Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 7, 2024

SFMH
ST. FRANCIS MEMORIAL HOSPITAL

Ontario Health

OVERVIEW

St. Francis Memorial Hospital (SFMH) is a small rural hospital located in Barry's Bay, Ontario, about three hours west of Ottawa. It serves a catchment area including the townships of South Algonquin, Madawaska Valley, Killaloe Hagarty & Richards, and the area of Hastings Highlands and Bonnechere Valley. The hospital also has a unique partnership within the Madawaska Communities Circle of Health (MCCH) to enhance partnerships and relationships with community-based partners. The MCCH, which includes hospital, long-term care, hospice, community health and support services, Home and Community Care Support Services (HCCSS), addictions treatment services, paramedic services, as well as many other health organizations, holds a collaborative mandate to enhance and support health of all residents in the Madawaska Valley. To date the MCCH is represented by more than 20 agencies including Algonquins of Pikwakanagan Family Health Team & community and home support services. MCCH also has patient and family representatives.

In 2021, SFMH embarked on a journey to refresh the strategic direction for the organization. Our mission "to provide high-quality, patient centred healthcare in collaboration with our partners" and our vision "to be a leader in health services that are patient centered, integrated and responsive to rural community needs" align with our Quality Improvement Plan (QIP) journey. We have been engaged in the development of a yearly quality improvement plan for many years and will continue our journey with the focus on success of the new strategic plan for the organization. The mission, vision, values, and strategic direction provide the direction for the delivery of quality health services. The Quality Improvement Plan is aligned with the hospital's four key strategic directions, with an

emphasis on the provision of quality health care services:

Quality of Care:
We are committed to improving the patient and family experience by:
- Working to successfully complete the Emergency Redevelopment project.
- Meeting the targeted objectives on all patient services and patient safety.
- Integrating patient and family experience into planning and decision making.
- Emphasizing performance measurement and reporting, while focusing on patient safety, timeliness, quality and transparency.
- Providing access to care without barriers.

Strength in People:
We are committed to recruiting, developing and retaining qualified staff by:
- Improving recruitment plan ensuring inclusivity.
- Ensuring a healthy and safe workplace.
- Demonstrating and supporting Just Culture, innovation, learning and Continuous Quality Improvement.
- Improving staff engagement.

System Integration:
We are committed to improving our partnerships to increase effective, seamless patient centered care by:
- Demonstrating Ontario Health Team leadership.
- Ensuring a patient centered approach.
- Investing in technological systems to further our Vision.

Financial Performance:
We are committed to maintaining sustainable financial stability by:
- Leading as a resource-conscious health provider.
- Continuing to actively seek improvement through efficiency and sustainability.

The Quality Improvement Plan (QIP) is based on priorities identified by the Continuous Quality Improvement Committee (CQI) of the Board, Senior Management Team and sub-committees. The QIP is a tool to affirm and map the commitment of the Board of Directors and all staff in the continuous pursuit of positive clinical outcomes, positive patient experiences and positive staff work life. The plan is aligned with accreditation standards and recommendations. The balanced scorecard approach ensures key improvement initiatives in the areas of safety, effectiveness, access to care integration and patient-centered care are being tracked/monitored.

CQI is a method that evaluates and continuously improves the caliber of care and service delivered from a patient perspective. CQI embraces quality by focusing on continuous process improvement, teamwork and staff/patient empowerment.

Each member of the Senior Administration team will work with their departments to develop/define improvement targets and initiatives to align with the strategic priorities. The mode for improvement used to effectively analyze and implement change will be the “Plan, Do, Study, Act” (PDSA) model.

The 2024/2025 aims and measures can be viewed in the attached detailed work plan. Targets and benchmarks along with change

ideas are clearly identified within the workplan.

ACCESS AND FLOW

SFMH plays an active role in the OVOHT and within this structure, SFMH is a lead in patient navigation. SFMH administration also meets regularly within the local Renfrew County area Healthcare partners including: HCC, RH (Champlain Gardens), LTC (Valley Manor), Hospice (MVHPC), Community Paramedics, Barry's Bay and Area Home Support, Madawaska Valley Association for Community Living (MVACL), and Madonna House Nursing etc. Problem solving occurs at the local level and SFMH Chief Nursing Executive attends and shares at the Regional Acute Care & Patient Flow Tables. Many OVOHT working groups exist to support navigation and access to care. We have shared cQIP initiatives targeting frail elderly patients and mental health and addictions.

cQIP includes:
- ALC Days (supported by warm transfer objectives)
- ER visits as first point of contact for mental health and addictions related care.
- New pathways supporting right care at the right time.
- Digital tools for unattached patients (use of VTAC).

