Ontario Health
Quality

Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

June 26, 2020

HDH HANOVER & DISTRICT HOSPITAL

OVERVIEW

Hanover and District Hospital (HDH) continues to work with its partners to provide a full range of primary acute care hospital services and selected secondary services to meet the needs of the population of Hanover and the surrounding rural townships. Our mission is to provide exceptional care. Our vision is to "partner for excellence in rural health care" living by our values of integrity, compassion and collaboration. The HDH Board of Governors, staff and physicians maintain an unyielding focus on four strategic directions;

- Deliver safe and effective patient care responsive to the needs of our regions;
- Strengthen partnerships and community engagement;
- Ensure the financial sustainability of the hospital; and
- Support our current and future health care team.

The Board of Governors, staff, physicians and community partners work together to accomplish seamless care that provides core rural health services close to home and formalizes clear pathways for referrals to additional services. Thus, the overall objective is to strive for integration and continuity of care across the healthcare sector. HDH partners with peer acute hospitals; community agencies, long term care homes, mental health and addictions and social service providers. All of those provide, refer and connect residents of the region to ensure they receive optimal care.

HDH provides the people we serve access to the care they need through the 24/7 Emergency Department, Acute Care Unit (inclusive of medical/surgical beds, multipurpose ICU and RCU beds), Physiotherapy Program, Cardiac Rehabilitation Program, Surgical Services Department, Family Centered Birthing Unit, Hemodialysis Unit and Palliative Care Services. Access is provided within the organization to Community Mental Health and Addiction Services, Home and Community Support Services, Home and Community Care SWLHIN, Victorian Order of Nurses (VON), Hanover Family Health Team and the Hanover Medical Associates. HDH's ambulatory clinics include; pediatrics, urology, orthopedic, endocrinology/diabetes, surgical ophthalmology, obstetrics, PICC placement and renal dialysis.

HDH has and will continue to maximize opportunities for service integration and coordination between acute, primary care and community care providing selected acute care, surgical and other health care services. HDH has been accredited with Exemplary Status in two consecutive surveys. This reflects that our Board, staff and physicians strive to surpass the fundamental requirements of the accreditation program. Accreditation has aligned and assisted the staff of our health care organization to improve our performance, focusing on quality improvement and safety initiatives for the benefit of the patients and the services we provide.

The QIP continues with the direction of the Board of Governors, staff, physicians and patient and family advisors for the coming year in the quality dimensions through the 2020/21 initiatives. This year, the 2020/21 measurable outcomes will be achieved through hospital peer reviews, integration, partnerships, clinical outcome review, process audits, variance analysis, patient, staff and physician satisfaction surveys, staff education and training and other appropriate quality improvement techniques. In doing so, the QIP will specifically focus on measurable indicators, changes and ideas under the chosen quality dimensions.

Dimension: Efficient
Indicator Name: Alternative Level of Care (ALC) Rate
This indicator measure the total number of ALC days contributed by ALC patients within the specific reporting month/quarter using near-real time acute and post-acute ALC information and monthly bed census data. This indicator parallels the Hospital Service Accountability Agreement (H-SAA) performance measure of 11–12.7%

Dimension: Timely
Indicator Name: Time to Inpatient Bed (Mandatory Indicator)
This indicator is measured in hours using the 90th percentile, which represents the maximum length of time that 90% of patients admitted from the ED wait for an inpatient bed or an operating room. The wait time goal from the Emergency Department to an inpatient bed will be 1.25 – 1.5 hours

Indicator Name: Discharge Summaries Sent from Hospital to Primary Care Provider within 48 hours of Discharge
This indicator measures the percentage of patients discharged from hospital for which discharge summaries are delivered to their primary care provider within two business days of patient's discharge from hospital. The target goal will be 95% of summaries transcribed, signed and sent within two business days of patient's discharge from the hospital for the time period.

Dimension: Patient-Centered
Indicator Name: Patient Experience: Did you receive enough information when you left the hospital?
This indicator will measure the percentage of respondents who responded positively to the 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?" counting the number of respondents who registered any response to this question, but no inclusive of non-respondents. The goal percentage of positive respondents is 95%

Dimension: Safe
Indicator Name: Number of Workplace Violence Incidents (Mandatory Indicator)
This indicator measures the number of reported workplace violence incidents by hospital workers (as defined by OHSA) within a 12-month period including physicians and those who are contracted by other employers (e.g. security etc.) as defined by the Occupational Health and Safety Act. The goal set for this indicator is to continue to monitor and encourage reporting of the number of workplace incidents by our staff, physicians and partners.

