Theme I: Timely and Efficient Transitions

Measure

Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Total number of alternate level of care (ALC) days contributed by ALC patients within the specific reporting month/quarter using near-real time acute and post-acute ALC information and monthly bed census data	C	% / All patients	CIHI portal / April - December 2022	34.10	21.30	The target has not changed since 2022, but given the ongoing reduction in Long Term Care beds in our region as well as the need for the hospital to have opened an ALC unit off site (which is included in our overall data), it is unrealistic to target a reduction in this area. Continuing to strive for 21.3% ALC is a stretch target. This indicator is associated with the QCH Strategic Goal identified as "Seamless System of Care".	Home and Community Care Support Services

Change Ideas

Change Idea #1 Education of care teams regarding ALC designation, its appropriate use, and the required information to provide to patients and families.

Methods	Process measures	Target for process measure	Comments
Manual tracking of this indicator is required. This is to be collected by the Social Work Manager.	Number of patients who are who are receiving active medical care and inappropriately designated ALC.	50% reduction in inappropriate use of ALC by November 2023 (i.e. 6-7 days).	We currently have several patients coded as ALC who are receiving active medical treatment. Baseline data: Average of 12.82 additional days spent in acute care by ALC patients in November 2022.

Change Idea #2 Implementation of a mobility team to assist with reactivation of patients to reduce ALC days and enable discharge from hospital to home.			
Methods	Process measures	Target for process measure	Comments
Decision support provides a report outlining the number of days that ALC patients are admitted to acute care.	Avoidance of ALC days	With a current median of 12.82 days in November 2022, we are targeting a 20% reduction in November 2023 or an average of 1026 days in November 2023	The use of the mobility team increases the chance patients can return home rather than having to wait for a retirement home or long term care bed because they have deconditioned during their hospital course.

Change Idea #3 Trial a centralized process for referral to Rehabilitation programs			
Methods	Process measures	Target for process measure	Comments
A report exists through Decision Support to measure acute ALC days.	“Acute” ALC days (i.e. how many ALC patients are occupying acute care beds)	With a baseline of 12.82 days in November, we are targeting a 20% decrease in acute ALC days for the month of November 2023.	Developing a centralized referral for potential Rehabilitation space helps to expedite the process and avoid unnecessary ALC days in an acute care setting while awaiting transfer to subacute programs.

Change Idea #4 Implementation of a remote care monitoring program in partnership with Home and Community Care (HCSS) for ALC patients.			
Methods	Process measures	Target for process measure	Comments
Daily ALC rates are tracked through Decision Support	Average daily ALC rates	Average daily ALC rate of 93 in November 2023. This is a reduction of 10% from the rate of 104 in November 2022	Intended to provide intensive wrap-around support on discharge home to facilitate earlier discharge than would otherwise be possible. Avoidance of ALC days and monitoring readmission rates as a balancing measure.

Measure

Dimension: Efficient

Indicator #2	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	C	Proportion / All patients	Local data collection / Most recent 6 month period	CB	CB	As noted above, we are collecting baseline information (CB) to guide decisions about our targets for this indicator. The baseline will be established once the Hospital Patient One Year Mortality Risk (HOMR) report is functioning in the electronic system, and appropriate tools are created electronically. This indicator is associated with the QCH Strategic Goal identified as "Seamless System of Care".	Canadian Institute of Health Research, Montfort Hospital

Change Ideas

Change Idea #1 1. Implement the Edmonton Symptom Assessment System (ESAS) score and the Advanced Care Planning (ACP) report

Methods	Process measures	Target for process measure	Comments
Meditech report has been developed to identify patients at risk for 1-year mortality (i.e. those who have a positive HOMR score). The Care Facilitator in the unit will track and monitor application of the ESAS and ACP for each HOMR positive patient.	% HOMR positive patients on A3 Medicine unit who have the ESAS and ACP applied	75% from July to September 2023	

Change Idea #2 Provide information to physicians and nurses about the HOMR score, the ESAS and the ACP on the implementation unit (A3)