SFMH is also monitoring many internal quality indicators related to patient flow such as time to inpatient bed and time to physician initial assessment, as well as waitlist monitoring and triaging of referrals for outpatient services. SFMH participates in the OH ALC Best Practices work to reduce and prevent ALC in the hospital.

EQUITY AND INDIGENOUS HEALTH

Health equity refers to the study of causes of differences in the quality of health and healthcare across different populations. SFMH embraces the opportunity to ensure quality of healthcare across different populations.

In August 2018 SFMH began working with the regional Indigenous Diabetes Navigator. Some SFMH staff on the front line participated in a two-part Indigenous Perspectives on Harm Reduction course in January 2018. Additionally, all staff were invited to take part in an Indigenous Culture training education session to increase awareness. In September 2023 the SFMH management team participated in a Kairos Blanket Ceremony at Pikwakangan First Nations. The Kairos Blanket Exercise is an experiential workshop that explore the nation-to-nation relationship between Indigenous and non-Indigenous peoples in Canada. Blankets are arranged on the floor and represent land and participants are invited to step into the roles of the First Nations, Inuit and later Metis peoples.

The main quality improvement initiative for 2024/2025 is to support St. Francis Memorial Hospital's role in the Ottawa Valley Ontario Health Team. Initiatives and work will target two populations: those with mental health and addictions and the elderly specifically (ALC). Access, quality and patient flow are important pieces for this work.

SFMH participates in the IDEA committee which meets regularly. This committee helps the local MCCH strive for a diverse and inclusive culture where staff, patients and the community feel welcome, respected, safe and valued in our environment. The focus of the committee is to support the experience of the following:
- Our people (including all our staff, physicians, volunteers and

learners) – ensuring that they are comfortable contributing their unique skills and talents to deliver measurable results.
- Our patients (including their families and care partners) – ensuring that they are comfortable in their care experience and receiving the highest possible quality of care.
- Our population that we serve – ensuring that they see our organization as a safe place to access care and address their health needs.

Some initiatives at SFMH to improve inclusion, diversity, equity and accessibility are:

- Establishment of an IDEA committee. We have a PFAC member embedded on this committee.
- SFMH participates on the Regional IDEA committee.
- SFMH continues to recruit and engage employees to increase awareness and expand the committee participation and reach.
- In each weekly communique, we highlight notable days of all cultures for staff to learn more about.
- Posters are created throughout the year to raise awareness on notable dates of all cultures.
- Actively participating in Regional Initiatives.
- SFMH is committed to providing an inclusive, barrier-free work environment. If an applicant on a job posting requires accommodations during any phase of the recruitment process, they can connect with Human Resources.

The IDEA committee also provides a cultural event calendar in our weekly communique and recognizes events throughout the year, such as Black History Month and the National Day for Truth and Reconciliation. In addition to training on accessibility for staff, and training on pronouns and gender diversity, SFMH also provides indigenous cultural safety training, and provides safe spaces for smudging and culturally important practices. Patients are also able to self-identify in their My Chart their own gender and pronoun preferences and can change this on their own.

SFMH has access to the census data of the broader community and reviewing this against our organizations personal demographics, where available, to see if they reflect this of the broader community. SFMH also actively participates on a number of regional hospital and healthcare IDEA committees to share best practices.

PATIENT/CLIENT/RESIDENT EXPERIENCE

The Patient and Family Advisory Council was established at SFMH in fall of 2015. The terms of reference/reporting structure for the Hospital was developed in 2015 and the first Patient and Family Advisory Council (PFAC) meeting was held in January 2016. The PFAC continues to meet regularly and members provide recommendations on improving the planning, delivery and evaluation of care services at SFMH. Members insights, recommendations and advice help to inform programs and practices aimed at improving the patient experience and advancing person-centered care. PFAC representatives participate on the following sub-committees: Care Team, Quality Risk and Safety, Infection Prevention & Control and the Inclusion, Diversity, Equity and Accessibility (IDEA) Committee.

