2024/25 Quality Improvement Plan "Improvement Targets and Initiatives"

William Osler Health System 2100 Bovaird Drive East, Brampton , ON, L6R3J7

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**
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 if you are not working on this indicator) C = Custom (add any other indicators you are working on)	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 if you are not working on this indicator) C = Custom (add any other indicators you are working on)	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 if you are not working on this indicator) C = Custom (add any other indicators you are working on)	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 if you are not working on this indicator) C = Custom (add any other indicators you are working on)	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 if you are not working on this indicator) C = Custom (add any other indicators you are working on)	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 if you are not working on this indicator) C = Custom (add any other indicators you are working on)	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 if you are not working on this indicator) C = Custom (add any other indicators you are working on)	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 if you are not working on this indicator) C = Custom (add any other indicators you are working on)	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 if you are not working on this indicator) C = Custom (add any other indicators you are working on)	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 if you are not working on this indicator) C = Custom (add any other indicators you are working on)	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 if you are not working on this indicator) C = Custom (add any other indicators you are working on)	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 if you are not working on this indicator) C = Custom (add any other indicators you are working on)	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 if you are not working on this indicator) C = Custom (add any other indicators you are working on)	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 if you are not working on this indicator) C = Custom (add any other indicators you are working on)	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 if you are not working on this indicator) C = Custom (add any other indicators you are working on)	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 if you are not working on this indicator) C = Custom (add any other indicators you are working on)
Alternate Level of Care (ALC) Throughput Ratio															
Access and Flow	**Efficiency**	Alternate Level of Care (ALC) Throughput Ratio	O	Newly designated or discharged ALC patients within a specific time frame	Wait Times Information System (WTIS)	951*	0.98%	1.00%	HSAA Targets		1) Development and rollout of ALC dashboard (ongoing reassessment)	1. Develop an Education & Communication plan for the ALC dashboard 2. Develop and operationalize a cross-sector ALC dashboard , to support line of sight and accountability.	1. Education & Communication plan for the ALC dashboard 2. Pilot launch of ALC dashboard	1. By Q3 2024/25 2. By Q3 2024/25	

											2) Blaylock risk assessment (early identification)	1) Completion of Blaylock Risk assessment for all inpatient admissions to Medicine units 2) Blaylock risk assessment score to be displayed on the bullet round board, so that the inter-professional team can understand the risks and decide the appropriate care plan.	1. Rate of completion of Blaylock Risk assessment (inpatient admissions to Medicine units)	1. 90% by Q4 2024/25	
											3) Proactive transitions	1)Action planning based on Blaylock scores 11+ for Transitional Care Coordinators and Allied staff	1. Development and education of Action based plans for TCC and Allied staff	1. 100% TCCs and 80% of Allied staff to be educated by Q4 2024/25	
											4) Senior Friendly Care processes (Emergency Department)	1) Geriatric Emergency Medicine (GEM) nurse consults for admits more than 65 years of age 2) Comprehensive Geriatric Assessment on admits more than 65 years of age	1. % of admits >65 years of age who receive a GEM nurse consult/Comprehensive Geriatric Assessment	1. 90% by Q4 2024/25	
Percentage Surgical Long Waiters															

Access and Flow	**Timely**	Percentage (%) Surgical Long Waiters	C	Number of patients on Osler's surgical wait list whose total number of days waiting for their surgical procedure exceeds the associated Priority Level Access Target at the end of the reporting period.	Wait Times Information System (WTIS)	951*	42.1%	30%	HSAA Targets		Wait Times Information System (WTIS) Management Infrastructure	1. Implement WTIS Office setup 2. Develop and roll out wait time policy 3. Recruit WTIS Coordinators and provide comprehensive training to ensure their operational readiness 4. Generate a Weekly Project Update Report by assigning team members to collect and streamline the reporting 5. Regularly review and train to enhance accuracy in prioritization by service and individual physicians for the P2 Priority Patients	1. WTIS office live and operational 2. Establish and introduce a comprehensive wait time policy 3. Successful recruitment and operational readiness of WTIS Coordinators 4. Ensure the consistent generation of a Weekly Project Update Report through the assignment of team members to collect and streamline reporting 5.Improve in accuracy of priorities by service and individual Physicians for the P2 Priority Patients	1. WTIS office is 100% operational by Q2 FY 2024/25 2. Policy established and rolled out by Q2 FY 2024/25 3. 2 of WTIS Coordinators recruited by Q2 FY 2024/25 4. Achieve 90 % compliance in the Weekly Project Update Report by Q2 FY 2024/25 5. Attain 80% compliance in the accuracy of priorities by service and individual physicians for the P2 Priority Patients by Q2 FY 2024/25	

