2018/19 to 2019/20
Quality Improvement Plan

Ross Memorial Hospital

ROSS MEMORIAL HOSPITAL
Kawartha Lakes

OVERVIEW

At Ross Memorial Hospital (RMH), we are committed to partnering with you to achieve ***Exceptional Care – Together.*** Our relentless pursuit of continuous quality improvement involves input from patients, families, staff, physicians, board members, volunteers, and community members. This partnership is vital to our ability to provide safe, high quality care. We thank you for your contribution and for taking the time to read our 2019/20 Quality Improvement Plan (QIP).

The QIP is an integral part of our quality management framework and is aligned to our three Strategic Directions and Service Excellence commitment of ***Being Kind, Taking Care of Each Other*** and ***Putting Others First***:

Figure 1: Ross Memorial Hospital Strategic Framework 2018-2021

Our 2019/20 QIP Focus Areas

RMH is committed to patient safety and becoming a high performing learning organization. As a result, we have met with the people we serve to develop the following Quality Improvement Initiatives for 2019/20.

1. We will advance Appropriate Care in the Appropriate Care Places.
2. We will enhance Communications and Care Continuity from Hospital to Primary Care.
3. We will continue to provide Service Excellence and Exceptional Care Together.
4. We will continue to provide a Safe Workplace.
5. We will continue to improve Palliative Care Management.
6. We will advance Integrated Care Management for Patients with Addictions and Homelessness.
7. We will continue to improve Medication Reconciliation across the Continuum of Care.
8. We will proactively identify and effectively manage Patients at Risk for Deterioration.

QUALITY IMPROVEMENT ACHIEVEMENTS FROM THE PAST YEAR (2018/19)

Our teams have demonstrated their commitment to patient safety and continuous quality improvement as is evident in several Quality Improvement (QI) initiatives that we are very proud of and would like to share with you!

Patient Experience Partner (PEP) Rounding

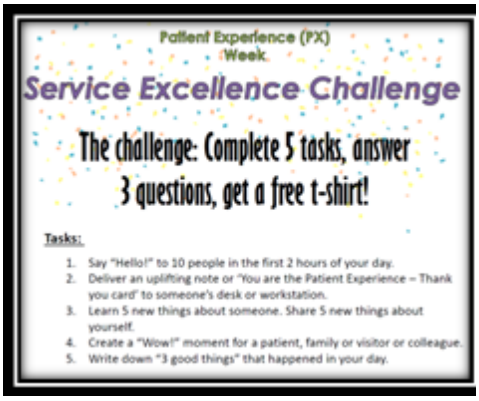
'Patient-to-Patient' dialogue is an innovative QI approach and is making a positive difference in our patent care and experiences. Through our Patient Family Council, we implemented an innovative Patient Experience Partners (PEPs) Rounding Program where former patients collect real-time patient and family experience feedback. We felt there was an opportunity for our hospital to engage patients in real-time to better understand and improve their experience. We were thrilled when our PEP Rounding initiative was identified as a leading practice by Health Quality Ontario (HQO).

PEP rounding is the practice of carefully selected and trained PEPs engaging with patients and families to learn about their experiences in real-time, effectively responding to their concerns, and enhancing communication. During these visits, the PEPs give patients and families an opportunity to voice concerns, compliments, comments, and listen for themes that align with our patient experience measures. Feedback gathered during rounds is documented and utilized to: efficiently address individual patient concerns; improve communication on multiple levels; enhance staff experience and engagement and provide metrics for quality improvement initiatives.

PEP rounding on Surgical Unit ~ 93% responded "Definitely, Yes" to the question "Would you recommend this Hospital to family or friends who required care?"

Service Excellence

RMH embarked on an organizational wide "*Service Excellence"* initiative to improve the patient/family experience, staff experience and co-workers experience. We recognized that a strong quality culture and a high performing learning organization will be made possible through true partnerships with our patients and with one another. As a result, the RMH Service Excellence commitment was developed and simply states ~ To deliver excellent service by ***Being Kind; Taking Care of Each Other and Putting Others First***. When individuals have the opportunity to authentically engage with patients and their co-workers, they report less stress, less burnout, and much more satisfaction in their jobs.

