual care adoption including the need for support and consideration to: patient and family experience, workflow, policy and procedure, clinical practice, education and training, technology and devices, among many other things. Lessons learned through the pandemic have resulted in St. Joseph's and London Health Sciences Centre prioritizing virtual care as an integrated project portfolio.

In September 2020, St. Joseph's endorsed $1.6 million dollars to provide support to clinical teams in the ongoing adoption of virtual care and contribute to the ongoing formalization of the virtual care strategy for St. Joseph's. A goal to reach 50 per cent virtual care overall volume for ambulatory services has been established for St. Joseph's.

Work completed to date has resulted in numerous virtual care assets for St. Joseph's including:

- A citywide medical lead for virtual care has been appointed, which will help establish a "virtual-first" future for St. Joseph's and London Health Sciences Centre.
- A city-wide Virtual Care Patient and Family Experience survey enables continuous quality improvements to the virtual care program
- Webex has been established as a corporately approved video platform for patient video visits
- Education and training are available for providers on the use of the technology
- Clinical areas are equipped with necessary technology to perform virtual care appointments
- A Patient and Family Support Line provides technology troubleshooting for virtual care appointments
- Alignment has been created across the organization related to privacy, risk, patient experience, and professional practice (i.e. consent)

- The role of change management and adoption specialist has been created to support the implementation of virtual care technology, processes and workflows across St. Joseph's.
- Standardization of virtual care registration and scheduling practices has been developed
- A new public webpage provides questions and answers for patients about virtual care and what to expect. For physicians and staff, a new intranet page provides information on how to prepare, schedule and run virtual care appointments with patients.

The fourth quarter of 2020/21 prioritized balancing rapid implementation of virtual care with project planning and prioritization for fiscal 2021/22. Active involvement of more than 20 patient and family members as well as staff and physicians are supporting the co-design of the virtual care strategy and service enhancement at all levels.

The next stage of work will be to finalize a city-wide virtual care strategy, identify priority areas to enhance and standardize the delivery of virtual care, and to define organizational requirements to sustain and operationalize ongoing delivery of virtual care across the St. Joseph's. This work will prioritize continuous quality improvements through regular evaluation cycles and validate virtual care as value-based health care. Read how programs have adopted virtual care in innovative and highly effective ways on St. Joseph's website. This rapid adoption of virtual care, which has been critical in ensuring the continuation of patient care despite restrictions due to the pandemic, has garnered significant positive feedback from appreciative patients.

"It was a great feeling to be supported and have check-ins about my care. During a time of isolation, I was not isolated from my physiotherapy. I just can't say enough good things. I feel very grateful." (Patient)

"*I would like to see virtual care continued big time. It's very important for people of my age. They stumbled upon something extremely good and efficient. I see nothing but positives."* (Patient)