In 2021, the Patient and Family Advisory Council Terms of Reference were updated to include partnership with Madawaska Valley Hospice Palliative Care (MVHPC) and Barry's Bay and Area Home Support (BBAHS). SFMH has a very strong relationship with

these partners.

In June 2019, SFMH, along with several other organizations forming part of an Alliance, implemented a new Electronic Health Record (EHR). PFAC members have been actively engaged in many change processes/activities and have made recommendations regarding communications for My Chart, which is patients' ability to view their own health records. SFMH is now able to respond to real time data and increased patient safety through the use of EHR which includes point of care (POC) bar code scanner for two client identifiers. The Patient & Family Advisory Council advises the hospital on matters pertaining to the patient experience as one example of their role. The PFAC has been involved with a number of change initiatives implemented in 2023 such as revising the SFMH Patients, Family and Caregivers Rights and Responsibilities, reviewing patient education handouts, and helping to optimize “My Chart”. We will continue to engage and involve the group in the 2024/2025 year.

SFMH uses a variety of other approaches to engage patients, families and caregivers such as:
- Nurses make post discharge phone calls to patients who are 65 and older, after discharge, to get feedback on the care they received at SFMH. The information is tracked, trended and is reported back to Board Continuous Quality Improvement (CQI) and the Quality, Risk and Safety (QRS) Committee.
- Inpatient and program specific outpatient surveys are also utilized. These surveys questions are reviewed regularly at Care Team and PFAC for feedback.

SFMH will continue to meet all standards relating to patient and family centered care and have seen significant benefits with the implementation of the Electronic Health Record in 2019. We now have timely access to information, smooth transitions of care and improved patient safety. SFMH continues to improve usage of these tools and data from our electronic health record.

SFMH’s Patient and Family Advisory Council is an active participant in developing the QIP. They also review and provide feedback on our draft QIP Plans. PFAC endorses our QIP annually.

PROVIDER EXPERIENCE

The Quality Improvement Plan for 2024/2025 continues to focus on initiatives that will engage all clinicians, leadership and staff at our organization. Our hospital values promote leadership and innovation by all our staff in the development of programs and services.

SFMH values working closely with our partners and strives to meet the needs of all that we serve. In 2024-2025, we will continue to focus on mental health and wellness education for the leadership team and all employees. The IDEA committee will help with this work.

SFMH continually offers mental health supports that are available through our region and the Employee Assistance Program (EAP) in our weekly communiques. Staff meetings are held regularly for team members to engage and provide feedback.

In October 2021, The Province of Ontario announced the approval of this OHT which is made up of health and social service providers in most townships and municipalities in Renfrew County as well as South Algonquin Township. This new OHT for our area will result in

a regional coordinated health care approach that will connect family physicians/nurse practitioners and their patients more effectively with hospitals, paramedics, long-term care, mental health services, community health centers and other parts of the health care sector. In February 2022, the Ottawa Valley Ontario Health Team (OVOHT) was formed. Since the approval in October 2021, 50 agencies and organizations have officially signed on to be part of the OVOHT, including SFMH.

The initial focus of the Ottawa Valley Ontario Health Team will be on frail seniors and those struggling with mental health and addictions as well as helping residents connect with family doctors and primary care teams. Within the QIP you will note custom, collaborative initiatives directed at these two population groups (targets are OVOHT specific, not agency specific).

The catchment area covered by this newly announced OVOHT includes a broad and diverse set of communities in and around the Ottawa Valley. The area stretches from Renfrew to Deep River, and includes the communities of Calabogie, Barry's Bay, Eganville, Cobden, Pembroke, and Petawawa, as well as those along Highway 60 to South Algonquin Township. The area covers approximately 7,600 square kilometers and 80,000 residents.
There are several working groups/committees that help review/attain the goals of the OVOHT such as the Steering committee, Governance, Finance & Sustainability, Quality Improvement Support, Education, Communications, Digital Health, Data Analysis, Measures & Metrics and Patient, Family and Caregiver Network.

