Theme I: Timely and Efficient Transitions

Measure

Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Alternate Level of Care (ALC) rate	C	Rate / All patients	CIHI DAD / 2022	18.86	18.00	We selected 18.00 as this is the target set in 2022/2023 and while progress has been made, we have not yet reached it.	Home and Community Care, HPE OHT

Change Ideas

Change Idea #1 Maximize enrollment in the Quinte@Home program which launched in February 2022.

Methods	Process measures	Target for process measure	Comments
Regular attendance of the Quinte@Home coordinator at bedscrum and bullet rounds to identify appropriate referrals. Referral process led and managed by the Quinte@Home Coordinator to ensure consistency and central visibility of activity.	Number of patients enrolled in the Quinte@Home program.	80 patients will be enrolled by the end of Q4.	

Change Idea #2 Leverage the ED diversion teams to maximize number of ED diversions.

Methods	Process measures	Target for process measure	Comments
Partner with Alzheimer's support resource in the ED, expand the service hours of existing ED diversion team, enhanced collaboration with early mobility team.	Number of ED diversions (all four hospitals) each month.	60 ED diversions a month by the end of Q4.	

Change Idea #3 Maximize use of beds at the Quinte Gardens Transitional Care Unit.

Methods	Process measures	Target for process measure	Comments
Regular review at bedscrum of existing referrals for ongoing appropriateness and transition planning. Implementation of NP-MRP model of care at Quinte Gardens. Clarify eligibility criteria and refine referral process to minimize delays in acceptance.	Percentage of beds occupied each quarter.	90% of Quinte Gardens beds filled with appropriate patients.	

Measure Dimension: Timely

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Emergency Department as a First Contact for a Mental Health or Addictions Condition	C	% / ED patients	See Tech Specs / October 2021 -September 2022	32.40	31.00	Target to reflect Hastings Prince Edward OHT target as this is a cQIP indicator.	HPE OHT

Change Ideas

Change Idea #1 Increase awareness of the access options for Quinte Health's Crisis Intervention Centre.

Methods	Process measures	Target for process measure	Comments
Creation of an awareness campaign. Exploration of potential metrics to evaluate success of campaign.	Completion of an awareness campaign with timeline.	Awareness campaign will be created by the end of Q1.	

Change Idea #2 Work with the HPE OHT to identify how Quinte Health can support AccessMHA implementation in the southeast region.

Methods	Process measures	Target for process measure	Comments
Attendance at OHT planning tables, review of current Quinte Health services to understand how they may support implementation, provide support as required to OHT as planning evolves.	Participation of Quinte Health staff on HPE OHT work teams linked with this cQIP indicator.	Participation of Quinte Health staff on 100% of HPE OHT work teams associated with this indicator.	

Theme II: Service Excellence

Measure

Dimension: Patient-centred

Indicator #3	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 consecutive 12-month period	CB	57.10	Same target as previous years which we have not yet been able to meet and also reflects a target at or above Ontario IP Community Hospital average.	

Change Ideas

Change Idea #1 Review and revision of existing PODS with input from a Patient Leader.

Methods	Process measures	Target for process measure	Comments
Systematic review led by professional practice of each PODS for currency and accuracy. Stakeholders will include a minimum of one Patient Leader, physicians, nursing and allied health and community partners where appropriate.	Percentage of PODS revised.	100% of existing PODS revised by the end of Q2	

Change Idea #2 Implementation of patient experience surveying using new vendor.

Methods	Process measures	Target for process measure	Comments
We do not have patient satisfaction data for the entire 22/23 fiscal year and the methods for obtaining feedback have changed. Creation of processes and tools to ensure surveying methodologies are possible will be a focus in Q1 followed by examination of the data and identification of additional improvement opportunities.	Surveying with new vendor implemented with dashboard results available to leaders.	Leaders will have access to, and be trained on use of, patient experience dashboards by the end of Q1.	

Change Idea #3 Implementation of leader rounding that is focused on patient's perception of discharge readiness.

Methods	Process measures	Target for process measure	Comments
Managers will use predicted date of discharge to identify those patients with anticipated discharge in the following 48 -72 hours. Managers will round on those patients to discuss discharge readiness and identify any concerns/information needs they may have and relay to the care team. Development of standard questions to guide the discussion will be developed.	Implementation of leader discharge rounding.	Leader discharge rounding will be implemented on one med/surg unit by the end of Q1.	