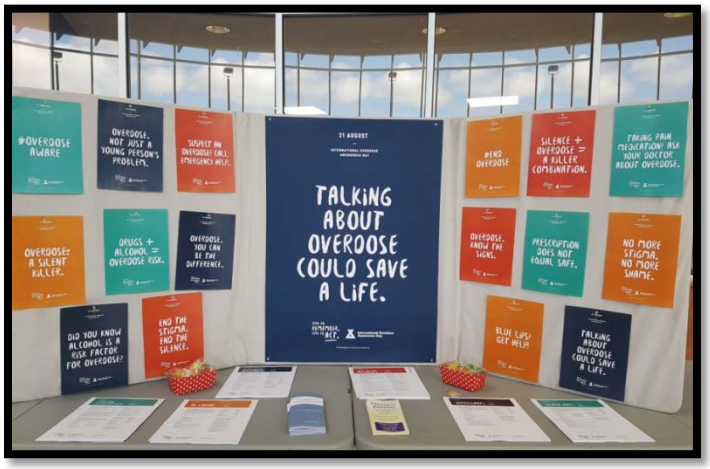


In addition, a Wellness Working Group was established to engage staff, advance teamwork and to promote 'fun'. Several wellness and mental health awareness initiatives were implemented including celebrating October as the 'Healthy Workplace' month where staff received free massages and seminars. A family skate day and birthday celebrations have also occurred.

ACT Our patient satisfaction scores have gone from 1.5% below the LHIN average to 10% above.

International Overdose Awareness Day

Collaboration and integration with Community Partners is crucial to ensure we are providing exceptional care across the care continuum for our patients and family members. For the second year in a row, we joined the international health care community to recognize Overdose Awareness Day. An information booth was set-up in the main lobby for all staff, physicians, patients and the public. Information was provided on the signs and symptoms of overdose from various substances and community resources for those struggling with addiction and mental health issues. In addition, our community partner PARN (Peterborough AIDS Resource Network) provided the resources for members of staff or the public to obtain a free Naloxone Kit.



 Based on the 2013 and 2015 reports, Kawartha Lakes ranked the 4th highest of Opioid users in Ontario and the 4th highest rate of Opioid-Related deaths.

Alternative Level of Care (ALC)

As part of our continued quality improvement towards *exceptional quality patient care and experiences,* an Alternate Level of Care (ALC) Avoidance action plan was implemented with our community partners. The overarching goal is to ensure patients are in the appropriate care setting based on care needs. The action plan is aligned to Cancer Care Ontario's (CCO) ALC Avoidance twelve (12) leading practices targeted to address three areas known to impact performance: 1) Avoid all unnecessary hospital admissions; 2) Identify and divert patients at risk of becoming ALC and 3) Effective and timely management of patients designated ALC.

A Leading Practices Working group was established and a targeted action plan was implemented. The teams have worked and will continue to work to integrate these practices into day to day care and service delivery.

 Since our last assessment completed in November 2017, we have significantly improved our performance moving from 4 Met; 13 Almost There and 34 Unmet to **41 Met; 16 Almost There and 4 Unmet**. This is outstanding progress. Despite continuous efforts in implementing the action plan, there is continued pressure in the community and lack of Long Term Care beds.

Patient Early Warning Systems

This year we expanded the implementation of the National Early Warning Score (NEWS) 2 system. It is a track and trigger system that identifies a patient's health decline and causes immediate action. This system empowers staff to take action based on early warning signs of patient deterioration, with the intent of catching and correcting potentially life threatening changes in clinical status. This guides the healthcare team's care approach, leading to better patient outcomes.

 NEWS2 has provided the clinical staff a common language for describing a patient's status and the numeric score provides an objective and standard method to communicate.