Dimension: Effective
Indicator Name: Repeat Emergency Visits for Mental Health
This indicator measures the percentage of unscheduled repeat emergency visits following an emergency visit for a mental health condition. The goal set for this year is to establish a baseline number regarding repeat emergency visit for mental health conditions.

Dimension: Equitable
Throughout all chosen indicators, HDH will be engaging community members/ patients through surveys and the Patient and Family Advisory Committee (PFAC), for the purposes of improving quality, integration and coordination to ensure the delivery of appropriate

high quality coordinated care. Also, as a small hospital we continue to monitor the Quality Based Procedures (QBPs) following their processes and aligning our services to meet the best practices established. The QIP is aligned with HDH's strategic plan, operational plan, service accountability agreements and hospital goals and objectives as well as the provincial priorities and LHIN initiatives.

The suggested indicators that HDH chose not to include as priority indicators in the QIP as they are either not in our realm of control, not applicable to our organization or are not stretch targets include;
• Number of inpatients receiving care in unconventional spaces or ER stretchers - This is not a stretch target for HDH; we do not place patients in hallways. Patients have access to nurse call bells, washrooms and suction/oxygen.
• Complaints acknowledged in a timely manner - This is not a stretch target for HDH; complaints are acknowledged within 48 hours.
• Documented assessment of palliative care needs among patients identified to benefit from palliative care – This indicator is not applicable as data collection is not yet mature enough to validate accurate picture of results.
• Medication reconciliation at discharge – This is not a stretch target for HDH with past performance being 98% and above.

DESCRIBE YOUR ORGANIZATION'S GREATEST QI ACHIEVEMENT FROM THE PAST YEAR

The QIP, from the past year, was instrumental in guiding our hospital to obtaining the target goals set out in the plan. It enabled our hospital to examine our internal processes, as well as work with our community and primary care partners, to drive towards successfully achieving our targets. HDH's only struggle with the QIP, is the ALC metric. There continues to be systemic barriers in the current health care system such as lack of long-term care beds and lack of Personal Support Workers in the community setting that negatively impact reducing the ALC rate at HDH.

Our organization's greatest QIP achievement from the past year would be seeing the link and transition of the indicators creating the bigger picture of patient care. Post discharge phone calls and surveys would ask the patient if they received enough information when they left the hospital. With this information, collected HDH learned of missed appointments, misunderstandings of follow-up treatments and thus created plans to ensure continuum of care. Discharge summaries completed within 2 business days of discharge sent from hospital to community care provider created a strong partnership in the community with current information in the continuum and coordination of care.

The number of mental health and addictions patients attending the emergency department has increased workplace violence and remains a critical concern. This past year tracking the number of workplace violence incidents (overall) within a 12-month period including physicians and those who are contracted by other employers established a baseline for data. Staff was able to understand the need for ongoing violence in the workplace education and training. The Board of Governors too, were able to understand the need for added costs of hiring a security firm to assist with managing the increasing number of mental health and addiction cases at the hospital, particularly in the emergency room.

The community, patients, and family members have been involved

in sharing experiences, opinions, and ideas about the health care services we provide the improvement of these services to them through meetings, presentations, surveys and satisfaction data. HDH is actively seeking out the perceptions, understanding and advice of our stakeholders through public engagement sessions, as well as through health care partners for hospital services. Through engagement sessions and patient feedback, we identify and work on issues to improve the health of our communities as well as shape and develop the content of our QIP.

COLLABORATION AND INTEGRATION

HDH is stand-alone in name only. We work very closely with our partners in the community, mental health, and primary and long-term care sectors to support our patients. Collaboration is a key value at HDH that we believe best supports the patients that we serve. The Hanover Family Health Team and Canadian Mental Health Association (CMHA) will be integral partners in assisting with reducing the number of repeat Emergency Department visits related to mental health. The Hanover Family Team, the primary care physicians and Home and Community Support Services have been long-standing partners in assisting patients at HDH in discharge planning home, and will thereby continue to be partners in helping reduce the ALC rate at HDH, Further, in reducing the incidence of violence, HDH will partner with CMHA to support ongoing education initiatives regarding therapeutic communication. Local police services will also be integral partners in working on joint initiatives to support front-line staff in workplace violence prevention.

