HANOVER & DISTRICT HOSPITAL

Operational Plan

Reviewed 2024-25

Operational Plan Overview

Enablers

Communicate • Educate • Lead • Innovate • Advocate

- CEO Forums
- Nursing Forums
- Work Life Pulse Survey
- Strategic Partnerships (Hanover Family Health Team, Long Term Care, Regional Hospitals, Public Health Unit)
- Departmental Budget Reviews Monthly
- Patient Satisfaction Surveys and Feedback
- Department Goals and Objectives
- Committees (Patient & Family Advisory Committee, Patient Safety & Risk Management, Professional Practice/Product Evaluation Committee, Ethics, Infection Prevention and Control, Health Equity, Occupational Joint Health & Safety, Wellness & Mental Health Champions)
- Departmental Huddles
- Patient Rounding
- HIROC Risk Assessments
- Small, Rural and Northern Committee (OHA)
- Quality Goals and Objectives
- Regular Safety Debriefs – Patient and Staff
- Inter-Hospital Laboratory Partnership (IHLP)
- Scheduled Mock Codes
- Grey-Bruce Hospital-Police Transition Protocol
- Saugeen Obstetric Group – MoreOB principles and practices (past partner)
- Grey Bruce Ontario Health Team
- Grey Bruce Mental Health Network
- Grey Bruce Integrated Health Coalition
- Georgian Bay Information Network (GBIN)
- Biannually Reviewed Policies and Procedures
- Anti-microbial Stewardship
- Medical Advisory Committee
- Nursing Education Plan
- Health Equity Education Plan
- Wellness & Mental Health Champions
- Departmental Meetings and Staff Rounding
- Achieving Excellence Leadership Group
- Board of Governors
- Grey Bruce Health Services Radiology Group
- Grey Bruce Health Services Pharmacy

Purpose

The purpose of the Operational Plan is to act as a roadmap in guiding the organization in achieving its Strategic Goals and Objectives and overall Mission, Vision and Values of, *Partnering for Excellence in Rural Health Care*. The Operational Plan will essentially uphold the Strategic Plan of the hospital. It will guide leaders within the organization in achieving our Mission, Vision and Values of *Providing Exceptional Care.*

The Operational Plan will assist HDH in achieving the following strategic directives:

1. To deliver safe and effective patient care responsive to the needs of our region;
2. To strengthen partnerships and community engagement;
3. To ensure the financial stability of the hospital; and
4. To support our current and future health care team.

The plan will be reviewed annually and will outline strategic priorities, opportunities for improvement and areas of focus for the year. Under the direction of the President & CEO, the Senior Leadership group, in collaboration from our managers, frontline staff, patient and family advisors and physicians, will determine the annual strategic goals and objectives and quality improvement plan initiatives, and seek final approval from the Board of Governors.

Objectives of the Operational Plan:

- Promoting quality patient care, in collaboration with quality metrics, performance improvement and project initiatives;
- Deliver patient care that demonstrates best practice and is innovative;
- Enhance patient satisfaction;
- Enhance program delivery;
- Enhance patient safety;
- Develop and sustain partnerships within the region;
- Consistently deliver outcomes to effectively meet the needs of our community;
- Maintain a healthy workforce, clinical skillset and expertise; and
- Fiscal responsibility.

Specific Components

The following components of the Operational Plan are supportive of the Strategic Plan and are as follows:

Quality Improvement Plan (QIP)

A Quality Improvement Plan (QIP) is a formal, documented set of quality commitments aligned with system and provincial priorities that a health care organization makes to its patients/clients/residents, staff and community to improve quality through focused targets and actions. Annually, HDH staff, physicians, Patient and Family Advisors, and Board of Governors in concert with our strategic plan and the priority indicators as identified by Health Quality Ontario, develop a comprehensive QIP that supports staff and patients.

Operating Budget and Capital Planning

The budgeting process is integral to ensuring the financial sustainability of the hospital, delivering safe and patient-centred care within the available resources. The operating budget is developed annually in collaboration with managers, patient and family advisors and physicians, to align with and support our strategic directives. The operating budget is presented to the Finance/Audit and Property Committee of the Board of Governors for approval, and the process is managed through the Hospital Annual Planning Submission (HAPS) and the Hospital Service Accountability Agreement (HSAA). The hospital's Vice President, Finance & Operations is responsible for the ongoing monitoring and implementation of the operating budget, with the support of the hospital's leadership and management team. Financial results are reported monthly to Senior Leadership, and the Finance/Audit and Property Committee of the Board of Governors. Financial results are reported quarterly to the Ministry of Health, as required by the HSAA.

The capital budget is developed annually in collaboration with managers, patient and family advisors and physicians and presented to the Finance/Audit and Property Committee who make a recommendation to the Board of Governors for approval. Resource allocation is determined based on the priorities identified in the HDH Strategic Plan. The hospital's Vice President, Finance & Operations is responsible for the ongoing monitoring and implementation of the capital plan with the support of the hospital's management team.

The annual operating and capital budgets are also presented to the hospital's Fiscal Advisory Committee, as required by the Public Hospitals Act.

Risk Management Plan

The Risk Management Plan is a primary tool for implementing the organization's overall risk management strategies. It is designed to provide guidance and structure for the hospital's clinical and administrative services that drive quality patient care while fostering a safe environment for staff and patients.

This risk management plan is reviewed annually by the Patient Safety and Risk Management Committee, and is presented to the Quality Governance and Risk Management Committee of the Board of Governors for approval. The hospital's Risk Manager is responsible for the ongoing monitoring and implementation of the plan with the support of the hospital's leadership and management group.

Patient Safety Plan

The intention of the Patient Safety Plan is to support and uphold our strategic initiative to *deliver safe and effective patient care responsive to the needs of our region.* The Patient Safety Plan outlines a comprehensive approach that ensures that quality and safety driven initiatives are in place to support patients. Further, the Patient Safety plan supports initiatives of the QIP. It is a living plan that is continuously being modified to reduce patient safety breeches.

While ensuring the safe care of patients is everyone's responsibility, the Risk Manager in collaboration with the Patient Safety and Risk Management Committee will lead the Patient Safety Plan with support from the Senior Leadership and management groups. The Patient Safety Plan is reviewed annually.

Human Resources Plan

The Human Resources Plan is a vital component to support and advance the HDH Strategic Plan. The Human Resources Plan provides important framework and guides the organization' recruitment and retention activities. This plan outlines the needs of the organization to enable proactive planning to ensure the hospital attracts, develops and nurtures our workforce, and is able to respond to the changing landscape.

The Manager, Human Resources and Physician Recruitment is responsible for the ongoing monitoring and implementation of the Human Resources Plan, with support from the hospital's leadership and management group. This plan is reviewed annually.

Engagement and Communications Plan

The Engagement and Communication Plan for Internal and External Stakeholders is an essential element in upholding the hospital's Strategic Plan from year to year. Effective communication with not only our internal team members, but also our external stakeholders and the patients that we serve is paramount in our delivery of safe and effective care. Conveying the information of our organization, the programs and services, challenges encountered and the accomplishments to our staff, physicians, our Board of Governors, our Patient and Family Advisory Committee, Auxiliary, Foundation and community is vital to ensuring confidence in our organization.

Infection Prevention and Control Plan

The Infection Prevention and Control (IPAC) Plan is paramount in ensuring the health and safety of patients, physicians, staff, and volunteers. The IPAC Plan supports and upholds the strategic initiative to *deliver safe and effective patient care responsive to the needs of our region.* Under the direction of the Infection Control Manager, the infection control program fosters a culture of accountability, education, and continuous improvement. The plan is reviewed annually by the Infection Control Manager and IPAC Committee.

Accessibility and Health Equity Plan

The Accessibility and Health Equity Plan is a commitment to upholding the standards outlined in the province's *Accessibility of Ontarians with Disabilities Act, 2005.* The plan describes the measures taken in the past and plans for the future to identify, remove and prevent barriers for staff, patients, family members, health care practitioners, volunteers and members of the community.

The Accessibility and Health Equity Plan is reviewed and updated annually by the Health Equity Committee and provided annually to the Board of Governors.

Annual Deliverables

ACTION ITEM	WHAT	WHO	WHEN
Committees *(Patient Safety, Professional Practice/ Product Evaluation, Ethics, Occupational Health & Safety, Patient &*	• Quality Metrics • Quality Initiatives & Projects	• Committee Chair • Committee Members • VP Patient Care Services/CNO	• Monthly to quarterly or as needed

Family Advisory Committee, Health Equity, Code Team, Wellness & Mental Health)			
Departmental Goals & Quality Initiatives	• Quality Metrics	• PCMs • VP Patient Care Services/CNO • VP Operations & Finance	• Quarterly
Data Utilization	• Population, program, disease specific data	• Manager of Health Records & Privacy Officer – reports to MAC	• Quarterly or as needed
Environmental Scan & Service Delivery	• Health Equity, Mental Health & Addictions, Diversity, Ambulatory Clinics	• VP Patient Care Services/CNO • Manager of Health Records, Registration & Privacy Officer • Leadership • Board of Governors	• Quarterly/Annually or as needed
Finance & Operational Planning	• H-SAA metrics (current ratio, gross margin) • Budget variances	• VP of Finance & Operations • Leadership	• Monthly
Human Resources Plan	• Work Life Pulse Survey Results • Turnover • Absenteeism	• Manager, Human Resources	• Quarterly or as needed
Patient Satisfaction	• Satisfaction survey results • Patient Complaints	• VP of Patient Care Services/CNO	• Monthly/Quarterly
Partnerships	• Internal and external partnerships	• Leadership	• Ongoing

Appendices:

Appendix A: Quality Improvement Plan
Appendix B: Annual Strategic Initiatives
Appendix C: Quality Goals & Objectives
Appendix D: Risk Management Plan
Appendix E: Patient Safety Plan
Appendix F: Patient Quality Metrics
Appendix G: Human Resources Plan
Appendix H: Engagement & Communications Plan for Internal & External Stakeholders
Appendix I: Infection Prevention & Control Plan
Appendix J: Accessibility and Health Equity Plan

Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

April 2, 2024

HDH HANOVER & DISTRICT HOSPITAL

Ontario Health

OVERVIEW

Hanover and District Hospital (HDH) is a rural hospital that provides exceptional care in all that we do. HDH works closely with our health system partners to provide a full range of acute care services, and selected secondary care services to meet the needs of the region that we serve. The hospital's vision is to "partner for excellence in rural health care" while living our values of integrity, compassion and collaboration.

These past few years have been particularly challenging for HDH. The hospital has been under tremendous pressure in relation to the Emergency Department closures in the south Grey Bruce region. However, HDH is proud that our hospital has remained steadfast in our commitment to ensure that patients in our region have access to Emergency Department Care when they need it the most. Further, the patient experience at HDH is paramount in all that we do; as such, we are proud that our patient satisfaction scores have been reflective of the exceptional care that HDH provides.

Looking ahead, this year's quality improvement plan (QIP) seeks to 1) Enhance the overall patient experience across all departments – Especially, the Emergency Department, and 2) Optimize patient flow initiatives such as facilitating timely access to inpatient beds and ensuring our patients are prepared for their discharge home. Lastly, this year's QIP will place a special focus on Diversity, Equity, Inclusion and Anti-Racism for both of staff and patients.

