Quality Improvement Plan (QIP) Narrative

London Health Sciences Centre

Great people. Great care.

Overview

London Health Sciences Centre (LHSC) is one of Canada's largest research-intensive, academic acute care hospitals. We are committed to collaborating with patients, families, and system partners to deliver excellent care experiences and outcomes, educate the health-care providers of tomorrow, and advance new discoveries and innovations to optimize the health and wellbeing of those we serve.

In the past year, LHSC has remained committed to quality, safety, and accountability, while navigating the challenges of our health care system. Our Continuous Improvement of Care program has guided efforts to enhance health care outcomes, fostering a culture where everyone collaborates to make meaningful improvements.

As part of our Quality Improvement Plan (QIP) development for this year, the Quality, Patient Safety, and Performance team conducted a focused engagement from September to October 2024. This effort aimed to understand what "quality care" means to patients, families, staff, and physicians. We collected feedback through:

- Surveys administered to staff and physicians through unit rounding, and to patients, families, staff, and physicians at engagement booths at both University and Victoria campuses.
- Patient Partners interviewed for in-depth qualitative responses.
- A survey link, shared with all employees via email, sent to patient partners, and posted on LHSC's social media for community participation.

We received over 1,250 unique responses. The top themes identified as key to quality care were client-centered care, accessibility, and appropriateness, emphasized by both patients, families and our staff and physicians.

The foundation of our QIP is understanding current issues by engaging those who give and receive care. By listening to their experiences, we can prioritize improvements that matter most to them. These themes along with system priorities identified by Ontario Health shaped our Quality Improvement Plan indicators for the coming year. The following will be LHSC's Quality Improvement Plan indicators for FY2025/26:

1. Length of Emergency Department Wait for Bed at 90th Percentile
2. Emergency Department Wait time to Physician Initial Assessment 90th Percentile
3. 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?
4. Discharge Medication Reconciliation
5. Average Emergency Department wait time to Physician Initial Assessment for individuals with sickle cell disease (CTAS 1 or 2)

Access and Flow

Hospitals in Ontario continue to have more demand for health services than available capacity. LHSC is focused on our ability to improve hospital bed utilization while maintaining a high standard of clinical care. Patient Flow is a key contributor to continuous improvement at LHSC with a particular focus on adopting standardized and disciplined approaches to optimize patient flow. Patient Flow collaborates with internal and external partners to place the right patient in the right bed the first time.

Ontario Health at Home and Community Support Services Partnership

LHSC partners with Ontario Health at Home and our Community Support Services partners to participate in Collaborative rounds. Together, we work to develop comprehensive plans to offer wraparound support for patients in the community awaiting their most suitable alternative level of care placement. This encompasses facilitating enrollment in Adult Day Programs, arranging transportation, organizing respite stays, and providing meal services.

LHSC to Home Program

This year LHSC launched its LHSC to Home program which aims to provide wrap around supports for patients in the home for up to 16 weeks through partnership with a community service provider. Our target population for this program is those at risk of being designated Alternate Level of Care (ALC) or those already designated ALC. The program was launched on November 15 with our Inpatient Medicine teams at Victoria Hospital and then University Hospital. LHSC is continuing to expand the program and has set a target to have 200 patients through the program by March 31, 2025.

Middlesex London Complex Case Resolution Table

The Middlesex-London Complex Case Resolution Table focuses on addressing patient-specific situations at the local level. It facilitates collaboration between hospital and community sector partners to ensure patients have appropriate access to the support and services they need to live in the community. Through focused case-resolution discussions, the table develops creative solutions to overcome barriers to discharge or prevent hospitalizations, meeting the unique needs of each patient. The Middlesex London Complex Case Resolution Table brings members of hospital and community together monthly to anonymously discuss patients struggling to get to their next care destination.

Equity and Indigenous Health

Indigenous Health Education, Resources and Improvements

The Indigenous Health team at LHSC is responsible for providing education and consultation services to LHSC leaders, physicians, and staff to help build system-wide capacity to better serve Indigenous patients. As part of our fundamental commitments, LHSC is working to address barriers that Indigenous patients experience when trying to access and receive care. By engaging community partners, patients, visitors, and Team LHSC, we will continue to build our knowledge and understanding to enhance care experiences, improve health outcomes, and build an environment where Indigenous patients, families and visitors feel safe, valued and welcomed.

A new initiative this year was LHSC hosting the first-ever Youth Indigenous Career Fair the idea for the event emerged during a meeting between the London District Chiefs Council, Southern First Nations Secretariat, and members of LHSC's Executive team, to give Indigenous youth the opportunity to explore the many career options available in the field of health care before they need to make choices about post-secondary education.

Other improvement initiatives include Indigenous Midwives (IMs), hospital leaders, and provincial and national Indigenous health leaders engaging in a collaborative effort to develop a pathway for IMs to obtain privileges at LHSC. This work highlights the driving forces and community benefits of seeking hospital integration for IMs, as well as the challenges and barriers faced in forging culturally responsive and strengths-based care pathways. We engaged in meaningful and reciprocal dialogue with Indigenous perinatal health and wellness experts, capturing their input and feedback on how hospitals can better support IMs. In creating a privileging pathway for IMs, we are building accountability in our organization to Calls to Action #18-24, as we work towards creating a health care system that is inclusive, culturally responsive, and supportive of Indigenous care providers.

Black Health Services at LHSC

The Black Health team was established at LHSC in May 2023 and operates as an integral part of the Equity, Diversity and Inclusion team. Black Health was established in acknowledgement of the many inequities in health care that exist and to actively engage in working towards identifying and dismantling systemic, institutional and attitudinal barriers to improve the health care experiences and health outcomes of Black people. The Black Health team works on a variety of community engagement and improvement initiatives including a project this year which involved working alongside the community to pilot blood pressure screening and education by navigators and nursing volunteers to over 50 members of the Black community. LHSC is hosting three students from Western's Black Leadership University Experience (B.L.U.E.) program for mentorship placements. Western B.L.U.E. provides in-person, paid, part-time leadership experiences for 20 Black students. The experiences are funded by the university and hosted by organizations in the London area.

