Outcomes
Quality education and training

TAHSN Learner Engagement - Recommendation (%)

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>EVP/VP/ Chief Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2019/20</td>
<td>Pam Hubley</td>
</tr>
</tbody>
</table>

**Definition**
Percentage of students who either agreed or strongly agreed with the TAHSN survey question, "I would recommend a placement here to my fellow student."

**Data Source:** Medical, Clinical and Corporate Student Satisfaction Surveys

**Significance**
**Favorable trend:** Higher than Target

**Key Performance Indicator reported to:**
Corporate SC

**Performance Analysis**
The Learner Engagement Survey is provided to all clinical, corporate and medical learners. YTD, 7 departments/disciplines have a survey response rate of 5 or more. For these departments, the percentage of students who either agreed or strongly agreed with the TAHSN survey question 'I would recommend a placement here to my fellow student' is shown in the TAHSN Survey Results table below.

<table>
<thead>
<tr>
<th>Department Name</th>
<th>% Strongly Agree/Agree</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td>96%</td>
<td>n = 96</td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td>97%</td>
<td>n = 31</td>
</tr>
<tr>
<td>Social Work</td>
<td>83%</td>
<td>n = 12</td>
</tr>
<tr>
<td>Child Life</td>
<td>100%</td>
<td>n = 11</td>
</tr>
<tr>
<td>Radiologist/Technologist</td>
<td>60%</td>
<td>n = 5</td>
</tr>
<tr>
<td>Medical Residents</td>
<td>100%</td>
<td>n = 13</td>
</tr>
<tr>
<td>Medical Fellows</td>
<td>63%</td>
<td>n = 8</td>
</tr>
</tbody>
</table>

**Action Plan**
- Results are disseminated to clinical, corporate and medical departments with greater than or equal to 5 responses on an annual basis. Aggregate learner engagement data is also submitted to the TAHSN Education Committee.
- An organization-wide Student Experience Committee meets quarterly to review results and identify opportunities to create an optimal teaching and learning environment.
- The Learner Hub (SickKids Interprofessional Student Centre) has been created by the Learning Institute to streamline student related processes across the organization.

<table>
<thead>
<tr>
<th>Action Lead</th>
<th>Action Status</th>
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<tbody>
<tr>
<td>Kelly McMillen</td>
<td>In Progress</td>
</tr>
</tbody>
</table>
### Quality

**Eliminate Preventable Harm**

**Serious Safety Event Rate (SSER)**

![Graph showing Serious Safety Event Rate (SSER) from FY 2016/17 to FY 2019/20]

- **YTD**: 0.37
- **TAR**: 0.40

<table>
<thead>
<tr>
<th>Timeframe</th>
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<tbody>
<tr>
<td>FY 209/20</td>
<td>Dr. Lennox Huang</td>
</tr>
<tr>
<td></td>
<td>Jeff Mainland</td>
</tr>
</tbody>
</table>

**Definition**

Number of patient Serious Safety Events /10,000 adjusted patient days.

**Data Source**: Risk Management (Harm Index) / Finance

**Significance**

**Favorable trend**: Lower than Target

**Key Performance Indicator reported to**: Corporate SC

### Performance Analysis

- Skills development & training
- Standardize & Optimize Process
- Create awareness & share lessons learned

<table>
<thead>
<tr>
<th>Action Plan</th>
<th>Action Lead</th>
<th>Action Status</th>
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</thead>
</table>
| • Skills development & training - Plan: Continue with EP and LM teaching, disseminate EP online learning module for refresher training, continue work with Human Resources on EP plan for new hires.  
  • Standardize & Optimize Process - Plan: Continue using SSE database. Optimize report functionality.  
  • Create awareness & share lessons learned - Plan: Continue to post safety stories for new and completed SSE reviews. Develop a communication plan for each Serious Safety Event that identifies target audience, modes of sharing and necessary approvals. | Mollie Lavigne  
Shagan Aujla | In Progress |
Quality
Eliminate Preventable Harm
Rate of Potentially Preventable Hospital Acquired Conditions

