Let's Make Healthy Change Happen.

Quality Improvement Plan (QIP) Narrative for Healthcare Organizations in Ontario

3/27/2018

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

University Health Network's (UHN) 2018/19 Quality Improvement Plan (QIP) represents our commitment to improve the quality of care we provide to Canadians. As Canada's largest research hospital, it is not only important but our responsibility to lead by example and provide safe, efficient care for those we serve.

Our primary value as an organization is that the needs of patients come first. To uphold this value, we work closely with our patients to inform our annual QIP priorities, targets and activities. While developing last year's QIP, we engaged our Patient Partners in a series of focus groups and identified what was most important to them with respect to patient safety. For instance, Patient Partners helped shape interventions to reduce pressure injuries by collaborating with staff in a working group and consulting with them through surveys. This helped ensure that clinicians provided patient education using the principles of health literacy. Furthermore, our Patient Partners contributed to a poster that was presented at two conferences ("Caring Safely: Driving Preventable Harm to Zero with Patient Partners at UHN", presented at HIROC [Healthcare Insurance Reciprocal of Canada] and Health Quality Transformation 2017).

Beyond this primary value, there are certain priorities that tie UHN together:

- **Caring Safely:** committing to zero preventable harm at our hospitals;
- **Operational Excellence:** delivering the greatest value for our patients;
- **Patient Experience**: empowering them to participate in their healthcare; and,
- **People & Culture:** enabling our staff to do their best work.

Collectively, these are known as UHN's Foundational Elements and drive the day-to-day work of our organization. The 2018/19 QIP was developed to better reflect the broad scope of work at UHN. As such, our QIP includes indicators for each of the four Foundational Elements. Some indicators from the 2017/18 QIP have carried over so we can continue to monitor and improve our progress.

This year, we raised our level of patient engagement by involving our Patient Partners earlier in the QIP process and updating them on our indicator progress throughout the year. Our Patient Partners collaborated on the development of change ideas for Operational Excellence, Patient Experience, and People & Culture. As Patient Partners are already deeply ingrained in our safety transformation, no separate engagement for QIP was done for Caring Safely.

Describe your organization's greatest QI achievements from the past year

Caring Safely and our Medical Assistance in Dying (MAID) program are two exemplary cases of UHN living its primary value.

UHN and SickKids are collaborating on Caring Safely to help eliminate preventable harm to both staff and patients. Launched in 2015, Caring Safely is a major strategic initiative that acknowledges how hospitals are complex systems where medical errors can and do happen. In order to tackle errors head on, Caring Safely aims to create a culture where staff and patients

embrace safety as a core value. Part of this work involves training all staff and physicians in error prevention and safety behaviours. More than 75% of all UHN staff and physicians (including leadership) have completed training, representing a significant step towards embedding high reliability and safety behaviours throughout the organization.

Palliative Care is a shared focus of Ontario and UHN. We support patients or family members who are having difficulty coping with their illness or treatment, from assessment to the end of life. This includes work being done for patients who request Medical Assistance in Dying (MAID). Patient Partners were engaged in 2016 during the development of MAID processes to ensure that UHN was responsive to patient needs and to understand what would be most important to them in this process. Below is a portion of a letter we recently received which expresses gratitude for those who provide the MAID service at UHN (edited to protect the privacy of this family):

> *From that time (diagnosis and treatment) until her death, she and her family received the best of care, timely, competent and so compassionate from the primary team in the clinic, the palliative care team and finally the MAID team. From her request for information about MAID to the implementation of the procedure she felt so supported as did the rest of her family. The MAID coordinator was with us every step of the way. The steps in the procedure were explained to my daughter and to us in a very accessible manner by the physician. Nothing was rushed, there was lots of time and many opportunities for questions and discussions.*

The MAID example above illustrates the profound impact our work can have on the people we serve.

Resident, Patient, Client Engagement and relations

The number of Patient Partners recruited and the engagement activities they participated in exceeded our targets for 2018/19 (Target: 90 onboarded Patient Partners; Actual: 100 onboarded). In Q3 alone, we held 38 Patient Partner engagement activities across the organization, consulting with them in focus groups and surveys; and collaborating with them in working groups, committees and hiring panels. As mentioned above, Caring Safely Error Prevention Training is being rolled out across the organization and some of our Patient Partners have participated in co-facilitating training workshops.