Theme III: Safe and Effective Care

Measure

Dimension: Effective

Indicator #4	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–Dec 2022 (Q3 2022/23)	CB	CB	This metric was chosen as an areas of focus as Quinte Health would like to identify and implement a reliable and sustainable medication reconciliation method for discharging patients with a BPMH that is portable on transitions through the care pathway.	

Change Ideas

Change Idea #1 Develop a process for reliably monitoring medication reconciliation at discharge completion.

Methods	Process measures	Target for process measure	Comments
Work with health records to capture completed medication reconciliation completion upon review of discharge charts. Data to be collected by service monthly and shared through the ROP report card, Program Advisory Quality agendas, Pharmacy and Therapeutics and MAC.	Baseline data is available by service.	Baseline data is available by the end of Q1.	

Change Idea #2 Increase completion of timely medication reconciliation at admission.

Methods	Process measures	Target for process measure	Comments
Explore ability to complete BPMH in the ED, prior to completion of admission orders. Focused attention on current completion rates within 48 hours of admission and identification of barriers to meeting the target.	Percentage of medication reconciliations completed within 48 hours of admission.	80% of patients have a medication reconciliation completed within 48 hours of admission.	

Measure

Dimension: Safe

Indicator #5	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.	P	Count / Worker	Local data collection / Jan 2022–Dec 2022	82.00	75.00	The focus of our activity will be reduction of WPV events that result in harm and thus expect to see a decline in overall number of events. We have selected a modest target as this metric is heavily influenced by the reporting culture.	

Change Ideas

Change Idea #1 Initial Violence Risk Assessments completed by Occupational Safety.

Methods	Process measures	Target for process measure	Comments
Using our new violence risk assessment tool, occupational safety will lead the completion of an initial assessment in every department. Teams will use this assessment to identify mitigation strategies and ensure an informed workforce.	Percentage of departments with a completed initial workplace violence assessment.	100% of departments will have completed assessment by the end of Q1.	FTE=1077

Change Idea #2 Annual review of workplace violence risk assessment by the team to ensure ongoing accuracy and relevance.

Methods	Process measures	Target for process measure	Comments
Managers of departments will review the initial assessment completed by Occupational Safety with their teams to ensure accuracy and make any necessary changes. This will be submitted to Occupational safety and completion of this on an annual basis will be tracked through Occupational Safety.	Percentage of departments that have completed a review of their workplace violence risk assessment.	100% of departments will have reviewed their initial workplace violence risk assessment and submitted to Occupational Safety by the end of Q4.	

Measure

Dimension: Safe

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of admitted patients with one or more hospital acquired pressure injuries.	C	% / All inpatients	In house data collection / IPUP results from March 2022	13.50	10.00	This represents a 25% reduction in hospital acquired pressure injuries and is close to the Ontario benchmark of 9.8%.	

Change Ideas

Change Idea #1 Complete quarterly PI prevalence audits on med/surg inpatient units to increase awareness and timeliness of data.

Methods	Process measures	Target for process measure	Comments
Professional Practice and the Wound Care nurse will work with the leadership on six med/surg units to conduct regular PI prevalence audits and data will be shared with the team for discussion and identification of unit level improvement opportunities.	PI prevalence audit completed each quarter.	100% of identified units will have at least one PI prevalence audit completed each quarter.	

Change Idea #2 Review of documentation practices in order to identify opportunities to improve timeliness and accuracy of PI documentation.

Methods	Process measures	Target for process measure	Comments
During quarterly PI prevalence audits documentation will be reviewed and trends/patterns identified. Information will be shared with the team so that improvement opportunities can be generated and monitored for impact.	Completion of documentation audits on selected units each quarter.	100% of selected unit managers will receive the results of their teams documentation audit.	

Change Idea #3 Creation of a tailored wound and PI prevention education plan for each unit.

Methods	Process measures	Target for process measure	Comments
Survey staff to understand knowledge and skill gaps related to pressure injury prevention and wound care. Use the survey data, PI prevalence audit data, and focus group discussions to create and deliver an education plan tailored to each units unique needs.	Create and deliver tailored unit specific education plan.	Create and deliver a tailored unit education plan to three units by the end of the fiscal year.	