Theme I: Timely and Efficient Transitions

Change Ideas

Change Idea #1  Identified staff and physicians are educated on ALC designation.

Methods

<table>
<thead>
<tr>
<th>Access and Flow Committee, in collaboration with Quality/Safety/Risk, will create and deliver multi-modal ALC education for staff, and physicians. Access and Flow Committee will track compliance of completion and education uptake on a monthly basis until 100% of target audience is reached.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education is provided to appropriate/relevant staff and physicians.</td>
</tr>
<tr>
<td>100% of education provided to staff and physicians identified.</td>
</tr>
</tbody>
</table>
### Change Idea #2  Build educational materials for patients and family re: Home First Philosophy.

<table>
<thead>
<tr>
<th>Methods</th>
<th>Process measures</th>
<th>Target for process measure</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access and Flow Committee will co-design educational materials with/for patients and families re: Home First Philosophy. Access and Flow Committee will determine how these educational materials are distributed across the organization and disseminated. We will partner with our Patient and Family Advisory Committee (PFAC) to build meaningful educational materials for this target audience.</td>
<td>Educational materials for patients and families re: Home First Philosophy are built.</td>
<td>100% of educational materials built for patient and families.</td>
<td></td>
</tr>
</tbody>
</table>

### Change Idea #3  Implement a Geriatric Activation Team (GAT) to support discharge home from the ED.

<table>
<thead>
<tr>
<th>Methods</th>
<th>Process measures</th>
<th>Target for process measure</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>GAT team to be hired and supported by the GAT team Supervisor. With support of Decision Support Team, the Access and Flow Committee will track progress of the GAT through their monthly meetings and scorecard.</td>
<td>Proportion of GAT encounters that resulted in a discharge home from the ED.</td>
<td>Collecting Baseline</td>
<td></td>
</tr>
</tbody>
</table>

### Change Idea #4  Implement a standardized Estimated Discharge Date (EDD) Process in at least 1 in-patient unit.

<table>
<thead>
<tr>
<th>Methods</th>
<th>Process measures</th>
<th>Target for process measure</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>With the support of Quality, Safety, Risk, and the Acute Care Team, Access and Flow Committee will oversee a standardized process for EDD in Acute Care. Access and Flow Committee will collaborate with the in-patient unit teams, Professional practice and Quality to determine how to best implement a standardized process for EDD.</td>
<td>EDD process implemented in at least 1 in-patient unit.</td>
<td>100% of EDD process implemented in at least 1 in-patient unit.</td>
<td></td>
</tr>
</tbody>
</table>
### Measure

<table>
<thead>
<tr>
<th>Indicator #2</th>
<th>Type</th>
<th>Unit / Population</th>
<th>Source / Period</th>
<th>Current Performance</th>
<th>Target</th>
<th>Target Justification</th>
<th>External Collaborators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Mental Health: Counselling Waitlist (average days waited)</td>
<td>C</td>
<td>Days / Clients</td>
<td>In house data collection / April - December 31, 2023</td>
<td>276.00</td>
<td>180.00</td>
<td>35% reduction of average days waited.</td>
<td>Community Mental Health: Counselling Waitlist (average days waited)</td>
</tr>
</tbody>
</table>

### Change Ideas

**Change Idea #1  Build a Waitlist Maintenance Protocol.**

**Methods**

<table>
<thead>
<tr>
<th>Process measures</th>
<th>Target for process measure</th>
<th>Comments</th>
</tr>
</thead>
</table>

**Change Idea #2  Implement the Waitlist Maintenance Protocol.**

**Methods**

<table>
<thead>
<tr>
<th>Process measures</th>
<th>Target for process measure</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients reached within the Waitlist Maintenance Protocol.</td>
<td>100% clients reached within the Waitlist Maintenance Protocol.</td>
<td></td>
</tr>
</tbody>
</table>

**Change Idea #3  Continue to flag prioritized clients on the waitlist.**

**Methods**

<table>
<thead>
<tr>
<th>Process measures</th>
<th>Target for process measure</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prioritized clients are reached within 30 days of referral.</td>
<td>100% of prioritized clients are reached within 30 days of referral.</td>
<td></td>
</tr>
</tbody>
</table>
Change Idea #4  Optimize internal and external referral pathway workflow.