Patients are also becoming more engaged at the Committee and Board level at UHN. For example, Patient Partners are sharing their stories related to safety and quality at the Safety and Quality Committee of the Board. After one of our Patient Partners shared their story of experiencing a pressure injury, they were asked to accompany the new Chair of the Minister's Patient & Family Advisory Council to present their story at a meeting with the Deputy Minister. This Patient Partner said:

> *I'm very comforted to know by being involved with the Patient & Partner Program that my experience and voice as a patient is being directly heard and acted upon by hospital frontline staff all the way up to the Deputy Minister of Health to give me the best possible patient-centered care.*

There is now standing committee membership of Patient Partners on Toronto Rehab and Princess Margaret's Safety and Quality Committee. UHN's Quality of Care Committee will be bringing Patient Partners on as members in April 2018. Patients have also been involved in hiring panels for leadership positions, including the search committee for UHN's new President & CEO.

For this year's Quality Improvement Plan, Patient Partners were paired with Foundational Element working groups for consultation and contribution towards the change ideas that will lead us to achieving our indicator targets for this year. Looking ahead, the intention will be to engage Patient Partners through various methods in each Foundational Element as the implementation of those change ideas occurs throughout 2018/19.

It has been more than a year since the myUHN Patient Portal was launched. More than 40,000 patients have signed up since. myUHN is a secure website where patients and caregivers can engage in their own care by accessing their health record information, receive lab results in real time and view their appointment schedules. We are continuing to increase our registration options so that patients across UHN have seamless access to their health information.

In September 2017, we surveyed patients about their experience with myUHN. 9,827 people responded (37% response rate) and the majority of patients reported that myUHN improved their patient experience. Some highlights of the survey are as follows:

- 94% of patients felt better prepared for their appointment;
- 94% believe it helps them better communicate with their care team;
- 94% want to see their results as soon as they are ready, even if they are worrisome; and,
- 91% of patients believe it helps them make decisions about their care.

Population Health and Equity Considerations

A population health management approach is critical for the future of all healthcare organizations. Given the inherent demographic shifts of aging and complex populations, as well as the importance of equitable access to care, UHN has been working to increase the presence of population health throughout the organization.

One way we have done this is through our continuing role as the Hospital Resource Partner for the Primary Care Strategy within the Mid-West Toronto Sub-Region. The Mid-West Sub-Region benefits from strong relationship networks such as the SCOPE (Seamless Care Optimizing the Patient Experience) integration project, the SPIN (Solo Practitioners in Need) collaboration among Community Health Centres (CHC) and collaborative partnerships with the five Family Health Teams (FHT) and among the three hospitals.

Health Links work continues to thrive based on connections made with a range of health service providers – from the various primary care models (solo general practitioners, CHCs, FHTs), hospital partners, as well as a robust representation of community support agencies stretching from the waterfront region to Oakwood and Eglinton.

This work aligns with the Toronto Central Local Health Integration Network's (TC LHIN) focus on the next phase of Health Links maturation and includes working groups to:

- adopt best practices;
- evaluate the Coordinated Care Plan process; and,
- test innovative models of attaching and coordinating care for complex patients in the hospital and in the community.

The Mid-West Sub-Region works collaboratively with Home and Community Care to address the needs of marginalized complex patients within local neighbourhoods and is working to embed the Health Care Connector role to improve patient attachment and access.

Primary Care engagement activity is ongoing with projects underway to:

- spread specialist access (e.g. secure email onboarding, e-consult, Central Intake pilot, design of the Specialist Directory);
- enhance access to interprofessional teams via the spread of SPIN and TIP (Telemedicine Impact Plus) initiatives; and,
- planning for a new Interprofessional Team for the Weston-Pellham Park neighbourhood to improve equity and access for our local population in collaboration with community partners.

Improving health equity is important at UHN. Recognizing the diverse community that we serve, we provide translated educational materials (print and online), offer multi-lingual collections in the Patient and Family Libraries and provide simultaneous interpretation at health education events. We offer translation services at no cost for more than 180 different spoken languages through the phone and face-to-face interpretation, ensuring patients are able to interact with care providers in the language of their choice. We also have an American Sign Language interpreter available for patients who are deaf, deafened or hard of hearing. These practices create a safer healthcare environment by ensuring that informed decisions are made and consent for procedures is obtained appropriately.