ACCESS AND FLOW

At our institution, the pursuit of improved patient care is a perpetual journey. Grounded in a process-driven approach, we meticulously evaluate and refine our practices, leveraging direct feedback from patients alongside performance metrics to steer our course. This relentless commitment to refining our processes ensures that every aspect of care delivery is scrutinized and optimized to meet the evolving needs of our patients.

Our QIP serves as our guiding beacon in our relentless pursuit of enhancing the patient experience. Through a series of carefully curated initiatives, we are dedicated to ensuring that patients receive timely access to care precisely where and when they need it most. By aligning our efforts with the principles of the QIP, we are committed to streamlining processes and optimizing resources to facilitate efficient and effective care delivery. Our focus will be ensuring timely access to inpatient beds from the Emergency Department and ensuring that medication reconciliation and instructions are understood and communicated to the patients at discharge to prevent future readmission.

EQUITY AND INDIGENOUS HEALTH

At HDH, our commitment extends beyond providing exceptional healthcare to fostering a workplace and patient care culture rooted in diversity, equity, inclusion, and anti-racism. We recognize that embracing diversity enriches our organization, making us more resilient, innovative, and empathetic in our approach to 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 undertaken a significant initiative in developing a comprehensive five-year work plan to guide our efforts in promoting diversity, inclusion, equity and anti-racism. This plan serves as a roadmap, outlining key strategies and actions to address disparities and advance equitable healthcare practices within our organization. In creating 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 central to our approach. The past two years, HDH has actively engaged in Indigenous education and training, and will continue to do so this year in our quest to provide inclusive care. This year, our plan is to provide education on LGBTQ2S+ to ensure that our staff are equipped with the knowledge and skills to provide respectful and inclusive care.

HDH is steadfast in 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 HDH, we prioritize the patient experience above all else. To ensure that we continuously meet and exceed patient expectations, we employ a multifaceted approach to gather valuable feedback. Our Patient and Family Advisory Committee (PFAC) serves as a vital resource, providing insights and perspectives that help shape our practices and policies. Additionally, we regularly conduct surveys to capture feedback directly from patients and their families, allowing us to identify areas for improvement and celebrate successes. Furthermore, our commitment to excellence extends beyond the initial encounter, as we conduct follow-up phone calls to gather post discharge feedback and address any lingering concerns. By actively listening to the voices of those we serve, we can adapt and evolve to deliver the compassionate, patient-centered care that defines our commitment to excellence at HDH.

In the past year, our Patient and Family Advisors were instrumental in providing valuable information that improved the patient's experience with the following projects: parking, registration kiosks locations, creating a patient information pamphlet for HDH's flex clinic, and creating patient friendly signage. The PFAC is also actively involved with helping HDH determine strategic and QIP goals.

PROVIDER EXPERIENCE

At HDH, our strategic focus on our people and teams underscores our commitment to fostering a workplace culture that thrives on positivity and support. With a staff workplace satisfaction rate of 92%, we take great pride in the dedication and passion of our team members. Central to our efforts is our Wellness and Mental Health Committee, which spearheads initiatives aimed at nurturing a healthy and balanced work environment. Through a variety of activities and programs, we prioritize the well-being of our staff, promoting both physical and mental wellness. Additionally, we have created a Recognition Program to recognize and appreciate the exceptional care provided by our staff. We utilize various channels, including thank you notes, shout-outs, appreciative social media posts, team meetings and huddles. These gestures not only express our gratitude but also reinforce the sense of camaraderie and teamwork that defines our workplace culture. At HDH, we are committed to partnering our staff to create an environment where they feel empowered, valued, supported, and inspired to deliver exceptional care each day.

HDH places a strong emphasis on staff education and development. We recognize that providing our team members with the knowledge and tools they need is essential for delivering exceptional care to our patients. Through comprehensive training programs, workshops, and continuing education opportunities, we empower our staff to continually enhance their skills and stay abreast of the latest advancements in healthcare. By investing in staff education, we not only ensure the delivery of high-quality care but also foster a culture of continuous learning and professional growth, leaving our staff feeling valued.

SAFETY

At HDH, ensuring safety is vital to our mission of providing exceptional care. We have implemented a range of initiatives dedicated to safeguarding both our staff and patients. Our incident management system serves as a crucial tool for promptly reporting and addressing any incidents that may occur, allowing for thorough follow-up and resolution. Additionally, our Patient and Medication Safety Committee meticulously reviews all medication-related, falls, and miscellaneous incidents to identify opportunities for improvement and prevent future occurrences. We maintain robust policies for patient safety, subject to annual review to ensure they remain current and effective. HDH has an active Joint Health and Safety Committee that is focused on ensuring that the workplace is a safe environment. Regular inspections, from a safety lens, are conducted to ensure staff and patient safety.

POPULATION HEALTH APPROACH

HDH is dedicated to ensuring that patients receive high quality care close to home through strategic partnerships with a variety of organizations. One such collaboration is with Bright Shores Health System, where we've established an outpatient Rapid Access Addiction Medicine (RAAM) Clinic within our hospital premises, providing timely and specialized care for individuals facing addiction challenges. Additionally, our close partnership with the Hanover Family Health Team enables us to deliver comprehensive support to obstetrical and postpartum patients, ensuring continuity of care and optimal outcomes for mothers and newborns, as well as support to our Acute Care Unit.

Furthermore, our alliance with Home and Community Care Support Services (HCCSS) allows us to extend our reach through Flex Clinic care, delivering essential medical services to patients within our region who may face barriers to accessing traditional healthcare settings. These partnerships exemplify our commitment to innovation and community engagement, ensuring that individuals in our area have access to a broad spectrum of healthcare services tailored to their specific needs.

At HDH, our longstanding dedication to collaboration and partnership underscores our mission to provide compassionate and comprehensive care that enriches the lives of our patients and strengthens the health of our community.

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: 1) President & CEO (Administrator), 2) Chief of Staff, 3) 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.

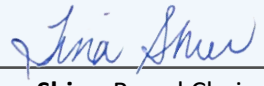
CONTACT INFORMATION/DESIGNATED LEAD

Executive Assistant to the CEO
(519) 364-2340, ext. 209

SIGN-OFF

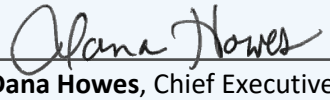
It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan on **April 1, 2024**



Tina Shier, Board Chair

Pamela Matheson, Board Quality Committee Chair



Dana Howes, Chief Executive Officer

Other leadership as appropriate

Access and Flow

Measure - Dimension: Timely

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department wait time to inpatient bed	O	Hours / ED patients	CIHI NACRS / ERNI hospitals: December 1st 2022 to November 30th 2023. Non-ERNI hospitals: April 1st 2023 to September 30th 2023 (Q1 and Q2)	6.23	6.00	To facilitate efficient patient flow management, ensuring timely access to inpatient beds for high-acuity cases and enhancing overall hospital throughput.	

Change Ideas

Change Idea #1 Review and improve current policy.

Methods	Process measures	Target for process measure	Comments
1) Educate staff on new policy and expectations for admitting patients to the Acute Care Unit from the Emergency Department, 2) Ensure that the repatriation policy is being upheld by our local hospital partners (SBGHC) to ensure that there are available Acute Care for admission.	# of patients who meet the 90th percentile for wait times (this will exclude admitted patients from SBGHC who are expected repatriate to their home hospital)	We are targeting to improve our current performance; ideally less than 6 hours	

Change Idea #2	Utilize NP to create a fast track to allow low CTAS patients to move through the department quicker allowing patients requiring admission access to MD/care quicker.		
Methods	Process measures	Target for process measure	Comments
Work with our frontline staff and NP to create a fast-track.	# of patients who accessed the fast-track during Monday to Friday (9am to 5pm)	Correlate fast track data with data from the # of patients who meet the 90th percentile for wait times.	

Equity

Measure - Dimension: Equitable

Indicator #4	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	CB	80.00	To align with provincial initiatives and empower staff to cultivate a more inclusive healthcare environment.	Rainbow Health Ontario, Consultants

Change Ideas

Change Idea #1 Provide all staff with the opportunity to complete the Rainbow Health Ontario 2SLGBTQ Foundations Course.

Methods	Process measures	Target for process measure	Comments
Health Equity Committee will consult experts at Rainbow Health to provide Foundations Course.	Completion of Foundation course with 80% of staff completing.	80% of staff will complete relevant heath equity, diversity, inclusion and anti-racism education.	

Change Idea #2 Continue to provide educational opportunities for Indigenous education via Workshops and Lunch and Learn.

Methods	Process measures	Target for process measure	Comments
Healthy Equity Committee will continue to work with South West Ontario Aboriginal Health Access Centre to provide local education.	# of Workshop or Lunch and Learns offered.	1-2 Sessions this fiscal year.	

Experience

Measure - Dimension: Patient-centred

Indicator #5	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	94.46	95.00	95-100% of respondents who responded “Yes” 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?	Hanover Family Health Team, Grey Bruce Diabetes, Home Care Community Support Services

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
Hand out prepared packages to patients on commonly admitted conditions.	1) Audit the education section of the CareNet on patient e-chart with a goal of 100% of charts, 2) Monitor the number of reorders for education packages for HDH, 3) Continue to monitor patient responses/satisfaction surveys indicating that they have received sufficient information prior to discharge	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: 433 Survey responses available are: • Yes • Somewhat • No

Change Idea #2 Clinical Brain Train Board on Lexicom and include on huddle boards.

Methods	Process measures	Target for process measure	Comments
1) Orientate nurses to Lexicom annually to continue information being provided regarding medication and medical conditions to patients, 2) Discuss patient education at rounds, 3) Continue to provide every patient, upon admission, with the Welcome Information leaflet on Acute Care.	1) Audit the education section of the CareNet on patient e-chart with a goal of 100% of charts, 2) Continue to monitor patient responses/satisfaction surveys indicating that they have received sufficient information prior to discharge	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%	

Change Idea #3 Charting that Clinical Education was given to patient.

Methods	Process measures	Target for process measure	Comments
Review documentation of education charting in CareNet system.	1) Audit the education section of the CareNet on patient e-chart with a goal of 100%, 2) Continue to monitor patient responses/satisfaction surveys indicating that they have received sufficient information prior to discharge	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%	

Safety

Measure - Dimension: Effective

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged.	O	% / Discharged patients	Local data collection / Most recent consecutive 12-month period	96.36	95.00	To promote medication and patient safety by ensuring the medication reconciliation is a standardized process for all discharged patients.	Brightshores Health System (Pharmacy Department), Community Pharmacies consulted (as needed)

Change Ideas

Change Idea #1 To continue to maintain a high medication reconciliation rate at discharge.

Methods	Process measures	Target for process measure	Comments
1) Education on importance and proper completion of medication reconciliation, 2) Education for nurses and Physicians, 3) Continue to audit charts to determine compliance	1) Education sessions to all staff, 2) Audit medication reconciliation quarterly	Maintain target of 95-100%	

Measure - Dimension: Effective

Indicator #2	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.	C	Number / Staff	Local data collection / 2024-25	16.00	16.00	Monitor and encourage reporting of the number of workplace violence incidents.	Brightshores Health System, Keystone, CMHA, Police/Hospital/Stakeholder Partnership Committee

Change Ideas

Change Idea #1 Identify causes, challenges, gaps and develop education/safety networks for staff.

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.	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.	We are targeting the tracking/collection of numbers to monitor the number of workplace violence incidents.	

Change Idea #2 Continue to build on a culture of violence awareness and responsiveness and will continue to encourage reporting of violent incidents.