Research Project - Putting Quality Food on the Tray

Focus Groups were held with the University of Guelph and Waterloo research project titled "Putting Quality Food on the Tray" for which RMH was selected as a participant. This project will raise the profile of food as a

core determinant of health within the hospital setting by implementing a formalized process for evaluation of food satisfaction. The overall aim is to raise the profile of food served in Ontario Hospitals, moving it from being seen as an amenity to something that is crucial to the wellbeing of patients. The focus groups included interdisciplinary Team Members and our Patient Experience Partners.

Better hospital food, better health is part of the Healthier Hospital program.

Workplace Violence Prevention

Workplace Violence in healthcare is not acceptable and is an ongoing concern for workplace safety. It is a key priority for our Board and is part of our QIP and strategic plan '*To Be an Exceptional Workplace.'* The number of Workplace Violence Incidents is reported to the Board on a quarterly basis. Incidents of violence causing staff injury are reported to the Joint Health and Safety Committee monthly, or in cases where there is healthcare, modified work or lost time, they are reported within 72 hours and are investigated. Managers complete the Aggressive Behaviour Code White form and submit to the Code White Committee after each incident.

Building upon our successes from last year, the following will be implemented:

- Annual Departmental and Direct Care Violence Risk Assessments and Corrective Action Plan - 100% completion by Aug 2019.
- Aggression and Violence screening for patients and Identification of Patients at Risk for Violence – Completed.
- Workplace Violence and Harassment Prevention Program. Target completion date: August 2019.
- Communication regarding patient risk for violence at all times of Transfer of Accountability. Target completion date: March 2019.
- Staff training in Gentle Persuasive Approach. Target completion date: April 2019.

In addition, the Workplace Violence and Harassment Prevention Steering Committee started its work on the prevention program in the 2018/19 fiscal year and have made great progress in reducing the number of Workplace Violence Incidents especially in the Emergency Department (ED).

Our 2018/19 QIP outcomes are as follows:

- ✓ Internal security services personnel in ED 24/7 was implemented.
- ✓ Security services personnel - access to paid duty officers, when needed, has been implemented to support ED staff communicating with police regarding patients that are at high risk for violence; as well, ED staff will have access to security staff to perform one-to-one monitoring.
- ✓ Environmental Assessment completed by Ontario Shores Centre for Mental Health Services provided recommendations for ED Staff training in Non Violence Crisis Intervention program -75% completed. Staff also received training on addictions.
- ✓ Mental health patients' placement to a non-triggering environment with a dedicated Mental Health Assessment Room.
- ✓ Patient aggressive behaviour screening and patient flagging implemented.
- ✓ Personal Safety Alarms implemented in ED and Diagnostic Imaging.

We could not have done any of this without the support and engagement of our Patient Family Council, Quality, Safety and Risk Council, our staff, physicians, board members, community partners and our volunteers!

Contact Information

If you wish to contact Ross Memorial Hospital with questions, concerns or suggestions related to our Quality Improvement Plan, please contact quality@rmh.org.

Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2018/19 QIP

The Progress Report is a tool that will help organizations make linkages between change ideas and improvement, and gain insight into how their change ideas might be refined in the future.

Measure/Indicator from 2018/19	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
"Would you recommend this emergency department to your friends and family?"	52	60	68	We exceed the LHIN average in all quarters related to patient engagement this fiscal year. Performing very well in these areas: nurses and physicians explained things understandably; treated with courtesy and respect as well as the overall rating of ED care.