We began to collect health equity data in April 2013. The standardized questionnaire consists of eight questions that are voluntarily filled out by patients once every five years. Data collected is accessible and visible in UHN's Electronic Medical Record (EMR) and is part of the patient chart. This data has and will continue to help us inform future programming efforts and reveal areas for which quality improvement initiatives should be targeted.

Access to the Right Level of Care: Addressing ALC

Over the last few years, UHN has continued to work to reduce the number of patients identified as Alternate Level of Care (ALC). We have seen a decrease in the number of open ALC cases year-over-year: 146 in December 2015, 136 in December 2016 and 98 in December 2017. We will continue to monitor our ALC cases and are exploring new ways of bringing patients the right care, at the right time, in the right place.

In December 2017, we opened the Hillcrest Reactivation Centre, a cross-sector partnership with Saint Elizabeth Health Care. Hillcrest fills a gap in the healthcare system by providing an innovative reactivation and reintegration model that focuses each client, their family, and their care team on the goals of going home with the appropriate supports in place.

Hillcrest has helped reduce ALC pressures on acute care hospitals within the TC LHIN. As of February 2018, 65 of the 75 care spaces were occupied at Hillcrest. Since its opening, 20 patients have been reactivated and discharged home. Beyond this, we have received numerous patient stories that outline the impact of this new level of care including one about a Mrs. AB. When Mrs. AB was admitted to Hillcrest in December 2017, her goals were getting support with medication management and to facilitate her transition home. According to Mrs. AB, "hospitals are good for what they do," but Hillcrest is helping people "meet their own needs." While at Hillcrest, Mrs. AB was supported in gaining strength and independence with her activities of daily living, enjoyed exercising, recreational activities, and appreciated the home-like atmosphere. After three-and-a-half weeks, Mrs. AB was discharged home. According to Home and Community Care, who had worked with her in the past, they had never seen her so well-prepared, calm and confident after discharge from hospital.

Workplace Violence Prevention

Workplace violence is not only a priority for the province, but is also a key component of our safety transformation. UHN recognizes that most acts of violence are preventable within the workplace. Creating a culture that supports this philosophy will inevitably reduce and eliminate harm experienced by violent acts. Naturally, understanding why these events occur is key to preventing future events. Encouraging reporting and situational awareness are two factors that are critical in the development of effective preventative measures. The goal is to move from being reactive to building systems that support early detection and correction.

UHN's Workplace Violence Prevention Plan is embedded in Caring Safely and aims to reduce the rate of harm experienced by workers at UHN. Our series of targeted prevention strategies include but are not limited to the following:

- analysis of data to determine where and how violence is experienced and the effectiveness of preventative measures;
- application of a risk methodology that quantifies level of risk related to violence based on probability and severity of harm;
- implementation of a multi-tiered approach to education which includes situational learning to mitigate risks related to violence, aggression and responsive behaviours; and,
- development and implementation of behavioural management strategies that include how to recognize, communicate and manage those individuals who demonstrate behaviours that are likely to result in harm to others. A Patient Partner was a member of the Behavioural Safety Alert Working Group.

Through an in-depth analysis of UHN's workplace violence data, we identified an increasing trend of reported workplace violence incidents. Based on fiscal year data from 2014 to 2017, there was a 216% increase in reported workplace violence incidents (from 222 to 701). Although the number of incidents reported continues to rise, the ratio of harm decreased from 14.4% to

5.6% (FY 2014-2017). This demonstrates an improvement in our reporting culture and effective preventative measures that result in a reduction of harm to workers.

In 2016, UHN adopted the Serious Safety Event Classification system, which categorizes events that are preventable and reach the worker as Serious Safety Events (SSE) with five levels of harm. The details of UHN's Workplace Violence data are reviewed monthly with leadership, the Joint Health and Safety Committees and/or Health and Safety Representatives. The Workplace Violence SSE data is displayed in UHN's Safety Scorecard and is reported regularly to the UHN Safety and Quality Committee of the Board, included in UHN's QIP and made available on the UHN Caring Safely intranet site.