Methods	Process measures	Target for process measure	Comments
Attendance at education sessions will be tracked by the A3 Management team. There is a list of part time and full time nurses to form the denominator. All hospitalists will be included	Percent of nurses and hospitalists who have information provided	80% of nurses and hospitalists who work on A3 will receive targeted education	

Change Idea #3 Spread implementation of ESAS and ACP to three other Medicine units (D3, C4, ACE)

Methods	Process measures	Target for process measure	Comments
A Meditech report has been developed to identify patients at risk for 1-year mortality (i.e. those who have a positive HOMR score). The Care Facilitator in the unit will track and monitor application of the ESAS and ACP for each HOMR positive patient.	Percent of HOMR positive patients on target units who have the ESAS and ACPR applied	80% of all patients with a positive HOMR will have the ESAS and ACP completed.	

Measure

Dimension: Timely

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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.	C	Hours / All patients	CIHI NACRS, CCO / December 2021 to November 2022	34.90	27.40	The median time from the disposition date/time to a patient arriving in an inpatient bed in high-volume Emergency Departments in Ontario is 27.5 hours. We have a robust strategy to address this challenge. Our stretch goal is an improvement of over 20%, and is measured over the entire year rather than just the third quarter as was noted in the previous report. This indicator is associated with the QCH Strategic Goal identified as "Exceptional Care Experience".	

Change Ideas

Change Idea #1 Discharge champions on Medicine units will ensure that a Predicted Date of Discharge (PDD) is entered within 24 hours of admission			
Methods	Process measures	Target for process measure	Comments
Measured on the patient flow scorecard	Percent of medical inpatients who have a PDD listed within 24 hours of admission	By December 2023, 90% of medical inpatients will have a PDD within 24 hours	The predicated discharge date allows the patient and family to plan toward discharge based on the average length of stay for Medicine patients.

Change Idea #2 Reduce the amount of time that patient porters experience in delays.			
Methods	Process measures	Target for process measure	Comments
Transport Tracking system provides a report on transport wait times in minutes.	The number of minutes of delay in a month	Reduction of 25% by end of April 2023 to 3,776 minutes of delay. Reduction of an additional 25% by December 31, 2023 (2,832 minutes)	How to reduce the time for patients moving from the ED to their assigned inpatient room 20 delays in February 2023 resulting in 5,034.61 minutes.

Change Idea #3 Develop standard work for non-urgent transport booking processes			
Methods	Process measures	Target for process measure	Comments
Decision Support will report discharge times for all patients discharged with non-urgent transport.	Percent of patients discharged prior to 1400 hrs	75% of patients discharged with non-urgent transport are discharged prior to 1400 hrs.	Making efforts to have discharges effected earlier in the day assists with moving patients from the Emergency Department into an inpatient bed more quickly.

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 consecutive 12-month period	57.19	60.00	With a new patient satisfaction process in place, we are yet to determine the impact of the process itself. A modest 5% improvement is achievable. This indicator is associated with the QCH Strategic Goal identified as "Exceptional Care Experience".	Qualtrics, Community Paramedics, Home and Community Care Support Services

Change Ideas

Change Idea #1 Increase the number of nurses trained as discharge champions on each Medicine unit

Methods	Process measures	Target for process measure	Comments
The current discharge champions, who will be providing this broadened education, will track the attendance at each session.	Percent of full time and part time medicine nurses trained as discharge champions	80% of all full and part-time medicine nurses will be trained as discharge champions by April 30, 2023	Total Surveys Initiated: 285

Change Idea #2 Add the "satisfaction with discharge information" question to the Medicine post discharge follow up phonecall for patients identified as being at risk for readmission.

Methods	Process measures	Target for process measure	Comments
The Care Facilitator will track the patient responses during the post discharge phone call	Percent of patients who respond verbally that they are satisfied with the discharge information provided.	80% of patients will verbally report that they are satisfied with the discharge information provided.	

