Theme I: Timely and Efficient Transitions

Measure

Dimension: Timely

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital.	P	% / Discharged patients	Hospital collected data / Most recent 3 month period	84.90	85.00	After successfully reaching our target for 2021/22, our focus in 22/23 will be to sustain the improvements made over the past 18 months. Due to our Complex Program and current structure related to visit patterns, there will always be a % that do not meet the 48 hour turnaround within a sub acute care framework.	

Change Ideas

Change Idea #1 Continue to monitor sustainment of completion rates by program and physicians and work directly with those physicians outside the 48 hour target. Focus on reduction of > 72 hour turnaround times.

Methods	Process measures	Target for process measure	Comments
Data collection to continue through Cerner reports to monitor turn around times by program and physician	% or discharge summaries completed in >72 hours as well as >48 -<72 hour category. Monitor times 2nd and 3rd notices are sent out to physicians for incomplete charts.	Maintain those > 72 hours to less than 10% of total Complex Program discharges. monitor > 48 hours but < 72 hours - target 0	Improvement priorities will be focused on addressing those > 72 hours and understanding factors that impact the turnaround time . We have transitioned to an electronic record with front end dictation and voice recognition so documentation should be real time. There may be impacts related to Complex Continuing Care and physician visit impacts.

Theme II: Service Excellence

Measure

Dimension: Patient-centred

Indicator #2	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 mos	38.65	43.00	We have targeted a 5% increase in this indicator which is considered an aggressive target from an NRC perspective for our one year improvement goal . There is also a significant % in "Quite a Bit" response category (30%) . The NRC Average is 59% .	

Change Ideas

Change Idea #1 Sustain current improvements being shown in the real time survey results in providing enough information at discharge to patients/families

Methods	Process measures	Target for process measure	Comments
Consultation with PFAC and Unit Based Council Teams to review patient experience data quarterly and review of patient comments and feedback to support development of change ideas. Develop scripting for letter to provide patients with Home and Community Care Information .	Enough information about medication indicator % patients discharged home that were contacted within 72 hours for follow-up check and discharge survey Enough information provided at discharge and if not , what information was missing ? (real time indicator) Real time survey question : Did you received enough information on discharge ?	Target 10% improvement for patients reporting they had enough information about medications at discharge. Target: 80% of patients discharged home will be contacted within 72 hours for follow up . Received enough information at discharge (real time survey) : Target >90% yes	Total Surveys Initiated: 169 Work will continue with collaboration with Home and Community Care on feedback received during discharge process and service expectations. Any gaps in home care do reflect on HDGH feedback from patients as it is seen as part of their care with us (post leaving here during those first few days) . We will be moving to using the CPES indicator for this QIP tracking in alignment with Ontario Health definition and comparison .

Measure

Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
I think the services provided here are of high quality	C	% / Mental health patients	Other / 21/22 YTD	92.50	93.00	This is a new indicator for QIP monitoring and is meant to reflect overall patient experience and quality of care for our Mental Health Inpatient population. The target is based on sustainment of improvements over the next fiscal year	

Change Ideas

Change Idea #1 Development of monthly structured rounds with a checklist and trial of new version of rounds by Sept 30, 2022

Methods	Process measures	Target for process measure	Comments
Develop plans for sharing information with patients and look at possibly inclusion where appropriate of patient into formal rounds. Setting of EDD during a patients stay to help mitigate unexpected discharges	1. EDD targets discussed and/or set where applicable within 30 days of admission (to be developed) 2. MH Rounds attendance will be tracked for physicians (to be developed) 3. MOnitor OPOC results " #12-I was involved as much as i wanted to be in decisions about my treatment and support " (baseline : 73 % Agree/Strongly Agree) 4. Monitor OPOC results " #10 - I received clear information about my medication " (baseline : 80% Strongly Agree/Agree)	1.% of patients with an EDD discussed within 30 days post admission . (to be developed) 2.% attendance at rounds monthly(to be developed) 3. OPOC indicator #12 - involved in care - increase by 5% 4.OPOC indicator #10 - I received clear information about my medication - increase by 5%	The main goals will be implementing structured rounds and sharing of information and greater interaction with patients related to decision making and understanding of medications.

Change Idea #2 Develop a plan around increasing activities available to patients(i.e nurse led grounds, input from patients on what activities they are interested in having)

Methods	Process measures	Target for process measure	Comments
Through review of patient OPOC surveys and direct feedback/input from patients Monitor Code White incidents (time of day) to identify where additional activities may be required.	Monitor OPOC indicator related to enough activities from patient perspective. Monitor # of code white to determine if activities help reduce the number of incidents (due to boredom)	1. Increase OPOC indicator for " #33- there were enough enough activities of interest to me during my free time " target to increase strongly agree/Agree by 5% . 2. Develop a target for Code White reduction by September 2022.	Through Mental Health Transformational Planning activities , review of OPOC results and experience indicators most impacting patient experience related to quality care will be included in program review.

Theme III: Safe and Effective Care

Measure

Dimension: Effective

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged.	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / October 2021– December 2021	92.05	95.00	We continue to maintain a target of over 90% completed . Target will increase slightly with target of reducing the missed medication reconciliation with program transition improvements to achieve a 95% target. This indicator remains high overall and close to 100% for discharged patients.	

Change Ideas

Change Idea #1 Pharmacy /Physician Leads to continue to review monthly completion of medication reconciliation and follow up with individual physicians as required

Methods	Process measures	Target for process measure	Comments
Focus on re-education and monitoring of "transitions" by program . Review incomplete Medication Reconciliation errors and follow up with individual physicians for learnings and improvements. This will include a workflow review for "HOLD" medications pending results process.	% transitions that have Medication Reconciliation completed # of incomplete medication reconciliation due to med rec error .	Reduce number of transitions incomplete by 50% by fiscal year end . Reduce the number of incomplete due to error by 50% by fiscal year end.	The focus of this improvement project will be on the transitions and medication errors which cause an incomplete medication reconciliation . Overall , we have a sustained rate around 91% for the past two years as an existing improvement project.

Measure

Dimension: Safe

Indicator #5	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.	P	Count / Worker	Local data collection / January - December 2021	32.00	0.00	Our target for violence incidents is zero as an organizational strategic goal and set to be consistent with our message of zero tolerance . We continue to have a process to review each incident and apply learnings. We did have a large decline in incidents over the past year from 74 incidents in 20/21 to 32 incidents in 21/22. Fiscal Year was used .	

Change Ideas

Change Idea #1 Continue to provide staff education and training to all staff and review all incidents. Conduct a deep dive review into the past two years of data and the impact of COVID on incidents by program and type of incident. Review findings for learnings .

Methods	Process measures	Target for process measure	Comments
Monitor impacts of increasing clinics and programs and the increase of visitors/Designated Care Partners back into the building and impacts on incidents against staff.	% of incidents with/without injury Monitor # of incidents by program /time period	100% without injury is target 20% reduction in # incidents overall by program/service categories.	FTE=941 There have been significant declines over the past year in incidents against employees during COVID .Understanding any learnings from this decline and factors contributing to it are important in sustaining and continuing to reduce incidents across the organization.