Advancing Accessibility and Inclusion

LHSC is committed to identifying and removing barriers that present a challenge to people when accessing the spaces, information or services they need. To advance work in this important area, our 2024-2029 Accessibility Plan outlines strategies to improve accessibility and inclusion for patients, families, visitors, members of the community and Team LHSC. Our Accessibility Plan represents the path forward for LHSC to ensure that people of all abilities can access services, spaces, employment, and information in a way that meets their individual needs. It identifies our goals and outlines opportunities to improve accessibility and inclusion in five key areas:

- General accessibility.
- Customer service.
- Employment.
- Information and communications.
- Design of public spaces.

Patient Experience

At LHSC, we are committed to the principles of people-centred care. People-centred care recognizes the ways in which the knowledge of those with lived experience can be used to not only inform their own care but work in partnership with organizations to inform program design and improvements in care that impact others. Using a people-centred care approach means acknowledging the value of care providers and recognizing the powerful role of their relationships with patients and families in the overall care experience.

Launch of Patient Survey Dashboard

Last year, LHSC launched our largest patient survey program ever, surveying both inpatients and outpatients within two weeks of their care. The response to data has been incredible, with over 73,000 responses received. To better understand and share data from the survey our Patient Experience team worked collaboratively with our Decision Support team to launch the Patient Survey Dashboard. The dashboard was implemented to allow functionality to view both quantitative and redacted qualitative data in a variety of ways, including by survey type, question and individual units. In addition to the new dashboard to better share survey data. LHSC is working on increasing email collection and exploration of other survey modalities to ensure that all patients and families can share their experience of care. The next phase of Patient Experience Surveying is the establishment of a Patient Experience Survey Steering Committee. The Committee will be established in Q4 of fiscal year 2024/25 to provide strategic oversight of patient experience surveying at LHSC. The Committee's goal is to ensure that appropriate processes are in place to support the growth and development of patient experience surveying.

Focus on Continuous Quality Improvement

Patient Experience has been working collaboratively with Decision Support, Quality, Patient Safety and Performance, and area leaders to identify areas of focus based on survey results. Our Patient and Family Partners were key in the identification of our patient experience survey indicator for the Quality Improvement Plan. For the indicator: 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? our performance target was set at 65 per cent and there has been a focus on areas performing below that target. Working groups for these areas have been established and have developed strategies for quality improvement opportunities. Strategies include refreshing patient orientated discharge information, focus groups with patient and family partners to identify suggestions for improved communication, and incorporating key information on TV monitors in the Emergency Department waiting room.

Through weekly huddles, areas are sharing their strategies and learnings to take advantage of organizational best practices and innovative approaches. A key success factor for these initiatives is the involvement of Patient Engagement. LHSC's Patient Engagement framework emphasizes the importance of actively involving patients and caregivers in a spectrum of engagement approaches, including sharing information, consulting with patients, deliberating on health issues, and collaborating with stakeholders to co-create solutions.

Provider Experience

LHSC is committed to continuously innovating in recruitment/retention, workplace culture and staff experience. The following were introduced at LHSC in 2024:

Strategic Recruitment:

- Revitalized recruitment strategy and branding; resulted in a 52 per cent increase in LinkedIn engagement and national recognition.
- Enhancement and optimization of the Clinical Extern Program; creating a robust pipeline of nursing talent while supporting student learning and professional growth.
- Increased and consistent use of the Community Commitment Program for Nurses (CCPN) to attract and retain nursing staff, addressing critical workforce needs; 74 per cent of LHSC nurses in the CCPN program indicated they are satisfied with their current employment.

Workplace Culture & Employee Experience:

- Introduction of unlimited mental health benefits for all employees, highlighting LHSC's prioritization of employee well-being and removal of financial barriers to accessing mental health support.

- Implementation of leadership training (Working Minds) to provide leaders with the tools to support worker mental health and reduce stigma, further embedding a culture of wellness across the organization.
- Launch of Great Moments, a program aimed at recognizing and celebrating the work of Team LHSC.

As a result of this work, LHSC achieved notable milestones in 2024 including the following recognition:

- The Recruitment team was recognized by HR Canada Awards as an Excellence Awardee in Best HR Communication Strategy, reflecting innovative and effective approaches to talent acquisition; and
- LHSC was nominated for the London Chamber of Commerce's 2025 Business Achievement Awards in the "Excellence in People & Culture" category, showcasing the organization's commitment to fostering a supportive workplace culture.

Safety

At LHSC, a four-year plan for patient safety was developed starting in 2022 and extends to 2026. The Patient Safety Plan is based on three pillars: Health Equity, Just Culture, and Patient and Family Partnership. Action items for each year of the plan are developed separately to provide flexibility, allowing for adjustments to action items based on the organization's evolving needs, and those of its staff, patients, and community. In April 2024, the 2022-2026 Patient Safety Plan moved into the implementation phase. Instrumental in 2024 was patient partners' involvement in the development of the action items. Below are three key highlights of patient safety initiatives that were implemented:

Implementation of SPEAK: System Promoting Excellence, Accountability and Knowledge

This year LHSC implemented our new safety incident management system, SPEAK which covers the reporting of patient safety, staff safety and workplace violence incidents, as well as patient feedback. SPEAK encourages a two-way dialogue about safety, which is represented in the icon by conversation bubbles. The implementation of SPEAK is a direct response to feedback LHSC received in the 2023 Team LHSC Survey and the ongoing Patient Safety Culture Survey. Benefits of the new system include:

- Quick and easy to complete incident reports, generally taking three to five minutes,
- A dashboard that provides trending and analysis of data, and
- A way for those who enter events to learn what happened after a review is complete.

