Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2017/18 QIP

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.

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

NOTE: CB = Collecting Baseline.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
1	From National Research Corporation Canada (NRCC): "Overall, how would you rate the care and services you received at the hospital (inpatient care)?" The indicator is expressed as a percent (%) of those who responded with a rating of 9 or 10 inclusively on a scale of 0 to 10 where 0 = poor experience and 10 = very good experience. (%; A random sample of UHN Acute and Rehab Inpatients; Q1 and Q2; NRC Picker)	947	CB	CB	71.4%	With the introduction of the new measurement survey in 2016/17, we are continuing to build toward a more valid interpretation (total number of surveys received). The survey data received currently has a 3-6 month delay.

Change Ideas from Last Years QIP (QIP 2017/18)	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?
Increase the number of patients and caregivers partnering across the organization on planning and decision-making activities.	Y	The target of 90 Patient Partners (total cumulative) was surpassed for the year, resulting in an increased ability to ensure Patient Partners are integrated into meaningful engagement activities across UHN. The Patient Partners program has 100 Patient Partners as of March 31, 2018. Examples of engagement include having patient representation on the CEO Search Advisory Committee.
Increase the number and diversity of patient and caregiver engagement activities at the organizational, program and unit level.	Y	The target of 90 Patient Partners (total cumulative) was surpassed for the year, resulting in an increased ability to ensure Patient Partners are integrated into meaningful engagement activities across UHN. The Patient Partners program has 100 Patient Partners as of March 31, 2018. We will continue to increase the diversity of our patient and caregiver engagement activities in 2018/19. One example of this is that we will continue to conduct community outreach within diverse patients groups for the myUHN Patient Portal.

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2	Number of acute inpatient falls (SSE 1-5) per 1,000 acute inpatient days. (Acute inpatient falls rate per 1,000 acute inpatient days; Acute inpatients; Q1-Q3; Patient Safety Incident Reporting System)	947	CB	CB	0.35	Classifying harm by Serious Safety Events (SSE) 1-5 is a new measurement system recently introduced at UHN which accounts for preventability. 2017/18 was a baseline year to better understand the Falls SSE rate. After developing a better understanding of the SSE measurement, the falls acute measure/indicator using the SSE classification system is the number of acute patient falls (SSE 1-5) per 10,000 adjusted patient days. The focus for 2018/19 will be to improve the reliability of this measure.

Change Ideas from Last Years QIP (QIP 2017/18)	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?
Refine falls inpatient Prevention Bundle.	Y	The Falls Prevention Bundle was refined and posted on the Corporate Intranet for broad sharing across the organization. Test units included TGH 10ES and PMH 16P, which trialed five spot audits/week with respect to adherence to the Falls Prevention Bundle. Initiated post fall follow up at unit/site huddles (TGH) to identify gaps in adherence to Falls Risk Assessment/Interventions.
Define falls outpatient Prevention Bundle	Y	Refined screening questions and developed algorithm of possible Fall prevention interventions in outpatient settings. Testing a "Post Visit" screening question as patients Falls risk may have changed due to lengthy clinic visit/interventions, etc. Testing is underway with the Transplant Day unit at TGH. There are limitations with respect to available resources in outpatient settings once a patient is identified as a falls risk. It is difficult to standardize falls screening in outpatient settings as there are varying staffing and resourcing compliments and initial connection points with patients (for example, sometimes this is prior to appointment, other times it is at intake).
Define debrief form/process for fall prevention in the inpatient setting.	Y	Broad sharing of Post Fall Discussion Tool across organization. We collaborated with the Patient and Family Education group for Patient Engagement questions to include during post fall reviews. Education provided to Patient Safety Specialists for inclusion of the patient perspective in Falls debriefs. Used by managers/delegates with support from site Falls Committee members for information gathering prior to debrief. Received and incorporated feedback from all four sites.
Define safety huddle/visual board requirements for falls.	Y	Test units are using visual boards to highlight adherence to the Falls Prevention Bundle and tracking days/setting targets. Units are also using visual boards to highlight barriers to Fall Prevention and capture the number of days since the last fall. TGH is tracking falls and completion of risk assessment/interventions at the site huddle level.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
3	Number of acute inpatients newly diagnosed with nosocomial C. Difficile (CDI) per 1,000 acute inpatient days. (Nosocomial Acute Inpatient CDI rate per 1,000 acute inpatient days; Acute inpatients; Q1-Q3; Infection Prevention and Control C. difficile database)	947	0.48	0.48	0.51	There has been an increase to the CDI nosocomial acute inpatient rate this year, however fluctuation in this rate is to be expected. In Q4 of FY 2017/18, the rollout of the CDI prevention bundle began in select clinical units, with the aim of 100% adherence to CDI prevention and management practices. Over the coming years, as more units adopt the CDI prevention bundle, we anticipate a decrease in the rate of infection.

