Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

April 5, 2024

Brockville General Hospital

Ontario Health

OVERVIEW

Brockville General Hospital is your community hospital. Together, we are dedicated to the health and wellbeing of our friends, families, and neighbours. Our hospital has a long history of rising to the challenge when the community is in need. Whether pioneering local access to care, building modern diagnostic, surgical, and healing spaces, or tackling the pressures facing our healthcare system, we are here to serve you.

Through teamwork, partnership, and the support of our community, we proudly offer a range of services and quality, compassionate care in Leeds and Grenville. We are the heart of community health. We are Brockville General and we are right here, with you.

At Brockville General, we believe in achieving excellence together. We are driven by the needs of our community, and we collaborate with our patients, their families, and our partners to deliver the best healthcare experience. Over the past year, we have focused on patient and family-centred care as well as our workplace culture. We are proud that this was recognized by Accreditation Canada in their December 2023 survey report:

“At the core of Brockville General’s vision and strategy is a commitment to exceptional patient and family-centred care. Most patients and families interviewed expressed a high level of satisfaction with their care, noting the professionalism, respect, and compassion of staff. This is confirmation that these core values are embedded in the culture of our organization.”

Our 2024-25 Quality Improvement Plan (QIP) is organized in the

four priority categories set out by Ontario Health (access and flow, equity, experience, and safety). This aligns well with our local priorities which move us forward on our strategic goals. This QIP includes the priority indicators identified by Ontario Health East. Other indicators include external or regulatory requirements, such as our service accountability agreements and opportunities identified in our Accreditation Report.

This QIP is ambitious, particularly in the context of the pressure on staff across the hospital due to unprecedented demand for services in addition to efforts this year to bring our new Magnetic Resonance Imaging (MRI) unit into service and implement a regional health information system. However, the QIP reflects our continued pursuit of excellence on behalf of our friends, family and neighbours.

ACCESS AND FLOW

We recognize our crucial role within the healthcare system and have developed initiatives to improve outcomes and relieve pressure on the system. Our patients and their families rely on us to be good partners with our healthcare colleagues to ensure a seamless experience and safe care transitions. At the same time, we must acknowledge system-wide pressures beyond our control that impact hospital operations and measures. This includes the Emergency Department where challenges accessing primary care increase patient volume, while a lack of available long-term care and community-based care impacts patient flow.

This QIP includes activities intended to have a positive impact on our system partners. For example, we are committed to improving our ambulance offload times because we know it’s important for our paramedics to respond to our patients who may be waiting next. It also recognizes we are not always the best option for patients who have progressed beyond the acute phase of their condition but have continued care needs due to a chronic condition and require an alternate level of care. Just as ambulance services rely on us, we rely on our system partners to support patients in the most appropriate care setting.

EQUITY AND INDIGENOUS HEALTH

We have completed many activities to identify and reduce disparities in health outcomes, access, and experiences within our community. Examples include implementing new translation services, accessibility plans, health promotion, and connecting patients with social workers. We are proud of our accomplishments so far but recognize there is more to do.

Developing a formal framework and work plan, while determining ongoing outcome measures to validate that we are reducing disparities for our patients is a significant undertaking. It is equally important to celebrate the diversity of our healthcare workers and create an inclusive work environment which ensures equal opportunities for professional growth. We continue to develop our EDI framework and work plan to demonstrate our accountability to build awareness and understanding of these issues. This is reflected in the indicator we have selected as we continue to mature our formal program.

PATIENT/CLIENT/RESIDENT EXPERIENCE

We have a variety of ways to engage with our patients and their families as partners. We hear feedback through our patient relations processes. This feedback is valuable in responding to patient needs and provides data that's vital to inform improvement activities.

Understanding what is needed more broadly, we then need to design our programs in more detail. The meaningful inclusion of patient and family advisors in design, planning, implementation, and evaluation of our services must be done methodically. To achieve this, Brockville General not only has a Patient and Family Advisory Council, we include patient and family advisors at program planning tables and on special projects.

Our patient and family advisors also contributed to the development of this QIP. Specifically, they are co-designing our patient and family guides and championing the evaluation and update of our Designated Care Partner Program.