Celebrating Patient Safety Champions at LHSC

During Canadian Patient Safety Week (October 28 to November 1), LHSC celebrated the work and dedication of many team members who all have a role to play in patient safety. With over 40 nominations for the Patient Safety Champion Awards, this year's recipients were selected from a highly competitive group. The Patient Safety Champion Awards recognize the dedication and outstanding work of individual staff, physicians, leaders, patient partners and teams in improving patient safety.

Ontario Health's Never Events Hospital Reporting initiative

LHSC has been monitoring Never Events as a measure of preventable patient harm since July 2020. With the introduction of the provincial Never Events reporting project, LHSC has a well-defined process for identifying and reviewing all never events. Over the past year, LHSC has worked diligently to enhance our process for all quality and safety reviews including an expedited triage process for serious safety events, a focused approach to pressure injury reviews, and thorough root cause analysis and quality of care reflective review process. Through these enhanced tools, we are striving to ensure a timely and focused approach to our Never Event review process.

Currently all Never Events at LHSC are reviewed using a quality-of-care reflective review process. This process includes timely collaboration with the clinical leadership and care providers who were involved in the event to establish a timeline. Upon completion of the sequence of events, a collaborative review meeting is held with all key contributors to complete a detailed root cause analysis and fish bone diagram that allows us to better understand the system factors that contributed to the Never Event occurrence. This same group then addresses the root causes and contributing factors through the development of focused recommendations developed using the Institute for Safe Medication Practices Hierarchy of Effectiveness. All recommendations are then reviewed by the organization's Quality of Care Committee, or in the instance of a Pressure Injury related Never Event, by the Pressure Injury Steering Committee.

This approach enables us to truly understand the factors that led to the occurrence of a Never Event, to develop effective recommendations to reduce the risk or recurrence, and to allow a corporate approach to larger event categories such as Pressure Injuries. Overall, this has enabled an effective connection and sharing opportunities with the Ontario Health reporting system.

Palliative Care

Our commitment to providing high-quality palliative care begins with a strong clinical presence across all points of care within LHSC, within both our inpatient and ambulatory care programs. Our dedicated teams provide consultation services, as well as inpatient care to ensure that we deliver palliative care for patients and their families that is both personalized and accessible. Having a widespread presence of providers throughout our health-care

organization allows us to meet unique patient and family needs, providing comfort and support during challenging times.

A multidisciplinary team approach to care: This provides a robust patient care experience where care is wrapped around our patients and their families as we embrace them with the appropriate supports required.

Ongoing educational supports for our people: Enabling great care delivery through palliative care learning and training opportunities that allow our team members to remain current with best practices. Regular rounding with care providers and involvement in research and quality care initiatives also keep our team at the forefront of palliative care practices.

Engaged member in the community of practice: Direct collaboration with other care providers within palliative care, community care, and hospice care, directly connects our team to additional services that enable comprehensive care that goes beyond our hospital's walls to be provided to individuals and families.

Quality improvement focused: Patient and care provider feedback and a data tracking dashboard guide decision making and inform enhancements that promote excellence in care delivery. The addition of new equipment and the establishment of a quality subcommittee further underscore our commitment to maintaining the highest standards of care.

Population Health Management

LHSC is committed to transforming health together with our community and system partners. We recently launched a new Community Advisory Committee to provide a direct connection between LHSC and the community we serve. This Committee ensures the needs, views, and opinions of the community are considered as the hospital continues its work to strengthen our operations.

Understanding our populations and their diverse needs is critical to the work we do and enables proactive planning to deliver person-centred care, particularly with a rapidly growing and evolving population in London. One recent example is our partnership with Youth Opportunities Unlimited (YOU) to launch a community youth hub located at Victoria Hospital for young Londoners living without housing. This hub offers vital support and a secure, supportive environment where youth can stabilize, access health care, and connect with wraparound services as they transition toward stable housing. Youth currently make up 26 per cent of the homeless population in London and Middlesex, highlighting the critical need for targeted support.

We are also an active partner with our Middlesex London Ontario Health Team and are engaged in several population health management-focused initiatives including integrated clinical pathways for COPD, heart failure, and lower limb preservation. Through these

pathways, we are working across the system to develop seamless care models and targeted interventions for specific populations including Indigenous communities, people without access to primary care, and people with multiple chronic diseases.

All of these initiatives are rooted in co-design with local health, social services, and community partners – working collectively towards better health across our region.

Emergency Department Return Visit Quality Program (EDRVQP)

The Emergency Department Return Visit Quality Program is an Ontario wide audit and feedback program involving routine analysis of emergency department return visits resulting in admission. Where quality issues are identified, hospitals take steps to address the root causes. Completion of these audits in 2024 resulted in the identification of two major themes that were considered opportunities for quality improvement at LHSC:

- Long wait times, ambulance offload delays, and wait room crowding; and
- Education and training.

Understanding the increasing impacts and risks of these themes, LHSC has responded and developed a comprehensive list of mitigation and improvement initiatives. Highlights of these key initiatives include:

Intermediate Zone: This zone is an adaptation and expansion of both University and Victoria Hospitals' previous emergency department fast-track areas. This zone has one dedicated physician and two registered nurses to streamline flow and provide efficient and high-quality care.

Ambulance Triage/Offload Process: All patients that arrive in the Emergency Department (regardless of mode of arrival) are assessed and triaged by a Triage trained nurse. Based on assessment by the nurse, the triaged patients are directed to one of three areas: waiting room, hallway stretcher, or care space within the department. This new flow process assists patient flow, allowing the Emergency Department to initiate medical directives/interventions sooner and more quickly return ambulances back to the community.

Escalation and Code Gridlock Policy: The Escalation and Code Gridlock procedure is designed to ensure effective patient flow during periods of high occupancy. Before declaring Code Gridlock, a series of proactive escalation actions are implemented when triggers, such as high occupancy projection rates, delays in admissions, and Emergency Department and/or Critical Care capacity challenges are identified.

