Theme I: Timely and Efficient Transitions

Measure

<table>
<thead>
<tr>
<th>Indicator #1</th>
<th>Dimension: Efficient</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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<tr>
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</tr>
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<td></td>
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</table>

<table>
<thead>
<tr>
<th>Indicator #1</th>
<th>Type</th>
<th>Unit / Population</th>
<th>Source / Period</th>
<th>Current Performance</th>
<th>Target</th>
<th>Target Justification</th>
<th>External Collaborators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of individuals for whom the emergency department was the first point of contact for mental health and addictions care per 100 population aged 0 to 105 years with an incident MHA-related ED visit.</td>
<td>A</td>
<td>Rate per 100 ED patients</td>
<td>See Tech Specs / April 2020 – March 2021</td>
<td>42.27</td>
<td>31.48</td>
<td>KW4 OHT</td>
<td>KW4 OHT</td>
</tr>
</tbody>
</table>

Change Ideas

Change Idea #1 See KW4 OHT cQIP - We will work with KW4 OHT to flag patients residing in our 4 priority neighbourhoods, who accessed the ER as a first point of contact.

Methods

<table>
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<tr>
<th>Process measures</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Provide needed data on patients on the 4 postal codes.</td>
<td>In Q3 of 2022-2023</td>
<td>N/A</td>
</tr>
</tbody>
</table>
## Change Ideas

**Change Idea #1**

See KW4 OHT cQIP - We will work with our OHT to utilize new proposed community supports to provide more ‘home first’ care.

### Methods

- **Process measures**
  - Using a risk assessment tool (i.e. AUA) we will identify patients in the ED who are deemed as high risk for hospital admission and who might otherwise become ALC.

### Target for process measure

- Develop and trial risk assessment tool in the Emerg at St. Mary’s.
- By Q4 we will finalize risk assessment tool to be used, identify change management strategy, develop and roll-out training and communication.

### Comments

- N/A

## Measure

**Dimension:** Efficient

<table>
<thead>
<tr>
<th>Indicator #2</th>
<th>Type</th>
<th>Unit / Population</th>
<th>Source / Period</th>
<th>Current Performance</th>
<th>Target</th>
<th>Target Justification</th>
<th>External Collaborators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of inpatient days where a physician (or designated other) has indicated that a patient occupying an acute care hospital bed has finished the acute care phase of his/her treatment.</td>
<td>A</td>
<td>% / All patients</td>
<td>CIHI DAD / April 2020 – March 2021</td>
<td>13.55</td>
<td>16.00</td>
<td>Aim to keep less than 16% - true measure of our ability during recent environment.</td>
<td></td>
</tr>
</tbody>
</table>

## Change Ideas

**Change Idea #2**

Placing supports in the ED for OT &/OR PT to assist patients we plan to admit with a goal of preventing hospital decline and reducing the length of admissions.

### Methods

- **Process measures**
  - Analyzing the impact.

### Target for process measure

- Average length of stay for the frail and elderly pre and post pilot project.
- Developing baseline and decrease.

### Comments

- N/A

## Measure

**Dimension:** Timely

<table>
<thead>
<tr>
<th>Indicator #3</th>
<th>Type</th>
<th>Unit / Population</th>
<th>Source / Period</th>
<th>Current Performance</th>
<th>Target</th>
<th>Target Justification</th>
<th>External Collaborators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time interval between the time the patient left the ED for admission to an inpatient bed.</td>
<td>C</td>
<td>Hours / All patients</td>
<td>CIHI NACRS, CCO / Q3</td>
<td>21.00</td>
<td>24.00</td>
<td>Reasonable target.</td>
<td></td>
</tr>
</tbody>
</table>

## Change Ideas

Report Access Date: June 24, 2022
### Change Idea #1 Create full Quality Improvement Plan with relevant stakeholders.

<table>
<thead>
<tr>
<th>Methods</th>
<th>Process measures</th>
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<tbody>
<tr>
<td>15 members of the hospital wide team attend a QI workshop facilitated by CQUIPS at University of Toronto ON May 31, 2022.</td>
<td>Workshop objectives measured at end of the day.</td>
<td>80% satisfaction at evaluation of event.</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### Change Idea #2 Develop process map for any unit specific issues.

<table>
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</thead>
<tbody>
<tr>
<td>Meet individually with managers to map out processes.</td>
<td>Process maps completed and gaps identified.</td>
<td>All 6 hospital inpatient units have a completed process map by September 2022.</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### Change Idea #3 Identify communication efficiencies for notification of bed availability.

<table>
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<tbody>
<tr>
<td>Work with all stakeholders to identify, test and implement solutions to concerns such as the need to call a busy charge nurse multiple times to identify if a bed is clean and ready for a transfer.</td>
<td>Develop a process map that identifies communication barriers.</td>
<td>By end of September (Q2).</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### Change Idea #4 Create phase two of quality improvement plan.

<table>
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<td>15 members of the hospital wide team attend a QI workshop facilitated by CQUIPS at University of Toronto in November 2022.</td>
<td>Workshop objectives measured at end of the day.</td>
<td>80% satisfaction at evaluation of event.</td>
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### Change Ideas

**Change Idea #1** Pull patient to the cardiac Cath Lab rather than wait for a pull.

**Methods**

Rather than wait in ED for the cath lab to be ‘ready’ to receive patient during business hours, call porter and transfer patient to the cath lab to wait for next steps there.

