Theme I: Timely and Efficient Transitions

Measure

Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Unconventional spaces	P	Count / All inpatients	Daily BCS / TBD	CB	CB	As per HQO advice, currently collecting baseline data for this indicator.	Royal Victoria Regional Health Centre, Georgian Bay General Hospital, Collingwood General and Marine Hospital

Change Ideas

Change Idea #1 Explore and draft short admission process for predicated admissions <24hrs

Methods	Process measures	Target for process measure	Comments
Review current process and draft short admission intervention in Electronic Medical Record (EMR)	Complete literature review and draft short admission process with Meditech Expanse Partners	Complete literature review by end of Q2 and discuss draft process by end of Q4	

Change Idea #2 Explore data tracking opportunities during Meditech Expanse project (Electronic Medical Record)

Methods	Process measures	Target for process measure	Comments
Explore alternative methods for tracking and reporting bed availability to streamline processes and support access and flow.	Complete assessment of possibilities in tracking data/reporting with Meditech Expanse partners.	Assessment to be completed by end of Q3	

Change Idea #3 Review transfer of accountability process.

Methods	Process measures	Target for process measure	Comments
Review the current Standard Operating Procedure (SOP) for Transfer of Accountability and provide education to Inpatient Unit and Emergency Department nursing staff.	Quarterly review of progress at Team Huddles and attendance tracking.	80% sign off by nursing staff on education related to Transfer of Accountability by end of Q4.	

Measure **Dimension:** Efficient

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Diagnostic Imaging Report Turnaround Time for Mammography Screening.	C	90th percentile / Patients	In house data collection / Q3 Oct - Dec	281.00	336.00	Sustain performance 336hrs or less over each quarter within the calendar year	

Change Ideas

Change Idea #1 Sustain radiologist complement and introduce recruitment efforts as required.

Methods	Process measures	Target for process measure	Comments
Agenda item at monthly Governance Meeting for review and discussion.	Total FTE (full time equivalent) compliment	4 FTE (full time equivalent) radiologists	

Change Idea #2 Training for Booking Clerks in relation to mammography procedures to reduce variation and ensure consistent patient experience

Methods	Process measures	Target for process measure	Comments
1:1 training sessions for each Booking Clerk with training manual development	% of Booking Clerks trained in mammography booking	100% of Booking Clerks trained by Q2	

Measure **Dimension:** Timely

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
The time interval between the Disposition Date/Time (as determined by the main service provider) and the Date/Time Patient Left Emergency Department (ED) for admission to an inpatient bed or operating room.	M	Hours / All patients	CIHI NACRS, CCO / Oct 2019– Dec 2019	11.93	10.00	Modest, realistic improvement target set	

Change Ideas

Change Idea #1 Develop short admission process for predicted admission <24hrs

Methods	Process measures	Target for process measure	Comments
Review current process and devise short admission intervention in Electronic Medical Record (EMR).	Test process with 20 patients and run through PDSA cycles (Plan, Do , Study, Act)	20 successful short form admissions by Q4	

Change Idea #2 Improve data tracking for bed availability to admission

Methods	Process measures	Target for process measure	Comments
Investigate ways of tracking and reporting with Housekeeping Teams and Inpatient Units for Bed Clean/Available to patient admitted to unit	% of patients within 90 minutes from bed clean to admitted	80% within 90minutes	

Change Idea #3 Review transfer of accountability process

Methods	Process measures	Target for process measure	Comments
Review transfer of accountability process and responsibilities. Develop standard processes for "pull system" from units to ED when possible. Training on new process for all Charge Nurses	% of charge nurses trained on revised process	100% of Charge Nurses trained by Q2	

Change Idea #4 Enhance use of documentation tools at the bedside for vital signs and admission assessment to ensure accurate timely documented occurs.

Methods	Process measures	Target for process measure	Comments
Increase quarterly login at the bedside terminals (The Hub)	Monitor the login at bedside terminals (The Hub) on a quarterly basis	5% improvement each quarter	

Theme II: Service Excellence

Measure

Dimension: Patient-centred

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of respondents who responded “completely” to the following question: 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?	P	% / Survey respondents	CIHI CPES / Most recent 12 months	65.35	70.00	Maintain Performance.	

Change Ideas

Change Idea #1 Expand use Patient Orientated Discharge Summary (PODS) for chronic conditions

Methods	Process measures	Target for process measure	Comments
Develop Patient Orientated Discharge Summary (PODS) for Chronic Heart Failure and Stroke	Patient Orientated Discharge Summary (PODS) implemented with PDSA cycle feedback during Q3	Gather feedback from 10 patients discharged with Patient Orientated Discharge Summary (PODS) package with these conditions.	Total Surveys Initiated: 127

Change Idea #2 Enhanced educational offerings on The Hub bedside information system

Methods	Process measures	Target for process measure	Comments
Develop patient education published to The Hub bedside system with mechanism for patient survey feedback	Patient education offerings implemented with feedback survey via The Hub bedside system during Q3	50% of patient rated education as useful via The Hub bedside system survey	

Measure

Dimension: Patient-centred

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of complaints acknowledged to the individual who made a complaint within five business days.	P	% / All patients	Local data collection / Most recent 12 month period	73.15	90.00	Maintain stretch target set in 19/20	

Change Ideas

Change Idea #1 Conduct further data analysis and trending to give leaders specific opportunities for improvement

Methods	Process measures	Target for process measure	Comments
Utilizing the "themes" for feedback and target specific education around scenarios for improvement	Baseline data for themes and education	Baseline completed by Q3 and education by Q4	

Change Idea #2 Review mapping in Safety Quality Information System (SQIS) to ensure notifications for complaints are effective and timely

Methods	Process measures	Target for process measure	Comments
Complete data mapping exercise for departments and Leaders	No of defect notifications received incorrectly	Zero defects received by Q2	

Theme III: Safe and Effective Care

Measure **Dimension:** Effective

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Proportion of hospitalizations where patients with a progressive, life-limiting illness, are identified to benefit from palliative care, and subsequently (within the episode of care) have their palliative care needs assessed using a comprehensive and holistic assessment.	P	Proportion / All patients	Local data collection / Most recent 6 month period	CB	CB	Collecting baseline data via new HOMR (hospital one year mortality ratio) tool and other assessments tools.	