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>EVP/VP/ Chief Lead</th>
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</thead>
<tbody>
<tr>
<td>FY 2019/20</td>
<td>Judy Van Clief</td>
</tr>
<tr>
<td></td>
<td>Karen Kinnear</td>
</tr>
<tr>
<td></td>
<td>Dr. Lennox Huang</td>
</tr>
<tr>
<td></td>
<td>Dr. Jim Drake</td>
</tr>
</tbody>
</table>

Definition
Select Current Hospital Acquired Conditions (HACs) reported on the hospital Harm Index Report/1000 patient days (excluding Serious Safety Events and VAP) (Including: SSI, CLABSI, PU, ADE, CAUTI, Falls)

Data Source: HAC Data

Significance
Favorable trend: Lower than Target

Key Performance Indicator reported to:

<table>
<thead>
<tr>
<th></th>
<th>QIP</th>
<th>Corporate SC</th>
<th>Org. Perf</th>
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</table>

Performance Analysis

<table>
<thead>
<tr>
<th>CY</th>
<th>CLABSI</th>
<th>SSI</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>70</td>
<td>27</td>
</tr>
<tr>
<td>2018</td>
<td>65</td>
<td>26</td>
</tr>
<tr>
<td>2019</td>
<td>48</td>
<td>35</td>
</tr>
</tbody>
</table>

Ongoing strategies will focus on successful implementation of bundles and audits across the hospital and standardization of all care related to HACs.

Action Plan

1. Support progress towards standard practice
   • Employ Leader Methods tools to build and reinforce accountability and to find and fix problems preventing standard practice
2. Optimization and sustained bundle adherence >90%
   • Additional products/equipment
   • Coaching and supporting auditors and staff
   • Sustainable HAC education plan
   • Family and patient engagement

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<tbody>
<tr>
<td>Shagan Aujla</td>
<td>In Progress</td>
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</table>
Quality
Improve equitable and timely access

Average LOS (MOH) for the Lower 99% of Inpatients

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>EVP/VP/ Chief Lead</th>
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</thead>
<tbody>
<tr>
<td>FY 2019/20</td>
<td>Marilyn Monk</td>
</tr>
</tbody>
</table>

**Definition**
The average length of stay for the lowest 99% of inpatients. Note that the excluded 1% represents a exceptionally long stay patients who require individual management and whose LOS would be unaffected by defined change initiatives for the lowest 99%.

**Data Source**: BI - Inpatient Activity App

**Significance**
Favorable trend: Lower than Target

**Key Performance Indicator reported to**: Corporate SC

**Performance Analysis**

**Action Plan**

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<th>Action Lead</th>
<th>Action Status</th>
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<tbody>
<tr>
<td>TBD</td>
<td>In Progress</td>
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</tbody>
</table>
Quality
Improve equitable and timely access
% ED Patients Waiting > 2 hrs. before PIA (%)

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>EVP/VP/ Chief Lead</th>
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<tbody>
<tr>
<td>FY 2019/20</td>
<td>Judy Van Clieaf</td>
</tr>
</tbody>
</table>

**Definition**
Service standard calculating number of ED patients who waited longer than 2 hours for an initial assessment by a defined care provider (MD,NP,PA)

**Data Source:** Qlikview ED App

**Significance**
**Favorable trend:** Lower than Target

**Key Performance Indicator reported to:** Corp. SC

**Performance Analysis**

**Action Plan**

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<tbody>
<tr>
<td>Linette Margallo</td>
<td>In Progress</td>
</tr>
</tbody>
</table>
**Quality**

Improve equitable and timely access

**Time to Inpatient Bed (90th Percentile) (Hrs.) (Mandatory)**

<table>
<thead>
<tr>
<th>YTD</th>
<th>6.41</th>
</tr>
</thead>
<tbody>
<tr>
<td>TAR</td>
<td>5.04</td>
</tr>
</tbody>
</table>

### Timeframe

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>EVP/VP/ Chief Lead</th>
</tr>
</thead>
</table>
| FY 2019/20 | Dr Jeremy Friedman  
|            | Judy Van Clief    |

### Definition

Time interval between ED disposition date/time and patient left ED date/time for admitted patients to an inpatient bed or operating room - @ 90th%ile level.

