Access and Flow | Efficient | Custom Indicator

Indicator #8

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 (Queensway Carleton Hospital)

Last Year		This Year	
34.10	**21.30**	**14.40**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Education of care teams regarding ALC designation, its appropriate use, and the required information to provide to patients and families.

Process measure

- Number of patients who are who are receiving active medical care and inappropriately designated ALC.

Target for process measure

- 50% reduction in inappropriate use of ALC by November 2023 (i.e. 6-7 days).

Lessons Learned

ALC designation is a complex issue. Education across all care teams and chart audits and follow up was key to the success of this work.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Implementation of a mobility team to assist with reactivation of patients to reduce ALC days and enable discharge from hospital to home.

Process measure

- Avoidance of ALC days

Target for process measure

- With a current median of 12.82 days in November 2022, we are targeting a 20% reduction in November 2023 or an average of 1026 days in November 2023

Lessons Learned

Several PDSA cycles implemented to find the best approach and utilization of resources to support the complex patient needs.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Trial a centralized process for referral to Rehabilitation programs

Process measure

- "Acute" ALC days (i.e. how many ALC patients are occupying acute care beds)

Target for process measure

- With a baseline of 12.82 days in November, we are targeting a 20% decrease in acute ALC days for the month of November 2023.

Lessons Learned

A centralized process built into the EMR support efficient referral and assessment process.

Change Idea #4 ☑ Implemented ☐ Not Implemented

Implementation of a remote care monitoring program in partnership with Home and Community Care (HCSS) for ALC patients.

Process measure

- Average daily ALC rates

Target for process measure

- Average daily ALC rate of 93 in November 2023. This is a reduction of 10% from the rate of 104 in November 2022

Lessons Learned

ALC rates continue to be a complex issue. The focus of this program shifted from requiring an ALC designation to qualify for the program, to prevention of becoming ALC through earlier referrals.

Indicator #5

Proportion of hospitalizations where patients with a progressive, life- limiting illness, are identified to benefit from palliative care, and subsequently (within the episode of care) have their palliative care needs assessed using a comprehensive and holistic assessment (Queensway Carleton Hospital)

Last Year		This Year	
CB	**CB**	**78**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

1. Implement the Edmonton Symptom Assessment System (ESAS) score and the Advanced Care Planning (ACP) report

Process measure

- % HOMR positive patients on A3 Medicine unit who have the ESAS and ACP applied

Target for process measure

- 75% from July to September 2023

Lessons Learned

This report has been implemented on the A3 Medicine unit to support identifying HOMR-positive patients. The necessary assessments are then completed by the frontline staff. The workload associated with this process has proven to be more labour-intensive than originally thought, and introducing further automation to the process would support sustainable workflows going forward.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Provide information to physicians and nurses about the HOMR score, the ESAS and the ACP on the implementation unit (A3)

Process measure

- Percent of nurses and hospitalists who have information provided

Target for process measure

- 80% of nurses and hospitalists who work on A3 will receive targeted education

Lessons Learned

The process of disseminating information, providing education, and facilitating communication has been ongoing for approximately one year leading up to the official implementation. Prior to the go-live date, this effort was reiterated to ensure clarity and readiness among stakeholders. Continuous reinforcement and reminders have been essential throughout this journey, underscoring the importance of ongoing physician engagement and support.

Change Idea #3 ☐ Implemented ☑ Not Implemented

Spread implementation of ESAS and ACP to three other Medicine units (D3, C4, ACE)

Process measure

- Percent of HOMR positive patients on target units who have the ESAS and ACPR applied

Target for process measure

- 80% of all patients with a positive HOMR will have the ESAS and ACP completed.

Lessons Learned

Challenges such as competing priorities and limited resources hindered our ability to extend the initiative across all the medicine departments effectively. To address this, we have initiated a trial period on the A3 medicine unit for the next six months, focusing on refining and streamlining the process. Our aim is to ensure that the workload associated with the initiative remains reasonable, realistic, and aligned with best practices. We plan to target the scaling of this process for 2025, with the intention of incorporating valuable lessons learned during the trial period.

