

Theme I: Timely and Efficient Transitions

Measure Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Virtual Care Utilization - Ambulatory Visits	C	Other / Other	In house data collection / 2023	35.00	30.00	<p>While the target was surpassed every month throughout 2021/2022, there are two significant risks that are likely to impact success going forward:</p> <p>1) Returning to pre-COVID-19 behaviours and need for in person visits that have been delayed over the course of the pandemic</p> <p>2) New PSA and changes to virtual care billing.</p> <p>Additionally, work this year will be focused on enhancing the user experience, ensuring the right patient is being seen using the most appropriate modality for their care, and maintaining the quality of visits conducted virtually.</p>	

Change Ideas

Change Idea #1 Patient and family caregiver satisfaction

Methods	Process measures	Target for process measure	Comments
Patients and families are invited to complete a survey about their SickKids virtual visit experience during a period of ~6 weeks each winter (beginning in 2021). The survey is sent to patients and/or family caregivers the day after an Epic-integrated virtual visit.	1. Overall satisfaction of virtual visit as measured by the percentage of respondents who answer "strongly agree" or "somewhat agree" to the question: "Overall, I was satisfied with my/my child's recent virtual visit."	Greater than or equal to 90% positive response	Virtual care is a component of the SickKids 2025 Strategic Plan

Change Idea #2 Optimize virtual visit waiting experience for patients receiving care via virtual visit

Methods	Process measures	Target for process measure	Comments
Thanks to a recent Zoom update, the virtual visit waiting room was updated in January 2023 to include SickKids specific information and instructions on who to contact if they experience technical difficulties. In the experience survey last year, patients and families reported wait times averaging less than 15 minutes. Capturing an accurate measure of time to start of visit and number of patients who leave without being seen, will help to target areas with high wait times, improve the virtual visit experience and reduce no show rates	1. Percent of patients leaving a virtual visit without being seen 2. Percent of patients waiting less than 15 minutes for their virtual visit to start	Establish baseline data for both measures.	Dependency: Upgrade Epic-Zoom integration with Smart on Fast Healthcare Interoperability Resources (FHIR)

Theme II: Service Excellence

Measure **Dimension:** Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Adequate patient communication at discharge: Connected Care	C	Other / Other	EMR/Chart Review / 2023	CB	75.00	This indicator is new to SickKids and has not previously been implemented, therefore 2023 activity will be used to establish baseline and future targets. A target of 75% has been set based on similar questions asked in the past about confidence with knowledge and skills at discharge.	

Change Ideas

Change Idea #1 Align Epic documentation practice with patient experience measure

Methods	Process measures	Target for process measure	Comments
1. Revise flowsheet to capture family caregiver assessment of receiving adequate information about the new medical technology prior to discharge 2. Monthly Epic reports to analyze data including ED visits and unplanned admissions	Presence of revised Connected Care clinic flowsheet row	Revised clinic flowsheet row in place by February 1, 2023	Key collaborators on this initiative: Epic Analyst, Connected Care leadership, Epic Business Intelligence (BI) team

Change Idea #2 Increase number of virtual visits

Methods	Process measures	Target for process measure	Comments
1. Expand criteria for patients receiving a virtual visit after discharge 2. Pre-schedule virtual visits with families prior to discharge when possible and leveraging MyChart (pilot self-scheduling module expected to be tested)	Total number of initial virtual visits completed after discharge	700 virtual visits/year	Key collaborators include Connected Care Nurses (CCRN), Connected Care program coordinator, and Connected Care leadership.

Theme III: Safe and Effective Care

Measure Dimension: Effective

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of patient Serious Safety Events (SSE)/10,000 adjusted patient days	C	Other / Other	In house data collection / Rolling 12-month average	0.67	0.50	The 2023 SSER target is based on incremental improvement towards a longer-term target (3-year Caring Safely Goal of 0.2 by the end of 2024). This long-term goal is based on best peer performance and the hospital's previous best performance.	

Change Ideas

Change Idea #1 Communicate lessons learned (contributing factors and corrective actions) within SickKids as one mechanism to prevent repeat events.

Methods	Process measures	Target for process measure	Comments
1. Provide timely SSE summaries including corrective actions to Quality Committees and Leadership teams. 2. Provide SSE summaries including corrective actions to relevant staff members. 3. Complete and communicate an annual Common Cause Analysis (CCA) of all SSEs.	1. Percent of SSE summaries for review/endorsement/approval by Quality Management Council (QMC), Senior Management Committee (SMC), Board Quality and Safety Committee (BQSC). 2. SSE summaries and discussions provided at least annually for Clinical Operations Management Forum , Morbidity and Mortality Committee and Patient and Family Experience Advisory Committee. 3. Completed annually at the end of fiscal year by Quality Management Department.	1. 100% of SSE Summaries reviewed and endorsed at QMC, SMC, and BQSC. 2. SSE summaries/discussions presented at least annually at identified forums 3. Annual completion of SSE Year in Review CCA	Learning from SSEs informs annual Quality and Safety strategic priorities.

