## Access and Flow | Efficient | Optional Indicator

### Indicator #1

Alternate level of care (ALC) throughput ratio (Hotel Dieu Shaver Health and Rehabilitation Centre)

| Last Year | | This Year | | |
|---|---|---|---|---|
| **1.07** | **1.07** | **1.22** | **14.02%** | **NA** |
| Performance (2024/25) | Target (2024/25) | Performance (2025/26) | Percentage Improvement (2025/26) | Target (2025/26) |

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

ALC Rounds meeting with Home and Community Care Support Services (HCCSS)to review all cases likely destined for LTC.

**Process measure**

- Regularity of ALC Rounds meetings.

**Target for process measure**

- Weekly meetings to take place.

**Lessons Learned**

Implementation of new Health Information System (HIS) posed some challenges with weekly meetings. However, we did meet as often as possible and particularly when there were challenging discharges.

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

Patient Flow meetings including representation from across the interdisciplinary team occur every day at 3:00 p.m. to review patient referrals, patient discharge dates and identify recommended interventions that may assist in facilitating safe and timely discharges.

**Process measure**

- Regularity of daily teleconference meetings.

**Target for process measure**

- # of daily teleconference meetings conducted.

**Lessons Learned**

Daily in-person meetings continued throughout the year. This resulted in meeting and achieving our target of ALC throughput.

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

Command Centre teleconference meetings to take place daily including representation from senior and front line levels of staff - from HDS, our acute care partner, Niagara Health, and Home and Community Care Support Services - to identify patient flow pressures and bottle necks, with the purpose of identifying immediate strategies to alleviate any barriers and facilitate expeditious patient flow on a case by case immediate basis.

**Process measure**

- Regularity of daily teleconference meetings.

**Target for process measure**

- # of daily teleconference meetings conducted.

**Lessons Learned**

Daily meetings support appropriate admissions to our facility. We were also able to support our acute care partners during times of bed pressures.

**Change Idea #4** ☑ Implemented ☐ Not Implemented

With the implementation of the new HIS, we are hoping to use the CareView boards in conjunction with Capacity management board to further assist with patient flow.

**Process measure**

- No process measure entered

**Target for process measure**

- No target entered

**Lessons Learned**

No lessons learned entered

**Comment**

Staff Training and education is underway on new Health Information System tools with the hopes of full implementation by fiscal year 2025-2026.

## Access and Flow | Efficient | Custom Indicator

| Indicator #4 | Last Year Performance (2024/25) | Last Year Target (2024/25) | This Year Performance (2025/26) | Percentage Improvement (2025/26) | This Year Target (2025/26) |
|---|---|---|---|---|---|
| Meet optimal wait times for internal inpatient to outpatient services based on stroke wait times. (Hotel Dieu Shaver Health and Rehabilitation Centre) | 31.00 | 28 | 18.00 | -- | NA |

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

Continue to review and analyze wait time data on a regular basis to ensure interventions can be flagged if there is an identified problem.

**Process measure**

- Number of reviews conducted and number of analyses completed.

**Target for process measure**

- At least one (1) review and one (1) analysis conducted monthly.

**Lessons Learned**

Monthly reviews continue.

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

Continue to communicate wait time status to all relevant parties on a regular basis.

**Process measure**

- Wait times to be reported quarterly, unless there are identified anomalies, in which case reporting to other involved managers, and Executive VP of Operations should take place as soon as possible after identification of the problem.

**Target for process measure**

- Continued administration of current process.

**Lessons Learned**

Quarterly reviews and distribution of information continues.

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

Continue process to identify and implement interventions as necessary to ensure wait times stay within identified limits.

**Process measure**

- Number of identified and implemented interventions as required and as feasible.

**Target for process measure**

- Continuing administration of current process.

**Lessons Learned**

There is a new stroke team started in Oct 2024. This change will have positive impact on the wait times.

**Comment**

We hope to see the continued improvement in wait times with the implementation of new stroke team while keeping in mind the nature of stroke presenting to us given the increase in number of strokes across the region.

**Equity | Equitable | Custom Indicator**

**Indicator #2**

Development of training materials and completion of training in DEI Essentials for Managers, Human Resources and DEI Committee members. (Hotel Dieu Shaver Health and Rehabilitation Centre)

| Last Year | | This Year | | |
|---|---|---|---|---|
| **CB** | **CB** | **80.00** | **--** | **NA** |
| Performance (2024/25) | Target (2024/25) | Performance (2025/26) | Percentage Improvement (2025/26) | Target (2025/26) |

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

Research and development of DEI Essentials Training.

**Process measure**

- Completion of package for HDS.

**Target for process measure**

- Completion by mid 2024.

