AIM		Measure								Change				
Quality dimension	Issue	Measure/Indicator	Type	Unit / Population	Source / Period	Organization 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) A= Additional (do not select from drop down menu if you are not working on this indicator) C = custom (add any other indicators you are working on)														
Effective	Effective transitions	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?	P	% / Survey respondents	CIHI CPES / April - June 2017(Q1 FY 2017/18)	936*	56.34%	62.00%	Reduce gap in performance relative to best performing organization.	Develop and expand the patient oriented discharge summary (PODS) pilot project.	1) Use tools and lessons learned from the pilot area and expand into high patient volume areas. 2) Patient follow-up phone calls to assess the effectiveness of the process. 3) Monitor patient survey results	1) PODS process replicated in high patient volume areas. 2) Follow-up phone call survey results. 3) CIHI CPES Survey results.	1) PODS process replicated in 4 clinical areas by December 31,2018. 2) 100% Positive response 3) >62% Positive response	
		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.	A	% / Discharged patients	Hospital collected data / most recent 3 month period	936*	31.80%	50.00	Reduce gap in performance relative to best performing organization.	Educate on expectation of 48hours to complete discharge summary (MAC rules and regulations).	Physician education sessions.	Education completion.	100% of physicians educated by June 1, 2018	- Continue to make data available to Chair Chiefs - Target high patient throughput areas for staged spread of the pilot initiative.
										Enhance monitoring, feedback, and reporting capability.	1) Introduction/education on physician scorecard. 2) Weekly feedback to physicians. 3) Monthly performance reporting.	1) Introduction/education delivered. 2) Weekly feedback mechanism operational. 3a) Patient discharge to dictation (hours). 3b) Dictation to Transcription (hours). 3c) Transcription to Authentication (hours).	1) 100% of physicians educated by June 1, 2018. 2) Operational by November 2018. 3) 48 hours (total).	
Safe	Safe care/Medication safety	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.	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / October – December (Q3) 2017	936*	66.40%	77%	Reduce gap in performance to best performing organization.	Enhance monitoring, feedback, and reporting capability.	1) Align indicator to physician balanced scorecard. 2) Review roles and responsibilities. 3) Enhance monitoring and non-compliance escalation processes. 4) Provide weekly performance feedback.	1) indicator added to physician scorecard. 2) Roles and responsibilities reviews completed. 3) Weekly compliance reviews conducted in target areas. 4) Indicator performance feedback mechanism in place.	1) Indicator added Q2 2017/18. 2) Reviews completed by June 30, 2018. 3) Compliance audits operational by June 30, 2018. 4) Operational by November 2018	
	Workplace Violence	Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.	MANDATORY	Count / Worker	Local data collection / January - December 2017	936*	844	886.00	Target a 5% increase in reporting to account for potential under-reporting at present.	Implement standard tool for individual patient risk assessments.	Use of Public Services Health & Safety Association (PSHSA) Acute Care Violence Assessment Tool (VAT) as part of a new Hospital wide flagging policy and procedure.	Quarterly compliance audit reports.	VAT tool completed for 100% of patients flagged for violent behaviour.	The VAT tool will be implemented no later than May 1, 2018. No later than September 3, 2018 a quarterly audit report will be provided to the JHSC for one year following the new flagging policy and procedures implementation and annually thereafter.
										New and updated training program for all supervisors, managers, directors inclusive of in charge person (ICP) and charge nurses in high risk for violence units who have not had previous LHSC 8 hour Supervisory Competency training as well as any and all new supervisors	Implement Supervisory Competency training relying upon the PSHSA Leadership Program (5 modules).	Supervisory competency training compliance rates.	By December 31st 2018, 80% of current outstanding leaders and 80% of new supervisors have received the PSHSA training.	New training requirements comes into effect January 1, 2018. By January 2018 PSHSA training sessions will be booked for calendar year 2018
										Adopt standard violence risk assessment tool for individual units.	Implement PSHSA Violence, Aggression & Responsive Behaviour (VARB) tool for workplace violence risk assessment for acute care.	Percentage of violence risk assessments using the VARB tool.	100% of VRA's will use the VARB tool by December 15, 2018.	Training for the electronic version of software use will be completed by January 31, 2018.

										Mandatory search policy for patients and visitors on adult mental health unit, addition of metal detecting equipment.	Develop necessary policy and procedures. Security staff conducting searches will be provided with the necessary equipment to conduct searches, including metal detecting equipment.	Security guard training: - Search policy - Use of hand held metal detectors.	100% of security guard training completed by January 15, 2018.	No later than January 15, 2018 a mandatory search policy for patients and visitors on B7 will be implemented and security staff will be provided and trained on the use of hand held metal detectors.
										Ensure all workplace violence policies, procedures, measures, and training will be reviewed and updated to reflect the new measures and procedures listed above.	LHSC leadership review in consultation with the JHSC.	Percent of policies, procedures, measure and training reviewed and updated.	100% of policies, procedures, measure and training reviewed and updated by June 30, 2018.	
Timely	Timely access to care/services	Total ED length of stay (defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ED) where 9 out of 10 complex patients completed their visits	A	Hours / Patients with complex conditions	CIHI NACRS / January - December 2017	936*	12.8	12.70	Reduce gap in performance relative to best performing organization. Halt upward trend.	Implement new ED decanting protocols	1) Introduce/educate clinical programs on ED decanting protocols. 2) Establish protocol triggers. 3) Monitor and manage protocol activatation and execution. 4) Monitor clinical program ED wait for inpatient bed time.	1) Clinical programs educated on new protocols. 2) Protocol triggers established and communicated. 3a) Number of protocol activations. 3b) Time in protocol activation. 4) ED Wait for inpatient bed.	1) 100% programs educated by March 31, 2018. 2) Established and communicated by March 31, 2018. 3a,b) Establish baselines by June 30, 2018. 4) Target 17.2 (hours)	
										Open additional mental health department beds	Realign bed map to accommodate extra mental health beds.	Beds open and in operation.	Newly funded beds open by March 31, 2018.	
										Reduce inpatient length of stay (LOS)	1) Establish Expected Date of Discharge (EDD) processes in high LOS areas. 2) Weekly reviews of barriers to discharge. 3) Follow discharge algorithm for escalation of issues.	1) Audit EDD documentation. 2) Weekly reviews conducted. 3a) Number of times escalation algorithm enacted. 3b) Success rate for escalation algorithm.	1) Process and audits in place by June 30, 2018. 1a) 100% of EDD documentation completed. 2) Weekly reviews in place by June 30, 2018. 3a) Algorithm monitoring in place by June 30, 2018. 3b) 100% Success rate.	