Access and Flow | Timely | Custom Indicator

Indicator #8

Time interval between the time the patient left the ED for admission to an inpatient bed. (St. Mary's General Hospital)

Last Year		This Year	
42.40	**24**	**37.80**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☐ Implemented ☑ Not Implemented

Physically move discharged patients.

Process measure

- % of patients that we can move to a discharge chair.

Target for process measure

- 20% of discharge patients will be moved.

Lessons Learned

St. Mary’s has now completed a surge plan that has effectively managed recent surges, by opening temporary spaces to flow patients out of the ED. Work will continue to consider how to promote timely discharge identification, early discharges and alternate locations for patients who are ready to discharge but have not yet left. This is work that will continue through targeted quality initiatives with internal metrics.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Improve visibility of discharge status of patients.

Process measure

- % of bed boards used in daily discharge huddles.

Target for process measure

- 100% of bed boards used.

Lessons Learned

Electronic bed boards are used daily to review confirmed/potential discharges and plan daily flow, and on the units to manage discharges. As well, the current occupancy pressures and the time to inpatient bed in the previous 24 hours are shared at a Daily Safety Sync meeting.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Analyze short admissions of less than 24 hours.

Process measure

- Analysis completed by June 2023.

Target for process measure

- 100% completed.

Lessons Learned

Data was reviewed to analyze and theme the reasons for short stays to determine if there are any preventable admissions. A space located adjacent to the ED, is being investigated as a Short Stay location, with a model focused on quick follow-up care and discharge.

	Last Year		This Year	
Indicator #6	**52**	**60**	**0.98**	**NA**
Percentage of STEMI cases within 90 minute benchmark (St. Mary's General Hospital)	**Performance (2023/24)**	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Environmental scan of cardiac centres.

Process measure

- Understandidng of peer processes for the 'door' time when the time to ECG starts.

Target for process measure

- 100% will be completed.

Lessons Learned

Confirmed that the metric “time of arrival to ECG” should be measured from the time triage ends to ECG improved this metric.

In Q3, the ED and cardiac teams achieved target of 98% of STEMI cases meeting the 90-minute door to percutaneous coronary intervention benchmark. The processes and protocols to support STEMI management are working well, however it is recognized that the step of the process that is most critical, and most variable, is the door to ECG time in ED. The working group will continue meeting to focus on sustaining consistent processes for timely ECG capture following presentation to ED.

Monitoring of this Indicator will continue at the program level for 2024’25.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Education to all ED staff including triage and Lab staff.

Process measure

- Communication complete to all groups by December 2023.

Target for process measure

- 100% communication will be completed.

Lessons Learned

Education at ED huddles was initiated on chest pain protocol followed by targeted education for triage staff and the lab staff to ensure that the ECG is the first test obtained.

Change Idea #3 ☑ Implemented ☐ Not Implemented

New equipment to be purchased in ED for registration.

Process measure

- New kiosk purchased in spring of 2023.

Target for process measure

- 100% will be completed.

Lessons Learned

New accessible Registration Kiosk was purchased. Upgrade to improve the effectiveness to identify patients requiring timely assessment and intervention related to cardiac events is planned.

Experience | Patient-centred | Priority Indicator

Indicator #5

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? (St. Mary's General Hospital)

Last Year		This Year	
CB	**75**	**60.61**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ **Implemented** ☐ **Not Implemented**

Engage with patients in our selection of patient education materials.

Process measure

- PFAC approves process for updating new patient education materials.

Target for process measure

- 100% approval of process.

Lessons Learned

Our journey to collect Patient Experience data was longer than first anticipated and created a scarcity of data throughout the 2023-24 period. In early December last year, in partnership with GRH, patient e mail collection at registration was implemented and subsequently, we launched our long-awaited survey using the Qualtrics digital platform. Response rates have been better than anticipated and we now have meaningful data flowing in to measure planned change initiatives. This indicator will remain on the 2024'25 QIP.