Change Ideas from Last Years QIP (QIP 2017/18)	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?
Pilot stool documentation tools.	Y	Pilots were completed and standardized stool documentation tools roll out began in May 2017.
Clorox wipes rolled out to additional outpatient areas.	Y	Clorox wipes rolled out to six additional outpatient areas/clinics at Toronto General in October 2017.
Percentage of completed intervention implementations related to environmental controls (standardized cleaning checklist & ATP monitoring).	Y	All interventions related to environmental controls were successfully rolled out at all sites this year.
Rollout standardized terminal cleaning checklist at all sites.	Y	Standardized terminal cleaning checklist roll out began at all sites in April 2017.
ATP monitoring in use at all sites for CDI terminal cleans.	Y	ATP monitoring roll out began at all sites for CDI terminal cleans in April 2017.

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4	Number of adverse drug events (Serious Safety Events 1-5 & Precursor Safety Events 1-3) per 10,000 medication doses. (ADE rate per 10,000 medication doses; All UHN inpatient units and selected outpatient/ambulatory areas that store and administer medications; Q1-Q3; Patient Safety Incident Reporting System (medication incidents) & BDM Pharmacy (medication doses))	947	CB	CB	1.82	Due to data limitations, it was not possible to capture the number of adverse drug events (ADE) (Serious Safety Events 1-5 & Precursor Safety Events 1-3) per 10,000 medication doses. As such, the current performance of 1.82 reflects the number of adverse drug events (minor, moderate, severe and critical) per 10,000 medication doses. ADEs have not historically been captured on the QIP and as such, it was a baseline year.

Change Ideas from Last Years QIP (QIP 2017/18)	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?
Reinforce medication safety principles through education.	Y	eLearning module was posted to the MyLearning system in April 2017. As of February 2018, we are at 76% completion across UHN. We are on track to achieve 80% completion by March 31, 2018.
Investigate causes of missed/extra doses phenomena.	Y	To date, eight focus groups have been held to investigate the causes of missed/extra doses phenomena.
Identify interventions to address high-alert medication incidents.	Y	Three interventions have been identified and are in progress: 1) Updated documentation forms for Heparin IV orders; 2) Collaboration with the Surgical Site Infections group to refine existing Insulin order sets; and 3) Clean up of high alert medication order sets as part of "Medication Clean Up" project.
Develop a strategy to find a closed loop solution for Alaris IV pumps to reduce adverse drug events.	Y	Completed a Medication Management Assessment with our infusion pump vendor to inform a strategy currently being developed to move towards a closed loop solution for Alaris IV pumps.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
5	Number of adverse drug events near misses (Precursor Safety Events 4 & Near Miss Events 1-3) per 10,000 medication doses. (ADE near miss rate per 10,000 medication doses; All UHN inpatient units and selected outpatient/ ambulatory areas that store and administer medications; Q1-Q3; Patient Safety Incident Reporting System (medication incidents) & BDM Pharmacy (medication doses))	947	CB	CB	0.93	Due to data limitations, it was not possible to capture the number of adverse drug events (ADE) (Serious Safety Events 1-5 & Precursor Safety Events 1-3) per 10,000 medication doses. As such, the current performance of 0.93 reflects the number of adverse drug events (minor, moderate, severe and critical) per 10,000 medication doses. ADEs have not historically been captured on the QIP and as such, it was a baseline year.