Change Ideas	Was this change idea implemented as intended?	Outcome
Create a culture of Service Excellence.		Fifty two percent of ED staff have attended the corporate Service Excellence training program focusing on a client centric service model focusing on improving communication, active listening, problem-solving, establishing a trusting empathetic relationship, and first contact resolution. By March 31, 2019 ninety two percent of staff will have completed training. Training all hospital staff on the same competencies gives a standard process to deal with clients / families and creates a sense of team spirit.
Create more opportunities to obtain individualized, real-time feedback from patients and enhance our ability to make improvements based on this feedback.		In March of 2018, we began real time patient satisfaction surveys with our Patient Experience Partners (PEPs). This has allowed us to intervene immediately on pressing issues related to patient satisfaction. Concerns and compliments are tracked and trended and we have followed up on specific concerns with regards to wait times, lack of beds and patient meals. We have shared many positive comments with staff about their caring attitudes and compassion. Satisfaction scores continue to improve with real-time surveying.
Enhance communication with patients and families.		In December 2018, we implemented an electronic patient tracking board “Pulse Check” which gives the ED team visualization of every patient in the department, shows length of stay and allows the team to electronically access diagnostic results allowing us to reduce our length of stay. This system

also provides data on an electronic display in the waiting room, giving patient and family up-to-date information on the current wait time to see a physician.

Measure/Indicator from 2018/19	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
"Would you recommend this hospital to your friends and family?" (Inpatient care)	57	70	69	

Change Ideas from Last Years QIP (QIP 2018/19)	Was this change idea implemented as intended?	Outcome
Create a culture of Service Excellence.		As part of our celebration of Patient Experience week, RMH launched the Service Excellence program. We recognized that a strong quality culture and a high performing learning organization will be made possible through true partnerships with our patients and with one another. As a result, RMH Service Excellence commitment was developed and simply states ~ To deliver excellent service by Being Kind; Taking Care of Each Other and Putting Others First. When individuals have the opportunity to authentically engage with patients and their co-workers, they report less stress, less burnout, and much more satisfaction in their jobs. Staff had the chance to win a free t-shirt by completing the Service Excellence Challenge of being kind, taking care of each other and putting others first. Throughout the year, we realized a significant improvement in our patient satisfaction results and staff engagement going from 1.5% below to 10% above the LHIN average which is 61.8% (as of Q4). The majority of participants would recommend the Service Excellence program.
Create more opportunities to obtain individualized, real-time feedback from patients and enhance our ability to make improvements based on this feedback.		The implementation of an innovative Patient Experience Partner (PEP) Rounding Program where former patients collect real-time patient and family experience feedback has made a tremendous impact. The PEP program showed that 90% of patients answered “Definitely, yes” to this question compared to only 50-60% in the NRC post-discharge survey. It also provides immediate service recovery at point of care and advances a culture of continuous quality improvement. Our advice to others includes: ensure visible supportive leadership to encourage buy-in from managers and engagement of the frontline staff; provide clear and consistent communication and messaging to ensure all staff were aware of the program and receptive to having PEPs interviewing patients on units; use an electronic tool to capture data and generate reports; and share monthly outcomes with staff and management.

Enhance communication with patients and families about integrated plan of care.		Staff members communicate the plan of care to patients and families at all transition points during admission, transfer and discharge. In addition to the primary nurse involving the patient in the care plan; this year attention was directed to completing the communication white boards in the patient rooms. Education to staff occurred at communication huddles on the expectation of filling in the white board twice daily. Nurses have implemented transfer of care/shift hand off at the bedside which enhances communication to the patient. Physicians, nurses and therapy staff communicate the following information on the patient white boards: the provider name, document estimated discharge date and patient goals. There has been an uptake by the staff as evident by audits and improvement in patient satisfaction surveys.

Measure/Indicator from 2018/19	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
% of inpatients with Stage 1 or higher Hospital-Acquired Pressure Injury.	12	8	Not available until June/July 2019.	Current performance will not be available from Hill-Rom until June/July 2019.

Change Ideas from Last Years QIP (QIP 2018/19)	Was this change idea implemented as intended?	Outcome
Re-establish the wound care team with representation from nursing, physio, Dietician, Quality and Risk; Adhoc - Pharmacy and Support Services.		The Wound Care Committee meet once a month with 20 minutes of the one hour meeting dedicated to educating the members on staging of pressure injury wounds, and the right wound care products used for the right wound. This past year, focus has been on identification of pressure injuries and documentation with implementation of early interventions to prevent the pressure injuries from getting worse. The Wound Care Committee has reviewed and revised the wound assessment tool. A poster has been developed outlining the various wound care products and the indications for use on the various types of pressure injuries to be used as a guide by nursing and physicians.

