2024/25 Quality Improvement Plan

"Improvement Targets and Initiatives for TORONTO Region"

Key Messages:

This is a temporary excel work plan template for planning purposes, there is no upload function to Navigator

Navigator will be open for hospitals in mid-January after pre-population of administrative data takes place

Three indicators have been identified as priorities by your region, and are encouraged for consideration to include in your QIP.

M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) O= Optional (do not select if you are not working on this indicator) C = Custom (add any other indicators you are working on)

AIM		Measure									Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Access and Flow	Efficient	**Reduction in the Alternate Level of Care (ALC) Rate**	P	ALC patients/all patients	Patient Flow Department		3.8	Reduction of 10% (3.4)	Health Quality Ontario recommends 5-10% increase or decrease when deciding a quality improvement project target		1. Create a system for early ALC identification and escalation	1. Develop criteria and identify thresholds for timely escalation of patients at risk of becoming ALC by Jan 2024 2. Educate physicians, managers and staff on the system 3. Incorporate education material in the presentation described above by Feb 2024	% of ALC patients identified % of staff who received the education	TBD	
											2. Training staff on delirium prevention and management, and seniors' sensitivity.	1. Obtain resources from the Regional Geriatric Program (RGP) to obtain insight into educational material 2. Create learning modules for orientation (new staff) by Jan 31st, 2024 3. Create an annual eLearning module (for existing staff) by Mar 31st, 2024 4. Initiate the new training rollout by Feb 1st, 2024 5. Consider having a one-time organization-wide Grand Round session on the topic of Ageism and Senior Sensitivity by April 30th, 2024	% of staff receiving training	TBD	
											3. To provide an Estimated Date of Discharge (EDD) to the patient within 4 calendar days of admission	1. Identify top 3 internal barriers to providing EDD within 4 calendar days of admission 2. Collaborate with internal stakeholders to address barriers and streamline EDD communication process 3. Update and approve patient brochures for each clinical program with more accurate admission and Length of Stay (LOS) information 4. Upload approved patient brochures on intranet for usage by external and internal partners by March 31st 2024	100% of updated Runnymede program brochures uploaded to iconnect Approval of new program brochures 80% of patients receiving EDD within 4 calendar days	TBD	
	Timely	**Increase and Maintain Occupancy Rate >95%**	P	Patients/Operational Beds	Patient Flow Department		87% Q1 rehab occupancy 89% Q2 Rehab occupancy	Increase to >95%	Health Quality Ontario recommends 5-10% increase or decrease when deciding a quality improvement project target		1. Strengthening partnerships with acute care partners to improve access and flow (HRH, SJHC)	1. Attend Join Discharge Rounds biweekly with the Humber River Hospital (HRH) team 2. Send daily occupancy information to acute care partners 3. Generate and send daily census reports to senior leadership informing them of census and mitigation strategies employed to address low census	Maintain occupancy at >95% % of discharge rounds attended	TBD	
											2. Flex beds to accommodate acute care admissions during outbreaks at Runnymede (i.e. LTLD admission on MC floor)	1. Admit LTLD patients to Medically Complex (MC) floor to maintain occupancy rate above 95% 2. Flex High Tolerance Short Duration (HTSD)/Low Tolerance Long Duration (LTLD) beds as necessary to accommodate acute care admissions	Maintain occupancy at >95% Number of LTLD patients admitted to MC unit	TBD	
											3. Work with acute care to develop "pull strategies" to maintain flow especially during surge	1. Met with Unity Health and HRH's transition team (managers and directors) in early November to discuss admission criteria and programs Runnymede offers 2. Shared updated admission criteria and slide deck outlining clinical programs with Unity Health team and HRH team 3. Maintain daily communication with transitions managers at HRH and SJHC to prioritize admissions from acute care	Maintain occupancy between >95%	TBD	
Equity	Equitable	Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, and inclusion, and antiracism education	P	Number of staff who have completed the education / all staff	Human Resources		TBD	50% of staff receiving education	Health Quality Ontario recommends 5-10% increase or decrease when deciding a quality improvement project target		1. Include diverse membership on committee to guide the Equity, Diversity, and Inclusion (EDI) process	1. Invitation for Expression of Interest	Number of membership fulfilled	TBD	
											2. Creation of EDI committee/group	2.1 Developing a draft Terms of Reference 2.2 Terms of Reference to be approved by Senior Leadership and Board	Terms of Reference approved	TBD	
											3. Rollout of EDI training plan for staff, Senior Leadership, and the Board	3. Webinars and e-learning	50% of staff attendance	TBD	
Experience	Patient-centered	Percentage of respondents who responded "completely" and "quite a bit" to the following question: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?	P	% of respondents who responded "completely" and "quite a bit" / total number of respondents	Qualtrics		TBD	10% plus baseline	Health Quality Ontario recommends 5-10% increase or decrease when deciding a quality improvement project target		1. Revision of Patient-Oriented Discharge Summary (PODS) Tool	1. Process mapping to determine the current process 2. Perform gap analysis 3. Create an action plan to address gaps	1. Chart Audit for PODS completion 2. Completion of top 3 gaps identified	TBD	
											2. Pulse survey administration two days prior to the discharge date	Survey to include a question: - Do you feel you received enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?	% of patients/families who provided positive responses to the survey questions	TBD	
											3. Post Discharge Phone Call	Conducting a post-discharge follow-up phone call with standardized questions 48-72 hours after discharge from the hospital	% of patients who responded "completely" and "quite a bit"	TBD	
											4. Qualtrics Survey	Survey with standardized questions sent by email after discharge from the hosoital	% of patients who responded "completely" and "quite a bit"	TBD	
Safety	Safety										1. Reduce the content requirement of the workplace violence incident report form	1. A working group to be held with Quality, Risk and Privacy, Occupational Health, and Patient Care teams to decide what information needs to be gathered in the incident reporting form 2. Quality, Risk, and Privacy Department to work with Information Services to reduce the number of fillable fields in the incident report form	Incident report form size reduced	TBD	Purpose: To increase workplace violence reporting
											2. Attend safety huddles to promote workplace violence reporting	Managers and educators to attend safety huddles.	# of safety huddles attended	TBD	Purpose: To increase workplace violence reporting
											3. For staff and volunteers to have a standardized understanding of workplace violence	Education and different approaches		TBD	Purpose: To decrease workplace violence reporting
											4. Conduct an anonymous staff survey for psychological safety related to joy in work	1. Create a survey 2. Roll out survey 3. Collate data	Survey to be completed	TBD	Purpose: To decrease workplace violence