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Investigate causes of missed/extra doses phenomena.	Y	To date, eight focus groups have been held to investigate the causes of missed/extra doses phenomena.
Identify interventions to address high-alert medication incidents.	Y	Three interventions have been identified and are in progress: 1) Updated documentation forms for Heparin IV orders; 2) Collaboration with the Surgical Site Infections group to refine existing Insulin order sets; and 3) clean up of high alert medication order sets as part of "Medication Clean Up" project.
Develop a strategy to find a closed loop solution for Alaris IV pumps to reduce adverse drug events.	Y	Completed a Medication Management Assessment with our infusion pump vendor to inform a strategy currently being developed to move towards a closed loop solution for Alaris IV pumps.

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6	Number of newly diagnosed Central Line Infection (CLI) cases in the ICUs per 1,000 central line days. (ICU CLI rate per 1,000 central line days; UHN ICU patients (CICU, CVICU, MSICU, MSNICU); Q1-Q3; Infection Prevention and Control database)	947	0.89	0.89	2.18	This year is considered a maintenance year for CLI. Major improvements related to CLI data collection and surveillance were made in September 2017. This rate increase can be attributed, in part, to improved CLI data collection and surveillance. It is also relevant to note that the CLI Hospital Acquired Condition (HAC) intervention implementations are planned for the latter half of the fiscal year. The CLI HAC anticipates that once all prevention bundle elements are in place, a meaningful improvement in the outcome indicator will be possible.

Change Ideas from Last Years QIP (QIP 2017/18)	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?
Test standardized maintenance bundle kit in the ICUs.	Y	Maintenance bundle kits and associated education were created. Kits and education were tested in a pilot unit (CICU). Education has also been rolled out to other ICU areas. Overall, usage of the kit was found to be high – 40 kits have been used over a one month period in CICU. Product evaluation forms were collected to obtain staff feedback on the kit. Staff expressed a high degree of satisfaction with the kit as well as the education.
Identify insertion best practices for UHN and test re-education methods in ICUs.	Y	Re-education on insertion best practices began in Q4 in ICU areas. We will better understand its impact in the upcoming year.
Identify and test safety behaviours related to reducing lines via existing means (i.e. safety huddles/visual boards).	Y	Safety behaviours have been embedded within educational materials and shared with staff. The following error prevention tools have been explicitly linked to central line insertion and central line maintenance activities: Stop, Think, Act, Review (STAR); Ask, Request, Concern, Chain of Command (ARCC); and Cross-Check. Safety behaviours are also raised/discussed during safety huddles and during "Rounding to Influence" activities.
Number of pilot tests of the central line infection prevention bundle completed in UHN ICUs.	Y	Pilot testing in CICU began in November 2017. CVICU, MSICU, and MSNICU are on track for completion by March 31, 2018.
Continued progress on CLI documentation and data collection using the EPR.	N	Conversations with the UHN Digital team are ongoing and an electronic solution to data collection is being actively explored. An implementation plan has yet to be created.

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7	Number of Patient Safety Events classified using the “Safety Event Classification Levels of Harm”. Note: The “Safety Event Classification Levels of Harm” include: Serious Safety Events, Precursor Safety Events & Near Miss Events. Currently we are focused on classifying the Serious Safety Events only. (Number of Patient Safety events reported; All current incident types excluding Privacy and Workplace Violence event types.; Q1-Q3; UHN Incident reporting eForm)	947	CB	CB	1.37	UHN has been promoting a culture of increased safety incident reporting. With this enhanced focused on increased reporting, the number of SSEs reported at UHN has continued to increase as expected.

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Education to clinical and medical leads on the "Safety Event Classification Levels of Harm".	Y	Clinical and medical leads have been educated through Caring Safely Leadership Modules. There is ongoing review of Safety Event Classification at debriefs and Quality of Care Committee meetings. Further review at leadership forums might be helpful as part of an education sustainability plan.
Patient Safety team to move to one severity classification framework.	Y	All incidents codes are now documented as per HPI classification in the incident reporting log and the team’s workbook. Our clinical teams are beginning to get used to the language and classification through continual review. Removing the previous classifications from the incident reporting system is a priority for the team.
Develop guiding principles for Patient Safety team to ensure consistency with severity classifications.	Y	Consistency is important to ensure that there is no under reporting of SSEs. As such, a UHN SSE reference tool is required and is in the process of being developed. Furthermore, an SSE Classification Committee could review cases when consensus about the classification has not been achieved. The team is in the process of determining the structure of such a committee and recommendations for implementation.

