Theme I: Timely and Efficient Transitions

Measure

Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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.	P	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / Jul 2019 - Sep 2019	20.10	20.10	We have exercised opportunities with our more rural partner hospitals to move ALC patients out of the acute care setting. These efforts have resulted in maximal use of local beds. No other partner opportunities are available to improve this measure.	Arnprior and District Memorial Hospital, Carleton Place and District Memorial Hospital, Almonte General Hospital

Change Ideas

Change Idea #1 Continue to work with small hospital partners with vacant beds to rehouse ALC patients from the acute centre.

Methods	Process measures	Target for process measure	Comments
Social Work data tracks the number of patients transferred to the smaller community hospitals.	Number of ALC patients transferred from QCH to one of the partner community hospitals	12 patients in 2020 will be transferred to a partner small hospital for care.	Because ALC patients generally stay in hospital for prolonged periods, our experience has shown that adding 1 patient per month to the transfer to small community hospitals is a reasonable goal

Change Idea #2 Participate in a regional group to develop a 146-bed alternative facility for ALC patients in Ottawa

Methods	Process measures	Target for process measure	Comments
Final release papers delivered to regional leadership to allow occupation of the premises.	Facility is turned over to regional leadership for occupation by patients	Facility open and available to ALC patients by August 2020	Completion of this change idea is entirely dependent on Ministry approval for funding, which has not been secured at the time of this Quality Plan submission.

Measure

Dimension: Efficient

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Unconventional spaces	P	Count / All inpatients	Daily BCS / TBD	CB	CB	Criteria defining the exact measure for what constitutes an unconventional space are not available provincially. Internally, we include any patient who is not placed in a purpose built location for their admission to hospital. We continue to move forward with innovative ideas to safely house patients in transition from the Emergency Department to an in patient unit.	

Change Ideas

Change Idea #1 Add 18 transitional beds in an existing vacant area of the hospital to accommodate the high number of admitted patients in conventional and unconventional spaces.

Methods	Process measures	Target for process measure	Comments
Decision Support tracks the number of patients in all areas of the hospital.	Total patient days admitted to the transitional beds from September 2020 to December 2020.	1000 patient days from September 1 to December 31, 2020.	With an average of 12 patients in Emergency overload every day, we expect to accommodate transitional admission for up to 1000 patient days. Patient comfort will improve as will cohorting of resources to care for these patients.

Change Idea #2 Repurpose administrative office space to accommodate a second transitional unit that will be a permanent solution to the need for transitional space.

Methods	Process measures	Target for process measure	Comments
Bed count of designed bed spaces	Number of beds created for transitional patients as of January 2021	Minimum of 14 beds will be permanently created as transitional space	The renovation will be self-funded Use of the space is expected to be available as of March 31, 2021.

Measure

Dimension: Timely

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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.	P	% / Discharged patients	Hospital collected data / Most recent 3 month period	84.20	90.00	We are experiencing a challenge with the introduction of voice recognition dictation technologies that are currently embedded in the electronic medical record. Until this is fully resolved, it is not reasonable to set the target higher. However, utilization of the voice recognition system is at 99%, placing us in a good position to see significant improvement in the future.	

Change Ideas

Change Idea #1 We will develop standard work to incorporate a review of discharge summary chart deficiencies in real time by our health records clerical staff.

Methods	Process measures	Target for process measure	Comments
Health records will build a process to review charts for discharged patients daily to identify missing discharge summaries and placing a deficiency flag for physician follow-up and are report will be made available from our EMR to measure this process.	Number of deficiency flags identified by Health Records clerical staff on the day the discharge summary is due.	80% of deficiency flags will be identified on the day the discharge summary is due.	We will update existing deficiency policy to align with real-time reinforcement and provide subsequent education and communication to physicians to reinforce this change (e.g. who is responsible for completing a discharge summary, proper use of discharge summary templates that are distributed via HRM to primary care vs. progress notes or transfer notes).

Measure **Dimension:** Timely

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
The 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.	M	Hours / All patients	CIHI NACRS, CCO / Oct 2019– Dec 2019	30.98	27.10	There are many incremental changes being implemented to address this indicator through the work of a dedicated task team. We anticipate that we will continue to see a 4% growth in the number of patients seen in the ED, but are still intending to move this target back at least to a level achieved in 2018.	

