Access and Flow | Efficient | Custom Indicator

Indicator #9

Total number of alternate level of care (ALC) days contributed by ALC patients within the specific reporting period, divided by the total number of inpatient days (midnight census) in the same period. (Hotel Dieu Shaver Health and Rehabilitation Centre)

Last Year		This Year	
9.47	**13**	**3.86**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

ALC Rounds meeting with Home and Community Care Support Services (HCCSS)to review all cases likely destined for LTC

Process measure

- Regularity of ALC Rounds meetings

Target for process measure

- Weekly meetings to take place

Lessons Learned

Weekly ALC rounds/meetings continue which review current ALC patients as well upcoming challenging discharges that are not yet designated as ALC.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Patient Flow meetings including representation from across the interdisciplinary team occur every day a 3:00 p.m. to review patient referrals, patient discharge dates and identify recommended interventions that may assist in facilitating safe and timely discharges.

Process measure

- Regularity of Patient Flow meetings

Target for process measure

- Daily meetings to take place

Lessons Learned

Daily patient flow meetings include interdisciplinary staff. When required, Pharmacists are consulted for safe care transition.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Command centre teleconference meetings to take place daily including representation from senior and front line levels of staff - from HDS, our acute care partner, Niagara Health, and Home and Community Care Support Services - to identify patient flow pressures and bottle necks , with the purpose of identifying immediate strategies to alleviate any barriers and facilitate expeditious patient flow on a case by case immediate basis.

Process measure

- Regularity of daily teleconference meetings.

Target for process measure

- # of daily teleconference meetings conducted.

Lessons Learned

Our intake nurse participates in daily meetings with the partner organizations which assists in correct placement of patients to the most appropriate bed types.

Change Idea #4 ☑ Implemented ☐ Not Implemented

Interdisciplinary team charged with immediate identification and referral/escalation of complex cases.

Process measure

- # of cases referred for escalation or resolved without escalation.

Target for process measure

- Reduction in number of escalated cases and/or timely resolution of escalated cases.

Lessons Learned

Interdisciplinary case conferences occur weekly. Patients/family members are included in family meetings for complex cases to collaborate and arrange for most appropriate discharge setting.

Comment

This measure is largely outside of HDS control and is dependent upon bed pressures throughout the Region, the pressures on Home and Community Care Support Services, and patient's/family's LTC choices. Significant fluctuations in rate of ALCs can occur throughout the year depending on pressures on our acute care partners.

Indicator #2

Meet optimal wait times for internal inpatient to outpatient service based on stroke wait times. (Hotel Dieu Shaver Health and Rehabilitation Centre)

Last Year		This Year	
22	**25**	**31**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Continue to review and analyze wait time data on a regular basis to ensure interventions can be flagged if there is an identified problem.

Process measure

- Number of reviews conducted and number of analyses completed.

Target for process measure

- At least one (1) review and one (1) analysis conducted monthly.

Lessons Learned

Monthly reviews continued. For financial reasons there was a two week Christmas shutdown and a one week summer shutdown of all HDS outpatient programs which negatively impacted wait times.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Continue to communicate wait time status to all relevant parties on a regular basis.

Process measure

- Wait times to be reported quarterly, unless there are identified anomalies, in which case reporting to other involved managers, and Executive VP of Operations should take place as soon as possible after identification of the problem.

Target for process measure

- Continued administration of current process.

Lessons Learned

Regular review with Executive VP of Operations including available options (see below) were completed. Challenges like health human resources and continuing COVID restrictions (i.e. smaller group numbers) also impacted wait times.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Continue process to identify and implement interventions as necessary to ensure wait times stay within identified limits.

Process measure

- Number of identified and implemented interventions as required and as feasible.

Target for process measure

- Continuing administration of current process.

Lessons Learned

Hospital submitted an application to Core Health to support an increased capacity in Outpatient programs, but unfortunately the funding was not received in time to effect wait times for this year.
Also, a Niagara Ontario Health Team submission went into Ontario West for a proposal to increase in home stroke rehabilitation services. To date, an approval has not been received, but still hopeful.