<table>
<thead>
<tr>
<th>Methods</th>
<th>Process measures</th>
<th>Target for process measure</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH leads will continue to optimize the internal and external referral workflow with the help of Informatics and Decision Support teams at NHH, and within the Region.</td>
<td>Referral pathway workflow framework completed.</td>
<td>100% Referral pathway workflow framework completed.</td>
<td></td>
</tr>
</tbody>
</table>
### Theme II: Service Excellence

#### Measure

<table>
<thead>
<tr>
<th>Indicator #3</th>
<th>Dimension</th>
<th>Type</th>
<th>Unit / Population</th>
<th>Source / Period</th>
<th>Current Performance</th>
<th>Target</th>
<th>Target Justification</th>
<th>External Collaborators</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of positive responses to, “Do you feel you received the information you needed before you left the hospital?”</td>
<td>Patient-centred</td>
<td>C</td>
<td>% / All patients</td>
<td>In house data collection / January 1 - December 31, 2023</td>
<td>CB</td>
<td>CB</td>
<td>Generating an NHH baseline for the target.</td>
<td></td>
</tr>
</tbody>
</table>

#### Change Ideas

**Change Idea #1**  Implement interim patient and caregiver experience survey.

<table>
<thead>
<tr>
<th>Methods</th>
<th>Process measures</th>
<th>Target for process measure</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Experience Working Group, Patient Relations, and Quality/Safety/Risk will oversee and manage the implementation of the new patient experience survey, including all the ways it will be accessed by patients. The Patient Experience Working Group will continue to gather feedback on the implementation, ease of access, and results with key stakeholders in the organization.</td>
<td>Interim patient experience survey implemented.</td>
<td>100% Interim patient experience survey implemented.</td>
<td></td>
</tr>
</tbody>
</table>
Change Idea #2  Build a strategy to improve the uptake of the patient and caregiver experience survey.

Methods | Process measures | Target for process measure | Comments
--- | --- | --- | ---
Patient Experience Working Group, Patient Relations, and Quality/Safety/Risk will oversee and manage the implementation of the new patient experience survey, including a strategy to improve the uptake of the patient and caregiver experience survey. | Total # of surveys completed. | Collecting Baseline |

Change Idea #3  Monitor After Visit Summary printed for patients at discharge.

Methods | Process measures | Target for process measure | Comments
--- | --- | --- | ---
In collaboration with Clinical Informatics, Patient Relations, and Decision Support, Quality/Safety/Risk will monitor the practice of After Visit Summary printed for patients at discharge. | % of patients at discharge with a completed After Visit Summary. | Collecting Baseline. |

Measure  Dimension: Patient-centred

<table>
<thead>
<tr>
<th>Indicator #4</th>
<th>Type</th>
<th>Unit / Population</th>
<th>Source / Period</th>
<th>Current Performance</th>
<th>Target</th>
<th>Target Justification</th>
<th>External Collaborators</th>
</tr>
</thead>
<tbody>
<tr>
<td>People Satisfaction Engagement Rate (%)</td>
<td>C</td>
<td>% / Survey respondents</td>
<td>Staff survey / Survey Results as of December 2023</td>
<td>CB</td>
<td>CB</td>
<td>Generating an NHH baseline for the target.</td>
<td></td>
</tr>
</tbody>
</table>

Change Ideas

Change Idea #1  Build staff, physician, and midwife survey to measure engagement and satisfaction.

