Access and Flow

Measure - Dimension: Efficient

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Alternate level of care (ALC) throughput ratio	O	Ratio (No unit) / ALC patients	WTIS / July 1 2023 - September 30, 2023 (Q2)	0.92	1.00	In alignment with evidence based practice.	

Change Ideas

Change Idea #1 Disseminate educational materials for patients and family re: Home First Philosophy.

Methods	Process measures	Target for process measure	Comments
Oversight via Access and Flow Committee - in collaboration with our Patient and Family Advisors, NHH will monitor and track quarterly data/progress.	Educational materials disseminated for patient and families.	100% of patient and families will receive educational materials related to the Home First Philosophy.	The change idea will be tracked and monitored at our Quality Practice Committee.

Change Idea #2 Implement Geriatric Assessment Team mobile for acute inpatient unit support.

Methods	Process measures	Target for process measure	Comments
Oversight by Access and Flow Committee, increase awareness to staff/education initiatives, close collaboration with community partners.	- Average length of stay for patients assessed by GAT mobile. - # of GAT mobile assessments that led to hospital discharge.	Collecting baseline related to length of stay for patients assessed by GAT mobile.	This process measures will be monitored and reported at our Quality Practice Committee and other venues.

Change Idea #3 Implementation of process for care planning with patients and families as part of the care team to address concerns for discharge planning.

Methods	Process measures	Target for process measure	Comments
Oversight by Access and Flow Committee - collaboration with clinical informatics - addressing learning needs of in patient unit staff.	Total # of completed care plans.	Collecting baseline for the total number of completed care plans.	This process measures will be monitored and reported at our Quality Practice Committee and other venues.

Measure - Dimension: Timely

Indicator #11	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Community Mental Health: Counselling Waitlist (average days waited) (#)	C	Number / Mental health patients	In house data collection / January 1 - December 31st, 2024	231.60	180.00	Multi-year project. Target has not been met for the current year.	

Change Ideas

Change Idea #1 Optimize internal and external referral pathway workflow.

Methods	Process measures	Target for process measure	Comments
Oversight by Community Mental Health Quality and Practice Committee.	Referral pathway workflow framework completed.	100% of referral pathway workflow framework completed.	This process measures will be monitored and reported at our Quality Practice Committee and other venues.

Change Idea #2 Analyze current workflow for referral pathways for mental health in EMR (EPIC).			
Methods	Process measures	Target for process measure	Comments
Oversight by Mental Health Quality and Practice Committee, working in collaboration with the team, clinical informatics, and regional supports.	Current state analyzed and data validated.	100% current state analyzed and data validated.	This process measures will be monitored and reported at our Quality Practice Committee and other venues.

Change Idea #3 Optimize workflow for referral pathway in EMR (EPIC).			
Methods	Process measures	Target for process measure	Comments
Oversight by Mental Health Quality and Practice Committee, working in collaboration with the team, clinical informatics, and regional EPIC supports.	Workflow standardized.	100% of workflow standardized.	This process measures will be monitored and reported at our Quality Practice Committee and other venues.

Equity

Measure - Dimension: Equitable

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of staff, physicians, midwives, and volunteers who have completed hospital approved equity, diversity, and inclusion education (%)	C	% / Staff	Hospital collected data / January 1 - December 31 2024	CB	CB	More data need to determine baseline.	

Change Ideas

Change Idea #1 Develop comprehensive list of hospital approved awareness/education resources for 2024/25.

Methods	Process measures	Target for process measure	Comments
Oversight by EDIAC.	Total # of equity, diversity, inclusion training approved for 2024/25.	Collecting baseline for the total # of equity, diversity, inclusion training approved for 2024/25.	This process measures will be monitored and reported at our Quality Practice Committee and other venues.

Change Idea #2 Implement training and awareness education for 2024/25.

Methods	Process measures	Target for process measure	Comments
Oversight by EDIAC	% of staff, physicians, midwives, and volunteers reached.	Collecting baseline for the % of staff, physicians, midwives, and volunteers reached.	This process measures will be monitored and reported at our Quality Practice Committee and other venues.