Access and Flow | Timely | Custom Indicator

Indicator #7

The (90th percentile) 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. (Queensway Carleton Hospital)

Last Year		This Year	
34.90	**27.40**	**28.80**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Discharge champions on Medicine units will ensure that a Predicted Date of Discharge (PDD) is entered within 24 hours of admission

Process measure

- Percent of medical inpatients who have a PDD listed within 24 hours of admission

Target for process measure

- By December 2023, 90% of medical inpatients will have a PDD within 24 hours

Lessons Learned

Medicine patients do have a PDD documented within the Teletracking system, with reasonable consistency. The Care Facilitators are documenting the PDD within the Teletracking system post-rounds, based on the outcome of the discussion. The focus for next year will be to optimize the documentation of the PDD within the medical record and looking to interface the Teletracking/ Meditech system.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Reduce the amount of time that patient porters experience in delays.

Process measure

- The number of minutes of delay in a month

Target for process measure

- Reduction of 25% by end of April 2023 to 3,776 minutes of delay. Reduction of an additional 25% by December 31, 2023 (2,832 minutes)

Lessons Learned

The return portion of transportation continues to cause delays. The use of the communication tool has deviated from the standard work, which has demonstrated some regression from the initial improvement. Maintaining education for the ACCs has been identified as an ongoing challenge, and it should be incorporated into their standard work to ensure sustainability.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Develop standard work for non-urgent transport booking processes

Process measure

- Percent of patients discharged prior to 1400 hrs

Target for process measure

- 75% of patients discharged with non-urgent transport are discharged prior to 1400 hrs.

Lessons Learned

Escalation of non-urgent transport delays process created and working well. It is important to have one key contact managing any Non-Urgent Transport issues.

Equity | Equitable | Custom Indicator

	Last Year		This Year	
Indicator #1 Percent positive response to the Employee survey question "I feel as if I belong at QCH" (Queensway Carleton Hospital)	**71** Performance (2023/24)	**80** Target (2023/24)	**NA** Performance (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Develop Diversity, Equity and Inclusion strategies through consultation

Process measure

- Creation of written strategy

Target for process measure

- Written strategy created by May 31, 2023

Lessons Learned

The strategy was developed with stakeholder engagement. The strategy is currently being communicated across the organization and at various leadership forums.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Launch Diversity, Equity, Inclusion Council for Queensway Carleton Hospital

Process measure

- Counsel created and meeting held

Target for process measure

- First meeting held by June 30, 2023

Lessons Learned

The Council was deployed with a focus of growth, development and refinement in the 2024-25 FY.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Develop anti-discrimination and anti-racism policies

Process measure

- Approval of policies for anti-discrimination and anti-racism

Target for process measure

- Policies approved by November 30, 2023

Lessons Learned

Development is underway. Many policies have been reviewed with and EDIB lens, and changes proposed to align with current practices and the EDIB strategy.

Change Idea #4 ☑ Implemented ☐ Not Implemented

Standardize hiring and selection processes to include transparency and an EDI lens

Process measure

- New processes completed

Target for process measure

- New processes implemented by November 30, 2023

Lessons Learned

Processes in development and further supported by the recruitment of a coordinator.

Change Idea #5 ☑ Implemented ☐ Not Implemented

Increase number of employees who are trained on Indigenous Cultural Awareness (San'yas training program)

Process measure

- Number of staff completing training

Target for process measure

- 50 additional staff trained from April 1 to December 31, 2023

Lessons Learned

This past year, the senior leadership team completed the Ontario Indigenous Cultural Awareness program.

Comment

The survey was not repeated during the QIP cycle, therefore, the indicator data cannot be updated at this time. The survey will be repeated in the 2024/25 fiscal year.

Experience | Patient-centred | Priority Indicator

Indicator #4

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? (Queensway Carleton Hospital)

Last Year		This Year	
57.19	**60**	**61.26**	**67.40**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Increase the number of nurses trained as discharge champions on each Medicine unit

Process measure

- Percent of full time and part time medicine nurses trained as discharge champions

Target for process measure

- 80% of all full and part-time medicine nurses will be trained as discharge champions by April 30, 2023

Lessons Learned

100% of the medicine nurses have been training in discharge practices to support safe and efficient discharge/transitions from the hospital. Reinforcement of practice and bringing the topic to the frontline team in a regular and consistent manner was impactful. Challenges experienced resulted

Change Idea #2 ☐ Implemented ☑ Not Implemented

Add the "satisfaction with discharge information" question to the Medicine post discharge follow up phonecall for patients identified as being at risk for readmission.