**Note:** % of Patients exceeding 4 hrs wait for an IP Bed will also be provided to support the analysis.

**Data Source:** Qlikview ED App

### Significance

**Favorable trend:** Lower than Target

**Key Performance Indicator reported to:**

- QIP
- Corp SC
- Org. Perf

### Performance Analysis

![Graph showing Time to Inpatient Bed (90th Percentile) (% of Patients Exceeding 4 hrs Time to IP Bed)]

### Action Plan

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<tr>
<td>Linette Margallo</td>
<td>In Progress</td>
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</tbody>
</table>
Quality
Improve effectiveness and efficiency of patient-centered care

Percent False Positive Diagnosis of UTI in ED Patients (%)

<table>
<thead>
<tr>
<th>Quarter</th>
<th>YTD</th>
<th>TAR</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>41%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q2</td>
<td>34%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q3</td>
<td>32%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q4</td>
<td>33%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY 2019/20</td>
<td>35%</td>
<td></td>
<td>25%</td>
</tr>
</tbody>
</table>

**Definition**
Improve diagnostic stewardship by reducing the false positive diagnosis rate of urinary tract infections (UTIs) in ED patients to 25% or less; provide timely notification of urine culture results to 100% of patients and families with a UTI diagnosis.

**Data Source**: Epic Beaker and ASAP

**Significance**
Favorable trend: Lower than Target

**Key Performance Indicator reported to:**
Corp. SC

**Performance Analysis**
- Q4 showed stable performance with the false positive diagnosis rate of 33.3%.
- 97% of patients and families with a false positive UTI diagnosis received timely notification of negative urine culture results and to discontinue empiric antibiotics (improved from 88% last quarter, aim 100%).
  - This notification process resulted in a total of 121 antibiotic days saved in Q4 (711 antibiotic days saved for the fiscal year).

**Action Plan**
1) Physicians not following the recommended Choosing Wisely UTI Empiric Treatment Pathway will be targeted with audit & feedback
2) Further data analysis to be completed to determine if modifications to the UTI Empiric Treatment Pathway are needed.

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>FY 2019/20</td>
<td>Dr. Jeremy Friedman</td>
</tr>
</tbody>
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<tbody>
<tr>
<td>Dr. Olivia Ostrow</td>
<td>In Progress</td>
</tr>
</tbody>
</table>
Quality
Eliminate Preventable Harm
Barcode Medication Administration Compliance (BCMA) (%)

YTD 92.0%
TAR 91.0%

Timeframe | EVP/VP/Chief Lead
---|---
FY 2019/20 | Karen Kinnear

<table>
<thead>
<tr>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>% compliance with barcode scanning medication administration (hospital wide).</td>
</tr>
<tr>
<td>Data Source: Epic</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Significance</th>
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</thead>
<tbody>
<tr>
<td>Favorable trend: Higher than Target</td>
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</table>

<table>
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<tr>
<th>Key Performance Indicator reported to:</th>
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<tbody>
<tr>
<td>Org. Perf. Corporate SC</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Performance Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>SickKids has now been live with Barcode Medication Administration (BCMA) since June 2018.</td>
</tr>
<tr>
<td>BCMA scanning compliance combines the number of opportunities to scan the patient as well as the medication (order) yielding a rate.</td>
</tr>
<tr>
<td>During Q4, we have continued to sustain our organizational BCMA rate above target and achieving a mean YTD compliance rate of 92%.</td>
</tr>
<tr>
<td>Our current goal is to support all teams in achieving a mean rate that exceeds our set target of 91%. Currently there are three teams that are within 1.1% of our hospital target, and three others that have made excellent gains. We continue to work with these teams.</td>
</tr>
<tr>
<td>The BCMA Steering Committee is continually exploring opportunities to maximize BCMA rate accuracy. We have committed human resources (Pharmacy, Nursing) to partner with teams to continue to enhance our BCMA rates, as we strive towards or hospital stretch target of 95%.</td>
</tr>
</tbody>
</table>

