Access and Flow | Timely | Priority Indicator

Indicator #6

Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital. (Timmins And District General Hospital)

Last Year		This Year		
28.83	**50**	**59.00**	**104.65 %**	**NA**
Performance (2022/23)	Target (2022/23)	Performance (2023/24)	Percentage Improvement (2023/24)	Target (2023/24)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Work with health records to improve dictation time to ensure timely delivery of discharge summaries by implementation a voice system.

Process measure

- Monthly auditing of dictation time.

Target for process measure

- Dictation times will be reviewed on a monthly basis.

Lessons Learned

Dictation software improved time for completion of discharge summaries.

Access and Flow | Efficient | Optional Indicator

Indicator #3

Number of individuals for whom the emergency department was the first point of contact for mental health and addictions care per 100 population aged 0 to 105 years with an incident MHA-related ED visit. (Timmins And District General Hospital)

Last Year		This Year		
28.54	**25**	**NA**	**--**	**NA**
Performance (2022/23)	Target (2022/23)	Performance (2023/24)	Percentage Improvement (2023/24)	Target (2023/24)

Change Idea #1 ☐ Implemented ☑ Not Implemented

Monitor Crisis Call data and begin working at ensuring warm handoff between clients who are contacting our crisis line with relevant community agencies that could support the client in community versus connecting with our Emergency Department for support.

Process measure

- 1: Number of clients not connected to Mental Health or Addiction Services 2: Number of clients not connected that receive warm hand off to relevant community support

Target for process measure

- •Decrease the number of clients contacting the crisis line who are not connected to services by 50% •Increase the number of clients contacting the crisis line who receive a warm hand off to a community agency i.e. CMHA, SCAS, Mobile Crisis, CWMS

Lessons Learned

Organizational priorities did not allow for the change idea to be implemented this year.

Indicator #5

Percentage of inpatient days where a physician (or designated other) has indicated that a patient occupying an acute care hospital bed has finished the acute care phase of his/her treatment. (Timmins And District General Hospital)

Last Year		This Year		
43.00	**40**	**21.80**	**49.30%**	**NA**
Performance (2022/23)	Target (2022/23)	Performance (2023/24)	Percentage Improvement (2023/24)	Target (2023/24)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Implement a Geriatric Emergency Management Nurse Cinician in our Emergency Department to assess frail at risk seniors and ensure they are linked to appropriate and specialized geriatric services in the community to support their

Process measure

- To hire person in a role, facilitate training and implement in the Emergency department

Target for process measure

- Post position in Q1, hire candidate in Q2, train in Q2 and have role in place by Q3.

Lessons Learned

Nurse has been hired ; currently completing orientation and training. Has worked with regional partners for support.

Comment

ALC data for current performance is April 2022 - Jan 2023.

Equity | Equitable | Custom Indicator

	Last Year		This Year		
Indicator #1	**CB**	**CB**	**47.00**	**--**	**NA**
Improve access to and utilization of Withdrawal Management Beds within the Hospital. (Timmins And District General Hospital)	Performance (2022/23)	Target (2022/23)	Performance (2023/24)	Percentage Improvement (2023/24)	Target (2023/24)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Increase district community/stakeholder awareness of addiction medicine services offered at TADH.

Process measure

- # of completed engagement sessions.

Target for process measure

- Engagement sessions will be completed in each of the identified communities by the end of Q3.

Lessons Learned

We have seen an increase in the utilization of the withdrawal management beds and introduced residential treatment beds and supportive treatment beds. Occupancy/utilization continues to increase.

Experience | Patient-centred | Priority Indicator

Indicator #7

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? (Timmins And District General Hospital)

Last Year		This Year		
97.42	**99**	**97.71**	**0.30%**	**98**
Performance (2022/23)	Target (2022/23)	Performance (2023/24)	Percentage Improvement (2023/24)	Target (2023/24)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Gather details from survey participants who do not feel they received enough information from hospital related to their health after discharge.

Process measure

- % of comments received for answers that do not indicate the person received enough information.

Target for process measure

- 80% of negative answers will have a comment starting in Q2.

Lessons Learned

Patient Engagement Lead followed up with discharged patients, asking questions to better understand what information they needed. Some patients did not retain discharge information that was provided and required confirmation of follow-up appts, health teaching, and supplies.

Safety | Safe | Priority Indicator

Indicator #2

Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged. (Timmins And District General Hospital)

Last Year		This Year		
81.57	**85**	**67.76**	**-16.93%**	**71**
Performance (2022/23)	Target (2022/23)	Performance (2023/24)	Percentage Improvement (2023/24)	Target (2023/24)

Change Idea #1 ☐ Implemented ☑ Not Implemented

Implement medication reconciliation in additional hospital units (focus on surgical).

Process measure

- •Meeting with Chief of Staff for buy-in. •Chief of Staff discussion with surgeons. •Process development to facilitate discharge medication reconciliations.

Target for process measure

- Medication reconciliation at discharge will be implemented on the surgical unit by the end of Q3. By the end of Q4, 50% of discharges will have a medication reconciliation completed.

Lessons Learned

Will review spread to other others in 2023-2024.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Increase interprofessional collaboration by partnering with pharmacy to support medication reconciliation.

Process measure

- Process review to be completed by end of Q2.

Target for process measure

- Process review completed with identified process changes.

Lessons Learned

Pharmacy currently assists with medication reconciliation as they review medications upon admission.

	Last Year		This Year		
Indicator #4	**274.00**	**400**	**238.00**	**13.14%**	**225**
Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period. (Timmins And District General Hospital)	**Performance (2022/23)**	**Target (2022/23)**	**Performance (2023/24)**	**Percentage Improvement (2023/24)**	**Target (2023/24)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Increase staff education regarding reporting of workplace violence incidents.

Process measure

- # of education events for staff re: reporting

Target for process measure

- 1: At least 1 email will be sent reminding staff about reporting incidents. 2: Workplace violence reporting will be discussed in at least 1 staff meeting/huddle in every department.

Lessons Learned

Managers provided reminders/education during huddles. This will continue as we have Agency Nurses and new hires that continue to join our organization.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Improve the reporting process and analysis of reports related to workplace violence incidents.

Process measure

- Number of reviews completed of current state for reporting.

Target for process measure

- A review of the current state for reporting will be conducted by end of Q2.

Lessons Learned

Review of reporting was conducted with Occupational Health and Safety Coordinator. Paper (carbon copy) continues to be kept on the departments to make it easy for staff who do not work at a computer to report, and the online reporting continues.

Safety | Effective | Custom Indicator

	Last Year		This Year		
Indicator #8	**CB**	**6**	**6.00**	**--**	**NA**
Senior Leadership participation during Safety and Quality Walks. (Timmins And District General Hospital)	Performance (2022/23)	Target (2022/23)	Performance (2023/24)	Percentage Improvement (2023/24)	Target (2023/24)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Engage Senior Leadership in patient care areas through participation in Patient Safety and Quality walkabouts; these walkabouts are scheduled on a monthly basis (they were delayed during the pandemic). The Patient Safety and Quality Committee is reintroducing walkabouts and will include at least 1 member of the senior leadership team.

Process measure

- # of Senior Leadership Safety Walkabouts in a 12 month period

Target for process measure

- 6 (the QIP is being completed in June; the calendar invites will be sent out by the end of June)

Lessons Learned

SLT participation in PSQ walkabouts increased their visibility within the organization and allowed them to better understand the work of our front-line staff.