Our patient experience, professional practice and quality teams have begun work to revamp patient teaching and education materials, including leveraging the new patient bedside terminals to deliver teaching information to patients and family on demand. Additionally, the current discharge teaching program is due for a refresh to continue to align with best practices, including health literacy, health equity, and opportunities to translate materials into common languages. This is an exciting opportunity to engage in co-design with patients and has the endorsement of the Patient & Family Advisory Council.

Safety | Effective | Priority Indicator

Indicator #4

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. (St. Mary's General Hospital)

Last Year		This Year	
73.14	**75**	**77.97**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Ensure processes in Electronic Medical Record meet needs of discharge physician.

Process measure

- Reported satisfaction with documentation process for 5 physicians.

Target for process measure

- 80% satisfaction recorded.

Lessons Learned

Improvement of this indicator started with a manual audit to understand the issues, which centred on more timely and accurate completion of the Best Possible Medication History (BPMH). Our Joint Medication Safety Steering Committee continues to provide oversight to this initiative. Despite St. Mary’s tracking above target, plans to monitor and emphasize discharge med rec as a joint priority with our partner Grand River Hospital, are ongoing.

The Committee’s plans include improving timely BPMH, ensuring all nurses have access to an appropriate second source to complete the BPMH, and physician education. At SMGH, the introduction of an admissions nurse in the ED will also support the timely and accurate completion of the BPMH, a critical foundational step to effective med rec on discharge. Initial work to provide a Transfer Med Rec that is complete and easy to read is also demonstrating value. Oversight will continue through the joint committee and this indicator will continue to be reported to program Quality & Operations committees, as well as to the Board Quality Committee. In 24’25, this work will align with our shift to focusing on Choosing Wisely, specifically the module Fewer Sedatives for Your Older Relatives - Reducing Sedative use in Elderly Patients.

Safety | Safe | Custom Indicator

Indicator #3

Hand Hygiene before care (St. Mary's General Hospital)

Last Year		This Year	
79	**85**	**56.79**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ **Implemented** ☐ **Not Implemented**

Monthly audit process.

Process measure

- All 15 units have an audit at least twice a year.

Target for process measure

- 100% completed.

Lessons Learned

Please refer to comments for Hand Hygiene after care.

Indicator #2

Hand Hygiene after care (St. Mary's General Hospital)

Last Year		This Year	
84.50	**85**	**75.30**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ **Implemented** ☐ **Not Implemented**

Share audit results to motivate change.

Process measure

- Percentage of clinical units with hand hygiene on their quality and operations scorecard.

Target for process measure

- Hand Hygiene indicators on 100% of scorecards.

Lessons Learned

During our implementation work for this change idea, our Infection Prevention & Control (IPAC) team focussed on how we collect hand hygiene data. As a result, it was identified that current audit methodology was not in alignment with the technical specifications of this indicator. A new audit structure was designed by IPAC, to better facilitate accurate monitoring and reporting.

The infection control practitioners are doing high frequency, short duration observations to provide an increased opportunity for real-time coaching and limit observation bias. Their direct involvement with the audits has yielded concrete improvement opportunities, and therefore focused initiatives for greater impact overall.

Ultimately, more accurate and meaningful audit results are now shared with departments on their scorecards. The accompanying analysis by IPAC is more relevant to the frontline teams and the hope is as this continues to be a focus on program score cards, engagement in change ideas will be enhanced.

Indicator #7

Positive Patient ID band (St. Mary's General Hospital)

Last Year		This Year	
70	**80**	**76.70**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ **Implemented** ☐ **Not Implemented**

Create full quality improvement plan with relevant stakeholders.

Process measure

- Working group's objectives measured for satisfaction.

Target for process measure

- 80% satisfaction with evaluation.

