Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 9, 2023

OVERVIEW

The Lennox and Addington County General Hospital is committed to providing the highest quality of care possible for the communities we serve. Our goal is to embed our core values "Teamwork, Respect and Communication" into all the services we provide. Our Quality Improvement Plan (QIP) is driven by our corporate mission "to be a progressive rural health system, dedicated to improving the health of our patients and our communities". Our 2023/2024 QIP sets out key strategies to enhance our quality of care, improve safety, increase satisfaction and achieve better clinical outcomes for patients and residents.

We have aligned our QIP with our strategic plan, service accountability agreements, accreditation standards and best practices. This alignment allows better use of resources to the areas where they will have the greatest impact on improving patient satisfaction.

Our Quality Improvement Plan was developed in consultation with clinical teams, staff, physicians, patients, residents and members of our Patient and Family Advisory Council. Feedback from Patient/Resident Surveys, Incident Reviews and the Patient Relations Process were reviewed and informed the development of change ideas in the QIP.

PATIENT/CLIENT/RESIDENT ENGAGEMENT AND PARTNERING

We have a variety of methods to engage patients, caregivers, and families in our quality improvement planning and our quality improvement activities. Information is gathered through various sources. Some sources are listed below.

• Patient satisfaction surveys from various departments in the organization.

• Post discharge phone calls to ask about the total inpatient care experience. A scripted dialogue encourages feedback about their hospital stay, what we could improve on as well as confirming if they feel they had all the resources they needed when they arrived home.

• The Patient and Family Advisory Council (PFAC) is actively involved as partners in driving quality and safety in all aspects of the patient experience. PFAC is represented in membership on our Quality Committee, as well as the Acute Inpatient Emergency, Ambulatory, and Convalescent Clinical Teams.

• Feedback received through compliments and complaints.

The information gathered from our patients, residents, caregivers and family members is used to identify successes and opportunities for improvement. Suggested improvements are used to identify areas of focus, which drives the development of our QIP and quality improvement activities.

The PFAC summarized some contributions over the last three years in the table below; however, one of the most-recent co-design projects is Just-in-Time Rounding (JITR). JITR was born out of PFAC and its feedback regarding JIT practices in Western Canada as a way to leverage patient feedback prior to PODS or discharge phone calls. JITR will be conducted monthly by the CNE and is tied to this coming year's QIP. Feedback from JITR will be shared with PFAC, Clinical Teams, and the Frontline.

PFAC Policy Co-Design	PFAC Project Engagement	Ongoing PFAC Activities
Resuscitation	Inspire Program: Breathe Program	PODS Implementation
Restraint Prevention, Application and Management	Health Hub/Home and Community Care, Chronic Disease Clinic, Hip Fracture Project, Diabetic Education	PFAC Terms of Reference
End of Life Discussion	Patient Electronic Resources	PFAC Recruitment
Patient Satisfaction Surveys	Senior Friendly Project	Variety of Patient Surveys: ER, Acute Care, Patient Safety, NRC
Restroom Symbols (Transgender Sensitivity)	ER Admit Project	QIP (Annual)
Cannabis Use	Cardiorespiratory Rehabilitation	PFAC Annual Evaluation
Patient Valuables Storage	Accreditation Preparation: ACER, Med. Safety Committees	LACGH Communication Plan: Strategies for Informing Patients and Families
Opioid Safety	Virtual Care Project	Ontario Health Team Initiatives
Rounding Process	Snoezelen Sensory Room	Expanded involvement in LACGH Clinical Teams: Convalescent Care/LTC, Ambulatory Care
Strategic and Operational Plan	Patient Community Roundtable	Patient Information Brochures (COPD, Falls, Discharge)
Terminal Illness Support Pamphlet	Ontario Health Team Implementation	Website Development
Patient Safety Survey	Hospital Website Re-design	Accreditation
COVID-19 Visitation Policy, Family Presence/Palliative Patients	Medication Management, Vanessa's Law	
Full Disclosure Policy	Hospital Information System (HIS)	
Mammography Patient Experience Evaluation	Patient Room Evaluation	
Ethical Decision Making Framework	Provincial PFAC Analysis	
Green Zone, After Hours Patient Care Strategies	Caregiver IDs	
Patient Engagement Webinar	Just-in-Time Rounding	
Client Safety Plan	End-of-Life Booklet	

PROVIDER EXPERIENCE

For many segments of society, there has been a return to a sense of normalcy to before the pandemic. Students are back to school, staff are returning to work in person, people are gathering in large groups. But for our healthcare teams, the pandemic continues. These individuals have not had a break in three years and many staff are communicating frequently that this has been the most challenging time of their careers as a result of accumulated fatigue.

Globally there is a shortage of healthcare professionals pronounced by the ongoing impacts from the pandemic. It is expected that the HHR pressures will continue over the next few years. As a result, the Hospital is facing unprecedented challenges in recruiting and retaining staff. Since June 1st, 2022 LACGH has had forty-three (43) staff resignations, which includes all status and all departments

(full-time, part-time, temporary and casual). Of the 43 resignations, there were seven (7) Registered Nurse resignations.

In an effort to address the fatigue and support staff, workgroups were developed to identify strategies on how best to support the entire workforce. Together, these workgroups have identified the need to communicate pandemic-specific mental health resources, sourcing rooms for staff physically-distanced breaks, massage chairs, and delivering a "kindness/wellness" cart with snacks to staff. This cart was created to visit all units, both clinical and non-clinical, on a rotating schedule to deliver personal care items. The preparation taken to put this concept into action has paid off, as the feedback has been extremely positive for not only staff for the operators, our volunteers, of the cart who are now encouraging the organization to continue this endeavour. The initiative provides the opportunity to exhibit the Hospital's appreciation with this simple, kind gesture.

At a department level, teams have also implemented several measures to support each other within the current healthcare environment:

- Staff, physicians, and administration have formed interdisciplinary Working Groups to improve engagement. The purpose of these workgroups are to identify and action ideas for improvement at the unit level to improve staff satisfaction. Some of the change ideas resulting from these workgroups include implementation of daily departmental huddles and the formation of a Recruitment and Retention group.
- In some cases, alternative staffing models were implemented on a temporary basis when staffing levels were critical in order to maintain essential services. For example, when the laboratory department was critically short of Technologist staff, the lab team co-developed schedules with varying shift length and call schedules to continue to provide care. In addition to this schedule change, the laboratory department recruited technicians to support technologists until recruitment of technologists was complete – a process that took 18 months.

WORKPLACE VIOLENCE PREVENTION

Workplace violence prevention is a priority for LACGH and this year our focus is building our reporting culture. It is embedded in our Hospital orientation and reviewed annually by all staff. Furthermore, each incident and the improvements identified are reviewed by a multidisciplinary group at every JOHSC meeting, clinical team meeting, Quality Committee meeting, and included in the Board package monthly. Quarterly review of the incident and prevention initiatives are trended in the Hospitals Balanced scorecard. Work Place Violence ("WPV") data is extrapolated from the RL6 Incident Reporting System. The reporting period is Q4-Q3.

