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.	P	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July - September 2018	30.15	22.50	ALC at census continues to rise creating pressures on our beds. It is important to aim for a reduction however there are many barriers in our catchment to finding housing for our ALC patients.	

Change Ideas

Change Idea #1 ELOS process standardization

Methods	Process measures	Target for process measure	Comments
1) Continual PDSA of process 2) Ongoing education 3) Socialization of process to reach all patients 4) Work with communications team to broaden patient awareness through different forms of media 5) Socialize/educate concept of ELOS process to community groups (pre-hospital)	Measure compliance with the following process steps; 1) ELOS assigned to acute inpatient when admitted >80% completion in first year 2) BRASS score for all patients 65 and greater within 24 hours >80% completion in first year 3) whiteboard audits >80% completion in first year	Measure compliance with the following process steps; 1) ELOS assigned to acute inpatient when admitted >80% completion in first year 2) BRASS score for all patients 65 and greater within 24 hours >80% completion in first year 3) whiteboard audits >80% completion in first year	

Measure

Dimension: Timely

Indicator #2	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 / October 2018 – December 2018	21.25	21.10	A small percentage of patients remaining in the ED for 21 hours. Although it is important to aim for a reduction, the organization must first understand the current situation and processes in order to drive change and make sustainable improvements	

Change Ideas

Change Idea #1 Discover and explore the barriers that contribute to increased length of stay in the ED

Methods	Process measures	Target for process measure	Comments
1) Collect baseline data 2) Conduct an analysis 3) Stakeholder review of the facts/ challenges	Data analysed by May 2019	100% data analysed by May 2019	

Change Idea #2 Select initiatives to address identified barriers

Methods	Process measures	Target for process measure	Comments
Conduct root cause analysis	Rapid improvement event	Completed by July 2019	

Change Idea #3 Develop Workplan for improvements

Methods	Process measures	Target for process measure	Comments
Based on root cause analysis select improvements and develop workplan	Workplan developed by Sept 2019	Workplan developed by Sept 2019	

Change Idea #4 Implement 1 change idea

Methods	Process measures	Target for process measure	Comments
TBD based on change idea(s)	TBD based on selected initiative(s)	TBD based on selected initiative(s)	

Theme II: Service Excellence

Measure

Dimension: Patient-centred

Indicator #3	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	72.73	80.00	The organization wishes to promote a culture of patient engagement ensuring that they are adequately prepared for transitions by receiving the information that they need.	

Change Ideas

Change Idea #1 Develop reporting process to Inpatient Medicine and Surgery

Methods	Process measures	Target for process measure	Comments
Develop report and mechanism to share it with the managers.	80% of positive responses	80% of positive responses	

Change Idea #2 Survey results shared at huddle

Methods	Process measures	Target for process measure	Comments
Report delivered to managers in format that is easily shared with frontline staff.	# of times survey results shared at huddle	# of times survey results shared at huddle	

Theme III: Safe and Effective Care

Measure **Dimension:** Safe

Indicator #4	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 / January - December 2018	1258.00	1258.00	Continue to establish reporting structure and implementation change ideas as described which are intended to reduce the # of overall incidents. However,the impact of these improvements are unknown, therefore the target remains unchanged.	

Change Ideas

Change Idea #1 1) Annual WPVP mandatory education 2) iReport QRM 3) Risk assessments as below

Methods	Process measures	Target for process measure	Comments
1) eLearn annually 2) Data reporting within event reporting system - new reporting system to be implemented in the fall 2019 3) Engaging employees in risk assessment processes	1) % of mandatory eLearns complete 2) Implementation of Quality Risk Module 2) % risk assessments complete	1)100% 2)by April 2020 3)100% for a total of 68	FTE = 1680

Change Idea #2 1) Implementation of NEW staff duress dystem 2) Electronic Security Indicator 3) Workplace Violence Prevention Posters

Methods	Process measures	Target for process measure	Comments
1a) Establish implementation committee with robust stakeholder membership to develop a plan and oversee progress of the implementation of the Stanley Personal Alarm System 1b) needs assessment for off site locations 2) Implementation of MEDITECH 6.1 3) Across entire organization	1) Implementation of the new staff duress system 2) Implementation of MEDITECH 6.1 3) Posters visibly displayed across the organization	1) Implementation of staff duress system by fall 2019 2) Implementation of meditech 6.1 by October 2019 3) Posters visibly displayed across the organization by summer 2019	

Change Idea #3 Re-evaluation of the existing risk assessments

Methods	Process measures	Target for process measure	Comments
1) Establish 2019-20 Risk Assessment schedule across the organization 2) Work place violence incident data analysis (workplace violence dashboard) 3) Coach and support each team in the re-evaluation of their 2018-19 risk assessment; 4) Centralized Risk Assessment Tracker	% risk assessments complete	100% of risk assessments completed by March 31, 2020	

Measure

Dimension: Safe

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% Alternate Level of Care Days (ALC)	C	% / Mental health patients	WTIS, CCO, BCS, MOHLTC / 2019-2020	56.00	51.00	5% reduction.	

Change Ideas

Change Idea #1 To establish a clear process for establishing the goals for admission to program.

Methods	Process measures	Target for process measure	Comments
Hospital staff and physicians are clear on how early discharge planning is incorporated into the admission process and monitored. Incorporation of new referral for admission to Regional MH program to identify goals for admission that are agreed upon by community partners, patient/family and hospital.	ALC escalation process developed and implemented (Monthly clinical team meetings including family (OPOP) and community partners to monitor progress and address issues/barriers as they arise. Identify community programs and services and additional funding required to support patients with transition)	ALC escalation process developed and implemented	

Change Idea #2 Establish a clear discharge destination prior to admission.

Methods	Process measures	Target for process measure	Comments
1) Social Work attends ALC rounds and comes prepared to participate in a discussion on the barriers to discharge for clients, and of potential discharge delays/issues. 2) Social Work to coordinate case conferences with family and community partners to ensure appropriate discharge destinations are remain secured for discharge. 3) Team to monitor and ensure care plan goals/objectives are progressing to support discharge plan. RAI CAPs used to guide care planning at OPOP meetings. RAI CAPs triggered will decrease quarterly to progress to discharge.	ALC escalation process developed and implemented (Evaluating new ALC standard work and escalation process that is in place. Advocate for support of existing services in addition to other MH programs and services by strengthening additional partnerships. Monthly case conferences are held with clinical team, family and community partners to prepare for transition to discharge destination)	ALC escalation process developed and implemented	

Change Idea #3 Avoidable admission to inappropriate bed.

Methods	Process measures	Target for process measure	Comments
1) Education to community and partners on programs and services offered at NBRHC. 2) Work with community partners to develop care plans while on waitlist to sustain patients in the community and avoid admission to inappropriate beds.	ALC escalation process developed and implemented (Advocating for supports and funding in the community. Working in partnerships to ensure proper support in place while awaiting planned admission to Regional Bed)	ALC escalation process developed and implemented	