Theme I: Timely and Efficient Transitions | Timely | Mandatory Indicator

Indicator #5

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.

Last Year		This Year	
41	**35.80**	**23.82**	**25**
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

ED-to-Admitted Meeting Identified Actions

Target for process measure

- 90% identified Action Items complete by defined due date

Lessons Learned

The "Patients in Motion" meeting was reinvigorated by renewing and expanding membership to include supporting departments (ie: Diagnostic Imaging)

Change Idea #2

Surge and Overcapacity planning

Target for process measure

- 100% funded occupancy at midnight with no admissions in ED on a daily basis

Lessons Learned

Bed meetings have been regularly evaluated for effectiveness and flow, and bed meetings have been implemented on weekend shifts.

Change Idea #3

Supporting ED Patients with flow guidance

Target for process measure

- Increase in Admission Diversions and Admission Avoidances per shift

Lessons Learned

Progress has been made in terms of developing ED Navigator role posting; integration of navigators is expected to provide ongoing and enhanced support to patients with respect to flow.

Theme I: Timely and Efficient Transitions | Timely | Custom Indicator

Indicator #6

Total ED length of stay (defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ED) where 9 out of 10 complex patients completed their visits

Last Year		This Year	
11.50	**10.20**	**8.40**	**--**
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

Improve the discharge process to ensure that patients who are ready for discharge can be discharged regardless of weekday or weekend. This will increase patient satisfaction as well as improve the flow of patients throughout the hospital.

Target for process measure

- Increase the number of weekend discharges by March 31, 2020

Lessons Learned

Evaluated bed management practices for after-hours leaders, implemented weekend bed meetings to create consistent communication and patient flow practice with great success

Change Idea #2

Exploration of a more consistent Results Pending area.

Target for process measure

- Plan in place by Jun 30, 2019 Once Results Pending area in place, target 85%+ occupancy in area during open hours.

Lessons Learned

We have modified some our workspace to accommodate a dedicated Results Pending area with positive to impact to ED Length of Stay and ED Wait Time to Inpatient Bed

Change Idea #3

Explore process flow opportunities

Target for process measure

- No target entered

Lessons Learned

Conducted a current state value stream mapping exercise to identify areas to improve patient flow through ED,

Theme I: Timely and Efficient Transitions | Efficient | Priority Indicator

Indicator #7

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.

Last Year		This Year	
23.21	**19.20**	**20.68**	**21**
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

Patients with responsive behaviors - build staff confidence in managing this population

Target for process measure

- 1. 5 GPA training sessions per year for a minimum of 50 staff 2. Changes to create a safe room on IMRS by December 31st 2019 3. Improved confidence (based on baseline survey completed Dec 2018) among clinical staff in caring for behavioural patients. 4. Co-horting pilot trialed on IMRS by Dec 31, 2019

Lessons Learned

Work on this initiative was focused on one area specifically, and preliminary results are showing limited increase in confidence; it is expected that more consistent messaging and support, along with consistent debrief mechanisms will help encourage resilience for front-line staff.

Change Idea #2

Improve Bed Transitions for ALC Unit

Target for process measure

- 1. Completed ALC standard of care - July 30th 2019 2. Evaluation of Standard of Care Pilot - September 30th 2019 3. Roll out to S1, IMRS, C5 and C6 as applicable- December 31st 2019

Lessons Learned

By providing ALC patients a specific space in the hospital, we are better able to facilitate their transition to their next appropriate point of care.

Change Idea #3

Continue to collaborate with our community partners at regular ALC rounds to enhance early identification and monitoring of our patients requiring discharge to alternate levels of care

Target for process measure

- Increased telehomecare referrals; increased Healthlinks referrals

Lessons Learned

Community partners continue to meet and work through individual cases, as well as identifying ongoing improvement initiatives to help improve patient flow generally; understanding the barriers to discharging ALC patients back into the community has been helpful for many stakeholders through these meetings.

Theme II: Service Excellence | Patient-centred | Priority Indicator

Indicator #3

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?

Last Year		This Year	
57	**60**	**52.13**	**--**
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

1)Explore opportunity for post-Discharge follow-up phone calls to reinforce instructions and address opportunities for improvement by the Admission Discharge Transfer nurse and/or modified staff.

Target for process measure

- 100% SOP developed by Q1 2019/2020; 50% Discharge Calls completed based on number of Medicine patients discharged per quarter

Lessons Learned

Identifying the appropriate resource for Post-Discharge Follow-Up calls has been a challenge, considering the difficulty of adequately diagnosing medical concerns over the telephone; learnings of this project have led the project team to explore some alternative solutions that are expected to improve patient experience, community integration, and OSMH performance data.

Change Idea #2

Reinforce commitment to Estimated Date of Discharge practices

Target for process measure

- 90% Audited Compliance by October 2019

Lessons Learned

Specifically, we focused here on providing physician access to populate the Depart Tool embedded in our EMR; we are currently waiting for the change to be activated by our EMR partners.

