Theme I: Timely and Efficient Transitions

Measure **Dimension:** Timely

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
The 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.	M	Hours / All patients	CIHI NACRS, CCO / Oct 2019– Dec 2019	35.47	20.00	Target set for 2019/20 and not met in that year.	

Change Ideas

Change Idea #1 Review QHC's 2019/20 overcapacity plan and implementation and develop recommendations for 2020/21.

Methods	Process measures	Target for process measure	Comments
Through QHC's Surge & Overcapacity committee QHC's response to overcapacity in 2019/20 will be reviewed for opportunities/activities to embed into the 2020/21 overcapacity plan.	2020/21 overcapacity plan developed through Surge & overcapacity committee.	2020/21 overcapacity plan created by end of Q2.	

Change Idea #2 Collection and analysis of data at various stages of the patient journey.

Methods	Process measures	Target for process measure	Comments
Analysis of the stages of a patient journey (presentation at ED through to discharge) with a focus on identifying bottlenecks and primary drivers of current wait time for admitted patients.	Develop a list of primary drivers of ED wait time for inpatient bed.	List is developed by end of Q1	

Change Idea #3 Prioritize focus based on impact to ED wait time for inpatient bed.

Methods	Process measures	Target for process measure	Comments
Using analysis a stage will be selected and a project team will be created to develop a project plan with a goal of positively impacting ED wait time for inpatient bed. Developed project plan(s) will provide organizational direction and timelines for specific activities that will reduce ED wait time for inpatient bed.	Development of a minimum of one project team and associated project plan.	Project plan(s) will be developed by end of Q2.	

Theme II: Service Excellence

Measure **Dimension:** Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of discharged patients who completed a real-time survey.	C	% / Discharged patients	In-house survey / April 1 - March 31	CB	CB	Initial work is the develop the tools and process. Collecting baseline will allow us to understand current state and set improvement targets/activities from there.	

Change Ideas

Change Idea #1 Standardize the length and organizational questions of real-time surveys

Methods	Process measures	Target for process measure	Comments
Meet with managers to review real-time surveys and revise to include a maximum of 8 questions with 3 of the 8 being standard organization wide questions.	Percentage of surveys reviewed and revised.	100% by end of Q2	

Change Idea #2 Provide managers with real-time notification of survey results.

Methods	Process measures	Target for process measure	Comments
Set up managers with survey monkey app on their phones that will notify them when a survey is completed. Explore capability to have app flag certain types of responses for follow-up.	Percentage of managers set up with app.	100% by end of Q2.	

Change Idea #3 Provide patients and families with a variety of methods for completing real-time surveys prior to discharge.

Methods	Process measures	Target for process measure	Comments
Consult with patients and families about how they would like to provide feedback. Test and implement multiple survey methodologies.	# of survey methodologies selected and implemented.	Minimum of 3 methodologies available to patients by the end of Q2.	

Change Idea #4 Improve the currency and use of whiteboards as communication tools for patients and families.

Methods	Process measures	Target for process measure	Comments
Survey patients on units with existing whiteboards to determine what elements of the whiteboard are essential for them. Create standard messaging to be shared at huddles specific to whiteboard expectations. Audit the currency of key whiteboard elements monthly.	% of whiteboards with current information in areas identified as important to patients and families.	90% of whiteboards will have current information in key areas.	

Theme III: Safe and Effective Care

Measure **Dimension:** Effective

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged.	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / Oct 2019– Dec 2019 (Q3 2019/20)	CB	CB	At present QHC does not have a reliable and accurate method for tracking completed discharge medication reconciliation.	

Change Ideas

Change Idea #1 Apply process improvement and lean principles to increase the pharmacy technician full time equivalent's available to complete medication reconciliation at admission.