PROVIDER EXPERIENCE

We know that our friends, families, and neighbours are counting on us for their healthcare. We need to be here for our community. Brockville General has put considerable focus on the well-being of our team and creating a safe and supportive environment, so that we can give our best to our patients. This includes looking at care models so that our healthcare workers can fully contribute their skills and abilities while they partner with patients and families to deliver the best healthcare experience.

Hospital leadership also makes communication with staff a priority to ensure transparency in decision making. This includes maintaining a robust intranet with specific pages for new projects, bi-weekly newsletters and a monthly Staff Forum moderated by our President and CEO.

Like most Ontario hospitals Brockville General has seen some staff turnover in the past few years. The work we have done to ensure a safe, healthy, positive and professional work culture has led to better retention rates than most of our peers. We are proud of our partnership with the City of Brockville to develop a recruitment campaign that showcased both what our hospital offers professionally with the quality of life that comes with living in our beautiful and vibrant community.

SAFETY

While, Brockville General performs well on patient safety indicator, we recognize that patient safety events do occur in healthcare. How we respond and learn from them is crucial to improving. A little over a year ago we introduced a new safety reporting system to ensure consistency in the information collected about safety risks and errors; staff or patient safety incidents including near misses and incidents resulting in harm; and contributing factors. We have evaluated the new tool and continue to make improvements. Our goal over the next year is to develop patient safety education to share learnings more broadly across the organization.

Further, the priorities set out in our QIP are informed by the analysis supported by our patient safety reporting system. This includes targeted improvements in medication reconciliation, violent incidents, positive patient identification, and falls.

POPULATION HEALTH APPROACH

Brockville General is an anchor member of the Lanark, Leeds and Grenville Ontario Health Team (OHT). To serve the unique needs of our community, the OHT has focused on three projects to build a strong primary care system. When patients have access to primary care, their health outcomes improve. Primary care is a key partner in supporting patients and families to manage chronic conditions, urgent care needs, and proactive disease prevention. This alleviates pressure on the hospital's emergency and acute care services.

In addition, throughout the pandemic and up until last summer, the hospital partnered with primary care teams in our region to operate an Assessment Centre to provide patients with the right care in the right setting.

Brockville General has also started planning for the next phase of our capital redevelopment. This is crucial as we must be prepared to meet the increasing healthcare demands of our community due to population growth and an aging demographic.

EXECUTIVE COMPENSATION

Brockville General includes a performance-based component to its executive compensation framework. This framework applies to the Chief Executive Officer, the Chief of Staff, and the executive members of our Senior Leadership Team. A percentage of the executive's compensation (5%) is tied to the achievement of annual goals and objectives aligned to the organization's strategic goals. This includes the quality improvement plan. This approach ensures organizational alignment, as it carries goals through to the individual executive's portfolio. Executive compensation is linked, in part, to the outcomes achieved in our quality improvement plan. The specific performance goals which drive quality and organizational improvement for 2024-25 will be identified and approved by the Board of Directors.

CONTACT INFORMATION/DESIGNATED LEAD

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SIGN-OFF

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan on **April 5, 2024**

Original Signed By

Jim Cooper, Board Chair

Original Signed By

Elenor Newman, Board Quality Committee Chair

Original Signed By

Nick Vlacholias, Chief Executive Officer

Other leadership as appropriate

Access and Flow | Efficient | Custom Indicator

Indicator #8

Total number of all ALC patients (Brockville General Hospital)

Last Year		This Year	
28	**19**	**32**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Engage with families and community partners to ensure patient needs are met Outreach Team engages with patient/family and community partners on admission so that patients are discharged home safely or placed in a care setting which best meets their needs. 1. Early Intervention Outreach Team (EIOT) 2. Home 1st Meeting

Process measure

- 1. EIOT activation 2. Successful vs unsuccessful discharges

Target for process measure

- 1. 1-2 activations/ day 2. 75% or higher discharge success

Lessons Learned

Early Intervention Outreach Team (EIOT) – partnered with Internal Medicine (IM) and Nurse Practitioner (NP) clinic in Ambulatory Care Unit, the NP clinic is currently running 3 days per week, IM clinic running 2 days per week , a referral can be sent by EIOT or Emergency Room (ER) staff with physician sign off for 24-48 + hour follow up with the NP in clinic, if the patient is discharged from ER, priority given to those without a family doctor, but all patient referrals are triaged and seen. This clinic is also seeing patients for 2nd and 3rd dose of Covid anti-virals (again with the same referral form).