Change Idea #3 Development and provision of standardized discharge information to Medicine patients

Methods	Process measures	Target for process measure	Comments
The current discharge champions, who will be providing this broadened education, will verify that training in the standard language is included in all training sessions.	Standardized language has been developed and all new discharge champions trained on it's use.	80% of full and part time nurses on A4, A3, ACE, C4 and D4 will be trined in using the standardized language.	Standardized language will be used by the discharge champions to ensure the patient receives all necessary information and has questions answered during the post-discharge phone call

Theme III: Safe and Effective Care

Measure

Dimension: Effective

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of post operative patients who have undergone primary hip and knee replacement who return to hospital with a surgical site infection.	C	% / Other	Local data collection / January to December 2022	2.30	1.80	This is the first year of actively pursuing reductions in infection for the primary hip and knee replacement population. While this is a majority surgical intervention in orthopedics, it does not include all orthopedic cases. Our efforts are focused on the primary hip and knee replacement cases. Ultimately, we will be planning to see this target decrease further over time. This indicator is associated with the QCH Strategic Goal identified as "Exceptional Care Experience".	

Change Ideas

Change Idea #1 Complete onsite process observations of current state to identify 3 areas for improvement based on best practice review

Methods	Process measures	Target for process measure	Comments
Onsite observation and comparison to best practices	Number of measures identified for targeted improvement	Three areas of improvement identified for process improvement	Target areas will be implemented as soon as possible and may be added this fiscal year as late change ideas for this quality indicator.

Change Idea #2	Patients undergoing primary total hip and knee replacement will consume a high carbohydrate product prior to surgery		
Methods	Process measures	Target for process measure	Comments
Number of patients in the target population provided by Decision Support. Day Surgery Care Facilitator will manually track documentation of this event.	Percent of target patients consuming the high carbohydrate product	Patients presenting to the hospital will either bring their own drink or it will be provided by the hospital. If it is the former, the target is 60%; if it is the latter, the target is 90%.	A pilot program will be implemented in May 2023. Twelve weeks after the beginning of the program, compliance results will be measured. The initial test group is patients undergoing primary hip/knee surgery. The plan is scale up to include other patients once the processes are stabilized.

Change Idea #3	Implementation of pre-operative skin antisepsis with 2% Chlorhexidine gluconate (CHG) body cleanser for all pre-operative patients. To be completed in day surgery.		
Methods	Process measures	Target for process measure	Comments
The number of patients in the target population will be provided by Decision Support. The Day Surgery Care Facilitator will manually track documentation of the application of the skin antiseptic.	Percent of primary total hip and knee replacement patients who undergo skin antisepsis with 2% CHG body cleanser in the pre-operative unit.	90% of patients undergoing total hip and knee replacement will undergo skin antisepsis with 2% CHG body cleanser.	

Change Idea #4	Ensure clipping of all hair from near the operative site prior to the patient entering the Operating Room.		
Methods	Process measures	Target for process measure	Comments
OR circulating nurse will confirm that no hair removal was required after the patient entered the OR theatre. The day surgery care facilitator will gather data concerning hair removal.	Percent of patients undergoing primary total hip or knee replacement who require hair removal in the Operating Room	Zero patients will arrive in the Operating Room with a need for additional hair removal	

Measure

Dimension: Safe

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Voluntary Turnover Rate: Full and part time employees who leave the organization.	C	% / Other	Local data collection / April to December 2022	9.80	9.00	This is a key performance indicator that is reported monthly to the Leadership Team and the Board of Directors to help us understand positive work life. This indicator is associated with the QCH Strategic Goal identified as "Positive Work Life".	

Change Ideas

Change Idea #1 Spread optimized nurse staffing schedules with a relief budget to the Acute Care of the Elderly Unit

Methods	Process measures	Target for process measure	Comments
An occupancy report is reviewed monthly between the unit manager and Human Resources to monitor vacant positions.,	Percent of available rotations on the schedule filled	By June 30, 100% of available rotations will be filled	

Change Idea #2 Adjust nurse:patient ratios to improve patient safety and nurse satisfaction

Methods	Process measures	Target for process measure	Comments
The assignment sheet will reflect the new nurse:patient ratio	Number of Medicine units (ACE, and C4)whose staffing ratio has been adjusted to 1:6 on night shift	ACE and C4 medicine units will have schedules adjusted by May 15, 2023	Currently all medicine units are staffed at 1:7 for night shit; we are moving toward 1:6 staffing for all medicine units.