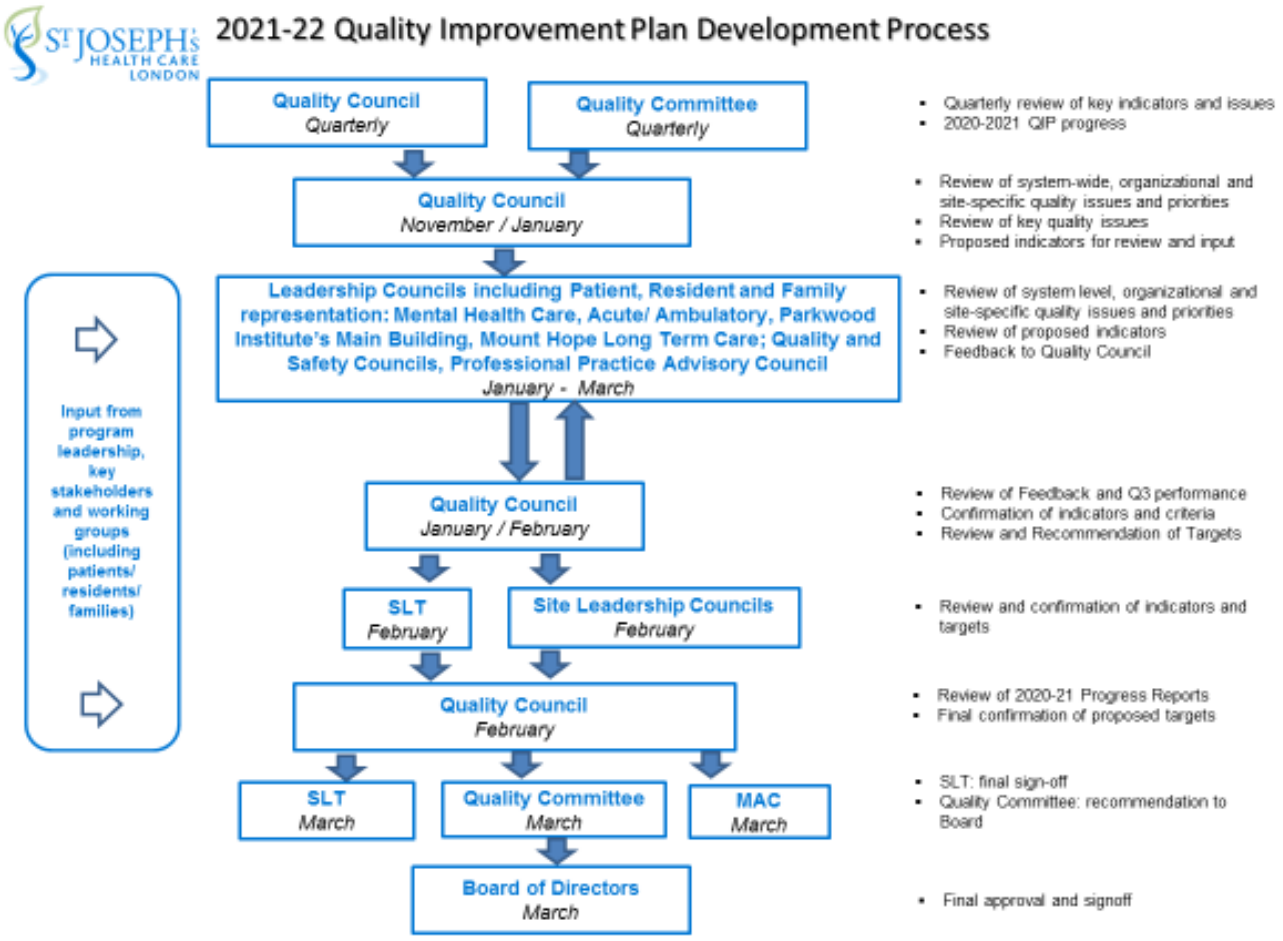
Patient, Resident and Family Partnership Initiatives

Purposefully partnering with patients, residents and caregivers as full partners in care has been a strategic priority for St. Joseph's since 2015. This care philosophy was guided by best practice in the creation of the Care Partnership framework (2016), the organization's participation as one of four Ontario hospitals funded to improve caregiver experiences by the Change Foundation (2017-2020), and, most recently, the establishment of a Care Partnership Office (2021). With the principle of care partnership thriving across all facets of the organization, St. Joseph's Care Partnership Office will sustain and continue to leverage the power of patient, resident and caregiver lived experience to proactively create meaningful change in how care is delivered and received across the organization. With a focus on quality improvement, care partners will be engaged in various ways across a continuum, from involvement and empowerment to co-design of direct care, research and advocacy.

Read what one patient says about being a partner for change at St. Joseph's

Engagement of Staff, Clinicians, Patients, Resident and Families

Our Quality Improvement Plan goals and indicators are developed with input from family, resident and patient councils across the organization. Membership includes staff, clinicians, leaders, patients, residents and family members



Executive Compensation

At St. Joseph's, all leaders (coordinator, director, executive) have clearly established goals for 2021-2022 and where applicable, goals are aligned with QIP priorities. Targets, 90-day plans, and monthly tracking of progress are conducted with leaders.

Our executive compensation is linked to performance in the following ways:

- Given the transition in the CEO role in 2021/22, the Board will further deliberate to determine any at risk compensation for 2021/22.

- Vice presidents have three per cent of their current annual salary compensation at risk related to the achievement of annual QIP indicator targets outlined below.

- Integrated vice presidents (those who work at both St. Joseph's and London Health Sciences Centre) will have the three per cent of their annual salary that is dependant on achievement QIP indicator targets evenly split between each organization (50 per cent St. Joseph's and 50 per cent London Health Sciences Centre).