Home First Refresh education is being dispersed throughout the organization to ensure the home first philosophy is followed in all programs. Some groups have already received this education, some groups will be receiving this education (including physicians) in coming weeks. This refresh educational material was produced by the SE regional patient flow working group, which includes representation from Home and Community Care Services as well as the 6 regional hospitals,and was signed off and implemented by all 6 hospitals in our region.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Implementation of a Transitional Care Unit

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

BGH began participating in the regional ALC Leading Practices group and completed a self-assessment in Q2, which will help guide areas of focus and next steps. Careful review of Ontario Health's ALC Leading Practices Guide will also inform future enhancements in this area.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Implementation of Integrated Rehab

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Integrated Inpatient Rehab went live in June 2023. Progress continues to be monitored regularly via the Program QIP for Rehab, with regular discussion at Rehab Program Council meetings.

Comment

We must acknowledge system-wide pressures beyond our control that impact hospital operations and measures. This includes the Emergency Department where challenges accessing primary care increase patient volume, while a lack of available long-term care and community-based care impacts patient flow.

Access and Flow | Timely | Custom Indicator

Indicator #5	Last Year		This Year	
Percent discharge summaries sent from hospital to community care provider within 48 hours (Brockville General Hospital)	**71** Performance (2023/24)	**85** Target (2023/24)	**71** Performance (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Discharge Summary Distribution Ineffective and we will implement process to ensure discharge summaries are sent to patients PCP within 48 hours of discharge Make it easier for physicians to submit discharge summaries and refine the reporting methods.

Process measure

- % of discharges where physician selected correct note type. % of acute discharge summaries completed for internal transfers from acute to Rehab/MH/CMM

Target for process measure

- Improvement of 5%

Lessons Learned

The methodology for acquiring and analyzing discharge summary data has been improved to account for discharge summaries recorded in the incorrect location within the patient record. In addition, statistics now include discharges from inpatient mental health (historically, these discharges were not tabulated).

Change Idea #2 ☑ Implemented ☐ Not Implemented

Education to physicians that they are required to complete a discharge summary for the acute portion of the stay for patients that transfer from acute to Rehab/MH/CCC.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Education is ongoing.

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

Education to physicians about the importance of selecting the correct note type and discharge summary and the correct visit.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Education is ongoing.

Equity | Equitable | Custom Indicator

	Last Year		This Year	
Indicator #1 Equity, Diversity and Inclusion Framework (Brockville General Hospital)	**CB** Performance (2023/24)	**CB** Target (2023/24)	**CB** Performance (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Develop an equity diversity and inclusion framework which considers our patients, people and partners. The framework will explicitly identify and address systemic racism, discrimination, and inequalities.

Process measure

- Progress will be monitored through the project schedule.

Target for process measure

- Quarterly progress reports

Lessons Learned

The Hospital has developed an EDI charter. The framework includes high-level goals. Overarching corporate policies as well as training and education will continue to be developed. High-level goals have been identified and overarching corporate policies and training and education will continue to be developed. Developing this framework is a significant project for the hospital, requiring concentrated effort to complete background research. Allotting more time for this research to be completed and shared would have been beneficial.

Experience | Patient-centred | Priority Indicator

Indicator #6

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? (Brockville General Hospital)

Last Year		This Year	
CB	**50**	**NA**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☐ Implemented ☑ Not Implemented

The problem is that surveys are not being completed. We need to increase the collection of survey results.

Process measure

- 1. Number of phone calls made 2. Number of surveys handed out at discharge 3. Number of patient emails collected 4. Procurement progress

Target for process measure

- 1. 25/month 2. 50% of acute inpatient discharges (~2350) 3. 50% of patients registered 4. Complete by Q1

Lessons Learned

The hospital implemented manual survey collection. Surveys were promoted within the units and in discharge packages. Unfortunately, survey uptake was not successful. We then made post-discharge phone calls. This proved to be resource intensive and a challenge given human resources pressure.

Moving forward with delivering surveys by email to patients who visited the emergency department or had an acute inpatient stay will alleviate the current gaps. This implementation is scheduled to be complete by April 2024.

