Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 28, 2025

Ontario Health

OVERVIEW

Hanover and District Hospital (HDH) is committed to delivering exceptional rural health care. As a key provider of acute and selected secondary care services, HDH works closely with health system partners to meet the needs of our community. Guided by our vision, "Partnering for Excellence in Rural Health Care," we uphold our core values of integrity, compassion, and collaboration in everything we do.

Recent years have posed significant challenges, particularly with Emergency Department closures across the South Grey Bruce region. Despite these pressures, HDH has remained steadfast in ensuring that patients in our region have consistent access to emergency care when they need it most. Our unwavering commitment to patient-centered care is reflected in our high patient satisfaction scores, a testament to the dedication of our staff and the exceptional service they provide.

Looking ahead, our 2025 Quality Improvement Plan (QIP) will be guided by Ontario Health and the Ministry of Health, focusing on three key priorities:

1.Enhancing the patient experience – With a particular emphasis on the Emergency Department, we are committed to improving care across all hospital departments.

2.Optimizing patient flow – By facilitating timely access to inpatient beds and ensuring seamless transitions home, we aim to enhance care efficiency and reduce wait times.

3.Advancing diversity, equity, inclusion, and anti-racism – We are

strengthening our commitment to fostering a more inclusive and equitable health care environment for both staff and patients.

ACCESS AND FLOW

At Hanover and District Hospital (HDH), the pursuit of improved patient care is a continuous journey. Guided by the ALC Leading Practice Guide, the Pay for Results Emergency Department Initiative, and our own performance metrics, we are committed to optimizing access and patient flow. Our approach is rooted in continuous evaluation, drawing from direct patient feedback alongside key performance indicators to refine and enhance care delivery.
To ensure patients receive timely access to the right care in the right place, we will strengthen our partnerships with community providers, long-term care facilities, rehabilitation centers, and hospice services. These collaborations are essential in facilitating smooth transitions and preventing unnecessary hospital stays.
Our Quality Improvement Plan (QIP) serves as our strategic framework for enhancing the patient experience. Through targeted initiatives, we aim to streamline processes, optimize resources, and improve care efficiency. Key priorities include:

• Prioritizing timely ambulance off-loading and reducing the number of patients waiting for a bed at 0800 hours, ensuring that patients are promptly transferred from emergency care to inpatient care.

• Enhancing discharge planning, including medication reconciliation and clear patient instructions, to prevent avoidable readmissions.

• Prioritizing delirium screening and subsequent care plans in accordance with Ontario's Delirium Quality Standard to improve early detection and management.

By aligning our efforts with these guiding principles, HDH remains dedicated to delivering efficient, patient-centered, and high-quality rural health care.

EQUITY AND INDIGENOUS HEALTH

At Hanover and District Hospital (HDH), our commitment goes beyond providing exceptional healthcare—we embrace diversity, equity, inclusion, and anti-racism as central to everything we do. The new strategic plan reinforces this vision by prioritizing equity, diversity, and inclusion across all aspects of our organization. We recognize that embracing diversity strengthens our resilience, enhances innovation, and deepens empathy in both patient care and staff support. We are dedicated to cultivating an environment where every individual, regardless of background or identity, feels valued, respected, and empowered to thrive.

The Health Equity Committee at HDH has taken a significant step in advancing these principles by developing a comprehensive five-year Health Equity Plan. This plan serves as a roadmap, outlining key strategies and actions to address disparities and promote equitable healthcare practices within our organization. In crafting this plan, HDH has actively sought input and collaboration from leaders representing Indigenous communities and other diverse groups. By engaging in meaningful consultation, we ensure that the perspectives and needs of these communities are at the heart of our approach.

Over the past three years, HDH has prioritized Indigenous education

and training, and this year we will continue these efforts in our ongoing commitment to inclusive care. This past year we also focused on providing education on LGBTQ2S+ issues to equip our staff with the knowledge and skills to deliver respectful and inclusive care.

HDH remains steadfast in its dedication to upholding the principles of diversity, equity, and inclusion, striving to create a healthcare environment where everyone has equitable access to quality care and opportunities for optimal health and well-being.

PATIENT/CLIENT/RESIDENT EXPERIENCE

At Hanover and District Hospital (HDH), we prioritize the patient experience above all else. To ensure that we consistently meet and exceed patient expectations, we take a comprehensive approach to gathering valuable feedback. Our Patient and Family Advisory Committee (PFAC) plays a critical role in shaping our practices and policies, providing insights and perspectives that are essential to improving care.