Action Plan
1. Monitor and trend BCMA compliance rates monthly to monitor trends and ensure sustained, incremental improvement, especially in those units with rates <91%.
2. Continue to support units with lower compliance rates, using strategies established during BCMA Improvement Pilot Project (assistance with reporting, identification of variation across staff, etc.) and local clinician consultation re: issues and barriers to BCMA.
3. Continue to ensure that unit leaders have access to on-line BCMA Monitoring/Reporting Tool Kit and are supported to access and use their reports.
4. ID Band Working group has been meeting regularly to address the identified ID band challenges, develop education tools and strategies for use by nurses to orient families to the importance of ID bands, which ultimately enhances our ability to successfully scan patient and medication and improve patient safety.
5. Met with ID Band vendor and discussed child/family/nurse feedback re: bands and discussed improvement opportunities for the future.
6. Continue to identify opportunities for removal of non-scannable medications and advocate for removal and/or barcode application when appropriate, to ensure that our denominator is correct and therefore compliance rates are accurate.
7. Convene a working group to review BCMA compliance rate improvement work to date and identify creative approaches to reach our stretch target of 95%, e.g., design-thinking processes.

<table>
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<tr>
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<tbody>
<tr>
<td>Mary McAllister Helen Edwards</td>
<td>In Progress</td>
</tr>
</tbody>
</table>
Quality
Champion continuous improvement
Inpatient Communication Dimension (Guardian) – top box responses (One Quarter Behind)

Timeframe
EVP/VP/ Chief Lead
FY 2019/20 Q3
Pam Hubley

Definition
Percentage of the most positive/top box responses to the NRC Health inpatient survey related to Communication Dimension pertaining to the Guardian (4 point scale & composite of 6 questions: kept informed in ED; Nurses explained things well; MDs explained things well; providers explained things well; received enough test information; told how to report mistakes).

Data Source: NRC Health (Ontario Pediatric Patient Experience of Care Survey)

Significance
Favorable trend: Higher than Target

Key Performance Indicator reported to:
- QIP
- Corporate SC
- Prog. SC

Performance Analysis

<table>
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<th>Action Plan</th>
<th>Action Lead</th>
<th>Action Status</th>
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<tbody>
<tr>
<td></td>
<td>Karima Karmali</td>
<td>In Progress</td>
</tr>
</tbody>
</table>
Quality

Champion continuous improvement

Overall Satisfaction (Inpatient) - % top box responses
(One Quarter Behind)

YTD 80.7%
TAR 82.0%

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>EVP/VP/ Chief Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2019/20 Q3</td>
<td>Pam Hubley</td>
</tr>
</tbody>
</table>

Definition

Percentage of most positive/top box responses (i.e. scores of 9 and 10) to the NRC Health pediatric inpatient survey question: Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your child's stay?

Data Source: NRC Health (Ontario Pediatric Patient Experience of Care Survey)

Significance

Favorable trend: Higher than Target

Key Performance Indicator reported to:

- Corp. SC
- Prog. SC

Performance Analysis

Action Plan

Action Lead: Karima Karmali
Action Status: In Progress
Quality

**Improve equitable and timely access**

**Backorder Rate (%)**

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>EVP/VP/Chief Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2019/20</td>
<td>Laurie Harrison</td>
</tr>
</tbody>
</table>

**Definition**

Number of order lines not filled / Number of lines ordered through the Cardinal Stockless Program

**Data Source:** Daily report from Cardinal

**Significance**

**Favorable trend:** Lower than Target

**Key Performance Indicator reported to:**

**Performance Analysis**

Indicator severely impacted by PPE shortages related to COVID-19 Pandemic. If affected items were not considered, performance was in the 2-3% range during the quarter

**Action Plan**

- Close work with major suppliers and distributors to manage allocations and backorders.
- Longer term backorders and shortages are anticipated in many categories due to worldwide manufacturing and raw material issues after pandemic emergency.