- The following two St. Joseph's QIP indicators are tied to performance-based compensation:
    - Percent of discharge summaries sent to care health providers responsible for post-discharge care within 48 hours of a patient's discharge.
    - Percent of medication safety events with a debrief completed within 10 business days (wrong drug/ wrong patient events and other medication events of severity level 3 or greater)

Compensation will be awarded as follows:

- The two indicators carry equal weight (each one is worth 50 per cent)
- For each indicator:
    - Less than 50 per cent of target achieved = none of the compensation at risk will be awarded for that indicator
    - 50 to 99 per cent of target achieved = compensation at risk will be awarded for that indicator pro-rated based on per cent of target achieved
    - 100 per cent or more of target achieved = 100 per cent of compensation awarded for that indicator

Indicator	Current	50 percent of Target	Target
Discharge summaries sent to health care providers responsible for post discharge care within 48 hours of discharge	54.6%	59.8%	65%
Percent of medication safety events with a debrief completed within 10 business days	100%	100%	100%

Contact Information

Vivian Capewell,
Director, Quality Measurement and Clinical Decision Support

Sign-off

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan.

_____
Howard Rundle
Chair, Board of Directors

_____
Donna Ladouceur
Chair, Quality Committee of the Board

_____
Gillian Kernaghan
Chief Executive Officer

2021/22 Quality Improvement Plan
"Improvement Targets and Initiatives"

St. Joseph's Health Care London - Hospital Workplans

AIM		Measure								Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Org ID	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) C = custom (add any other indicators you are working on)														
Theme I: Timely and Efficient Transitions	**Timely**	Percentage of inpatients discharged from hospital for which discharge summaries are delivered to the health care providers responsible for post-discharge care within 48 hours of patient's discharge from hospital.	P	% / Inpatients (Mount Hope Centre for Long Term Care excluded)	**Hospital collected data / Most recent 3 month period**	714*	54.60%	65%	Recommendation to increase target. Multi-year goal for continued increase to align with CPSO guidelines.	1) Implement electronic reminders for providers once 48 hours has passed since discharge and a discharge summary remains incomplete.	1.1) Engage ITS to collaborate on the development of an electronic reminder. 1.2) Engage site leadership councils on possible decisions on the structure/timing of reminders once exploration is complete with ITS. 1.3) Initiate a pilot of this initiative if deemed necessary/valuable (e.g. one service). 1.4) Implement reminders across the organization (and possibly across the region as this may need to be a region-wide standard tool that is developed.	1) Number of physicians receiving electronic reminders of an incomplete discharge summary.	1) 100% of providers receiving electronic reminders once a discharge summary is overdue.	
										2) Identify use of auto-authentication functionality (to sign a note automatically and speed up distribution to post-discharge care providers) by service to understand utilization of the functionality.	2.1) Modify existing dashboards to report use of auto-authentication functionality at the corporate, site and service levels.	2) Services able to see their use of auto-authentication functionality.	2) All services capable of seeing their use of auto-authentication functionality via electronic dashboards.	
										3) Implement auditing processes for discharge summaries within Health Information Management.	3.1) Develop a quality assurance review framework for HIM staff to review discharge summaries (dictated and typed notes, including auto-authenticated notes) 3.2) Develop a feedback process to manage outcomes identified by quality reviews (feedback loops to dictators/authors, transcription service provider, reporting of results by service etc.) 3.3) Review a sample of discharge summaries for quality, accuracy and completeness monthly.	3.1) Quality assurance framework developed. 3.2) Feedback process developed for (a) dictators/authors and (b) transcription service provider. 3.3) Number and % of total discharge summaries reviewed monthly.	3) 1% of discharge summaries reviewed monthly	
										4) Review total deficiencies of tracked notes (as outlined in the Compliance and Monitoring of Clinical Documentation policy) by service for potential future quality improvement strategies.	4.1) Assemble data outlining provider deficicies for all tracked notes by service for the most recent 12 months where deficiency tracking was in place (*note this was paused during parts of the pandemic responses so the timeline may span more than 12 months to capture accurate date).* 4.2) Analyze assembled data for trends by service and by tracked note type for future potential actions.	4.1) Tracked note deficiencies data assembled for a 12 month period where deficiency tracking was active. 4.2) Trend analysis completed 4.3) Possible future actions identified and investigated.	4) Tracked note deficiencies data assembled for the most recent 12 month period that deficiency tracking was active and analysis of data complete including future potential actions for future-year QIP.	