The Workplace Violence Prevention Plan aims to:

- eliminate preventable harm experienced by workers;
- align practices with those that effectively manage violence, aggressive and responsive behaviours;
- assess and address known risks of violence; and,
- develop situational-based education to prepare healthcare professionals and service providers (including all members of the interdisciplinary team) to effectively and safely identify, assess and, where needed, treat those with complex behaviours.

Performance-based Compensation

The following indicators were selected to be linked to executive compensation as they reflect each of our four Foundational Elements (please see table below):

Indicator	Rationale	Target
Pressure injuries (acute inpatient): Pressure injury incident density rate	**Caring Safely** represents our commitment to zero preventable harm, for our patients and our staff. Pressure injuries are one of six Hospital Acquired Conditions (HACs) that UHN aims to reduce by 30% over the next three years.	3.83%
Workplace violence: Percent lost time	**Caring Safely** represents our commitment to zero preventable harm, for our patients and our staff. We strive to provide a safe environment for our people to do their best work, including working towards the elimination of harm caused by workplace violence.	1.59%
Canadian Patient Experience survey: Percent who responded with a rating of 9 or 10 inclusively	Engaging with patients and caregivers to learn about their experiences of care and the opportunities our organization has for improvement will allow UHN to better meet the needs of patients and caregivers. Achieving this target will reflect our commitment to improving **Patient Experience** through patient engagement activities in the organization.	70%
Same-day surgical cancellation: Percentage of same day surgery cancellations	Cancelling surgeries on the same day is distressing for patients and their caregivers. We are committed to improving health system resource issues and maintaining **Operational Excellence** so we can continue delivering elective and non-elective surgeries with the fewest number of cancellations possible.	5%
Employee engagement	Our best work at UHN relies on the engagement and commitment of our amazing **People & Culture**. Executive leaders at UHN are most responsible for modeling and inspiring other leaders to create an engaging workplace experience for all UHN staff.	55%

The following portions of variable compensation will be linked:

- President and Chief Executive Officer 25%
- EVP and Chief Business Officer 20%
- EVP Human Resources 20%
- EVP and Chief Operating Officer 20%
- EVP and Chief Medical Officer 20%
- EVP Technology & Innovation 20%
- EVP Science & Research 20%
- EVP Education 20%
- VP Patient Experience & Chief Health Professions 20%
- Clinical Vice Presidents 20%
- Chiefs 20%

The five targets will be equally weighted. The following incentives will be available for each target:

- Target achieved 100%
- 80% of target achieved 80%
- 50% of target achieved 50%

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

Mr. Brian Porter, Chair, Board of Trustees
Dr. G. Ross Baker, Chair, Safety and Quality Committee
Dr. Charlie Chan, Interim President & Chief Executive Officer

2018/19 Quality Improvement Plan
"Improvement Targets and Initiatives"

University Health Network 190 Elizabeth St., R. Fraser Elliott Building, 1st Floor

AIM		Measure						Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	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**	Readmissions (COPD, CHF, GI and CAP). The MLAA readmission rate is used. It is risk-adjusted.	% / Patients readmitted to TGH/TWH with similar coding as previous visit within 30 day period	Intellihealth (TC LHIN) / Q2-Q3	21.30%	14.70%	This target is aligned with the TC LHIN Readmissions Project, which is focused on a joint strategy to reduce avoidable readmissions through the identification of best practices and LHIN-wide initiatives.	Utilize the patient identification tool to identify high-risk readmission patients.	Implementation of identification tool to determine appropriate variables to improve sensitivity for high risk patients in our catchment area.	Implement the patient identification tool. Utilization of completion tool.	Adoption and usage of identification tool in Emergency/ Admissions/ General Internal Medicine settings.	
								Standardize discharge checklists to encompass teach back, medication reconciliation and scheduling follow up appointments in the community.	In collaboration with community partners, improve coordination and communication with family physician and home and community care by standardizing discharge checklists.	Discharge checklist created. Implemented in General Internal Medicine.	Increased adoption rate.	
								Standardize order sets for these high-readmission rate patients.	Create standardized order sets for each disease through best practice identification within the TC LHIN and Province.	Implement within General Internal Medicine.	Increased adoption rate.	Currently completing an environmental scan to determine usage of order sets.

