Theme I: Timely and Efficient Transitions

Measure

Dimension: Timely

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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.	P	% / Discharged patients	Hospital collected data / Most recent 3 month period	94.00	90.00	Sustain previous performance from FY 2020-21, target >=90%.	

Change Ideas

Change Idea #1 Design a new physician onboarding and orientation process to include education and information on the importance of completed Discharge Summaries for the primary provider within 48 hours of a patient's discharge.

Methods	Process measures	Target for process measure	Comments
Working collaboratively with representatives from medical affairs, pharmacy and clinical leadership, develop and implement a remodeled onboarding process to commence at the end of May 2022 for the physician group with targeted education on the importance and expectations of patient Discharge Summary completion.	Refreshed onboarding process to commence at the end of May 2022. Target of two (2) physician onboarding sessions to take place on a monthly basis over the next year providing specific information about STEGH's target for completed Discharge Summaries.	A minimum of two (2) physician onboarding education sessions to take place monthly that address the importance of Patient Discharge Summaries.	

Change Idea #2 Create a guideline on Discharge Summary expectations for all privileged physicians.

Methods	Process measures	Target for process measure	Comments
Development of completed guideline / standard operating procedure (SOP) addressing Discharge Summaries to be completed for all privileged physicians working at STEGH. Physicians will be required to review education guideline during orientation.	Guideline / SOP compliance for this metric tracked weekly at leadership huddle where performance will be discussed. Area leaders will continue to follow-up with Departmental Chiefs and individual physicians to sustain and improve.	Guideline / SOP completed and approved for roll out by end of Q3, with 100% of physicians orientated to the guideline / SOP end of Q4.	

Change Idea #3 Provide weekly Discharge Summary data to physician and operational leaders.

Methods	Process measures	Target for process measure	Comments
Provide weekly performance data to area leadership to create a process for direct follow-up with physicians.	Decision Support will send compliance reports directly to physician and operational leaders in order to have a clear line of sight on metric performance and where improvements can be made.	100% of physician and operational leaders will receive weekly information on the performance of physicians for completing discharge summaries to primary care providers within 48 hours of the patient discharge.	

Theme II: Service Excellence

Measure

Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of respondents who responded "Yes Definitely" to the following question: When you left hospital, did the hospital make sure you had follow-up care with a doctor or other health care professional?	C	% / Survey respondents	Local data collection / January - December 2021	94.30	90.00	Sustain the current target of >=90%.	

Change Ideas

Change Idea #1 Review discharge information package distributed to patients / caregivers containing follow-up information.

Methods	Process measures	Target for process measure	Comments
Through a process of patient co-design, the hospital will review and standardize the discharge information package and the associated discharge process components across STEGH.	In addition to the improvements made to the discharge process through patient co-design, STEGH will also ensure that patients receive a discharge follow-up phone call and that staff follow a standardized discharge process so all patients are receiving the same information when planning for home.	100% of staff are orientated to discharge process and standardized package by end of Q4. 100% of patients receive a follow-up phone call following discharge from hospital by the end of Q4.	

Change Idea #2 Continue to enhance clinical leaders and clinical resource nurses (CRN) rounding on patients by engaging patients and families in determining their information needs are being met for their discharge. Clinical leaders and CRNs are rounding on patients and will incorporate asking about preparedness for discharge.

Methods	Process measures	Target for process measure	Comments
Using evidence based leadership practices, patient rounding will also target patients being discharged home to ensure that the patient feels that they have the information they need for a successful discharge home.	Patients being discharged home will be rounded on by either a clinical leader or CRN to ensure that the standardized discharge process has been followed and the patient is confident in the follow up care arranged.	100% of patients being discharged home will be rounded on by either a clinical leader or CRN to ensure process is followed and the necessary discharge arrangements have been made.	

Theme III: Safe and Effective Care

Measure

Dimension: Effective

Indicator #3	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 / October 2021– December 2021	93.67	90.00	Sustain previous performance from FY 2020-21, target >=90%.	

Change Ideas

Change Idea #1 Update medication reconciliation policy so that it clearly outlines expectations for medication reconciliation (including discharge for both inpatients and selected ambulatory clinics).

Methods	Process measures	Target for process measure	Comments
Through a collaborative process involving representatives from professional practice, pharmacy, medical affairs and clinical leadership. This policy will be used to re-educate and promote the importance of Medication Reconciliation at Discharge.	The compliance with this policy will be measured through weekly monitoring of percentage of completed Medication Reconciliation at Discharge. Post pandemic refresher of education for physicians / providers on completion of Medication Reconciliation at Discharge. Note. Patients who are Expired, Sign out Against Medical Advice and Discharges with length of stay of 28 hours or less along with OB will be excluded from the calculation.	1) Updated policy approved, distributed to leadership and posted to internal website by end of Q4. 2) 100% of education on policy for both physicians and staff to be completed by end of Q4.	

Change Idea #2 Provide timely and understandable data to physician and operational leadership that illustrates performance around this metric.

Methods	Process measures	Target for process measure	Comments
Performance results to be sent to physician and operational leaders for review and follow up with medical teams.	Weekly monitoring of percentage of completed medication reconciliation at discharge via emailed report. Note. Patients who are Expired, Sign out Against Medical Advice and Discharges with length of stay of 28 hours or less along with OB will be excluded from the calculation.	100% of physician and operational leaders will receive weekly audit and compliance reports that will be used to guide follow up and performance opportunities.	

Measure

Dimension: Safe

Indicator #4	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 / January - December 2021	119.00	119.00	Continue to encourage all violence incidents to be reported.	

Change Ideas

Change Idea #1 Review violence incidents and trends, Workplace Violence Risk Assessment action plans, and recommend / select measures to control the hazards / risks.

Methods	Process measures	Target for process measure	Comments
Carry out an in-depth review of the adverse event reporting specifically pertaining to workplace violence and harassment.	Over the course of the year, workplace violence incidents and trends will be monitored and trended so that a monthly report can be reviewed by the necessary stakeholders.	By the end of Q4, a monthly report on the number of workplace violence incidents reported by hospital workers will be developed for unit level leadership, Joint Health and Safety Committee (JHSC) members and the Workplace Violence Prevention Committee members with a focus on trends in violent incidences.	FTE=770

Change Idea #2 Evaluate workplace harassment and violence statistics and trends to ensure the effectiveness of measures in mitigating hazards / risks.

Methods	Process measures	Target for process measure	Comments
Each month review workplace harassment and violence statistics and trends to ensure the effectiveness of measures in mitigating hazards / risks.	On a monthly basis present the number of workplace violence incidents broken down by verbal and physical abuse. Identifying opportunities for improvement.	By the end of Q4, execute two (2) workplace harassment and violence prevention initiatives that have been discussed and developed by the Violence Prevention Committee.	

Change Idea #3 Evaluate the training program for all staff and make recommendations for improvement based on learning needs and desired outcomes.

Methods	Process measures	Target for process measure	Comments
Solicit feedback from staff on existing workplace violence prevention training through post training surveys / employee experience surveys.	All solicited feedback from staff will be gathered and trended to identify if/where modifications or enhancement to training can be made.	By the end of Q4, develop a set of recommendations that address any changes or additions desired by staff that enhance the current workplace violence prevention training.	