											Engage-ment and education initiatives for sur-geons and surgeon of-fices	1.Provide compre-hensive training to surgeons' office staff and sur-geons on WTIS Office	1a. Deliver compre-hensive training sessions to surgeons' office staff and sur-geons re-lated to WTIS Office (i.e., Dash-boards, Pol-icy, Weekly reports). 1b. Improve individual physicians' long wait-ers on the waitlist to 30%,	1. Achieve 100% com-pletion of education sessions by surgeons office staff by January 2024 and all surgeons by February 2024, with ongoing ed-ucation re-fresh in-cluded as part of the sustainabil-ity plan. 2. Decrease individual physicians' long wait-ers on the waitlist to 30%, demon-strating im-provement by March 31, 2025.	
											Develop dashboards with en-hanced functional-ity by incor-porating visual cues and alerts within the WTIS and surgeons' offices	1.Imple-ment dash-boards for oversight: A: Open Case Detail Dashboard (live) B: Closed Case Detail Dashboard (live) C: Open Case Sum-mary Dash-board D: Close Case Sum-mary Dash-board	1. Opera-tionalize Dashboards for WTIS and for Sur-gical Teams	1. All dash-boards are operational by January 30, 2025	

											Optimize the allocation of open or unassigned Operating Room (OR)	1. Develop a clear prioritization criteria to identify patients with long wait times who will benefit the most from open or unassigned OR blocks. 2. Utilize the established prioritization criteria to allocate open or unassigned OR blocks efficiently, ensuring optimal support for patients experiencing extended wait times.	1. Develop prioritization criteria for the effective utilization of allocated open or unassigned OR blocks 2. Utilization of open or unassigned OR blocks in accordance with the established prioritization criteria.	1. Prioritization criteria for utilization of allocated open or unassigned OR blocks is developed by Q1 FY 2024/25 2. 90 % utilization of open or unassigned OR blocks by March 31, 2025	
Were you involved in your care in a way that you wished? - Yes, definitely															

Experience	**Patient-centred**	Were you involved in your care in a way that you wished? - Yes, definitely	C	Number of inpatients surveyed in the timeframe that responded 'Yes, Definitely' to the question "Were you involved in your care in a way that you wished?"	Patient Experience Call Centre Data	951*	78.50%	80.10%	2% improvement on CY 2022 target		1.Achievement of RNAO People Centred Care (PCC) Best Practice Guidelines (BPG) Year 1-2 deliverables. Documentation of: 1) Inpatient Nursing Assessment Question: "What is most important to you today? 2) Inclusion of family presence and reinforcement of admission goal during Nursing Bedside Report.	PCC BPG deliverables are a standing agenda item on PCC Working Group Practice expectations monitored through the RNAO BPG Steering Committee Nursing & Professional Advisory Councils ongoing consultation regarding implementation	Quarterly MEDITECH documentation audits of: 1) verbatim responses to PCC BPG question during inpatient nursing admission assessment 2) involvement in family presence and reference to admission goal at nursing bedside report.	1) 75% documentation of PCC BPG question during inpatient nursing admission assessment 2) 90% of family presence at nursing bedside report by Q4 March 31, 2025	
											2. Standardize inpatient White Board (WB) process (specialized units exempt)	Finalize WB internal and external environmental scan Develop recommendations for standardized format and process	1) Environmental scan completion 2) Installation of new WBs and/or revision of current format & confirmation of WB best practices 3) Education of interprofessional staff	1) Q2 2) Q4 3) Q4 80% of completion of the White Boards end of Q2 FY 25-26	

											3. Patient Experience iHuddle Curriculum	Interactive coaching at iHuddles related to Empathy, Confidence, Enough Information at Discharge, Transition Planning, and Involvement in Care	1) iHuddle evaluation results overall and per topic 2) Number of units that received iHuddle coaching 3) Evidence of feedback to influence the People Centred Care LMS Module	1) 80% respondents positively (Yes Definitely) 2) All IP and OP units by Q4 March 31, 2025 3) Completion of People Centred Care LMS Module by Q1 FY 25-26	
											4. Patient Engagement through IBT Utilization	Using IBT as a clinical patient education & engagement tool Patient and families informed of IBT as education tool via brochure, WB and meal tray placemat. Staff informed of IBT as education tool through ihuddles, staff education and PEO led IBT demonstrations.	1) Utilization rate (%) of patient education module through IBT 2) Number of units that have received PEO IBT demonstrations 3) Staff feedback post demonstrations	1) 50% utilization of IBT patient education module 2) 80% of staff responding positively (Yes Definitely) and feeling confident in using the IBT as a clinical resource tool.	
Falls Rate per 1,000 Patient Days [Best Practice Spotlight Organization (BPSO) and Dedicated Education Units (DEU)]															
Safety	**Safe**	Falls Rate per 1,000 Patient Days [Best Practice Spotlight Organization (BPSO) and Dedicated Education Units (DEU)]	C	Number of falls (all degrees of harm, excluding 'Near Misses') on EGH Respirology, EGH 6W Gen Med, EGH 7E	DATIX (numerator- number of falls) and Meditech (denominator- patient days)	951*	4.32%	4.10%			1. Expand the number of Falls Champions	1. Selection, training and tracking of falls champions 2. Sustain the number of newly trained Falls Champions	1. 12 of newly trained Falls Champions	12 champions by 2024 Q4	