SFMH also has an active Employee Wellness committee, collects provider feedback via surveys, actions items as readily as possible and strives to be an employer of choice. Physician recruitment and other staff recruitment remains high priority for the senior leadership team and the Board.

SAFETY

The Quality Improvement Plan for 2024/2025 continues to focus on patient safety. SFMH is committed to providing an atmosphere of quality healthcare and safety for our patients and our staff. The Hospital has implemented many patient safety initiatives and continually looks for new opportunities for improvement.

Patient Safety is a priority at St. Francis Memorial Hospital. It is one of the quadrants that make up our Quality Framework.
- Access
- Appropriate (effective and efficient)
- Safety
- Satisfaction

SFMH strives to create a Patient Safety Culture that features:
- Acknowledgement of the high risk and error-prone nature of health care activities.
- A blame free environment where individuals are able to report errors and close calls without fear of reprimand or punishment.
- An expectation of collaboration to seek solutions and create action plans.
- A willingness on the part of the organization to divert resources for addressing safety concerns.

SFMH has robust policies on incident and near miss reporting. It is the responsibility of each staff member who has knowledge of an

adverse event, critical incident, unsafe condition or near miss (including medication and equipment errors) to report them in a timely manner and through the appropriate channels in order to provide an opportunity for early recognition, mitigation of negative patient outcomes and prevent risk of reoccurrence.

All patient related incidents are reported through the Patient Safety Company Risk Incident Management System (RIMS). Description of the event, interventions, expected outcomes and follow up that may be required and any disclosure that occurred is documented in this system. The applicable department manager receives the report for further review/investigation which is then forwarded to the Chief Operating Officer (COO) and Vice President of Patient Care/CNE for further investigation / recommendations using the Quality-of-Care review form for documentation purposes.

SFMH follows a Just Culture philosophy. This emphasizes implementing evidence-based practices, learning from error and providing constructive feedback rather than blame and punishment. Disclosure does not imply assignment or acceptance of fault. Reporting an incident is an important part of professional accountability and leadership is tasked to support patients, families, physicians and staff to understand what contributed to the incident, identify action to prevent recurrence, share lessons learned (education) and to reduce harm. Conversations with patients, families, physicians and other care team members are critical to the process. A summary of all incident reports and recommendations are brought to the Board CQI Committee, Medical Advisory Committee (MAC) and Management Team on a quarterly basis.

Staff also complete education related to patient safety as part of their learning requirements. SFMH organizes an annual skills fair day for clinical staff members to focus on areas that require further education/skill in order to keep patients safe. SFMH also offers training for staff from external partners (i.e., Gentle Persuasion Approaches, Advanced Cardiovascular Life Support [ACLS}, equipment training etc.), virtual training opportunities, and annual Surge Learning (learning management system) modules to complete.

In addition, we also collate and analyze fall and medication errors and present them in an Ensuring Safety for Patients (ESP) poster for staff to review. This summary captures the number of incidents, risk level, follow-up/actions and ways to improve patient safety for the upcoming quarter. These are posted on departmental quality bulletin boards and reviewed during huddles.

In 2023 SFMH partnered with TOH to have access to Virtual Critical Care (VCC) 24/7 which has prevented transfers to tertiary care. Additionally, other ER MD’s have access to a peer-to-peer program.

SFMH has prepared and submitted an application to the Registered Nurses' of Ontario Association (RNAO) to become a Best Practice Spotlight Organization (BPSO). This work included review/identification of Best Practice Guidelines (BPGs), staff education and identification of Best Practice Champions. As of February 2024, SFMH has been notified of a successful application to be designated as a Best Practice Spotlight Organization and work will commence to implement SFMH specific Best Practice Guidelines.

SFMH achieved Accredited with Exemplary Standing in 2021 with

Accreditation Canada. This is the highest designation that an organization can achieve. Work continues to ensure patient safety through compliance with the Required Organizational Practices (ROP) put in place by Accreditation Canada. SFMH also participates in regular Ontario College of Pharmacists evaluations. SFMH performs well meeting these critical patient and provider safety standards.