Change Idea #3 Develop plan to improve completion for subsequent year.

Methods	Process measures	Target for process measure	Comments
Oversight by EDIAC.	Plan to improve completion for subsequent year created.	100% Plan to improve completion for subsequent year created.	This process measures will be monitored and reported at our Quality Practice Committee and other venues.

Measure - Dimension: Equitable

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Total number of co-designed hospital programs, policy or resource packages with Indigenous community partners (#)	C	Number / Other	In house data collection / January 1 - December 31, 2024	CB	CB	More data need to determine baseline.	

Change Ideas

Change Idea #1 Co-design hospital program(s) policy or resource packages with indigenous community partners

Methods	Process measures	Target for process measure	Comments
Oversight by EDIAC in collaboration with indigenous community partners.	Co-design at least one hospital program policy or resource package with indigenous community partners.	Collecting baseline for the number of hospital program policy or resource package with indigenous community partners.	This process measures will be monitored and reported at our Quality Practice Committee and other venues.

Change Idea #2 Implementation of co-designed program(s), policy or resource packages at NHH.

Methods	Process measures	Target for process measure	Comments
Oversight by EDIAC.	Implement hospital program policy or resource package in at least one area/department of NHH.	100% Implement hospital program policy or resource package in at least one area/department of NHH.	This process measures will be monitored and reported at our Quality Practice Committee and other venues.

Experience

Measure - Dimension: Patient-centred

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of positive responses to, "Do you feel you received the information you needed before you left the hospital?" (%)	C	% / All patients	In-house survey / January 1 - December 31, 2024	74.40	100.00	Based on previous years performance.	

Change Ideas

Change Idea #1 Track, trend, and analyze responses to this survey question on a quarterly basis.

Methods	Process measures	Target for process measure	Comments
Oversight by Senior Leadership Team.	Total # of surveys completed.	300 surveys completed.	The change idea will be tracked and monitored at our Quality and Practice Committee and other venues.

Change Idea #2 Implement timely reporting pathway (e.g., up to QPCs and CBS).

Methods	Process measures	Target for process measure	Comments
Oversight by Senior Leadership Team.	Reporting pathway for internal review and analysis implemented.	100% of the review and analysis implemented.	The change idea will be tracked and monitored at our Quality and Practice Committee and other venues.

Change Idea #3 Develop action plans to address result trend.

Methods	Process measures	Target for process measure	Comments
Oversight by Senior Leadership Team.	Action plans developed to address results trend for at least one hospital program.	100% of action plans developed.	The change idea will be tracked and monitored at our Quality and Practice Committee and other venues.

Measure - Dimension: Patient-centred

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Interim experience survey engagement rate (%) inclusive of staff, physicians, and midwives (formerly People Satisfaction Engagement Rate)	C	% / Staff	In-house survey / One-time Survey	53.00	100.00	Data based on previous years results.	

Change Ideas

Change Idea #1 Implement survey in 2024/25.

Methods	Process measures	Target for process measure	Comments
Oversight by HR.	Survey completion rate	60% Survey completion rate.	This process measures will be monitored and reported at our Quality Practice Committee and other venues.

Change Idea #2 Validate survey results.

Methods	Process measures	Target for process measure	Comments
Oversight by HR.	Results validated.	100% of results validated.	This process measures will be monitored and reported at our Quality Practice Committee and other venues.

Change Idea #3 Develop action plan based on survey results.

Methods	Process measures	Target for process measure	Comments
Oversight by HR	Action plans completed.	50% Action plans completed.	This process measures will be monitored and reported at our Quality Practice Committee and other venues.

Change Idea #4 Develop quarterly progress report for action plans.

Methods	Process measures	Target for process measure	Comments
Oversight by HR	Track and monitor progress of action plans, quarterly.	100% of progress tracked quarterly.	From previous year's survey

Safety

Measure - Dimension: Effective

Indicator #1	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.	O	% / Discharged patients	Local data collection / Most recent consecutive 12-month period	CB	CB		

Change Ideas

Change Idea #1			
Methods	Process measures	Target for process measure	Comments
			NHH has decided to remove this indicator from the QIP but continue to track and trend this indicator on our Corporate Balanced Scorecard.