	Decrease workplace violence	P	All staff and Volunteers	Incident Management System		TBD	5% decrease in Workplace Violence Reports from Baseline	Health Quality Ontario recommends 5% increase or decrease when deciding a quality improvement project target		5. Socialize Patient Rights and Responsibilities	Webinars, MEMO, staff meetings, safety huddles	1. Number of programs where Patient Rights and Responsibilities are socialized	TBD	Purpose: To decrease workplace violence
										6. Review Workplace Violence Policy and integrate and escalation process/flow chart for patients and family members (verbal warning, cautionary letter, serving of trespass notice, declaring persona non-grata)	Review Workplace Violence Policy and integrate and escalation process/flow chart for patients and family members (verbal warning, cautionary letter, serving of trespass notice, declaring persona non-grata)	2. Policy updated and approved	TBD	Purpose: To decrease workplace violence
										7. Establish a process for addressing patients who are repeat offenders	Establish a process for addressing patients who are repeat offenders	3. Process established and integrated into the policy	TBD	Purpose: To decrease workplace violence
										8. Monitoring the rate of workplace violence resulting in lost hours due to injury	Extracting the data from leave data from Human Resources and/or Occupational Health		TBD	Purpose: To decrease workplace violence
										9. Different approaches to managing violence from cognitively intact patients and cognitively impaired patients		Approaches have been developed	TBD	Purpose: To decrease workplace violence