Last year, there were 48 WPV incidents. Aggression of a patient/resident towards a staff member is responsible for the majority of WPV incidents. In most cases, these acts are driven by the patient's mental health or cognitive impairment. In a few cases, there was damage to LACGH property as a result of patient behaviours. Other WPV triggers include on-going Covid-19 restrictions and wait times.

Notwithstanding the number of WPV incidents that have been reported, staff injury is relatively rare with the vast majority being no-harm/mild harm incidents. Nearly all WPV types involved a patient/resident of LACGH acting against a staff member (Type II).

Although Behavioral Crisis Alerts ("BCA"), flags indicating a patient may exhibit violent behaviour, were in place before the WPV incident, and some BCA's were put into the medical record after a small number of incidents, the large number of BCA status' are "unknown". The usage of BCA's is an area which could be improved upon going forward.

All workplace violence incidents are investigated and followed up and any necessary corrective actions identified and implemented. Through the corrective action feedback process, staff, within various departments, have identified the need and have requested training in the area of workplace violence. As a result of this request, the organization, with endorsement by The Joint Health and Safety Committee, has brought forward Management of Resistive Behaviour (MORB) training, MORB is focused on communication and verbal de-escalation and is offered as a "court defensible" training program to mitigate risk (physical injury, civil and criminal liability). This training will be introduced to the organization over the coming months.

PATIENT SAFETY

Patient Safety Incidents ("PSI") are entered into the incident reporting software by staff members and are reviewed on a daily basis. New file alerts trigger the appropriate director/manager to review the file. The Director of Risk Management reviews files daily to assign specific tasks and follow-up are completed in a timely manner. All patient safety incidents and apparent organizational trends are reported on as a standing item on all clinical teams meetings throughout the organization. This includes the Acute Care/Emergency Department Team, Surgical Care Team, Diagnostic Imaging Care Team, Ambulatory Care Team and the Medication Safety Team. In addition to regular reporting, significant care events, never-events, patient complaints and critical incidents may be reviewed individually on an ad-hoc basis to meet legislative and quality of care requirements as the case may be.

During the 2022-23 period LACGH began tracking a never event: the number of Form 1 patients who elope from the organization without the knowledge of staff whilst awaiting transfer to a Schedule 1 facility. In order to track these incidents, security officers and staff are able to report the elopement into the incident reporting system for review and are reported in the QIP. There is also coding in the patient documentation that allows clinical staff to make an entry for Elopement (Form 1) for data collection. New organizational policies have been developed to specifically meet the security needs of Form 1 patients. These policies and new procedures have increased security's presence in the Emergency Department to mitigate risk to the patient and the organization.

These security services are strengthened with the organization's close working relationship with local law enforcement. There is on-going work with our regional partners to facilitate timely transfers of our patients to the appropriate schedule 1 facility through the lens of patient and staff safety.

HEALTH EQUITY

LACGH is working to address health equity for the population it serves through several strategies including those identified through the introduction of the Hospital's Accessibility Advisory Group (AAG). The AAG's membership includes a volunteer member from the community. The community volunteer has brought significant value and feedback to the group and will be meeting with the

Hospital Patient Family Advisory Committee to review the suggestions that have been brought forward to date.

Highlights of the AAG are listed below:

- An assessment that the Hospital physical disability accommodation requirement is in good order.
- An on-going patient perspective review of the mental or learning disability accommodation needs in different Hospital departments and programs. As an example, volunteers have assisted patients with questionnaires on the tablets since some patients are not capable of learning the tablet or reading/understanding the questions.
- Recognition that patients with anxiety disorders may require volunteer assistance in the waiting room as an emotional support. This will be further discussed at Patient/Family Advisory Council and with Volunteer Services.

In addition to the work of the AAG, on an on-going basis LACGH exercises the use of interpreters for patients and families whenever needed to support safe and effective communication. LACGH also utilizes social services and the community services to support patients and families with health equity disparities.

From a staff diversity, equity and inclusion perspective, the Hospital has introduced a staff demographic survey for all new hires. This survey will be distributed to all existing staff over the coming year. This survey will assist in providing baseline data and identifying areas of concerns and developing objectives.

EXECUTIVE COMPENSATION

It is mandatory under the Excellent Care for All Act (ECFAA) to link compensation for the Chief of Staff (COS), Chief Executive Officer (CEO) and other executives reporting to the CEO to the achievement of performance targets in our organizations Quality Improvement Plan (QIP). Performance-based executive compensation is linked to achieving specific QIP targets, as well as achieving success on selected corporate goals and objectives. The amount of compensation that is performance-based for the executive team has been set at 3% for 2023/2024 year. The performance-based compensation will be tied to the achievement of the following QIP indicators as well as the achievement of selected corporate goals and objectives:

- 15% relative reduction in the percentage of surgical case long-waiters
- 10% relative increase in the percentage of IPU survey 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?
- 15% increase in the number of reported workplace violence incidents and near-misses.

Theme I: Timely and Efficient Transitions

Measure

Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of surgical case long-waiters	C	% / All surgical procedures	Local data collection / 2023	15.00	13.00	Provincial target is 20% (Internal target: reduce our baseline by 15%)	

Change Ideas

Change Idea #1 Heighten awareness and cause of long-waiters through routine individual case review and tracking

Methods	Process measures	Target for process measure	Comments
1) Review of Novari data 2) Communication to physicians regarding over target cases 3) Inclusion in SCT scorecard	1) Standard communication to physicians developed 2) Percentage of SCT meetings where scorecard is reviewed with long-waiters	1) April 30 ,2023 2) 90%	

Theme II: Service Excellence

Measure

Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (Lennox And Addington County General Hospital)	P	% / LTC home residents	In house data, NHCAHPS survey / Apr 2022 - Mar 2023	92.31	97.00	5% increase	

Change Ideas

Change Idea #1 Pair survey data with just in time (JIT) surveying and feedback with residents, caregivers, and staff.

Methods	Process measures	Target for process measure	Comments
1) Leader rounding bi-weekly with developed script 2) Data collated and presented to staff at huddles	1) Count of residents rounded on bi-weekly 2) # of improvement suggestions made through leader rounding bi-weekly 3) # of improvements implemented bi-weekly identified through leader rounding	1) 4 residents/ biweekly 2) CB 3) CB	Total Surveys Initiated: 20 Total LTCH Beds: 22

Measure

Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (Lennox And Addington County General Hospital)	P	% / LTC home residents	In house data, interRAI survey / Apr 2022 - Mar 2023	100.00	100.00	Maintain	

Change Ideas

Change Idea #1 Pair survey data with just in time (JIT) surveying and feedback with residents, caregivers, and staff.