Methods	Process measures	Target for process measure	Comments
1) Police-Hospital Committee meetings twice annually and as needed, 2) Provide education to staff defining the terminology with respect to violence and harassment, 3) Mandatory CPI training for all staff, 4) Staff to complete annual patient safety survey regarding violence in the workplace, 5) Wellness and Mental Health Champions available to staff as a resource and encourage reporting when applicable, 6) Overnight security in the ED hired, 7) Debriefs/reviews on all violent incidents, 8) Annual Non-Violent Crisis Intervention Training	1) Monitor the number of staff with CPI training against those who still need training, 2) Review survey results	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.	

Measure - Dimension: Effective

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Medication reconciliation upon internal transfer to Surgical Services	C	% / Other	Local data collection / 2024-25	84.00	95.00	To promote patient safety, enhance patient outcomes and satisfaction.	Brightshores Health System (Pharmacy Department), Community Pharmacies as needed

Change Ideas

Change Idea #1 To ensure that medication reconciliation is occurring at the transfer of care of surgical patients.

Methods	Process measures	Target for process measure	Comments
1) Education on importance and proper completion of medication reconciliation, 2) Education given to nurses and physicians, 3) Audit charts to ensure that medication reconciliation is happening at transfer of care to surgical services	1) Education sessions to all staff, 2) Audit medication reconciliation of all surgical patients to ensure that medication reconciliation is completed	We are targeting for 95-100%	

Partnering for Excellence in Rural Health Care
Strategic Plan Quality Goals & Objectives 2023-24

STRATEGIC DIRECTION #1 DELIVER SAFE AND EFFECTIVE PATIENT CARE RESPONSIVE TO THE NEEDS OF OUR REGION	Providing excellent care to patients is at the core of everything we do. We must stay apprised of the changing needs in our community and ensure our services are adaptable to meet patients' current and future needs. For HDH, delivering safe and effective patient care means:		
WE WILL…	**ANNUAL PRIORITIES 2023/2024**	**METRICS**	**LEADERSHIP**
1. We will deliver high quality care	• ***BIGDOT***QIP Initiative:** 90th percentile Emergency Department (ED) wait time to inpatient bed	We are targeting to improve our current performance; ideally less than 6 hours.	VP of Patient Care Services/CNE
	• ***BIGDOT***QIP Initiative:** Ensure patients receive enough information about if they were worried about their condition/treatment after leaving the hospital	95-100% of respondents who responded "Yes" 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?	VP of Patient Care Services/CNE
2. We will provide a safe physical environment for our patients and staff.	• ***SCORECARD*** Monthly Hand Hygiene Audits	95 to 100% compliance on Hand Hygiene before and after patient contact	Senior Leadership Team
	• ***SCORECARD*** **QIP Initiative:** Medication Reconciliation at discharge	100% completion of medication reconciliation upon discharge	VP of Patient Care Services/CNE
	• ***BIGDOT*** **QIP Initiative:** Medication Reconciliation completion upon internal transfer to Surgical Services	100% completion of medication reconciliation upon internal transfer to Surgical Services	VP of Patient Care Services/CNE
	• ***SCORECARD***Report/Track number of falls that occur causing significant harm.	# of falls reported causing significant harm.	VP of Patient Care Services/CNE
	• ***BIGDOT*** **QIP Initiative:** Continue to encourage reporting of workplace violence incidents	Report on the number of workplace violence incidents reported by hospital	Senior Leadership Team

Partnering for Excellence in Rural Health Care
Strategic Plan Quality Goals & Objectives 2023-24

		workers	
	• ***SCORECARD***Ensure timely follow-up, resolution and communication of incident reports (i.e. RL6s)	95% of all RL6s resolved and communicated on within thirty (30) days of submission (less needle stick/WSIB)	Senior Leadership Team
	• Continue to promote a "Just Culture of No Blame" to encourage open learning and a safe patient environment.	Increase reporting of incidents	Senior Leadership Team
	• Perform Infection Control Departmental Assessments providing education based on findings.	Complete minimum of 1 Infection Control Departmental Assessment per month	VP of Patient Care Services/CNE
	• Implement new *Never Events* reporting criteria.	Report baseline findings.	VP of Finance & Operations
3. We will use technology and updated equipment proactively.	• Continue to work with GBIN partners to enhance the electronic patient record.	Report back on specific initiatives	Senior Leadership Team
	• Utilize technology and equipment to improve processes of health care professionals.	Report back on specific initiatives	Senior Leadership Team
	• Utilize technology and equipment to improve the patient experience.	Report back on specific initiatives	Senior Leadership Team
4. We will work with others to help our patients navigate the health care system.	• Continue to participate in advancing the designated Grey-Bruce Ontario Health Team cQIP by supporting efforts as appropriate. (cQIP attached)	Report back on specific initiatives	Senior Leadership Team
	• Continue to work with community resources to help patients receive the right care in the right place.	Report back on specific initiatives	Senior Leadership Team
	• Explore/Research modalities to enhance patient communication when translation is needed.	Report back on specific initiatives	Senior Leadership Team
STRATEGIC DIRECTION #2 STRENGTHEN PARTNERSHIPS AND	For HDH to be successful, it is critical that we are open to working together and collaborating with other health care providers as well as our patients. We must work to eliminate silos, which currently exist in the Grey Bruce area and improve coordination and communication.		

HANOVER & DISTRICT HOSPITAL

Partnering for Excellence in Rural Health Care
Strategic Plan Quality Goals & Objectives 2023-24

COMMUNITY ENGAGEMENT	For HDH, strengthening partnerships and community engagement means:		
WE WILL…	**ANNUAL PRIORITIES 2023/2024**	**METRICS**	**LEADERSHIP**
1. We will treat patients as partners and involve them in hospital planning.	• ***BIGDOT*** Integrate Patient & Family Advisors into new hospital initiatives regarding hospital planning.	Report back on involvement/interaction	VP of Patient Care Services/CNE
2. We will communicate and promote the health care services available to patients and residents.	• Improve and review hospital website to include all available health care services.	Qualitative report back	President & CEO
	• Review and enhance the profile of HDH health care services within the community.	Qualitative report back	Senior Leadership Team
3. We will pursue and maintain partnerships with other health care providers to enhance patient care.	• Explore expansion of services provided to outpatients.	Qualitative report back	Senior Leadership Team
	• Explore opportunities to expand outpatient Surgical Services program	Qualitative report back	VP of Patient Care Services/CNE
	• Collaborate with the Hanover Family Health Team on training/education to improve the Medical Assistance in Dying process.	Report back on specific initiatives	VP of Patient Care Services/CNE
4. We will engage with our community to improve health outcomes, and be responsive to emerging needs.	• Utilize opportunities to create a visible HDH presence in the broader community regarding programs, services and future opportunities.	Qualitative report back	Senior Leadership Team
STRATEGIC DIRECTION #3 ENSURE THE FINANCIAL SUSTAINABILITY OF THE HOSPITAL	**HDH prides itself on our track record of solid financial status and we will work to continue this recognition moving forward.** **For HDH, ensuring the financial sustainability of the hospital means:**		
WE WILL…	**ANNUAL PRIORITIES 2023/2024**	**METRICS**	**LEADERSHIP**

HANOVER & DISTRICT HOSPITAL

Partnering for Excellence in Rural Health Care
Strategic Plan Quality Goals & Objectives 2023-24

1. We will advance our strategic priorities in a financially responsible way.	• Endeavour to align with HSAA financial indicators	Report back on progress of this initiative as completed	VP of Operations and Chief Financial Officer
	• ***BIGDOT*** Align financial performance with planned operational budget	Reported actual budget compared to planned budget.	VP of Operations and Chief Financial Officer
2. We will explore revenue opportunities, funding and operational efficiencies.	• Review purchasing to ensure full advantage of group purchasing opportunities.	Report back on progress of this initiative as completed	VP of Operations and Chief Financial Officer
3. We will invest in equipment and infrastructure.	• Apply for Exceptional Circumstance (ECP) grants through Health Infrastructure Renewal Fund (HIRF) to leverage funding for larger infrastructure projects	Report back on ECP applications, HIRF infrastructure projects, funding opportunities as they present.	VP of Operations and Chief Financial Officer
	• Apply for one time operating funding opportunities	Report back on opportunities.	VP of Operations and Chief Financial Officer
	• Optimize accessibility and storage to improve provider and patient experience.	Report back on specific initiatives	Senior Leadership Team
	• Continue to work with Ministry partners and community stakeholders for the future vision of the ED.	Report back on progress of this initiative as completed	Senior Leadership Team
4. We will pursue partnerships to make the best use of resources.	• Identify operational partnership opportunities to maximize use of limited resources.	Report back on opportunities.	Senior Leadership Team
STRATEGIC DIRECTION #4 SUPPORT OUR CURRENT AND FUTURE HEALTH CARE TEAM	**Our staff and physicians are critical to care delivery. We are committed to investing in our staff and physicians to ensure they have the required support, training and resources to deliver the best care possible.** **For HDH, supporting current and future health care teams means:**		
WE WILL…	**ANNUAL PRIORITIES 2023/2024**	**METRICS**	**LEADERSHIP**
1. We will support training and ongoing education.	• Continue utilizing a clinical education plan and monthly calendar	Report on actions quarterly.	VP of Patient Care Services/CNE

Communicate • Educate • Lead • Innovate • Advocate

	• ***BIGDOT*** **QIP Initiative:** 80-100% of full-time and part-time staff to complete relevant equity, diversity, inclusion, and antiracism education.	% Full-Time and Part-Time Staff Completion of Rainbow Health Ontario 2SLGBTQ Foundations Course	Senior Leadership Team
	• ***SCORECARD*** Monitor the number of reported phish emails by staff utilizing the report phish function	Number of reporting phish emails utilizing the report phish function	VP of Operations and Chief Financial Officer
	• Continue to identify and expand opportunities for internal trainers and shared learning opportunities with community partners.	Report back on the progress of this initiative as completed	Senior Leadership Team
	• Completion of mandatory Cybersecurity Training by all staff.	Report back on progress of this initiative as completed	VP of Operations and Chief Financial Officer
	• Develop comprehensive learning plan that prepares staff for urgent Code situations that arise.	Report back on progress of this initiative as completed	VP of Patient Care Services/CNE
2. We will recruit and retain staff, physicians and volunteers to meet the current and future needs of our patients.	• Operationalize the new succession plan previously developed.	Report back on progress of this initiative as completed	Senior Leadership Team
	• Review and Refresh Human Resources Plan to meet current needs.	Completion by second quarter, report back on progress of this initiative as completed.	Manager of Human Resources
	• ***BIGDOT*** Maintain/Improve staff and physician overall satisfaction scores on the Workforce Survey on Wellbeing, Quality and Safety (previously known as the Workplace Pulse Survey).	Achieve rating of 80% or greater for the question, “Overall how would you rate your organization as a place to work?” for “Excellent”, “Very Good” & “Good”. Maintain rating of 80% or greater for the question, “How would you rate this organization as a place to practice medicine?”	Senior Leadership Team

HANOVER & DISTRICT HOSPITAL

Partnering for Excellence in Rural Health Care
Strategic Plan Quality Goals & Objectives 2023-24

3. We will promote a positive work culture and strive for work life balance.	• Continue to support and prioritize the annual wellness and mental health plan as a tool to improve work culture.	Report back on progress of this initiative as completed	Senior Leadership Team
4. We will recognize and appreciate our staff, physicians and volunteers.	• Launch/Promote new recognition program for staff.	Complete by the end of the fourth quarter	Manager of Human Resources
	• Investigate developing volunteer recognition.	Report back on progress of this initiative as completed	Manager of Human Resources