**Action Lead:** Steve Wood

**Action Status:** In Progress
**Infrastructure**

Optimizing current and developing new physical infrastructure

**Project Horizon Progress to Plan (%)**

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>EVP/VP/ Chief Lead</th>
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<tbody>
<tr>
<td>FY 2019/20</td>
<td>Peter Goldthorpe</td>
</tr>
</tbody>
</table>

**Definition**

Percentage of progress on milestones met for Project Horizon.

**Data Source:** Financial Project Tracking

**Significance**

**Favorable trend:** On Target

**Key Performance Indicator reported to:**

Corporate SC

**Performance Analysis**

- Project Horizon continues to progress according to its critical path. Shoring of the site for the new Patient Support Centre (PSC) was completed and site excavation is in progress.
- 100% construction drawings for the core/shell were completed in February 2020. Design development for the interiors of the PSC is now complete and detailed drawings are in progress.
- Revised cost estimates for the building have been received from the Construction Manager (PCL) and will be reviewed with the Executive Steering Committee in April 2020. District energy contracts with Enwave have been executed.
- Functional programming work and related planning for the Patient Care Tower (PCT) continues and is expected to be completed in Fall 2020.
- A consultant has been procured to develop a digital strategy and ICAT (Information, Communication, Audio-Visual, Technology) roadmap that will inform the planning progress for the PCT.
- Planning for the decanting of the Black and Hill Wings continues. Various technical studies have been completed and a contract with the architects (Stantec/KPMB) to advance the planning has been completed.

**Action Plan**

1. Obtain Notice of Approval Conditions (NOAC) from City of Toronto (Target: May 2020).
2. Advance interior design work for Patient Support Centre (PSC). 70% Construction Drawings to be completed by end of August 2020.
3. Advance excavation of PSC site in order to initiate construction of the PSC in July 2020.
4. Advance functional programming work for Patient Care Tower (Target Completion: Fall 2020).
5. Advance decanting/re-location planning for Black/Hill Wings and initiate early works when feasible.

<table>
<thead>
<tr>
<th>Action Lead</th>
<th>Action Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>David Hope</td>
<td>In Progress</td>
</tr>
</tbody>
</table>
Energy Use Intensity (EUI)\par

Timeframe | EVP/VP/ Chief Lead
--------- | -------------------
FY 2019/20 | Laurie Harrison

**Infrastructure**

Environmental Sustainability

**Energy Use Intensity (EUI)**

- The Q4 energy use intensity value is 0.6164 GJ/m²/yr, which is 0.0321 GJ/m²/yr higher than Q4 target as 0.582. This is largely caused by the usage of four tissue culture machines installed by DPLM in room 3139 in Nov 2019. Usage of these machines requires a dedicated exhaust system to ensure that toxins are removed from the building, but such a system is currently not in place, and so the entire building’s ventilation system must be working to remove the toxins. Extra heating energy is required to condition the ventilation.

- The accumulated energy use intensity in 2019/20 is 1.9074 GJ/m²-yr, which is 0.0159 GJ/m²-yr over the annual target as 1.8915. The extra energy use over annual target is mainly associated with the unplanned ventilation requirement in Q4.

**Performance Analysis**

- **Favorable trend:** Lower than Target
- **Key Performance Indicator reported to:** Corporate SC

**Action Plan**

To fix this issue and work towards our upcoming KPI goal, the planning department is working to install a ventilation system specifically for the tissue culture machines which will reduce overall energy consumption.

**Action Lead:** Allan Dai

**Action Status:** In Progress
The following initiatives are planned to be worked on once things return to normal:

- Update organics posters (due to change in vendors)
- Introduce compostable take-out containers in Terrace Cafe and catering
- Update recycling centres with up to date recycling and waste posters at the hospital
- Expansion of clinical recycling pilot in 5A and 5B
- Implementation of green procurement policy
- Update lunch rooms/kitchenette with proper recycling/waste bins and posters (hospital)
- Bins to recycle wrist band cartridges and batteries will be provided in most nursing stations to increase capture rate.
Health Systems
Improve equitable and timely access
Boomerang Health Physician Patient Visits

YTD 13662
TAR 7228

Timeframe
FY 2019/20
EVP/VP/ Chief Lead
Jeff Mainland

Definition
Number of patients seen by physicians

Data Source: OSCAR (Electronic Medical Record)

Significance
Favorable trend: Higher than Target

Key Performance Indicator reported to:
Corporate SC

Performance Analysis
Factors contributing to exceeding targets include higher than expected primary care, consulting paediatric and orthopedic surgery volumes.