In addition to PFAC, we are committed to continuous improvement through the use of the Ontario Hospital Association's (OHA) Patient Experience Survey. This standardized survey allows us to gather feedback from patients across our clinical areas, offering valuable data that will help us benchmark our performance against other hospitals. By using this tool, we can better understand patient experiences, identify areas for improvement, and ensure that we remain focused on delivering high-quality care.

Our commitment to excellence extends beyond the initial encounter. We conduct follow-up phone calls with patients post-discharge to gather feedback and address any lingering concerns. Actively listening to the voices of those we serve allows us to adapt and evolve, ensuring we consistently deliver compassionate, patient-centered care.

Over the past year, our Patient and Family Advisors were instrumental in providing valuable information that improved the patient experience. The PFAC is also actively involved in helping HDH set strategic and Quality Improvement Plan (QIP) goals, further strengthening our efforts to enhance care and outcomes for all patients.

PROVIDER EXPERIENCE

At HDH, we are dedicated to fostering a positive, supportive workplace culture. Our Wellness and Mental Health Committee leads initiatives focused on promoting both physical and mental well-being for our staff. In partnership with the Canadian Mental Health Association, we will continue offering in-house workshops on topics such as stress management, developing resiliency, and general wellness. Additionally, we are committed to providing weekly wellness literature to our staff through HDH's newsletter. We also recognize exceptional care through our Recognition Program, using thank you notes, shout-outs, social media posts, and team meetings to express gratitude and strengthen camaraderie.

We prioritize staff education and development, offering training, workshops, and continuing education opportunities to ensure our team has the tools and knowledge needed to deliver exceptional care. This investment in professional growth not only enhances care quality but also cultivates a culture of continuous learning, making our staff feel valued and empowered.

SAFETY

At HDH, ensuring safety is integral to our mission of delivering exceptional care. To guide our work, we have implemented Healthcare Excellence Canada's Quality Care and Patient Safety Framework, which aligns our efforts with best practices in healthcare safety. A key new initiative is the Never Events program, where we will provide focused education and actively participate in this Ontario Health initiative to prevent avoidable, serious incidents.

Our incident management system plays a crucial role in reporting and addressing incidents promptly, allowing for thorough follow-up and resolution. Additionally, our Patient and Medication Safety Committee reviews all medication-related, falls, and miscellaneous incidents to identify opportunities for improvement and prevent recurrence. We also maintain robust patient safety policies, subject to annual review to ensure their effectiveness.

Furthermore, HDH's active Joint Health and Safety Committee ensures a safe workplace environment. Regular safety inspections are conducted to safeguard both staff and patients, reinforcing our commitment to a safe, high-quality healthcare environment

POPULATION HEALTH MANAGEMENT

HDH is committed to delivering high-quality care close to home through strategic partnerships with various organizations. One of these collaborations is the Flex Clinic, operated in partnership with Ontario Health atHome, which provides comprehensive outpatient care services. The clinic offers a wide range of treatments and services, delivered by skilled Registered Nurses and Registered Practical Nurses, including IV therapy and medication administration, wound care and dressing changes, post-surgical follow-up care, and medical monitoring and assessments. Referrals to the Flex Clinic are managed through the Ontario Health atHome Program.

Additionally, HDH has established an outpatient Rapid Access Addiction Medicine (RAAM) Clinic in collaboration with Bright Shores Health System. This clinic provides timely, specialized care for individuals facing addiction challenges. Our partnership with the Hanover Family Health Team further enhances our ability to offer comprehensive support to obstetrical and postpartum patients, ensuring continuity of care and optimal outcomes for both mothers and newborns, as well as providing support to our Acute Care Unit.

Through our collaboration with Home and Community Care Support Services (HCCSS), we extend our reach, offering essential medical services to patients who may face barriers to accessing traditional healthcare settings. These partnerships reflect our ongoing commitment to innovation and community engagement, ensuring access to a wide spectrum of healthcare services tailored to meet the specific needs of individuals in our region.

At HDH, our longstanding dedication to collaboration and partnership is central to our mission of providing compassionate, comprehensive care that enhances the well-being of our patients and strengthens the health of our community.

EMERGENCY DEPARTMENT RETURN VISIT QUALITY PROGRAM (EDRVQP)

Hanover and District Hospital (HDH) will be participating in the Emergency Department Return Visit Quality Program (EDRVQP) and implementing several quality improvement initiatives aimed at enhancing the patient experience and improving flow through the department. As part of the 2025/26 Quality Improvement Plan (QIP), HDH will focus on key metrics, including the daily average of patients waiting in the ED at 8 a.m. for an inpatient bed, the 90th percentile for ambulance offload time, and the 90th percentile for ED wait time to physician initial assessment. Educational sessions will be conducted to ensure that staff understand the importance of these initiatives in improving patient experience, maintaining quality of care, and ensuring the capacity to serve patients efficiently. Monthly audits of these metrics will be performed and reported to the senior team and the Medical Advisory Committee. Additionally, daily staff and physician huddles will take place to address any issues in real time, allowing for timely adjustments to optimize results. To support these efforts, policy development will be explored to establish clear procedures for managing patient flow through the ED, ensuring consistency and sustainability in the hospital's approach.