The return visit quality work and audit findings are embedded within the ongoing quality improvement initiatives of the Emergency Departments. The success of these initiatives is contingent on the ongoing re-evaluation of the efficiency of the strategies in place, and

finding opportunities to strengthen processes, training and education of Emergency Department staff and physicians.

Executive Compensation

The 2025/2026 QIP is linked to executive pay for performance and is consistent with the Excellent Care for All Act. The link to performance establishes how leadership will be held accountable for achieving targets set in the QIP. The performance-based compensation allows senior executives and CEO to have an opportunity to earn a percentage of their bonus. The five quality improvement indicators selected for the executive pay for performance include:

- Length of Emergency Department (ED) Wait for Bed at 90th Percentile
- 90th Percentile Emergency Department Wait time to Physician Initial Assessment
- 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?
- Discharge Medication Reconciliation
- Average ED Wait Time to Physician Initial Assessment for individuals with sickle cell disease (CTAS 1 or 2)

These performance indicators are incorporated into our corporate scorecard and are updated weekly, monthly and/or quarterly with ongoing tracking and monitoring.

Contact Information/Designated Lead

Sarah Muto

Director, Quality, Patient Safety, and Performance

E: Sarah.Muto@lhsc.on.ca

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

Board Chair _____ (signature)

Board Quality Committee Chair _____ (signature)

Chief Executive Officer _____ (signature)

EDRVQP lead, if applicable _____ (signature)

Appendix B: Quality Improvement Plan FY2024/25 Progress Report

The Progress Report is a tool that helps organizations make linkages between change ideas and improvement and gain insight into how their change ideas might be refined in the future.

Ontario Health (OH) uses updated Progress Reports to share effective change initiatives, spread successful change ideas, and inform curriculum for future educational sessions.

The Quality Improvement Plan is a living document, and the change ideas may fluctuate as we test and implement throughout the year. In the progress report we reflect on which change ideas had an impact and which ones we were able to adopt, adapt or abandon. This learning will help build capacity across the province.

Indicator from 2024/2025	Performance stated on QIP 2024/25	Target stated on QIP 2024/2025	Current Performance 2024/25	Comments
Percentage of Board and executives who have completed relevant equity, diversity, inclusion, and anti-racism education	Not Available	100.0%	100.0% Q3 FY 2024/25	Meeting Target
Change Ideas from 2024/2025 QIP	**Was this change idea implemented as intended? (Y/N)** **Lessons Learned:**			
Source online e-learning modules on broad range of topics related to equity, inclusion and anti-racism including Black Health **Method:** In collaboration with the Learning and Development team we are exploring potential learning partners such as University of Western's Digital Equity Diversity and Inclusion Learning modules **Process measure and Target:** Modules are available on iLearn	**YES: This change idea was implemented.** The Introduction to Anti-Black Racism module was adapted from Toronto Academic Health Sciences Network (TAHSN) and made specific for LHSC. This course teaches staff to recognize the historical and ongoing legacy of Anti-Black Racism in Canada. Acknowledge the different levels of Anti-Black Racism and their impacts. Identify Anti-Black Racism in the workplace and what to do about it. This module was made available to all staff through our iLearn system. This module was included as part of our Board and Executive mandatory training.			

Source online e-learning modules on broad range of topics related to equity, inclusion and anti-racism including Indigenous Health **Method:** In collaboration with the Learning and Development team we are exploring potential learning partners such as University of Western's Digital Equity Diversity and Inclusion Learning modules **Process measures and Target:** Modules are available on iLearn	**YES: This change idea was implemented.** The Indigenous Health modules were adapted from Ontario Health and included as part of our Board and Executive mandatory training. These learning modules were part of the Indigenous Relationship and Cultural Awareness Courses and completed via Ontario Health eLearning portal.
Develop a learning and development strategy for equity and inclusion that understands the needs of the organization and creates a pathway to determine who needs what training when **Method:** Hire a learning and development specialist to develop a corporate wide strategy and conduct an organizational needs assessments Determine role specific learning requirements Determine an organizational learning pathway that includes required training and timing for each role **Process measures and Target:** Organizational needs assessment completed Role specific learning plan developed Organizational learning pathway with mandatory requirements developed	**YES: This change idea was implemented.** Over the past year, several Indigenous Cultural Safety training events were held, supported by funding from Ontario Health for Indigenous Cultural Safety training. Additionally, this year Ontario Health provided funding for a temporary position dedicated to advancing anti-Black racism education. Through this initiative, we are evaluating our existing education on Equity, Diversity, and Inclusion (EDI) concepts and anti-Black racism. The individual in this temporary role is tasked with identifying best practices and providing recommendations to the organization by year-end regarding the future direction of our EDI and anti-Black racism education. **Lessons Learned:** Looking ahead to the next fiscal year, LHSC will develop an education framework focused on key priority areas to advance our organizational learning. This framework will address both personal bias and stigma, as well as existing skills and knowledge gaps, positioning us to make meaningful progress. The framework will also outline the most effective methods for delivering education with the highest impact, and we will collaborate with research partners to ensure the framework has a meaningful and lasting effect.