Process measure

- Percent of patients who respond verbally that they are satisfied with the discharge information provided.

Target for process measure

- 80% of patients will verbally report that they are satisfied with the discharge information provided.

Lessons Learned

Initially, integrating this change idea into the post-discharge calls (LACE calls) seemed feasible. However, upon closer examination of the workflow, the limitations in reaching a broad patient population, and the increase in workload, it became apparent that this approach might not be practical. Moreover, the proposed yes/no response question was deemed insufficient for gaining valuable insights into the information shared or lacking, further questioning the effectiveness of this approach.

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

Development and provision of standardized discharge information to Medicine patients

Process measure

- Standardized language has been developed and all new discharge champions trained on it's use.

Target for process measure

- 80% of full and part time nurses on A4, A3, ACE, C4 and D4 will be trined in using the standardized language.

Lessons Learned

Collaboration within the Medicine group proved pivotal in the development and refinement of the discharge standard practice work implemented over the past year. Initially, we encountered challenges in gaining momentum and effectively deploying the initiative. However, by leveraging project management and change management principles, we successfully realigned our objectives and fostered alignment and implementation. With a pivot in our approach and the implementation of PDSA cycles, we observed targeted success and increased uptake, demonstrating the effectiveness of our collaborative efforts.

Indicator #3

Percentage of reported incidents of violence with no associated injury. (Queensway Carleton Hospital)

Last Year		This Year	
73	**75**	**68**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Expand Behaviour Support Ontario (BSO) education sessions beyond nursing to allied health, support services (e.g. security, environmental services) and others

Process measure

- Number of staff trained through BSO education sessions

Target for process measure

- 25 staff trained in Behaviour Support by Q4 2023-2024

Lessons Learned

17 staff in total were trained, which did fall below the targeted 25, but we did successfully complete the education and implement the change initiative for the 17 staff. Salary increases impacted the available funds impacted the number of staff who were able to be trained.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Increase capacity in each training session for Gentle Persuasive Approach (GPA) techniques

Process measure

- Number of people in each session and number of sessions provided

Target for process measure

- 120 staff will be trained by Q4

Lessons Learned

The change idea was initiated, and was able to train 112 staff, which did fall a bit short from the target of 120 staff. Several last minute sick calls on the day of the course impacted the volume of staff who attended. In the future, we will look to creating a wait list of interested staff so to have staff ready and identified to fill last minute vacancies.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Update the training and increase the frequency of training related to flagging patients for a history of violence

Process measure

- Percent of targeted staff who are trained in flagging a patient for violence within two years

Target for process measure

- Thirty percent of staff will have successfully completed the training within two years as of December 2023

Lessons Learned

Violence flagging process was incorporated into the corporate manager onboarding training offered.

Change Idea #4 ☑ Implemented ☐ Not Implemented

Track and provide feedback to managers concerning appropriate use of the violence flagging system.

Process measure

- Percentage of patient charts appropriate flagged with a violence indicator

Target for process measure

- Eighty percent of patient charts will be appropriately flagged by December 2023

Lessons Learned

An emphasis on ensuring patients and/or the family member are notified of the flag.

Change Idea #5 ☑ Implemented ☐ Not Implemented

Provide education on management of patients with delirium across the Emergency Department and all inpatient units (all Medicine units, D4 Surgery, ICU, Mental Health, Park Place and D3) with roll-out of new delerium policy.

Process measure

- Number of people educated in the identification, prevention and management of delirium

Target for process measure

- By end June 2023, 200 nursing staff will be provided education in delirium; in addition, 100 interdisciplinary staff will be trained.

Lessons Learned

During QCH's Corporate Delirium Awareness Week Education from March 13-17, 2023, we successfully launched the new Corporate Delirium policy. With 27 education sessions held, we were thrilled to have a total attendance of 268 staff members. Additionally, we found that huddles provided an effective platform for addressing questions and fostering connections with the care teams regarding the delirium policy.

