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 discharge summaries (Turn Around Time) completed within 48 hours of discharge. (Four Counties Health Services Corporation)	C	% / All inpatients	Local data collection / Q1-Q3	52.00	58.00	Multi year strategy. Year 2- Sustain achievement and continue to improve	
Percentage of discharge summaries (Turn Around Time) completed within 48 hours of discharge. (Strathroy Middlesex General Hospital)	C	% / All inpatients	Local data collection / Q1-Q3	40.00	50.00	25% improvement. Continue to improve	
Percentage of discharge summaries (Turn Around Time) completed within 48 hours of discharge.	C	% / All inpatients	Local data collection / Q1-Q3	42.00	50.00	20% improvement at MHA level. Continue to improve.	

Change Ideas

Change Idea #1 1)Working group was established and an action plan for improvement developed in FY - 22/23 to increase percentage of discharge summaries dictated within 48 hours. 2) Provider champions are engaged. 3) Pilot project with “auto-authentication” - Complete and evaluated. Plan is to spread the learning to other departments. Technology opportunity assessment for smooth transition is underway.

Methods	Process measures	Target for process measure	Comments
Monthly meetings with all stakeholders to review data.	Provide regular reporting to providers on performance and education support. Develop communication and awareness campaign for providers. Quarterly review by Board Quality Committee.	58% of the discharge summaries are dictated within 48 Hours of inpatient discharge.	In FY 23/24 we are working on increasing count of discharge summaries completed within 48 hours after 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 “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? (Four Counties Health Services Corporation)	P	% / Survey respondents	CIHI CPES / Most recent consecutive 12-month period	CB	50.00	No data for FY 22/23 due to lack of survey tool (NRC picker). Qualtrics implementation in progress. This year is baseline data collection year.	
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? (Strathroy Middlesex General Hospital)	P	% / Survey respondents	CIHI CPES / Most recent consecutive 12-month period	CB	50.00	No data for FY 22/23 due to lack of survey tool (NRC picker). Qualtrics implementation in progress. This year is baseline data collection year.	
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	CB	50.00	No data for FY 22/23 due to lack of survey tool (NRC picker). Qualtrics implementation in progress. This year is baseline data collection year.	

Change Ideas

Change Idea #1	Transition year from NRC picker to new vendor Qualtrics. 1) Exploring technology options to increase survey uptake. 2) Develop process for communication to staff on units regarding metric performance monthly i.e., Units Huddles 3) Promote patient survey completion at discharge 4) Establish process at discharge to ask patients if they received the info they need for discharge, if they have any additional questions & who to contact after discharge if they have questions.

Methods	Process measures	Target for process measure	Comments
Working with Health Records Department developing strategy to increase collection of email id's	Monthly count of completed surveys shared back with patient care managers.	50% completed surveys responses evaluated every month.	This year we are shifting to electronic survey collection method.

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. (Four Counties Health Services Corporation)	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / Oct–Dec 2022 (Q3 2022/23)	65.96	75.00	14% improvement. Continuous Improvement. Year 2 of continuous improvement	Neighborly Pharmacy
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. (Strathroy Middlesex General Hospital)	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / Oct–Dec 2022 (Q3 2022/23)	87.60	95.00	Continuous Improvement. Year 2 of multi - year strategy	Neighborly Pharmacy
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)	84.22	95.00	Continuous Improvement. Year 2 of multi-year strategy.	Neighborly Pharmacy

Change Ideas

Change Idea #1	1) MHA Working group to be established and action plan for improvement to be developed. 2)Engagement with providers (physicians & NPs) to provide monthly reporting to providers on performance. Recruitment is underway for charge nurse 3)Working with Clinical Informatics to provide education to providers, and audit incomplete med recs at discharge in timely manner provide regular reporting to providers on performance and education support 4) Communication and awareness campaign for providers 5) Engagement with Pharmacy on opportunities for improvement.

Methods	Process measures	Target for process measure	Comments
Conduct monthly audits and review by pharmacy manager.	Quarterly report to physicians of med reconciliation performance. Real time follow-up to medication reconciliation medication errors.	95% completion of med reconciliation at discharge by all HCP. Reduction in medication reconciliation medication errors	At FCHS recruitment of charge nurse is underway. Lack of charge nurse has impacted performance at FCHS.

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. (Four Counties Health Services Corporation)	P	Count / Worker	Local data collection / Jan 2022–Dec 2022	7.00	7.00	Sustain improvements	
Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period. (Strathroy Middlesex General Hospital)	P	Count / Worker	Local data collection / Jan 2022–Dec 2022	9.00	9.00	Sustain current performance.	
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	16.00	16.00	Sustain improvement made in last few years. We have very open reporting culture.	

Change Ideas

Change Idea #1 1) Establishment of Workplace Violence Prevention Committee and audit our processes and data to ensure that we are capturing and de-briefing all workplace violence incidences. 2) Emergency Codes review and revisions, including Code White, to ensure alignment with workplace violence prevention strategies. 3) Share information with all the concerned personal in the circle of care as soon as patient is flagged in the electronic system. 4) Consistent practice in checking patient history prior to admission and appropriate medication regime review.

