Experience | 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? (Timmins And District General Hospital)

Last Year		This Year		
97.71	**98**	**99.47**	**1.80%**	**NA**
Performance (2023/24)	Target (2023/24)	Performance (2024/25)	Percentage Improvement (2024/25)	Target (2024/25)

Change Idea #1 ☐ Implemented ☑ Not Implemented

Enhance data collection to allow for comparator information.

Process measure

- Review CPERS licensed vendors and pricing.

Target for process measure

- Follow-up completed and report prepared for leadership to consider implementation.

Lessons Learned

A meeting was held to review CPERS; no decision was made.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Improve consistency and quality of discharge information provided to patients by ensuring instructions are easy to understand/accessible.

Process measure

- Meetings with ER, medical, surgical and OBS departments to review process and patient materials provided. Ensure Meditech Expanse project improves the discharge information process.

Target for process measure

- Review of current state completed by Q2. Plan for Meditech Expanse d/c summaries is completed by Q4.

Lessons Learned

Discharge process review was started in fall of 2023. The project continues as the team reviews roles and gaps in current process. The implementation of Meditech Expanse may also provide opportunities to improve health teaching.

Change Idea #3 ☐ Implemented ☑ Not Implemented

Review pre and post-op patient satisfaction based on the implementation of Seamless MD.

Process measure

- Number of patient satisfaction surveys completed

Target for process measure

- 90% of patients using the Seamless MD program will complete the survey.

Lessons Learned

Not initiated due to other priorities.

Safety | Safe | Custom Indicator

	Last Year		This Year		
Indicator #4	**6.00**	**8**	**10.00**	**--**	**NA**
Senior Leadership participation in Patient Safety and Quality walkabouts. (Timmins And District General Hospital)	**Performance (2023/24)**	**Target (2023/24)**	**Performance (2024/25)**	**Percentage Improvement (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ **Implemented** ☐ **Not Implemented**

Advanced planning to ensure SLT availability.

Process measure

- Calendar invitations sent by May 2023

Target for process measure

- Invitations sent and confirmed.

Lessons Learned

A reoccurring meeting has been set in the SLT schedules to ensure advanced notice. At least 1 SLT member has attended each walkabout (up to 3-4 at times).

Change Idea #2 ☐ **Implemented** ☑ **Not Implemented**

Host staff education re: PSQ walkabouts.

Process measure

- Request presentation at all-staff meeting by end of Q1.

Target for process measure

- Presentation booked: Q1 Presentation delivered: Q2

Lessons Learned

All-staff meeting format has changed in the last year; 1 opportunity was used to provide education re: patient falls instead.

Safety | Safe | Priority Indicator

	Last Year		This Year		
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. (Timmins And District General Hospital)	**67.76** Performance (2023/24)	**71** Target (2023/24)	**66.31** Performance (2024/25)	**-2.14%** Percentage Improvement (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☐ Implemented ☑ Not Implemented

Implement Meditech Expanse Feb 2024 to facilitate medication reconciliation.

Process measure

- Training sessions completed, successful "go-live"

Target for process measure

- Implementation of Meditech Expanse across all hospital departments, with utilization of all modules and functionalities by February 2024.

Lessons Learned

Go-Live has been rescheduled to April 2024. Training has been completed by "super-users" and is scheduled for front-line staff in Q4.

Change Idea #2 ☐ Implemented ☑ Not Implemented

Review medication reconciliation processes with ER and in-patient unit staff to identify barriers to completion.

Process measure

- Number of educators engaged in process review. Number of clerks engaged in process review. Number of pharmacy team members engaged in process review.

Target for process measure

- Initial engagement with educators, clerks and pharmacy by end of Q1.

Lessons Learned

Other QI projects occurred across the hospital. Discharge planning was reviewed in a process mapping exercise with the medical unit: still ongoing.

	Last Year		This Year		
Indicator #2	**238.00**	**225**	**237.00**	**0.42%**	**NA**
Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period. (Timmins And District General Hospital)	Performance (2023/24)	Target (2023/24)	Performance (2024/25)	Percentage Improvement (2024/25)	Target (2024/25)

Change Idea #1 ☐ Implemented ☑ Not Implemented

Increase training for staff re: de-escalation.

Process measure

- Review costs and timeframe for training. Explore possibility to partner with other regional partners for cost sharing travel expenses for facilitation.

Target for process measure

- Cost estimate and program overview received by Q1. If approved, implementation plan is established within 1 month.

Lessons Learned

TADH is currently implementing Relational Security across the Hospital. To date, members of the leadership and SLT have attended education sessions. Front-line leads are identified and will begin to receive training in the following months. All employees will receive training.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Develop and implement a Proactive Behaviour Team to review Code Whites in the hospital within 24 hours.

Process measure

- Number of Code Whites reviewed by PBT as a quarterly percentage.

Target for process measure

- 60% of Code Whites will be reviewed by PBT for Q4.

Lessons Learned

The PBT was implemented in October 2023. Security, OHS, MHU Management and Educator, ER Director, a Clinical Director and Risk Leads attend regularly. All incidents of violence are reviewed. The group meets 3 times a week.

Change Idea #3 ☑ **Implemented** ☐ **Not Implemented**

Increase staff reporting of all incidents of workplace violence to ensure accurate data collection.

Process measure

- Number of departments that have included the topic in staff huddles or meetings.

Target for process measure

- All departments will have discussed workplace violence reporting during a huddle or meeting. Presentation complete at an All Staff meeting.

Lessons Learned

Staff continued to be encouraged to complete incident reports.