Methods	Process measures	Target for process measure	Comments
1) Leader rounding bi-weekly with developed script 2) Data collated and presented to staff at huddles	1) Count of residents rounded on bi-weekly 2) # of improvement suggestions made through leader rounding bi-weekly 3) # of improvements implemented bi-weekly identified through leader rounding	1) 4 residents/ biweekly 2) CB 3) CB	Total Surveys Initiated: 20 Total LTCH Beds: 22

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?	P	% / Survey respondents	CIHI CPES / Most recent consecutive 12-month period	69.29	75.90	NRC Average (2021-22)	

Change Ideas

Change Idea #1 Optimize Personalized Discharge Practices

Methods	Process measures	Target for process measure	Comments
1) Assign Staff MRP to review the POD with the patient prior to discharge 2) Staff education on the POD 3) Staff education on teach back methods 4) Additional question added to rounding script regarding preparation for discharge if applicable	1) Staff Assigned 2) # of Staff education competence quizzes completed 3) % of patients who receive their POD 4) # of JIT feedback comments regarding post-discharge treatment	1) Assignment confirmed by April 30, 2023 2) CB 3) 90% declare receipt of their PODS 4) CB	Total Surveys Initiated: 140

Theme III: Safe and Effective Care

Measure

Dimension: Effective

Indicator #5	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)	98.00	99.00	Sustain Success. Focus on quality of Med Rec.	

Change Ideas

Change Idea #1 Increase the proportion of patients who receive medication education from a pharmacist at discharge

Methods	Process measures	Target for process measure	Comments
1. Engage a small working group to map current state and develop lean future state for pharmacist involvement at discharge (i.e. triage algorithm) 2. Develop educational materials for Staff/Patient/Family to be shared at admission	1. New Process Implemented 2. Educational Material available 3. Percentage of Patients who respond "completely" to the survey question "Before you left the hospital, did you have a clear understanding about all of your prescribed medications, including those you were taking before your hospital stay?" increases. 4. Percentage of patients receiving med rec at discharge from most appropriate source increases.	1. New Process Implemented by Sept 30 2. Educational Material available by Sept 30 3. Survey results show increase from 78 % to 84% by Jan 2024 4. Increase from 32.4 % to 47.4% by Jan 2024	

Measure

Dimension: Safe

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Lennox And Addington County General Hospital)	P	% / LTC home residents	CIHI CCRS / Jul - Sept 2022	19.30	CB	Collecting Baseline	Medisystems

Change Ideas

Change Idea #1 Complete admission medication review within 72 hours of admission and implement deprescribing pathways where applicable.

Methods	Process measures	Target for process measure	Comments
1) Engagement with Medical Director, Pharmacy, and care team 2) Review any case where antipsychotics were ordered/given without a psychosis diagnosis through case review 3) Provide educational opportunities and add education to Moodle to increase Staff/Resident/Family knowledge in regards to anti-psychotic medications.	1) Percentage of new admissions who had their medication review completed within 72 hours 2) Number of LTC residents who had antipsycotics on their medication list at time of medication review without a psychosis diagnosis 3) # of case reviews required per month 4) Modules available on Moodle	1) 98% 2) CB 3) Electronic education accessible by September 30 , 2023	

Measure

Dimension: Safe

Indicator #7	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	48.00	55.00	Focus is to build a reporting culture as we are aware WPV incidents are still under reported.	Paladin

Change Ideas

Change Idea #1 1) Continue to build a reporting Culture 2) Optimize use of Behaviour Crisis Alert

Methods	Process measures	Target for process measure	Comments
1) Engage with Paladin for staff training 2) MORB (management of resistive behaviour) training for all staff with patient involvement including Clerical support. 3) Engagement at huddles regarding behavior alerts/ patients at risk 4) Provide training to staff/physicians regarding reporting of BCA flags in the incident reporting system.	1) # of staff that received MORB training 2) # of patients with behaviors flagged in the system 3) BCA report shared at Clinical Team Meetings	1) CB 2) CB 3)1st report shared by May 30, 2023	FTE=364

Equity

Measure

Dimension: Equitable

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of people who feel LACGH adequately support diversity, equity, and inclusion (DEI).	C	% / Worker	Local data collection / 2023-24	CB	CB	Collecting Baseline	

Change Ideas

Change Idea #1 1. Assess current state perception of DEI with staff 2. Assess staff demographic data 3. Initiate the development of a long-term diversity and inclusion strategy, including cultural education, unconscious bias training, measurable success metrics, inclusion monitoring and review.

Methods	Process measures	Target for process measure	Comments
1. Create a staff survey, disseminate the survey , review the survey results, and draft and action plan based on gaps identified in the results. 2. Leverage HR and HIS data to create a current state report and compare it to the community demographics. 3. Assemble a DEI workgroup	1. Staff survey disseminated 2. Staff DEI Workgroup Assembled 3. Action Plan Created 4. Demographic Analysis completed	1. Staff survey disseminated by Aug 30 2. Staff DEI Workgroup Assembled by Sept 30 3. Action Plan Created by Oct 30 4. Demographic Analysis completed by Dec 30	

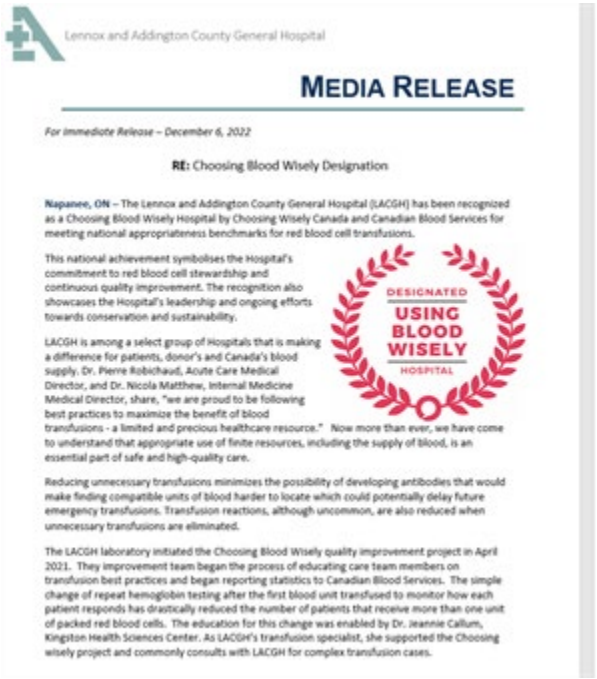
Excellent Care for All

Quality Improvement Plans 23/24 (QIP): Progress Report on the 2022/23 QIP

The Progress Report is a tool that will help organizations make linkages between change ideas and improvement, and gain insight into how their change ideas might be refined in the future. The new Progress Report is mostly automated, so very little data entry is required, freeing up time for reflection and quality improvement activities.

Ontario Health (OH) will use the updated Progress Reports to share effective change initiatives, spread successful change ideas, and inform robust curriculum for future educational sessions.