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Theme II: Service Excellence	**Patient-centered**	Number of New Patient and Family Partners Recruited and Completing Corporate On-boarding Process.	C	Number / New recruits to the organization as well as existing patient and family partners and Patient, Resident and Family Council members	**Hospital collected data / 2020-21**	714*	51	100	Continuation of 2020-21 target is aligned with implementation of change ideas that were halted in 2020-21 due to the pandemic.	1) Launch recruitment materials to staff, patients and family partners	1.1) Distribute materials including rounding and huddle aids to clinical program areas and support services; post on intranet and external website; 1.2) Attend staff and physician leadership meetings, and 1.3) Align with volunteer services, including identification of potential care partners with volunteer intake. 1.4 external recruitment campaign	1.1) Percentage of areas that receive recruitment materials 1.2) Number of leadership meetings attended 1.3) Include communication in volunteer intake and orientation about care partnership 1.4) Number of external visits to care partnership webpage 1.5) Engage diverse community.	1.1) 100% of areas receive recruitment materials by end of Q2; materials posted to intranet and website by end of Q1; 1.2) Information shared at leadership meetings by end of Q2; 1.3) 100% of new volunteers would receive information about the care partnership office 1.4) 300 unique website visits by end of Q3 1.5) Place 2 community recruitment based advertisements by end of Q3	
										2) Audit and evaluate recruitment, intake and orientation for Care Partners	2) Develop assessment survey for staff and for patient and family partners	2) Percentage of surveys completed; percentage positive results related to awareness and effectiveness of recruitment intake and orientation	2) 40% survey response rate by end of Q3; 80% results are percentage positive related to awareness and effectiveness	
										3) Develop standardized approach and framework for patient and family councils to raise visibility	3.1) Audit and analysis of current council structures 3.2) Co-design overarching council framework for consistency and alignment.	3.1) Conduct 1 audit and analysis of current council structures. 3.2) Co-design overarching council framework for consistency and alignment .	3.1) Audit and analysis complete by the end of Q2 3.2) Framework completed and implementation plan developed by end of Q3	
										4) Partner with Western Ontario Health Team to co-design patient engagement for year 1 population.	4.1) Recruit and onboard COPD/ CDF patients and caregivers; 4.2) Build capacity and skill in patient/caregiver engagement and co-design build capacity and skill 4.3) Develop understanding of patient, caregiver and health care provider experiences; 4.4) Ensure a sustainable model for patient engagement and co-design for the WOHT beyond Year One	4.1) Number of patients and care givers recruited and onboarded 4.2a) Number of co-design sessions offered 4.2b) Number of patients who have participated in co-design sessions. 4.3) Key findings summarized from co-design sessions and reflecting system wide collaboration of WOHT 4.4) Model for continued engagement and co-design developed delivered	4.1) Ten patients/ caregivers recruited by the end of May 2021 4.2a) Two learning sessions by the end of May 4.2b) 10 patient and family care partners have participated in co-design session by end of May 2021. 4.3) Report finalized by end of August 2021. 4.4) Model for sustainable engagement and co-design delivered August 2021.	
										5) Continuation of leader and staff education of patient and family centered care, co-design, and care partnership	5) Evaluate online learning modules.	5) Number of staff who have completed eLearning modules.	5) 90% of staff have completed eLearning module by Q3.	
										6) Establish baseline metrics to build quality targets.	6) Track meaningful targets to understand where and how care partners are contributing across the organization.	6.1) Number of hours care partners have contributed to the organization. 6.2) Number of initiatives that care partners have contributed to across the organization	6) Capture metrics to establish baseline for 2021 by Q3	

