Theme I: Timely and Efficient Transitions

Measure

Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Reduce blood product wastage (decrease in cost of wasted blood).	C	Dollars / All patients	Hospital collected data / Month	14300.00	7500.00	Canada has had repeated blood shortages leading to denial of transfusions for a limited number of patients. Compared to our peer hospitals, KHSC has significantly higher wastage. Canadian Blood Services and the Ontario Ministry of Health have advised us that our blood wastage must be reduced.	

Change Ideas

Change Idea #1 Implement unit and program specific live-time dashboards to identify blood wastage trends.

Methods	Process measures	Target for process measure	Comments
Create an electronic unit-based dashboard and launch to leaders and Clinical Learning Specialists (CLS).	Dashboard created and all clinical leaders/CLSs on-boarded.	Electronic dashboard built and 100% of leaders and CLSs on-boarded by end of Q1.	

Change Idea #2 Complete focused one-on-one education for nursing staff in areas of high wastage.

Methods	Process measures	Target for process measure	Comments
Bedside education completed with every nurse.	# of nurses educated.	>95% of nursing staff educated by Q4.	

Change Idea #3 Implement blood Usage mandatory e-learning training for RNs.

Methods	Process measures	Target for process measure	Comments
Creation of mandatory LMS model for all RNs.	# of nurses who have completed the LMS module.	>95% of staff completed eLearning by Q4.	

Change Idea #4 Use KHSC lived experience and best practices from Toronto General Hospital to redesign the blood box packing configuration.

Methods	Process measures	Target for process measure	Comments
Redesign blood box packing, specifically the configuration of ice packs. Implement new configuration and educate front-line staff on packaging/process change.	Packaging change implemented.	Implemented in all units by Q3.	

Measure

Dimension: Efficient

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Average number of lab tests per patient, per visit.	C	Count / All inpatients	Hospital collected data / April 1 - March 31	16.00	13.00	The target selected for reduction in the number of tests/patient/visit is based on the peer data available from Gemini. Achieving an average of 13 will place KHSC slightly below the aggregate average.	

Change Ideas

Change Idea #1 Reduce volume of blood in collection tubes (this includes testing within Clinical Biochemistry, Hematology and Transfusion medicine).

Methods	Process measures	Target for process measure	Comments
Implement lithium heparin, serum and EDTA blood tubes with reduced volume.	1. Red Blood Cell (RBC) transfusion rate. 2. # of tubes received with appropriate volume.	RBC Transfusion volume reduction of 4% from baseline by Q4.	

Change Idea #2 Syringe used as primary collection device for lactate testing.			
Methods	Process measures	Target for process measure	Comments
Modify LIS for all locations (in addition to POCT) for lactate to be collected in syringe.	1. Transfusion rate in ICU patients. 2. Audit of ICU lactate results 3. Recollection rate for lactate testing.	RBC Transfusion volume reduction of 4% from baseline by Q4.	

Change Idea #3 Stop bicarbonate, urea and creatinine testing in dialysis patients.			
Methods	Process measures	Target for process measure	Comments
Change ordering practice in Nephrocare.	Audit of creatinine, urea, bicarbonate testing in dialysis patients.	Less than 10% of dialysis patients routinely tested for creatinine, urea and bicarbonate.	

Change Idea #4 Repeat HbA1c testing not less than every 90 days.			
Methods	Process measures	Target for process measure	Comments
Alignment of clinical programs (Endocrinology and Nephrology). Build of warning rule in LIS.	# of patients with HbA1C testing <90 days.	Less than 40% of patients with repeat testing every 75 days.	

Theme III: Safe and Effective Care

Measure

Dimension: Safe

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% of Code White incidents where opportunities for improvement were identified.	C	% / All patients	Hospital collected data / FY24	CB	CB	In FY23, the QIP focused on the number of incidents of patient violence. The FY24 indicator shifts the focus to the actions undertaken to review and improve processes after an incident. In FY24 we will collect baseline as this is a new documentation process.	

Change Ideas

Change Idea #1 Revise existing Code White Debrief form and a fields in the SAFE Reporting tool to improve the process of documenting and actioning identified opportunities for improvement.

Methods	Process measures	Target for process measure	Comments
Revise Code White Debrief form. Revise SAFE reporting tool to collect enhanced information. Create communication plan to roll out changes to leaders and front-line staff.	Revisions completed to debrief form. Revisions completed to SAFE reporting tool. Changes communicated to all leaders.	Form revisions complete. Process changes communicated to all leaders.	

Change Idea #2	Using feedback/information obtained from Code White incidents, along with other data sources, identify and implement corporate and unit specific initiatives, training, and resources to better support the psychological well-being of our staff and prevent psychological injury and burnout, and		
Methods	Process measures	Target for process measure	Comments
1) Analyze feedback and aggregate data from other sources (e.g. Code White debriefs, short term disability and psychological injury data, 2023 Staff & Physician Experience survey, other surveys/measures of psychological stress) to identify learning and staff support needed. 2) Create an action plan of proposed areas of focus for implementation in FY24 to support improved psychological wellbeing of our staff.	1) Analysis complete. 2) Action plan developed.	Analysis and action plan complete.	

Change Idea #3	Identify unit and/or corporate specific training needs/improvements that would help in preventing patient violence and code whites, and assist staff in more effectively managing the risk of violence.		
Methods	Process measures	Target for process measure	Comments
With Code White incidents as the backdrop, identify the knowledge/skill gaps though assessment of code white incidents/incident reviews, and engagement of appropriate stakeholders (e.g. CLSs, Professional Practice, Program Managers/Directors, Leadership & Talent Development).	1. Needs Assessment completed. 2. Recommendations formulated for approval (Business case developed should additional funds be necessary).	1. Needs assessment completed in Q1. 2. Recommendations formulated before end of Q2, with business case(s) if needed.	

Change Idea #4	Based on opportunities already identified from code whites, develop and roll out a formal crisis management/debriefing policy and/or toolkit for leaders to ensure clarity and consistency on the provision of crisis management support to staff as a strategy to minimize the impact of psychological harm.		
Methods	Process measures	Target for process measure	Comments
Engage stakeholders, including the Workplace Violence Working Group, JHSC, etc. to develop and roll out these leader resources.	Tools completed and leaders orientated to them.	Orientation complete.	