2024/25 QUALITY GOALS & OBJECTIVES

HANOVER & DISTRICT HOSPITAL

DELIVER SAFE AND EFFECTIVE PATIENT CARE RESPONSIVE TO THE NEEDS OF OUR REGION

- Decrease 90th percentile emergency department wait time to inpatient bed ***(QIP)***
- "Did you receive enough information about what to do if you were worried about your condition/treatment after you left the hospital? to 95-100% ***(QIP)***
- 100% completion of medication reconciliation upon internal transfer to Surgical Services ***(QIP)***

STRENGTHEN PARTNERSHIPS AND COMMUNITY ENGAGEMENT

- Integrate Patient & Family Advisors into new hospital initiatives regarding hospital planning

ENSURE THE FINANCIAL SUSTAINABILITY OF THE HOSPITAL

- Align financial performance with planned operational budget

SUPPORT OUR CURRENT AND FUTURE HEALTH CARE TEAM

- 80-100% of full-time and part-time staff who have completed relevant equity, diversity, inclusion, and antiracism education. ***(QIP)***
- Maintain/improve staff and physician overall satisfaction scores on the Workforce Survey on Wellbeing, Quality and Safety
- Number of reported workplace violence incidents

SCORECARD

- 95-100% compliance on Hand Hygiene before and after patient contact.
- 100% completion of medication reconciliation upon discharge ***(QIP)***
- Resolve and communicate 95% of RL6s within 30 days of submission (less needle stick/WSIB)
- Report/Track the number of falls that occur causing significant harm
- Monitor the number of reported phish emails by staff utilizing the "report phish" function

HANOVER & DISTRICT HOSPITAL

Risk Management Plan

2023-24

Reviewed March 2024

Risk Management Plan

The purpose of the risk management plan is to protect patients, staff members and visitors from inadvertent injury. The plan is also designed to protect the organization's financial assets and intangibles, such as reputation and standing in the community.

The risk management plan is a primary tool for implementing the organization's overall risk management strategies. It is designed to provide guidance and structure for the hospital's clinical and administrative services that drive quality patient care while fostering a safe environment for staff and patients.

The focus of the risk management plan is to provide an ongoing, comprehensive, and systematic approach to reducing risk exposures. Risk management activities include identifying, investigating, analyzing, and evaluating risks, followed by selecting and implementing the most appropriate methods for correcting, reducing, managing, transferring and/or eliminating them.

Under the direction of the risk manager, the risk management program provides for collaboration among all departments, services, and patient care professionals within the hospital. Hanover and District Hospital's risk management plan provides policies, procedures and protocols to address events which may include organizational-related liability, professional liability, general liability and workers' compensation. The identification, investigation and management of accidents, injuries and other potentially compensable events are a primary responsibility under the risk management plan. This process is directed by the risk manager and others who are delegated to participate in the various components of managing adverse events occurring with patients, staff, visitors and organizational assets.

Risk management will influence, persuade and educate leaders within the following departments in order to achieve quality care in a safe environment and protect the organization's resources:

- Administration including Human Resources
- Allied Health and Adjunct Professional Services (Laboratory, Diagnostic Imaging, Infection Control, Rehab Services)
- Health Records & Data/Health Information and Privacy Management
- Maintenance
- Clinical (Surgical Services, Emergency Department, Acute Care, Obstetrics, Dialysis)
- Employee Health
- Environmental Services, Dietary, Medical Device Reprocessing
- Medical Staff

Objectives of the Risk Management Plan

The objectives of the risk management program include, but are not limited to:

- Promoting the quality of patient care, in collaboration with quality/performance improvement activities;

- Enhancing patient satisfaction;
- Minimizing the frequency and severity of adverse events;
- Supporting a culture of just-cause; non-punitive culture that promotes awareness and empowers staff to identify risk-related issues;
- Enhancing patient safety through participation in organizational safety strategies and other patient safety initiatives;
- Enhancing environmental safety for patients, visitors and staff through participation in environment of care-related activities;
- Utilizing risk management strategies to identify and minimize the frequency and severity of near misses, incidents and claims;
- Managing adverse events and injuries;
- Evaluating systems that can contribute to patient care, error or injury;
- Educating stakeholders on emerging and known risk exposures and risk reduction initiatives;
- Achieving requirements promulgated by Accreditation Canada; and
- Complying with provincial mandates, applicable laws, regulations and standards.

Specific Components

The risk management plan will include the following components:

Incident Reporting

Incident reporting is intended to provide a systematic, organization-wide program of reporting risk exposures to identify potential future liability. The risk management program includes an event reporting system that is used to identify, report, track, and trend patterns of events with the potential for causing adverse patient outcomes or other injuries to people, property or other assets of the organization. It is designed to reduce or ameliorate preventable injuries and property damage, and minimize the financial severity of claims.

The risk manager tracks and trends event data in order to report those findings to the following committees: Patient Safety and Risk Management, Professional Practice, Patient and Family Advisory Committee and, the Board of Governors quarterly.

Certain specific events (i.e. – missing narcotics) must be reported to governmental agencies through delineated methods. This is often a responsibility of the risk manager and a senior leader, and compliance within established guidelines and time frames is critical.

Reporting Risk Management Activities as Part of the Quality/Performance Improvement Process

Recognizing that the effectiveness of risk management activities is contingent upon collaboration and integration with the quality/performance improvement activities, the risk manager will work with various hospital committees such as Patient Safety and Risk Management, Professional Practice, Occupational Health and Safety, and Senior Administration.

Monthly summaries of incidents and their resolutions are circulated throughout the organization via eBlast, and posted on huddle boards. It is reported to the Board quarterly.

Educational Activities

The risk manager will provide or facilitate orientation programs for all new employees and contracted staff. Annually activities will include:

- Code review and mock code events scheduled annually;
- Ongoing Non-Violent Crisis Intervention Training;
- Annual CBRNE Training;
- Twice per year Brain Train: First Event (occupational health and safety/infection control and emergency codes) and Second (patient safety protocols and policies);
- Annual infusion device training;
- Annual certification training as needed (Advanced Cardiac Life Support, Neonatal Resuscitation, Pediatric Cardiac Life Support); and
- Timed Code-Red and Green exercise annually.

Management of Patient and Family Complaints/Grievances

The management and resolution of patient and family complaints will be managed in accordance with hospital policy. Complaints are reported to the Board three times per year.

Patient Satisfaction

The organization will measure patient satisfaction and respond to issues identified in patient satisfaction surveys. The results are reviewed quarterly and presented to Patient Safety and Risk Management, Professional Practice, Patient and Family Advisory Committee.

HIROC Risk Assessment and Claims Management

Risk Assessment (3-Year Plan)

Hanover and District Hospital collaborates with Healthcare Insurance Reciprocal of Canada (HIROC) to assist the hospital with ongoing risk assessment via checklists. The hospital engages in 3-year long risk assessment and improvement cycles. Risk Assessment Checklists, also referred to as RAC, is a tool that enables the hospital to systematically self-assess compliance with evidence-based mitigation strategies for HIROC's top risks. The top risks are ranked by those which lead to significant medical malpractice claims. The following areas completed a RAC assessment:

- Failure to Communicate/Respond to Critical Test Results;
- Failure to Pay Benefits/Overtime;
- Patient Falls;
- Employee Fraud;
- Healthcare Acquired Infections;
- Health Care Acquired Pressure Injuries;
- Inadequate Triage Assessment;
- Failure to Identify/Manage Neonatal Hyperbilirubinemia and Hypoglycemia;
- Abuse of Patients;
- Fire Losses;
- Failure to Interpret/Respond to Fetal Health Surveillance Patterns
- Mismanagement of IV Oxytocin
- Failure to Appreciate Status Changes/Deteriorating Patients

- In-Care Suicide/Suicide Attempts
- Medication Adverse Events
- Failure to Identify/Manage Postpartum Hemorrhages and Hemorrhagic Shock
- Therapeutic Drug Monitoring
- Cyber Loss
- Diagnostic Errors
- Privacy Breach
- Mismanagement of Neonatal Resuscitation
- Inappropriate Credentialing, Re-appointment and Performance Management
- Shoulder Dystocia
- Vaginal Birth After Prior C-Section
- Retained Foreign Items
- Assisted Vaginal Deliveries
- Windstorms
- Water and Sewage Losses
- Failure to Communicate Fetal Health Status
- Delayed Decision to Delivery Time for Caesarean Sections

Claims Management:

- Reporting potentially compensable events, unexpected outcomes or patient complaints to the involved department manager, the insurance carrier as appropriate and the organization's risk manager;
- Performing initial and ongoing investigation and interviews;
- Documenting activities and correspondence related to the investigation of the event;
- Protecting and preserving the patient health information record and/or other documents and evidence for potential future litigation;
- Organizing, managing and maintaining claim files;
- Limiting access to claim files to only authorized individuals under direct supervision of the risk manager;
- Coordinating activities with the defense team and providing input into the strategy for each claim;
- Reporting claim management activity to quality/performance improvement and appropriate organizational leaders;
- Participating in establishing defense/settlement posture;
- Resolving claims within established limits of authority;
- Maintaining confidentiality of protected documents;
- Reviewing, vetting and accepting legal service as appropriate; and
- Timely forwarding subpoenas, summons and complaints to legal counsel.

Legal

HDH retains Miller Thomson Advocates as the legal counsel.

Reports to the Governing Body via Quality Governance and Risk Management Committee

The risk manager will provide the following reports quarterly to the Quality Governance and Risk Management Committee:

- Patient Safety/Risk Management Report
- Staff Safety Report
- Hospital Acquired Infections
- Hand Hygiene
- Surgical Safety Checklists

Adverse advents or any other risk related item that affects the hospital will be brought to the Board's attention promptly. The Board Chair will determine if a special meeting of the Board needs to be called.

The annual HIROC Risk Management report will also be shared with the Board.

Review of the Risk Management Plan

The risk management plan will be reviewed, updated, and approved annually, or as needed. Dated signatures and titles from appropriate parties should be obtained at the time of the approval.

Annual Evaluation of the Risk Management Program

The risk management program will be evaluated by the governing body annually.

Tina Shier, Board Chair — March 26, 2024 — Date

Dana Howes, President & CEO — March 26, 2024 — Date

Megan Soers, Risk Manager — March 26, 2024 — Date

HANOVER & DISTRICT HOSPITAL

Patient Safety Plan

2024-25

Introduction

Hanover and District Hospital (HDH) is strongly committed to ensuring that patient safety is the underpinning of all of our programs and services in our goal to deliver exceptional patient care. Patient safety is paramount, and HDH promotes a culture of patient safety.

The notion of ensuring patient safety begins with HDH's Strategic Plan. The strategic direction to *Deliver Safe and Effective Patient Care Responsive to the Needs of our Region* is at the forefront of operations and initiatives. For HDH, delivering safe and effective patient care responsive to the needs of our region means:

- We will deliver high-quality care;
- We will provide a safe physical environment for our patients and staff;
- We will use technology and update equipment proactively; and
- We will work with others to help our patients navigate the health care system.

Through this strategic direction, as well as the development of the Quality Improvement Plan and Risk Management Plan, annual safety goals are identified in collaboration with our staff, physicians, and patient advisors and through analysis of data. Each year, HDH strives to make continuous and sustainable safety and quality improvements.