Change Idea #3 Optimize use of decentralized learning and growth funding to support nurses to remain at Queensway Carleton Hospital

Methods	Process measures	Target for process measure	Comments
Tracking of decentralized learning and growth spending through the office of the Vice President of Patient Care.	Amount of available earning and growth funds remaining in the allocation	75% of all funds will be spent, or be earmarked for specific learning and growth initiatives by December 2023	The remaining monies are spent in the 4th quarter which will not be measurable in the timeframe of this year's QIP.

Change Idea #4 All staff and leaders voluntarily leaving Queensway Carleton Hospital (QCH) will undergo an exit interview through the Human Resources team

Methods	Process measures	Target for process measure	Comments
VIP tracking system will identify that an exit interview has taken place.	Percent of voluntary exiting staff who have undergone interview prior to leaving QCH.	100% of voluntarily exiting staff will be interviewed.	Exit interviews lead to clearer understanding of factors that may be modified to enhance work satisfaction for current and future employees.

Measure

Dimension: Safe

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of incidents reported related to issues in management of medications per 1000 patient days	C	Rate / All patients	In house data collection / June to December 2022	5.68	5.00	This target represents an over 10% reduction in errors per 1000 patient days. This indicator is associated with the QCH Strategic Goal identified as "Exceptional Care Experience".	Champlain Hospitals Alliance of Meditech Partners

Change Ideas

Change Idea #1 Implementation of override control protocols for withdrawals of controlled substances from the ADC

Methods	Process measures	Target for process measure	Comments
An override report is generated daily from the ADC for all inpatient areas to determine rate of overrides.	Percent of medication transactions that are overridden	In all inpatient areas, less than 2% of medication transactions are overridden.by the end of June 2023	Only verified orders (by a pharmacist) flow to the ADC. If there is an override, the order has not been verified by a pharmacist, posing a risk to patient safety. It also impacts the risk of diversion when narcotics are being handled.

Change Idea #2	Reduce the number of incidents due to missed or delayed medications as a result of patients being transferred from the Emergency Department (ED) to an inpatient unit without the prescribed medications provided in the ED being transported with the patient.		
Methods	Process measures	Target for process measure	Comments
A baseline will be established in the pharmacy by measuring the number of patient medication strips returned to pharmacy for admitted patients through the ED for 3 weeks in March 2023. The same measure will be repeated for a final result in March 2024.	The number of patient medication strips returned to pharmacy for admitted patients through the ED.	50% reduction in patient specific medication strips returned to pharmacy from the ED.	Phase one is the implementation of a standardize method for medication collection and storing in the ED, which includes the centralization of patient specific meds in ED Observation medication room, Standard Work for ACC and Pharmacy, as well as revamping of the Observation c-locker. Phase two is a change in the means by which medications are transferred for admitted patients. This entails a new process allowing staff to tube medications from the ED to inpatient units, rather than by means of porter handoff. This will ensure that all meds are transferred to the patient's designated location upon being admitted and booked for transport.

Change Idea #3	Standardize the workflow of drug administration using a CADD pump to reduce variation in practice and limit opportunity for errors.		
Methods	Process measures	Target for process measure	Comments
Analysis of RL reporting system	Number of RLs related to errors in programming CADD pump	2 or fewer incidents for the months of Sept-Dec 2023.	While the number of CADD pump errors are low, the potential risk associated with this medication modality is extremely high.

Measure

Dimension: Safe

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of reported incidents of violence with no associated injury.	C	% / Worker	In house data collection / 2022	73.00	75.00	This is an area that has been a priority at Queensway Carleton Hospital for several years. We have and expect to make incremental gains in maintaining or improving our reporting culture while not having an increase in injury of our staff. With increased reporting we anticipate having more reports of "near miss" events or events with no associated injury. These reports inform program and educational changes without waiting for a negative outcome from a violent event. This indicator is associated with the QCH Strategic Goal identified as "Positive Work Life".	