Indicator from 2024/2025	Performance stated on QIP 2024/25	Target stated on QIP 2024/2025	Current Performance 2024/25	Comments
Discharge summary sent within 48 hours of discharge	68.9%	80.0%	67.8% Q3 FY 2024/25	Target Not Met to Date
Change Ideas from 2024/2025 QIP	**Was this change idea implemented as intended? (Y/N)** **Lessons Learned:**			
Quality improvement education College of Physicians and Surgeons of Ontario hospital focus **Method:** • Physicians can sign on and work with LHSC's Centre for Quality Innovation and Safety to learn quality improvement root cause analysis methodology **Process Measure and Target:** Number of Root Cause Analyses and collaborative sessions and number of change ideas generated from root case analyses- Complete	**YES: This change idea was implemented.** LHSC is in its second year of participation in the CPSO Quality Improvement Program. This year, 86 physicians have enrolled to work on initiatives focused on either completing discharge summaries within 48 hours or improving discharge medication reconciliation processes. Participating physicians receive performance reports that detail their individual progress on completing discharge summaries within 48 hours. They use the data and quality improvement tools provided through the program to guide their improvement efforts. Plans are underway to interview all participating physicians to gain insights into the successes and challenges they have experienced with their quality improvement initiatives. **Lessons Learned** After the first year of the program, it became evident that follow-up with physicians is essential to understanding the progress of their quality improvement efforts. Establishing internal mechanisms to share successful improvements, particularly in completing discharge summaries within 48 hours, is crucial. Identifying local champions who can drive and sustain these improvements as part of the quality improvement plan is also important. An additional lesson is the need to better integrate the CPSO program into broader quality improvement efforts at LHSC. The program has the potential to further develop physicians' quality improvement skills, which can be leveraged to support the hospital's overall quality improvement goals.			
OneChart functionality improvements	**YES: This change idea was implemented.**			

Method: OneChart to automatically pull data fields into a note to assist with efficient completion **Process Measure and Target:** • Data fields identified • Review and testing that the appropriate information is being • automatically pulled • Functionality is validated and used to assist in Discharge Summaries	One Chart Phase II as part of the OneChart initiative Dragon Medical One (DMO) went live with early adopters. Dragon Medical One is a documentation companion that empowers clinicians to create comprehensive clinical documentation and more naturally navigate workflows using just their voice. Functionality such as Dragon Medical One are being explored as potential enablers to drive organization improvement for discharge summaries within 48 hours. LHSC is also, exploring functionality of automatically copying the primary care physician on the discharge summary to ensure information is being shared directly with the primary care physician.
Identify high volume/quantity users for high impact priority areas and explore discharge summary quality **Method:** Target improvement strategies and spread to those high-volume areas in greatest need of improvement Explore measuring quality of discharge summaries and balancing measures **Process Measure and Target:** Champion list of those leaders or areas lessons learned have been shared with/spread to	**YES: This change idea was implemented.** Each quarter, an analysis was conducted to identify areas that required performance improvement and could have the greatest impact on overall results. This report was submitted to the Medical Advisory Committee (MAC). Area leaders received quarterly updates on discharge summaries completed within 48 hours, along with additional performance measures, including the time from discharge to dictation, dictation to transcription, and transcription to authentication. Leaders were able to access data across departments to compare their performance against others.
Establish a Resident Quality Council **Method:** Continue to increase visibility and understandability of the data (better graphs and trending), expand use of storytelling and using the data to inform change **Process Measure and Target:** Number of edits, editing patterns, to the discharge summary	**NO: This change idea was not implemented.** Given the rotating nature of the resident program, residents have provided feedback that a council focused on standardizing organizational practices across departments would be beneficial. The proposed idea was to establish a resident council that could better interpret data related to discharge summaries and develop standardized strategies for improvement that could be implemented organization wide. **Lessons Learned** Due to organizational changes this year, there was no sponsorship for this initiative. For a new resident council to be successfully implemented, it is essential to engage key partners who recognize the value of the initiative. LHSC was unable to test this concept this year.

Indicator from 2024/2025	Performance stated on QIP 2024/25	Target stated on QIP 2024/2025	Current Performance 2024/25	Comments
Patient Safety Culture Survey - 'Overall Rating Score'	61.0%	64.0%	57.0% Q3 FY 2024/25	Target Not Met to Date
Change Ideas from 2024/2025 QIP	**Was this change idea implemented as intended? (Y/N)** **Lessons Learned:**			
Learning from Incident Management Systems Improvement Commitment **Method:** Implementation of a new incident management system, with multiple modules that allow for data analytic sharing and patient experiencing from Incident Management Systems **Process measure and Target:** • Project Plan developed • Stakeholder engagement • New software implemented • Data and analytics framework developed	**YES: This change idea was implemented.** This year LHSC implemented our new SPEAK system which covers the reporting of patient safety, staff safety and workplace violence incidents, as well as patient feedback. SPEAK encourages a two-way dialogue about safety, which is represented in the icon by conversation bubbles. The implementation of SPEAK is a direct response to feedback LHSC received in the 2023 Team LHSC Survey and the ongoing Patient Safety Culture Survey. **Lessons Learned** As part of the new incident reporting system rollout, offering weekly drop-in sessions for leaders to discuss any challenges has been important as these sessions provide immediate feedback and solutions. Implementing a triage process to prioritize and address critical barriers has also been crucial for timely resolution.			
Implementation of Continuous Improvement of Care **Method:** Rollout of the continuous improvement of care model to drive quality and safety at all levels of the organization, through leader and staff education by empowering our people to solve problems and improve outcomes, and by advancing a culture of evidence-informed decisions.	**YES: This change idea was implemented.** Continuous Improvement of Care is a method of driving quality and safety at all levels of the organization. It provides a platform to empower staff and physicians to solve problems and improve outcomes while advancing a culture of evidence-informed decisions. LHSC's Quality, Patient Safety and Performance regularly offers two trainings for all staff and a training for new leaders. Training is mandatory for all leaders and optional for all other staff. The Structured Problem Solving course focuses on how teams can use continuous improvement of care tools to improve their processes. The session focuses on how to use a structured method to identify, discuss and solve problems that occur. The Supporting Collaborative			