Guiding Principles for Patient Safety at HDH

- We believe that patient safety is everyone's responsibility – Staff, Physicians, Board of Governors, Volunteers and Patient Advisors;
- We will work in collaboration with our Staff, Physicians, Volunteers, Board of Governors and Patient Advisors to promote a culture of patient safety;
- We believe that robust patient safety initiatives and practices are essential in providing quality care and must be a part of all patient interactions;
- We approach patient safety as a continuous pursuit; it is embedded in all the work that we do throughout HDH with our patients;
- HDH will engage in continuous improvement initiatives to ensure that best practices for safety are always in place; and
- We promote patient safety from a learning lens where staff feel safe and supported to report errors, adverse events and good catches and view them as an opportunity to improve processes.

HDH's Commitment to Patient Safety

1. **<u>Structures that Support Patient Safety at HDH</u>**

    a. ***Board of Governors and the Quality Governance & Risk Management Committee of the Board***
    In accordance with the *Excellent Care for All Act (ECFAA)* the Board of Governors is legislated to be responsible for patient safety and protections, and quality care. The Quality Governance & Risk Management Committee of the Board reviews patient safety metrics, safety initiatives, and safety related incidents and provides oversight of the annual strategic plan initiatives and the Quality Improvement Plan.

b. Senior Leadership, Risk Manager and the Achieving Excellence Leadership Group

Senior Leadership, Risk Manager and the Achieving Excellence Leadership Group are stewards of patient safety and quality across the organization; they are responsible for promoting a culture of safety and a no blame approach. The CEO is responsible to the Board for ensuring that patient safety measures and quality are upheld.

c. Committees at HDH:

The following Committees at HDH support patient safety;

- Patient Safety and Risk Management Committee;
- Infection Prevention and Control;
- Professional Practice Committee;
- Ethics;
- Patient and Family Advisory;
- Occupational Health and Safety; and
- Medical Devices Reprocessing Committee.

d. Risk Management Plan and HIROC Risk Management Assessment Plan

HDH's Risk Management Plan promotes continuous, proactive and systematic processes to understand, manage and communicate risk from an organization-wide perspective in a cohesive and consistent manner.

HIROC's Risk Management Assessment Plan tracks and monitors associated risks in HDH's operations by determining the probability of a risk occurring multiplied by the impact should that risk occur. The resulting risk scores inform priorities for action to mitigate risk.

e. RL6 Patient Safety Incident System Incident

Incident reporting and management is integral to HDH's approach to patient safety. It is the responsibility of all staff, physicians, and volunteers, who observe, are involved in, or are made aware of an adverse event or near miss to ensure the incident is reported. Our RL6 system supports the documentation and tracking of patient safety incidents, findings, recommendations and actions/improvements. The RL6 system also allows for reporting of and follow through on feedback from staff, patients and caregivers.

All incidents and good catches are discussed/analyzed monthly at the Patient Safety and Risk Management Meeting. Quality Improvement projects are then developed to address patient safety issues and reduce the incidence of further occurrence. An incident report is then disseminated widely across the organization for all staff, physicians and volunteers for review. The Board receives quarterly reports on patient safety metrics via various reports.

f. Violence Reporting Hotline

Recognizing that it is important to report all incidents that breech patient safety in a timely manner, HDH has created a Violence Reporting Hotline so that staff can report incidents in a timely fashion. The incidents will then be entered into the RL6 system.

g. Scope of Internal Safety Initiatives – Ongoing Patient Safety Programs and Initiatives

HDH Patient Safety Programs:

- Huddles
- Daily Discharge Rounds
- Quality Safety Metrics
- Choosing Wisely
- Hand Hygiene Audits
- Patient and Family Advisory Committee
- Vanessa's Law
- Falls Prevention Program
- Audits: Documentation, Arm banding, PPE Donning & Doffing, Falls, Bedside Whiteboards
- Newborn Wellness Check-ups
- Pharmacy Medication Reviews
- Rounding – staff and patients
- Leadership Patient Rounding
- Bedside Transfer of Accountability (TOA)
- Corporate and Unit Based Orientation
- Clinical Education Calendars
- Arm banding in ER
- Senior Friendly Framework
- Pressure Ulcer Prevention
- Enhanced Observation Policy
- Discharge Planning – Family conferences
- Violence Reporting Hotline
- Patient Alerts – Cerner
- Medication Reconciliation

Patient Quality Metrics:

- RL6 Incident Reporting (Med Errors, Falls, Good Catches, Hospital Acquired Pressure Ulcers)
- Medication Reconciliation at Admission & Discharge
- Medication Reconciliation – transfer to surgical services
- Hospital Acquired Infections (MRSA, C-Diff)
- Surgical Site Infections
- Surgical Safety Checklist
- Hand Hygiene Compliance
- Patient Safety Culture Survey
- Hospital Acquired Pressure Ulcers
- Blood Bank – Routine Transfusions
- Blood Bank – Urgent Transfusions
- Laboratory Turn Around Time
- Patient Infection Rates (MRSA & C-Diff)
- Venous Thromboembolic Prophylaxis (VTE)- Admission
- Laboratory Turn Around Time – ER
- Decision to Admit Time

Safety Program:

- Immunization Programs
- Emergency Preparedness Plan
- Infection Prevention and Control Program
- Preventative Maintenance Program
- Antimicrobial Stewardship
- Accreditation Canada
- Employee Safety/EFAP

Environmental Safety Issues:

• Product Recalls • Drug Recalls • Product/equipment malfunction	• Air Quality Reports • Infection Control Audits (ATP testing) • Workplace Violence (RL6) • Security Incidents (RL6)

h. **External – Accreditation Canada Required Organization Practices (ROPs)**
Examples of HDH's Performance Related to 6 Patient Areas of ROPs include:

Safety Culture	• Measurement of Quality Indicators • Program Councils focus on quality of care and patient safety • RL6 Incident Reporting System • Integrated Risk Management Program and risk assessment • Surgical Safety Checklist before and after procedures • Patient Safety Culture Survey
Communications	• Medication Reconciliation on Admission • Transfer of Accountability and Standardized Shift report • Staff and Patient Rounding • Patient Quality Metrics • "Connect MyHealth": process allowing patients to access their medical record • Discharge Summaries – sent to Primary Care Provider
Medication Use	• 90 Day medication reviews on long stay patients • Audits of VTE (Venous Thromboembolism Prophylaxis) • Antibiotics prophylaxis in surgery • Audits of safety reports for medications and Do Not Use abbreviations • Infusion Pump Training
Infection Control	• Monthly Hand Hygiene audits • Orientation and Staff/Volunteer education • PPE Audits • ATP Audits
Risk Assessment	• Falls and Medication error reporting (RL6) • Quality Reviews and Quality of Care reviews (under Quality of Care Information Protection Act [QCIPA] for high risk and critical incidents • Risk Management Program • Risk assessments for falls, pressure ulcers, and medication reconciliation
Worklife/Workforce	• Workplace Violence Program • Workplace Violence During Care Transitions Policy • Grey-Bruce Police-Hospital Protocol • Non-Violent Crisis Intervention Program and training

	• Responsive Behaviour education (Gentle Persuasive Approach, Delirium, Dementia)

i. Additional Accreditation Bodies

The HDH Laboratory is regularly assessed and accredited by the Institute for Quality Management in Hospitals (IQMH). Their mission is to elevate the integrity of the medical diagnostic testing system by providing rigorous, objective, third-party evaluation according to international standards.

In Diagnostic Imaging, the Mammography Accreditation program is reviewed and accredited by the Canadian Association of Radiologists. The following areas are assessed: personnel requirements, quality control, equipment specifications and breast image quality.

The Ontario College of Pharmacists has an accrediting arm that is tasked with ensuring the HDH pharmacy meets the requirements as outlined in the Drug and Pharmacies Regulation Act (O.Reg.264/16).

j. External Partnerships

HDH is committed to addressing Patient Safety at the system level, including working with our regional healthcare partners to develop a comprehensive Ontario Health Team that is capable of addressing patient safety and improving the quality of care.

HDH works closely with police services throughout the Grey-Bruce region. Most recently working together to create the Grey-Bruce Police-Hospital Protocol. This protocol ensures that patients are transitioned utilizing patient-centered approach that promotes safety from one provider group to another.

HDH has contracted an outside security firm to provide on-site security services in our Emergency Department on both a regularly schedule shift and as needed on a call-in basis. Security is often brought in to ensure the safety of patients experiencing a mental health crisis.

Infection Control consultant services is a partnership that was pursued to ensure patient safety. Dr. Michael Gardam provides infection control consultative support on an as needed basis.

HANOVER & DISTRICT HOSPITAL

PATIENT QUALITY METRICS

PATIENT SAFETY

Indicator	Reported Frequency	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	YTD 2023/24	Benchmark Value	Benchmark Source	2022/23
Date		Apr '23 June '23	July '23 Sept '23	Oct '23 Dec '23	Jan '24 Mar '24				
Types of medication errors: Omission	Q								
Wrong Patient									
Wrong Medication									
Wrong Route									
Wrong Time									
Wrong Dose									
Miscellaneous									
Total									
Medication Good Catches									
Medication Reconciliation (Admission)	Q								
Medication Reconciliation (Discharge)	Q								
Medication Reconciliation (Internal transfer to Surgical Services)	Q								
Laboratory									
Laboratory Turn Around Time – ER Patient (CBC, INR, BUN, Troponin 1)	Q							IHLP	
Blood Bank - Routine Transfusion	Q							IHLP	
Blood Bank - Urgent Transfusion	Q							IHLP	
Patient Falls	Q								
Patient Falls Causing Significant Harm	Q							Internal	
Patient Fall Good Catches	Q								
Patient Infection Rates (per 1000 patient days) MRSA C-Diff	Q							Safer Healthcare Now (SHCN)	
Surgical Safety Checklist (Ministry)	Q								
VTE screening in admission	Q								
Pressure Wound • Hospital Acquired • HR Coded	Q								
Hand Hygiene Compliance (Acute) • Before Pt./Environ Contact • After Pt./Environ Contact	Q								
Hand Hygiene Compliance (ER) • Before Pt/Environ Contact • After Pt/Environ Contact	Q								
Overall Hand Hygiene Compliance • Before Pt/Environ Contact • After Pt/Environ Contact	Q							QIP	
Patient Safety Culture Survey	Q2 yrs							Accreditation Canada	

HANOVER & DISTRICT HOSPITAL

Human Resource Plan
2021-2023

Introduction

HDH's Human Resources Service Mission is singularly focused on attracting, hiring, and retaining a vibrant, inclusive workforce who possess a spirited capacity of compassion, for continuous improvement and for contributing to the development of a strong collaborative culture in order to consistently meet and exceed the evolving needs and performance objectives of the hospital.

We are aware of the Health Human Resourcing challenges that are facing all Canadian providers of health care. The competition for Registered Nurses, Lab Technicians, and other roles is becoming fiercer. HDH needs to be competitive and chosen to be the employer of choice. Therefore, we must remind the people we wish to attract and/or retain of the very real opportunity that a career with HDH presents for making a difference in the lives of others.

The Human Resource Plan guides the development and helps with the availability of that workforce. This will ensure that we maintain our ability to deliver high quality services to Hanover and surrounding communities. Today's workers place a higher value on balancing their home and work lives; where employees seek meaningful and rewarding work.