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8	Number of persons developing a new pressure injury per 1,000 acute inpatient days (Incident Density Rate). (Pressure Injury Incident Density rate per 1,000 acute inpatient days; Four acute inpatient pilot units (TGH - 6A and 6B; TWH - 3B and PMH - 15B); Q1-Q3; Electronic Patient Record)	947	CB	CB	3.97	UHN established a pressure injury incident density baseline rate of 4.03. This baseline data is based on a rolling six month average (FY 2017/18 April-September) and captures performance prior to introducing pressure injury HAC prevention activities. The PI HAC will continue to reinforce pressure injury reporting in EPR.

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Increase reporting of Braden Risk Assessment and Skin Assessment in the EPR for the four pilot units.	Y	Pilot units are reporting Braden Risk Assessment and skin assessment in EPR. Leaders of the units are reinforcing the expectation to complete assessments in EPR at daily huddles; using “Rounding to Influence” with staff who do not complete assessments in EPR; using audits to monitor rates of completion of assessment. The team continues to work with UHN Digital to make enhancements to EPR.
Finalize format and content of education to ensure widespread knowledge of standardized practices related to pressure injury prevention for the four pilot units.	Y	Pressure Injury Prevention bundles were finalized to include standardized practices. Anticipated completion of education within all pilot units by end of March 31, 2018.
All nursing staff on the four pilot units re-educated on documenting assessments via EPR.	Y	All nursing staff on pilot units received the review of EPR documentation for Skin Assessment and Braden Risk Assessment.

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9	Number of rehab/CCC inpatient falls (SSE 1-5) per 1,000 rehab/CCC inpatient days. (Rehab/CCC inpatient falls rate per 1,000 rehab/CCC inpatient days; Rehab/CCC inpatients; Q1-Q3; Patient Safety Incident Reporting System)	947	CB	CB	0.5	Classifying harm by Serious Safety Events (SSE) 1-5 is a new measurement system recently introduced at UHN which accounts for preventability. 2017/18 was a baseline year to better understand the Falls SSE rate. After developing a better understanding of the SSE measurement, the falls rehab/Complex Continuing Care (CCC) measure/indicator using the SSE classification system is the number of rehab/CCC patient falls (SSE 1-5) per 10,000 adjusted patient days. The focus for 2018/19 will be to improve the reliability of this measure.

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Refine falls inpatient Prevention Bundle.	Y	The Falls Prevention Bundle was refined and posted on the Corporate Intranet for broad sharing across the organization. Test units included TGH 10ES and PMH 16P, which trialed five spot audits/week with respect to adherence to the Falls Prevention Bundle. Initiated post fall follow up at unit/site huddles (TGH) to identify gaps in adherence to Falls Risk Assessment/Interventions.
Define falls outpatient Prevention Bundle.	Y	Refined screening questions and developed algorithm of possible Fall prevention interventions in outpatient settings. Testing a "Post Visit" screening question as patients Falls risk may have changed due to lengthy clinic visit/interventions, etc. Testing is underway with the Transplant Day unit at TGH. There are limitations with respect to available resources in outpatient settings once a patient is identified as a falls risk. It is difficult to standardize falls screening in outpatient settings as there are varying staffing and resourcing compliments and initial connection points with patients (for example, sometimes this is prior to appointment, other times it is at intake).
Define debrief form/process for fall prevention in the inpatient setting.	Y	Broad sharing of Post Fall Discussion Tool across organization. We collaborated with the Patient and Family Education group for Patient Engagement questions to include during post fall reviews. Education provided to Patient Safety Specialists for inclusion of the patient perspective in Falls debriefs. Used by managers/delegates with support from site Falls Committee members for information gathering prior to debrief. Received and incorporated feedback from all four sites.
Define safety huddle/visual board requirements for falls.	Y	Test units are using visual boards to highlight adherence to the Falls Prevention Bundle and tracking days/setting targets. Units are also using visual boards to highlight barriers to Fall Prevention and capture the number of days since the last fall. TGH is tracking falls and completion of risk assessment/interventions at the site huddle level.