PATIENT/CLIENT/RESIDENT PARTNERING AND RELATIONS

HDH is always cognizant of striving for the vision of a patient centered model: a system centered on the needs of demographics and the people's needs and preferences. Knowledgeable and involved patients, informed and investing in their own health care will reflect in the overall improvement of the broader health care system. Patients bring their unique and important perspective about the care and services provided. They know firsthand about the experience they receive at HDH and in other organizations, and on the coordination and cooperation among health care providers involved in their care. At HDH, we strive to involve patients, their families and other caregivers, and the public in meaningful engaged care or as partners in its improvement.

Recognizing the importance to focus on the patient, a learning health care facility like HDH is one in which patients and their families are key drivers of the design and operation of the learning process. The Patient and Family Advisory Committee (PFAC) and the Medical Advisory Committee (MAC) are utilized 100% for important feedback. These committees involve physicians, patients, clients, residents, families, other caregivers, and the public, who are full, active participants in care and engaged with the organizational decisions, the overall health experience of care, and the improvement of economic outcomes.

This is important as the ripple effect of discharge planning is placing an increased burden of care on the family caregiver. Discharge planning is significant for the growing number of the older population, or outcomes. There is an increased risk for readmission. The role of discharge planning and transitions in care are important and play a role in bridging the gap between the care provided in hospital and the care needed in the community. The

need for a coordinated approach with physicians, patients, clients, residents, families, other caregivers, other services and the public includes clear communication, distribution of information, and active support linking to community services. It is our goal that ensuring positive and strong partnerships and relations with the informed, involved patient and family members will entail positive outcomes, allowing nurses and others involved with the care process to better reconcile the family caregivers' needs and expectations.

WORKPLACE VIOLENCE PREVENTION

Patient and staff safety are of paramount concern. Workplace violence prevention is a strategic priority for our organization with the growing number of mental health patients being police escorted to the emergency department and a continued increase in overall acute incidents.

HDH recognizes the importance of creating a culture of awareness regarding violence in the workplace that includes bullying, verbal, emotional and physical violence – This includes identifying tangible steps toward changing attitudes, teaching defensive skills, and providing support for prevention and escalation of violence and harm. As an organization we are focused in making our health care environment safer and being more responsive to occurrences of violence. To assist the staff a security firm was hired 2 years ago to provide when needed coverage, since then there is now a security guard in the Emergency Department every night from 11pm to 7am. Further, the personnel of the firm have been provided with the same training as the staff at the Hanover Hospital.

The Code White policy is regularly reviewed by our staff and leadership team to ensure optimal patient and staff safety. Proper restraints for code white patients have been purchased, and key staff and security have all been trained. A quasi-designated "mental health safe" room within the emergency department was established that has minimal equipment in it for code white patients. Staff receives regular code white training from two in house Crisis Prevention Intervention (CPI) Train the Trainers; it was the goal of HDH to have 100% of full and part time staff trained this past fiscal year.

All staff are encouraged to practice personal safety measures when entering or leaving the building after hours; park in the designated staff on call parking spots across from the emergency department doctor's entrance (close to the building) and to use a buddy system when leaving the building after hours. Staff working alone or few in number are provided personal safety alarms. The security firm hired also assists staff with building security, code white scenarios and guarding violent patients. The security team was provided all the training that our hospital staff receives, which includes CPI in-house training.

HDH has a monthly workplace inspection program where all hospital departments are inspected for violence and safety concerns. We annually administer a workplace violence survey to gain feedback and insight from our staff and volunteers. A mandatory annual education fair is held to ensure that all staff, physician and volunteers receive necessary safety education (some of the many elements covered during this fair include; violence and respect in the workplace, organization policies and procedures pertaining to code of conduct, personal alarm use, code white training and response).

