Theme I: Timely and Efficient Transitions | Efficient | Additional Indicator

Indicator #3

Percentage of inpatient days where a physician (or designated other) has indicated that a patient occupying an acute care hospital bed has finished the acute care phase of his/her treatment. (Queensway Carleton Hospital)

Last Year		This Year	
21.30	**21.30**	**34.10**	**--**
Performance (2022/23)	**Target (2022/23)**	**Performance (2023/24)**	**Target (2023/24)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Adjust patient care model at the offsite Alternate Level of Care (ALC) centre to provide resources that will assist with discharge of ALC patients to Long Term Care Homes and Retirement Homes.

Target for process measure

- By December 31, 2022

Lessons Learned

A recreologist and a behaviour therapist have been added to the team for our offsite ALC patients. These resources have helped to create care plans for complex patients with responsive behaviours to facilitate discharge to Long Term Care.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Implement Alternate Level of Care Best Practice guidelines

Target for process measure

- by December 2022

Lessons Learned

The ALC Best Practice Organizational Self Assessment is complete. As anticipated, this work has led to identifying several opportunities for improvement that are now being considered for implementation.

Change Idea #3 ☑ **Implemented** ☐ **Not Implemented**

Improve internal flow of acute patients to post acute destinations; Complete Value Stream Map process to identify efficiencies and role clarification to improve timely triaging patients

Target for process measure

- By December 2022

Lessons Learned

The Value Stream Mapping exercise was completed prior to December 31, 2022. Several improvements have been made as a result, including streamlining the flow of these patients to our off site ALC unit as well as improving the Rehabilitation referral process.

Change Idea #4 ☐ **Implemented** ☑ **Not Implemented**

Home and Community Care Partnership- establish a cross community panel to review long stay ALC patients with complex discharge needs

Target for process measure

- By November 2022

Lessons Learned

This change idea is in process as of January 2023, but has not yet been completed. The Terms of Reference for the Long Stay panel have been created. We are awaiting guidance from the Home and Community Care Support Services to initiate the panel.

Change Idea #5 ☑ **Implemented** ☐ **Not Implemented**

Development of new, external site for ALC patients with a focus on appropriate infrastructure for patient comfort and safety

Target for process measure

- By end August 2022

Lessons Learned

Our new external ALC site was opened at Park Place Retirement Home in October 2022. Our ability to effectively transfer patients to the off site beds has improved with this new site.

Comment

Our changes have been successful, but not able to overcome the effect the pandemic wrought on an already precarious situation. We continue to mitigate the impact of the loss of 850 long term care beds in our region as well as the mounting challenge of finding appropriate care settings for the increased number of patients with complex discharge issues.

Theme I: Timely and Efficient Transitions | Timely | Custom Indicator

Indicator #6

The (90th percentile) 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. (Queensway Carleton Hospital)

Last Year		This Year	
27.90	**26.50**	**37.50**	**--**
Performance (2022/23)	**Target (2022/23)**	**Performance (2023/24)**	**Target (2023/24)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Systematic identification of Predicted Discharge Date (PDD) on every inpatient within 24 hours of admission on A4 Rehabilitation unit.

Target for process measure

- 75% of all inpatient charts will have the PDD completed by December 31, 2022

Lessons Learned

Education has been completed with both physicians and nurses to imporve compliance with this initiative. Successful identification of the predicated discharge date allows patients and families to prepare for the transition home without delay.

Change Idea #2 ☐ Implemented ☑ Not Implemented

Paramedic Training for IV pumps and PICC line care for community paramedics to support earlier discharge to the community.

Target for process measure

- 20 patients will have paramedic support on discharge by the end of December 2022

Lessons Learned

While training was provided to paramedics, Home and Community Care Services indicated that there were no gaps in care provision that could be addressed through use of paramedic resources to support early discharge.
Other initiatives: Community paramedics attend weekly rounds on medicine units to identify patients for their community program. Remote monitoring for ALC patients will be initiated in January in partnership with community paramedics

Change Idea #3 ☑ Implemented ☐ Not Implemented

Conduct a value stream mapping exercise to identify focused areas for improvement in patient flow

Target for process measure

- Conduct Value stream mapping and identify 3 areas of improvement by the end of August 2022

Lessons Learned

Value Stream Mapping was completed, with 3 areas of improvement identified and in progress of being addressed. This includes processes for movement of patients, environmental services activities, and processes for booking non-urgent transportation.