Comment

Number of patients affected by stroke in the region continues to increase, however, current funding model does not allow for resources to increase capacity for outpatient program services.

Access and Flow | Timely | Custom Indicator

Indicator #7

Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital. (Hotel Dieu Shaver Health and Rehabilitation Centre)

Last Year		This Year	
84.70	**85**	**86.32**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Review and audit completed discharge summaries that are delivered to primary care physicians within 48 hours of discharge and report findings to HRQCRM Committee, MAC, Senior Team and Quality Improvement Committee of the Board.

Process measure

- Completion of review of number of discharge summaries that are sent to primary care physicians within the 48 hour time frame.

Target for process measure

- Continued review and reporting for all discharged patients.

Lessons Learned

Recognized need for training when staff absences occur (i.e. ward clerk).

Change Idea #2 ☑ Implemented ☐ Not Implemented

Review of process and training as required for new MRP'S completing the summary, and ward clerks that FAX the reports.

Process measure

- Successful development and delivery of education and training program.

Target for process measure

- Ongoing review, analysis and reporting monthly.

Lessons Learned

Ongoing Prescriber education and training continues. As noted above, ensure appropriate training to any relief clerical staff.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Audit results to be monitored with interventions identified as necessary

Process measure

- Committee to review audit results on a monthly basis.

Target for process measure

- Review of statistics and identification of interventions to continue.

Lessons Learned

Continued monthly reporting. Review of these reports helped in identifying need for training of relief staff.

Comment

With migration to the new hospital information system, we anticipate very timely electronic delivery of discharge summaries to primary care providers.

Experience | Patient-centred | Custom Indicator

Indicator #6

Percentage of complaints acknowledged to the individual who made a complaint within five (5) business days. (Hotel Dieu Shaver Health and Rehabilitation Centre)

Last Year		This Year	
100	**95**	**100**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Enhanced publication of the contact information for the Patient Relations Process Delegate.

Process measure

- Completion of notice and number of notices that are distributed.

Target for process measure

- Notices placed at all elevators, Nursing stations, scheduling offices and in the Patient and Family Handbook.

Lessons Learned

Information posted in high traffic areas i.e. elevators, nursing stations. The Patient and Family Handbook is also updated to include this information.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Identify appropriate backup for acknowledgement of documented patient complaints in the absence of the Patient Relations Process Delegate.

Process measure

- Completion of identification and communication.

Target for process measure

- Ongoing communication.

Lessons Learned

Implementation of new Health Data Coordinator role to ensure coverage in the absence of patient relations process delegate.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Formal tracking of all formally documented complaints including time lines for first acknowledgement, substance of complaint, nature of resolution and resolution timelines.

Process measure

- Completion and maintenance of tracking document on a quartely basis with reporting to Quality Improvement Committee of the Board.

Target for process measure

- Ongoing to include quarterly reporting.

Lessons Learned

Compliant. The information is also shared with various committees of the hospital including Quality Improvement Committee of the Board.

Comment

Current process has been successful and the hospital is committed to responding to all documented complaints as quickly as possible.

Indicator #8

Survey 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?

(Hotel Dieu Shaver Health and Rehabilitation Centre)

Last Year		This Year	
100	**95**	**100**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Continuation of surveys to be conducted with patient three or fewer days before anticipated discharge date.

Process measure

- Successful completion of in-house surveys prior to discharge.

Target for process measure

- 100% of patients with pre-scheduled discharge dates to be surveyed.

Lessons Learned

We have a team of four Patient and Family Advisors (PAs) and one member as a back up to ensure surveys are done daily. In addition, staff/ MRPs also recognize the importance of discharge information and work with PAs to ensure patients get the information that they require before discharge.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Continued communication between patient advisors and clinical managers to ensure that any concerns identified are flagged and, if possible addressed prior to discharge.

Process measure

- Number of patient advisors instructed on process to follow with clinical manager.

Target for process measure

- All patient advisors who administer the survey provided orientation on process to follow with clinical manager.

