Let's Make Healthy Change Happen.

Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

Kingston General Hospital

4/1/2014

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a quality improvement plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to HQO (if required) in the format described herein.

Overview

Kingston General Hospital is a community of people dedicated to transforming the patient and family experience through innovative and collaborative approaches to care, knowledge and leadership. As southeastern Ontario's leading centre for complex-acute and specialty care and home to the Cancer Centre of Southeastern Ontario, KGH serves almost 500,000 people through its Kingston facility and 24 regional affiliate and satellite sites. Fully affiliated with Queen's University, KGH is a research and teaching hospital which is home to 2,400 health-care students and 175 health researchers. KGH has been ranked since 2011 as one of Canada's Top 40 Research Hospitals by Research Infosource. The KGH 2015 strategy for achieving *Outstanding Care, Always,* has lead the organization on a journey of quality improvement enabling our vision to be a top performer making *Outstanding Care, Always* a reality for every patient, every day. KGH has maintained an unyielding focus on four strategic directions to achieve this goal:

1. Transform the patient experience through a relentless focus on quality, safety and service
2. Bring to life new models of interprofessional care and education
3. Cultivate patient-oriented research
4. Increase our focus on complex-acute and specialty care

The QIP 2014-15 will focus on 8 priority measures as suggested by Health Quality Ontario (HQO):

1. Reduce emergency department wait times
2. Improve organizational financial health
3. Reduce unnecessary deaths in hospital
4. Reduce unnecessary time spent in acute care
5. Reduce unnecessary hospital admission
6. Improve patient satisfaction
7. Increase the proportion of patients receiving medication reconciliation upon admission
8. Reduce hospital acquired infection rates

Our commitment to transforming the patient experience and providing care that is consistently safe and patient-centered is deeply rooted into the QIP 2014-15. Along with the principles that guide our work – respect, engagement, accountability, transparency and value for money – our QIP 2014-15 clearly resonates with the Excellent Care For All Act and its goal of fostering a culture of continuous quality improvement and integration where the needs of patients come first.

Integration & Continuity of Care

Health care in the South East LHIN, is actively undergoing transformation in the way that all providers integrate health service delivery in the region. Through a collaborative stakeholder consultation involving KGH, its partner hospitals and the Community Care Access Centre (CCAC), the Clinical Services Roadmap (CSR) was developed. The CSR focuses on seven areas of improvement to find better ways to improve access to care and streamline the continuity of care between providers while simultaneously improving quality of care and the patient experience. These areas of focus and resulting work plans include:

1. **Cardiovascular care** (*focusing on chronic heart disease management and a reduction in readmission to hospital following a cardiac incident)*,
2. **Emergency department wait times** *(and the need to improve processes that will reduce the amount of time people wait to receive care)*,
3. **Healthcare acquired infections (HAI)** *(to reduce the number and severity of infections caught in health care settings; focus on hand hygiene compliance and regional initiatives)*,
4. **Mental health & addiction services** *(ensuring patients receive the right care at the right time in the right place)*,
5. **Restorative care** *(focused on coordinating care between health-care providers, rehabilitation specialists, and managing chronic continuing care)*,
6. **Maternal and high- risk newborn care** *(to ensure the latest treatments and services are used when caring for high-risk mothers and their babies)*, and
7. **Surgical services** *(creating a regional, collaborative plan to manage effective inter-hospital care, including repatriation protocols)*.

KGH, Kingston and the region are actively involved in Health Links. The SE LHIN has seven Health Links that are looking at ways to connect family physicians and their patients with hospital specialists and community supports. The Kingston and Kingston Rural Health Link will develop plans and measure results to:

- Improve access to care for patients with multiple, complex conditions
- Reduce avoidable emergency department visits
- Reduce unnecessary readmission to hospitals shortly after discharge
- Reduce the wait time for referral from the primary care doctor to a specialist

Within KGH, our Patient and Family Centred Care (PFCC) approach has firmly taken root over the past four years, and continues to flourish. Its evolution has been with the full support of our Board of Directors and senior leadership and has garnered national and international recognition. The concept is articulated in the KGH 2015 Strategy, and milestones and measures have been incorporated into the performance management system.