The focus in this Human Resource Plan is put on the following areas:

1) Recruitment;
2) Creating a diverse and inclusive workplace;
3) Enhance employee engagement and wellness

Strategic Goals vs. Human Resource Goals

The Human Resources Plan is based on the organization's strategic goals and objectives.

These are:

1) Deliver safe and effective patient care responsive to the needs of our region
2) Strengthen partnerships and community engagement
3) Ensure the financial sustainability of the hospital
4) Support our current and future health care team

These strategic goals will be supported by the Human Resource goals and objectives presented and analyzed in the Human Resource Plan.

Values

HDH provides patient care and client services based on the following values:

- Integrity – to make decisions in a manner that is consistent, professional fair and balanced;
- Compassion – sympathetic consciousness of others' distress together with a desire to alleviate it;
- Collaboration – to enhance efficiency and credibility of our clients and staff;

To complement these core values expressed in the Strategic Plan, it is important to identify corporate human resource values that will guide our decision making and actions, as well as the way we interact with one another and with those we seek to serve. These values are:

- Respect: We value a workplace culture where people respect one another in their interactions with co-workers and clients.

- Integrity: We value a workplace culture where personal and professional integrity cause us to behave in an ethical and balanced way.
- Diversity: We value a workplace where diversity, in all its forms, is encouraged and recognized for its contribution to a more creative, rewarding, and productive workplace.
- Accountability: We value a workplace where accountability for our actions, our interactions, the objective and wise use of resources, and responsibilities for our successes and failures is reflected in how we conduct ourselves.

Human Resource Goals, Objectives and Strategies

This Human Resource Plan has five goals which we will work on to achieve in a two year period, between 2021and 2023.

Goal 1: **All performance reviews for full time and part time employees will be completed by the end of the year.**

Objectives:

- **Fairness:** HDH wants to ensure that decision making process associated with its human capital is aligned with related policies, and is entirely objective and consistent.
- **Providing exceptional care**: HDH aims at having the right employees with the right skills in the right place at the right time, and at ensuring the consistent application of human resource policies and practices throughout HDH.

Strategies:

- **Service excellence**: We must ensure that the health care service we provide the community, and the way we deliver the service, is continually monitored for its value. The following initiatives are reviewed and updated: *Performance management* (employees need to know how their efforts affect the business goals of HDH. Performance management will continue to highlight the relationship between individual performance, rewards and recognition, and HDH's objectives.

Goal 2: **Overall how you would you rate your organization as a place to work?" Achieve rating of 85-90% for "excellent", "very good", and "good".**

Objectives:

- **Committed employees**: HDH wants to ensure that recruitment and orientation programs support the hiring of all employees who are personally committed to providing a high-quality of care.
- **Welcoming culture**: HDH will provide equitable and easy access to employment opportunities, and will foster a culture where new workers are welcomed, and oriented to achieve their career goals in health care.
- **Career advancement**: HDH wants to raise awareness about the many challenging and rewarding opportunities available within the hospital.

Strategies:

- **Retention Strategies**: Once selected for employment at HDH, new workers must be welcomed and encouraged to stay. HDH can deliver the services expected by our patients only by attracting and retaining employees who are truly committed to exceptional care. The following will be enhanced and/or implemented: *Orientation; Employee recognition programs* (Having made a commitment to,

and having been selected for, a career with HDH, it is important that employees are informally and formally recognized for their contributions and achievements); *Ongoing communications initiatives; Employees' satisfaction survey; (*To provide employees an effective way to provide feedback and stay informed.)

- **Enhance wellness programs***:* HDH aims at promoting well-being of its employees through development of new and implementation of current wellness programs that assist in the well-being of employees both on and off the job.

Goal 3: **Recruit and retain a diverse workforce that meets the needs of the organization.**

Objectives:

- **Increase the percentage of active open positions filled within the targeted deadline**: The objective is to fill positions in a timely fashion, ensuring key positions are filled.
- **To maximize hiring effectiveness and reduce cost-to-hire:** The objective is to ensure there are no delays, keeping candidates engaged and ultimately reduce the cost in hiring, by hiring star employees.

Strategies:

- **Recruitment:** HDH must develop outreach initiatives that will help us look for potential candidates. It is no longer enough to expect potential employees to come looking for us; we must develop outreach initiatives that will help us look for them. Strategies to address these essential needs include the following: *Ongoing job postings; Word of mouth strategies; Referral programs; Cooperation with Universities and Colleges.*

Goal 4: **To enhance the volunteer program.**

Objectives:

- **Improving HDH's volunteer program**: The objective is to create a diverse program that welcomes all individuals from our community who wish to give their time to make HDH a better hospital.

Strategies:

- **Partnering with local high schools and youth groups**: HDH will partner with local high schools to create a program which will allow students to complete their volunteer hours while learning about the different opportunities within the hospital.
- **Improve Orientation and Support**: HDH will improve the volunteer orientation program, creating both in person and virtual options. Review technological options for scheduling.

Goal 5: **To support a DEI (Diversity, Equality & Inclusion) culture.**

Objectives:

- **Adopting a broad DEI culture**: HDH aims at creating programs which recognize all aspects of diversity among its workers, and communities the hospital serves.

Strategies:

- **DEI partnerships**: These will include building more proactive relationships with HDH clients, key community-based groups, and professional associations to promote a diverse and inclusive workplace.
- **Diversity education**: Education will be provided to its employees on a number of different topics to provide a wide value of diversity. Diversity will be a theme in future orientation and on-going training.

- **Health Equity Committee**: The Health Equity Committee will create a culture, working in partnership both internally and externally, to make recommendations and initiate strategies to remove barriers of accessing healthcare to enhance the patient and workplace experience.

HDH strives to be a workplace that is reflective of the growing diversity within our community and to create a more respectful and inclusive workplace. HDH will be an organization where valuing diversity is a positive choice, not an obligation.

Action Plan

The following plan begins the process of identifying measures of success against which HDH will assess the company's progress. This latter task will also be a key part of the development and implementation of the strategies described within this plan. Some of these strategies will evolve as the plan itself is implemented and tested over the next two years.

HDH will need to regularly assess the company's progress towards achieving objectives identified in this Human Resource Plan. The development of these measures of success and indicators will be an evolving and continuous process throughout the life of this plan.

Goal # 1	Critical Actions to Take	Person Responsible	Next two years target (2021 and 2023)	Outcomes	Measurements/ Indicators
All performance reviews due within the calendar year for full time and part time employees will be completed by the end of the year.	*Performance evaluations*	Human Resources Manager Operational Managers	Annual and probationary performance appraisal process in place and working; disciplinary process (when necessary) implemented	100% of new full time and part time workers evaluated in the probationary performance appraisal process. 100% of full time and part time workers undergoing the bi-annual performance appraisal process 80% of staff highly satisfied with performance evaluation process	Number and percentage of performance evaluations completed each year (includes bi-annual performance appraisal process as well as the probation performance appraisal process)

Goal #2	Critical Actions to Take/ Strategies	Person Responsible	Next two years target / Objective	Outcomes/ Results	Measurements
Overall how you would you rate your organization as a place to work?" Achieve rating of 85-90% for "excellent", "very good", and "good".	*Orientation* *Talent Management Process* *Exit Interview Enhancements* *Retention Strategies* *Enhanced Learning and Development Strategy – Reviewing both Clinical and Non Clinical roles*	Human Resources Manager	*Develop Talent Management Process* *Enhance Orientation programs*: 1) corporate 2) department; *Create a Recognition Program (staff to staff, public to staff and management to staff)* Ongoing provision of learning opportunities – *Create Individual Development Plans* Ongoing communication initiatives leading to fair treatment of workers based on dignity, respect, open communication and loyalty *Improve Exit Interview process and reporting* *Enhance Employee Wellness Program*	100% of new workers undergoing the corporate orientation after being hired 80% of workers satisfied with the orientation program Overall, 40% of workers recognized by the management annually 12 workers recognized and rewarded in the program "Employee of the Month" annually Newsletters/Eblasts sent monthly No complaints on lack of clear patterns of communication and lack of support by the management 85-90% positive responses related to working at HDH on survey	Work-Life Pulse survey Level of employee engagement (measured by a number of responses for all, sent by HDH, surveys, questionnaires, etc.) Number of HDH workers recognized by the management for their contributions and achievements Reviewed and strengthen communication mechanisms The management's commitment to staff well-being, health and safety

Goal #3	Critical Actions to Take/ Strategies	Person Responsible	Next two years target / Objective	Outcomes/ Results	Measurements
Recruit and retain a diverse workforce that meets the needs of the organization	*Recruitment of staff and Credentialed Staff* *Employee Value Proposition (EVP)*	Human Resources Manager Management team	Ongoing posting of job openings on the organizational website, and on the job-search portals. Becoming a recruiter on LinkedIn *Create a Referral Program* Ongoing cooperation with universities and colleges to attract more new graduates than in the previous years	Equitable and accessible employment opportunities (objective assessment of the fit between the skills and qualifications of the prospective worker and the needs of HDH)	Number of workers hired each year Number of referrals Number of jobs posted Percentage of new graduates hired (out of all new workers) Number of job application received every year

Goal # 4	Critical Actions to Take/ Strategies	Person Responsible	Next two years target / Objective	Outcomes/ Results	Measurements
Improve the volunteer program	*Engage with high schools and youth groups to create a more inclusive and learning opportunity.*	Human Resources Manager Volunteer Auxiliary	Build partnerships with local schools and youth groups. Embrace technology to streamline scheduling.	A more robust volunteer program which is diverse and engages with different age demographics	A program that includes students and youth from the community.

Goal # 5	Critical Actions to Take/ Strategies	Person Responsible	Next two years target / Objective	Outcomes/ Results	Measurements
To support a diverse workforce	*Diversity partnerships and education*	Heath Equity Committee Human Resources Manager	All policies and procedures reflecting cultural diversity Ongoing cooperation with key community-based groups, and professional associations as stakeholders to promote a diverse and inclusive workplaces – CCDI Rainbow Ontario Ongoing increase of workers' awareness and value of diversity and knowledge of diversity influencing patient care	Educational sessions on impact of diversity on communication between patients and health care providers Creating Sacred Room Land Acknowledgement No complaints by workers and patients on discrimination based on the prohibited grounds No complaints on violation of the Employment Standards Act and the Human Rights Code by HDH	Work-Life Pulse Survey Number of new stakeholders promoting diversity Number of educational initiatives promoting diversity

Conclusion

For this plan to succeed it needs the support of all the staff and the commitment of senior management, this is a shared commitment to the overall achievement of the plan and essential to organizational success.

Engagement & Communications Plan for Internal and External Stakeholders

2024/25

About Hanover & District Hospital

Hanover and District Hospital (HDH) was originally established in 1923 and a new acute care hospital was built in 1973. A state-of-the-art facility with a 24-hour Emergency Department, the hospital operates as a 28-bed acute care organization with services and programs that include day surgery, two operating suites, obstetrics unit, multi-purpose intensive care, palliative care services, rehabilitation services, dialysis unit, specialist clinics, laboratory and diagnostic imaging.

HDH's vision is to partner for excellence in rural health care. Our vision depicts our commitment to partnering with other health service providers in the Grey Bruce area and beyond to ensure that patients receive the care they need and deserve.

Executive Summary

Hanover and District Hospital's Engagement and Communication Plan is intended to guide the organization in communicating with its patients, people, community and partners. The Plan has been created to ensure that stakeholders in the catchment area of HDH are informed of appropriate activities and actions of the Hospital. The purpose, audience, message, and relations with the media and key stakeholders in the community remain vital.