Develop Continuous Improvement of Care Sustainability Plan. **Process measures and Target:** • Number of board members and executives trained on the executive management • system. • Sustainability plan developed. • Status exchanges and huddle quarterly compliance audits	Improvement session focuses on how to work on collaborative improvements and what to do with larger problems that come up within the team. Status exchanges and huddles occur across the organization with a designated quality and patient safety consultant for each of the clinical areas. **Lesson Learned** Due to organizational changes this year, the implementation of the executive management system was revised several times. This was to ensure alignment with new organizational priorities. Sustainability of Continuous Improvement of Care requires that the organization embed the tools into quality and performance structures. The development of LHSC's Integrated Quality Management Plan will focus on how the organization has a systematic and structured approach for maintaining and providing high quality care.
Improved Serious Safety Event Process **Method:** Closing the loop of incidents for Serious Safety Events back to staff, patients and families. **Process measures and Target:** • Number of times findings from the series safety event review is shared with staff. • Number of times recommendations are shared from Series Safety Events with staff. • Number of times recommendations are shared from Series Safety Events reviews shared back to patients and families.	**YES: This change idea was implemented.** This year there has been an increased emphasis on the importance of closing the loop with staff members following patient safety incidents. To improve the consistency with which leaders are providing support and closure to staff following incidents and incident reporting, increased emphasis has been placed on completing follow-up or closing the loop with staff. The improvements that have been completed over the past year include a formal reporting process for leaders through the quality of care review presentation for all serious safety events. Leaders are engaging with staff who submitted adverse event reports, and those involved in a serious safety event to provide support, and include these staff in the review process. In addition, expectations have been established for leaders to communicate the recommendations from serious safety events to those directly impacted/involved, to their department, as well as more broadly across the organization or like programs as applicable. In addition to the closing the loop processes within the serious safety event process, a process has also been created through the SPEAK event management system to improve communication with staff following any adverse event, near miss, or good catch. Through the SPEAK system, leaders can directly enter their follow-up process and gratitude to the staff for entering the event. In addition, staff can access the events they have entered to monitor progress and updates from leaders. LHSC is finalizing the LHSC Disclosure Policy, that has included engagement with leadership and patient partners and helps to solidify expectations and accountabilities for closing the loop. From a patient perspective, the expectation for disclosure that a review is occurring following a serious safety event has been established with leaders. With the support of patient relations, these

	conversations are occurring more frequently allowing the opportunity for transparency, and closure for patients and families impacted by a serious safety event. In addition, this process allows patients and families the opportunity to share their perspectives and ask questions that they would like included within the review process. To support this ongoing disclosure, the Disclosure of Patient Harm procedure has been revised and is currently in the process of review and finalization.
Patient Safety Plan Implementation **Method:** Implement Psychological Safety training for all formal leaders Continuation of Just Culture training for all formal leaders **Process measure and Target:** Number of formal leaders trained in Psychological Safety and Just Culture	**YES: This change idea was implemented.** Just Culture training is available for all leaders at LHSC. 85% of leaders have completed the training. The training teaches leaders how to use the Just Culture Algorithm. A tool grounded in systems engineering, human factors and law. Leaders can use this tool to reinforce behaviour that improves systems and reduces negative outcomes, with the goal of improving patient safety. Benefits of embedding Just Culture principles and framework include reducing adverse events, improving systems, improving operational reliability, and improving team morale. LHSC completed an environmental scan of peer hospitals to understand if and how acute care hospitals consider the impact of psychological harm, to patients and staff members, during their safety incident review process. Input from the scan was invaluable in understanding current practices and improving support for patient and staff well-being.

Indicator from 2024/2025	Performance stated on QIP 2024/25	Target stated on QIP 2024/2025	Current Performance 2024/25	Comments
Percentage of patient respondents who responded “completely” "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?"	58.8%	65.0%	64.7% Q3 FY 2024/25	Approaching Target
Change Ideas from 2024/2025 QIP	**Was this change idea implemented as intended? (Y/N)** **Lessons Learned:**			
Patient Experience Survey Results Collection and Dissemination Process Development and Continuous Improvement	**YES: This change idea was implemented.** Patient Experience team worked collaboratively with our Decision Support team to launch the Patient Survey Dashboard. The dashboard			

Methods: Scorecard and dashboard data dissemination and utilization to drive quality improvement. Expand access to this question by including it on all surveys. Areas who are performing below peer programs, will be engaged to identify opportunities to improve and partner with Patient Engagement to involve patient and family partners in developing and implementing improvements. Tools can include focus groups, tracers, and process mapping. A Patient Experience Survey Working Group will be established to monitor and evaluate the patient experience survey process and identify opportunities to reach patients and care partners who do not have email. **Process Measures and Targets:** • Inclusion of this survey question on all 9 surveys to increase access • Percent of engagement requests • Develop the workplan for the upcoming year	was implemented to allow functionality to view both quantitative and redacted qualitative data in a variety of ways, including by survey type, question and individual units. In addition to the new dashboard to better share survey data LHSC is working on increasing email collection and exploration of other survey modalities to ensure that all patients and families can share their experience of care. Patient Experience worked collaboratively with Decision Support, Quality, Patient Safety and Performance, and area leaders to identify areas of focus based on survey results. A pareto analysis was completed to identify key areas that would drive organization wide improvement. Working groups for these areas were established and they developed strategies for quality improvement opportunities. Strategies include refreshing patient orientated discharge information, focus groups with patient and family partners to identify suggestions for improved communication, and incorporation of key information on tv monitors in the Emergency Department waiting room. New this year LHSC initiated weekly performance huddles that included this patient experience indicator. Through weekly huddles areas are now sharing their strategies and learnings to take advantage of organizational best practices and innovative approaches. The following improvement themes have been identified through those weekly huddles: patient experience and engagement, survey data analysis, communication and information clarity, staff engagement and feedback mechanisms, and discharge processes. This year LHSC is also establishing the Patient Experience Survey Steering Committee that will provide strategic oversight of patient experience surveying at LHSC. The Committee's goal is to ensure that appropriate processes are in place to support the growth and development of patient experience surveying. **Lessons Learned** Utilizing data to identify areas for improvement was important for aligning our quality improvement resources effectively. Weekly sharing of improvement ideas and area-specific data created numerous opportunities for enhancement. Establishing a process for prioritizing these new ideas and monitoring the data after implementation is key to understanding the true impact on how we are delivering information at discharge to our patients.
Patient and Family Partner teamwork **Method:**	**YES: This change idea was implemented.** Through a new business partner model, the Patient Engagement Team is assigned to support all Patient Family Advisory Councils (PFACs) and the Patient Experience Advisory Committee (PEAC)