Change Ideas

Change Idea #1 Develop a field in the electronic record to capture the potential discharge date for all patients within 24 hours of admission

Methods	Process measures	Target for process measure	Comments
Report available in Meditech	percent of inpatients who have a recorded PDD within 24 hours of admission	In December, 2020, 90% of Medical and Surgical inpatients will have a PDD listed within 24 hours of admission	By establishing a discharge date early in the admission, comprehensive plans can be put in place to ensure timely discharge of inpatients, making the availability of beds for ED patients more predictable and accessible thereby decreasing the time to admission from the ED.

Change Idea #2 Establish a process to ensure the actual time of discharge for every patient is recorded in real time and available to the ACC clerks for recording in the patient chart.

Methods	Process measures	Target for process measure	Comments
Manual tracking by the ACC staff of known discharge times for all discharged patients on C4 and D4.	An accurate time of discharge is available for every discharge medical and surgical patient from C4 and D4 in December 2020	90% of patients discharged from C4 and D4 in December 2020 will have a recorded time of discharge that is accurate.	The more accurate the discharge time is known to be, the more quickly a bed can be cleaned to be made available for the next ED admission. We do not feel that this process improvement will be 100% compliant within the timeframe identified.

Theme II: Service Excellence

Measure

Dimension: Patient-centred

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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?	P	% / Survey respondents	CIHI CPES / Most recent 12 months	61.89	66.50	Our efforts are intended to bring the rate of highest response (i.e. "completely") at least back to the level we had seen a year ago.	

Change Ideas

Change Idea #1 Create a best practice transition team to review and assess compliance with the guidelines outlined in the HQO Transition Tool between hospital and home and develop tools, including education to mitigate identified gaps

Methods	Process measures	Target for process measure	Comments
Progress will be tracked on the accountability agreement for the Medicine and Surgery inpatient teams.	A process to mitigate gaps identified in our compliance with the HQO Transition Tool will be develop for 90% of gaps	90% of identified gaps will have a plan developed for mitigation by December 31, 2020.	Total Surveys Initiated: 378 Experience has demonstrated that some best practices are not feasible to be implemented without significant resources. Only once we are able to review and assess the gaps will we know whether all are within our capacity to address. Therefore, the target is set for 90% of identified gaps.

Change Idea #2 Establish standard work for a consistent message that nurses will provide to patients prior to discharge on Medicine and Surgery in patient units.

Methods	Process measures	Target for process measure	Comments
Data will be collected in a spreadsheet for analysis, tracked on monthly scorecard and reported through the Unit Leadership Team.	10 Process Observation per month will be completed to ensure nurses are meeting the requirements outlined for consistent messages.	80% of nurses will complete all parameters identified in the consistent messaging in December 2020.	Champion will develop the message and facilitate educating the nurses regarding a clear and standardized method for consistent discharge processes.

Measure

Dimension: Patient-centred

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of complaints acknowledged to the individual who made a complaint within five business days.	P	% / All patients	Local data collection / Most recent 12 month period	97.71	98.00	Given our current rate of compliance that is exceeding 97%, we will concentrate our energies on quality improvement in other areas.	

Change Ideas

Change Idea #1

Methods	Process measures	Target for process measure	Comments
			No specific initiatives are being dedicated to improving this indicator further as our efforts will be placed on other priorities.

Theme III: Safe and Effective Care

Measure

Dimension: Effective

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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.	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / Oct 2019–Dec 2019 (Q3 2019/20)	87.59	88.00	We are setting our target at the previous level to allow time to improve data capture for those patients who receive no discharge meds, but for whom we must verify that the Medication Reconciliation was consciously considered. The introduction of COPE in late fall will ultimately provide improvement in the discharge BPMH completion rate as well as improvement in capture of all data.	

Change Ideas

Change Idea #1 Implement CPOE in late fall with a forced function requiring physicians to review and reconcile all home medications and in hospital medications to determine which medications are required on discharge

Methods	Process measures	Target for process measure	Comments
A report will be available in Meditech to allow comparison of number of patients discharged (excluding newborns and deceased patients) to the number of discharge prescriptions	Percent of discharge prescriptions found in the electronic record	25% of patients discharged to home, retirement homes or Long Term Care Homes or transferred to another hospital will have a discharge prescription in their electronic chart by 31 December 2020	There will be a learning curve for physicians to change their practice. Following the implementation of CPOE in late fall 2020, and the learning necessary to apply the new processes, we anticipate that by December 2020, at least 25% of discharge prescriptions will be found in the electronic record, and will ultimately target 100% over the next year.