As an organization we have implemented enhanced communication strategies pertaining to violent or potentially violent patients which include; 'Blue Stop Sign' posted on the patient doorways for aggressive or potentially aggressive patients, 'System Alerts' that identify patients that have a history of aggressive behaviour, "Dealing with Difficult Patients and Families" reference list that clearly outlines that resources for staff to utilize and a "Zero Tolerance" policy and posters, which are displayed throughout the organization. We continue to work closely with Public Services Health and Safety Association (PSHSA) to review our program and utilize existing toolkits and resources made available to the Acute Care sector. Further, a violence in the workplace hotline was also created so staff can promptly communicate incidents of violence.

The Joint Health and Safety Committee (JHSC) in conjunction with the Code White team ensure that annual mock training is provided in order to ensure that staff is well educated and trained to respond to emergency situations.

VIRTUAL CARE

Virtual care is definitely well-utilized at HDH. Most frequently used in the form of virtual visits. HDH uses the Ontario Telemedicine Network (OTN) to support virtual visits of patients with specialists at regional and tertiary hospitals. The Emergency Department at HDH is heavily dependent on this technology to support assessments of mental health patients by psychiatrists and crisis workers at other centers. Community and primary care partners frequently access HDH's OTN equipment for their patients as well. Essentially, OTN allows patient to access care at the right place and the right time.

HDH has also launched MyChart which is an online website where patients can create and manage their own personal health information based on clinical and personal information. MyChart allows patients to virtually access their medical history and test results in a timely manner. The Novari scheduling system is used by HDH surgeons, as well as visiting surgeons, to schedule patients for their surgical procedures. The Novari system has created a system to schedule patients while maximizing operating room time. The introduction of registration kiosks at HDH have been implemented for the clinic settings. Patients have the ability to self-register for appointment upon arrival. HDH, in conjunction with the Grey Bruce Ontario Health Team, to explore the eReferral implementation for patients in the Grey Bruce region.

EXECUTIVE COMPENSATION

The Board agrees the following executives will be linked to the organization's achievement of the targets set out in the annual QIPs:

- President CEO (Administrator)
- Chief of Staff
- Senior Management reporting directly to the President CEO

Each year, QIP targets are reviewed with the Board Governors indicating the degree to which the targets have been met. As indicated in the Hospital Board Policy and QIP, 5% of the President/CEO annual base salary (step increase) is considered to be 'at risk' and is linked to achieving 100% of the targets set out in the QIP. Achievement of all targets would result in 100% payout; partial achievement of targets will result in partial payout, as determined by the Board of Governors.

Summary: Performance based compensation accounts for 5% of each executive's annual compensation.

SIGN-OFF

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan on **May 28, 2020**

Lorna Eadie Hocking, Board Chair

Tina Shier, Board Quality Committee Chair

Dana Howes, Chief Executive Officer

Corwin Leifso, Other leadership as appropriate

Theme I: Timely and Efficient Transitions

Measure

Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Total number of alternate level of care (ALC) days contributed by ALC patients within the specific reporting month/quarter using near-real time acute and post-acute ALC information and monthly bed census data.	P	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / Jul 2019 - Sep 2019	29.47	11.00	Monitor the ALC rate	Grey Bruce Ontario Health Team, Home and Community Care SW LHIN, Physicians, Long Term Care

Change Ideas

Change Idea #1 • We are changing the process to reflect Provincial approach, therefore expect our results to increase while noting patient volumes should remain consistent. • Continue to work with Home and Community Care SW LHIN (formerly CCAC) daily to discharge plans • Continue to work with our LTCH partners to understand the pressures that they are facing which impact their ability to accept admissions i.e. not accepting new admissions, outbreaks, sharing of transfer information, medication lists in timely manner and mutually agreeable discharge times, • Continue to meet regularly with the SW LHIN Home and Community Care to review ALC patients, complete family meetings to discuss discharge options, to review LTCH applications in progress and maximize facility choices and options for acceptance of idle beds • Continue to promote returning home with families, nursing staff and physicians. The Home First program has been paused for some time now due to insufficient resources to staff it • Discuss ALC rates at Utilization and Medical Advisory Committee meetings • Set discharge date and plan at every admission • Early diversion in ED of “Failure to Cope” patients – involved with Home and Community Care SW LHIN from point of assessment in ED • Meet with long term care (LTC) and lodges to discuss ALC issues and care coordination • Grey Bruce Ontario Health team’s plan to support care transitions of frail seniors across the health care continuum – Engaging nursing home and Home and Community Support to create new and innovative approaches to support care transitions.

