Excellent Care for All Act
Quality Improvement Plans 2023/24: Progress Report on the 2022/23 LHSC Quality Improvement Plan

The Progress Report is a tool that will help organizations make linkages between change ideas and improvement, and gain insight into how their change ideas might be refined in the future. The new Progress Report is mostly automated, so very little data entry is required, freeing up time for reflection and quality improvement activities.

Ontario Health (OH) will use the updated Progress Reports to share effective change initiatives, spread successful change ideas, and inform robust curriculum for future educational sessions.

Realizing that the Quality Improvement Plan is a living document and the change ideas may fluctuate as you test and implement throughout the year, we want you to reflect on which change ideas had an impact and which ones you were able to adopt, adapt or abandon. This learning will help build capacity across the province.

Measure/Indicator from 2022/23	Current Performance as stated on Quality Improvement Plan 2022/23	Target as stated on Quality Improvement Plan 2022/23	Current Performance 2023	Comments
Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged. (Rate per total number of discharged patients; Discharged patients; October 2021– December 2021; Hospital collected data)	75.39%	85.00%	75.6% Q3 fiscal year 2022/23	The average result of the 11 large hospitals sharing results publicly on their Quality Improvement Plans at the end of fiscal year 2021/22 was 88.6%. Target Not Met to Date 

Change Ideas from Last Years Quality Improvement Plan (2022/23)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Medication reconciliation at discharge Increase provider accountability to drive performance	Yes	We engaged with providers over the past year on the topic of medication reconciliation to better understand the challenges faced in ensuring consistency and standardization. Several strategies were identified that we will continue to advance in future. Our first strategy was creating additional functionality within the electronic health record that allows providers to reduce the number of "clicks" required to reconcile and complete orders. Our second strategy was to send physician leaders monthly metric reports regarding medication reconciliation and best possible medication history compliance rates in their areas, and by provider to allow them to visualize performance. This has allowed for focused follow-up and identification of improvement opportunities within programs who aren't meeting target. We ensured there was substantive physician membership and input into the Medication Reconciliation Optimization Committee (MROC). We also focused on knowledge translation and communication. We ensured there were several opportunities for presentations and continued discussion at venues such as the Medical Advisory Committee, Department Head Committee, and Resident Committee. There have been several lessons learned throughout the past year, and as indicated in the summary, many centered around increasing communication and ensuring multiple opportunities for provider input. This learning will be reflected in the Medication Reconciliation Optimization Committee's Sustainability Plan going forward to ensure increased and continued physician/resident engagement, and as well, physicians and residents will be invited to participate in small working groups looking at process improvement in their areas.

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Medication reconciliation at discharge Establish Medication Reconciliation Optimization Committee	Yes	The Medication Reconciliation Optimization Committee was established in February 2022 and is jointly led by Pharmacy, Patient Safety, and Quality and Performance. This Committee has a formal Terms of Reference and membership that spans a wide number of leader types and clinical services. The Committee has met routinely on a monthly basis and has been able to generate valuable discussion and concomitant ideas about how to improve medication reconciliation awareness as a best practice for patient safety. Lessons learned throughout the establishment of the Medication Reconciliation Optimization Committee is that the membership of this group is key to its success, and having a variety of clinical services and leaders, providers, and staff representation ensures that all viewpoints and perspectives are considered. This Committee will continue to meet on a monthly basis and has started to establish a Sustainability Plan to inform future work.

Measure/Indicator from 2022/23	Current Performance as stated on Quality Improvement Plan 2022/23	Target as stated on Quality Improvement Plan 2022/23	Current Performance 2023	Comments
Number of workplace violence incidents reported by hospital workers (as defined by Occupational Health and Safety Act) within a 12 month period. (Count; Worker; January - December 2021; Local data collection)	1238	1238	731 Q3 fiscal fear 2022/23	No peer data of large enough sample size for an average, however peer workplans on Quality Improvement Plans for this indicator were reviewed. Target Met 

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Focus on transparent reporting of incidents and trends	Yes	Leaders encouraged their staff to report all incidents of violence. Impact from this idea is difficult to track as it was rolled out informally. As well, we are still tracking data to better understand 'baseline' to establish the validity of the reported data.
Maintain the Joint Health and Safety Committee workplace violence sub-committee to monitor trends and support the Internal Responsibility System	No	Although this subcommittee existed, meetings were generally suspended as pandemic related work took precedence. To mitigate the pause, workplace violence was prioritized within the larger monthly Joint Health Safety Committee meetings. Individual cases were reviewed and statistical information indicating trends was reviewed regularly. By March 31, 2023 this sub-committee is planned to be re-instituted.