POPULATION HEALTH APPROACH

Through the Ottawa Valley Ontario Health Team, extensive data on the population of the OHT was collected and shared with members to better inform organizations on key metrics relating to population health to help understand the (changing) nature of the population we serve. Themes included: Age, Gender, sexual orientation, Marital status, Employment, Education, Income, Indigenous, Francophone, other languages, Newcomers to Canada, Visible minorities, Religion (e.g., Mennonite), military families, People with disabilities, People with MH/SU conditions. This information focused on trends, not comparisons to other places. Most data was for Renfrew County and District Health Unit geography but some was for smaller sub-areas.
This initiative will work to enhance and harmonize collection of patient/client demographics to support equitable care and planning, equity analysis using available health service data (e.g., by gender, age, neighborhood income).

The population health data available through the OVOHT and supported by analytics continues to drive new and innovative care pathways based on best practices to better serve our aging population targeting the most common chronic conditions, reducing unnecessary ER visits and improving overall health. Renfrew County Public Health and Public Health Ontario are essential partners in this work in addition to the many primary care service providers and external services/HC partners.

EXECUTIVE COMPENSATION

Two percent of compensation for executives (defined as Chief Executive Officer, Chief Operating Officer, Chief of Staff, VP Patient Care Services/Chief Nursing Executive, VP Corporate Services and VP Financial Services) is linked to three of the five following indicators:

- 90th percentile for ambulance off load time
- % of patients discharged from hospital where AVS was shared with primary care provider.
- Number of workplace violence incidents

The Senior Executive team will be responsible for ensuring success in the three key indicators. Refer to the QIP Workplan for specific performance targets for 2024/2025.

As per the above statement, two percent of executive compensation will be associated with three of five QIP indicators within the SFMH plan.

Indicator data will be reviewed at the CQI Committee quarterly, with regular feedback to the Finance Committee and the Hospital Board of Directors to ensure targets are met.

CONTACT INFORMATION/DESIGNATED LEAD

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OTHER

SFMH will continue in the EHR project and will work towards achieving HIMSS level 7. We are currently at HIMSS level 6 in the Atlas Alliance, which is excellent and ahead of many other hospitals in the province/country. In 2024/2025 we will continue to utilize real time data and dashboards during meetings.

Physician recruitment is ongoing at SFMH. There is an identified need for physicians in our community as we experience tremendous Health Human Resource (HHR) pressures. Attracting and retaining HHR talent is a major priority for both physicians, nursing, and allied health groups.

SIGN-OFF

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan on

_____

Board Chair

Board Quality Committee Chair

Chief Executive Officer

Other leadership as appropriate

Access and Flow | Efficient | Custom Indicator

Indicator #3

Number of individuals for whom the emergency department was the first point of contact for mental health and addictions care per 100 population aged 0-105 years with an incident MHA-related ED visits. (St. Francis Memorial Hospital)

Last Year		This Year	
44.76	**20**	**24**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Increase the knowledge of external service delivery partners for MH and Addictions

Process measure

- Number of ER RNs and MDs trained to support MH-A patients

Target for process measure

- 1-2 ER RNs will be trained each month

Lessons Learned

Addition of Health 811 is important

Access and Flow | Timely | Custom Indicator

	Last Year		This Year	
Indicator #1 Inpatient % ALC Days (St. Francis Memorial Hospital)	**12.90** **Performance (2023/24)**	**17.10** **Target (2023/24)**	**30** **Performance (2024/25)**	**NA** **Target (2024/25)**

Change Idea #1 ☐ Implemented ☑ Not Implemented

Home First Philosophy sustained-Joint Discharge Rounds will ensure all options are considered in advance of any decisions to awaiting LTC Introduction of a n NP will support reduction of ALC through participation in joint discharge rounds

Process measure

- Inpatient Pulse Dashboard will be monitored

Target for process measure

- Realtime data used to support decision making; right patient, right bed

Lessons Learned

NP was required in a more focused way in ER
Still planning to implement in future

Equity | Equitable | Custom Indicator

Indicator #5

Percentage of internal staff of RV and SFMH that have participated in DEI training (St. Francis Memorial Hospital)

Last Year		This Year	
CB	**CB**	**17**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Leadership Team will support IDEA committee objectives and increase knowledge of EDI framework

Process measure

- Percentage of employees trained

Target for process measure

- collecting baseline

Lessons Learned

17% which is 25/146 staff between Rainbow Valley and SFMH

Experience | Patient-centred | Priority Indicator

Indicator #6

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? (St. Francis Memorial Hospital)