Change Ideas

Change Idea #1 Expand Behaviour Support Ontario (BSO) education sessions beyond nursing to allied health, support services (e.g. security, environmental services) and others

Methods	Process measures	Target for process measure	Comments
Advanced Practice Nurse in Geriatrics manually tracks all staff trained	Number of staff trained through BSO education sessions	25 staff trained in Behaviour Support by Q4 2023-2024	Providing education associated with Behaviour Support gives staff additional tools to de-escalate situations that can arise with patients experiencing dementia, with a goal to avoiding a violent interaction.

Change Idea #2 Increase capacity in each training session for Gentle Persuasive Approach (GPA) techniques			
Methods	Process measures	Target for process measure	Comments
The Advanced Practice Nurse in Geriatrics manually tracks all sessions offered	Number of people in each session and number of sessions provided	120 staff will be trained by Q4	The team is planning to have up to 20 people trained in each of 6 education sessions planned.

Change Idea #3 Update the training and increase the frequency of training related to flagging patients for a history of violence			
Methods	Process measures	Target for process measure	Comments
Report of training compliance in the "VIP" employee tracking system	Percent of targeted staff who are trained in flagging a patient for violence within two years	Thirty percent of staff will have successfully completed the training within two years as of December 2023	Increase the training frequency to every 2 years and ask that 30% of our staff adhere to the increase in frequency for the first year. This target will be expanded next year.

Change Idea #4 Track and provide feedback to managers concerning appropriate use of the violence flagging system.			
Methods	Process measures	Target for process measure	Comments
Incidents of violence are tracked and compared to the patient record. The information is recorded and compiled by the Safety Coordinator.	Percentage of patient charts appropriate flagged with a violence indicator	Eighty percent of patient charts will be appropriately flagged by December 2023	In 2022, 71% of targeted patient charts were appropriately flagged.

Change Idea #5 Provide education on management of patients with delirium across the Emergency Department and all inpatient units (all Medicine units, D4 Surgery, ICU, Mental Health, Park Place and D3) with roll-out of new delerium policy.			
Methods	Process measures	Target for process measure	Comments
The Geriatric team, under the Advanced Practice Nurse for Geriatrics will manually collect the number of staff educated at every unit huddle and during 2 nursing skills days (in March and May 2023)	Number of people educated in the identification, prevention and management of delirium	By end June 2023, 200 nursing staff will be provided education in delirium; in addition, 100 interdisciplinary staff will be trained.	Following June 2023, a survey of 100 full time nurses will take place to evaluate the education provided.

Equity

Measure

Dimension: Equitable

Indicator #9	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percent positive response to the Employee survey question "I feel as if I belong at QCH"	C	% / Worker	In-house survey / Q1 2023-2024	71.00	80.00	Our initial efforts for addressing the issues of Diversity, Equity and Inclusion are focused on ensuring we have an appropriate staff base to care for our patient population. Our goal is to move to a state where our front line staff reflect the diversity of the patients we serve. The target is considered a stretch target given that the change ideas are in the early phase of development. This indicator is associated with the QCH Strategic Goal identified as "Positive Work Life".	

Change Ideas

Change Idea #1 Develop Diversity, Equity and Inclusion strategies through consultation

Methods	Process measures	Target for process measure	Comments
Self-measure based on creation of strategy	Creation of written strategy	Written strategy created by May 31, 2023	

Change Idea #2 Launch Diversity, Equity, Inclusion Council for Queensway Carleton Hospital

Methods	Process measures	Target for process measure	Comments
Counsel created and meeting held	Counsel created and meeting held	First meeting held by June 30, 2023	

Change Idea #3 Develop anti-discrimination and anti-racism policies			
Methods	Process measures	Target for process measure	Comments
Self-identified that policies created and approved	Approval of policies for anti-discrimination and anti-racism	Policies approved by November 30, 2023	

Change Idea #4 Standardize hiring and selection processes to include transparency and an EDI lens			
Methods	Process measures	Target for process measure	Comments
Self-identified changes in processes	New processes completed	New processes implemented by November 30, 2023	

Change Idea #5 Increase number of employees who are trained on Indigenous Cultural Awareness (San'yas training program)			
Methods	Process measures	Target for process measure	Comments
A report of training is sent from the online education platform for this training to the QCH Organizational Learning and Wellness Specialist.	Number of staff completing training	50 additional staff trained from April 1 to December 31, 2023	