				Cardiology, BCH Respirology, BCH Stroke and BCH Gen Med 3 in the timeframe.							2. Roll out the revised Bedside Mobility Tool	1. Upgrade the existing bedside mobility tool to a validated version 2. Provide staff education on the revised tool	1. The existing bedside mobility tool is upgraded to a validated version 2. % of staff trained on a validated bedside mobility too	1. By Q3, 2024/2025 2. 80% of FT and PT nursing staff completed training by 2024 Q4	Include purpose and importance of tool in narrative
											3. Develop and implement LMS for Falls Management System	1. Design and develop LMS Module 2. Pilot LMS Module with staff on the 6 units	1. LMS module is developed 2. Staff Compliance on LMS completion	1. LMS Module developed by Q3, 2024/2025 2. 100% of active nursing staff by Q4 2024/25	Covered in corporate orientation - review pilot, timelines, clinical vs non clinical
											4. Improve side rail documentation for patients deemed high risk for falls	1. Revise documentation to incorporate side rails on meditech 2. Establish baseline of current bottom side rail usage 3. Educate nursing staff on how to complete side rail documentation	1. The documentation on the side rales is incorporated on Meditech 2. The baseline of current bottom side rail usage is established 3. % of patients with completed side rail documentation	1. By Q2, 2024/25 2. By Q3 2024/25 3.100% of patients have side rail documentation completed by 2024 Q4	Jan 29th GO LIVE (not including porters, only nurses)
Percentage of Staff Leaders, Physician Leaders, Board and Community Members who have Completed Equity, Diversity and Inclusion and Anti-Racism Education															
Equity	**Equitable**	Percentage (%) of Staff Leaders, Physician Leaders, Board and Community Members who have Completed Equity, Diversity and Inclusion and Anti-Racism Education	O	Staff Leaders, Physician Leaders, Board Members, and Community Members		951*	No Data Currently there are 166 leaders (78 clinical and 88 non-clinical), 77 physician leaders and 12 external Board members and 4 committee members	85.0% Target reflects 220 out 259 participants completing the essential workshops	HSAA Targets		1. Equity, Diversity and Inclusion and Anti-Racism learning to be offered as an essential training for Staff Leaders, Physician Leaders, Board and Community Members	1.Staff Leaders: Foundational education will be coordinated through the LMS system. 2.Physician Leaders: Foundational education will be delivered through a	1. Staff Leaders: Completion captured by tracking through LMS system 2. Physician Leaders: Completion will be tracked via MSO 3. Board and Community Members: Completion	85% completion: 1. Staff Leaders: Recommended EDI learning has been completed before the end of the fiscal year. For leaders two EDI learnings with 85% completion. 2. Physician	85% recognizes that at any given point in time when you are pulling reports from the system you will be transitioning - new hires, sick or pregnancy leaves, etc. We will use as a base

												workshop. 3 Board and Community Members: Foundational education will be delivered in workshop format.	of education tracked through the board office	Leaders: Recommended EDI learning has been completed before the end of the fiscal year. 3. Board and Community Members: Recommended EDI learning has been completed before the end of the fiscal year. For board members, one workshop training with 85% completion.	the Employee and Physician Engagement Survey (inclusion questions) and Patient Engagement Survey (discrimination complaint and health equity questions) to trend impact on learnings within the culture of the organization. Trending will be monitor throughout our EDI and Health Equity framework and programs - foundational training (QIP year 1) is a portion of this broader work. EDI learning will be identified and recommended (by Senior Lead, Strategic Advisor, EDI) for completion by Osler leaders

											2. Develop a Communication Plan and Pre-Post self assessment tool for Staff Leaders, Physician Leaders, Board and Community Members	1. Plan will consist of communicating the importance of completing the EDI learning 2. Brief survey will be created to capture a pre and post assessment of learning outcomes and input on future potential education areas of focus	Pre and post survey Pre-Post self assessment tool from all leaders. For staff leaders, the communication to participate in courses will come from the Organizational Development. Physicians leaders will receive their communication through the MSO.	85% for each group. 1. Staff Leaders 2. Physician Leaders 3. Board Community Members	A link to pre-survey link will be sent to staff leaders as a strategy to collect baseline data. the For physicians, pre-surveys will be distributed via the MSO office, ahead of the in person physician education workshop. Post-surveys will be sent either at 3 or 6 months to follow up on EDI learnings.

											3. Goals and actions related to EDI training included in Leadership performance review for Staff Leaders and Physician Leaders. (Board and Community Members are excluded from this change idea)	1. Staff Leaders & Physician Leaders: EDI learning will form part of each leaders development plans	1a. Staff Leaders: Through regular performance/development plan check-ins 1b. Physician Leaders: Through regular department and division meetings.	1. 85% completion of performance review with EDI reference actions	This will ensure that is it a prioritized learning and managers can work to aligning the learnings of this foundational education to specific work in the department/program the manager leads. For physicans, EDI learning will be tracked by the MSO as there cannot be any updates to CMaRS in 2024. Going forward (2025-2026) once there is coordination between the LMS and CMaRS and aligmment, EDI goals can be added to performance reviews. On going monitoring will occur with the board office.