ID	Measure/Indicator from 2022/23	Org Id	Current Performance as stated on QIP2022/23	Target as stated on QIP 2022/23	Current Performance 2023	Comments
1	Choosing Wisely Level Achieved (Number; N/a; 2022-23; Choosing Wisely Canada)	592	CB	3.00	2.00	Becoming a Choosing Wisely Hospital is part of LACGH's operational roadmap in out current strategic plan.



Lennox and Addington County General Hospital

MEDIA RELEASE

For Immediate Release – December 6, 2022

RE: Choosing Blood Wisely Designation

Napanee, ON – The Lennox and Addington County General Hospital (LACGH) has been recognized as a Choosing Blood Wisely Hospital by Choosing Wisely Canada and Canadian Blood Services for meeting national appropriateness benchmarks for red blood cell transfusions.

This national achievement symbolises the Hospital's commitment to red blood cell stewardship and continuous quality improvement. The recognition also showcases the Hospital's leadership and ongoing efforts towards conservation and sustainability.

DESIGNATED USING BLOOD WISELY HOSPITAL

LACGH is among a select group of Hospitals that is making a difference for patients, donor's and Canada's blood supply. Dr. Pierre Robichaud, Acute Care Medical Director, and Dr. Nicola Matthew, Internal Medicine Medical Director, share, "we are proud to be following best practices to maximize the benefit of blood transfusions - a limited and precious healthcare resource." Now more than ever, we have come to understand that appropriate use of finite resources, including the supply of blood, is an essential part of safe and high-quality care.

Reducing unnecessary transfusions minimizes the possibility of developing antibodies that would make finding compatible units of blood harder to locate which could potentially delay future emergency transfusions. Transfusion reactions, although uncommon, are also reduced when unnecessary transfusions are eliminated.

The LACGH laboratory initiated the Choosing Blood Wisely quality improvement project in April 2021. They improvement team began the process of educating care team members on transfusion best practices and began reporting statistics to Canadian Blood Services. The simple change of repeat hemoglobin testing after the first blood unit transfused to monitor how each patient responds has drastically reduced the number of patients that receive more than one unit of packed red blood cells. The education for this change was enabled by Dr. Jeannie Callum, Kingston Health Sciences Center. As LACGH's transfusion specialist, she supported the Choosing wisely project and commonly consults with LACGH for complex transfusion cases.

"The path to achieving our choosing blood wisely designation was truly a collaborative one. It required sustained efforts from multiple groups including Laboratory, Nursing, Management, I.T., and Physicians" comments Dr. Robichaud. Pam Hodgen, Laboratory Charge Technologist adds that "by reducing the number of units we transfuse we not only make transfusion safer for patients, we also reduce healthcare costs and unnecessary laboratory testing. Working together with the various departments has helped achieve this prestigious goal. Way to go team!"

Photo (pictured Left to Right): Dr. Nicola Matthews – Medical Director, Internal Medicine / Marie-France Paradis – Manager, Clinical Informatics and Clerical Services / Pam Hodgen – Charge Technologist, Laboratory / Diane Makin, Medical Laboratory Technologist / Dr. Pierre Robichaud – Medical Director, Acute Care

Realizing that the QIP is a living document and the change ideas may fluctuate as you test and implement throughout the year, we want you to reflect on which change ideas had an impact and which ones you were able to adopt, adapt or abandon. This learning will help build capacity across the province.

Change Ideas from Last Years QIP (QIP 2022/23)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
1. Leverage engagement from year one to apply for high designation 2.	Yes	This year Choosing Wisely Canada changed their designation process to a points based system. The LACGH Choosing wisely workgroup adapted the

Continuously monitor performance and optimize outcome	project plan to align with the new designation system. As a result 2/5 points have been awarded to LACGH toward a Quality Improvement designation through receiving a Choosing Blood wisely Designation after extensive work in optimizing transfusion practices. LACGH has built on this work and submitted it's application for choosing labs wisely by showcasing changes made to out EHR that alter providers to choosing wisely recommendations, uncouple previously coupled lab tests, remove tests from the provider order catalog, standardize pick times, and reduce the number of blood tubes used. To monitor the uptake of the changes implemented reports are produced and reviewed by the Choosing Wisely Physician Champion and discussed with relevant providers where indicated.

ID	Measure/Indicator from 2022/23	Org Id	Current Performance as stated on QIP2022/23	Target as stated on QIP 2022/23	Current Performance 2023	Comments
2	Count of events where patients, under the highest level of observation (Form 1), leave the ED without the knowledge of staff (Number; ED patients; 2022-13; In house data collection)	592	CB	0.00	2.00	

Realizing that the QIP is a living document and the change ideas may fluctuate as you test and implement throughout the year, we want you to reflect on which change ideas had an impact and which ones you were able to adopt, adapt or abandon. This learning will help build capacity across the province.

Change Ideas from Last Years QIP (QIP 2022/23)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
1. Address process for timely transfer to KHSC 2. Optimize by-pass process	Yes	This change idea was was implemented with modifications based on the lessons learned with the improvement process. Changes Implemented Include: 1. Implementation of a standardized reporting process – RL6 Incident Reporting and Security Officer Daily Occurrence Report of Form 1 Elopement by Security and Staff. From implementation of this reporting process we were able to identify how many times this never-event actually happened and engage with external stakeholders to reduce incidents. 2. Enhanced LACGH engagement with OPP. Per legislative requirements, OPP unable to by-pass LACGH with psychiatric cases. 3. Policy/Procedure for Security Presence in ED was created and implemented in January 2023 including Security management of Form 1 patients. This change enhances the Security presence in the ED and removed staff uncertainty around managing Form 1 patients. 4. Action Plan per new Security Presence Policy implemented January 2023. 5. Engagement with KHSC is focused, ongoing, and included the following progress: • We met with KHSC in September to discuss the timely transfer of patients requiring MH care/support at a scheduled facility. A priority area of focus as a starting point were those patients that were in a ‘psychotic state’ and were not safe to be in a non-scheduled facility-suggestion from KHSC was to meet as a Region • We met with the Region in October to discuss transfers to scheduled facilities from non-scheduled facilities-agreement was reached that it is not safe to hold Form 1 patients in a non-scheduled facility. KHSC was to look further at process within their organization for timely transfers • Further discussion was had with KHSC in

December regarding experiences with our transfers as they work through their processes for accepting and transferring of patients • We will continue to monitor this and debrief with KHSC as cases present • There is no by-pass protocol completed at this time, KHSC continues to look at their processes/ programs • Discussions to continue in March/April with the Director of the Mental Health Program

ID	Measure/Indicator from 2022/23	Org Id	Current Performance as stated on QIP2022/23	Target as stated on QIP 2022/23	Current Performance 2023	Comments
3	Emergency Department Wait Time CTAS 3-5 (Hours; ED patients; 2022-23; CIHI CCRS, CIHI NACRS)	592	5.43	4.00	5.75	For the purpose of this report item #1 in the change idea is reported with the indicator "Percentage of staff who, because of measures put in place to address workplace violence, strongly agree that they feel safe at work" while items 2 and 3 and reported above.