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Number of workplace violence incidents reported by hospital workers Maintain training for all supervisors, managers, directors inclusive of in charge person and charge nurses	Yes	Training for health and safety awareness was required. Training was comprised of an introductory iLearn (self-directed online learning platform) followed by a two-day course focused on health and safety awareness and legislative requirements under the Occupational Health and Safety Act. Although this training emphasized the leaders' obligations under the Occupational Heath and Safety Act it did not directly address violence prevention and may be too indirect to have significant impact on this quality improvement plan initiative. General knowledge of accountability under the Occupational Health and Safety Act was helpful to increase supervisor awareness of their responsibility for creating a safe work environment. More specific training related to violence prevention was also made mandatory. The specific workplace violence training provided learning that was more directly targeted to the violence indicator on the Quality Improvement Plan.
Number of workplace violence incidents reported by hospital workers Roll-out a new mandatory workplace violence prevention training program for all staff	Yes	Mandatory workplace violence prevention training has been initiated and has been completed by over 50 per cent of all staff. What we learned was that the de-escalation component of this training is likely one of the most valuable tools for staff in order to prevent an incident of violence.

Measure/Indicator from 2022/23	Current Performance as stated on Quality Improvement Plan 2022/23	Target as stated on Quality Improvement Plan 2022/23	Current Performance 2023	Comments
Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital. (%; Discharged patients; Most recent 3-month period; Hospital collected data)	60.50%	65.00%	63.8% Q3 fiscal year 2022/23	Variability has reduced, but we continue to perform below peers. The average result of 13 large hospitals who have this indicator on their public provincial Quality Improvement Plan this year at the end of fiscal year 2021/22 was 78.6%. Approaching Target 

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Set performance expectations and increase accountability to drive performance	Yes	1. Setting expectations across all levels of leadership is critical to drive performance as there is an understanding of the focus required to achieve the result. Quarterly performance was shared with the Medical Advisory Committee and additional clinical leaders monthly. What we learned was while change ideas can be generated across any level of the organization the accountability needs to be with specific groups for removal of barriers, alignment with strategic focus or resources attached to change. LHSC teams such as Quality and Performance, Health Information Management, Clinical Solutions, Decision Support, and physician champions can provide data and information and assist teams with quality improvement best practices however additional physician leadership is required to integrate the change. Recently, LHSC recruited new leaders for Fiscal Year 2023/24: a new Medical Advisory Committee chair and Corporate Medical Executive which we believe will assist with our physician leadership presence and accountability to drive this measure.

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		2. Accountability - 48-hour email alerts were sent to the Most Responsible Person (MRP)
Provide education and communicate resources available to consultants/residents/fellows to support timely discharge summary completions	Yes	Information sharing progress steps made: 1. Frequency, 2. Distribution, 3. Mode, 4. Format, 5. Sharing/spread of best practice, and 6. Focus on high volume programs with greatest opportunity for improvement. Monthly data distribution commenced (frequency) and to more leaders (distribution was expanded to residency program directors and the LHSC Surgical Quality Council in addition to chairs, directors, and department site leads). Direct emails helped push data to those with an opportunity to improve. Data format was also enhanced. Sharing and spread of best practice also occurred, interviews with top performers and low performers, for example the Medicine Clinical Teaching Unit.

Measure/Indicator from 2022/23	Current Performance as stated on Quality Improvement Plan 2022/23	Target as stated on Quality Improvement Plan 2022/23	Current Performance 2023	Comments
Time to Inpatient Bed: Time interval between the Disposition date/time and the date/time patient Left the Emergency Department (ED) for admission to an inpatient bed or operating room at the 90th percentile (Hours; All patients; Most recent 3-month period; Canadian Insitute for Healthcare Information National Ambulatory Care Reporting System)	20.60	17.00	28.1 hours Q3 fiscal year 2022/23	Peer benchmarks in fiscal year 2022/23 Q2: provincial average was 34.5 hours and Ontario teaching hospitals 31.5 hours. Target Not Met to Date 

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Establish “simple to read” education for the Emergency Department and inpatient teams inclusive of physicians (consultants, fellows, residents), nursing and regulated health professionals to understand the measure and the relative impact of the measure on patient quality of care (e.g., experience, safety).	Partially	We pivoted from this to a real time Emergency Department wait time view for staff and the public for time to physician initial assessment. We also built a clinical team real time view of patient occupancy. This enhances the team’s ability to monitor and manage capacity, influencing flow into and through the hospital.

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Leverage data reporting tools to monitor admitted patient wait times and track when patients are nearing and over the target. Explore options to utilize the upcoming 3Terra pilot to track performance, report on adherence to the target, and identify causes for not achieving the target.	Partially	We are leveraging data reporting tools to review (versus monitoring in real time) admitted patient wait times and track when patients are nearing and over the target. We are also exploring options to utilize the 3Terra dashboards to track performance, report on adherence to the target, and identify causes for not achieving the target. Phase 1 (completed) The monthly Emergency Room Pay-for-Results dashboard reporting process and product was redefined, from a static pdf report to a dynamic Power BI report. The Emergency Department dashboard suite of reports was built by our vendor (3Terra) in collaboration with our Decision Support team, who confirmed specifications, performed validation and Quality Assurance testing. New functionality allows indicator filtering by site, period and physician. Decision Support validated the 3Terra Power Business Intelligence Dashboard indicators in April and May 2022, then posted them into the LHSC Clinical Operations Reporting production environment in June 2022. At that time, Decision Support held orientation sessions with various Emergency Department leaders, and then continue to support ongoing requests for training. Coding turnaround time improvements helped minimize the lag time between discharge date and leader review (from seven weeks to five weeks post month-end).