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Theme II: Service Excellence	**Patient-centered**	Percentage of respondents who responded "completely" to the following question, Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?	C	% / Survey respondents: Complex Care, Specialized Geriatric Services & Rehabilitation Programs at Parkwood Institute	**CIHI CPES / Most recent available results (2020-21 Q2)**	714*	50.00%	58%	Work continues to implement change ideas that were halted in 2020-21 due to the pandemic. In 2021-22 the indicator has been expanded to include the Complex Care patient population.	1.) Understanding the data: Calls to discharged patients to understand their transition experience	1) Leaders to contact patients, using a standardized script, question the patient/family on their recent experience with transition from hospital to home. Ask specifically if they feel they are completely satisfied with the information they received from hospital staff, as related to the indicator.	1) Number of discharge phone follow-up calls completed.	1) By the end of Q1, leaders from each program (Rehab, SGS and Complex Care) will have contacted 10% of discharged patients within the quarter to discuss their experience.	
										2) Understanding the data: Review of provincial data and peer hospitals	2) Decision Support to obtain data from NRC for comparator sites with high performing results. We will review data and consider contacting these organizations to learn of strategies to support this indicator	2) Number of peer organizations contacted.	2) By the end of Q1, 75% of identified high performing peer organizations have been contacted to identify additional strategies for consideration	
										3) Implement the transition bundle initiatives: Patient Oriented Discharges (PODs)	3) PODS: Co-design with patients, family members and staff what needs to be included in the POD Summary. Implement using a PDSA approach. Finalize a plan for sustainability.	3) Percent of patients audited who receive POD summary; Percent of units that will implement POD	3) By the end of Q3, 75% pts wo were audited will have received a PODS at time of discharge. By the end of Q3, 100% of the units will have implemented PODs	3) Each unit will develop audit target number based on number of patients discharged.
										4) Implement the transition bundle initiatives: Teach Back Strategy	4) Teach back: Confirm the "train the trainer model" for building capacity amongst staff for completing teach back. Identify tools/resources to support. Co-design the process and documentation to ensure there is clear accountability by staff and patient and family upon completion.	4) Number of staff trained on teach back methodology	4) By Q3 , 50% of full time nursing staff and 70% of allied health will have received the teachback training	4) Rehab initiative only - CC will start later
										5) Implement the transition bundle initiatives: Follow up phone calls.	5) Follow up phone calls: Design and implement processes to complete follow up phone calls for patients being discharged from an inpatient bed.	5) Number of units using follow-up phone calls	5) By Q3, 100% of units (N of 6) will be using follow-up phone calls	5) Each unit will establish target numbers for phone calls

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Theme III: Safe and Effective Care	**Effective**	Percentage of initial ambulatory clinic visits with medication reconciliation completed	C	% of Initial appointment with a prescriber / Ambulatory clinics where managing medications ia a component of care; Includes in-person and virtual visits. (virtual visits added in 2021-22)	**Electronic Health Record Documentation / October - December 2020 (Q3)**	714*	17.70%	35%	Annual target will be re-set to an achievable and sustainable level for 2021-22; Aligned with implementation of change ideas that were halted in 2020-21 due to the pandemic.	1) Present to patient and Family Councils to increase engagement in this quality initiative	1) Attend Patient and Family councils to explain the importance of collecting accurate information, share initiatives, and gather feedback	1) Number of patient and family council meetings attended.	1) All councils attended by the end of Q3.	