Challenges, Risks & Mitigation Strategies

KGH is the only hospital in the SE LHIN providing adult tertiary complex-acute care. As a result, high occupancy levels remain an ongoing challenge. The increasing frequency of gridlock status has prompted KGH to make improving patient flow a top corporate priority. An extensive continuous improvement process with broad stakeholder engagement has identified many process improvement cycles encompassing key QIP metrics including emergency department flow including length of stay, readmissions, medication reconciliation and infection control.

Nevertheless, there are challenges and risks we face in relation to the proposed QIP:

1. External challenges and risks:
    - Fiscal challenges with the implementation of a new funding model and new QBP initiatives
    - Resource requirements to support the new Ministry initiative known as Health Links
    - Ongoing support for the SE LHIN Clinical Services Road Map
2. Internal challenges and risks:
    - Rising volume of ED activity and admissions over the last fiscal year impacting ED wait times
    - Sustainability of the targets we have reached and organizational capacity to meet any additional external challenges and risks

Information Management Systems

KGH tracks 116 indicators in depth on a quarterly cycle. Each indicator is purposely aligned to improvement priorities and milestones that are set annually to support the KGH 2015 strategy. Programs with continuous-improvement tactics manage priorities specifically linked to the QIP. Each indicator has its own stretch target based on best practice, provincial best or theoretical best achievement. Corporate accountability for review lies with the Quality of Patient Care Committee of the Board.

Engagement of Clinical Staff & Broader Leadership

The initiatives and performance targets set out for the 2014-15 QIP are the outcome of a comprehensive planning process, priority setting and engagement. A recent staff and physician NRC engagement survey has guided selection of QIP initiatives with identified action plans that have been established with stretch goals and targets. The QIP is integrated into an ongoing cycle of planning and performance management at KGH and embedded within the annual corporate plan of the hospital. The rigor of this process enables leaders to be held accountable for results. Systems have been put in place to monitor our progress and communicate results to all levels of the organization, the community and Ministry. All programs and departments will be formulating tactical plans using continuous improvement principles to address the QIP and initiatives set out in the annual corporate plan. Physicians working through the Medical Advisory Committee's (MAC) Quality Committee have created clinical department-specific QIP's that align to the KGH QIP. Commitment to drive quality of care into the clinical departments is evident with physician specific metrics focusing on patient care.

Accountability Management

KGH has a comprehensive performance management program. Each year, KGH creates an Annual Corporate Plan (ACP) that includes: performance milestones, annual targets, and tactical plans to deliver on our hospital's strategy. The QIP targets and initiatives are also incorporated into the Annual Corporate Plan. Regular reporting of progress against the plan is delivered to leaders, staff members, the Board and our community. Quarterly reviews of the ACP are completed by the executive and Board.

Executive compensation is linked to the QIP. Each executive, including the President and CEO, has pay at risk that is tied to achieving QIP goals for 2014-15. The amount of pay at risk for executives ranges from three to seven percent of total cash compensation. The payment of pay at risk related to the QIP occurs following the fiscal year end evaluation of results. The amount awarded will be based upon the Board of Directors' evaluation of performance against specific thresholds in the Executive Performance Agreements that align to the Quality Improvement Plan.

Health System Funding Reform

HSFR has been a significant transformational change for health-care organizations. As a result of some of the changes underway, KGH has utilized materials and toolkits through the Ministry's Health Data Branch to provide the programs with tools to meet the obligations of Quality Based Procedures (QBPs) throughout fiscal 2013-14. The complexity of maintaining the additional QBP programs in fiscal 2013-14 and the next two waves in 2014-15, has prompted a redesign at KGH. A QBP toolkit recently released from the OHA to support implementation of QBPs has provided KGH with new tools to refresh and realign accountability of the working groups to a central steering committee. This will ensure internal action plans adopt clinical best-practice pathways while aligning to QIP improvement tactics.

Working with our regional partners and the SE LHIN, service capacity planning for orthopedics and ophthalmology, in addition to the CSR will support and be supported by our QIP priorities to mitigate admissions and time spent in the hospital.

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

Tom Buchanan Board Chair	Geoffrey Quirt Quality Committee Chair	Leslee Thompson President & CEO

Instructions: Enter the person's name. Once the QIP is complete, please export the QIP from Navigator and have each participant sign on the line. Organizations are not required to submit the signed QIP to HQO. Upon submission of the QIP, organizations will be asked to confirm that they have signed their QIP, and the signed QIP will be posted publically.