Implement Post Fall Assessment at Toronto Rehab.	Y	Post Fall Assessment is in testing across Toronto Rehab. Gaps in post fall management of patients was identified during debriefs. Initial feedback on the Post Fall Assessment document is that it is too lengthy and not necessarily transferable to acute care settings in its present state. Currently we are collaborating with Healthcare Human Factors to improve usability.

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10	Number of Serious Safety Events (resulting in harm to workers) per 200,000 hours (100 FTE). (Number; All UHN employees (excludes non-UHN employees, students, volunteers, service providers, contractors); Q1-Q3; Employee Incident Reporting System (Parklane/VIP))	947	CB	CB	3.64	Experienced a reduction in overall SSER from 5.68 for April 2017 to 3.64 for December 2017. This is a 35.9% reduction. This reduction can be attributed to an increased focus on manager follow-up, reporting incidents at daily safety huddles, director involvement in organizing debriefs and all change ideas implemented as planned.

Change Ideas from Last Years QIP (QIP 2017/18)	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?
Implement electronic incident reporting system with a single portal of entry for all incident types.	Y	87% of incidents were reported using the Online Incident Reporting System. We are on track to meet our target of 90%. We have increased accessibility of the Online Incident Reporting System through the installation of computer stations at all Occupational Health Clinics. We continue with communication and education of the roles and responsibilities of managers to follow-up with incident reports and encourage reporting.
Conduct a comprehensive review of the current state of UHN's cause analysis program for employee incidents.	Y	We conducted a comprehensive review of UHN’s current cause analysis program for employee incidents. Through the review it was identified that various disciplines across UHN use different methods to identify causes of errors. There is a lack of a standardized process to determine the causes of errors, develop and share corrective actions to prevent reoccurrence.
Identify phases and common components of desired incident causal analysis program and compare with UHN's current state of analyzing employee incidents.	Y	Gap analysis completed and standardized components of the incident cause analysis program were finalized and aligned with patient safety process. Components of the process include Initiate, Screen (classification of events), Analyze, Develop & Implement (corrective actions) and Monitor (progression of change).

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11	Number of serious safety events (resulting in harm to workers) related to musculoskeletal injuries (MSD) per 200,000 hours (100 FTE). (Number; All UHN employees (excludes non-UHN employees, students, volunteers, service providers, contractors); Q1-Q3; Employee Incident Reporting System (Parklane/VIP))	947	2.14	2.14	2.00	Although only 2 out of 3 change ideas were implemented, a 6.5% reduction was achieved from target to current performance. The reduction can be attributed to staff being more conscious of working safely, incident follow-ups and SSE investigations which are reinforcing safe work practices and MSD problem solving around injury prevention. Baseline was achieved and a strong reporting culture is evident at UHN.

Change Ideas from Last Years QIP (QIP 2017/18)	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?
Identify high risk areas for MSD related incidents.	Y	Analyzed data to determine two high risk areas based on frequency and severity of MSD incidents and injuries. Two high risk areas were identified: Environmental Services and Multi-Organ Transplant.
Conduct cause analysis of MSD serious safety events in two departments identified as high risk.	N	Conducting a cause analysis of MSD serious safety events was not completed in the two high risk areas identified however, a cause analysis was completed for an MSD event that occurred at TGH in the OR and this cause analysis was presented to UHN leadership. Limited resources were available to apply the cause analysis framework to additional MSD events, however we will continue to discuss prioritizing initiatives and how to best allocate resources.
Conduct focus groups to review in detail incidents that result in harm to workers.	Y	The focus group process included basic training about MSD hazards. We are conducting expanded focus group discussions with frontline staff across UHN to identify trends and contributing factors related to MSD hazards and injuries, what issues they encounter, how they report and escalate issues, and how issues are addressed.