Change Idea #4 ☑ Implemented ☐ Not Implemented

Develop a standardized approach to discharge rounds to ensure the most efficient use of time and the most effective planning

Target for process measure

- 3 units by December 31, 2022

Lessons Learned

This work has been completed and is in the pilot stage on our A3 Medicine unit.

Change Idea #5 ☑ **Implemented** ☐ **Not Implemented**

Review work of previous A3 to diagnose major factors slowing discharge of patients.

Target for process measure

- By December 31 ,2022

Lessons Learned

This review was completed. The findings underscored some of the other initiatives and reinforced that the new Value Stream Mapping work was required to understand our current processes.

Change Idea #6 ☑ **Implemented** ☐ **Not Implemented**

Open MH Unit with 24 private rooms to decrease wait time due to isolation, gender, reactive behaviours.

Target for process measure

- By September 2022

Lessons Learned

The new Mental Health unit was opened in December 2022. This has offered expanded compliance for admitting patients requiring isolation, resulting in fewer Mental Health patients being admitted off service or remaining in the Emergency Department due to infection control needs. More importantly patients are reporting enhanced recovery with more privacy and suitable space.

Comment

The unanticipated impact of the pandemic, resulting in significantly higher Emergency Room visits and consistently challenged in-patient occupancy has negatively impacted our ability for these changes to have the desired outcome. Significant focus continues in this area of hospital operations.

Theme II: Service Excellence | Patient-centred | Priority Indicator

Indicator #4

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? (Queensway Carleton Hospital)

Last Year		This Year	
57.62	**60**	**57.19**	**60**
Performance (2022/23)	**Target (2022/23)**	**Performance (2023/24)**	**Target (2023/24)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Identify discharge champions on each Medicine unit (A3, ACE, A4 and C4)

Target for process measure

- 2 trained discharge champions on each unit by December 31, 2022

Lessons Learned

We identified and trained two discharge champions on each of the targeted units and are now in the process of expanding this program to 80% of the full and part time nurses.

Change Idea #2 ☐ Implemented ☑ Not Implemented

Discharge champions will speak to patients in the same language the satisfaction survey utilizes

Target for process measure

- Percent of discharge champions who follow scripted standard work based on audit of conversations with patients

Lessons Learned

This work is continuing in 2023-2024 with our expanded discharge champion program.

Change Idea #3 ☐ Implemented ☑ Not Implemented

Transition Tool which is the patient document for all instructions needed after discharge will be adapted to the electronic platform. Requires comparison to current discharge package.

Target for process measure

- By December 2022.

Lessons Learned

This work is in progress. The edits are complete and this work is in the queue for implementation through our electronic health record. The Guidelines Applied in Practice (GAP) tools are now electronic for two specific syndromes: Acute Coronary Syndrome and Heart Failure.

Comment

Please note that our performance is based on 2021-2022 data as that is the last data available to our organization at this time. We have introduced an internally-directed patient satisfaction survey to allow us to have data in the period prior to the system provided by our new provider, Qualtics, to be implemented.

Theme III: Safe and Effective Care | Safe | Priority Indicator

	Last Year		This Year	
Indicator #2 Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period. (Queensway Carleton Hospital)	**534** Performance (2022/23)	**534** Target (2022/23)	**676** Performance (2023/24)	**--** Target (2023/24)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Train specific Behavioral Support (BSO) champions on targeted units. This involves specific training in Gentle Persuasive Techniques and NICHE training.

Target for process measure

- Ten BSO champions will be trained

Lessons Learned

While this goal is in progress, we have identified 24 (rather than the 10 that were targeted) to receive BSO training. The change has made an impact with staff confidence in managing behaviours on the units.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Provide Managers with weekly reports on reported events that are approaching 30 days open to help facilitate closure within 30 days.