Methods | Process measures | Target for process measure | Comments
--- | --- | --- | ---
Human Resources will collaborate with Decision Support to build a staff survey. | Employee survey completed. | 100% Employee survey completed. |

Report Access Date: June 01, 2023
<table>
<thead>
<tr>
<th>Change Idea #2</th>
<th>Implement people engagement survey.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methods</td>
<td>HR will be responsible for disseminating the people engagement survey in collaboration with appropriate stakeholders.</td>
</tr>
<tr>
<td>Process measures</td>
<td>% of staff, physicians, midwives who have completed the survey.</td>
</tr>
<tr>
<td>Target for process measure</td>
<td>At least 60% of staff, physicians, midwives have completed the survey.</td>
</tr>
<tr>
<td>Comments</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Change Idea #3</th>
<th>Validate survey results.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methods</td>
<td>HR, in collaboration with Decision Support, will oversee the validation of survey results. Results will be disseminated to appropriate stakeholders.</td>
</tr>
<tr>
<td>Process measures</td>
<td>% of survey results validated.</td>
</tr>
<tr>
<td>Target for process measure</td>
<td>100% of survey results validated.</td>
</tr>
<tr>
<td>Comments</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Change Idea #4</th>
<th>Develop action plan based on survey results.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methods</td>
<td>HR, in collaboration with appropriate stakeholders/teams, will oversee the development of an organizational action plan based on staff survey results.</td>
</tr>
<tr>
<td>Process measures</td>
<td>Action plan completed.</td>
</tr>
<tr>
<td>Target for process measure</td>
<td>100% action plan completed.</td>
</tr>
<tr>
<td>Comments</td>
<td></td>
</tr>
</tbody>
</table>
Theme III: Safe and Effective Care

Measure

<table>
<thead>
<tr>
<th>Indicator #5</th>
<th>Dimension: Effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>P</td>
</tr>
</tbody>
</table>

Change Ideas

Change Idea #1  Analyze the current workflow of BPMD within the EMR.

Methods

- Process measures: Current state analyzed and data validated.

Target for process measure: 100% current state analyzed and data validated.

Comments:

Change Idea #2  Optimize Workflow for BPMD.

Methods

- Process measures: Workflow standardized across organization.

Target for process measure: 100% workflow standardized across organization.

Comments:
**Change Ideas**

**Change Idea #1**  Reinstitute NVCI education using a train-the-trainer model of delivery.

<table>
<thead>
<tr>
<th>Methods</th>
<th>Process measures</th>
<th>Target for process measure</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>JOHSC will collaborate with Quality/Safety/Risk, Professional Practice, and Mental Health to monitor and track the progress of this indicator.</td>
<td>NVCI education plan reinstituted at NHH.</td>
<td>100% of education plan reinstituted at NHH.</td>
<td>FTE=540</td>
</tr>
</tbody>
</table>

**Change Idea #2**  Continuation of the use of the workplace violence risk assessments embedded in the workplace inspection process.

<table>
<thead>
<tr>
<th>Methods</th>
<th>Process measures</th>
<th>Target for process measure</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>JOHSC will collaborate with Quality/Safety/Risk, Professional Practice, and Mental Health to monitor and track the progress of this indicator.</td>
<td>Workplace risk assessments completed during inspections.</td>
<td>100% Workplace risk assessments completed during inspections.</td>
<td></td>
</tr>
</tbody>
</table>

**Change Idea #3**  Seek opportunities to enhance the workplace violence risk assessments within the Community Mental Health Program.

<table>
<thead>
<tr>
<th>Methods</th>
<th>Process measures</th>
<th>Target for process measure</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>JOHSC will collaborate with Quality/Safety/Risk, Professional Practice, and Mental Health to monitor and track the progress of this indicator.</td>
<td>Opportunities to mitigate workplace violence in the Community Mental Health Program identified.</td>
<td>100% of opportunities to mitigate workplace violence in the Community Mental Health Program identified.</td>
<td></td>
</tr>
</tbody>
</table>

**Measure**  Dimension: Safe

<table>
<thead>
<tr>
<th>Indicator #6</th>
<th>Type</th>
<th>Unit / Population</th>
<th>Source / Period</th>
<th>Current Performance</th>
<th>Target</th>
<th>Target Justification</th>
<th>External Collaborators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.</td>
<td>P</td>
<td>Count / Worker</td>
<td>Local data collection / Jan 2022–Dec 2022</td>
<td>94.00</td>
<td>0.00</td>
<td>NHH is committed to providing a safe and respectful workplace for all employees.</td>
<td></td>
</tr>
</tbody>
</table>

Report Access Date: June 01, 2023
Change Idea #1  Optimize BCMA EPIC reports for clinical utility.