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12	Number of serious safety events (resulting in harm to workers) related to slips, trips and falls per 200,000 hours (100 FTE). (Number; All UHN employees (excludes non-UHN employees, students, volunteers, service providers, contractors); Q1-Q3; Employee Incident Reporting System (Parklane/VIP))	947	0.52	0.52	0.42	Experienced a 19.2% reduction from target to current performance. All change ideas were implemented as planned. The reduction can be attributed to increased awareness of Slips, Trips and Falls (STF) through the awareness campaign, news stories, video, and STF hazard reporting using the online incident reporting system and change ideas below. Baseline was achieved and a strong reporting culture is evident at UHN.

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Conduct environmental scan and literature review of provincial tools.	Y	Environmental scan and literature review were completed using sources which include, but are not limited to, the following: Ontario Ministry of Labour, Canadian Centre For Occupational Health and Safety, National Institute for Occupational Health and Safety, Public Services Health and Safety Association and Health and Safety Ontario.
Develop and implement standardized hazard identification and prevention checklist.	Y	Developed and implemented a standardized STF hazard identification assessment checklist. The Joint Health and Safety Committee completed standard STF hazard identification and prevention checklists during monthly inspections. 88% of hazard assessments were completed, including research areas which have 100% completion.

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13	Number of serious safety events (resulting in harm to workers) related to workplace violence per 200,000 hours (100 FTE). (Number; All UHN employees (excludes non-UHN employees, students, volunteers, service providers, contractors); Q1-Q3; Employee Incident Reporting System (Parklane/VIP))	947	0.44	0.44	0.24	Experienced a 45.5% reduction, with all change ideas completed. UHN's Workplace Violence Prevention Plan is embedded in our Caring Safely Foundational Element. Baseline was achieved and a strong reporting culture is evident at UHN.

Change Ideas from Last Years QIP (QIP 2017/18)	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?
Deliver UHN customized crisis intervention training for employees in high risk units.	Y	71% of staff have completed crisis intervention high risk training (as of December 2017). Challenges experienced include; over capacity protocols in areas identified as high risks. This has contributed to low attendance and registration. Most sessions ran with less than 100% capacity. We will continue to track completion in FY 2018/19. In the future, we will schedule fewer sessions during the months of flu seasons (November to March) and coordinate sessions with managers to avoid high peak activity periods.
Revise workplace violence policy and program to ensure it meets current requirements and includes all identified measures and procedures.	Y	The Workplace Violence Policy and Program has been revised and communicated to staff via presentations, all user e-mails from leadership, posting on the Corporate Intranet and a new eLearning module.
Conducting risk assessments for all areas previously identified as moderate risk.	Y	56% of areas deemed moderate risk have completed up to date risk assessments. Due to competing operational priorities, the risk assessment schedule was not adhered to (e.g. Ministry of Labour proactive inspections required the reallocation of resources). There is a greater focus in Q4 to complete all moderate risk area risk assessments.
Assess current UHN flagging system to identify gaps and prepare recommendations.	Y	UHN flagging system was assessed and the following gaps have been identified: no flagging policy/program and lack of assessment to determine when a flag is required.

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14	Percentage of UHN staff and physicians who have completed training in safety behaviours and error prevention tools. (Number of staff and physicians who have completed education/total number of staff and physicians; All employees of UHN – clinical and non-clinical, as well as all physicians credentialed to practice at UHN; 2017/18; Completion numbers from Learning Management System (LMS) registration and attendance sheets, plus manual attendance tracking for research, Michener staff, and anyone without LMS access)	947	CB	75.00	75.00	We have successfully rolled out Safety Behaviour and Error Prevention Training to staff and physicians throughout the year.

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Training all UHN Managers and above in high reliability leadership methods, including error prevention tools and safety behaviours.	Y	The final and seventh leadership methods module was delivered in October 2017 and make-up sessions are being held for those who have not completed all modules. 82% of UHN leaders have completed all seven leadership method modules.
Training all UHN staff and physicians in error prevention tools and safety behaviours.	Y	75% of all staff and physicians completed their Safety Behaviour and Error Prevention Training. We are working with Physician Leads to increase physician participation in training, including holding sessions during division meetings.