AIM	MEASURE												
Quality Dimension	Outcome Indicator	Population/ Unit	Baseline	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Timely	Emergency Department Wait Time CTAS 3-5	Avg hrs/ patients CTAS 4&5 not admitted	5.43	4.00	5.68	5.27	5.48	6.02	6.07	6.17	5.97	6.04	6.07

Quality Dimension	Focus	Target	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Trend Line	YTD
Patient Centered	LWBS	<3%	9.3%	9.4%	8.9%	10.8%	11.1%	11.1%	10.6%	10.7%			11.18%
Efficient	Pull Times for ICU (Admit Request to in ICU Bed) - 90% in <90 min	90%	35%	8%	38%	33%	43%	24%	19%	16%	21%		25.75%
	Pull Times for ICU (Admit Request to in ICU Bed) - <1.5 hrs (avg.)	<1.5 hrs	6.35	8.45	3.07	5.02	5.72	8.77	6.07	8.27	5.31		6.62
	Pull Times for ACU (Admit Request to in ACU Bed) - <8 hrs (avg.)	<8 hrs	4.74	4.78	4.15	4.32	4.83	5.06	4.77	7.26	4.43		4.96
	ICU Occupancy	%	60%	52%	38%	39%	52%	42%	40%				
	ACU Occupancy	%	109%	115%	101%	106%	117%	120%	107%				
Timely	Emergency Wait Time CTAS 1-3 (90th%ile)	8 hrs	11.26	9.40	7.68	8.44	11.05	10.13	9.09	10.70	12.33		9.47
	Emergency Wait Time CTAS 4-5 (90th%ile)	4 hrs	5.68	5.27	5.48	6.02	6.07	6.17	5.97	6.04	6.07		5.75
	Time to Physician Initial Assessment CTAS 1 (min)	<15 min	-	26	1	2	14	-	18	24	1		9
	Time to Physician Initial Assessment CTAS 2 (min)	<15 min	43	58	55	56	67	55	60	50	70		57
	Time to Physician Initial Assessment CTAS 3 (min)	<60 min	124	126	135	151	137	141	165	144	140		140
	Time to Physician Initial Assessment CTAS 4 (min)	<60 min	134	130	141	160	151	147	159	153	144		147
	Time to Physician Initial Assessment CTAS 5 (min)	<60 min	91	71	84	121	93	125	102	93	168		105

Realizing that the QIP is a living document and the change ideas may fluctuate as you test and implement throughout the year, we want you to reflect on which change ideas had an impact and which ones you were able to adopt, adapt or abandon. This learning will help build capacity across the province.

Change Ideas from Last Years QIP (QIP 2022/23)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
1. Assess current state perception of safety 2. Assess root causes of wait time 3. Assemble interdisciplinary workgroup to consider type, variability, and transparency of the indicators	Yes	The following changes were implemented: • Created a ED working group in September engaging front line staff and physicians to drive quality change- we meet monthly and review performance data, barriers and opportunities for improvement. • Developed an ED scorecard identifying goals and objectives that align with the QIP with focus on the Quality domains, safe, timely accessible (see attached) reviewed at each working group meeting. • The scorecard

drove the following changes to date: staff education particularly for PALS and ACLS, collaboration with ACU and ICU for pull times (ACU is below the Provincial average), staff model changes were implemented to improve patient flow and access to the ED (addition of a RPN (24/7 coverage), trial of Charge Nurse begins end of March). The addition of the RPN is resulting in less OT for missed meal breaks and better staff morale overall with the support. • Staff huddles were implemented in January, data is shared at the unit level through huddles (minimally 3x per week), discussed improvement ideas sought from staff , below 2 changes made: - One benefit that we experienced through the huddles was a significant improvement in our Blood Culture contamination once staff were aware of the data, practice changes were implemented - Purchased vital signs machines to improve patient care and staff workflow It is felt that the impact if the implemented changes was blunted by continuous HHR challenges coupled with the higher volume of ER visits (~15% higher than the previous year).

ID	Measure/Indicator from 2022/23	Org Id	Current Performance as stated on QIP2022/23	Target as stated on QIP 2022/23	Current Performance 2023	Comments
4	General Surgery Wait 2 (%; Patients; 2022-23; Publicly Reported, MOH)	592	83.00	95.00	92.00	

Realizing that the QIP is a living document and the change ideas may fluctuate as you test and implement throughout the year, we want you to reflect on which change ideas had an impact and which ones you were able to adopt, adapt or abandon. This learning will help build capacity across the province.

Change Ideas from Last Years QIP (QIP 2022/23)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
1. Optimize flow between 3 OR rooms to address significant OR waitlist for General Surgery 2. Assess true current state wait time and project catch-up time frame	Yes	The change idea is fully implemented with improvement seen in year end data and in reducing the number of patients considered surgical long-waiters. Changes implemented to assess true current state and optimize flow include: • Development and implementation of a surgical unit scorecard • Scorecard data presented at committees monthly as a standing agenda item • Novari review is completed monthly and presented for completed volumes, long wait cases as a primary focus

ID	Measure/Indicator from 2022/23	Org Id	Current Performance as stated on QIP2022/23	Target as stated on QIP 2022/23	Current Performance 2023	Comments
5	Percentage of long-term care home residents not living with psychosis who were given antipsychotic medications (%; LTC home residents; 2022-23; In house data collection)	54783	22.00	11.00	15.00	This change idea was done in tandem with the same indicator for the Acute population.

AIM	MEASURE													
Quality Dimension	Outcome Indicator	Population/ Unit	Baseline	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
SAFE	Percentage of long-term care home residents not living with psychosis who were given antipsychotic medications	% /LTC Residents	22%	11%	22%	22%	26%	22%	18%	13%	6%	17%	0%	6%

Realizing that the QIP is a living document and the change ideas may fluctuate as you test and implement throughout the year, we want you to reflect on which change ideas had an impact and which ones you were able to adopt, adapt or abandon. This learning will help build capacity across the province.

Change Ideas from Last Years QIP (QIP 2022/23)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
1. Develop a data collection plan 2. Review all medications of residents for effectiveness 3. Increase Staff/Resident/Family knowledge in regards to psychotropic medications 4. Incorporate palliative care concepts in work.	Yes	• We did develop a data collection plan, in collaboration with Medisystems. The data is reviewed and presented to working groups and committees. It is important to note that due to the small denominator a 6% increase can indicate one patient. Work is needed in the next fiscal year to improve the efficiency of data collection as all cases currently require individual case review. • We developed a palliative care policy, and are working on a learning package for staff • We changed our assessment and documentation to include palliative care planning • CVC has developed a unit scorecard that represents areas of focus (including this indicator) and allows improvement tracking to occur at the unit level • We did not yet implement Order Sets that address deprescribing, as we are working on the Regional HIS project and this is on hold currently to ensure regional alignment. • We have discussed

yearly staff education becoming mandatory and initiated the process in February 2023.