Methods	Process measures	Target for process measure	Comments
• Track ALC, Readmission and LOS rates • Monitor rates of patients admitted with “Failure to Cope” as a diagnosis • Continue to monitor lab early morning turnaround times • Continually inform the SWLHIN when unable to send patients home with support • Continue to provide patient linkages to community supports programs, to enable patients to safely remain in their own home and manage disease condition	• ALC Rate • Home First Rate Suspended • LOS Rates • Education with MD’s around LOS and flagging their charts for LOS • Readmit Rates • Meet with LTCH in the area quarterly to discuss strategies to expedite admissions into LTCH	We are targeting for a percentage corridor of 11-12.7%	The small number of inpatient days for the hospital makes this a variable metric. Further, the ALC metric is a system wide issue; HDH plays a role but cannot control this metric solely. This is also an H-SAA target. Demographics of area reflect a higher population of frail elderly in this Grey Bruce region thus increase number of unstable elderly with a shortage of LTC beds. Huge PSW shortage in community. Difficult to get patients home. Lack of Nursing Home Beds and LTCH inability to admit new patients i.e. suspended admission to Brucelea Haven, largest LTCH in the area also creates more in hospital days

Measure

Dimension: Timely

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital.	P	% / Discharged patients	Hospital collected data / Most recent 3 month period	77.00	95.00	Increase discharge summaries sent from hospital to community care provider within 2 business days of discharge	Physicians, Residents

Change Ideas

Change Idea #1	• Physicians need to complete discharge summaries as soon as patient is discharged • Monitor and track completion time and time sent to community partners • Utilization Committee to review metric • Provide staff and physicians feedback when this metric does not meet performance target through monthly reports sent to physicians and reviewed by COS and CEO

Methods	Process measures	Target for process measure	Comments
• Monthly review of performance rolled up and individual tracking report cards • Track data in terms of the percentage of time our physicians meet target vs. Residents. Resident model – summaries need to be reviewed by their GP preceptor first before releasing	• Monthly review by COS and CEO	We are targeting to increase the discharge summaries sent from hospital to community care provider within two business days of discharge 95-100%	Work to migrate toward Dragon dictation. There is no Health Records transcriptionist after 4 pm Friday until Monday at 8 AM When a physician checks review the dictation does not go into the system until there is final review from the physician causing a delay.

Measure

Dimension: Timely

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
The time interval between the Disposition Date/Time (as determined by the main service provider) and the Date/Time Patient Left Emergency Department (ED) for admission to an inpatient bed or operating room.	M	Hours / All patients	CIHI NACRS, CCO / Oct 2019– Dec 2019	2.15	1.50	Reduce ED wait time for inpatient bed	Grey Bruce Ontario Health Team, Physicians

Change Ideas

Change Idea #1	• Medical Advisory Committee to review metric • Established education and common understanding and definition criteria for patient readiness to leave ED • Ensure residents are formally informed of this policy annually • Provide staff and physicians feedback when this metric does not meet performance target • Daily reports to Senior Team and PCM when a patient falls outside the expected corridor not currently being done • Review routinely at Acute Care and ED huddles • Engaging with the Acute Care Unit to identify patterns of admission times and patient flow and align nursing workflow • Consider standard discharge time • Closely monitor inpatient length of stay (LOS) to ensure in-patient beds are occupied appropriately • Charge nurse to keep Emergency Department inform of number of inpatient beds.

Methods	Process measures	Target for process measure	Comments
• Monthly review of performance rolled up	• Daily review of patients that have not met this target	We are targeting to reduce the ED wait time for inpatient bed target 1.25 -1.5 hours	

Theme II: Service Excellence

Measure

Dimension: Patient-centred

Indicator #4	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?	P	% / Survey respondents	CIHI CPES / Most recent 12 months	94.78	95.00	Increase the information provided to patients on what to do if they are worried about their condition or treatment after they leave the hospital.	Hanover Family Health Team, Diabetes Education, Home and Community Support

Change Ideas

Change Idea #1 • Take an inventory of patient information material and modify patient information with the guidance of the Patient and Family Advisors • Clinical Brain Train Board on Lexicom and include on huddle boards.