Measure - Dimension: Safe

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of workplace violence incidents resulting in lost time injury	O	% / Staff	Local data collection / Most recent consecutive 12-month period	CB	0.00	Reflective of a goal of a safe work environment.	

Change Ideas

Change Idea #1 Increase capacity for delivering NVCI training for hospital staff.

Methods	Process measures	Target for process measure	Comments
Oversight by JOHSC and Disability Support Services.	Proportion of clinical staff who have completed the training.	100% of staff have completed the training.	The change idea will be tracked and monitored at our Quality and Practice Committee and other venues.

Change Idea #2 Develop a “Track and Trend” tool for WPV Injury Incidents.

Methods	Process measures	Target for process measure	Comments
Oversight by JOHSC and Disability Support Services.	WPV injury incidents trending results completed quarterly.	100% WPV results trended quarterly.	The change idea will be tracked and monitored at our Quality and Practice Committee and other venues.

Measure - Dimension: Safe

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Barcode Medication Administration (BCMA) Completion Rate (%)	C	% / Staff	In house data collection / January 1 - December 31, 2024	86.70	90.00	Target improvement plans to maintain or stay below target.	

Change Ideas

Change Idea #1 Continue timely review of non-scanning medication issues.

Methods	Process measures	Target for process measure	Comments
Oversight by Q-CIPP Committee.	Track and monitor non-scanning medication issues monthly.	100% of issues tracked monthly.	The change idea will be tracked and monitored at our Quality and Practice Committee and other venues.

Change Idea #2 Implement manager/department specific reports for BCMA compliance.

Methods	Process measures	Target for process measure	Comments
Oversight by Q-CIPP Committee.	Manager/department specific reports are sent monthly or as needed.	100% of reports sent monthly.	The change idea will be tracked and monitored at our Quality and Practice Committee and other venues.

Measure - Dimension: Safe

Indicator #9	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Inpatient falls with injury rate (%)	C	% / All inpatients	In house data collection / January 1 - December 31, 2024	3.10	2.80	Reducing previous based to reflect improvement plans.	

Change Ideas

Change Idea #1 Implement care planning tool documentation process within EMR for inpatients who have history of falling within the last 30 days.

Methods	Process measures	Target for process measure	Comments
Oversight by Senior Leadership Team.	Implement this new process on at least one inpatient unit.	100% of new process implemented.	The change idea will be tracked and monitored at our Quality and Practice Committee and other venues.

Change Idea #2 Implement annual fall prevention education module for all clinical staff.

Methods	Process measures	Target for process measure	Comments
Oversight by Seniors Leadership Team and supported by Professional Practice.	Proportion of clinical staff who have completed the fall prevention education module.	100% of clinical staff who have completed the fall prevention education module.	The change idea will be tracked and monitored at our Quality and Practice Committee and other venues.

Change Idea #3 Conduct staff-based (including physicians) needs assessment for fall prevention and management on acute and post-acute in-patient units.

Methods	Process measures	Target for process measure	Comments
Oversight by Seniors Leadership Team with support by Quality/Safety.	- needs assessment completed for the 2 in-patient programs. - needs assessment results analyzed.	100% needs assessment completed.	The change idea will be tracked and monitored at our Quality and Practice Committee and other venues.

Measure - Dimension: Safe

Indicator #10	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Healthcare-Associated C-Diff Infection Rate (%)	C	% / All inpatients	In house data collection / January 1 - December 31, 2024	0.00	0.00	Never event.	

Change Ideas

Change Idea #1 Continue HAI c-diff pharmacy case reviews.

Methods	Process measures	Target for process measure	Comments
Oversight by IPAC.	Total # of HAI c-diff pharmacy case reviews.	Collecting Baseline	The change idea will be tracked and monitored at our Quality and Practice Committee and other venues.

Change Idea #2 Implement an interprofessional anti-microbial stewardship working group.

Methods	Process measures	Target for process measure	Comments
Oversight by IPAC.	Anti-microbial framework developed.	100% of framework developed.	The change idea will be tracked and monitored at our Quality and Practice Committee and other venues.