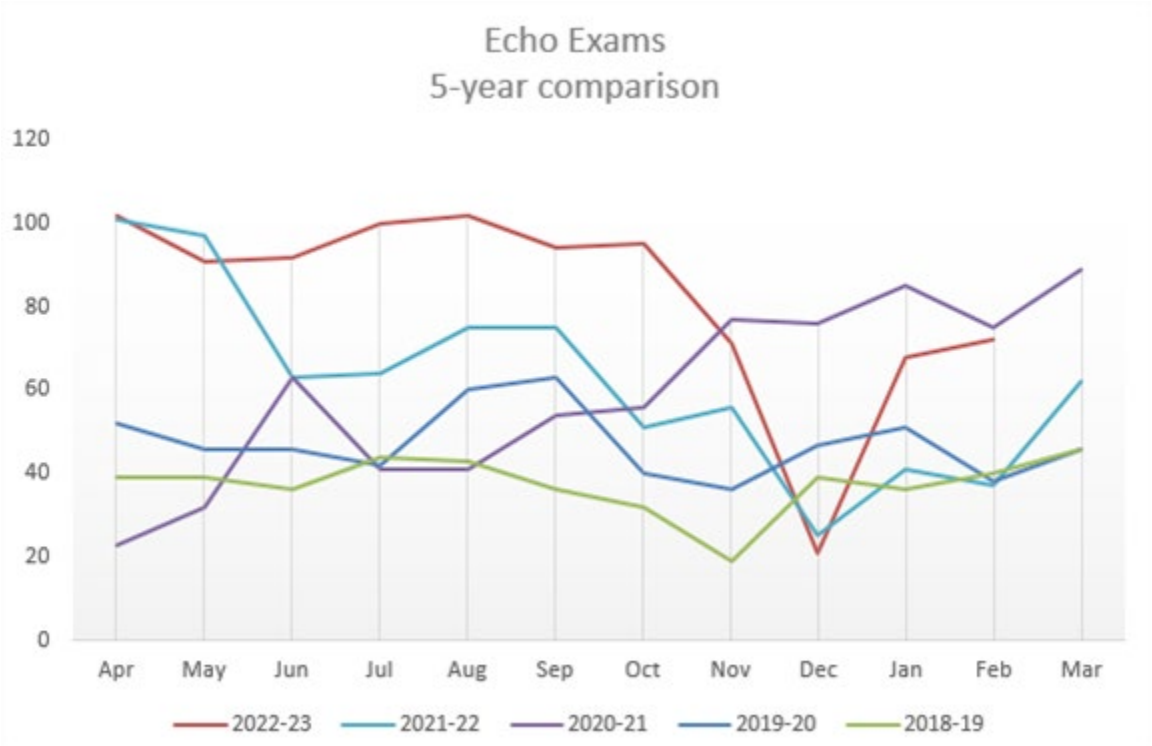
ID	Measure/Indicator from 2022/23	Org Id	Current Performance as stated on QIP2022/23	Target as stated on QIP 2022/23	Current Performance 2023	Comments
6	Percentage of patients newly prescribed benzodiazepine or sedative/hypnotics (BSH) for insomnia (%; All inpatients; 2022-23; Hospital collected data)	592	CB	CB	13.00	

Realizing that the QIP is a living document and the change ideas may fluctuate as you test and implement throughout the year, we want you to reflect on which change ideas had an impact and which ones you were able to adopt, adapt or abandon. This learning will help build capacity across the province.

Change Ideas from Last Years QIP (QIP 2022/23)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
1. Develop a data collection plan 2. Develop process to review BSH medication initiated in hospital regularly to assess indication, effectiveness and safety. 3. Increase Staff/Resident/Family knowledge in regards to BSH medications.	No	• We developed a data collection plan and this is reviewed and presented to working groups and committees (including PFAC). BSH review is completed at daily rounds with the Pharmacist. • The Acute Unit has developed a scorecard that represents areas of focus and allows improvement tracking to occur at the unit level • We did not implement Order Sets that include deprescribing pathways as we are working on the Regional HIS project and this is on hold currently • While education has taken place at the committee level with patients, staff, and physicians, work now underway to developing an online education module for easy reference.
Implement a way to assess impact of BSH medication on Falls	Yes	The RL6 incident reporting software will be used to assess if medication had an impact on a fall that a patient had. This information was being collected previously however it was not a mandatory field and now is. The information can now more accurately be used by the clinical teams to inform future ordering and deprescribing order sets.
Consider alternative insomnia treatments.	Yes	Clinical teams have developed and implemented pathways for the use of

melatonin. Melatonin was added to the formulary in 2020.

ID	Measure/Indicator from 2022/23	Org Id	Current Performance as stated on QIP2022/23	Target as stated on QIP 2022/23	Current Performance 2023	Comments
7	Percentage of patients re-admitted for cardiac related conditions (%; Hospital admitted patients; 2022-23; Hospital collected data)	592	18.40	13.80	6.40	



Realizing that the QIP is a living document and the change ideas may fluctuate as you test and implement throughout the year, we want you to reflect on which change ideas had an impact and which ones you were able to adopt, adapt or abandon. This learning will help build capacity across the province.

Change Ideas from Last Years QIP (QIP 2022/23)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
1. Increase access to echocardiography 2. Coordinate resources to implement an arrhythmia management clinic/program	No	1. Access to appropriate echocardiography services has been achieved through schedule optimization (~20% increase) 2. An arrhythmia management clinic/program was placed on hold at this time.
Create a report that identifies the percentage of people who re-visited the emergency department within 30 days for a cardiac related condition.	Yes	A data collection plan was created and data obtained indicating that 12-17% of patients re-visits the ED with cardiac related conditions within 30 days which is substantially less than the percentage re-admitted with cardiac related

conditions. Though review of the data we learned that some of the repeat visits related to emerge were to enable communication of follow-up tests (like Echocardiography/CT) or related to follow-up instructions to return if the patients condition remained unchanged or worsened.

ID	Measure/Indicator from 2022/23	Org Id	Current Performance as stated on QIP2022/23	Target as stated on QIP 2022/23	Current Performance 2023	Comments
8	Percentage of patients who are ALC and not living with psychosis who were given antipsychotic medications (%; ALC patients; 2022-23; Hospital collected data)	592	CB	CB	5.00	This change idea was done in tandem with the same indicator for the LTC population.

Realizing that the QIP is a living document and the change ideas may fluctuate as you test and implement throughout the year, we want you to reflect on which change ideas had an impact and which ones you were able to adopt, adapt or abandon. This learning will help build capacity across the province.