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Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Patient-centred	Person experience	Overall rating from Canadian Patient Experiences Survey (Q41).	% 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	Canadian Patient Experiences Survey / Q1-Q3	71.40%	70%	There was a shift to lower scores overall on patient experience following the implementation of a new survey in 2016. However, this new rigorous approach has created a better understanding of areas for improvement for patient experience at UHN.	Increase patient partnership recruitment to include representation from all sites and programs across UHN.	Create targeted recruitment strategy to ensure patient and family caregivers in the Patient Partners program are from all areas across UHN.	Number of Patient Partners onboarded by March 31, 2019. The Patient Partner population will be reflective of the care programs across UHN.	120	We currently have 97 Patient Partners in the program. Our target will be to recruit and onboard 23 new Patient Partners.
								Evaluate the impact of patient engagement on UHN committees, working groups, etc., through the Patient Partnerships program.	1) Patient Partners will be onboarded to the UHN Quality of Care Committee and the site-based Quality of Care Committees. 2) Distribute patient engagement survey to UHN Patient Partners and staff liaisons of these committees to determine their experience of partnering at this level of decision-making.	1) Number of Quality of Care Committees that have onboarded Patient Partners as members. 2) Implement a patient engagement survey to measure the impact of patient engagement in the Quality of Care Committees.	1) Establish baseline. 2) Will have distributed survey to 100% of Patient Partners and Staff involved in Quality of Care Committees.	
		Employee Engagement.	Engagement is measured by the % of respondents that score 5.01 out of 6 on a series of validated job and organizational engagement driver questions / All Full/Part-time permanent staff	Annually administered through a technology platform & external benchmarks procured from external vendor / Q3	CB	55%	The target for UHN is 55%, which is 1% higher than the captured average engagement score from survey vendor. As at November 2017, the vendor average is 54%. As the 2016 Employee Engagement Survey was measured using a different tool and engagement methodology, we will collect baseline data in FY 2018/19.	Improve response rate to the employee engagement survey.	Create and implement a strategy to boost response rates. Visit low response units and use mobile technology/kiosks to increase response rates, and recognize units/departments that reach 100% response rate within the first week of the survey.	Reported response rates by teams/departments produced three times per week during the two week survey.	75% overall response rate is the 2018 target (10% increase over last survey).	
								Focus and align efforts to improve engagement across UHN.	1) Executive Team to identify 1-3 areas of focus based on survey results, set targets, and focus strategies and initiatives that align and link to improving engagement. Involve a Patient Partner and employee groups in the planning process. 2) Align leadership accountability for execution, and cascade regular progress updates to employees (e.g. huddle boards, story telling (how changes are making a difference), "You Said, We Did" communications, to increase awareness of the areas of focus and actions taken.	1) 1-3 UHN-wide areas of focus, with identified targets are communicated within two months of the survey and communicated along with the individual unit/department scorecards. 2) Survey question on the Pulse survey "I am aware of the plans that were put in place to respond to the Employee Engagement Survey" will be used to measure the success of improved employee awareness.	1) UHN Executive Team finalizes 1-3 areas of focus. 2) Survey question about awareness on Pulse survey moves from 41% to 50%.	
								All units/departments develop and implement an engagement improvement action plan.	Simplify the action planning process, tools and supports for leaders. Leaders share results, and work with their team to identify one engagement objective (from the 3 areas of focus, if below the benchmark), and create and post their action plan on their huddle board to review quarterly.	Units/departments update their huddle boards with an engagement action plan dashboard and provide quarterly updates. Senior Leaders audit to validate if those who received a report have an action plan in place and posted on their huddle boards within six months of the survey.	100% of units/ departments have identified 1-2 areas of focus to build engagement documented in an engagement action plan.	

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Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Timely	**Timely access to care/services**	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)	ORSOS / Q1-Q3	6.50%	5.00%	The target has been aligned with the Surgical Efficiency Targets Program (SETP) which helps to optimize surgical capacity in Ontario, increases access to surgical services and maintains high-quality patient care. The decision to exclude “organ unacceptable” and “organ unavailable” for transplant patients was made because cancellation of these cases is due to issues beyond the control of the organization.	Work towards having a dedicated surgical stream for transplants at TGH and not mixing these with the other elective/non-elective surgical patients.	Complete analysis on cases cancelled due to transplant priority and determine operating room resources needed to set up dedicated transplant surgical suites.	Finalized decision by TGH Surgical Executive.	Decision finalized.	
								Addition of two Flex Rooms per week at TWH.	Measure compliance and utilization of the OR Flex Rooms.	Percentage utilization of OR Flex rooms.	System Implemented.	