Methods

- Process measures
- Clinical managers are utilizing the BCMA reports.
- Q-CIPP Committee will monitor and track the progress of this indicator.
- Clinical managers are utilizing the BCMA reports.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Dimension: Safe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator #7</td>
<td>Type</td>
</tr>
<tr>
<td>Percentage of patients safely receiving medication using barcode medication administration (BCMA) technology.</td>
<td>C</td>
</tr>
</tbody>
</table>

Change Idea #2  Provide education for all identified staff re: BCMA.

Methods

- Process measures
- Applicable staff have signed off on education provided.
- Q-CIPP Committee will monitor and track the progress of this indicator.
- 100% Applicable staff have signed off on education provided.

| Change Idea #3  Create feedback loop process for clinical staff. |
| Methods |
| Q-CIPP Committee will monitor and track the progress of this indicator. |
| Applicable staff reached. |
| 100% Applicable staff reached. |
### Change Ideas

#### Change Idea #1  Readiness assessment for implementation of Press Ganey’s Healthcare Performance Improvement (HPI).

<table>
<thead>
<tr>
<th>Methods</th>
<th>Process measures</th>
<th>Target for process measure</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated Quality, Practice, and Risk Committee will be responsible for monitoring and tracking the progress of this indicator.</td>
<td>Press Ganey’s HPI readiness assessment completed.</td>
<td>100% Press Ganey’s HPI readiness assessment completed.</td>
<td></td>
</tr>
</tbody>
</table>

#### Change Idea #2  Update incident reporting system (i.e., event severity, submission forms, etc.).

<table>
<thead>
<tr>
<th>Methods</th>
<th>Process measures</th>
<th>Target for process measure</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>In collaboration with Quality/Patient Safety/Risk, and other key stakeholders, the Integrated Quality, Practice, and Risk Committee will be responsible for monitoring and tracking the progress of this indicator.</td>
<td>Incident reporting system revision complete.</td>
<td>100% incident reporting system revision complete.</td>
<td></td>
</tr>
</tbody>
</table>
**Change Ideas**

**Change Idea #1**  Implement care planning tool documentation process within EMR for inpatients who have history of falling within the last 30 days.

**Methods**

In collaboration with the Seniors Care Committee, and Professional Practice, the Quality/Safety/Risk team will jointly monitor and track the progress of this change idea. Key stakeholders will be consulted as appropriate.

**Process measures**

Implement this new care documentation planning process on at least one inpatient unit.

**Target for process measure**

100% implemented on at least one inpatient unit.

**Change Idea #2**  Update fall prevention education module for all clinical staff.

**Methods**

In collaboration with the Seniors Care Committee, and Professional Practice, the Quality/Safety/Risk team will jointly monitor and track the progress of this change idea. Key stakeholders will be consulted as appropriate.

**Process measures**

Proportion of clinical staff who have completed the fall prevention education module.

**Target for process measure**

100% of clinical staff have completed the fall prevention education module.