EXECUTIVE COMPENSATION

As per Board Policy # 502, 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 Directors 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 Directors.

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 **March 28, 2025**

Tina Shier, Board Chair

Pamela Matheson, Board Quality Committee Chair

Dana Howes, Chief Executive Officer

EDRVQP lead, if applicable

Access and Flow

Measure - Dimension: Timely

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile ambulance offload time	P	Minutes / Patients	CIHI NACRS / For ERNI hospitals: Dec 1, 2023, to Nov 30, 2024 (Q1 and Q2)	16.00	16.00	We have set our target at current performance levels to first focus on improving data quality, ensuring reliable insights for future improvements.	Bruce County EMS, Grey County EMS

Change Ideas

Change Idea #1 Implement strategies to improve the accuracy, consistency, and timeliness of ambulance offload time data collection.

Methods	Process measures	Target for process measure	Comments
1) Conduct audits on data entry practices to identify errors and inconsistencies in offload time records. 2) Provide training for staff on proper data documentation and the importance of timely and accurate data entry. 3) Conduct regular Pay-for-Results Working Group meetings and huddles to examine and educate on metrics.	1) Data accuracy 2) Audit Frequency 3) Staff Training	1) Target quarterly audits to identify and correct data discrepancies 2) Collect baseline accuracy in recorded offload times 3) Target 95% of relevant staff trained on data entry protocol	

Change Idea #2 Collaborate with EMS to establish effective communication channels and ensure timely sharing of offload time information.			
Methods	Process measures	Target for process measure	Comments
1) Schedule regular meetings or communication touchpoints with EMS teams to discuss offload times and identify potential barriers. 2)Develop standardized communication protocols for both EMS and hospital teams, including expectations for reporting and response times.	Number of meetings held with EMS to review offload time performance.	Number of meetings with EMS: Target quarterly meetings to review offload time performance.	

Change Idea #3 Investigate opportunities for seamless data integration between EMS systems and the hospital's electronic health records (EHR) to automate offload time reporting.			
Methods	Process measures	Target for process measure	Comments
1) Collaborate with EMS and IT teams to evaluate existing data interfaces and assess their ability to transfer offload times automatically. 2) Explore the feasibility of integrating EMS software with the hospital's EHR system to capture offload times directly from EMS records.	Ability to implement data interface opportunity	Ability to implement data interface opportunity	

Measure - Dimension: Timely

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department wait time to physician initial assessment	P	Hours / ED patients	CIHI NACRS / ERNI hospitals: Dec 1, 2023, to Nov 30, 2024/Non-ERNI hospitals: Apr 1, 2024, to Sept 30, 2024 (Q1 and Q2)	3.07	3.07	We have set our target at current performance levels to first focus on improving data quality, ensuring reliable insights for future improvements.	

Change Ideas

Change Idea #1 Enhance the accuracy, completeness, and timeliness of data regarding ED wait times to Physician initial assessment.

Methods	Process measures	Target for process measure	Comments
1) Conduct regular data audits to identify inaccuracies or missing data in ED wait time logs. 2) Standardize the process for recording wait times to reduce data entry errors. 3) Provide staff training on the importance of accurate documentation and the role of data in decision-making.	1) Data Accuracy 2) Audit frequency 3) Staff training	1) Data accuracy: Collect baseline accuracy in recorded ED wait times to physician initial assessment. 2) Audit frequency: Target quarterly audits to review and correct data entry issues. 3) Staff training: Target 95% of ED staff and physicians trained on accurate data documentation.	

Change Idea #2	Educate physicians on the importance accurate data and reducing wait times to ensure consistent adherence to timeliness guidelines for initial assessments.		
Methods	Process measures	Target for process measure	Comments
1) Conduct educational sessions for physicians on the impact of ED wait times on patient care and outcomes. 2) Implement best practice guidelines for physicians to follow to improve initial assessment timeliness.	Number of educational sessions	Target 2 educational sessions for physicians.	