Experience | Patient-centred | Custom Indicator

Indicator #7

Program QIPs will be monitored quarterly and refreshed for the coming fiscal. (Brockville General Hospital)

Last Year		This Year	
CB	**14**	**8**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Engage and communicate with program councils and broader staff group.

Process measure

- Quarterly check-ins

Target for process measure

- Discussions at all program council meetings.

Lessons Learned

The target of 14 was based on a different program model. The program model was reviewed and updated; ultimately 11 program councils were identified. Eight program councils have been actively meeting. The remaining 3 will start meeting before the end of this fiscal.

The governance structure of program councils was reviewed and updated. A standardized terms of reference and work plan which includes QIP was implemented. This created the environment for programs to have these discussions.

As the program management model continues to mature, this structure will offer more opportunities to further the quality agenda.

Indicator #3

Number of program councils with Patient or Family Advisors (Brockville General Hospital)

Last Year		This Year	
4	**3**	**8**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

1. Continue recruitment efforts 2. Continue with orientation and onboarding 3. Promote program with Clinical Directors

Process measure

- Quarterly check-ins

Target for process measure

- 1 program / quarter with new advisor engaged.

Lessons Learned

We were very successful in recruiting patient and family advisors and exceeded our target. The orientation and onboarding process was updated to better support new advisors.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Develop an engagement framework to support retention.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

As we were onboarding, we realized staff and leaders needed better supports when they are partnering with our patient and family advisors. The framework helps identify the level of engagement that is needed for different work and how to match that for the advisors. It also provides tools to support discussions with advisors.

Safety | Effective | Priority Indicator

	Last Year		This Year	
Indicator #2 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. (Brockville General Hospital)	**CB** **Performance (2023/24)**	**100** **Target (2023/24)**	**72.50** **Performance (2024/25)**	**NA** **Target (2024/25)**

Change Idea #1 ☐ Implemented ☑ Not Implemented

1. Expand data to include all programs 2. Modify QCPR and order of operations for saving/printing discharge reconciliation 3. Reinforce education and training on discharge reconciliation process

Process measure

- Chart audits if patients are readmitted within 48 hours

Target for process measure

- 100% completion

Lessons Learned

Improved Quantity of Medication Reconciliation at Discharge performed from 65% to 80%. Improved average Medication Reconciliation at Discharge quality score from 55% to 63% in Dec 2023 chart audit.

The challenges related to the setup of the health record. As the hospital's new health record is implemented, we will explore new opportunities to capture data on medication reconciliation. We will also explore features which more easily enable patient education at discharge.

Communication to internal committees worked well and education did support the improvements. There is an opportunity for further targeted support.

Safety | Safe | Priority Indicator

	Last Year		This Year	
Indicator #4 Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period. (Brockville General Hospital)	**35** **Performance (2023/24)**	**35** **Target (2023/24)**	**47** **Performance (2024/25)**	**NA** **Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

1. Newly created Workplace violence/ aggression form. 2. Code white reporting has been built into workplace violence form

Process measure

- 1. Number of WPV forms completed in RLDatix from employees, students and affiliates

Target for process measure

- A WPV form is completed for every Code White/ workplace violence event

Lessons Learned

The implementation of the new tool has reduced the number of forms staff have to complete, which encourages reporting. Education also resulted in increased reporting.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Ongoing education for staff

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Resources on workplace violence, Code White, and behaviour alert were shared with staff via the BGH intranet. The learning module on patient violence flagging was also updated, with professional practice highlighting these updates in their communications with front line staff. Ongoing monitoring, follow up and debrief on workplace violence and Code White incidents. Mock Code Whites scheduled for Q4.

Access and Flow

Measure - Dimension: Efficient

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Alternate level of care (ALC) throughput ratio	O	Ratio (No unit) / ALC patients	WTIS / July 1 2023 - September 30, 2023 (Q2)	0.95	1.00	Patient needs are better and more efficiently met when they are in the most appropriate care setting (or care bed). Improvement is also very much dependent on system partner capacity.	Regional Hospitals, Home and Community Care, Local Long Term Care Homes

Change Ideas

Change Idea #1 The home first philosophy was reviewed and updated last year. This year will focus on promoting and the philosophy.