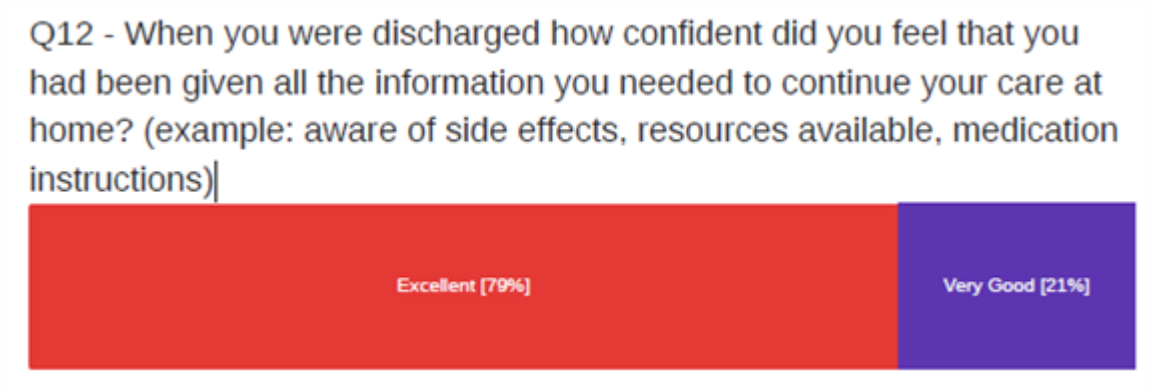
Change Ideas from Last Years QIP (QIP 2022/23)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
1. Develop a data collection plan 2. Review all medications of residents for effectiveness 3. Increase Staff/Resident/Family knowledge in regards to psychotropic medications 4. Incorporate palliative care concepts in work.	Yes	• We did develop a data collection plan with the pharmacy team. The data is reviewed and presented to working groups and committees. Work is needed in the next fiscal year to improve the efficiency of data collection as all cases currently require individual case review. • We developed a palliative care policy, and are working on a learning package for staff • We changed our assessment and documentation to include palliative care planning • Acute Care has developed a unit scorecard that represents areas of focus (including this indicator) and allows improvement tracking to occur at the unit level • We did not yet implement Order Sets that address deprescribing, as we are working on the Regional HIS project and this is on hold currently to ensure regional alignment. • We have discussed yearly staff education becoming mandatory and initiated the process in February 2023.
Leverage opportunities to create non-pharmacologic options to manage BPSD or Delirium	Yes	Two opportunities were leveraged to create better non-pharmacologic options to manage BPSD or Delirium in the acute care unit including 1. Snoezelen room use optimization: a process and policy was developed to allow for

enhanced patient monitoring and more frequent use 2. A cart of non-pharmacologic strategies was created nd implement (weighted blanket, doll therapy etc.)

ID	Measure/Indicator from 2022/23	Org Id	Current Performance as stated on QIP2022/23	Target as stated on QIP 2022/23	Current Performance 2023	Comments
9	Percentage of Patients who respond "completely" to the survey question "Before you left the hospital, did you have a clear understanding about all of your prescribed medications, including those you were taking before your hospital stay?" (90th percentile; All inpatients; 2022-23; NRC Picker)	592	78.00	84.00	100.00	This indicator was not able to be assessed using the data that was used as baseline data due to the unavailability of a standardized survey format since the contract with NRC was not renewed by the NRC and VOR platform implementation did not occur until partway through q4. As such the data used was available local survey data from the operating room where 100% of patients responded "excellent (79%)/very good (21%)" to the survey question "When you were discharged how confident did you feel that you had been given all the information you needed to continue your care at home? (example: aware of side effects, resources available, medication instructions)."

QIP Operational Milestones

Quality Dimension	Process Measures	Completion Status
Safe	Quarterly Reporting on Pharmacist Involvement at Discharge	Q1 = 35.3% Q2 = 32.4% Q3 = 33.83%



Realizing that the QIP is a living document and the change ideas may fluctuate as you test and implement throughout the year, we want you to reflect on which change ideas had an impact and which ones you were able to adopt, adapt or abandon. This learning will help build capacity across the province.

Change Ideas from Last Years QIP (QIP 2022/23)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Increase the proportion of patients who receive medication education from a pharmacist at discharge.	No	- A medication reconciliation report was created with qualitative indicators including the proportion of patients who receive medication education from a pharmacist at discharge. - Patient Oriented Discharge Summaries (PODS) continue to be utilized to engage patients/caregivers in pre-discharge awareness of their at home medication management. Education for the nursing staff involved has been a key focus this last year to improve utilization of the teachback tool. - In the next fiscal year work will begin to develop a triage algorithm for pharmacist involvement at discharge to ensure participation is appropriate and that the process is lean.

ID	Measure/Indicator from 2022/23	Org Id	Current Performance as stated on QIP2022/23	Target as stated on QIP 2022/23	Current Performance 2023	Comments
10	Percentage of people who feel LACGH adequately support diversity, equity, and inclusion (DEI). (%; Survey respondents; 2022-23; In house data collection)	592	CB	CB	NA	

Realizing that the QIP is a living document and the change ideas may fluctuate as you test and implement throughout the year, we want you to reflect on which change ideas had an impact and which ones you were able to adopt, adapt or abandon. This learning will help build capacity across the province.