**Process measures**

Door in door out time reduced.

**Target for process measure**

Reduce by 10 minutes by September 2022.

**Comments**

N/A

**Change Idea #2** Identify methods to improve ECG times.

**Methods**

Education for ED staff and Lab staff on reading ECGs for subtle changes for STEMIs.

**Process measures**

Education completed for Triage nurses, lab staff and Cath Lab inservices.

**Target for process measure**

All 3 groups completed by December 2022.

**Comments**

N/A

**Change Idea #3** Trial a patient lead kiosk prior to triage to assist in identifying patients at risk of STEMI in waiting room.

**Methods**

Triage is flagged for potential STEMI cases earlier and more ready to obtain ECG within 10 minutes.

**Process measures**

Door to ECG within 10 minutes.

**Target for process measure**

70 percent of STEMIs with door to ECG in 10 minutes.

**Comments**

Historical average is 38% of time completed within 10 min.

---

**Measure** | **Dimension:** Timely
---|---
| **Indicator #4** |
| **Type** | **Unit / Population** | **Source / Period** | **Current Performance** | **Target** | **Target Justification** | **External Collaborators** |
| % of STEMI cases within 90 min benchmark | C | % / Other | Other / Q3 | 0.56 | 0.60 | Stretch goal to be better than provincial average of 50%. |

**Report Access Date:** June 24, 2022
Theme II: Service Excellence

Measure | Dimension: Patient-centred
---|---
Indicator #5 | Type: Process measures

<table>
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<tr>
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<tbody>
<tr>
<td>% / All inpatients</td>
<td>80.40</td>
<td>85.00</td>
<td>Aim to improve over historical average of 83%.</td>
<td></td>
</tr>
</tbody>
</table>

Change Ideas

Change Idea #1  Improve communication to family and loved ones.

Methods | Process measures | Target for process measure | Comments
---|---|---|---
Adapt Care Partner policy to allow for increased access to patients. Currently limit to 1 per day with 2 hours. | Number of months we have access beyond 1 person for 2 hours per day from July 2022-March 2023. | More than one person for all 9 months | N/A

Change Idea #2  Offer physical supports such as noise cancelling headphones and blue tooth headsets for TVs

Methods | Process measures | Target for process measure | Comments
---|---|---|---
As we perform construction of our entire North side of the hospital, assign a contact to round daily on the units to offer supports related to construction noise. | Number of complaints regarding construction where no supports were offered. | Target is 0 complaints | N/A
Theme III: Safe and Effective Care

### Change Ideas

**Change Idea #1** Create full Quality Improvement Plan with relevant stakeholders.

- **Methods**
  - Process measures
  - Target for process measure
  - Comments
  - 15 members of the hospital wide team attend a QI workshop facilitated by CQUIPS at University of Toronto ON May 31, 2022.
  - Workshop objectives measured at end of the day.
  - 80% satisfaction at evaluation of event.
  - N/A

**Change Idea #2** Ensure scanning equipment functions in each unit.

- **Methods**
  - Process measures
  - Target for process measure
  - Comments
  - Manually walk through each unit and submit work orders for any broken equipment.
  - Work orders completed within 8 weeks of request.
  - 100% of work orders completed.
  - N/A

**Change Idea #3** Develop process map for any unit specific issues.

- **Methods**
  - Process measures
  - Target for process measure
  - Comments
  - Met individually with managers to map out processes.
  - Process maps completed and gaps identified.
  - All 9 hospital units have a completed process map by September 2022.
  - N/A

**Change Idea #4** Assess workflow concerns.

- **Methods**
  - Process measures
  - Target for process measure
  - Comments
  - Gather concerns, assess solutions, purchase equipment where required and remedy issues.
  - Workflow issues identified and addressed.
  - 100% issues addressed by March 2023.
  - N/A
Change Idea #5: Create phase two of quality improvement plan.

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<td>80% satisfaction at evaluation of event.</td>
<td>N/A</td>
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## Equity

### Measure

**Dimension:** Equitable

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<th>Indicator #7</th>
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<tr>
<td>Interpretation services used matches population expectations.</td>
<td>C</td>
<td>Other / All patients</td>
<td>Other / Q3</td>
<td>127.00</td>
<td>450.00</td>
<td>Expect that approx 2% of our patient population will require translation services. We want at least 1% of our patients using the service at least 2 times while a patient.</td>
<td></td>
</tr>
</tbody>
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### Change Ideas

**Change Idea #1** Evaluate quality of service.

#### Methods

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<tr>
<td>Develop feedback method from patients and families for services.</td>
<td>Feedback method developed and in place by December 2022.</td>
<td>End of third quarter (December).</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Change Idea #2** Ensure VOYCE tablets are fully utilized.

#### Methods

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<tbody>
<tr>
<td>Monitor use from each unit and review any underutilization.</td>
<td>Tablets are used in equal amounts across different units.</td>
<td>Tablet utilization is distributed across units (i.e., not all one unit.).</td>
<td>N/A</td>
</tr>
</tbody>
</table>