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15	Risk adjusted rate of surgical site infections (TGH General Surgery). (Risk adjusted rate of surgical site infections; Patients under the services of TGH General Surgery; July 2016 – June 2017; ACS NSQIP (American College of Surgeons' National Surgical Quality Improvement Program) and ON - NSQIP (Ontario collaborative))	947	12.01	12.01	11.60	This year is considered a maintenance year for SSI. The SSI HAC anticipates that once all prevention bundle elements are in place and fully incorporated into existing workflow, meaningful improvement in the outcome indicator will be possible.

Change Ideas from Last Years QIP (QIP 2017/18)	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?
Ensure appropriate perioperative normothermia for all surgical divisions.	Y	Active pre-warming in pre-operative care unit (POCU) has been implemented across all sites and staff have received associated education. Pre and post-implementation audits have shown that active pre-warming is effective at promoting perioperative normothermia. A 55% improvement was noted in patients whose temperature was > 36 degrees Celsius on arrival to the OR. Work is underway to identify resources to support ongoing auditing related to perioperative normothermia. An Operating Room (OR) Temperature and Humidity Policy has been drafted and shared. Additional thermometers have been installed. Work is underway to develop automated reporting of OR Temperature and Humidity for TGH and PMH sites.
Ensure bathing before surgery (decolonization) for all surgical divisions.	Y	Elective surgical patients receive education and a brochure detailing how to bathe before surgery. Spot Audits have shown that 100% of patients surveyed at TWH and TGH, received this education. Work is underway to survey patients on their ability to follow bathing before surgery recommendations to uncover compliance and barriers. Directions on how to bathe before surgery have also been shared with inpatient surgical units.
Ensure perioperative skin antisepsis (skin prep and draping in OR) for all surgical divisions.	Y	Audit completed in April/May of 2017 with support from Vendor outlining areas for improvement as well as current adherence to best practices. A Skin Prep Tip Sheet poster has been drafted and will be posted for reference in each OR. A review of resident and nursing education materials was also undertaken. Outdated educational materials have been updated to reflect current best practices. Work is underway to standardize skin prep trays across sites.

Follow skin closure protocols for all surgical divisions.	Y	Closing trays have been developed and implemented for applicable surgical cases across sites. Work is underway to capture compliance through electronic documentation. Currently, manual tracking is in place.
Provide prophylactic antimicrobial coverage and ensure appropriate use of prophylactic antibiotics for General Surgery and Orthopaedic Surgery.	Y	Baseline data for TGH General Surgery was obtained through an audit supported by the Antimicrobial Stewardship Program (ASP). Current performance on antibiotic choice, timing, duration, and re-dosing was collected. Current adherence to best practices was also assessed. We are working towards identifying opportunities to improve antibiotic administration that align with best practices.
Maintain perioperative glucose control for all surgical divisions.	Y	A process map is currently under development with large stakeholder input. Existing glucose management order sets and processes have been reviewed. Networking with other large surgical centres and a literature review have also been undertaken. Next steps include identifying the scale of the intervention and informing the development of a glucose control protocol.
Initiate all planned prevention bundle elements.	Y	All bundle elements have been initiated.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
16	Risk adjusted rate of surgical site infections (TWH General Surgery) (Risk adjusted rate of surgical site infections; Patients under the services of TWH General Surgery; July 2016 – June 2017; ACS NSQIP (American College of Surgeons' National Surgical Quality Improvement Program) and ON - NSQIP (Ontario collaborative))	947	4.82	4.82	4.81	This year is considered a maintenance year for SSI. The SSI HAC anticipates that once all prevention bundle elements are in place and fully incorporated into existing workflow, meaningful improvement in the outcome indicator will be possible.