Last Year		This Year	
40	**50**	**75**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Increase compliance with use of After Visit Summaries (AVS) for patients presenting to the ER lead by the Nurse Practitioner (NP)

Process measure

- Monitor data and review/develop strategies at the departmental meeting level

Target for process measure

- 100% of patients over the age of 65 will receive an AVS as they leave ER

Lessons Learned

AVS usage has improved and we see this in the comments sections of the surveys

Change Idea #2 ☑ Implemented ☐ Not Implemented

Increase electronic availability of education materials (Smart phrases in EPIC/EHR)

Process measure

- Increase compliance with AVS by MDs and Nursing Staff regardless of patient age

Target for process measure

- 75% of ER patients and 100% of IP will receive AVS

Lessons Learned

Increased compliance

Safety | Effective | Priority Indicator

Indicator #2

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. (St. Francis Memorial Hospital)

Last Year		This Year	
72	**100**	**NA**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Improve performance related to bedside discharge teaching including review of medications at discharge

Process measure

- # of surveys indicating "yes" I received enough information

Target for process measure

- 70% for first quarter

Lessons Learned

93.4%

Continue to strive to improve medication teaching at the bedside throughout the admission and not all at once upon discharge

Safety | Safe | Priority Indicator

	Last Year		This Year	
Indicator #4	**5**	**4**	**12**	**NA**
Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period. (St. Francis Memorial Hospital)	**Performance (2023/24)**	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Leadership will continue to foster a Just Culture, provide education, and respond readily to staff concerns in collaboration with the Occupational Health & Safety Committee.

Process measure

- Continue education and audits providing data to OHS and QRS/CQI All reported workplace violence incidents will be reviewed to identify further areas for improvement

Target for process measure

- Data will be reviewed and recorded/shared with committees and education will be delivered

Lessons Learned

Majority of incidents (9/12) were related to aggression in a single patient with dementia; Gentle Persuasive Approaches training occurred last quarter and we also held Crisis Prevention and Intervention Training

Access and Flow

Measure - Dimension: Efficient

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Alternate level of care (ALC) throughput ratio	O	Ratio (No unit) / ALC patients	WTIS / July 1 2023 - September 30, 2023 (Q2)	X	1.75	variability of capacity in other sectors to care for clients needing 24 hour care	

Change Ideas

Change Idea #1 Home First Philosophy Sustained; Joint Discharge Rounds will ensure all options are reviewed before deeming a patient ALC

Methods	Process measures	Target for process measure	Comments
Discharge planning will continue to begin on admission and all decisions will be made with patient and family involvement ensuring an understanding of right care, right place	Executive Dashboards will be reviewed regularly, and ALC data will be monitored, including utilization of acute beds. Joint discharge rounds will occur 2X/a week.	JDR has an escalation process which includes the Chief of Staff, COO and CNE	Capacity in other sectors is a variable out of our control; HHR challenges persist everywhere, especially in the home care setting.

Measure - Dimension: Timely

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile ambulance offload time	O	Minutes / Patients	CIHI NACRS / ERNI hospitals: December 1st 2022 to November 30th 2023. Non-ERNI hospitals: April 1st 2023 to September 30th 2023 (Q1 and Q2)	26.00	25.00	This is a new indicator for SFMH and during the summer months or when we are over occupancy due to capacity and resource issues in other sectors we see variability in off load times; we will monitor	

Change Ideas

Change Idea #1 SFMH will continue to monitor and improve the time from decision to admit to inpatient bed and monitor utilization and TAT of lab and x-ray to positively impact on flow in the ER

Methods	Process measures	Target for process measure	Comments
Ensuring all inpatient discharges occur before 10 AM to create capacity for ER admits	The Inpatient Team continues to monitor this performance on dashboards and implement strategies for improvement	Real-time data used for decision-making and presented to Care Team; charge nurses will ensure MDs prioritize the discharges when rounding.	