Communication is the process of transmitting ideas and information. For HDH this means conveying the information of our organization, the programs and services, the issues faced as an organization, and the accomplishments, to the Board Governors, Auxiliary, Foundation, Staff, Physicians and community.

Stakeholders

Any person that is affected by healthcare is considered a stakeholder. The stakeholders for communication and/or engagement are:

External Stakeholders

- Patients and Families
- Donors
- Health Service Providers
- Health Care Community Partners
- General Public
- Media
- Government (political leaders, mayors, town councilors)
- Ministry of Health (MOH)
- Ontario Health West (OHW)

Internal Stakeholders

- HDH Staff
- HDH Physicians
- HDH Auxiliary/Clinical Volunteers
- HDH Board of Governors
- HDH Foundation
- HDH Patient & Family Advisors

The President & CEO and Public Relations Committee will work with the Board Chair to communicate effectively. It is the goal of this plan to create a process of communication to ensure the success of HDH by engaging internal and external stakeholders in the process. Providing ongoing messaging through a variety of mediums develops trust and understanding with stakeholders. The communication plan can help raise awareness of the hospital's needs and challenges and also champion successes.

Planning Communication

The Public Relations Committee will be instrumental in raising awareness about the news and initiatives of HDH and the long-term benefits for our catchment area.

With each communication the following questions will need to be answered:

1. Why is this important to communicate? (**What's the purpose?)**
2. With whom do we want to communicate? **(Who are the stakeholders?)**
3. What do we want to communicate? **(What's the message?)**
4. How do we want to communicate it and through which medium? **(What communication tools are to be used?)**
5. What is the timeline of communications/presentations? **(Define when and who plans, prepares and presents)**
6. What needs to be developed? **(Develop material, ads, news articles etc.)**

The answers to these questions will establish the **action plan** to communicate successfully with the intended audience. This action plan will focus the messaging making it possible to target the stakeholders accurately, providing structure to define who HDH needs to reach and the medium. This process will make communication more efficient, effective and long lasting. More importantly, flexibility is key in planning and being prepared to adapt messaging to ensure success.

Communication Tools

When the target audience is identified strategies can be defined as to which communication tool would be used to achieve maximum outreach and efficient information sharing. HDH is committed to provide accessible communication for our patients and visitors. Persons with disabilities will be given an opportunity equal to that given to others and will be considered when planning communication.

HDH uses several methods to communicate including:

- Patient Interactions (Staff and patient contact)
- Word of Mouth
- Website – www.hdhospital.ca
- Social Media (Facebook https://www.facebook.com/HDHospital/, Twitter @HDHospital, Instagram, Linked In & YouTube)
- Advertising (Media Releases, News Stories, Other Publications)
- Community Engagements/Events
- Internal communications, including weekly e-blasts, staff forums and HDH Documents

Corporate Publications

Annual Report

Following the Annual General Meeting, the Hospital's annual report is released electronically on the website and social media.

Patient Information Guide

The Patient Information Guide is published annually at no cost to HDH as sponsors advertise in the publication. Hard copies are available in print for pick-up in high traffic locations (front lobbies & elevator), and electronically on the hospital's website.

Program/Service Brochures and Posters

These are developed as needed by program leaders and the Executive Assistant to the CEO using HDH's Graphic Standards. Templates are designed for patient information and presentation materials.

Media Relations

HDH recognizes that timely and accurate media attention can support recruitment and retention, employee and community engagement, reward and recognition, and fundraising and funding. Every effort is made to communicate with media in a proactive rather than a reactive manner via designated spokespersons. The hospital also provides press releases to the media when the need arises.

Digital Media

Corporate Website

The website is maintained by the Executive Assistant to the CEO and HR Administrative Assistant. The site will continue to evolve with new and improved content needed.

HDH Documents (Shared Drive) & Board Portal

The HDH Documents folder on the shared drive is used as a file storage and sharing system for memos, reports, hospital committee information etc. Memos and other items are regularly communicated via the "HDH E-blast". A portal for the Board of Governors is located on the hospital website. It houses policies, by-laws, agendas and other committee information.

Social Media

Guided by a Social Media Policy and Social Media Annual Plan, the Executive Assistant to the CEO creates and maintains social media presence on Facebook, Twitter, Instagram, LinkedIn and You Tube. Pages are regularly updated with timely content and photographs related to hospital activities, services, disruptions and wellness content.

Objectives

The Public Relations Committee is responsible for developing and implementing a communications action plan which includes strategies for communication throughout the year to HDH's stakeholders. The Public Relations Committee's goal is ***to promote clear messaging and communication throughout the Hanover and District Hospital organization and to internal and external stakeholders***

The objectives of the Public Relations Committee are;

1. To develop processes for communication via the HDH Communications: Action Plan (Appendix A), which will be updated annually by the committee;
2. To develop clear and consistent messaging and branding;
3. To improve the sharing of information between healthcare agencies/organizations;
4. To improve awareness of the role and successes of HDH as a leader in acute care; and

5. To improve information about services and resources.

The Hospital Brand

The Hospital is constantly growing and evolving. Communicating with a unified appearance for all formats will help our patients, staff, physicians and community better understand who we are, the services we offer and the values we share. (Refer to the Graphics Standards Manual) The *Accessibility for All Ontarians with Disabilities Act, 2005* and the HDH Accessibility Plan will be referenced when making communication decisions around branding.

Evaluation

For *internal* audiences, feedback to leaders, questions in forums and meetings, attendance at meetings and special events help provide an indication of the effectiveness and receptiveness of corporate messaging.

Measure of *external* communication, effectiveness can be gauged by media coverage (positive, negative, neutral), participation in Hospital events, letters to the editor, survey responses, social media followers, complaints related to communications, website traffic, donation influence and volunteer recruitment.

Related Policies

1. Board Policy # 301 – Board Linkage with Community
2. Board Policy # 302 – Board Linkage with Other Organizations
3. Board Policy # 503 – Communication and Supports to the Board
4. Board Policy # 504 – Development of Collaborative Partnerships
5. Administrative Policy # ADM 1-60 – Media Release
6. Administrative Policy # ADM 1-105 – Social Media

Appendix

Appendix A – HDH Communications: Action Plan

HDH Communications: Action Plan 2024/25				
	Description	**Frequency**	**Format/Channel**	**Audience**
1	**Website Updates (Content & News)**	Ongoing, as needed	• Blue Lemon Media Web Portal	All External & Internal Stakeholders
2	**Social Media**	Weekly	• Facebook • X (Formerly Twitter) • Instagram • LinkedIn • YouTube	All External & Internal Stakeholders
3	**Earned Media**	Monthly	• Local Radio and News Stations • The Post	All External & Internal Stakeholders
4	**Community Engagement/Events**	Two per year	• Virtual Platforms • In person	External Stakeholders
5	**Patient Information Guide**	Reviewed once/year	• Willow Publishing – no cost to HDH with advertising sponsors	Patients & Families
6	**Annual Report**	Annually	• Digital publication	All External & Internal Stakeholders
7	**EBlast**	Weekly	• Email newsletter	HDH Staff & HDH Physicians
8	**CEO/Staff Forums**	Monthly	• Virtual Forum • Email Distribution of Recording	HDH Staff & HDH Physicians
9	**HDH Documents**	Ongoing, as needed	• Shared Drive	HDH Staff & HDH Physicians
10	**Review Communication Plan & Graphic Standards Manual**	Annually	• Document	Internal Stakeholders

HANOVER & DISTRICT HOSPITAL

Infection Prevention & Control Plan 2024-25

Reviewed February 2024

Introduction

An effective infection control plan is paramount in ensuring the health and safety of patients, physicians, staff, and volunteers at Hanover & District Hospital (HDH). In a busy and fast-paced environment, the risk of hospital-acquired infections (HAIs) poses a constant challenge. The introduction of a comprehensive infection control plan is instrumental in mitigating these risks and maintaining a standard of care that prioritizes patient safety.

The infection control plan serves as a proactive and systematic approach to identify, prevent, and control the spread of infections within the hospital setting. By integrating evidence-based practices, guidelines, and protocols, the infection control plan aims to create a robust framework that aligns with the Provincial Infectious Diseases Advisory Committee on Infection Prevention and Control (PIDAC-IPC) standards, and other accredited Infection Prevention and Control (IPAC) guidelines. The plan is a dynamic strategy that is responsive to emerging infectious threats, technological advances, and healthcare trends.

Under the direction of the Infection Control Manager, the infection control program fosters a culture of accountability, education, and continuous improvement. It recognizes the collaborative effort required across all disciplines and departments to effectively manage and control the negative outcome potential from improper execution of IPAC practices. HDH promotes the belief that infection control is everyone's responsibility. Regular training, communication and monitoring mechanisms are integral components of this plan, supporting HDH's commitment to preventing the spread of infections and enhancing patient outcomes.

This infection control plan is the cornerstone of patient safety and quality healthcare. It reflects a commitment to excellence, ensuring the hospital remains a place of healing, where patients can receive high-quality care with confidence.

Specific Components

The infection control plan includes the following components:

Infection Prevention and Control Committee

All infection prevention and control activities are overseen by the hospital's Infection Prevention and Control Committee. The committee is comprised of representatives from the hospital (frontline staff and management), local long-term care facilities, primary care, Grey Bruce Public Health (GBPH) and the medical consultant. The committee meets on a bi-monthly basis.

Infection Control Medical Consultant

HDH retains the services of Dr. Michael Gardam as a Medical Consultant to the Infection Prevention and Control Committee and the Infection Control Manager.

Hand Hygiene

Hand hygiene audits are performed on a regular basis by trained auditors. These results are reported on a monthly basis. The monthly results are reviewed by the Infection Control Manager and the relevant departmental managers. The results are posted throughout the hospital for staff and patient viewing.

The Infection Control Manager also collates and reports quarterly and annual hand hygiene metrics. These reports are provided to the following committees: Infection Control, Patient Safety and Risk Management, Professional Practice, Medical Advisory Committee, Patient and Family Advisory Committee and, the Quality Governance and Risk Management Committee of the Board of Governors. These statistics are also placed on the website for full transparency to the public.

Appropriate Use of Personal Protective Equipment (PPE)

PPE, including masks, gloves, isolation gowns, and face shields, are located throughout the hospital and clinical areas for use by physicians, staff, volunteers, visitors and patients. Signage is used at entrance to patient rooms to signal when isolation precautions are in place. Healthcare professionals, staff, and visitors are required to comply with any precautions that are in place.
There are also organizational policies that outline the requirements of appropriate PPE use.

PPE audits are performed monthly to assess staff compliance and ability to don and doff PPE appropriately. These audits are compiled by the Infection Control Manager and reported at the Infection Control Committee. Education opportunities are given at time of observation if required and hospital-wide education is provided when multiple areas are assessed to need reminders.

Universal Screening and Surveillance of Antibiotic Resistant Organisms

Universal screening is required on all patients admitted to HDH's inpatient units. Samples are collected to screen for Antibiotic Resistant Organisms as outlined in the IPAC policy. Any positive results are recorded in the patients' chart for ease of identification to initiate additional precautions on any subsequent interactions.

In addition, patients are assessed using the Febrile Respiratory Illness (FRI) screening tool and will have all travel history documented to rule out any contagious endemic diseases.

Based on the results of the above-noted screening, appropriate additional precautions are implemented with signage placed at the entrance to the patient's room.