Change Ideas from Last Years QIP (QIP 2017/18)	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?
Ensure appropriate perioperative normothermia for all surgical divisions.	Y	Active pre-warming in pre-operative care unit (POCU) has been implemented across all sites and staff have received associated education. Pre and post-implementation audits have shown that active pre-warming is effective at promoting perioperative normothermia. A 55% improvement was noted in patients whose temperature was > 36 degrees Celsius on arrival to the OR. Work is underway to identify resources to support ongoing auditing related to perioperative normothermia. An Operating Room (OR) Temperature and Humidity Policy has been drafted and shared. Additional thermometers have been installed. Work is underway to develop automated reporting of OR Temperature and Humidity for TGH and PMH sites.
Ensure bathing before surgery (decolonization) for all surgical divisions.	Y	Elective surgical patients receive education and a brochure detailing how to bathe before surgery. Spot Audits have shown that 100% of patients surveyed at TWH and TGH, received this education. Work is underway to survey patients on their ability to follow bathing before surgery recommendations to uncover compliance and barriers. Directions on how to bathe before surgery have also been shared with inpatient surgical units.
Ensure perioperative skin antisepsis (skin prep and draping in OR) for all surgical divisions.	Y	Audit completed in April/May of 2017 with support from Vendor outlining areas for improvement as well as current adherence to best practices. A Skin Prep Tip Sheet poster has been drafted and will be posted for reference in each OR. A review of resident and nursing education materials was also undertaken. Outdated educational materials have been updated to reflect current best practices. Work is underway to standardize skin prep trays across sites.

Follow skin closure protocols for all surgical divisions.	Y	Closing trays have been developed and implemented for applicable surgical cases across sites. Work is underway to capture compliance through electronic documentation. Currently, manual tracking is in place.
Provide prophylactic antimicrobial coverage and ensure appropriate use of prophylactic antibiotics for General Surgery and Orthopaedic Surgery.	Y	Baseline data for TGH General Surgery was obtained through an audit supported by the Antimicrobial Stewardship Program (ASP). Current performance on antibiotic choice, timing, duration, and re-dosing was collected. Current adherence to best practices was also assessed. We are working towards identifying opportunities to improve antibiotic administration that align with best practices.
Maintain perioperative glucose control for all surgical divisions.	Y	A process map is currently under development with large stakeholder input. Existing glucose management order sets and processes have been reviewed. Networking with other large surgical centres and a literature review have also been undertaken. Next steps include identifying the scale of the intervention and informing the development of a glucose control protocol.
Initiate all planned prevention bundle elements.	Y	All bundle elements have been initiated.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
17	The number of same day cancellation and number of scheduled cases each month (excluding “organ unacceptable” and “organ unavailable” for transplant patients). The same day cancellation rate was calculated by dividing the number of same day cancellations by the number of scheduled cases. (%; All UHN surgical patients (excluding “organ/tissue unacceptable” and “organ/tissue unavailable” reasons for cancellations).; Q1-Q3; ORSOS)	947	6.00	5.00	6.5	Reducing same day surgical cancellations continues to be a priority for UHN. We will continue working towards having a dedicated surgical stream for transplant and emergency patients at the TGH site in an effort to reduce cancellations for elective/non-elective surgical patients.

Change Ideas from Last Years QIP (QIP 2017/18)	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?
Work towards having a dedicated surgical stream for transplants and not mixing these with the other elective/non-elective surgical patients.	Y	Throughout 2017/18 we have engaged with an industrial engineering group to develop a two stream (elective and non-elective) surgical model. This model would include having two dedicated rooms for transplant and emergency surgeries 24/7 at TGH, the site at which transplants are performed. We are in the process of determining the cost of this plan and will bring the proposal forward in 2018/19.
Implementation of daily review of key surgical efficiency metrics at TWH; same day cancellations is one of these metrics.	Y	We have embedded daily review of surgical efficiency metrics at TWH, following successful implementation at TGH. Six key surgical efficiency metrics from the week before are reviewed weekly at the OR Business meetings every Monday morning.
Addition of two Flex Rooms per week at TWH.	Y	From April to December 2017 we had two additional Flex Rooms and this strategy worked very well to keep same day cancellations to a minimum. We had to close the additional rooms in December due to lack of staffing resources, however we look forward to staffing up to the appropriate levels in the 2018/19 and re-opening the Flex Rooms.