• This fiscal year, a formal process will be put in place to ensure all Patient Experience Advisory Council and Patient and Family • Advisory Councils receive the summary data of patient experience surveys **Process Measures:** • Patient Experience surveys results reported to Patient Experience Advisory Council and Patient and Family Advisory Councils	which includes sharing the results of patient experience surveys to drive LHSC wide improvements. LHSC's PEAC is reviewing survey comments to inform how they can contribute the better informing patients about the support services available at LHSC (i.e. social work, patient navigators, etc.). **Lessons Learned** Direct feedback from members of PFAC and PEAC is that they want to contribute actively to improving services at the hospital and working collaboratively with the Patient Experience Office through Patient Engagement and reviewing feedback from patients, either through survey responses or complaints, will help them focus on key activities. Additionally, the new patient engagement business model will provide leaders (staff and physician) with direct access to engagement support to facilitate more involvement of patient and family partners in quality initiatives.

Indicator from 2024/2025	Performance stated on QIP 2024/25	Target stated on QIP 2024/2025	Current Performance 2024/25	Comments
Time to Inpatient Bed: Time interval between the Disposition date/time and the date/time patient Left the Emergency Department (ED) for admission to an inpatient bed or operating room at the 90th percentile	25.5 hours	23.0 hours	22.0 hours Q3 FY 2024/25	Meeting Target
Change Ideas from 2024/2025 QIP	**Was this change idea implemented as intended? (Y/N)** **Lessons Learned:**			
Continue to create capacity and build on accountability mechanisms to improve patient pull **Method:** • Spread and scale Transitional Care Units (TCU) • Iterate Emergency Department Push/Pull Strategy	**YES: This change idea was implemented.** Internal Admissions and Transfers Policy went live this year, putting into policy the expectation of relating patients to appropriate beds within 30 minutes of a bed assignment. Clinical teams continue to identify discharges as confirmed once orders are written by the medical team, expediting bed assignments and smoother transitions from the Emergency Department to the Inpatient areas. Anticipated Date of Discharge compliance is monitored and utilized to communicate unit level patient flow.			

• Anticipated Date of Discharge entered within 24hrs of inpatient admission and proactive discharge planning accountability within 48 hours • Transparency in Emergency Medical Services and LHSC data to support load leveling conversations between LHSC and Emergency Medical Services **Process Measure and Target:** • Alternate Level of Care Rate Anticipated Date of Discharge Recorded	LHSC to Home Program – provides wraparound services for patients in the home for up to 16 weeks through partnership with community service provider. Target population is those at risk of being designed Alternate Level of Care (ALC) or those already designated ALC. This was launched on November 15 and continues to expand, with a target of 200 patients through the program by March 31st, 2025.
Create reporting mechanism for bed status changes to enhance visibility of time from bed available to bed assigned **Method:** • Create reporting structure • Implement with Capacity Managers and Patient Access and Flow team • Implement with LHSC Clinical Managers and Directors **Process Measure and Target:** Time to Inpatient Bed – 23 Hours Time from bed available to bed assignment – Baseline reporting	**YES: This change idea was implemented.** LHSC's Patient Access Command Centre launched end of Q3 to include Capacity Managers and Admitting Clerks to streamline communication, reduce variance in bed assignment practices and ensure consistency in assigning patients with long waits for beds in ED. Future scaling of this initiative will include environmental services leadership, Infection Prevention and Control and potentially portering. Relaunched December 2024, The Escalation and Code Gridlock procedure is designed to ensure effective patient flow during periods of high occupancy. Before declaring Code Gridlock, a series of proactive escalation actions are implemented when triggers, such as high occupancy projection rates, delays in admissions, and Emergency Department and/or Critical Care capacity challenges are identified. These actions include notifying clinical managers, prioritizing discharges, managing overflow bed utilization, notifying community and regional partners as well as transferring patients as needed to maintain capacity. If the situation worsens and triggers surpass set thresholds, Code Gridlock is declared, and an emergency conference with key stakeholders is convened to further coordinate actions. This procedure ensures that resources are allocated efficiently, and patient safety is prioritized.
Development and implementation of the 2024/25 Pay-for Results (P4R) Action Plan. **Method:** • Development and implementation of the 2024/25 Pay-for-Results	**YES: This change idea was implemented.** The Emergency Department has leveraged Pay for Results opportunities with the Emergency Department Return Visit Quality Program to make progressive enhancements to LHSC's Emergency Department's metric dashboard and features 10 key metrics available to view in real-time. These key metrics include:

• (P4R) Action Plan will be data driven utilizing driver diagrams **Process Measure and Target:** Completion of the 2024/25 Pay-for-Results (P4R) Action Plan.	Ambulance Data (Emergency Medicine Service volumes, offload times, by acuity) Intermediate Zone (volumes, Physician Initial Assessment, reason for visit, disposition) 90th Percentile Time to Inpatient Bed Direct to Service 90th Percentile Physician Initial Assessment Emergency Department Length of Stay Left Without Being Seen Emergency Department Lab and Imaging Patient Survey Dashboard All cause Emergency Department Return Visits within 72 hours

Appendix C: Quality Improvement Plan FY2025/26 Work Plan

Measure: Length of Emergency Department (ED) Wait for Bed at 90 Percentile

Priority Issue: Access & Flow

Unit/Population	Source/Period	Current Performance	Target
Hours/Emergency Department patients	Canadian Institute for Healthcare Information National Ambulatory Care Reporting System (NACRS)/month recent 3-month period	22.0 Hours Q3 FY2024/25	22.0 Hours
Target Justification	Results trending and peer benchmarks. Our performance currently is better than our peers, however this target is anchored in data from the last several quarters and realistic with current system issues.		
External Collaborators	Private-Public partnerships for transitional care units in collaboration with Home and Community Care and local retirement homes, City of London Homeless Hub Strategy and partners and continued coalition with Emergency Medical Services (EMS).		