Measure/Indicator from 2018/19	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
Decrease incidents of failure to appreciate status change/deterioration: The number of Medical Emergency Team (MET) call patients transferred to the ICU with a noted deterioration 24 hours prior to the call.	Collecting baseline for comparison	20	12	Limited sample size as it is still being implemented and will be optimized across the hospital. As a result, it will continue as part of our 2019/20 QIP. MET calls have doubled and the numbers of ICU transfers post MET calls have decreased. Metrics will mature over time.

Change Ideas from Last Years QIP (QIP 2018/19)	Was this change idea implemented as intended?	Outcome
Utilize Early Warning Scores (EWS) to improve patient outcomes and standardize assessments of acute illness.		NEWS2 was first trialed on the Medical Unit starting in June 2018. The NEWS2 vital sign graphic was tested on this unit at first as a trifold document. Feedback from the staff and the Hospitalists required a change in the form and it became a stand-alone graphic insert in the main chart. NEWS2 to be implemented on the Surg/OBS unit. NEWS2 has provided the clinical staff a common language for describing a patient's status. The numeric score attached to a clinical scenario has been especially helpful to new nurses and provides an objective method to communicate and increases their critical thinking skills. MET calls for 2018 were 73; an increase from 53 in 2017. Of the 14% increase in calls, 30% of the call volume was related to NEWS2. The number of patients requiring ICU admission post MET call has decreased. In 2017, 17.8 % of patients admitted from the Medical Unit to ICU had the outcome of death compared to 2018 7.4% admitted from Medical to ICU expired. Sepsis remains the number one cause of death in the ICU. The sepsis one hour bundle has been re-educated to the acute inpatient units. Monthly audits completed noting percentage of triggered patients who received appropriate response escalation and percentage of patients with NEWS2. Advice: QI metrics are not always evident at first but evolves as the QI initiative gets underway due to secondary outcomes and new data capture. It is an evolving best practice.

Measure/Indicator from 2018/19	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
Decrease incidents of Falls with Harm: The total number of Falls with Harm reported per 1,000 patient days.	1.24	1.00	1.31	

Change Ideas from Last Years QIP (QIP 2018/19)	Was this change idea implemented as intended?	Outcome
Refresh corporate Falls Prevention Program.		• Roll out of "Universal Falls Precautions" Program occurred across the hospital. • An inventory of falls prevention equipment took place and gaps were identified and addressed. • New universal falls prevention tool was imbedded into nursing flow sheets and transfer of accountability forms. • A Working Group was established to develop a falls prevention educational piece for staff learning. Hospital orientation falls education was updated and rolled out. • Hospital wide audit for falls prevention compliance in early December and provided huddle discussion notes in follow up to teams. • Regular communications with front line staff members occur in huddles and notes for changes and new processes in falls prevention program review. • Trent students under the direction of the educator and manager are conducting research on a tool for falls prevention for ICU and ER. Discussion to continue with the team from ICU and ER on falls risk assessment based on researched material. Also they will review our educational plan. • Working group is looking at the data collection and verifying how the data is captured. All managers are reviewing Patient Safety incident reports related to falls and are evaluating the accuracy of the information.

Measure/Indicator from 2018/19	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
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?	46	57	58	Above the CELHIN 48%

