Access and Flow | Efficient | Custom Indicator

Indicator #1

% transitioned in accordance to targets from "Ready/Eligible " in Acute Care to "Admission " to HDGH .
(Hotel-Dieu Grace Healthcare)

Last Year		This Year	
87	**87**	**84**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Maximizes strategies related to internal transitions from complex to rehab to help address flow issues to CMC.

Process measure

- Monitor referral process and wait time from ready status transition from CMC to Rehab

Target for process measure

- 90% transitioned from CMC to Rehab within 2 days of "ready" status. (Internal transfers)

Lessons Learned

While HDGH met the target there remains, at times, a discrepancy between “patient ready” in acute care and “patient ready” as it pertains to the established HDGH medical stability criteria and RCA framework
• HDGH will continue to remain diligent in reviewing referrals and working with acute care partners in educating them on eligibility criteria and referral processes. This is especially important to ensure that patients are transitioned safely to the right bed at the right time and in addition avoid unnecessary ALC designations.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Review wait times collection processes and optimize accuracy of data

Process measure

- Complete review of data and provide a work plan for improvement of wait time data collection with quarterly milestones by June 30 , 2023 . Review % of work plan items completed quarterly.

Target for process measure

- 85% of work plan items identified that are completed each quarter.

Lessons Learned

We are lacking a standardized approach to recording and collecting wait times between programs – Mental Health and Addictions and Restorative Care
Efforts were made in providing education to the Mental Health and Addiction care providers to support standardized processes in capturing data between them and Restorative Care and as such ensuring greater accuracy in reporting wait times. Challenges include system limitations that we will be working in collaboration with Transform Shared Service on optimization opportunities with our HIS system (Cerner)

	Last Year		This Year	
Indicator #2 Alternate Level of Care (ALC) days expressed as % of all inpatient days in the same period (Hotel-Dieu Grace Healthcare)	**13** **Performance (2023/24)**	**14.50** **Target (2023/24)**	**9.50** **Performance (2024/25)**	**NA** **Target (2024/25)**

Change Idea #1 ☐ Implemented ☑ Not Implemented

AS per the ALC leading practice guide from Ontario Health, we will be developing a sfCare strategy and plan and integrating that as a foundation of care across the organization . This is focused on Organizational Leadership & Support and Older Adult & Caregiver Communication and Involvement . In alignment with Accreditation Canada standard that "services are co-designed to meet the needs of an aging population" and is considered high priority criteria.

Process measure

- Development of work plan to support sfCare Strategy Plan completed by December 2023 . % of milestones achieved annually in the approved work plan.

Target for process measure

- Achievement of 80% of identified milestones identified annually, by the end of each fiscal year

Lessons Learned

Not implemented as intended : While intended to create a work plan, priorities shifted with ALC being aligned with the provincial sfCare Strategy. Opportunities still exist to develop HDGH's sfCare Strategy however in the meantime the organization is focusing its efforts on ALC throughput and 95% occupancy rates to enhance local patient access and flow (OH Directive). In winter of 2023, HDGH opened a 20 bed surge unit. We learned very quickly that our region lacks access to beds for patients with cognitive behaviours such as dementia and Alzheimer like diseases

Comment

• HDGH is building relationships with BPSO and RGP and will be introducing an Elder Life Program to strengthen interactions with our patients and reduce the risk of delirium. In addition HDGH has implemented a pilot project called the Geriatric Urgent Response Team (GURT) that will go to patient's homes to assess their cognitive well-being and assist with system navigation to advert ED visits

Equity | Equitable | Custom Indicator

	Last Year		This Year	
Indicator #4	**CB**	**CB**	**CB**	**NA**
Increase awareness of diversity, equity, and inclusivity; project development milestone goals (Hotel-Dieu Grace Healthcare)	**Performance (2023/24)**	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ **Implemented** ☐ **Not Implemented**

Establishing an EDII work plan that emphasizes key areas of learning and development and contribute meaningfully to organizational strategic direction.

Process measure

- Development of strategic plan that embeds EDII in all that we do by September 2023 Creation of EDII work plan that will drive EDII initiatives and education in alignment with the strategic plan

Target for process measure

- Implementation of finalized EDII work plan and milestone identification for the next three years in alignment with strategic plan

Lessons Learned

Identified in Strategic Plan and one of the key initiatives. Work plan developed and education plan started for senior leadership level. Draft work plans for both EDI and Indigenous work have been completed and submitted to the Senior Management Council for approval. The EDI work plan was developed with the OH Framework in mind, however, the Indigenous work plan will need review now that OH released their First Nations, Inuit, Metis, Urban Indigenous work plan. Following approval of SMC, the EDII Alliance will begin implementing the plan. To note – HDGH hired an FTE Manager of EDI, who reports to the Director of Communications and Mission. This position, in place since the fall of 2023, has begun to implement items that are pending SMC approval. Items include – defining what is EDI at HDGH, and creating a statement of inclusion for Job Postings. Further to this, we have rolled out mandatory training for our SMC members based on recommended training from Ontario Health. These are items that are directly correlated to the HDGH draft EDII work plans.