Target for process measure

- By December 31, 2022, 80% of all workplace violence incident reports will be investigated and closed within 30 days

Lessons Learned

79% of reported events were investigated and closed within 30 days, which is an improvement over the previous year (70%).

Change Idea #3 ☑ Implemented ☐ Not Implemented

Spread Behaviour Support knowledge for care of patients with dementia. Requires dedicated funding through Learning and Growth funds.

Target for process measure

- 6 sessions with 12 participants in each session will be provided from June 2022 to December 2022 (72 trainees)

Lessons Learned

We are on track with the plan for 6 training sessions to be offered with a minimum of 12 participants in each session. Over 72 people have received this Behavior Support (BSO) training through the Gentle Persuasive Approach program.

Change Idea #4 ☑ Implemented ☐ Not Implemented

In order to maintain the safest environment as possible, all patients admitted to Mental Health will have their belongings searched for sharp or unsafe/contraband items.

Target for process measure

- By June 2022, 100% of patients will have their belonging searched upon admission

Lessons Learned

A recent audit identified that 99% of patients had their belongings appropriately searched, with clear documentation of the efforts.

Change Idea #5 ☑ Implemented ☐ Not Implemented

Development of a 4-bed psychiatric intensive care unit (PICU) to provide intensive therapies for patients who are severely ill and frequently known to be violent

Target for process measure

- By end September 2022, the PICU will be open

Lessons Learned

The psychiatric intensive care unit is completed and was opened in January 2023.

Change Idea #6 ☑ Implemented ☐ Not Implemented

Re-implementation of the Non-Violent Crisis Intervention (NVCI) training program expanded to physicians in high risk areas -

Target for process measure

- Schedule 18 NVCI training sessions in 2022. Train 1/3 (275) of the staff that are due for training by the end of 2022.

Lessons Learned

18 NVCI training sessions were held in 2022. Training was provided to 336 staff including 326 employees, 6 physicians and 4 EORLA staff. Current compliance for employees is 31% (the denominator has increased through the year). At least 2 emails were sent to Physicians in April/May offering NVCI.

Comment

We are extremely pleased with the reporting culture that has developed at QCH to ensure that all violent incidents are captured for analysis. The vast majority (73%) do not result in injury to our staff, which is an increase from previous years, further underlining the positive reporting culture.

Theme III: Safe and Effective Care | Effective | Custom Indicator

	Last Year		This Year	
Indicator #1 Number of incidents reported that identify delay or lack of response to a patient's condition as the specific event type. (Queensway Carleton Hospital)	**62** Performance (2022/23)	**56** Target (2022/23)	**51** Performance (2023/24)	**--** Target (2023/24)

Change Idea #1 ☐ Implemented ☑ Not Implemented

Integrate Welch Allyn vital signs machines to ensure NEWS2 score is populating.

Target for process measure

- 100% of targeted units (Periop and Emergency Department) integrated by January 2023

Lessons Learned

In order to implement this project properly, additional resources were needed to be captured. An analyst will be hired through Clinical Informatics to assist with the integration. We have expanded the number of associated vital signs machines that require integration within Day Surgery and in the ED.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Introduction of Simulation exercises throughout the organization to prepare frontline staff to recognize and respond to various emergency scenarios.

Target for process measure

- 3 simulation exercises will be run every 2 months from June to December 2022

Lessons Learned

Several simulation exercises have been held in the organization. A SIM team is in place and meeting monthly. Work is underway to obtain a new mannequin to enhance the experience. The feedback from this initiative has been extremely positive.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Make most effective use of the Rapid Response nurse as a support to front-line inpatient unit nurses.

Target for process measure

- No assignments will be allocated to the Rapid Response Nurse from October to December 2022 (Q3)

Lessons Learned

There have been very few shifts that required the rapid response nurse to carry a patient load. This has allowed the Rapid Response nurse to proactively round on the units and respond to front line questions and issues to help identify any patients at risk.