Action Plan
Onboard additional primary care paediatricians to meet the increased volumes/need.

Action Lead
Lara Pietrolungo
Action Status
In Progress
To enhance transitions and capacity within home care; Connected Care has committed to a 50% increase (over 2018 baseline) in the overall number of training modules completed by community and home care providers. Full and half-day modules covering 5 topics are offered at regular intervals throughout the year. Due to high uptake and demand from the community, Connected Care delivered 404 competency-based modules to home and community care providers in 2019 representing a 25% increase over its QIP target.

Due to COVID-19/visitor restrictions the following Connected Care modules were delivered virtually and did not include any on-site training/simulation:

- Paediatric Tracheostomy on March 30th - 13 CHCPs participated virtually
- Home Ventilation with a Tracheostomy on March 31st - 7 CHCPs participated virtually

To ensure the safety of our staff and learners, Connected Care has postponed in-person simulation based training until June 1st, 2020. To support our learners with access to virtual education, Connected Care has introduced a set of webinars with sessions available twice a week on the following topics:

- Paediatric Tracheostomy Care 101 (60 min)
- G/GJ tubes: Troubleshooting common problems (60 min)
- Suctioning: nasal, oral and nasopharyngeal (60 min)
- Central Venous Access Devices: Review of Line Care (60 min)

Action Plan

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<tr>
<th>Action Lead</th>
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<tbody>
<tr>
<td>Kate Langrish</td>
<td>In Progress</td>
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</table>
Innovation
Facilitate and promote the generation of new ideas

CIHR Project Grants Success Rate (%) (Bi-Annual Indicator)

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>EVP/VP/ Chief Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2019/20 Q3</td>
<td>Dr. Michael Salter</td>
</tr>
</tbody>
</table>

Definition
Canadian Institutes of Health Research (CIHR) success rate for project grants competition

Data Source: Canadian Institutes of Health Research (CIHR)

Significance
Favorable trend: Higher than Target

Key Performance Indicator reported to:

Performance Analysis
Fall CIHR Project Grant Competition Results: 21/75 SK applications (28%) less the National results of 17.64% (385/2183) applications includes project grants, excludes bridge and priority funding = 10.36% above national average.

Action Plan

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<tbody>
<tr>
<td></td>
<td>Susan Malench</td>
<td>In Progress</td>
</tr>
<tr>
<td></td>
<td>Ramune Pleinys</td>
<td></td>
</tr>
</tbody>
</table>
Innovation

Ensure innovations and new ideas are shared

**Number of License Agreements (#) (Bi-Annual Indicator)**

<table>
<thead>
<tr>
<th>YTD</th>
<th>TAR</th>
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<tbody>
<tr>
<td>38</td>
<td>38</td>
</tr>
</tbody>
</table>

### Definition

Number of new IP licenses executed.

**Data Source:** Manual Collection

### Significance

- **Favorable trend:** Higher than Target
- **Key Performance Indicator reported to:** None

### Performance Analysis

#### Action Plan

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<thead>
<tr>
<th>Action Lead</th>
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<tr>
<td>Ihor Boszko</td>
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<th>Timeframe</th>
<th>EVP/VP/Chief Lead</th>
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<tr>
<td>FY 2019/20</td>
<td>Dr. Michael Salter</td>
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People
Advance a Healthy and Safe Organization
Rate of SickKids new employees *trained** in Caring Safety Error Prevention (%) (Bi-Annual Indicator)

Timeframe | EVP/VP/ Chief Lead
--- | ---
FY 2019/20 Q3 | Dr. Lennox Huang
Jeff Mainland
Pam Hubley

Definition
Percentage of new SickKids employees trained in Caring Safely Error Prevention within 3 months of employment.