2014/15 Quality Improvement Plan for Ontario Hospitals
"Improvement Targets and Initiatives"

Kingston General Hospital 76 Stuart Street

AIM		Measure								Change				
Quality dimension	Objective	Measure/Indicator	Unit/ Population	Source/ Period	Org. Id	Current perf.	Target	Target justification	Priority level	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
Access	**Reduce wait times in the ED**	ED Wait times: 90th percentile ED length of stay for Admitted patients.	Hours / ED patients	CCO iPort Access / Q4 2012/13 – Q3 2013/14	693*	32.53	25	Based on SouthEast LHIN MLPA negotiated targets	Improve	1)Discharge Prediction on all clinical units: GRIDLOCK is a state of total congestion where patient need (inputs) far outweighs available bed capacity combined with an inability to move patients out of the ED to an inpatient bed in the necessary timeframes. KGH has made Gridlock a top priority in the organization. Prediction of discharge is a key component of knowing what resources are available on a daily basis to initiate processes to make the bed available in a timely fashion.	A discharge planning PDSA has been initiated to identify all steps in the discharge prediction process. A bed utilization flow sheet is updated every 8 hours and electronically circulated to all program leaders, directors and managers. The predicted discharge initiative will aim to have all discharges predicted in the subsequent 24 hours listed on the bed utilization. One medical and one surgical unit have piloted the discharge prediction process.	Daily bed utilization flow sheets will be analyzed to assess the number of units predicting discharges.	80% of clinical units will record predicted discharges daily in the bed utilization flow sheet	
										2)Improved ED specialist consult time: ED length of stay is the time encompassing the time of registration to leaving the ED. Many steps in the process have opportunities for reducing down times in the continuum of care. The length of time it takes the consultant to arrive in the ED is one of those opportunities.	A PDSA analysis will be conducted for key consulting services viz. Medicine, General Surgery and Orthopedic Surgery. Areas of opportunity will be identified and put into place and effect of consult times noted.	Reduction in time it takes for consulting services to see and assess patients in the ED. Current performance for these disciplines is more than 5 hours.	20% reduction in the time a consultant is notified to the decision to admit time by March 31, 2015	
										3)Bedmap redesign: Hospital bed occupancy rate varies greatly amongst admitting services with ranges of 120%. Despite the availability of beds during a Gridlock status, service mismatch to bed location is a quality of care risk due to a care provider expertise mismatch (off service). A bed map redesign will be implemented to increase bed availability to clinical services having a high occupancy rate to mitigate extended stays in ED waiting for bed availability and get patients admitted to the best location.	Extensive stakeholder engagement with all clinical program leaders will occur to review program strategies to level occupancy to 95% through realignment of beds with the expectation of zero decrease in service.	Stakeholder engagement is expected to completion by April 1, 2014 with subsequent bed realignment. Occupancy rates by program will be tracked and reviewed monthly at the Patient Flow Task Force Committee.	95% bed occupancy by Med-Surg programs by March 31, 2015	