**Lessons Learned**

Education package being revised and further developed.

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

Training package will be vetted and approved by DEI Committee.

**Process measure**

- Completion of vetting and review process with the DEI Committee.

**Target for process measure**

- Vetting and approvals completed by Mid 2024.

**Lessons Learned**

DEI committee discussed successes and challenges with the training they have completed. This feedback will be used for revising current training package.

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

Launch and completion of training for managers, Human Resources staff and DEI Committee members.

**Process measure**

- Number of representative staff members who have successfully completed the training.

**Target for process measure**

- 75% completion of training by the end of the 4th quarter 2024-2025.

**Lessons Learned**

33 of 41 (80%) Hospital leadership, DEI committee members including Human Resources staff successfully completed the training.

**Comment**

The 80% completion rate reflects the targeted group to collect baseline which included HDS leadership, DEI committee members and Human Resources staff.

**Experience | Patient-centred | Custom Indicator**

**Indicator #8**

Would you recommend inpatient care to your friends and family? (Hotel Dieu Shaver Health and Rehabilitation Centre)

| Last Year | | This Year | | |
|---|---|---|---|---|
| **100.00** | **95** | **99.86** | **--** | **NA** |
| Performance (2024/25) | Target (2024/25) | Performance (2025/26) | Percentage Improvement (2025/26) | Target (2025/26) |

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

Continue to increase and replace Patient Advisors to assist with sharing of patient experiences.

**Process measure**

- Number of new and replacement Patient Advisors recruited.

**Target for process measure**

- Maintain or increase number of active patient advisors.

**Lessons Learned**

Recruitment continues to be successful. We currently have 15 dedicated patient advisors who make every possible attempt to see patients in-person.

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

Patient Advisors to provide feedback to staff regarding the positive results of patient experience surveys and opportunities for improvement.

**Process measure**

- Sessions with Patient Advisors and staff to be conducted monthly, if possible.

**Target for process measure**

- Twelve (12) sessions held between staff and Patient Advisors per year.

**Lessons Learned**

Patient advisors provide support with the patient experience survey. They receive the monthly survey results in addition to the nursing clinical managers.

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

Results of patient experience surveys to be presented at the Clinical Quality Council that consists of frontline staff, management, physicians and Patient Advisors to better address successes on the nursing units and identify areas of opportunity to assist with patient satisfaction.

**Process measure**

- Present at least one scenario at each quarterly Clinical Quality Council.

**Target for process measure**

- Minimum of four (4) reviews annually.

**Lessons Learned**

The process continues.

**Comment**

Staff has been able to overcome the challenges associated with the implementation of new HIS to continue to provide a positive experience for our patients.

| | Last Year | | This Year | | |
|---|---|---|---|---|---|
| **Indicator #6** | **100.00** | **95** | **100.00** | **--** | **NA** |
| Percentage of complaints acknowledged to the individual who made a complaint within 3 to 5 business days (Hotel Dieu Shaver Health and Rehabilitation Centre) | Performance (2024/25) | Target (2024/25) | Performance (2025/26) | Percentage Improvement (2025/26) | Target (2025/26) |

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

Retain and train additional senior staff member on complaint response processes and requirements.

**Process measure**

- Completion of retention and training.

**Target for process measure**

- Recruitment and training to be complete in 2024.

**Lessons Learned**

There is consistently senior staff available to respond to any complaint brought forward, in the absence of the Patient Relations Process Delegate.

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

Enhanced publication of the contact information for the Patient Relations Process Delegate.

**Process measure**

- Completion of notice and number of notices that are distributed.

**Target for process measure**

- Notices placed at all elevators, Nursing stations, scheduling offices and in the Patient and Family Handbook.

**Lessons Learned**

Continued to remain at 100% response rate. Complaint process is clearly articulated in the Patients and Family Handbook, on the website and switch board staff are trained on escalation of complaint process.

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

Formal tracking of all formally documented complaints including time lines for first acknowledgement, substance of complaint, nature of resolution and resolution timelines.

**Process measure**

- Completion and maintenance of tracking document on a quarterly basis with reporting to Quality Improvement Committee of the Board.

**Target for process measure**

- Ongoing to include quarterly reporting.

**Lessons Learned**

No change. Current process is effective and efficient for our team.

**Comment**

We continue to watch this indicator closely as patients and family members expectations of the healthcare system are changing.

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**Indicator #7**

Survey 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? (Hotel Dieu Shaver Health and Rehabilitation Centre)

| Last Year | | This Year | | |
|---|---|---|---|---|
| **99.71** | **95** | **98.23** | **--** | **NA** |
| Performance (2024/25) | Target (2024/25) | Performance (2025/26) | Percentage Improvement (2025/26) | Target (2025/26) |

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

Continuation of surveys to be conducted with patient three or fewer days before anticipated discharge date.