Data Source: LMS

Significance
Favorable trend: Higher than Target

Key Performance Indicator reported to:
Corp. SC

Performance Analysis
Compliance for Q3 is 61% with 242 new staff out of 397 completing the Error Prevention session. If we were to remove residents and fellows this would result in 92% compliance (210 out of 228)

Action Plan
Action Status
Bonnie Fleming-Carroll | In Progress
YTD 8%
TAR 6%

People
Advance a healthy and safe organization

Lost Time Index (%)

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Definition
Percentage of lost time claims compared to the total number of employee incidents reported.

Data Source: Safety Reporting System

Significance
Favorable trend: Lower than Target

Key Performance Indicator reported to:

Performance Analysis
Q4 Results do not meet the Corporate Scorecard target of 6%
There were 7 Lost Time Incidents in Q4
Of the 7 LTIs:
2 Overexertion
2 Fall/Slip/Trip
1 Contact With Object (inanimate
1 Exposure To Blood/Body Fluid
1 Repetition
Injuries involved 3 nurses, 3 support staff, and 1 Technologist.
Of the 7 reported incidents, 3 are still pending WSIB Decision.
Those pending incidents could be approved or denied by WSIB, or abandoned by the employees. The reported LTI rate will be affected accordingly.

Action Plan
- We will continue to work on our three employee safety Caring Safely Pioneer Cohorts; Overexertions, Slips, Trips and Falls and Patient Behavioural Events.
- OHSS and managers continue to review and follow up on all events to ensure we learn from events so that they do not reoccur and create lost time injuries or more serious events.

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**People**

Advance a Healthy and Safe Organization

**Health and Safety Compliance (%)**

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**YTD 79%**

**TAR 85%**

**Definition**

The average of scores for manager responses to JOHSC recommendations within 21 days, manager responses to employee safety reports, and respirator fit testing compliance.

**Data Source:** HR Report Centre Reports, AEMS Reports and Manual Collection (Occupational Health Services)

**Significance**

Favorable trend: Higher than Target

**Key Performance Indicator reported to:**

**Performance Analysis**

Overall target has not been met. Composite rate for this quarter is 89.5%, representing a 3.4% improvement from the 86.1% reported last quarter.

- 100% of supervisors responded to JOHSC inspection reports within 21 days.
- A 6.7% improvement from last quarter. However, there were only 10 Inspections completed this quarter.
- 80.0% of supervisors responded to safety reports within 30 days. A 5.3% lower than last quarter.
- 88.6% of staff are compliant with respirator fit testing requirements. An 8.8% improvement from last quarter.
- YTD composite rate is 79.4%

**Action Plan**

For the second quarter this year, we continued to reach our target for this metric. We will do some appreciative inquiry around what went well in the past two quarters and try to replicate it for the next fiscal year. Some of the things include:

- Reminder emails from our system go out to managers about responding to JOHSC inspection reports
- We assigned the management of the Employee events in our Safety Reporting to one person so there is consistent follow up around events with managers
- For the first time in a long time we have also exceeded our target of 85% for N95 fit testing. We have achieved 88.6% compliance this quarter. This is due to a number of factors, including: offering more in unit fit testing sessions, and sending reminders to managers. We usually see a natural increase in this metric in the last quarter as managers try to meet their target for the end of their performance year. In addition with the emergence of the Coronavirus staff were more concerned about being ready and we have already seen a significant increase in staff coming to be fit tested.

**Action Lead**  
Laura Alexander

**Action Status**  
In Progress
**People**

Enhance Leadership Effectiveness

**Leadership Development Training (%) (Bi-Annual Indicator)**

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**Definition**

Percent of Leaders completing Leadership Development program

**Data Source:** Manual Collection Organizational Development

**Significance**

**Favorable trend:** Higher than Target

**Key Performance Indicator reported to:**

Corporate SC

**Performance Analysis**

- First two quarters completed and leadership participate to the programs are meeting and exceeding target with the exception of the Emotional Intelligence Program.
- Root cause analysis is underway with emphasis on enhancing participation and engagement into the program.

