Theme I: Timely and Efficient Transitions

Measure

Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Total ALC rate (%) (Acute & Non-Acute)	C	% / All inpatients	Other / YTD Q3 22/23 (April 2022-December 2022)	21.80	18.40	10% improvement over FY22/23 YTD October (20.4%)	

Change Ideas

Change Idea #1 Patient Flow Advisory Committee along with Discharge Planning/ALC Advisory Committee to develop initiatives in reducing wait times for inpatient beds and decrease in ALOS for ALC patients.

Methods	Process measures	Target for process measure	Comments
The Committee will share data trends, issues and create strategies to address prevalent issues and quality concerns; The Committee will support proactive discharge planning across GRH campuses and reduce reactive planning; Support discharge planning transition from Home and Community Care Services to GRH Review and educate criteria for post acute transition; Support ongoing evaluation of the Coordinated Bed Access process in partnership with HCCSS.	% of time EDD is entered on admission	EDD entered on 70% of admissions by end of Q1	

Measure

Dimension: Efficient

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Time to Inpatient Bed - 90th Percentile (hr)	C	Hours / Other	Other / YTD Q3 22/23 (April 2022-December 2022)	21.00	16.00	Provincial and National top decile in FY 21/22	

Change Ideas

Change Idea #1 Patient Flow Advisory Committee to meet monthly with program stakeholders/Directors to work on flow initiatives to reduce wait times to inpatient beds.

Methods	Process measures	Target for process measure	Comments
The Committee will drive a system approach to access, efficiency and patient flow; The Committee is responsible for developing and implementing standardized processes that will reduce bottlenecks and optimize and streamline patient flow across clinical programs and services across the Hospital.	% of time Overflow Algorithm's activated when triggers met; % of time ED Surge Protocol Activated when triggers met; % of time average daily admits holding without bed plan are greater than 12 or more.	90% of the time triggers are met a phase of the algorithm is activated every quarter; Admitted patients holding in the ED will be transferred to inpatient hallway stretchers 100% of the time ED Surge Protocol activated; Less than 10% of the time that the algorithm is activated there is no more than 12 admissions holding in ED without a bed plan each quarter	

Theme II: Service Excellence

Measure

Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Communication with Physicians and Nurses (%) - Composite Metric	C	% / Survey respondents	Other / April 2021-March 2022	74.10	80.00	Large community hospitals top decile (80%)	

Change Ideas

Change Idea #1 Through phase 2 of Huron Group partnership – implement customer service training in priority areas

Methods	Process measures	Target for process measure	Comments
Identify priority units for phase 2; Deliver AEDIT training in select areas to all staff and providers	% of staff that have completed AEDIT training; % of providers that have completed AEDIT training	90% of staff who have completed training; 90% of providers who have completed training	Patient experience data has not been captured since March 31, 2022 when the contract with the Ontario Hospital Association ended. A new agreement has been signed and it is anticipated that patient experience surveys will resume April 1, 2023.

Theme III: Safe and Effective Care

Measure

Dimension: Effective

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Medication Reconciliation on Admission (% of time Best Possible Medication History completed on admission) (%)	C	% / All inpatients	Other / YTD Q3 22/23 (April 2022-December 2022)	78.40	83.40	Provincial top decile medication reconciliation at Admission	

Change Ideas

Change Idea #1 Implement nursing completion of BPMH

Methods	Process measures	Target for process measure	Comments
Update requirement of training for nursing staff; Identify priority units for phased approach to implementation; Review and adjust nursing workflow as necessary; Review BPMH policy and procedures with a focus on roles and responsibilities; Monthly reporting on BPMH compliance by program on scorecards	% of staff that have completed required training; % completion of identification of priority units; % completion of nursing workflow review; % completion of updated BPMH policy/procedure; % of compliance with monthly BPMH reporting by program	100% of nursing staff who have completed required training; 100% milestone completion; 100% milestone completion; BPMH policy/procedure approved and implemented; 100% of programs in compliance with monthly BPMH reporting	

Measure

Dimension: Safe

Indicator #5	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	337.00	228.00	Workplace violence incidents will be decreased by implementing recommendations from 'Violence in the Workplace' review.	

Change Ideas

Change Idea #1 Implement recommendations from workplace violence program audit.

Methods	Process measures	Target for process measure	Comments
Statistical analysis of problem; Root cause analysis of most common trending injuries; Meet regularly with ED, SMH & Security leadership to implement workplace violence program audit recommendations; Evaluate & update code white/de-escalation training; roll out updated training Update Violence Prevention Committee Terms of Reference & membership; Improve compliance with Panic Alarm policy;	% of workplace violence audit recommendations open on target/open overdue/completed; % of time Electronic Personal Alarms (EPAs) are worn; % of staff in targeted high risk areas who have completed code white training;	50% of ED/SMH recommendations will be completed by Mar 31, 2023; remaining recommendations to be completed by Sept 30, 2024; EPAs will be utilized 95% of the time (ongoing; 100% of staff in high risk areas will be current with their code white training by Sept 30, 2023 (currently at ~73% current)	FTE=3066

Measure

Dimension: Safe

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Preventable Harm - Rate of Hand Hygiene Compliance Before Patient/Patient Environment Contact (%)	C	% / Other	In house data collection / YTD Q3 22/23 (April 2022-December 2022)	51.00	83.80	Goal is to achieve provincial top decile (98.1%) over two years. Year 1 (FY23/24) target is 83.8%, and year 2 (FY24/25) will be at 98.1%	

Change Ideas

Change Idea #1 Renew and strengthen hand hygiene program

Methods	Process measures	Target for process measure	Comments
Re-establish unit-level huddle discussions that include a focus on hand hygiene compliance; Establish increased frequency of hand hygiene audits for compliance data; Launch hand hygiene toolkit to support internal unit changes for improving hand hygiene practices;	Percentage of units with consistent focused discussions that include hand hygiene compliance; Number of hand hygiene audits conducted per unit/per quarter; Percentage of completion	100% of units with huddles incorporating compliance data; Sustained number of hand hygiene audits to ensure data quality to be established; 100% milestone completion	