Measure - Dimension: Timely

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percent of patients who visited the ED and left without being seen by a physician	O	% / ED patients	CIHI NACRS / April 1st 2023 to September 30th 2023 (Q1 and Q2)	2.80	5.00	It is unclear what further impact of lack of PCP may be; Also the impact of VTAC on ER avoidance;	

Change Ideas

Change Idea #1 Addition of and NP in the ER on a PT basis has helped improve wait times and patient flow

Methods	Process measures	Target for process measure	Comments
NP works 7.7 or 11.25 hours assisting during peek volume times	SFMH continues to collaborate with OVOHT partners and share ER alternatives such as RCVTAC	Real-time data will be reviewed and shared with partners	A Lack of PC options for non-urgent problems continues to impact on the ER

Equity

Measure - Dimension: Equitable

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	O	% / Staff	Local data collection / Most recent consecutive 12-month period	17.24	15.00	The SFMH IDEA (Inclusion, Diversity, Equity, and Accessibility) Committee is relatively new but a robust work plan is in development in conjunction with other hospitals in the Region and through an OVOHT working group	

Change Ideas

Change Idea #1 The IDEA committee meets regularly and bi-weekly newsletters reflect important dates and historical events

Methods	Process measures	Target for process measure	Comments
Last year 100% of the leadership team completed training and this year the committee intends to offer education to the front line staff	Completion rates of education will be reviewed at internal committees	Continue to expand this training across the organization	in 2023 SFMH Leadership participated in a blanket ceremony

Experience

Measure - Dimension: Patient-centred

Indicator #4	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?	O	% / Survey respondents	Local data collection / Most recent consecutive 12-month period	75.00	80.00	SFMH continues to improve response rates of inpatient surveys	

Change Ideas

Change Idea #1 Increase the frequency and quality of patient education at the bedside with patient, family, and care givers

Methods	Process measures	Target for process measure	Comments
Continue staff education and review feedback at departmental meetings; action readily during post-discharge phone calls if a need for more information presents itself	Review data at Care Team as sub-committee to CQI	Improve the quality of the AVS by making and utilizing more smart phrases (EPIC optimization) to ensure discharge information is complete and accessible in an understandable way	Total Surveys Initiated: 60

Measure - Dimension: Patient-centred

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Total number of visits to the Emergency Department with a main problem of Mental Health or Substance Use	C	% / ED patients	EMR/Chart Review / April 1 to September 30, 2024	CB	CB	SFMH just recently began tracking this indicator in partnership with OVOHT and the target population of MHA patients with a goal of right care, right place	

Change Ideas

Change Idea #1 OVOHT has included this indicator in the cQIP. SFMH will monitor at QRS and Board CQI

Methods	Process measures	Target for process measure	Comments
SFMH QRS and Board CQI as well as OVOHT patient navigation table will monitor and work collaboratively wit hour community MHA partners to improve this indicator	Monitor the # of ED visits in which the Community Mental Health Crisis team is consulted and/or the patient is discharged with information related to community resources	100% of MHA patients will be referred appropriately and receive community resources documents.	

Safety

Measure - Dimension: Effective

Indicator #1	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.	O	% / Discharged patients	Local data collection / Most recent consecutive 12-month period	91.84	100.00	Discharge medications and patient teaching are critical to patient safety. At SFMH patient AVS include medication lists and all changes as a result of hospitalization.	

Change Ideas

Change Idea #1 Improve pharmacy involvement related to complex discharges. Inpatient nurses are also responsible for this bedside teaching.

Methods	Process measures	Target for process measure	Comments
Charge RN will review upcoming discharges and ensure pharmacy is consulted appropriately	Performance will be monitored using the inpatient safety dashboard.	100% of patients discharged will have had BPMH and medication reconciliation completed and included in their AVS.	This is a ROP for Accreditation Canada.

Measure - Dimension: Safe

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of workplace violence incidents resulting in lost time injury	O	% / Staff	Local data collection / Most recent consecutive 12-month period	12.00	10.00	SFMH implements multiple strategies to reduce the incidence of workplace violence including staff training for working with residents with dementia and responsive behaviors.	

Change Ideas

Change Idea #1 Leadership will work with the Occupational Health and Safety Committee to provide education and implement additional safety practices

Methods	Process measures	Target for process measure	Comments
Monthly audits will be completed to ensure staff are wearing their personal safety alarms	Continued education and auditing related to Gentle Persuasive Approaches and other de-escalation techniques.	Data will be reviewed and discussed at huddles and at the Occupational Health and Safety Committee	