Change Ideas

Change Idea #1 Implement HOMR (Hospital One Year Mortality Index) Project. Early Identification of patients with palliative needs.

Methods	Process measures	Target for process measure	Comments
Introduce HOMR risk scoring via electronic medical record and flag patients who have threshold score	% of patients who are identified within the threshold score for palliative unmet needs	100% of patients admitted to F Wing inpatient unit with HOMR completed	

Change Idea #2 Patients who are identified as having palliative care needs have ESAS (Edmonton Symptom Assessment Scale) assessment completed and recorded in their care record.

Methods	Process measures	Target for process measure	Comments
ESAS (Edmonton Symptom Assessment Scale) assessment completed with patient and discussed with family members as required	% of patients who have an ESAS (Edmonton Symptom Assessment Scale) completed in their care record	100% of palliative patients admitted to F Wing inpatient unit who are identified as having unmet needs have a completed ESAS (Edmonton Symptom Assessment Scale) assessment	

Change Idea #3 Identify ways of gathering and discuss preferred location for death with patients and supporting caregiver/families.

Methods	Process measures	Target for process measure	Comments
Advanced care planning questionnaire to be given to all patients who are identified as having unmet palliative needs	% of patients who receive advanced planning questionnaire and education	75% of palliative patients admitted to F Wing inpatient unit who are identified as having unmet needs have their preference documented	

Measure

Dimension: Effective

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percent of unscheduled repeat emergency visits following an emergency visit for a mental health condition.	P	% / ED patients	CIHI NACRS / April - June 2019	30.25	30.00	Maitain performance	Hills of Headwaters Collaborative (OHT)

Change Ideas

Change Idea #1 Develop consistent approaches to patient care for patient with Mental Health needs

Methods	Process measures	Target for process measure	Comments
Develop tool for staff to use to identify the needs of individual patients. Partner with Patient Family Advisory to develop tool	Tool implemented for feedback through PDSA (Plan, Do, Study, Act) cycles.	Complete PDSA by end of Q1 and review	

Change Idea #2 Improve referrals to community services to ensure patients have support required to reduce re-visits

Methods	Process measures	Target for process measure	Comments
Referrals completed and sent to Community services	% of patients who have referral to community service	75% of referral to community service	

Change Idea #3 Develop short form survey for Crisis Worker to complete with patients after discharge from ED

Methods	Process measures	Target for process measure	Comments
Ensure patients needs are being met and followed up to prevent avoidable re-visits	% of patients who complete survey	75% of patients followed up with crisis worker	

Measure **Dimension:** Safe

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.	M	Count / Worker	Local data collection / Jan - Dec 2019	48.00	48.00	Maintain performance. Reporting culture work completed during 2019 therefore would expect similar performance.	

Change Ideas

Change Idea #1 Leverage Workplace Violence Prevention sub-committee to recommend actions from risk assessments

Methods	Process measures	Target for process measure	Comments
Develop action plan relating to Workplace Violence Prevention for recommendation to Joint Health & Safety Committee	% of actions completed by end of year	70% of actions completed.	FTE=454

Change Idea #2 Further disseminate de-escalation policies

Methods	Process measures	Target for process measure	Comments
Delivery of Management of Aggressive Behaviours (MOAB) training	Number of training sessions delivered successfully	4 sessions delivered within the year by Q4	

Change Idea #3 Education and training for identified high risk roles

Methods	Process measures	Target for process measure	Comments
Develop checklist for high risk roles for Leaders to support staff during onboarding and annual education.	Checklist developed for identified high risk roles and piloted with 2 Leaders	To be piloted by end of Q3	

Measure

Dimension: Safe

Indicator #9	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Reduce opioid prescriptions post-surgery	C	Count / All surgical procedures	In house data collection / January - December 2020	17080.00	15372.00	10% stretch target. 46% improvement seen in previous calendar year.	Wellington, Dufferin, Guelph Public Health Unit

Change Ideas

Change Idea #1 Develop poster education campaign. Review current media materials available for opioid education and reduction of use.

Methods	Process measures	Target for process measure	Comments
Poster to be co-designed with Patient Family Advisor Partnership group and feedback via wide stakeholder engagement and displayed in perioperative assessment clinic and physician offices.	% of physician offices displaying posters at 140 & 150 offices.	100% take up of posters at physician sites.	

Change Idea #2 Provide regular data to surgeons on opioid post surgery prescribing

Methods	Process measures	Target for process measure	Comments
Prescribing report sent to Chief of Departments	Quarterly reports generated by Pharmacy and sent to Chiefs	Quarterly reports sent with feedback on performance to Chiefs	

Change Idea #3 Deliver continuing medical education for physicians relating to opioid reduction. To be led by Anesthetist.

Methods	Process measures	Target for process measure	Comments
Hold 1 education session with Wellington Dufferin Guelph Public Health Unit	Session to be held by Q4	10 participants at session	