Lessons Learned

All Patient Advisors receive full on-site orientation, as well as working with another Advisor to ensure they understand their duties. There are also refresh education sessions for existing Advisors for them to keep abreast of changes.

Change Idea #3 ☑ Implemented ☐ Not Implemented

"Meet and greet" process by patient advisors to help familiarize patients/families with what they can expect from their inpatient stay and discharge journey, which includes review of the Patient and Family Handbook.

Process measure

- Number of Meet and Greet sessions successfully co-ordinated.

Target for process measure

- Gradual re-implementation post-COVID during periods when we are clear of outbreaks.

Lessons Learned

We have been successful in continuing to recruit new Patient Advisors to assist with this process of Meeting and Greeting patients within the first few days of their admission.

Comment

We are grateful to our patients and families for participating in these interviews and proud of our Patient Advisors for continued dedication in completing these tasks. We average an 86% rate of number of patients interviewed. Unit outbreaks impacted their ability to interview all patients.

	Last Year		This Year	
Indicator #4	**100**	**95**	**100**	**NA**
Patient experience: Would you recommend inpatient care to your friends and family? (Hotel Dieu Shaver Health and Rehabilitation Centre)	**Performance (2023/24)**	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Increase number of Patient Advisors to assist with sharing of patient experiences.

Process measure

- Number of new Patient Advisors recruited.

Target for process measure

- Increase in number of active patient advisors.

Lessons Learned

Post COVID pandemic we have been successful in recruiting and retaining three new advisors in addition to our existing pool of 12.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Patient Advisors to provide feedback to staff regarding the positive results of patient experience surveys and opportunities for improvement.

Process measure

- Sessions with Patient Advisors and staff to be conducted monthly, if possible.

Target for process measure

- Twelve (12) sessions held between staff and Patient Advisors per year.

Lessons Learned

Patient advisors have results reported at monthly PFAC (Patient and Family Advisory Council) meetings. Three of the patient advisors present information to staff throughout the hospital at least quarterly.

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

Results of patient experience surveys to be presented at the newly formed Clinical Quality Council that consists of frontline staff, management, physicians and Patient Advisors to better address successes on the nursing units and identify areas of opportunity to assist with patient satisfaction.

Process measure

- Present at least one scenario at each quarterly Clinical Quality Council.

Target for process measure

- Minimum of four (4) reviews annually.

Lessons Learned

Patient experience survey results are presented at each quarterly clinical quality council. Each meeting has an invited presentation from a patient or caregiver to tell their story of hospital experience- whether positive or offering opportunities for improvement.

Comment

We have consistently achieved very high results with our current processes and continue to research new opportunities for learning and partner with peer organizations.

Safety | Effective | Priority Indicator

Indicator #1

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. (Hotel Dieu Shaver Health and Rehabilitation Centre)

Last Year		This Year	
99.48	**90**	**89.92**	**90**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Expansion of medication reconciliation to all floors

Process measure

- Nursing Manager to complete new process and information for MRP's also.

Target for process measure

- Completed during COVID pandemic with continued education ongoing

Lessons Learned

All floors successfully completing medication reconciliation.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Continuing education of nursing staff and physicians working on any unit in the hospital.

Process measure

- Continuing education for all affected staff and physicians.

Target for process measure

- Ongoing as new staff and physicians are onboarded.

Lessons Learned

Yes. All staff upon orientation. Incorporated into the new prescriber onboarding checklist.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Physicians to be contacted a few days before anticipated discharge to be reminded of upcoming discharges to facilitate completion of medication reconciliation.

Process measure

- Number of calls completed by Health Records.

Target for process measure

- Ongoing process reviewed a few days prior to discharge to allow time to contact MRP.

Lessons Learned

Calls were made by health records team in conjunction with request to complete discharge summaries, has proven to be successful.

Comment

The baseline period and exclusion criteria for this indicator have been changed for 2024/25, so actual performance using the same methodology as our previous year QIP was 98.69%. Trial of Pharmacists on the units is underway. Having pharmacists on the units help triage patients for discharge readiness and counselling, and collaborate with prescribers and nursing staff for seamless transition of care.