										2) Validate data and optimize the accuracy of the reported metrics.	2.1) Investigate the corporate process for new appointment type creation, including consideration for inclusion in QIP reporting 2.2) Optimize the accuracy of the report identifying patient appointment types used by pharmacy technicians in DEMO and IDCP clinics to prioritize work. 2.3) Identify and resolve issues related to the mismatch between manually documented BPMH completion rate and the electronically captured data in DEMO and IDCP	2.1) Consistent process or gatekeeper identified to ensure new appointment types are included in the QIP data, as needed 2.2) Qualifying appointments are visibly identified on the request list in a timely and accurate manner. 2.3) Mismatch eliminated between the manually documented BPMH completion rate and the electronically captured data in DEMO and IDCP clinics	2.1) Process or gatekeeper identified by end of Q1 2.2) Pharmacy technicians in DEMO and IDCP have timely access to accurate patient lists to prioritize qualifying patient appointments by end of Q1 2.3) Accurate BPMH completion rate reporting in IDCP and DEMO by end of Q2	
										3) Increase access to QIP data through regular information push/standardized QIP scorecard	3) Establish a regular process for the access and distribution of quality improvement analytics to prescribers	3.1) QMCDS to optimize QIP scorecard to include ambulatory MedRec 3.2) Individual QIP results regularly pushed out to prescribers in select clinics 3.3) Follow-up process established for prescribers interested to better understand the QIP results	3.1) QIP scorecard includes ambulatory MedRec by end of Q1 3.2) Individual prescriber QIP results pushed out by QMCDS, at a regular frequency, to select clinics by end of Q2 3.3) Follow-up process established and communicated as part of QIP results push to individual prescribers by end of Q2	
										4) Reduce the number of paper prescriptions used within the ambulatory clinics where medication management is a major component of care	4.1) Identify top 3 ambulatory clinics using paper prescriptions 4.2) Engage the chair/chief and operational leadership in the clinics to identify barriers to using Cerner prescribing 4.3) Develop clinic-specific strategy and target 4.4) Work toward removing said barriers and supporting prescriber education, as necessary	4.1) Top 3 clinics identified by highest volume of paper prescriptions ordered from pharmacy 4.2) Clinics engaged in identifying barriers to using Cerner for prescribing medications 4.3) Clinic-specific strategy and target (% reduction) established 4.4) Barriers removed and Cerner prescribing education provided	4.1) Identify target clinics prior to start of 2021/2022 fiscal 4.2) Engage clinics and identify barriers by end of Q1 4.3) Develop clinic-specific strategy and target by end of Q2 4.4) Remove barriers, provide education, as necessary, and achieve clinic-specific targets by end of Q3	
	Safe	Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.	MANDATORY	Count (annual projection to fiscal year end) / all heathcare workers	**Local data collection / Jan - Dec 2020**	714*	1314	1050	The most recent annual projection includes one outlier quarter (significantly higher number of reported events than expected). Annual projection is 1002 with exclusion of outlier; target of 1050 is to sustain the current level.	1) Evaluate use of the electronic screening tool (Behaviour Safety Alert Tool or BSAT) and completion of safety plan documentation	1.1) Analysis of data to examine relationship between workplace violence events, BSAT risks, and presence of safety plan 1.2) Analysis of trends for patients with responsive behaviours and safety plan 1.3) Analysis of the quality of documentation and engagement of care partners in the development of the care plan and support plan	1) Project timelines	1) Analysis completed by Q3 for action plan development	
										2) Highlight value of Near Miss-No Injury reporting and follow-up	2.1) Analysis of Near Miss-No injury Data to identify trends in contributing factors to identify areas of opportunity for process improvements 2.2) Review of existing processes used post incident to verify reporting requirements are included (e.g. Post incident debriefs, daily huddles)	2) Project timelines	2) Analysis and review completed by Q3 for action plan development	