Change Idea #2 Improve development and implementation of corrective actions from Serious Safety Event (SSE) Root Cause Analyses (RCA)

Methods	Process measures	Target for process measure	Comments
1. Ensure recommended corrective actions are ranked as highly as possible on the Hierarchy of Effectiveness 2. Ensure SMART objectives are aligned with all corrective actions 3. Identify and assign an Improvement Specialist for corrective actions at a high level of complexity	1. Percent of times that corrective actions are based entirely on reminders and/or education programs. 2. Percent of times principles of SMART objectives are evident in corrective actions. 3. Percent of times an Improvement Specialist is assigned to high complexity recommendations (as ranked and determined by SSE Committee)	1. Fewer than 20% of times 2. 90% of corrective actions 3. 90% of the time	Properly developed, maintained, and sustained corrective actions are believed to prevent recurrence of SSEs

Measure **Dimension: Safe**

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of workplace violence incidents reported by hospital workers (as defined by OSHA) within a 12 month period.	P	Count / Worker	Local data collection / Jan 2022–Dec 2022	154.00	146.00	Target represents a 5% decrease from the 2022 rate. We are confident that we have optimized reporting to the extent possible using a voluntary reporting system, validated with 5 years of data collection. We are incrementally reducing the target in the hope of a continued 5% reduction year-on-year. New initiatives implemented in the hospital (BEST tool implementation and Code White Reviews) will hopefully decrease the total number of events.	

Change Ideas

Change Idea #1 Identify patients at risk by implementing an inpatient screener focusing on behaviour in three key areas: Psychiatry (7A/E), Neurology (5C), General Paediatrics (7B/C/D/E)

Methods	Process measures	Target for process measure	Comments
Chart reviews and electronic patient record (Epic) reports	Percent of behavioural health screening tools completed = Number of behavioural health screening tools completed/Number of new patient admissions (age 5 and older)	1. 60% of patients (age 5 and older) will be screened for behavioural health risks within 24 hours of admission to an inpatient unit (Psychiatry, Neurology, General Paediatrics) 2. 100% of the patients who score as high risk should have a flag in their chart and a sign placed on their door to identify potential risk to staff.	FTE=12604 This is a phased approach. Phase 1 includes the addition of patient flags. The results of Phase 1 will inform next steps related to planned Patient and Comfort/Safety Bundle rollouts. When high risk patients are identified, staff are prompted to obtain consults for CL Psychiatry, Child Life, Social Work, Speech Language Pathology as required. Staff are provided with a list of supportive and are directed to other tools and assessments to collect more information about patient triggers to mitigate risk.

Change Idea #2 Review of Code White events to ensure local and organizational contributing factors and preventative measures are identified and implemented

Methods	Process measures	Target for process measure	Comments
Data on Code whites will be collected via Safety Reporting and Security Reports and reviews will happen at the Code White Review Committee	Percent of Code Whites reviewed = Number of code whites reviewed by the Code White Review Committee/Total number of Code Whites reported	80% of Code Whites will be reviewed at the organizational Code White Review Committee. Prevention measures will be collected and prioritized to identify trends and hospital wide issues for targeted interventions	Baseline data collection and identified trends will inform future improvement work to mitigate Code White risk ideally leading to fewer staff safety incidents.

Measure **Dimension: Safe**

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of potentially preventable Hospital Acquired Conditions (HAC) per 1000 patient days	C	Rate per 1,000 patient days / All inpatients	Hospital collected data / 2023	1.10	1.10	Aim to sustain gains made on potentially preventable harms during the recovery phase of the pandemic as gains made in high frequency HACs reduce the margin for improvement. The HAC rate is a composite of 7 HACs (SSI, CLABSI, PI, ADE, CAUTI, Falls, UE).	

Change Ideas**Change Idea #1** Continued focus on achieving high levels of bundle adherence

Methods	Process measures	Target for process measure	Comments
1. Use of PowerBI dashboards to ensure accessibility, visibility, and transparency of process data 2. Use of Audit and Coach methods via Central Audit team and departmental safety coaches	1. Percent bundle adherence for all HACs 2. Number of documented audit and coach episodes per month	1. 90% bundle adherence for all HACs 2. At least 60 documented audit and coach episodes per month	Ongoing focus on HAC bundle adherence, particularly in lower frequency HACs to continue to sustain overall improvement.

Change Idea #2 Optimize Leader Methods to build and reinforce accountability for decreasing HACs, and finding and fixing problems related to bundle adherence.

Methods	Process measures	Target for process measure	Comments
1. Continue Executive and Senior Leader Rounding 2. Departmental discussions at improvement centres	1. Sustain departmental Leader Rounding episodes focused on HAC reduction. 2. Integrate HAC discussions into Leadership Methods training modular learning program for clinical leadership teams.	1. At least one HAC reduction-focused departmental Leader Rounding episode per month 2. Delivery of updated curriculum to at least 2 clinical leadership teams in 2023	Continued focus by hospital leadership on HAC reduction aligns with the hospital's Caring Safely strategy.