Safety | Safe | Priority Indicator

	Last Year		This Year	
Indicator #3	**92**	**60**	**101**	**NA**
Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period. (Hotel Dieu Shaver Health and Rehabilitation Centre)	**Performance (2023/24)**	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Continue meetings of the violence in the workplace working group to identify and develop recommended interventions to assist in the reduction of workplace violence and facilitate increased protection of staff, patients and visitors.

Process measure

- Continued meetings for the development of action initiatives.

Target for process measure

- Regular meetings to be held.

Lessons Learned

Implementation meetings continue with successful start and ongoing Orange Dot flagging of violent patients/ visitors in hospital information system.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Continue to monitor RLsolutions incident reporting system that includes the capacity to report violence/harassment in a customized set of appropriate fields in the reporting structure.

Process measure

- Continuous monitoring and implementation of modifications or improvements to the system as required.

Target for process measure

- Through 2023 2024

Lessons Learned

Reviewed by Quality Coordinator as well as Occupational Health and Safety Coordinator in discussion with the appropriate manager.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Go-live for the activation of a screen in Meditech (HIS system) to allow staff registering patients to be aware of those who were flagged as behavioural/aggressive while inpatients at the HDS or at the Niagara Health system.

Process measure

- Staff education has taken place and now waiting on successful activation in Meditech.

Target for process measure

- Early March 2023

Lessons Learned

Successfully implemented Orange Dot system (see above). Currently these patients are flagged in the HIS by next business day once an incidence is reported.

Change Idea #4 ☑ Implemented ☐ Not Implemented

Back loading of patients flagged with behaviours/aggression from April 2022 to present into the Meditech environment so staff can review care plans in advance of receiving patient to protect staff, other patients and visitors.

Process measure

- Completion of list form April 2022 to present.

Target for process measure

- Early March 2023.

Lessons Learned

Retrospective information from the previous two years was also entered into HIS.

Comment

A process for orientation of new staff and continuing education of current staff has been implemented via information sharing in huddles, meetings and mandatory annual online training.

Safety | Effective | Custom Indicator

Indicator #5

Percent of complex care patients with a new pressure ulcer in the last 3 months (Stage 2 or higher) (Hotel Dieu Shaver Health and Rehabilitation Centre)

Last Year		This Year	
0	**3**	**7.40**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Implementation of a Nurse-lead wound care team on 2nd floor (Complex Care, Rehab Lo and EOL) now in place on all units that has refined a documentation tool that facilitates assessment, planning and implementation of care plan for following wound best practice guidelines.

Process measure

- Completion of education material re: the wound care tool and tracking of education.

Target for process measure

- Through 2023 2024

Lessons Learned

Ongoing orientation to new staff and continuing education to all nursing staff regarding most appropriate wound care dressings, surfaces and monitoring.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Continue process to procure internal surfaces, rather than rentals, to both ensure that the appropriate surface is available in a more timely manner and to reduce cost associated with rentals.

Process measure

- Ongoing procurement of appropriate surfaces.

Target for process measure

- Through 2023 2024.

Lessons Learned

Continued scheduled replacement of bed surfaces throughout all hospital units.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Quality Improvement project/HFMEA on wound incidents are tracked for low intensity rehab patients as well as Complex Care and EOL patients through CCRS reporting.

Process measure

- Monitoring quarterly to ensure interventions/processes are effective.

Target for process measure

- Ongoing as required by CCRS clinical data capture for quarterly reviews.

Lessons Learned

Continued quarterly reporting. Recognition of an increase in incidents and investigation showed two patients that continued to show on the rolling quarterly reports. These two cases significantly skewed the results as our occupancy was low due to ongoing outbreaks.

Comment

Successes of wound care team were recognized. Given the small patient pool and nature of our referral sources, one or two cases can significantly skew our results. With the patient population that we have, this is an important indicator to continue tracking.