Change Ideas from Last Years QIP (QIP 2018/19)	Was this change idea implemented as intended?	Outcome
Complete SMART discharge project roll-out throughout Hospital.		The implementation of SMART (**S**igns and symptoms to look out for, **M**edication instructions, **A**ppointment, **R**outine and lifestyle changes, **T**elephone numbers and information to have handy) discharge project was part of the Patient Orientated Discharge Project; provincial roll out with University Health Network OPENLAB. The funding allowed for dedicated staff time to develop tools, obtain patient, family, physician and staff input and audit for quality and compliance during the implementation phase. Tools were revised based on the feedback during the focused implementation roll out. In responding to feedback from our partners in Long Term Care (LTC) and Retirement homes, a specific SMART discharge tool has been developed to meet their information needs. A feedback survey is being completed with the staff at the local LTC and Retirement homes. The patient's SMART discharge tool and their discharge prescriptions are all faxed to the primary care provider at time of discharge to improve transitions back to the community. The SMART discharge program is now integrated on all inpatient units and the diagnosis specific teaching sheets are available in outpatient units. Satisfaction surveys were completed with staff and patients during each implementation phase and either changes were made to the tool, process or education was provided to the unit staff. Ninety two percent of discharged patients have SMART discharge documents completed at the time of discharge.
Organize a 'Discharge Planning Month' to focus on progress to-date and re-energize stakeholders.		The successful implementation of SMART Discharge Project was celebrated hospital wide by sharing the program statistics of compliance and faxing the forms to Primary Care Providers. This focused on expanding patient and family awareness of the program material and celebration with the unit staff on a successful implementation. The units that had consistent audit compliance results to the discharge process had a celebration lunch.

Measure/Indicator from 2018/19	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
Improve Physician Experience: Average of two Worklife Pulse Survey Questions: "How satisfied are you with this organization as a place to practice medicine?" - Number of respondents who answered "Very satisfied" and "Satisfied" as a proportion of the total number of respondents; and "I have adequate opportunities to improve patient care, quality and safety" - Number of respondents who answered "Strongly Agree" or "Agree" as a proportion of total number of respondents.	67	70	70	Current performance will be measured in June 2019.

Change Ideas from Last Years QIP (QIP 2018/19)	Was this change idea implemented as intended?	Outcome
Ensure physicians are engaged in informed decision-making for Hospital change initiatives.	✓	All primary and secondary stakeholders are involved in change initiatives. • Introduced Vice President (VP) monthly reporting at Medical Advisory Committee (MAC). • MAC members are actively involved in decision making. Revised engagement tracking and it is used for all relevant change initiatives. • Established regular meetings with the physician quality lead, Chief Nurse Executive, VP Quality and Chief of Staff (COS). Review and revise terms of reference for committees which require physician attendance to ensure structure promotes physician attendance. • Departmental level – encourage physician involvement, example Health Records Committee (Quality Physician/ COS reps).
Improve physician scheduling practices.	✓	Promote predictability of physician schedules to improve work life experience. • Chiefs of Departments provide at minimum a three – four month schedule, except for those departments struggling with manpower issues.
Improve teamwork, collegiality and work environment for professional staff.	✓	Review physical space (i.e. office, unit work space) to ensure it is designed to optimize physician's ability to provide exceptional care and promote teamwork. • Held meetings with all Departments to address and understand issues from physicians following

the Work Life Pulse Survey.
- Based on feedback from the physicians developed a quality improvement plan for 2019/20.

Encourage participation of physicians, physician leaders, and administrative leaders in departmental and corporate initiatives.

- Physician lead will participate in the Clinical Information System meetings and liaise with the other three hospital physicians.
- Physician representation in key committees such as Transfusion, Safe Pharmacotherapy Committee, Credentials, Peri-operative Committee, MSK Regional Committee.

Measure/Indicator from 2018/19	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
Improve Staff Experience: Average of two Worklife Pulse Survey Questions: "Overall, how would you rate your organization as a place to work?" - Number of respondents who answered "Excellent" or "Very Good" as a proportion of total number of respondents; and "I feel I belong to a team." - Number of respondents who answered "Strongly Agree" and "Agree" as a proportion of total number of respondents.	50	60	51	This is only measured annually resulting in a 1% increase in 2018 compared with 2017.