---

**Measure**

**Dimension:** Safe

<table>
<thead>
<tr>
<th>Indicator #9</th>
<th>Type</th>
<th>Unit / Population</th>
<th>Source / Period</th>
<th>Current Performance</th>
<th>Target</th>
<th>Target Justification</th>
<th>External Collaborators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient falls with injury rate.</td>
<td>C</td>
<td>Rate / All patients</td>
<td>Hospital collected data / April 1 - December 31, 2023</td>
<td>2.00</td>
<td>2.80</td>
<td>10% reduction as per previous FY</td>
<td></td>
</tr>
</tbody>
</table>

---

**Report Access Date:** June 01, 2023
**Equity**

**Measure**  
**Dimension:** Equitable

<table>
<thead>
<tr>
<th>Indicator #10</th>
<th>Type</th>
<th>Unit / Population</th>
<th>Source / Period</th>
<th>Current Performance</th>
<th>Target</th>
<th>Target Justification</th>
<th>External Collaborators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate of racial harassment incidents for employees (denominator is total # of FTE’s).</td>
<td>C</td>
<td>Rate / Health providers in the entire facility</td>
<td>In house data collection / January 1 - December 31, 2023</td>
<td>CB</td>
<td>CB</td>
<td>Generating an NHH baseline for target.</td>
<td></td>
</tr>
</tbody>
</table>

**Change Ideas**

**Change Idea #1**  
Build pathway to track incidents of racism in NHH’s incident reporting platform (ATA).

**Methods**  
**Process measures**  
**Target for process measure**  
**Comments**

| Quality, Patient Safety, and Risk will collaborate with the Equity, Diversion, and Inclusion Committee and Occupation Health to monitor and track the progress of this indicator. | Pathway in ATA built. | 100% Pathway in ATA built. | |

**Change Idea #2**  
Implement new pathway to track incidents of racism in NHH’s incident reporting platform (ATA).

**Methods**  
**Process measures**  
**Target for process measure**  
**Comments**

| Quality, Patient Safety, and Risk will collaborate with the Equity, Diversion, and Inclusion Committee and Occupation Health to monitor and track the progress of this indicator. | Pathway implemented. | 100% Pathway implemented. | |
Change Idea #3  Disseminate new process to NHH healthcare providers to increase reporting.

<table>
<thead>
<tr>
<th>Methods</th>
<th>Process measures</th>
<th>Target for process measure</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality, Patient Safety, and Risk will collaborate with the Equity, Diversion, and Inclusion Committee and Occupation Health to monitor and track the progress of this indicator.</td>
<td>% of healthcare providers who received education/awareness.</td>
<td>100% of healthcare providers received education/awareness.</td>
<td></td>
</tr>
</tbody>
</table>

**Measure  **  **Dimension:** Equitable

<table>
<thead>
<tr>
<th>Indicator #11</th>
<th>Type</th>
<th>Unit / Population</th>
<th>Source / Period</th>
<th>Current Performance</th>
<th>Target</th>
<th>Target Justification</th>
<th>External Collaborators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of policies reviewed using the Health Equity Impact Assessment Tool.</td>
<td>C</td>
<td>Count / Other</td>
<td>In house data collection / April 1 - December 31, 2023</td>
<td>CB</td>
<td>CB</td>
<td>Generating NHH baseline for target.</td>
<td></td>
</tr>
</tbody>
</table>

**Change Ideas**

**Change Idea #1  **  Train Leadership Network on how to use the HEIA Tool.

<table>
<thead>
<tr>
<th>Methods</th>
<th>Process measures</th>
<th>Target for process measure</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality, Patient Safety, and Risk will collaborate with EDIAC and IQPRC to monitor and track the progress of this indicator.</td>
<td>Leadership Network Trained on HEIA Tool.</td>
<td>100% Leadership Network Trained on HEIA Tool.</td>
<td></td>
</tr>
</tbody>
</table>

**Change Idea #2  **  Adapt the HEIA Tool in the policy framework.

<table>
<thead>
<tr>
<th>Methods</th>
<th>Process measures</th>
<th>Target for process measure</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality, Patient Safety, and Risk will collaborate with EDIAC and IQPRC to monitor and track the progress of this indicator.</td>
<td>HEIA Tool adapted in NHH policy framework.</td>
<td>100% HEIA Tool adapted in NHH policy framework.</td>
<td></td>
</tr>
</tbody>
</table>