Change Ideas

Planned Improvement Initiatives (Change Ideas)	Methods	Process Measures	Target for Process Measure
Continue to create capacity and build on accountability mechanisms to improve patient pull	ALC Corporate Strategy to reduce variability in ALC approaches between departments and inpatient units Continuous Improvement of Access and Flow Command Centre	Alternative Level of Care (ALC) Rate Associated Date of Discharge (ADD) Time between bed status changes	LHSC-wide target ALC Rate 5.9% Increase compliance with ADD Reduce time between bed status changes

Focused department level improvement strategies	Mental Health and Medicine programs review performance data and change ideas on monthly basis at improvement teams EMPATH dedicated Mental Health space at Victoria Hospital ED	Alternative Level of Care (ALC) Rate Discharges completed by 11am	LHSC-wide target ALC Rate 5.9% LHSC-wide target Discharges completed by 11am 50.0%

Measure: Emergency Department (ED) Wait time for Physician Initial Assessment at 90 Percentile

Priority Issue: Access & Flow

Unit/Population	Source/Period	Current Performance	Target
Hours/Emergency Department patients	Canadian Institute for Healthcare Information National Ambulatory Care Reporting System (NACRS)/month recent 3-month period	6.3 Hours Q3 FY2024/25	6.0 Hours
Target Justification	Results trending and peer benchmarks. Currently not meeting internal target.		
External Collaborators	None		

Change Ideas

Planned Improvement Initiatives (Change Ideas)	Methods	Process Measures	Target for Process Measure
Continuous Improvement of Intermediate Care Zones	Intermediate Chair Program – efficiently cycle patients through the system Ongoing PDSA cycles of adaptation intermediate care zones	Left Without Being Seen Length of Stay (LOS) of non-admitted patients	Reduce % left without being seen Reduce LOS of non-admitted patients

Physician Schedule Improvement Strategy	Additional shifts to improve physician scheduling gaps. Utilize coverage to augment emergency department flow	Assess effectiveness of strategy and the impact on shifts	Reduce physician scheduling gaps

Measure: 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?

Priority Issue: Experience

Unit/Population	Source/Period	Current Performance	Target
%/Survey Respondents	OHA Patient Experience survey/ month recent 3-month period	64.7% Q3 FY2024/25	65.0%
Target Justification	There is no peer data available currently. Maintain current target and continue progress toward meeting the improvement goal.		
External Collaborators	Ontario Hospital Association (OHA)		

Change Ideas

Planned Improvement Initiatives (Change Ideas)	Methods	Process Measures	Target for Process Measure
Focused department improvements and sustainment	Utilize dashboard data to identify areas of improvement Share and spread actions implemented across departments	Utilization of patient experience dashboard	Increase utilization rate of patient experience dashboard
Establishment of Patient Experience Survey Steering Committee	New committee established to ensure that appropriate processes are in place to support the growth and development of	Focused committee workplan developed # of improvements made to patient experience survey	Completion of committee work plan

	patient experience surveying		

Measure: Discharge Medication Reconciliation

Priority Issue: Safety

Unit/Population	Source/Period	Current Performance	Target
%/Discharged patients	Hospital collected data CERNER/most recent 3- month period	74.0%	80.0%
Target Justification	Results trending and peer benchmarks. Currently not meeting internal target.		
External Collaborators	None		

Change Ideas

Planned Improvement Initiatives (Change Ideas)	Methods	Process Measures	Target for Process Measure
Focused Department Level Improvement Strategies	Utilize data to determine focused areas of improvement Set up working groups to identify change ideas and monitor performance	# of working groups established Best possible medication history	Increase best possible medication history completion
CPSO Quality Improvement Program Spread	Share successful improvement strategies and identify local physician champions as partners	Meeting with all physicians in cohort for feedback Themes identified through root cause analysis	100% of physician cohort contacted for feedback

Measure: Average Emergency Department Wait Time to Physician Initial Assessment for Individuals with Sickle Cell Disease (CTAS 1 or 2)

Priority Issue: Equity

Unit/Population	Source/Period	Current Performance	Target

Minutes/Emergency Department patients	Canadian Institute for Healthcare Information National Ambulatory Care Reporting System (NACRS)/month recent 3-month period	70.3 mins	Collecting Baseline
Target Justification	First year including the indicator on the QIP. It is important to first understand consistent and valid baseline data before setting a target.		
External Collaborators	None		

Change Ideas

Planned Improvement Initiatives (Change Ideas)	Methods	Process Measures	Target for Process Measure
Complete a deep dive into the reliability of data to ensure appropriateness in setting meaningful improvement targets.	Complete consultation with key partners to assess data source for accuracy, completeness, and consistency Monitor indicator as part of quarterly performance reporting process	Internal quarterly data is consistent with Ontario Health e-reporting Validated indicator definition added to internal indicator library	Internal quarterly data is consistent with Ontario Health e-reporting
Increase awareness of sickle cell disease (SCD) among ED staff to improve care in the emergency department.	Develop the Hemoglobinopathy/SCD Clinic internal and external website that will include housing local guidance documents to support ED providers in the acute management of SCD patients	Launch of education materials Utilization of education materials	Reduce rate of ED 30 day repeat visit for individuals with sickle cell disease