Effectiveness	**Improve organizational financial health**	Total Margin (consolidated): % by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expense, excluding the impact of facility amortization, in a given year.	% / N/a	OHRS, MOH / Q3 2013/14	693*	3.09	0	The variance between the actual financial position and budgeted financial position measures the accuracy of the planning model and management's ability to live within the available financial resources.	Maintain	1)Quality Based Procedure Steering Committee Implementation: HSFR process is entering into year 3 of the QBP rollout. Two waves of procedures is expected in 2014/15. Current management is coordinated by the individual program related to the QBP. Resource allocation in a vertically oriented system has taxed availability to support additional activity. The OHA QBP Toolkit will be implemented to support the expansion of the QBP. A Steering Committee will be implemented as per the toolkit.	The OHA QBP Toolkit will be used to set up a corporate oversight committee to support each QBP team.	Success of the Steering Committee will be each QBP reaching target volumes and budget when known.	100% QBP targets met by March 31, 2015	
	Reduce unnecessary deaths in hospitals	HSMR: Number of observed deaths/number of expected deaths x 100.	Ratio (No unit) / All patients	DAD, CIHI / 2012/13	693*	106	100	The Hospital Standard Mortality Ratio (HSMR) is an important quality of care measurement tool that provides a starting point to assess mortality trends, identify opportunities for improvement and track progress. The HSMR is adjusted for factors affecting mortality, such as age, sex, and length of stay. An HSMR equal to 100 suggests that there is no difference between the hospital's mortality rate and the overall average rate. An HSMR greater than 100 suggests that the local mortality rate is higher than the overall average whereas a HSMR less than 100 suggests that the local mortality rate is lower than the overall average. It is important to note that HSMR is not designed for comparisons between hospitals; it is intended to track a hospital's trend	Improve	1)Sepsis Mortality Review: the Dept of Medicine has the largest patient activity and bed occupancy. Mortality reviews to date based upon probability of death from the HSMR data set has not seen value to process improvement or quality of care concerns. A sepsis protocol was introduced last fiscal year. All deaths with a diagnosis of major sepsis will be reviewed by the Department. All other Departments will review all deaths.	Mortality review by the Department of Medicine will occur for all patients with a diagnosis of major sepsis. All other Departments will review all deaths. Recommendations will be put forth and implemented. Reporting of mortality review will be to MAC quarterly.	All recommendations from a mortality review will be acted upon and completed as appropriate. Frequency of use of the Sepsis Protocol will be documented	100% of Mortality reviews completed each quarter	
										2)Reduction in Ventilator Associated Pneumonia: Consistent application of a VAP prevention protocol. Checklists to be placed at every bedside and discussed on multidisciplinary rounds. Oversight of the process by the Patient Safety Coordinator	Review of data and trends in VAP by the Critical Care Program and Quality Committee quarterly	Number of cases of VAP reduced to Best of Peer Hospitals. Current 0.48 (Q3)	Best of Peers= 0. Provincial Avg = 1.03 (Q3)	
										3)MRSA admission screening: Screening of MRSA on admission is mandatory to document disease to enable accurate nosocomial acquisition of MRSA. Provincial reporting is only for nosocomial disease. Current screening is only completed in about 40% of patients available for screening.	Current accountability for screening is vague and inconsistent. A PDSA cycle will be completed to look at where and who has the best opportunity to conduct the MRSA screening. Infection Prevention and Control team will provide education to staff and monitor compliance and reviewed at the Patient Safety and Quality Committee	Number of patients who have a MRSA screen completed on admission	100% of patients admitted will have a MRSA screen completed within 24 hours of admission by December 31, 2014 (Q3)	