**Process measure**

- Successful completion of in-house surveys prior to discharge.

**Target for process measure**

- 100% of patients with pre-scheduled discharge dates to be surveyed.

**Lessons Learned**

Despite the periods when outbreaks occurred when our patient advisors could not survey the patients, we were still able to survey 78% of all discharges.

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

Continued communication between patient advisors and clinical managers to ensure that any concerns identified are flagged and, if possible, addressed prior to discharge.

**Process measure**

- Number of patient advisors instructed on process to follow with clinical manager.

**Target for process measure**

- All patient advisors who administer the survey provided orientation on process to follow with clinical manager.

**Lessons Learned**

Monthly reports are provided to the clinical managers who in turn present this information to the staff.

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

Meet and greet process by patient advisors to help familiarize patients/families with what they can expect from their inpatient stay and discharge journey, which includes review of the Patient and Family Handbook.

**Process measure**

- Number of Meet and Greet sessions successfully co-ordinated.

**Target for process measure**

- Complete implementation subject to inability to attend units in outbreak.

### Lessons Learned

The process continues, however, given the implementation of new HIS, the numbers were not tracked.

### Comment

The new HIS will provide better tools to the staff to prepare patients for their discharge.

## Safety | Safe | Optional Indicator

### Indicator #3

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. (Hotel Dieu Shaver Health and Rehabilitation Centre)

| Last Year | | This Year | | |
|---|---|---|---|---|
| **89.92** | **90** | **90.20** | **0.31%** | **NA** |
| Performance (2024/25) | Target (2024/25) | Performance (2025/26) | Percentage Improvement (2025/26) | Target (2025/26) |

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

Implementation of new orientation package for all prescribers.

**Process measure**

- Package to be delivered at orientation and included in continuing education.

**Target for process measure**

- Ongoing as new staff and physicians are onboarded.

### Lessons Learned

Implementation of new HIS effective Nov 9-2024 has impacted prescriber onboarding and orientation to the new system. Work continues to solidify the process.

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

Continuing education of nursing staff and physicians working on any unit in the hospital.

**Process measure**

- Continuing education for all affected staff and physicians.

**Target for process measure**

- Ongoing as new staff and physicians are onboarded.

**Lessons Learned**

Implementation of new HIS as noted above has created new learning opportunities and challenges of reworking the processes as we understand the systems better.

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

Physicians to be contacted a few days before anticipated discharge to be reminded of upcoming discharges to facilitate completion of medication reconciliation.

**Process measure**

- Number of calls completed by Health Records.

**Target for process measure**

- Ongoing process reviewed a few days prior to discharge to allow time to contact MRP.

**Lessons Learned**

Yes. With the new HIS, the reminders to prescribers are now sent by the charge nurse.

**Comment**

New Health Information System(HIS) implementation created unanticipated workflow challenges with the Medication Reconciliation processes. However, we were still able to achieve the target.

## Safety | Effective | Custom Indicator

| | Last Year | | This Year | | |
|---|---|---|---|---|---|
| **Indicator #5** Number of workplace violence incidents (Overall) (Hotel Dieu Shaver Health and Rehabilitation Centre) | **101.00** Performance (2024/25) | **90** Target (2024/25) | **61.00** Performance (2025/26) | **--** Percentage Improvement (2025/26) | **NA** Target (2025/26) |

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

Continue to monitor RL Solutions incident reporting system that includes the capacity to report violence/harassment in a customized set of appropriate fields in the reporting structure.

**Process measure**

- Continuous monitoring and implementation of modifications or improvements to the system as required.

**Target for process measure**

- Through 2024-2025.

**Lessons Learned**

Monitoring continues.

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

Monitor the activation of a screen in Meditech (HIS system) to allow staff registering patients to be aware of those who were flagged as behavioural/aggressive while inpatients at the HDS or at the Niagara Health system.

**Process measure**

- Regular audits completed to identify effectiveness of the process.

**Target for process measure**

- Audit results consistently indicating that all relevant patients are correctly flagged in the system.

**Lessons Learned**

Flagging process was changed in Nov 2024 for the new HIS. The flagging process is effective.

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

Increased reporting of violent patients.

**Process measure**

- Audit completed by Safety Coordinator in consultation with clinical management.

**Target for process measure**

- All identified violent incidents are appropriately recorded in the IRS.

**Lessons Learned**

Reporting of violent patients continue. This number can fluctuate due to the type of patient in our facility.

**Comment**

Planning/implementation, training with the new HIS combined with significant onboarding of new staff resulted in reduction in incident reporting.