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Safe	**Workplace Violence**	Number of workplace violence incidents (overall).	Count / Worker	Employee Incident Reporting System (Parklane/VIP) / NOTE: FTE 11694 from January 2018-December 2018	585 (January 2017 - December 31, 2017)	603	There will be a focus on Enhanced Reporting Culture, therefore we anticipate an increase from our current performance. The target represents a 3% increase in incidents from current performance.	Launch New Workplace Violence, Domestic Violence and Harassment policy and program.	Streamlined and updated eLearning to include new legislative changes. Information/instruction on reporting incidents of Workplace Violence and the definition of Workplace Violence included in education.	Number of training completions as recorded in UHN's Learning Management System, Research System and students.	100% completion of workplace violence, domestic violence and harassment eLearning module.	
								Continue with Safe Management Group (SMG) Crisis Intervention Training in high and moderate risk areas.	Customized Crisis Intervention Training delivered by Safe Management Group (SMG) to workers in high and moderate risk areas.	Number of training completions as recorded in UHN's Learning Management System.	100% completion of all workers in identified high risk areas and 90% of workers in moderate risk areas will have completed the training. (The number of training completions compared to the number of active FTE's in identified areas.)	
								Develop summary of findings for risk assessment completed in high risk areas and determine corrective actions.	Conduct an analysis of data collected from the Workplace Violence Risk assessments in high risk areas.	Complete comprehensive review of risk assessments and report on findings/recommendations.	100% of Workplace Violence Risk assessment data analyzed and reported.	
		Workplace Violence: Percent of Lost Time.	Number of Lost Time Violence Incidents / Total number of all reported violence incidents x 100	Employee Incident Reporting System (Parklane/VIP) / Q1-Q3	1.67%	1.59%	5% reduction in incidents of workplace violence that result in Lost Time. Preventative measure initiated as part of UHN's Workplace Violence Strategy. F2016 UHN Percent Lost Time = 1.04%.	Conduct workplace violence risk assessments for all areas previously identified as moderate risk.	Using UHN's workplace violence risk assessment tool to complete assessments.	Validate the risk level for each of these areas.	100% completion of risk assessment for areas identified as moderate risk.	
								Develop policy and procedure to apply Behavioral Safety Alert.	Focus Group discussions led by ethics, professional practice and key stakeholders.	Complete policy and program with toolkit for dissemination to all healthcare professionals.	100% completion of policy, program and toolkit.	
Safe	**Safe care / medication safety**	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 / Acute inpatients	Electronic Patient Record / Q1-Q3	3.97	3.83	UHN is targeting a 5% decrease from baseline, the first step in a larger 3-year target of a 30% reduction. It is anticipated that the rate will increase initially due to improved	Roll out pressure injuries prevention bundle to clinical units outlined in the FY 2018/19 HAC program implementation plan.	Ensure that all identified units have participated in the Pressure Injury HAC implementation activities as per FY 2018/19 implementation plan.	Percentage of identified units that have participated in the Pressure Injury HAC implementation activities as per FY 2018/19 implementation plan.	100% of identified units have participated in the Falls HAC implementation as per FY 2018/19 implementation plan.	