Lessons Learned

As work continued on the scanning for positive patient identification (PPID) metric in 23'24, it was identified that further breakdown of the key components for measurement and improvement purposes were necessary, as each presented unique challenges to be addressed. As such, this indicator was broken down into four measures (target remain 80.0 for all):

Medication PPID Scan Rate (%) - 76.7
Lab PPID Scan Rate (%) - 40.0
Medication Scan Rate (%) - 51.0
Lab Specimen Scan Rate (%) - 75.3

Lab PPID scanning continues to trend lower as the focus last fiscal year was on medication scanning. We are now using improvement practices implemented for medication PPID to improve lab scanning. Early results demonstrate increased compliance.

As with early work in medication scanning, we anticipate this will be a multi-year change process. Recognizing the extent of this work, the monitoring and planning will shift to a Corporate Quality Score Card to maintain focus and corporate planning.

Change Idea #2 ☐ Implemented ☑ **Not Implemented**

Ensure scanning equipment functions in each unit.

Process measure

- Work tickets completed within 1 week of requests and working group members train unit leads on troubleshooting.

Target for process measure

- 100% of work orders completed.

Lessons Learned

Partially implemented.
Throughout the work to understand scanning rates, we determined that our overall performance continues to be impacted by poorer performance in the Emergency Department (ED). We have learned that functional barriers were a significant issue. Additional scanners are now functioning in the ED and dedicated charging for the mobile workstations have been established. A slight improvement noted for the department. In focusing on the root cause of lower scanning rates, particularly after broad improvement work, aided in targeted quality improvement work. Change management is underway in our ED as a result. On inpatient units, equipment issues were for the most part resolved.

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

Develop process maps for any unit specific issues.

Process measure

- Process maps completed and gaps identified.

Target for process measure

- 100% completed.

Lessons Learned

Managers receive weekly and monthly reports to identify staff who are not scanning and are able to provide timely intervention and performance management.

Change Idea #4 ☑ Implemented ☐ Not Implemented

Assess workflow concerns.

Process measure

- Workflow issues identified and addressed.

Target for process measure

- 100% issues addressed by March 2024.

Lessons Learned

In the inpatient areas, compliance has consistently improved, as processes have become standard work for frontline staff. When subtracting the ED from the audited reports, the hospital is well over 80% and meets target.

Managers are using audit reports along with weekly analytics to support improvement through staff follow up and implementing performance plans when necessary. For example, one barrier identified was consistently scanning the medication package prior to opening as after opening the code may be damaged. Improvement was noted by using reminders at huddles.

	Last Year		This Year	
Indicator #1 Eliminate duplicate orders for lab specimens (St. Mary's General Hospital)	**CB** Performance (2023/24)	**CB** Target (2023/24)	**NA** Performance (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☐ Implemented ☑ Not Implemented

Establish technical and process workflows to reconcile lab orders at points of transfer between units.

Process measure

- Reduction in number of duplicate orders.

Target for process measure

- Once baseline is confirmed a goal of 25% reduction in duplicate orders.

Lessons Learned

This indicator was and continues to be an important clinical project. Our work to date has made significant progress in understanding the root causes. This has allowed us to better understand the complexity of the issues, and the scale of action required. While we have been unable to implement the change ideas to date, we consider this work beneficial in informing other projects already underway at St. Mary's, and this year's QIP.

We have recognized an opportunity for prescriber education to reinforce the importance of adhering to alerts within our electronic health record (EMR) platform. However, challenges in EMR infrastructure at the root of approximately one third of the duplicate generations are more challenging to rectify.

An initiative between to improve our EMR is underway. The issues leading to duplicate orders were not part of the original project scope, however, our work on this indicator has highlighted the need to continue to optimize the EMR system to address duplicate lab orders.

We have removed this indicator from our 2024'25 QIP. However, in opting to implement Choosing Wisely's Pause the Draws module, we will continue to focus on lab orders with an emphasis on process changes and education to improve practice within our current system, and prioritize this issue in any EMR changes in the future.