Methods	Process measures	Target for process measure	Comments
Working collaboratively with Safety office engage clinical managers, internal stakeholders to recruit and establish the committee membership. Total number of flags applied monthly and quarterly. Review by health and safety officer monthly or case by case basis and follow-up with area manager.	Monthly report to department managers and follow-up	All Workplace violence incidents are investigated, reviewed at Joint Occupational Health and Safety Committee monthly, and Quality, Safety and Risk Committee of the Board Quarterly.	FTE=133

Measure

Dimension: Safe

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Hand Washing Compliance - Moment 1 (before touching a patient) by Hospital Care Provider (Four Counties Health Services Corporation)	C	% / Health providers in the entire facility	In house data collection / Q1-Q3	CB	90.00	Multi Year Strategy. Year 1 - develop process & train staff.	
Hand Washing Compliance - Moment 1 (before touching a patient) by Hospital Care Provider (Strathroy Middlesex General Hospital)	C	% / Health providers in the entire facility	In house data collection / Q1-Q3	82.00	90.00	Multi Year Strategy. Year 1 - develop process & train staff.	
Hand Washing Compliance - Moment 1 (before touching a patient) by Hospital Care Provider	C	% / Health providers in the entire facility	In house data collection / Q1-Q3	82.00	90.00	Multi Year Strategy. Year 1 - develop process & train staff.	

Change Ideas

Change Idea #1 Working group to be established with IPAC and clinical managers and action plan to be developed.

Methods	Process measures	Target for process measure	Comments
Develop audit frequency, process, training materials and train staff.	Engagement with managers and physicians leaders on process, frequency to share metrics with managers, review opportunities for improvement and communication to clinical teams	Establish communication plan for front line staff for hand hygiene expectations	

Change Idea #2 Establish communication plan for front line staff for hand hygiene expectations.

Methods	Process measures	Target for process measure	Comments
IPAC team to develop communication plan.	IPAC team to engage with clinical managers, staff and physicians leaders for input on communication plan.	Communication plan shared with all clinical staff	

Measure

Dimension: Safe

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Inpatient Falls with Serious harm per 1000 inpatient days (only serious harm level 4-6 are included) (Four Counties Health Services Corporation)	C	Rate / All inpatients	In house data collection / Q1- Q3	CB	0.00	Continues improvement	
Inpatient Falls with Serious harm per 1000 inpatient days (only serious harm level 4-6 are included) (Strathroy Middlesex General Hospital)	C	Rate / All inpatients	In house data collection / Q1- Q3	0.01	0.00	Continues improvement. Aim for zero serious harm	
Inpatient Falls with Serious harm per 1000 inpatient days (only serious harm level 4-6 are included)	C	Rate / All inpatients	In house data collection / Q1- Q3	0.01	0.00	Continues improvement. Aim for zero serious harm following a fall.	

Change Ideas

Change Idea #1 Working group to be established with patient care managers and action plan to be developed. Review current practices and screening rate of all inpatients at risk of fall.

Methods	Process measures	Target for process measure	Comments
Engagement with managers on process regarding frequency to share metrics with managers, review opportunities for improvement and communication to clinical teams	Engage and involve patients and families through clear communication at point-of-care, ensuring high-risk patients are aware of their role in fall prevention.	All Falls with serious harm is investigated, reviewed at clinical Leadership and reported to Quality, Safety and Risk Committee of the Board.	

Equity

Measure

Dimension: Equitable

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of MHA leaders that have taken designated Justice, Equity, Diversity and Inclusion training. (Four Counties Health Services Corporation)	C	% / Other	Other / FY 202324	CB	100.00	Year 1 - develop and launch diversity training for focus areas	
Percentage of MHA leaders that have taken designated Justice, Equity, Diversity and Inclusion training. (Strathroy Middlesex General Hospital)	C	% / Other	Other / FY 202324	CB	100.00	Year 1 - develop and launch diversity training for focus areas	
Percentage of MHA leaders that have taken designated Justice, Equity, Diversity and Inclusion training.	C	% / Other	Other / FY 202324	CB	100.00	Year 1 - develop and launch diversity training for focus areas. In year 1 MHA Senior Leadership team complete the training.	

Change Ideas

Change Idea #1 Establish a JEDI Task Force to develop preliminary action plan; determine focus area(s) of focus for year 1 of plan; determine training options; confirm management inclusion group for year 1.

Methods	Process measures	Target for process measure	Comments
Internal data collection following the completion of training.	Number of MHA Senior Leaders who have completed the training	100% All Senior Leaders Completes the in - person or online training.	This is multiyear strategy. We expect in next 3 years all employees of the MHA will have completed the training.

Change Idea #2 Determine communication plan to public on JEDI focus. Determine community engagement plan around area(s) of focus. Determine community engagement plan around area(s) of focus.

Methods	Process measures	Target for process measure	Comments
In collaboration with external and internal stakeholders develop communication strategy.	Engage Senior Leadership team and a trainer to work on communication plan and develop training material.	Communication plan published on MHA website	