Measure - Dimension: Timely

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Daily average number of patients waiting in the emergency department for an inpatient bed at 8 a.m.	P	Number / ED patients	CIHI NACRS / Apr 1 to Sep 30, 2024 (Q1 and Q2)	0.37	0.37	We have set our target at current performance levels to first focus on improving data quality, ensuring reliable insights for future improvements.	South Bruce Grey Health Centre

Change Ideas

Change Idea #1	Review and optimize internal processes for overnight admissions to ensure timely patient placement and reduce wait times in the ER.		
Methods	Process measures	Target for process measure	Comments
1) Examine internal policies and review patient flow process daily 2) Provided education to staff and physicians on changes to current internal process 3) Incorporate within the overall P4R Committee work	1) Completion of revised policy and process for patient flow 2) Review frequency 3) Frequency of P4R huddles	1) Education and implementation of revised policy and process 2) Target monthly review and optimization of overnight admission processes 3) Target weekly P4R huddles to review and provide education on P4R metrics.	

Change Idea #2	Expand and enhance internal surge capacity to accommodate a higher number of patients during peak periods, reducing ER wait times for inpatient beds.		
Methods	Process measures	Target for process measure	Comments
1) Review surge protocols to quickly increase inpatient capacity during periods of high ED patient volume. 2) Increase flexibility in bed assignment	1) Surge protocol implementation 2) Flexibility in bed usage	1) Target activation of surge protocol within 4 hours of identifying high patient volume.	

Change Idea #3	Work with regional partners to coordinate bed leveling efforts and share resources, improving bed availability across the system and reducing ER wait times.		
Methods	Process measures	Target for process measure	Comments
1) Work with the SW Situational Surge Group 2) Continue collaboration with South Bruce Grey Health Centre in meeting regularly around repatriation 3) Include more Brightshores Health System in future repatriation touch bases.	Frequency of meetings	1) # of SW Situational Surge Group meetings attended 2) # of repatriation meeting touch bases with regional partners	

Change Idea #4	Enhance the accuracy, completeness, and timeliness of data on inpatient bed availability to enable better decision-making and more efficient bed management.		
Methods	Process measures	Target for process measure	Comments
1) Standardize data collection practices across departments and facilities to improve consistency. 2) Train staff on the importance of accurate data entry and the impact it has on patient flow.	1) Data Accuracy 2) Staff Training	1) Target quarterly audits to ensure accurate data 2) Target 95% of relevant staff trained on data entry protocols.	

Equity

Measure - Dimension: Equitable

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	O	% / Staff	Local data collection / Most recent consecutive 12-month period	96.67	95.00	% of executive-level and management staff	

Change Ideas

Change Idea #1 Provide all staff and management with multiple EDI educations opportunities through the Health Equity Committee.

Methods	Process measures	Target for process measure	Comments
1) Health Equity Committee will promote and organize Cultural Mindfulness Training. 2) Management will participate in Challenging Stigma Training with CMHA.	Encourage management, staff, physicians and external partners to participate in the training sessions provided	95% of executive-level and management staff to complete Cultural Mindfulness Training and Challenging Stigma Training.	

Experience

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of respondents who responded “completely” to the following question: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?	O	% / Survey respondents	Local data collection / Most recent consecutive 12-month period	95.66	95.00	95% of respondents	

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.

Methods	Process measures	Target for process measure	Comments
1) Audit the education handouts 2) Continue to monitor patient responses/satisfaction surveys indicating that they have received sufficient information prior to discharge	1) Handout review completed 2) Patient Satisfaction survey	1) Review 100% of handouts used to provide patient information 2) Achieve 95% for the patient satisfaction 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.	Total Surveys Initiated: 415

Safety

Measure - Dimension: Safe

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of delirium onset during hospitalization	O	% / Hospital admitted patients	CIHI DAD / April 1 to September 30, 2024 (Q1 and Q2), based on the discharge date	X	0.00	We will be collecting a baseline for this metric. We will first focus on improving data quality, ensuring reliable insights for future improvements.	

Change Ideas

Change Idea #1 Adopt and implement the Health Quality Ontario Delirium Aware Safer Healthcare (DASH) program to improve delirium screening, documentation, and early intervention practices across the hospital.

Methods	Process measures	Target for process measure	Comments
1) Integrate the DASH (Delirium Assessment Screening and Hospitalization) program into daily clinical practices for all hospitalized patients, especially those at higher risk for delirium. 2) Provide training to physicians, nurses, and allied health staff on using the DASH screening tool and recognizing early signs of delirium. 3) Develop clear protocols for documenting delirium assessments and any identified delirium symptoms in patients' medical records 4) Conduct periodic audits to ensure that the DASH screening tool is being used consistently and that delirium is being documented accurately.	1) Screening completion rate 2) Staff training 3) Audit frequency	1) Collect baseline of the number of at-risk patients screened for delirium using the DASH tool within 24 hours of admission. 2) Target 95% of relevant clinical staff trained on the DASH program and delirium identification. 3) Target quarterly audits of delirium screening and documentation practices to identify gaps and ensure consistency.	