**Action Plan**

- To fill our leadership program to at least 80% to max 100% capacity in order to enhance management effectiveness across SKs.
- Participation rates will be monitored, marketing campaigns to advertise program availability, one up leaders are informed about the learning content to encourage on-going coaching, HRBP will work with leaders to identify learners to take appropriate courses as part of Talent and Succession planning, follow up and review of the program with participants.

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### Timeframe

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### Definition

Increase the number of hits to the “Staff Mental Health” wellness web page by 10%

**Data Source:** Website Data

### Significance

- **Favorable trend:** Higher than Target

**Key Performance Indicator reported to:**

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### Performance Analysis

- In Q4 there were 2,061 visits to the staff mental health website (this includes the landing page and all pages within the site)
- These were accessed by 1,325 unique viewers.
- Employees spent on average 1:16 mins on page

### Action Plan

We continue to discuss and promote our mental health website and resources a number of ways including:

- new hire orientation
- new nursing orientation
- in our Peer Support and Trauma Response brochure
- during Trauma Response psychological debriefings
- Occupational Health Nursing visits

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There has been continued utilization of the program in the last quarter and we have seen a spike at the end of the quarter in response to COVID-19.

- Delivery of the mental health training session for a new nurse hire cohort with approximately 30 nurses being oriented
- Introduction of the first orientation to partners and family members of new hire nurses on a Saturday saw 16 participants. A panel of 3 SK nurses (with under 7 years seniority) spoke to the transition to nursing and the challenges and opportunities. A presentation was made to families to provide information on mental health and how they can support their nurse and a breakout session was facilitated for family members to engage in a learning exercise. A PAWS therapy dog was brought in and lastly, families were given a short tour of 4C which was vacant.
- We engaged in the rollout of the Peer Program to the Foundation with a series of walkabouts as well as a presentation at the Foundation Community Meeting. This is a fee for service arrangement that is being piloted
- Education around unique mental health issues within the RI and with students was provided through JOHSC meetings
- A meeting with RI Management & Faculty Support to discuss strategies to support PIs/Managers/Faculty and to expand out the RI peer cohort
- Consultation to BC Children and Women’s Hospital and to Lakeridge with request for services including consultation, peer program materials and training; legal prepared Service Agreements
- With evolvement of COVID-19 there was establishment of a staff support area in the WAV PlayPark where staff can step away for a physical and mental break from work. Peers have been scheduled throughout each day to be available and are tasked with ensuring compliance with social distancing, hand sanitization and support. The aim is to check in with staff on coping and monitor staff who may be experiencing difficulty.
- Peers working remotely continued to provide support to staff by text/phone/WhatsApp and email and some have supported by helping with administrative needs
- The research study being conducted with Memorial University Faculty of Nursing was completed and moved into data analysis phase
- Kelly continued as co-chair for the national expert advisory committee on peer support (on which Dr. Trey Coffey is a member along with OMA representation and provincial bodies and medical association memberships)
People
Advance in a healthy and safe organization

Workplace Violence Incidents Reported (Mandatory)

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**Definition**
Exercise of physical force by a person against a worker, in a workplace, that causes or could cause physical injury to the worker.

**Data Source:** Safety Reporting System

**Significance**
- **Favorable trend:** Higher than Target

**Key Performance Indicator reported to:**
- QIP
- Corporate SC

**Performance Analysis**
This quarter there were 38 incidents of violence reported. There were:
- 32 patient behavioural events
- 2 parent to staff events
- 4 Public to staff events

**Action Plan**
We continue to focus on three main areas this year:
1. Pilot implementation of a universal patient screening tool focusing on behaviour - Pilot began Jan. 2020 on 5C
2. Begin implementation of the new Code White Policy and enhanced Safety/Care Planning for high risk patients (both part of one continuum of practice) - work continues on this
3. Advance and support a reporting culture through the implementation of a robust communication strategy/campaign - We have implemented a new word mark and daily news article series on preventing workplace violence

**Action Lead**
Laura Alexander

**Action Status**
In Progress