Indicator #9

Voluntary Turnover Rate: Full and part time employees who leave the organization. (Queensway Carleton Hospital)

Last Year		This Year	
9.80	**9**	**7.12**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

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

Spread optimized nurse staffing schedules with a relief budget to the Acute Care of the Elderly Unit

Process measure

- Percent of available rotations on the schedule filled

Target for process measure

- By June 30, 100% of available rotations will be filled

Lessons Learned

Optimized nurse staffing schedules were deployed to the Acute Care of the Elderly Unit (ACE). There were unforeseen budgetary miscalculations, which unfortunately meant that the full changes of the schedule could not be implemented at this time. The department continues to assess the patient care needs and staff accordingly.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Adjust nurse:patient ratios to improve patient safety and nurse satisfaction

Process measure

- Number of Medicine units (ACE, and C4)whose staffing ratio has been adjusted to 1:6 on night shift

Target for process measure

- ACE and C4 medicine units will have schedules adjusted by May 15, 2023

Lessons Learned

Communication and engagement with frontline staff and all key stakeholders was key to the successes experienced with this initiative. There were challenges with the initial change, however, the with supports and open communication channels, we successfully implemented the change. Overall patient safety incidents have decreased since implementation and staff have expressed their satisfaction with the rotation change.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Optimize use of decentralized learning and growth funding to support nurses to remain at Queensway Carleton Hospital

Process measure

- Amount of available earning and growth funds remaining in the allocation

Target for process measure

- 75% of all funds will be spent, or be earmarked for specific learning and growth initiatives by December 2023

Lessons Learned

Learning and Growth funds were utilized for a wide array of learning opporunities, many of which had not been previously offered. L&G opportunities were shared through various forums including department newsletters, through the professional practice department and at department huddles, to encourage enrolment and availability of funds.

Change Idea #4 ☑ Implemented ☐ Not Implemented

All staff and leaders voluntarily leaving Queensway Carleton Hospital (QCH) will undergo an exit interview through the Human Resources team

Process measure

- Percent of voluntary exiting staff who have undergone interview prior to leaving QCH.

Target for process measure

- 100% of voluntarily exiting staff will be interviewed.

Lessons Learned

The exit interview tool and supporting policy were developed and deployed during this fiscal year. Exit interviews are extended to and available for employees and leaders leaving the organization to support continuous improvement and learnings.

Indicator #6	Last Year		This Year	
Rate of incidents reported related to issues in management of medications per 1000 patient days (Queensway Carleton Hospital)	**5.68** Performance (2023/24)	**5** Target (2023/24)	**5.12** Performance (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Implementation of override control protocols for withdrawals of controlled substances from the ADC

Process measure

- Percent of medication transactions that are overridden

Target for process measure

- In all inpatient areas, less than 2% of medication transactions are overridden.by the end of June 2023

Lessons Learned

Override restrictions were implemented on inpatient ADCs except the OR. This forces nurses to pull medication orders against and active order from the patient chart. Override reasons such as Codes can be provided in the case an active order does not exist. Override reports are sent each morning to the Clinical Manager to follow up with staff to ensure the override was appropriate.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Reduce the number of incidents due to missed or delayed medications as a result of patients being transferred from the Emergency Department (ED) to an inpatient unit without the prescribed medications provided in the ED being transported with the patient.

Process measure

- The number of patient medication strips returned to pharmacy for admitted patients through the ED.

Target for process measure

- 50% reduction in patient specific medication strips returned to pharmacy from the ED.

Lessons Learned

We were able to partially implement the full scope of the proposed change idea. This change idea consisted of two parts. All Emergency Department patient specific medications were centralized in bins within the Observation area medication rooms (this was Part 1 of the change idea). For Part 2 of the change idea, QCH trialed having the patient specific medications tubed to the patient's admitted floor. This was not successful. It was then tried to have the Emergency Department Care Facilitator follow up when an inpatient unit reported the patient medications did not arrive. This was also unsuccessful. We are going to undertake a third change process during the 2024-25 FY to see if we can implement sustainable change.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Standardize the workflow of drug administration using a CADD pump to reduce variation in practice and limit opportunity for errors.