Experience | Patient-centred | Custom Indicator

	Last Year		This Year	
Indicator #7	**88**	**90**	**97.50**	**NA**
Percentage of respondents who responded "Completely/Always" 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. (discharged) (Hotel-Dieu Grace Healthcare)	**Performance (2023/24)**	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Gather details from patient experience surveys and through the Discharge Transition nurse follow up call process, from those who feel they did not receive enough information. use language that corresponds with the information they receive (i.e., purple HDGH folder)

Process measure

- % of comments received for answers that do not indicate the person received enough information. Analysis completed quarterly on response data and suggestions. Trending information provided to the indicator lead for development of discharge information improvements and shared with program Unit Based Councils as well as PFAC (Patient Family Advisory Committee)

Target for process measure

- 1. 80% of negative responses will have comments starting in Q2. 2. 100% completion of quarterly analysis and feedback process to programs, Unit Based Councils & PFAC

Lessons Learned

Data collection is within the discharge survey completed by Quality Advocate within 72 hours post discharge and when respond No or Sometimes to this question, they ask for details. These are then shared with the experience survey results distribution channels.
The Discharge Transition nurse follow up call process has been put on hold for the time being due to resource availability)
Patient and family greatly appreciated the information given to them and the call to "check-in" on them post discharge to answer any questions or assist with system navigation.
HDGH will strive to reintroduce the Discharge Transition nurse follow up process as soon as resources allow.

Change Idea #2 ☐ Implemented ☑ Not Implemented

Review strategy to include scheduling of primary care follow up appointment within 7 days of discharge (prior to leaving the hospital and included in discharge package)

Process measure

- Where an appointment for primary care is identified, track the % of patients who have their primary care appointment booked prior to leaving the hospitals. A process will be identified and tested in a pilot phase for 6 months to collate data and evaluate effectiveness.

Target for process measure

- Target to be identified once the strategy is developed and pilot is completed to establish a baseline.

Lessons Learned

This has not been completed and will be transitioned to 24-25 Action Plan.

	Last Year		This Year	
Indicator #3	**92.50**	**93**	**93.80**	**NA**
I think the services provided here are of high quality -Inpatient Mental Health OPOC (Hotel-Dieu Grace Healthcare)	**Performance (2023/24)**	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Development of monthly structured rounds with a checklist and trial of new version of rounds

Process measure

- 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 (Ontario Perception of Care) 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)

Target for process measure

- 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%

Lessons Learned

In progress : Transitioned new Operations, Clinical Practice Manager, and Inpatient Psychiatry Lead for TNI.
Completed comprehensive engagement strategy for TNI model of care review with PMO support. New supportive roles for management (coordinator and analyst) will materialize in the fall to support this change initiative. Participating in the National Schizophrenia project with the Mental Health Commission and Ontario Shores which will include standardized scripting for physicians as it relates to important prescribed medications (Clozapine and LAIs). Project will launch in April. EDD - In progress - working on standard data collection process 2. Rounds attendance tracking - in progress -rounds are every 2 weeks and not currently an issue with attendance. Will be reviewed with TNI transformation planning. 3. OPOC #12 - increased to 78.6% from 73% 4. OPOC #10 - increased to 93.3% from 80% .

Change Idea #2 ☑ Implemented ☐ Not Implemented

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)

Process measure

- 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)

Target for process measure

- 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 2023.

Lessons Learned

In Progress: New roles within the model of care targeted for fall implementation will improve the availability of activities on the unit, including evenings and weekends. Program coordinator will help attach patients to activities in a way that is customized, and patient centered, in collaboration with program leadership. OPOC Question : Enough Activities : 75.5%

Safety | Effective | Priority Indicator

Indicator #5

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. (Hotel-Dieu Grace Healthcare)

Last Year		This Year	
CB	**97**	**95.68**	**97**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

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

Process measure

- 1. % transitions that have Medication Reconciliation completed 2. number (#) of incomplete medication reconciliation due to med rec error

Target for process measure

- 1. Reduce number of transitions incomplete by 50% by fiscal year end. 2. Reduce the number of incomplete due to error by 50% by end of fiscal year.

Lessons Learned

The area of focus for improvement is "transitions" by program.
Identified need to review workflows for "hold " medications.

Safety | Safe | Priority Indicator

	Last Year		This Year	
Indicator #6 Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period. (Hotel-Dieu Grace Healthcare)	**43** Performance (2023/24)	**0** Target (2023/24)	**24** Performance (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

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 have experienced a large decline in incidents over the past years from 74 incidents in 20/21 to 32 incidents in 21/22 and 33 incidents in 22/23. Fiscal Year was used.

Process measure

- % of incidents with/without injury Monitor # of incidents by program/time period.

Target for process measure

- 100% without injury is target 20% reduction in # incidents overall by program/service categories.

Lessons Learned

Monitoring impacts of increasing clinics and programs and the increase of visitors/Designated Care Partners back into the building has not impacted our workplace violence incidents by causing an increase in incidents against employees. Of the 24 incidents , there was only 1 case that resulted in lost time. The significant majority of the reported incidents at our organization continue to occur in our Regional Children's Centre which is a program specifically designed to service children experiencing a high level of behavioural escalation. We also continue to have incidents (<10) reported in our Mental Health programs (both residential and in-patient) which would reflect the vulnerable emotional state of these clients/patients. Incident reports from Restorative Care programs continue to remain low and are most typically associated with patients demonstrating a medical condition that impacts cognition and behaviour.

Comment

there may be some gaps in data due to cyber security event and data is currently being captured manually as system restoration has not taken place yet.