Measure **Dimension:** Effective

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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.	P	Proportion / All patients	Local data collection / Most recent 6 month period	CB	CB	Until we are able to implement a screening tool to identify the patients who would benefit from a palliative care assessment, we are unable to specify the target. We must involve partner hospitals in the prioritization of the report in the electronic record.	Hopital Montfort, Bruyere Continuing Care Inc.

Change Ideas

Change Idea #1 Develop a report to identify patients who score positively with the Hospital Patient One Year Mortality Risk (HOMR) tool.

Methods	Process measures	Target for process measure	Comments
With an electronic collection of specific indicators for the HOMR screening tool, a report will be generated to list the patients who screen positive.	Number of patients who screen positively in the HOMR score	Baseline to be established once theme HOMR report is functioning in the electronic system	Our goal is to screen the number of patients who screen positive with the patients who are already being referred to palliative care.

Measure **Dimension:** Effective

Indicator #9	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percent of unscheduled repeat emergency visits following an emergency visit for a mental health condition.	P	% / ED patients	CIHI NACRS / April - June 2019	20.09	17.20	We have made great strides in decreasing the readmission rate to hospital over the past year, and we believe that we can replicate that success for return visits to the Emergency Room for this population. The target meets our readmission results.	

Change Ideas

Change Idea #1 Create a Discharge Plan (hard copy) to all patients consulted to the Crisis Intervention Services RN in ED and discharged.

Methods	Process measures	Target for process measure	Comments
To be tracked by CIS team in the month October 2020.	Percentage of patients receiving Discharge Plan.	95% of all patients seen by CIS RN will be given a completed Discharge Plan	This document will include supportative community resources, consults to Outpatient QCH services if appropriate, reminder to follow up with their GP. It would also include the coping strategies identified by the patient during their consult, to ensure continued and sustainable recovery.

Change Idea #2 Wellness Check Services offered to Consult Liaison patients.

Methods	Process measures	Target for process measure	Comments
CNS will track all completed forms given to a patient in the month of September 2020.	Percentage of all patients seen by the CNS	100% will be offered to receive a follow up phone call from Wellness Check Service by the Mental Health Crisis Line.	Patients being consulted to Psychiatry within the hospital, with the exception of ED, will be seen by the Mental Health Clinical Nurse Specialist (CNS) and offered a follow up Wellness Check Service by Mental Health Crisis Line. This will provide support follow discharge from the QCH. Patients will be called at home within a week of their discharge to see how they are doing.

Change Idea #3 Develop Inpatient Wellness Plan (hard copy) to give to all admitted MH patients upon discharge from the Inpatient unit.

Methods	Process measures	Target for process measure	Comments
To be tracked by chart audit in the month October 2020.	Number of patients receiving discharge tool.	70% of all patients admitted to the Inpatient unit for 72 hours or more will be given a completed Wellness Plan.	This document will include a Wellness Plan, follow up appointments either at the QCH or within the community. It would also include the coping strategies that the patient identified during their admission, to ensure continued and sustainable recovery. Patient would be encouraged to share with their family members and other support as needed. The Wellness Plan would be scanned into the patient chart and can be reviewed if patient does come back to our or Montfort's ED. Accountability will be achieved by adding task of completing Wellness Plan to Discharge Standard of Work and Checklist.

Measure

Dimension: Safe

Indicator #10	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.	M	Count / Worker	Local data collection / Jan - Dec 2019	193.00	183.00	Our target represents a 5% reduction on our previous performance.	

Change Ideas

Change Idea #1 Enhance RL system to enable a fulsome investigation of violent incidents and educate managers on incident investigation and mitigation strategies to decrease incidents of violence.

Methods	Process measures	Target for process measure	Comments
Reports collated from the incident reporting and a final report available in February 2021	Percent of incidents investigated and closed by managers	95% of violent incidents reported in 2020 will be investigated and closed within 30 days	FTE=1396 Incident investigations that lead to implementation of mitigation strategies will result in a decrease of violent incidents. Promoting a transparent process with fulsome review of all violent incidents is expected to lead staff to greater compliance with reporting of any incident.

Change Idea #2 Expand Non Violent Crisis Intervention training content to add additional high risk areas based on our risk assessments and enhance the focus on de-escalation strategies.

Methods	Process measures	Target for process measure	Comments
Number of staff trained compared to the number of staff employed in the high risk area. Data is collected in the HRIS system.	Percent completion of NVCI training for high risk areas	85% of ED, Mental Health, ALC and Med/Surg (C4)staff will be trained	Target is chosen as 100% may not be possible given that this is an in-class training and must be scheduled around other priorities in the organization such as Connected Care training.