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Quality dimension	Objective	Measure/Indicator	Unit/ Population	Source/ Period	Org. Id	Current perf.	Target	Target justification	Priority level	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
								over time.		4)Reduction in Level 3 and Level 4 Falls: Recent Critical Incident Reviews have identified falls as a serious patient safety concern.	Using the PDSA methodology, identification of areas of opportunity will be identified. Re-education on the Falling Star program will be conducted on all units. The CAHO ARTIC 'Move On' Project will look to ensure save patient mobility assessments and environment are made. Purposeful hourly rounding by nursing staff will support the patient personal needs and environment are safe. Documentation on the Patient Care Record will conduct a falls risk assessment to trigger reduction strategies (bed alarm, hi-lo bed, patient communication strategies)	Monthly falls reporting through the Safe Reporting electronic Tool will be reviewed by the Falls Committee and to the Patient Safety Quality Committee. Tracking of fall incident alerts to managers and directors and sign off.	Zero Level 3 and 4 falls each quarter	
Integrated	**Reduce unnecessary time spent in acute care**	Percentage ALC days: Total number of acute inpatient days designated as ALC, divided by the total number of acute inpatient days.	% / All acute patients	Ministry of Health Portal / Q3 2012/13 – Q2 2013/14	693*	8.76	9.46	Provincial target 9.46, SE LHIN target approx. 12.6. Based on SELHIN methodology (current performance between provincial and SELHIN targets) our 2014/15 target is the provincial target of 9.46%.	Improve	1)Admission management partnership with CCAC for ED patients 7 days/week to reduce the percentage of ED patients admitted with primary ALC status	Through a formal working group inclusive of CCAC, ED, and Med-Surg care teams, support and process measures will be identified and planned for crisis assessment and placement of all patients identified as not meeting the criteria for care in an acute care facility. Programs will review and report to Patient Flow Task Force Committee on all patients admitted with ALC status.	Avoidance of admission of all patients with primary diagnosis of ALC status made within 72 hours of admission.	100% avoidance	
	Reduce unnecessary hospital readmission	Readmission to any facility within 30 days for selected CMGs for any cause: The rate of non-elective readmissions to any facility within 30 days of discharge following an admission for select CMGs.	% / All acute patients	DAD, CIHI / Q2 2012/13-Q1 2013/14	693*	17.63	12.9	30 day readmission rates in part reflect that patients received appropriate, timely care from physicians, nurses and other healthcare providers. Another factor that may contribute to lower 30-day readmission rates is well-prepared instructions for discharge from the hospital. Examples include instructions on proper medication use, diet, wound care management and follow up instructions. Availability and access to CCAC/home care will play an additional role. This indicator represents the readmission rate for selected CMGs to ANY facility within the SE LHIN. A low rate of readmission would therefore be reflective of quality of care by the discharging institution and care provided in the community.	Improve	1)Adoption of e-Discharge tool to improve the discharge summaries sent to the primary care providers within 72 hours of patient discharge	Discharges will be flagged on the electronic Patient Care System for each physician using the 'In Box' tool. The expectation is Discharges will be completed and signed off within 72 hours of discharge to enable electronic transmission to the primary care provider. Compliance at meeting the 72 hour target will be tracked monthly by physician and clinical division and department. Results will be sent to the Department Quality Committee's for review and MAC.	Percent e-Discharge summaries completed (electronically signed off) within 72 hour. Current performance =56%	80%	
										2)Two Health Links have been initiated in the immediate vicinity of KGH: the Kingston Health Links and the Rural Kingston Health Links. Focus is on supporting the Family Physicians/Health team on identification of chronic disease patients frequenting the emergency department of KGH. The two primary chronic diseases are COPD and CHF.	KGH will participate in the Health Links working groups to support the Family Physicians/Health team through data access. Solutions to supporting the patients in avoiding the non acute care hospital setting will be the goal of the working groups and secondarily mitigating readmission.	Admission rates for the identified patients will be monitored and PDSA process looked at to support process improvements.	Reduction in the readmission rate for all patients identified to the Kingston and Rural Kingston Health Links by 50%.	
Patient-centred	**Improve patient satisfaction**	From NRC Picker: "Overall, how would you rate the care and services you received at the hospital (inpatient care)?" (add together % of those who responded "Excellent, Very Good and Good").	% / All patients	NRC Picker / Oct 2012-Sept 2013	693*	95	97	Target is set on quarterly based on NRC picker results for our Teaching Hospital Peer group.	Improve	1)Adoption of the Cleveland Clinic's Communicate with H.E.A.R.T. (SM) Model. KGH has shown itself to be a leader in the patient centred model of care. The H.E.A.R.T. program will clearly take that foundation of the patient experience to the next level and be very complimentary to existing systems including the Patient and Family Advisory Committee and the Patient Advisors participating on all corporate committees of the hospital.	Communicate H.E.A.R.T. (SM) will be rolled out to all staff with a series of training sessions. Focus will be on the creation of staff awareness of the impact of every patient, visitor and employee interaction. In addition, creating an understanding of the role of caregivers in providing world class care through 9 service behaviours will be emphasized (Acknowledge the other person, introduce self and role, Use person's preferred name, clearly communicate expectations, offer to resolve concerns or move to the appropriate person, use active listening, communicate empathy, use common courtesy and offer help).	The number of staff participating in the training sessions.	500 staff will participate in the training sessions by March 31, 2015	
										2)Increase adoption of patient and family centered care standards in every clinical area.	All 5 patient and family centered standards (use of white boards, name tags worn correctly, patient-family led forum completed, hourly rounding, HEART communication) are implemented in all clinical areas.	Percent compliance with each of the 5 standards utilizing audit tool results.	85% compliance within each of the 5 standards across clinical areas .	