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M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) C = custom (add any other indicators you are working on)														
Theme III: Safe and Effective Care	**Safe**	Percent of specific medication errors with a debrief completed within 10 business days	C	% / Hospital inpatient medication administration errors: all wrong drug / wrong patient medication errors and all other types of medication errors with severity level 3/4/5. Mount Hope Centre for Long Term Care excluded	**Hospital collected data / October to December 2020 (Q3)**	714*	100%	100%	The target is based on sustaining current performance to support the hard-wiring of processes in all programs/ units.	1) Enhancement to Patient Safety reporting System (PSRS) and reporting.	1.1) Enhance PSRS to Include prompts to elicit more comprehensive completion of PSRS 1.2) Develop PSRS User Guide to distribute to clinicians	1.1) Stakeholder engagement (Nursing Council, pharmacy site leadership, QMCDS, clinical leaders) obtained regarding feedback for further support for PSRS completion 1.2) PSRS enhancement completed 1.3) PSRS User guide developed.	1.1) Stakeholder Feedback obtained by end of Q1. 1.2) PSRS System enhancement completed by end of Q2 - implementation and evaluation by end of Q3. 1.3) PSRS User Guide developed by end of Q2	
										2) Leaders to identify QIP medication errors which require a formal debrief and complete within 10 day timeframe	2.1) Enhance Medication Event Debrief resources for leader use 2.2) PSRS notification to include 'QIP/debrief within 10 day' flag when sent to leaders 2.3) Teams to develop standardized medication event review time within program to schedule debriefs within 10 day timeframe 2.4) Professional Practice to send out communication of updated process and monitor progress for leader identification and support of debrief process	2.1) Professional Practice to update Medication Debrief Resources to support the leader/delegate in completing thorough medication event debrief including the identification of systems and program-level learnings to implement 2.2) QMCDS support to add flag into notification 2.3) Feedback and ideas gathered from leaders and teams will be collected and reviewed and used to improve the process.	2.1) Flag added to PSRS notification by end of Q1 2.2) 100% of leaders engaged in debrief engaged by end of Q2 2.3) Communication regarding ongoing process improvements shared by end of Q2 process by end of Q3	
										3) Professional Practice to identify systems-level learning to inform corporate strategies to reduce mediation events	3) Professional Practice will review medication event debrief findings from QIP medication errors	3.1) Medication Safety Executive Committee will obtain and review completed Medication Event Review Tools 3.2) Engage leaders and clinicians for feedback o processes for implementation of learnings 3.3) Medication Safety Executive will identify systems learning and direct to appropriate teams/leadership structure for implementation Professional Practice will engage leaders and clinicians for feedback on processes	3.1) 100% of medication e vent review tools gathered and reviewed by end of Q2 3.2) 100% of leaders involved in debriefs engaged by Q2 3.3) Updates to tools implemented by Q3	
	Safe	Percentage of Columbia-Suicide Severity Rating Scale (C-SSRS) Lifetime Assessments complete within 3 days of inpatient admission.	C	% / Mental Health inpatients. Parkwood Institute and Southwest Centre for Forensic Mental Health included. One Geriatric Psychiatry Unit (H2) and one Dual Diagnosis Program Unit (G5) are excluded.	**Electronic documentation / 2020-21 Q3**	714*	84.70%	90%	Recommendation to increase the target further in 2021-22.	1) Improve the quality of C-SSRS Lifetime assessments.	1.1) Provide clinicians with specific feedback in regard to learning opportunities. 1.2) Train and leverage the expertise of CNS and ZS Champions to provide 1:1 follow up and education. 1.3) Annual e-learning module completion for required clinicians. 1.4) Development of a resource folder (including C-SSRS Lifetime information) for CNS/leaders.	1.1) Percentage of clinicians that are provided with feedback/ coaching for incomplete assessments within 3 days of patient admission. 1.2) Number of identified trained CNS and Zero Suicide Champions. 1.3) Percentage of required clinicians who complete annual e-learning module. 1.4) One resource folder is completed for CNS/leaders.	1.1) 100% of clinicians will receive 1:1 feedback/coaching for incomplete assessments within 3 days of patient admission. 1.2) 100% of intended CNS and Champions trained by end of Q1-21. 1.3) 100% of required clinicians will complete annual e-learning module. 1.4) Resource folder is complete by end of Q2-21.	
										2) Increase the number of C-SSRS Lifetime assessments completed within 3 days of inpatient admission.	2.1) Utilize self-serve analytics to identify and follow up with clinicians accordingly. 2.2) Enhance leadership/CNS engagement in holding clinicians accountable when appropriate. with ZS team as needed. 2.3) Engagement with QM&CDS as needed to improve quality/functionality of self-serve analytics.	2.1) Percentage of non-initiated C-SSRS Lifetime assessments that receive follow up (CNS/leader) and are completed within 3 days of patient admission. 2.2) Number of circumstances in which leader/CNS engage in a clinician accountability/disciplinary action. 2.3) Number of quality improvement strategies and outcomes to improve serve-serve analytics.	2.1) 100% of non-initiated C-SSRS Lifetime assessments receive follow up and are completed within 3 days of patient admission. 2.2) 100% of clinicians that are not following corporate expectations are engaged in performance management with their affiliated leader. 2.3) 100% of identified quality improvement strategies are brought forward to QM&CDS for follow-up.	
										3) C-SSRS Lifetime OneChart functionality improvements.	3) Continue to pursuit formerly requested adaptations to the C-SSRS Lifetime in OneChart to enhance quality, user experience, and forced functionality.	3) Percentage of CI/ITS requests that are fulfilled and alternative strategies for those that are not.	3) 100% of requests are reviewed with CI/ITS. 100% of unfulfilled requests are reviewed with alternative strategies.	
										4) Enhance leadership engagement and accountability in regards to clinician education and performance management.	4.1) Distribution of quarterly leader progress reports. 4.2) Leaders who are not meeting the QIP target will develop quarterly LEM goals and action items to achieve the QIP target.	4.1) Number of quarterly leader progress reports distributed. 4.2) Number of applicable leaders who complete a quarterly LEM goal with identified action items.	4.1) 100% of anticipated quarterly leader reports are distributed. 4.2) 100% of applicable leaders have completed quarterly LEM goals with identified action items.	