Methods	Process measures	Target for process measure	Comments
Explore opportunities to lean out processes in 4 remaining departments within pharmacy where technicians work (inventory, narcotics, sterile compounding and order entry).	Application of process improvement and lean principles result in additional pharmacy technician time available to complete admission medication reconciliation.	By the end of Q4 an equivalent of 1.0 full time equivalent pharmacy technician time is reallocated to admission medication reconciliation.	

Change Idea #2 Determine reliable method for capturing percentage of discharges with a completed medication reconciliation.

Methods	Process measures	Target for process measure	Comments
Create a multidisciplinary team to identify potential methods to consistently capture % of patients with a completed discharge medication reconciliation. Team to focus on single service (family medicine, internal medicine or surgery) to test ideas.	Development of accurate method for tracking % of completed discharge medication reconciliations.	Method tested and ready for implementation to services outside pilot group by end of Q4.	

Measure

Dimension: Effective

Indicator #4	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.	P	Proportion / All patients	Local data collection / Most recent 6 month period	CB	CB	QHC needs to spend time ensuring this population is clearly identifiable.	

Change Ideas

Change Idea #1 Select and use a recognized tool that supports early identification.

Methods	Process measures	Target for process measure	Comments
Review tools available and consult other organizations in our area to understand what they are using. Once the tool is selected it will be built into electronic system for use.	Tool is selected and available for use in the electronic system.	Tool is built and available for use by the end of Q1.	

Change Idea #2 Support nurses to understand how the tool is used in their clinical environment.

Methods	Process measures	Target for process measure	Comments
Provide education to nurses on use of the tool and the population subset this will be piloted with. Select population subset in consultation with physician lead (s) and staff.	Nurses are trained on the use of the tool and the patient population they will be assessing.	100% of nurses in pilot unit will be trained on the use of the tool by September 2020.	

Change Idea #3 Ensure providers have the skills and confidence to provide palliative care.

Methods	Process measures	Target for process measure	Comments
Support staff in pilot unit to attend Learning Essential Approaches to Palliative Care (LEAP-Core) training. Embed palliative care into unit level education days/sessions.	Staff receive training in palliative care.	80% of staff on unit attend an education day that includes palliative care. 12 staff from selected pilot department will attend LEAP-Core training.	

Change Idea #4 Improve accuracy and consistency with which patients are assessed and identified to benefit from a comprehensive assessment of palliative care needs.

Methods	Process measures	Target for process measure	Comments
Patients presenting to the pilot unit are assessed using the selected tool.	Patients presenting to the pilot unit are appropriately identified for palliative care follow-up.	75% of patients are appropriately identified.	

Measure

Dimension: Safe

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.	M	Count / Worker	Local data collection / Jan - Dec 2019	142.00	110.00	QHC has seen an increase in reported violence incidents. The target set is comparable to the volume of incidents seen in the 2019/20 FY.	

Change Ideas

Change Idea #1 Ensure clear communication about unit level risks in real time.

Methods	Process measures	Target for process measure	Comments
Implement a purposeful rounding process for security that enhances the connection between guards and front line staff in order to proactively identify concerns. This includes the development of a standard rounding script for guards and training for staff and guards on the process.	Implementation of standard rounding process.	Standard rounding process is implemented by end of Q3.	FTE=961

Change Idea #2 Support staff to appropriately and accurately identify people at risk for violence.

Methods	Process measures	Target for process measure	Comments
Review the Dynamic Appraisal of Situational Aggression (DASA) tool with staff and develop an audit tool and process to assess appropriate flagging of patients at risk for violence.	Staff are appropriately flagging patients at risk for violence using DASA tool.	80% of patients at risk for violence are accurately flagged.	

Change Idea #3 Ensure clear communication within the health care team about activities to minimize risk.

Methods	Process measures	Target for process measure	Comments
Development and implementation of an individualized care plan that details triggers and mitigation activities for patients flagged as at risk for violence.	Patients flagged as at risk for violence have an individualized care plan.	100% of patients flagged by Dynamic Appraisal of Situational Aggression (DASA) tool have completed care plan.	