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Quality dimension	**Issue**	**Measure/Indicator**	**Unit / Population**	**Source / Period**	**Current performance**	**Target**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**	**Comments**
							consistency in EPR documentation in acute care and then decrease once documentation and incident reporting are stabilized.	Standardize pressure injury incident reviews.	Use post Pressure Injury Discussion Tool for all serious safety event related pressure injury incidents.	Pressure Injury Discussion Tool is used for all serious safety events related to pressure injury incidents.	100% use of Pressure Injury Discussion Tool for all serious safety events related to pressure injury incidents.	
		Number of acute inpatients newly diagnosed with nosocomial C. Difficile Infection (CDI) per 1,000 acute inpatient days.	Nosocomial Acute Inpatient CDI rate per 1,000 acute inpatient days / All acute inpatients	Infection Prevention and Control C. difficile database / Q1-Q3	0.51	0.48	0.48 was the FY 2017/18 target but was not achieved. By rolling out the CDI prevention bundle and increasing prevention practices in key areas with high concentration of nosocomial CDI cases, a target of 0.48 is believed to be achievable.	Roll out CDI prevention bundle to clinical units outlined in the FY 2018/19 HAC program implementation plan.	Ensure that all identified units have participated in CDI HAC implementation activities (education, data collection, reinforcement) as per FY 2018/19 implementation plan.	Percentage of identified units that have participated in CDI HAC implementation activities as per FY 2018/19 implementation plan.	100% of identified units have participated in CDI HAC implementation activities as per FY 2018/19 implementation plan.	

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Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Safe	**Safe care / medication safety**	Number of acute falls (SSE 1-5) per 10,000 adjusted patient days.	Acute (SSE 1-5) falls rate per 10,000 adjusted days / All acute patients	Patient Safety Incident Reporting System / Q1-Q3	0.35	0.35	FY 2018/19 will be a year for establishing baseline using the Falls Serious Safety Event (SSE) Indicator. As UHN continues to improve the way we determine preventability, it is expected to see a greater number of events classified as preventable, as represented in the Serious Safety Event Rate (SSER). As such, the Falls SSE rate is anticipated to increase, therefore FY 2018/19 will target maintenance. NOTE: The total number of falls with significant harm is not expected to increase. The increase expected is in the number of identified preventable falls causing significant harm.	Roll out falls inpatient Prevention Bundle to clinical units outlined in the FY 2018/19 HAC program implementation plan.	Ensure that all identified units have participated in the Falls HAC implementation activities (education, data collection, reinforcement) as per FY 2018/19 implementation plan.	Percentage of identified units that have participated in the Falls HAC implementation activities as per FY 2018/19 implementation plan.	100% of identified units have participated in the Falls HAC implementation as per the FY 2018/19 implementation plan.	
								Improve consistency of classification of Falls as preventable.	Ensure subject matter experts from Falls Committee are present during Falls debriefs for potential Serious Safety Events. Build capacity in Patient Safety Specialist.	Subject matter experts from Falls Committees are present at Falls debriefs for potential Serious Safety Events to ensure that all debriefs result in determination of preventability.	Subject matter experts are present at 100% of Falls Debriefs for potential Serious Safety Events to improve classification of preventability.	
		Number of rehab/CCC falls (SSE 1-5) per 10,000 rehab/CCC adjusted patient days.	Rehab/CCC (SSE 1-5) falls rate per 10,000 rehab/CCC adjusted patient days / All rehab/CCC patients	Patient Safety Incident Reporting System / Q1-Q3	0.5	0.5		Ensure effective Falls Risk Screening is occurring in all outpatient areas and appropriate actions for those identified as high risk are in place.	Use Post Fall Discussion Tool for all potential Serious Safety Event Falls. Refine Outpatient Falls Screening Questions based on learning from pilot(s) to ensure consistent standardization of Falls Risk Screening in all outpatient areas.	Link in Accreditation Required Organizational Practices to perform "Just In Time" audits.	100% of identified outpatient areas using standardized Falls Screening questions.	
								Standardize Post Fall Debriefs.	Use Post Fall Discussion Tool for all potential Serious Safety Event Falls.	Post Fall Discussion Tool is used at all potential Serious Safety Event Fall debriefs.	Post Fall Discussion Tool is used at 100% of potential Serious Safety Event Falls debriefs.	
								Standardize Falls Patient Education Materials: 1) Pamphlets and 2) Posters.	Consolidate existing Patient Education material. Ensure it reflects Accreditation Canada and Caring Safely requirements, while reflecting the patient and family perspective. Engage patients in creation of materials. Priorities: 1) Pamphlets - Inpatient, Outpatient & Preventing Falls at Home; 2) Posters.	Ensure all areas are aware of, and have high quality, Caring Safely Falls approved materials available to them.	100% of Caring Safely Falls Patient Education materials are standardized and incorporate the patient and family perspective.	