Equity | Equitable | Custom Indicator

	Last Year		This Year	
Indicator #3 Interpretation services used matches population expectations. (St. Mary's General Hospital)	**127** Performance (2022/23)	**450** Target (2022/23)	**904** Performance (2023/24)	**--** Target (2023/24)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Evaluate quality of service.

Target for process measure

- End of third quarter (December).

Lessons Learned

Patient and staff feedback overwhelmingly positive.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Ensure VOYCE tablets are fully utilized.

Target for process measure

- Tablet utilization is distributed across units (ie not all one unit.

Lessons Learned

We did have a slight decrease in use in Q2 across several units. Reminders of the tablet availability quickly remedied this.

Theme I: Timely and Efficient Transitions | Efficient | Additional Indicator

Indicator #4

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. (St. Mary's General Hospital)

Last Year		This Year	
42.27	**31.48**	**NA**	**--**
Performance (2022/23)	**Target (2022/23)**	**Performance (2023/24)**	**Target (2023/24)**

Change Idea #1 ☐ Implemented ☑ Not Implemented

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.

Target for process measure

- In Q3 of 2022-2023

Lessons Learned

Use of SMGH ED for mental health and addictions not as large a contributor to regional improvements required.

Indicator #6

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. (St. Mary's General Hospital)

Last Year		This Year	
13.55	**16**	**14.10**	**--**
Performance (2022/23)	**Target (2022/23)**	**Performance (2023/24)**	**Target (2023/24)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

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.

Target for process measure

- Developing baseline and decrease.

Lessons Learned

The OT has been able to prevent further deconditioning. This initiative brought an additional complement to the multi-disciplinary team and fostered a more comprehensive care plan including advocating for in increase in home care services. LOS with patients where OT was involved went from 15 days to 6 days in Feb 2023.

Change Idea #2 ☑ Implemented ☐ Not Implemented

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

Target for process measure

- By Q4 we will finalize risk assessment tool to be used, identify change management strategy, develop and roll-out training and communication.

Lessons Learned

Collaborated with KW4 OHT.

Theme I: Timely and Efficient Transitions | Timely | Custom Indicator

Indicator #7

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	
21	**24**	**42.40**	**--**
Performance (2022/23)	**Target (2022/23)**	**Performance (2023/24)**	**Target (2023/24)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Create phase two of quality improvement plan.

Target for process measure

- 80% satisfaction at evaluation of event.

Lessons Learned

Completed and identified in strategic priority to expand equitable access to high, quality, empowered care.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Identify communication efficiencies for notification of bed availability.

Target for process measure

- By end of September (Q2).

Lessons Learned

Biggest opportunity was to plan for early patient discharge. Improvement of visibility for discharge needed and plan for bed board implementation on every clinical unit. Opportunity to pre plan day before for any discharges and have all discharge orders, plans in place.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Develop process map for any unit specific issues.

Target for process measure

- All 6 hospital inpatient units have a completed process map by September 2022.

Lessons Learned

Process map was completed as well as fishbone. Bed occupancy and discharge process were noted as main problems through simplifying the process map to understand where the bottlenecks are in the processes. Patients and their families can better plan for discharge if they are aware of a discharge tine. Transportation can be a barrier so proactive planning is important. Working on implementing on one of the medical units to trial a standard practice of one discharged patient each day going into a designated waiting area to wait for their ride. Plan to move this across all units and move to more than one patient each day.

Change Idea #4 ☑ Implemented ☐ Not Implemented

Create full Quality Improvement Plan with relevant stakeholders.

Target for process measure

- 80% satisfaction at evaluation of event.

Lessons Learned

Worked with U of T and CQuIPS program to develop aim statement and bring stakeholders to the table for clear understanding to tie interventions with root causes.

Indicator #1

% of STEMI cases within 90 min benchmark (St. Mary's General Hospital)

Last Year		This Year	
0.56	**0.60**	**52**	**--**
Performance (2022/23)	**Target (2022/23)**	**Performance (2023/24)**	**Target (2023/24)**

Change Idea #1 ☐ Implemented ☑ Not Implemented

Pull patient to the cardiac Cath Lab rather than wait for a pull.

Target for process measure

- Reduce by 10 minutes by September 2022.

Lessons Learned

Staffing in the Cath lab not able to support this on a consistent basis overnight and weekends. Did not want to create two different processes for ED staff to remember.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Identify methods to improve ECG times.

Target for process measure

- All 3 groups completed by December 2022.

Lessons Learned

Trialed an RPN in ED focused solely on completing medical directives including STEMIs beginning October 2022. The intended impact was not met and we are relooking at the role and connection with Lab for 2023/24.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Trial a patient lead kiosk prior to triage to assist in identifying patients at risk of STEMI in waiting room.

Target for process measure

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

Lessons Learned

Staff felt the kiosk was helpful to identify the needs of patients in the waiting room. The design of the 'repurposed' kiosks were deemed to be unsuitable for many patients (screens difficult, not able to access from wheelchair, not appropriate for sight limited).
Purchasing involved to source new accessible stands, site visits and cost comparison resulted in recommendation for 2023/24.

Theme II: Service Excellence | Patient-centred | Custom Indicator

Indicator #2

Inpatient: would you recommend this hospital to your family and friends? (St. Mary's General Hospital)

Last Year		This Year	
80.40	**85**	**NA**	**--**
Performance (2022/23)	**Target (2022/23)**	**Performance (2023/24)**	**Target (2023/24)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Offer physical supports such as noise cancelling headphones and blue tooth headsets for TVs

Target for process measure

- Target is 0 complaints

Lessons Learned

IPads and headsets were provided to inpatients through a Patient Experience Assistant staff member. We carefully planned for construction over 2022/23 that would affect patients, we provided noise cancelling headsets to the floors that would be affected.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Improve communication to family and loved ones.

Target for process measure

- More than one person for all 9 months

Lessons Learned

We continued to teach staff and physicians the importance of communication. This was improved in 2022 with the increase in physical presence of Care Partners at the bedside.

Theme III: Safe and Effective Care | Safe | Custom Indicator

Indicator #5

Patient ID band scan rate is used for required processes (i.e. medication and lab samples) (St. Mary's General Hospital)

Last Year		This Year	
0.47	**0.80**	**0.59**	**--**
Performance (2022/23)	**Target (2022/23)**	**Performance (2023/24)**	**Target (2023/24)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Develop process map for any unit specific issues.

Target for process measure

- All 9 hospital units have a completed process map by September 2022.

Lessons Learned

Process map was developed.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Assess workflow concerns.

Target for process measure

- 100% issues addressed by March 2023.

Lessons Learned

Project champion worked with unit managers to identify common workflow concerns and mechanisms to correct.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Create phase two of quality improvement plan.

Target for process measure

- 80% satisfaction at evaluation of event.

Lessons Learned

Project champion working with U of T CQUIPs and EQUIPs supports to look at best processes to engage staff who are not following policy/procedures.

Change Idea #4 ☑ **Implemented** ☐ **Not Implemented**

Ensure scanning equipment functions in each unit.

Target for process measure

- 100% of work orders completed.

Lessons Learned

Each unit analyzed the equipment and with IT submitted repair requests and managers maintained 'pressure' on IT to complete repairs in a timely manner.

Change Idea #5 ☑ **Implemented** ☐ **Not Implemented**

Create full Quality Improvement Plan with relevant stakeholders.

Target for process measure

- 80% satisfaction at evaluation of event.

Lessons Learned

Plan and next steps created by project lead and full team engagement in QI theory through U of T CQUIPs program.