Change Idea #3

Identify what information patients most need to know on discharge

Target for process measure

- No target entered

Lessons Learned

Focused specifically on leader rounding to ask patients what they would most want to know; identified top 5 case-mix groups for applicable inpatient groups, engaged Patient Family Advisory Council and learned they would most want to know who to call if they realized they had a question after discharge that they had not previously considered; currently reviewing bedside information binders to be provided to inpatients as a resource they can review during their stay to help inform them of their condition.

Theme III: Safe and Effective Care | Effective | Priority Indicator

Indicator #1

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.

Last Year		This Year	
83.28	**82**	**86.93**	**82**
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

The medication reconciliation process is a shared responsibility and requires an inter-professional team approach that includes pharmacists, physicians, nurses and other healthcare providers. Providing up to date education on the process is vital to a successful program. Ongoing education has shown success as illustrated. Focus now is to keep on target

Target for process measure

- New applicable credentialed staff receive Med Rec at Discharge training within 60 days of onboarding.

Lessons Learned

Medication Reconciliation education developed and integrated into onboarding packages for all staff, completion rates continue to be monitored

Change Idea #2

The Med Rec Sustainability Committee is focusing on areas of concern and working with front line staff to determine why the discharge report is not in the patient's chart and next steps, one area for improvement identified is to change the Med Rec at Discharge Report.

Target for process measure

- 1. New report deployed Q1 2. 90% applicable credentialed staff trained in use of new reporting tool by Q3

Lessons Learned

No lessons learned entered

Change Idea #3

Continue to monitor the performance of Medication Reconciliation on Admission and its impact on Medication Reconciliation on Discharge

Target for process measure

- No target entered

Lessons Learned

It is expected that completed Medication Reconciliation on Admission will support the completion of Medication Reconciliation on Discharge. To date, we've focused on monitoring this relationship to identify trends.

Theme III: Safe and Effective Care | Safe | Mandatory Indicator

Indicator #2

Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.

Last Year		This Year	
70	**92**	**106**	**108**
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

Develop and implement a standardized debriefing tool

Target for process measure

- 100% of managers with employees in "high-risk" areas trained to use debrief tool. 90% of code white incidents followed by debrief within 1 month.

Lessons Learned

No lessons learned entered

Change Idea #2

Staff Training on the prevention and management of aggressive behaviour

Target for process measure

- 1. 100% of staff in "high-risk" areas (as of March 31, 2019) to have training complete by October 2019 2. 95% of new staff complete training module within 60 days of Orientation.

Lessons Learned

No lessons learned entered

Change Idea #3

Staff Training on incident management and incident reporting . Just culture

Target for process measure

- 90%+ of applicable staff trained in violence incidents management and response training by March 2020.

Lessons Learned

No lessons learned entered

Theme III: Safe and Effective Care | Safe | Custom Indicator

Indicator #4

The number of lost time incidents due to workplace violence injury

Last Year		This Year	
10	8	4	--
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

Patient identification and care planning

Target for process measure

- 100% compliance with completion of risk assessment tool

Lessons Learned

Identifying potentially harmful patients' rooms with signage remains a core part of our Harmful Behaviour response tactic. It allows care team members to adequately prepare before entering a patient's room for potential risk.

Change Idea #2

Staff Training on the prevention and management of aggressive behaviour

Target for process measure

- 1. 100% of staff in (as of March 31, 2019) to have e-learning training complete by October 2019 2. 95% of staff in (as of March 31, 2019) to have 2-day training complete by October 2019 3. 95% of new staff complete training module within 60 days of Orientation.

Lessons Learned

Staff training as part of onboarding has continued to create practical opportunities for new team members to become familiar with some of the tactics of identifying and de-escalating aggressive behaviour.

Change Idea #3

Provide opportunities for interprofessional learning by simulating a violent patient incident (mock code white)in a environment that closely resembles real clinical situations.

Target for process measure

- 4 Mock Code White (violent patient simulation) exercises complete by March 31, 2020 4 Assessments of Code team performance and response by March 31, 2020

Lessons Learned

Recently OSMH's code white system was upgraded; this prevented some of the planned mocks to be carried out, however it is anticipated these changes will allow better response to the threat of violence from patients.

Change Idea #4

Flagging patients identified in workplace violence incidents will provide the staff caring for these patients with information that could prevent further incidents.

Target for process measure

- 100% of patients identified in workplace violence incidents are appropriately flagged (post-incident) in our EMR by March 31, 2020.

Lessons Learned

Flagging tools in our EMR allows care team members to identify those patients who presented a risk of workplace violence either on a previous visit or prior to being transferred to another unit in hospital.

Change Idea #5

Communication and education of zero-tolerance for violence to staff, patients, families, visitors

Target for process measure

- 100% completion on signage developed and posted Increased awareness of zero-tolerance expectations

Lessons Learned

No lessons learned entered

Change Idea #6

Workplace Violence risk assessments

Target for process measure

- Managers will have completed risk assessments by March 2020

Lessons Learned

Ongoing audits of the our workplace violence screening and tool are showing strong commitment to the process; as workers may be exposed to harmful behaviour, we must be careful to encourage ongoing commitment to established process to keep one another safe.