Methods	Process measures	Target for process measure	Comments
Management Approval Education Messaging on Home First	Total number of all ALC patients at the end of each week (average).	Ten to sixteen patients by the end of each week (average)	

Measure - Dimension: Timely

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile ambulance offload time	O	Minutes / Patients	CIHI NACRS / ERNI hospitals: December 1st 2022 to November 30th 2023. Non-ERNI hospitals: April 1st 2023 to September 30th 2023 (Q1 and Q2)	37.00	30.00	When paramedics wait for a patient to be transferred to the care of the hospital, they are not responding to calls during that time. We are aligning with the provincial target.	

Change Ideas

Change Idea #1 Continue to secure offload nurse, and review opportunities for improvements.

Methods	Process measures	Target for process measure	Comments
Reapply for offload nurse funding with Leeds and Grenville Paramedic Service. Review 'fit to sit criteria and offload criteria in Emergency Department and adjust as appropriate to improve wait times.	Ambulance offload time (minutes)(90th P).	30 minutes or less	

Measure - Dimension: Timely

Indicator #9	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percent of patients who visited the ED and left without being seen by a physician	O	% / ED patients	CIHI NACRS / April 1st 2023 to September 30th 2023 (Q1 and Q2)	9.90	6.00	The target recognizes that patients triaged at lower acuity (CTAS 4 and 5) are the patients who are leaving.	Primary Care

Change Ideas

Change Idea #1 Improve patient flow within the emergency department to support patients with lower acuity (CTAS 4 and 5).

Methods	Process measures	Target for process measure	Comments
Increase space/utilization of fast-track area. Explore opportunities for waiting room supports from ED Team including PSP/Volunteers/Crisis Workers.	Utilization of chaired spaces.	Determine baseline	

Measure - Dimension: Timely

Indicator #10	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Implement thrombolytics for stroke during 2024-25 Q1	C	Other / at-risk cohort	Local data collection / 2024-25 Fiscal Year	CB	CB	This will be a new service for Brockville General, saving precious time for patients experiencing a stroke. The goal is to implement the service and then look for further improvements.	Regional Stroke Network

Change Ideas

Change Idea #1 Implement thrombolytics in ED for stroke and expand CT services to 24/7

Methods	Process measures	Target for process measure	Comments
Establish a project team and work plan, change management plan, and communication plan. Track project milestones, implementation and performance metrics to be developed project team. The intended go live date is within Q1 of this fiscal year.	Median door to needle time for thrombolytics for qualifying patients presenting with stroke	<30 minutes as this is the provincial target.	

Equity

Measure - Dimension: Equitable

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	O	% / Staff	Local data collection / Most recent consecutive 12-month period	CB	75.00	Completion of current education is tracked for all new hires. We know this is 100%. We are aiming to continue to have all newly hired staff and physicians completing the current relevant education. With EDI framework, we are aiming to have 50% completion by all staff of the new relevant modules related to the EDI Framework.	

Change Ideas

Change Idea #1 Implementation of education related to our new EDI framework.

Methods	Process measures	Target for process measure	Comments
The finalization of the framework this fiscal will inform new education being planned. Review of external training to create education module related to EDI Framework should be complete by the summer. Creation of education module related to EDI Framework. New learning management system will help us track training.	Completion of modules by newly hired staff and physicians. Completion of new education module by all staff and physicians.	100% and 50% respectively.	Casual employees not included as a significant number do not consistently work and it has been found that the casual numbers skew the overall Hospital rates.

Experience

Measure - Dimension: Patient-centred

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of respondents who responded positively to the following question: "Would you recommend this hospital to your friends and family?"	C	% / Survey respondents	Local data collection / Most recent consecutive 12-month period	CB	CB	A new survey tool has been purchased and will be implemented early in the 2024-25 Fiscal. A baseline needs to be re-established.	

Change Ideas

Change Idea #1 Partner with patient and family advisors to roll out program specific patient facing materials.

Methods	Process measures	Target for process measure	Comments
Develop and implement a change management plan piloting for the Mental Health Program. Materials will have interactive elements. Staff and patient/families will need support to learn how to use the interactive guide together.	Number of patients / families who receive guides. 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?	All patients will receive guides. We will need to determine a baseline for the survey results.	