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Leverage data reporting tools to monitor admitted patient wait times and track when patients are nearing and over the target. Explore options to utilize the upcoming 3Terra pilot to track performance, report on adherence to the target, and identify causes for not achieving the target.	Partially	Phase 2: (in progress) Goal is to further improve timeliness of reporting by creating a version of the same Power Business Intelligence dashboard that is populated by an almost real time (next day) preliminary data feed. Although this data will be considered draft, it is directional and can be used on a weekly basis to help leaders track against performance goals. Use of almost real time data will also provide further options for weekly data analysis of key metrics to understand what is driving changes. LHSC Decision Support has been working with the vendor throughout the fall and started validating the new report in December 2022. Our goal is to move this dashboard into the production environment by the end of March 2023. The lesson learned and feedback from Emergency Department staff end users was that data needs to be timely with minimal delays for greatest actionability. The organizational lesson learned from this initiative was that having solely 'phase 1' was not sufficient for clinicians for to receive timely information for clinical decision making. The original change plan had solely one phase. As a result, 'phase 2' was planned through the Quality Improvement Plan cycle and will be implemented soon.

Measure/Indicator from 2022/23	Current Performance as stated on Quality Improvement Plan 2022/23	Target as stated on Quality Improvement Plan 2022/23	Current Performance 2023	Comments
Surgical Wait 2 - Priority 3&4 closed cases within target (Surgical wait times for lower priority surgeries - not life saving) (%; Total # of completed surgical cases; YTD; iPort)	63.00	71.00	61.5% Q3 fiscal year 2022/23	The Ontario average for Priority 3 & 4 closed cases in Q3 FY 2022/23 was 76% of cases within target. Target Not Met to Date

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Review data quality of wait list and monitor regular performance	Yes	Implemented a weekly review of all data and wait times. Weekly audits are completed by our internal Wait Times Office and any errors are corrected. This ensures that our data quality for Wait 2 details on completed cases is valid. Initial wait list clean-up was completed for open waiting cases. During initial wait list clean up, between August and November 2022, there were 825 cases removed from the open wait list for LHSC. This was 26 per cent of the patients who were identified for review. Patients were identified for review if they had already waited longer than their targets number of days, except for our highest volume service where patients over the 70th percentile of days were identified.

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Explore barriers to completing Priority 3 &4 cases within targets	Yes, ongoing	Due to the pandemic, challenges are still being experienced to complete Priority 3 & 4 cases within targets. Actualizing strategies to address the problem are challenging due to many interconnected barriers including human resource constraints within and outside of perioperative care.
Implementation of the surgical recovery plan	Affected by ongoing restraints	In order to address the surgical backlog, a multi-pronged approach was initiated. Project team and stakeholders were identified and engaged. Efforts are ongoing for recruitment and retention of staff, initial investigation and clean-up of the surgical wait list was completed. Further steps include investments in instrumentation, re-organization of space, changes to Operating Room grids, possible changes to staff schedules, and ongoing data analysis and evaluation. This work aligns with the strategic initiatives of the new Office of Capacity Management. Due to increased inpatient capacity as patients are sicker and urgent/emergent cases also increased, efforts to offset include increasing one day care patients. Finding the balance with addressing the wait listed patients within targets is necessary and challenging.

Measure/Indicator from 2022/23	Org Id	Current Performance as stated on Quality Improvement Plan 2022/23	Target as stated on Quality Improvement Plan 2022/23	Current Performance 2023	Comments
Wellness of Our People: Understanding our staff, physicians, learners, and volunteers feelings of level of support from leaders Self-Perception of Support (%; Worker; Most recent 3-month period; Hospital collected data)	936	60.00	65.00	62.3% Q3 fiscal year 2022/23	No peer data. Peer workplans on Quality Improvement Plan for wellness indicators generally were reviewed. Approaching Target 

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Launch a comprehensive, sustainable mental health strategy to support staff, leaders, professional staff, learners and affiliates	Yes	We have launched a multi-year mental health action plan and are in the first phase which includes data collection on occupational stress injuries and introducing training on psychological health and safety. Our internal staff support program has seen significant growth necessitating an additional hire, creation of policies and Standardized Operating Procedures to build a sustainable program.
Targeted focus on leader wellness and engagement	Yes	Two new Wellness Certificate Programs for leaders were launched in the past fiscal year. The content includes information and training on personal, team, and organizational resiliency and psychological health and safety. Leaders were also introduced to the CARE4ME Program offered by WhereWellnessWorks at LHSC.

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Align wellness strategies to Excellence Canada's Healthy Workplace Standards for psychological safety	No	The launch of this initiative was paused while the executive leadership collaborative was being reorganized to ensure alignment with the new vision. However, recognizing the unique needs of health-care workers, LHSC's Where Wellness Works Team has developed a comprehensive multi-year Wellness and Mental Health Action Plan. This plan is aligned to the Excellence Canada Healthy Workplace Standard and includes a mental health action plan to support both individuals and teams as well as targeted interventions for leader wellness and engagement.