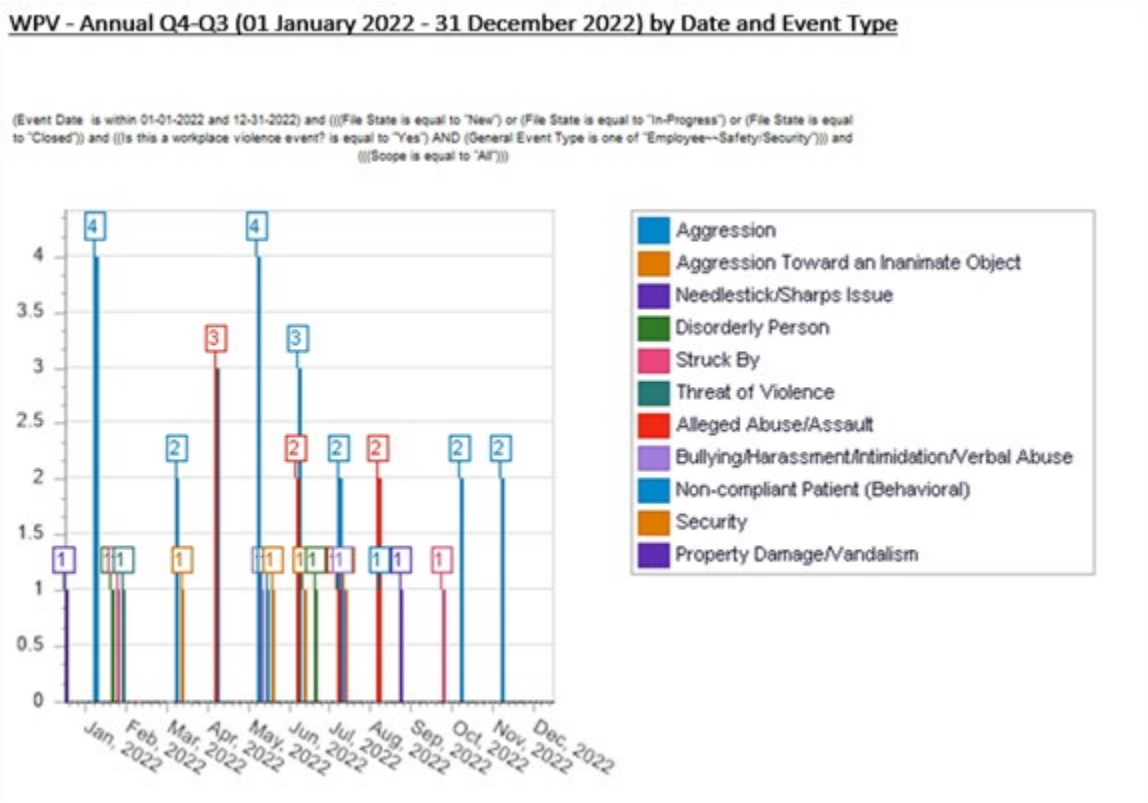
Change Ideas from Last Years QIP (QIP 2022/23)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
1. Assess current state perception of DEI with staff 2. Assess current state perception of DEI with patients 3. Assess staff, leadership, governance, patient, and resident demographic data 4. Initiate the development of a long-term diversity and inclusion strategy, including cultural education, unconscious bias training, measurable success metrics, inclusion monitoring and review.	No	A staff survey has been developed and disseminated to all new staff. The survey has been introduced to the remainder of the organization within the 2023 Annual Employee Education. Once the 2023 Annual Employee Education campaign has been completed, the surveys will be collated and baseline data will be communicated. We learned that leadership needs to be consciously aware that after two years within the pandemic that additional surveys can be challenge for staff who are mentally and physically exhausted and focusing on avoiding survey fatigue has been important. An effort has been made to ensure that the new survey is short and contextual.

ID	Measure/Indicator from 2022/23	Org Id	Current Performance as stated on QIP2022/23	Target as stated on QIP 2022/23	Current Performance 2023	Comments
11	Percentage of respondents who would "always" recommend LACGH to family (Number; Survey respondents; 2022-23; NRC Picker and Local Data Collection)	592	70.20	80.20	100.00	This indicator was not able to be assessed using the data that was used as baseline data due to the unavailability of a standardized survey format since the contract with NRC was not renewed by the NRC and VOR platform implementation did not occur until partway through q4. As such the data used was available local survey data from the operating room, diagnostic imaging, convalescent care, and Diabetes Education.

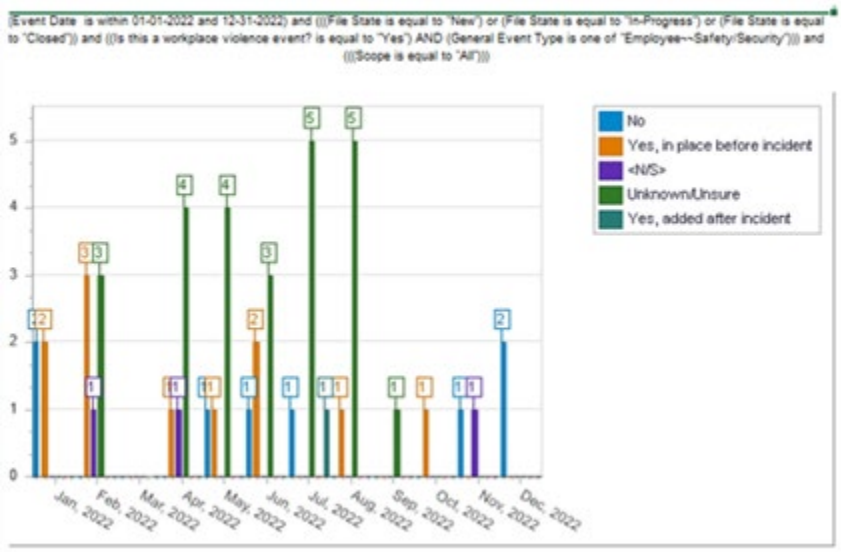
Realizing that the QIP is a living document and the change ideas may fluctuate as you test and implement throughout the year, we want you to reflect on which change ideas had an impact and which ones you were able to adopt, adapt or abandon. This learning will help build capacity across the province.

Change Ideas from Last Years QIP (QIP 2022/23)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
1. Ensure all surveys have the "would recommend" question 2. Plan change initiatives that address the poor performing areas of the most recent surveys	Yes	All surveys were reviewed and updated to ensure that the would recommended questions was included. Changes resulting from local survey feedback include: updates to Hospital website, changes to signage, the development of new patient handouts, and changes to electronic appointment reminders.

ID	Measure/Indicator from 2022/23	Org Id	Current Performance as stated on QIP2022/23	Target as stated on QIP 2022/23	Current Performance 2023	Comments
12	Percentage of staff who, because of measures put in place to address workplace violence, strongly agree that they feel safe at work. (%; Survey respondents; 2022-23; Staff survey)	592	45.00	60.00	NA	For the purpose of this report item 2 & 3 in the change idea are reported with the indicator "Emergency Department Wait Time CTAS 3-5" while item #1 is reported above.



WPV - Annual Q4-Q3 (01 January 2022 - 31 December 2022) by Date and Behavioural Crisis Alert



Realizing that the QIP is a living document and the change ideas may fluctuate as you test and implement throughout the year, we want you to reflect on which change ideas had an impact and which ones you were able to adopt, adapt or abandon. This learning will help build capacity across the province.

Change Ideas from Last Years QIP (QIP 2022/23)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
1. Assess current state perception of safety 2. Assess root causes of wait time 3. Assemble interdisciplinary workgroup to consider type, variability, and transparency of the indicators	Yes	The current perception of safety was assessed through newly implemented departmental huddles and established clinical team meetings. Three of the key findings in these huddles were a) The reporting culture is still building and has not yet saturated the organization. This culture build benefits from frequent discussions regarding the feeling of safety and individual feedback related to reported WPV incidents. b) We have opportunity in optimizing the use of behaviour crisis alerts. The Hospital is not utilizing these alerts to their full potential. Further education and reinforcement of reporting within the incident reporting system will be the focus in 23/2024. c) Staff feel they would benefit from additional training opportunities. As such training for all clinical and clerical staff will begin in April 2023. The Hospital Security Provider, Paladin, has been contacted with regards to staff training. JOHSC has endorsed the Management of Resistive

Behaviour program by Stay Safe International Programs as the most appropriate program.