Methods	Process measures	Target for process measure	Comments
• Hand out prepared packages to patients on commonly admitted conditions including COPD, DM, HTN, Angina, Arrhythmia, asthma etc. • Orientate nurses to Lexicom annually to continue information being provided regarding medication and medical conditions to patients • Discuss patient education at rounds • Work with HFHT to ensure that patients rostered with them receive information about community based education programs • Review documentation of education charting in CareNet system • Continues to provide every patient, upon admission, with the Welcome Information leaflet on Acute Care	• # of referrals that HFHT receives from HDH • Audit the education section of the CareNet on patient e-chart with a goal of 100% of charts reviewed. • Continue to monitor patient responses/satisfaction surveys indicating that they have received sufficient information prior to discharge • Utilization of post-discharge telephone follow-up call within 48-72 hours as a check in with patients	We are targeting to increase the information provided to patient on what to do if they are worried about their condition or treatment after they leave the hospital to 95-100%	Total Surveys Initiated: 690 Survey responses available are: • Yes • Somewhat • No

Theme III: Safe and Effective Care

Measure

Dimension: Effective

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percent of unscheduled repeat emergency visits following an emergency visit for a mental health condition.	P	% / ED patients	CIHI NACRS / April - June 2019	18.89	18.70	This is a data collection year for HDH and will aim to improve processes.	Grey Bruce Ontario Health Team, Hanover Family Health Team, Grey Bruce Public Health, Grey Bruce Canadian Mental Health Association, Keystone Child, Youth and Family Services, Grey Bruce Health Services, South Bruce Grey Health Centre

Change Ideas

Change Idea #1	• Inventory of actions of what HDH does to support patients not coming back • GB OHT's Year 1 focus is on Mental Health & Addictions – Initiatives such as timely access to primary and mental health care for those patients who visit Emergency Department's frequently; ride along programs with police • Naloxone kits to be distributed to overdose patients that present in the Emergency Department in partnership with Grey Bruce Public Health. • Rostered patients with HFHT with MH&A issue will be connected to the HFHT.

Methods	Process measures	Target for process measure	Comments
• # of Naloxone kits distributed • # of referrals to RAAM • Explore the possibility of tracking the number of CMHA referrals • # of referrals to GBHS detox • # of Psychiatry OTN Consults	• Patient education and promotion of community MH resources • Referring to community supports CMHA/Keystone	This year will be used to gather baseline data	

Measure

Dimension: Safe

Indicator #6	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.	M	Count / Worker	Local data collection / Jan - Dec 2019	38.00	38.00	Monitor and encourage reporting of the number of workplace violence incidents	Grey Bruce Canadian Mental Health Association, Keystone Child, Youth and Family Services, Police Services

Change Ideas

Change Idea #1	• Identify causes, challenges, gaps and develop education/safety networks for staff • Leadership Development Institute (LDI) to review Violence in the workplace legislation and policies at HDH • Continue to build on a culture of violence awareness and responsiveness and will continue to encourage reporting of violent incidents. • Standard topic on huddles – review incident reports and gain feedback. • Quadruple Aim • Community reach out with CMHA, Key Stone for shared education days – half-day education mandatory – gentle persuasion. Can invite community organizations to participate. • Continue to monitor debriefs and put to action improvement to improve safety and violent incidents. Debrief notes can be reviewed at huddles. • Establishment of Police-Hospital Committee • Ensuring that there is a risk-assessment hand-off between police and HDH staff for patients who have been brought in by police

Methods	Process measures	Target for process measure	Comments
• Use the RL6 in-house hospital incident and patient safety reporting systems for determining the number of workplace violence incidents. Violence Hotline initiated to help increase reporting of incidents. • Provide education to staff defining the terminology with respect to violence and harassment • Mandatory CPI training for all staff • Staff to complete annual patient safety survey regarding violence in the workplace • Mental Health Champions available to staff as a resource and encourage reporting when applicable. • Overnight security in the ED hired.	• Collect data on the number of violent incidents reported by workers, including physicians and those who are contracted by other employers (e.g. food services, security, etc.) as defined by the Occupational Health and Safety Act • Monitor the number of staff with CPI training against those who still need training • Review survey results	We are targeting the tracking/collection of numbers to monitor the number of workplace violence incidents. We will target the percentage of trained staff and ongoing education of mandatory departments i.e. ER, Switchboard/Registration, Environmental Services, Maintenance, Acute care and others as interested.	FTE=118 Overall target was kept the same to continue reporting