Change Idea #4 ☐ Implemented ☑ Not Implemented

In order to optimize the use of Rapid Response Assessments/Calls, the Rapid Response Team will offer a refresher/education session on “rapid response call-criteria and clinical roles” to the clinical units

Target for process measure

- 6 clinical units from September 2022 to March 2023

Lessons Learned

Proactive rounding has started. Development of education in progress.

Change Idea #5 ☑ Implemented ☐ Not Implemented

Embed training of the NEWS2 into training opportunities and workshops for nurse leaders at the point-of-care (Clinical Nurse Expert, Charge Nurse and Mentorship/Preceptor Workshops).

Target for process measure

- No target entered

Lessons Learned

In 2022/23 there were a number of workshops delivered including 4 Charge Nurse Workshops, 1 RPN Workshop, 2 Clinical Nurse Expert Workshops, and 2 Preceptorship Workshops. These workshops highlighted a variety of nursing leadership competencies so that the nurses could act as a resource and point of care leader on the unit. NEWS2 training was incorporated into each workshop to assist in building champions related to recognition of acute deterioration.

Comment

The introduction of robust simulation exercises has been instrumental in highlighting recognition and response to patient deterioration. We achieved our target for this year, and will continue to monitor this area carefully, conducting quality reviews to identify recommendations to continue to improve our ability to ensure staff recognize patient deterioration as quickly as possible. We have expanded the orientation program to focus on identification of deteriorating patients

Theme III: Safe and Effective Care | Safe | Custom Indicator

	Last Year		This Year	
Indicator #5 Rate of incidents reported related to issues in management of medications per 1000 patient days (Queensway Carleton Hospital)	**6.30** Performance (2022/23)	**6** Target (2022/23)	**5.68** Performance (2023/24)	**--** Target (2023/24)

Change Idea #1 ☐ Implemented ☑ Not Implemented

Improve flow of pre-operative orders from surgeon's office to QCH patient chart (the "hold queue"). Currently requires a booking clerk to transcribe orders into Meditech for post operative care, which results in human error.

Target for process measure

- 50% improvement from January to March 2022 to October to December 2022

Lessons Learned

A project manager was onboarded in October for the Computerized Physician Order Entry project as it pertains to Novari / Meditech. The launch of the new system to allow physicians to directly enter the information will be June 2023.

Change Idea #2 ☐ Implemented ☑ Not Implemented

Bar Code Scanning compliance of patient own medication: Compliance with scanning each medication prior to medication delivery, resulting in patients receiving the correct drug 100% of the time.

Target for process measure

- 85% by December 2022

Lessons Learned

A draft policy is under review. Requires further education in some areas. There is ongoing work on bar code scanning.

Change Idea #3 ☑ **Implemented** ☐ **Not Implemented**

Minimize soft Overrides on "Plum 360" Smart Pumps (most commonly used pump for large volume infusions). Nurses are over riding the soft limits on occasion to accommodate higher or lower rates than are programmed.

Target for process measure

- 70/1000 pump usages (current rate is 101/1000) for the quarter October to December 2022

Lessons Learned

Significant Work has been completed on the override Reports created for front line Managers. The QCH Smart Pump Committee has reviewed the Q3 2022 Smart pump alert report and identified the medications causing the most alerts. The committee has interviewed frontline staff and Nursing leadership to understand their workflows and why the alerts are occurring. Issues have been identified and changes to the drug library are being made which are scheduled to be updated on the pumps in April 2023. Any changes to alert frequencies will be identified on the Q2 CY2023 report (Apr to Jun). The process of reviewing, analyzing and making pump changes will continue routinely in the future.

Comment

While we continue to work with staff to ensure that processes are at the safest and most effective and efficient levels for all medication management, the impact of having Bedside Medication Verification, computerized physician order entry, and the electronic Medication Administration record have added to our medication safety program. Ongoing auditing and adjustment of processes will help us close any gaps that have arisen with the changes to ensure that we are using these technology interventions to their maximum effect.