Change Idea #2 Review and update Essential Care Partner Program

Methods	Process measures	Target for process measure	Comments
Partner with a Patient/Family Advisory Champion to evaluate the current program and recommend updates to policy, processes and staff education.	~Track project milestones, implementation and performance metrics to be developed project team ~Were your family or friends involved as much as you wanted in decisions about your care?	~Milestones completed ~baseline for survey question will need to be determined	

Safety

Measure - Dimension: Effective

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of violent incidents that result in physical harm	C	% / Staff	Local data collection / Most recent consecutive 12-month period	21.00	19.95	A safe work environment is critical to ensuring the wellbeing of our health care providers. The past several years we have been encouraging reporting. This year our focus will be to reduce harm. We are targeting a 5% reduction in harm.	

Change Ideas

Change Idea #1 Review Code White protocol: Education - NVCI and pinnel restraint training offered to all clinical units (mandatory for ED & MH). Encourage gentle persuasive techniques and de-escalation strategies, reporting of incidents.

Methods	Process measures	Target for process measure	Comments
Utilization of Communications Department to notify of education opportunities. Increased code protocol reviews. Recognition of patients who have potential to escalate – behavioural flag within health information system. Increased education opportunities and utilization of LMS. Identifying in performance appraisals when staff would benefit from this training. Monthly statistical analysis of violent incidents.	Compliance for the mandatory training. Debriefs on code calls.	Track and increase the number of training sessions attended. 100% of code white calls to have a debrief	

Measure - Dimension: Effective

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% of staff compliance with hand hygiene before patient environment contact	C	% / Other	Local data collection / Quarterly reporting	64.00	85.00	Hand hygiene is one of the best ways to reduce hospital acquired infections and protects our patients and staff. The target is set at or above provincial average. The current performance for after patient environment contact is 86% and the target is 90%	

Change Ideas

Change Idea #1 1. Hand hygiene observations 2. Enhance Messaging to staff 3. Auditors to give on-the-spot-feedback

Methods	Process measures	Target for process measure	Comments
1. Increase # of HH observer audits performed by leadership and department staff 2. Communication plan 3. Auditors will be coached to provide immediate feedback.	1. # of observer and self-audits 2. # Communications per month 3. % of audits with feedback given	1. 450 moments per month 2. 2 per month 3. 50%	

Measure - Dimension: Effective

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Inpatient falls resulting in harm: The number of reported falls (mild, moderate, severe and death) resulting in harm in inpatient areas as a proportion of 1000 patient days	C	Rate per 1,000 patient days / Other	Local data collection / December 31st 2023 (Q1 - Q3)	1.56	1.40	Patients are at greater risk of falling and injuring themselves as they find themselves in an unfamiliar environment while also adjusting to a change in their physical or cognitive functioning. We have seen a downward trend in falls aligned with the timing of the implementation of our transitional care unit. The target recognizes further improvement in our medical surgical inpatient unit.	

Change Ideas

Change Idea #1 Deployment of new beds with falls prevention features.

Methods	Process measures	Target for process measure	Comments
The beds will be deployed over the first half of the fiscal year. Deployment will include education on best practices and bed functionality to support falls prevention.	Total falls reported	decrease by 2% in that area.	

Measure - Dimension: Effective

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Positive Patient Identification: Percentage of times Two Patient Specific Identifiers are used before medication administration, treatments, tests, and procedures.	C	Count / Other	Local data collection / Audits conducted over the fiscal year	CB	CB	Like all hospitals, we have had turnover with nursing staff. We recognize we have many new nurses, and this is a practice we want to ensure is well understood and solidified.	

Change Ideas

Change Idea #1 Develop audit including tracer and feedback mechanism.

Methods	Process measures	Target for process measure	Comments
Professional Practice will observe practice and provide feedback in real time. Observations will begin in March.	#audits completed Rate of reported patient safety incidents related to patient identification.	Reduction in positive patient identification misses in Q4 as compared to baseline developed during first audit. We may see increased reporting of incidents with education.	Positive patient identification can avoid harmful incidents such as privacy breaches, allergic reactions, discharge of clients to the wrong families, medication errors, and wrong-person procedures.