2024/25 Quality Improvement Plan
"Improvement Targets and Initiatives"

AIM		Measure									Change			
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) O= Optional (do not select if you are not working on this indicator) C = Custom (add any other indicators you are working on)														
Access and Flow	**Efficient**	NEW Alternate level of care (ALC) throughput ratio	O	Ratio (No unit) / ALC patients The ALC throughput ratio is the number of discharged ALC cases divided by the number of new ALC cases.	WTIS / July 1 2023 - September 30, 2023 (Q2)	916*	n/a	1.00	Strategic Plan and required for HSAA		1. Continue to promote Headwaters2Home program 2. Continue to explore new partnerships through the OHT Integrated Care Advisory Committee	1. Promotion of home as destination from time of patient admission and through discharge planning meetings 2. Optimize Headwaters2 Home program	Daily reporting via Expanse - Daily Patient Report	1. OH has set target of no more than 5 ALC patients
	Timely	NEW 90th percentile ambulance offload time	O	Minutes / Patients	CIHI NACRS / ERNI hospitals: December 1st 2022 to November 30th 2023, in alignment with P4R indicators	916*	42 minutes at 90th percentile (Nov 2023)	40 minutes (5% improvement)	Provincial monitoring indicator	Total overall Central Region 90th percentile is 42 minutes	1. Continue Fit2Sit Program 2. Implement regional IT strategy to have Paramedic Report linked to Expanse 3.Implement measures to improve flow through ED, including rounding by inpatient MRP before 10 am to promote more timely discharges and admission orders	1. Optimizing patient flow - both inflow and outflow	Daily bed meeting review of admissions and discharges	Reduce offload time by 5%
Equity	**Equitable**	NEW Percentage of all staff (executive, leadership, and all staff) who have completed relevant equity, diversity, inclusion, and belonging education.	O	% / Staff	Local data collection / Most recent consecutive 12-month period	916*	n/a	100%			1. Develop new education module and embed into core Curriculum/Mandatory Training program	1. All staff (current and new hires) to complete the mandatory educaton module in Core 1 from April 1 to September 30.	Core Curriculum quarterly report	100% completion at end of Core 1 education module
Experience	**Patient-centred**	Percentage of respondents who responded “completely and almost always” 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?	O	% / Survey respondents	Qualtrics Patient Survey	916*	77%	75%		OHA, Qualtrics Working Groups	1. Review registration process to ensure it includes capture of patient email address as first step in process. 2. Develop/review current state for discharge package and education in each clinical area. 3. Engage Patient & Family advisors in organizational and department-based committees.	1. Optimization of Qualtrics across the organization, ensuring reasonable response rate for each survey population 2. Map current state of discharge process and associated patient information for each clinical area. 3. NEW: Recruit Patient & Family Advisors for department-based committees.	1. Number of survey responses received 2. Number of discharge process maps completed 3. Number of departments with PFA as part of the team	1. Determine response rate with new survey tool 2. Process Maps completed for all in-patient departments 3. 80% of patient and family advisors are actively participating in Quality and Practice Councils at department level.
Safety	**Effective**	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.	O	% / Discharged patients	Local data collection / Most recent consecutive 12-month period	916*	93%	90%			1 Track and optimize the number of patients who have a best possible medication history completed at time of admission. 2. Provide education to all interprofessional team members on role, process and accountabilities related to medication reconcilation at discharge. 3. Monthly audit of compliance with Discharge Medication reconciliation for qualifiying inpatients.	1. Monthly review of unit/program performance with focus on areas with lowest compliance. 2. Role specific education material created (or updated), including educational sessions if required	1. Educational materials/sessions completed and distributed 2. Report automated to appropriate leaders on a monthly basis from regional team	Monthly report automated and sent to CLT for review
	Safe	NEW Rate of falls with a harm level of moderate and higher	C	Rate: number of falls with moderate+ harm/total number of falls	Meditech SQIS Reports	916*	n/a	2%		Patient Safety Company, Regional EMR Partnership	1. Falls rates updated monthly on every Quality and Safety huddle board 2. Falls assessment completion rate reports sent weekly to program leaders.	1. Obtain additional chair alarms, mechanical lifts, and patient transfer devices.	1.Department specific report built and distributed monthly	1. Creation, distribution and posting of report on Quality and Safety Huddle boards
	Safe	MODIFIED Two Patient Identifiers	C	BMV Rate	Meditech	916*	74%	75% - increase over 23-24 from 50%	EMRAM 6 requirement and benchmark set by CARE - 4	Regional EMR Partnership	1. Ensure adequate equipment in each area 2. Program specific metrics reviewed at daily Quality and Safety huddles 3. Focus of work 2024-25: Emergency Department	1. Complete inventory of device requirements by department 2. BMV rates by department posted on Quality and Safety Huddle Board	1. Inventory completed and required devices ordered/deployed 2. Report by department created and sent out monthly	1. Inventory complete and required equipment deployed by end of Q1 2. Monthly reports complete for each department by end of Q1
	Safe	Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.	C	Count / Worker	Local data collection	916*	9	Monitor Only			1. Continue additional Management of Aggressive Behavior (MOAB) education. 2. Continued education on de-escalation practices. 3. Joint Health and Safety Committee (JHSC) to continue to review incidents for recommendations and action.	1. Number of staff who complete MOAB training 2. Develop action plans based on recommendations following incidents, inspections and risk assessment reviews at monthly JHSC meetings	1. Four sessions per calendar year 2. % of actions completed	1. Successful completion of all session by end of Q4. 2. 70% of recommended actions completed.
	Timely	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.	C	% of discharged patients	Hospital collected data/CIHI NACRS	916*	71%	75%		Regional EMR Partnership	1. Assess current state for discharge summary process and procedure. 2. Ensure physician engagement in any workflow. 3.	1. Review current documentation requirements and criteria. 2. Provide any necessary training, education for physicians regarding timelines for completion.	Discharge Summary Reporting Monthly	75% completion of summaries in the 48 hours

***Please note: Hand Hygiene Removed**