Change Ideas from Last Years QIP (QIP 2018/19)	Was this change idea implemented as intended?	Outcome
Promote "fun at work."	✓	The Wellness Working Group was established following a call for expression of interest in joining the group. A Working Group of fifteen members meets monthly. A number of staff wellness initiatives have been implemented including: a weight loss group, presentations on reducing mental health stigma, October 'Healthy Workplace' month that included free massages and seminars, a family skate day and birthday celebrations were also organized.
Implement and sustain Service Excellence behaviours.	✓	The feedback from the service excellence participants is very positive and highlights the areas of service recovery, building trust, learning the different communication styles, and hearing from other department team members on their experiences. All staff will participate in service excellence education. The principles of Service Excellence have been embedded into our Strategic Directions and Exceptional Care – Together by delivering excellent service by being kind, taking care of each other and putting others first. Ongoing education will take place throughout the upcoming year. Although many of the concepts are not new, it allows individuals to reflect and apply in day to day activities.
Take care of our workplace inside and out.	✓	One of the areas for improvement identified was revising our parking signage which occurred. The exterior gardens are created and cared for by staff in the various departments and they exemplify the values of the hospital and their beautiful spirits.

Measure/Indicator from 2018/19	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
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.	79	90	96	

Change Ideas from Last Years QIP (QIP 2018/19)	Was this change idea implemented as intended?	Outcome
Formalize MedRec on Discharge process to include tracking mechanism.		Processes for recording actions at discharge continue to be manual with no formal tracking process until the implementation of the Clinical Information System. Performance assessed by retrospective chart audit which is very time consuming. MedsCheck follow up occurs with their community pharmacists. Information is part of our SMART Discharge information sheet provided to the patient.

Measure/Indicator from 2018/19	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.	177	195	160	

Change Ideas from Last Years QIP (QIP 2018/19)	Was this change idea implemented as intended?	Outcome
Refresh violence prevention program by utilizing the Workplace Violence Toolkit developed by PSHSA which includes conducting organizational, departmental, and direct care risk assessments, patient assessments & flagging for violence, enhancing security measures, enhancing personal safety response systems, implementing renewed safety measures and care approaches to keep our staff and patients safe.		Through increased awareness of our Work Place Violence (WPV) prevention program, our original target was set to reflect an increase in WPV reporting. However, as we continue to enhance our WPV prevention program and implement various initiatives, we are in fact experiencing a decrease in incidents. As a result, we are decreasing our target by 10% in the upcoming 2019/20 QIP. The following QI initiatives have made a significant difference in promoting a violence-free workplace: • Internal security services personnel in ED 24/7 was implemented. • Environmental Assessment completed by Ontario Shores Centre for Mental health Services provided recommendations for ED Staff training in Non Violence Crisis Intervention program -75% completed. Staff also received training on addictions. • Mental health patients' placement to a non-triggering environment with a dedicated Mental Health Assessment Room. • Patient aggressive behaviour screening and patient flagging. • Personal Safety Alarms implemented in ED and Diagnostic Imaging.

Measure/Indicator from 2018/19	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
The total number of patients with medications reconciled within 24 hours of admission as a proportion of the total number of patients admitted to the hospital.	82	90	95	

Change Ideas from Last Years QIP (QIP 2018/19)	Was this change idea implemented as intended?	Outcome
Consolidate data from all areas of the hospital that perform admissions.	✗	A manual system of collecting data of BPMH from other departments was introduced for the Pharmacy team but compliance was low; moving forward, we will engage an interdepartmental group to devise a better solution for 2019/20. Ability to meet the 24 hour target of 90% was affected by high patient volumes and overall workloads.

Measure/Indicator from 2018/19	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
The total number of patients with medications reconciled within 24 hours of transfer as a proportion of the total number of patients transferred to a different level of care within the hospital.	Collecting baseline for comparison	90	58	The target set was not correct from the outset nor was the audit process and definitions.

Change Ideas from Last Years QIP (QIP 2018/19)	Was this change idea implemented as intended? (Y/N button)	Outcome
Formalize MedRec on Transfer process to include tracking mechanism.	✗	Systems remain manual; data obtained from retrospective chart audit. Training/education is required as well as frequent communications. We will continue to improve the current form and process as well as role clarity regarding roles and responsibilities and standard definitions.