AIM		Measure								Change				
Quality dimension	Objective	Measure/Indicator	Unit/ Population	Source/ Period	Org. Id	Current perf.	Target	Target justification	Priority level	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
Safety	**Increase proportion of patients receiving medication reconciliation upon admission**	Medication reconciliation at admission: The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital.	% / All patients	Hospital collected data / Most recent quarter available (e.g. Q2 2013/14, Q3 2013/14 etc)	693*	72	100	Internal stretch target	Improve	1)Providing all patients with the best possible medication history (BPMH) has been actively supported by dedicated Pharmacy Technicians in the ED for all admissions. Alternate admission points to the hospital are being address through the development of Order Sets (standardized preprinted orders). Expansion of the order set to all clinical programs will be initiated.	Order Set development the includes the BPMH with a standard set of admission orders will be developed and supported by the Pharmacy and the Order Set Committee.	Hospital wide compliance with medication reconciliation on admission will be monitored. Current performance is 72%	100% by March 31, 2015	
	Reduce hospital acquired infection rates	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1,000 - Average for Jan-Dec. 2013, consistent with publicly reportable patient safety data.	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / 2013	693*	0.55	0.37	Target is set quarterly based on provincial average.	Improve	1)Antibiotic Stewardship Program implementation	Expansion of the Antibiotic Stewardship program to all critical care areas of the hospital. Compliance and process will be monitored by the Infection Control Service and Infection Committee.	Antibiotics dispensed quarterly to ED and admitted patients per 1000 patient days. Current performance = 243	20% reduction in antibiotic defined daily dose	
		Hand hygiene compliance before patient contact: The number of times that hand hygiene was performed before initial patient contact divided by the number of observed hand hygiene indications for before initial patient contact multiplied by 100 - consistent with publicly reportable patient safety data.	% / Health providers in the entire facility	Publicly Reported, MOH / 2013	693*	83.7	95	Target is based on desired improvement.	Improve	1)Monthly hand hygiene audits on all units and wards.	Auditors will collect hand hygiene compliance for all 4 moments of care. Data will be collected electronically using the audit tool and recorded by provider group and clinical unit. Monthly data will be reviewed at the Patient Safety Quality and Risk Committee and MAC.	Unit and provider rates will be tracked. Education on hand hygiene compliance and value will be supplemented on all units by the Infection Prevention Team Specialists. Percent compliance by clinical unit will be posted publicly on the units and overall hospital compliance will be posted at main entrances. Percent compliance by provider will be reviewed at the Patient Safety Quality and Risk Committee and MAC. Unit educators will support education to staff.	Achieve goal of 95% compliance by March 2015	
	Reduce rates of deaths and complications associated with surgical care	Rate of 5-day in-hospital mortality following major surgery: The rate of in-hospital deaths due to all causes occurring within five days of major surgery.	Rate per 1,000 major surgical cases / All patients with major surgery	CIHI eReporting Tool / 2012/13	693*	10.52	8.68	Current performance and target based upon most recent data from CIHI (Fiscal 11/12)	Improve	1)A formal mortality review will be conducted on all patients dying within 5 days of major surgery. In the same fashion as the existing Critical Incident Reviews conducted under the ECFAA, recommendation will be made focusing on process improvement opportunities.	Mortality reviews for all mortality within 5 days of major surgery will be conducted by the respective department's quality committee. All recommendation will have a MRP assigned for implementation/completion. Completion rates for reviews will be monitored by the MAC's Joint Utilization and Quality Committee.	Rate of completion of the mortality reviews.	100%	NOTE: 11/12 performance (most current available) 10.52, peer target 8.68. Waiting for updated data from CIHI
		Surgical Safety Checklist: number of times all three phases of the surgical safety checklist was performed (briefing, time out and debriefing) divided by the total number of surgeries performed, multiplied by 100 - consistent with publicly reportable patient safety data.	% / All surgical procedures	Publicly Reported, MOH / 2013	693*	94.73	100	Target is based on best performance.	Improve	1)Compliance for all three phases of the surgical safety checklist by all surgical disciplines will be monitored with daily reporting of compliance with each phase for all surgical procedures.	Reporting will be separated by discipline and sent to the respective Department or Division for review and comment.	Compliance with performance on all 3 phases of the surgical safety checklist	100%	