Process measure

- Number of RLs related to errors in programming CADD pump

Target for process measure

- 2 or fewer incidents for the months of Sept-Dec 2023.

Lessons Learned

A working group reviewed present practice and worked with frontline staff to overcome identified challenges. Tip sheets were created and linked to the pumps to allow nurses to have a quick reference guide to standardized processes. A list of proposed changes to Meditech (the electronic medical record) hard coded build was submitted for review and to be submitted directly to Meditech. Simplification of Meditech IV infusion screens (included the location of documentation) and training provided to frontline nurses. A capital submission to replace Sapphire pumps with CADD pumps to reduce the number of pump models used at QCH to improve nursing familiarity.

Safety | Effective | Custom Indicator

Indicator #2	Last Year		This Year	
Percentage of post operative patients who have undergone primary hip and knee replacement who return to hospital with a surgical site infection. (Queensway Carleton Hospital)	**2.30** Performance (2023/24)	**1.80** Target (2023/24)	**2.10** Performance (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Complete onsite process observations of current state to identify 3 areas for improvement based on best practice review

Process measure

- Number of measures identified for targeted improvement

Target for process measure

- Three areas of improvement identified for process improvement

Lessons Learned

1) Data tracking forms indicated that, on average, the OR door to the external corridor was opened 10-16 times during a surgical case, which we know negatively contributes to surgical site infections (SSIs).
2) Fasting guidelines were updated, but anesthesia required extensive review. They include recommendations for patients to consume a high-carbohydrate drink 2-3h preoperatively.
3) IV Antibiotic administration was thought to be given in Day Surgery or sent with the patient charts to the OR for administration. Tracking forms indicated that antibiotic administration was often given by the AA in the block room or in the OR and infrequently within 30 minutes of cut time. However, there were challenges with compliance with completing the tracking forms.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Patients undergoing primary total hip and knee replacement will consume a high carbohydrate product prior to surgery

Process measure

- Percent of target patients consuming the high carbohydrate product

Target for process measure

- Patients presenting to the hospital will either bring their own drink or it will be provided by the hospital. If it is the former, the target is 60%; if it is the latter, the target is 90%.

Lessons Learned

1) Patients were provided with the high carbohydrate product in POAC and instructed to drink the beverage prior to leaving for hospital/3hr pre-op, resulted in less than expected compliance

2) Initially, all patients were included, but blood glucose level results were high in some patients with diabetes when tested in Day Surgery on the morning of surgery. This was in contradiction to the information provided by the vendor; as a result, all patients with diabetes were excluded from the trial. 7.12% of the total 320 patient tracking records indicated patients were excluded due to diabetes

Change Idea #3 ☑ Implemented ☐ Not Implemented

Implementation of pre-operative skin antisepsis with 2% Chlorhexidine gluconate (CHG) body cleanser for all pre-operative patients. To be completed in day surgery.

Process measure

- Percent of primary total hip and knee replacement patients who undergo skin antisepsis with 2% CHG body cleanser in the pre-operative unit.

Target for process measure

- 90% of patients undergoing total hip and knee replacement will undergo skin antisepsis with 2% CHG body cleanser.

Lessons Learned

1) When an initiative is completed on-site by hospital staff, compliance is high.
2) High compliance suggests that this may have been the greatest contributor to the reduction in SSI among this patient population
3) Compliance for completion of a manual tracking tool is generally done quite well upon patient arrival and decreases towards the time of patient discharge.

Change Idea #4 ☑ Implemented ☐ Not Implemented

Ensure clipping of all hair from near the operative site prior to the patient entering the Operating Room.

Process measure

- Percent of patients undergoing primary total hip or knee replacement who require hair removal in the Operating Room

Target for process measure

- Zero patients will arrive in the Operating Room with a need for additional hair removal

Lessons Learned

1) Frequent and continued monitoring of compliance in the use of the tracking tool was needed
2) The number of patients requiring hair removal is likely much less than previously anecdotally stated
3) An opportunity to enhance the cleaning process for the hair removal devices was identified and addressed.