Surveillance Reporting and Reportable Communicable Diseases

HDH complies with all mandatory infection control reporting. Positive confirmation of infectious diseases are reported to Grey Bruce Public Health in accordance with all applicable regulations.
On a monthly basis, hospital-acquired cases of Clostridium Difficile (C. Difficile), Methicillin-resistant Staphylococcus aureus (MRSA) and Vancomycin-resistant Enterococci (VRE) bacteremia are reported to Ontario Health (OH) through the Self-Reporting Initiative (SRI). Quarterly, Surgical Safety Checklist compliance is reported to OH through the SRI.

The pressure rate and nosocomial transmission of MRSA and C. Difficile is monitored daily and reported to the Infection Control Committee, Patient Safety and Risk Management Committee, Professional Practice Committee, Medical Advisory Committee, Patient and Family Advisory Committee and, the Quality Governance and Risk Management Committee of the Board of Governors. If any increase of transmission is noted, steps are taken to increase cleaning practices, perform point prevalence studies for admitted patients, and increase hand hygiene practices through education and increased audits.

Surgical Site Infection Surveillance

Surgeries performed at HDH are monitored by the Infection Control Manager for any surgical site infections that may arise subsequently. Any potential surgical site infections are brought to the attention of the surgeon, and feedback is received on the case. There is appropriate follow-up and remediation, if required. The surgical site infection rates are reported to the following committees: Infection Control, Patient Safety and Risk Management, Professional Practice, Medical Advisory Committee, Patient and Family Advisory Committee and, the Quality Governance and Risk Management Committee of the Board of Governors.

Outbreak Management

When a potential outbreak is recognized, the Infection Control Manager notifies the appropriate parties according to the Outbreak policy. The Outbreak Management Team will works collaboratively with GBPH to provide the best possible outcome for all patients, staff, and visitors.

Environmental Audits

In collaboration with the Environmental Services department, the Infection Control manager performs environmental audits on a regular basis to assess the effectiveness of cleaning and infection control practices. These audits are completed throughout the hospital using an ATP meter. The results of these audits are provided to the relevant department managers, the Environmental Services Manager, as well as the Infection Control Committee.

The audits are utilized for educational purposes. The Infection Control Manager, in conjunction with the Environmental Services Charge, will provide education and training on cleaning practices to Environmental Services staff, and staff within the impacted department to ensure those involved are knowledgeable and engaged in all infection control practices.

Use of UV Sanitizers and Cleaning Practices

HDH has invested in three (3) Clean Slate UV sanitizers, 2 UV washroom sanitizers, and 2 UV tower sanitizers for use throughout the hospital.

Clean Slate equipment provides a quick and effective solution for sanitizing handheld devices, includes mobile phones, pens, ID badges and stethoscopes and promotes hand hygiene and infection control. The devices are situated in areas for convenient use by staff.

The washroom sanitizers and tower sanitizers do not replace the need for routine or additional precaution cleaning, but are utilized as an adjunct to ensure that all potentially infectious/contagious microorganisms have been removed from the patient care area.

All cleaning practices and products utilized by HDH comply with PIDAC standards.

Educational Activities

The infection control manager will provide or facilitate education for all employees. These activities include:

- Infection control orientation for all new employees, students and volunteers on hand hygiene and donning/doffing of PPE
- Annual training on patient screening and isolation requirements through Brain Train program

- Informal feedback for staff regarding PPE donning and doffing practices
- Annual review of policies and cleaning practices in conjunction with IPAC guidelines
- IPAC education courses purchased by the hospital and distributed to employees
- Additional training, as required, based on results of environmental audits.

Construction or Facilities Projects

Plans for all construction and/or renovation projects undertaken by Facilities or an outside contractor are required to be reviewed by the infection control manager to ensure all IPAC guidelines are followed for the duration of the project. These projects may also be subject to inspection by the infection control manager.

Communication

Major policy changes, outbreak notification, changes in applicable practice and any reminders needed are communicated to all staff, physicians, and occupants of the building using a multi-faceted approach, including memos, departmental huddles, email communication, signage posted throughout the building.

There is also an IPAC communication board located in the service hallway that also displays these changes, the statistics collected by the Infection Control Manager and any other relevant information from GBPH.

Reports to the Governing Body via Quality Governance and Risk Management Committee

The following reports are provided quarterly to the Quality Governance and Risk Management Committee through the risk manager:

- Hand Hygiene
- Hospital Acquired Infections
- Surgical Site Infections
- Surgical Safety Checklists

Review of the Infection Control Plan

The infection prevention and control plan will be reviewed, updated, and approved annually, or as needed.

Hanover and District Hospital
Accessibility & Health Equity Plan
Five (5) Year Plan - 2021/22 – 2025/26

Submitted to
Dana Howes, President and Chief Executive Officer

Prepared by
Health Equity Committee

This publication is available on the hospital's Website
(www.hdhospital.ca)

Table of Contents

1. CEO MESSAGE:

Hanover & District Hospital (HDH) is committed to meeting the standards outlined in the province's *Accessibility of Ontarians with Disabilities Act*. The hospital incorporates these standards through our values of integrity, compassion and collaboration.

HDH is committed to provide an inclusive environment for all by continually improving access, by removing barriers and investigating new initiatives, to our hospital facilities, policies, programs, practices and services for our patients, family members, staff, healthcare practitioners, volunteers and members of the community with disabilities.

Our mission of providing exceptional care is at the forefront of our services that we provide. HDH is committed to promote inclusion for everyone with the respect and dignity they deserve.

Dana Howes
President and Chief Executive Officer

2. Introduction

Hanover & District Hospital (HDH) works 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.

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 formulizes a clear pathway for referrals to additional services. HDH partners with peer acute hospitals, community agencies; long term care homes, mental health and addictions and social service providers.

HDH provides the people we service access to the care they need through 24/7 Emergency Department, Acute Care Unit (inclusive of medical/surgical beds, multipurpose ICU and RCU beds), Physiotherapy Program, Surgical Services Department, Family Centred Birthing Unit, Hemodialysis Unit and Palliative Care Services.

3. HDH Commitment:

HDH is committed to fulfilling our requirements under the *Accessibility for Ontarians with Disabilities Act, 2005*. HDH is committed to promoting and providing an environment where respect, independence, and dignity are equally demonstrated at all times, to all patients. We shall provide accessible service for our patients and visitors. Persons with disabilities are given an opportunity equal to that given to others.

HDH is committed to addressing barrier removal strategies in:

- ongoing access improvements to facilities, policies, programs, practices and services for patients, their family members, staff, health care practitioners, volunteers and members of the community
- participation of people with disabilities in the development and review of its annual accessibility plans
- ongoing updates to the building's structure and equipment to ensure it meets accessibility standards
- ensuring hospital policies are compliant with the *Accessibility of Ontarians with Disabilities Act*
- provide training and maintain records on whom the training was provided

Many initiatives are underway across the organization to ensure that our care and services are accessible to people with disabilities.

4. Accessibility Plan Objectives:

The accessibility plan describes the measures that HDH has taken in the past and what the hospital is working at presently and in the future, to identify, remove and prevent barriers to people with disabilities who work in or use our hospital for services. The plan encompasses staff, patients, family members, health care practitioners, volunteers and members of the community.

The accessibility and health equity plan is reviewed and updated annually by the Health Equity Committee. The plan is presented annually at the Board of Governors for approval.

The accessibility plan will include strategies and actions applicable to Customer Services, Information and Communication, Employment and Training. **Note:** Procurement, Self-service Kiosks, Design of Public Spaces and Transportation are not applicable to us.

5. Accessibility Training:

HDH provides training as soon as practicable after hire and ongoing training of any changes to the policies. Annual accessibility training is provided during Brain Train.

The hospital maintains records of the training provided including the dates on which the training was provided and the number of individuals to whom it was provided.

6. Health Equity Plan:

The Health Equity Committee will create a culture, working in partnership both internally and externally, to make recommendations and initiate strategies to remove barriers of accessing healthcare to enhance the patient and workplace experience. This will involve the Accessibility for Ontarians with Disabilities Act, Senior Friendly Hospital framework, diversity, cultural

sensitivity and Indigenous awareness. The Committee is guided by the vision, mission and values of the Hanover & District Hospital and is accountable to senior management.

The Health Equity Committee's responsibilities and objectives are:

- To develop and/or recommend strategies to implement improvements in systems and processes that align with the goals of the organization, consistent with the provincial Senior Friendly Hospital framework, to enable seniors to maintain optimal health and function while they are hospitalized, so they can successfully transition home or to the next level of appropriate care;
- To ensure that legislative requirements with respect to the *Accessibility for Ontarians with Disabilities Act*, 2005 are met; evaluate and make recommendations on matters related to goods, services, accommodation, employment, buildings, wayfinding, structures and premises that will impact patient, staff or visitor accessibility;
- To build capacity to provide safe, quality care for diverse and vulnerable populations through increasing the cultural competencies of Hanover & District Hospital employees by providing proactive education and organizational training and development aimed at creating an environment that embraces diversity and cultural sensitivity, including Indigenous;
- Establish a monitoring framework to ensure continuous improvement to measure the effectiveness of implementation strategies and monitor indicators related to health equity and accessibility (for example patient satisfaction, employee and physician experience use of translation services and opportunities for improvement arising from complaints); and
- To create a healthier and more inclusive workplace environment for all staff, volunteers and physicians.

7. Communication and Information:

The hospital's accessibility and health equity plan is posted on the Hanover & District Hospital website. On request, the accessibility and health equity plan is made available in hard copy, electronic format, in larger print or on audiotape.

8. Past Achievements to Remove and Prevent Barriers

HDH is proud of the accomplishments to remove accessibility barriers to allow access to all. Refer to Appendix A for the *Accessibility Barrier-Removal Accomplishments*.

9. Current Five-Year Accessibility Plan

Refer to Appendix B for our *Current Five-Year Accessibility Plan*

APPENDIX:

Appendix A – Accessibility Barrier-Removal Accomplishments (2005 – 2020)
Appendix B – Current Five-Year Accessibility Plan (2021/22 – 2025-26)

ACCESSIBILITY PLAN APPENDIX A:

Accessibility Barrier-Removal Accomplishments (2005 – 2020)

1. Wheelchair accessible washroom renovated in Dialysis/Family Health Team
2. Wheelchair accessible washroom in renovated in patient Room 117
3. Website Update to meet AODA standards (2020)
4. More wheelchairs purchased for mobility
5. Removal of stone wall at front entrance for wheelchair storage; more accessible
6. Implemented customer service training/education on how to approach and talk to people of all abilities
7. Hearing/visually impaired phones; large number pad
8. Wheelchair accessible washroom renovation on Unit 2
9. Purchased four "Evacu-Trac" units for stair evacuation; used for mobility impaired patients in an emergency; one unit is at each stairwell; ongoing staff training on Evacu-Trac equipment; ongoing staff training provided
10. Waiting room seating replaced with firmer/higher chairs; bariatric seating included
11. Main front entrance to hospital had step removed and a concrete ramp installed to make it wheelchair accessible
12. Main front doors changed from manual to automatic sliding doors
13. Concrete sidewalk at outer edge of front canopy was ramped to allow wheelchair access from the pavement to sidewalk
14. The main front entrance to the hospital had a step removed and a concrete ramp installed to make it wheelchair accessible
15. The main hospital entrance doors were manual swing doors and upgraded to automatic sliding doors to produce hands free entrance
16. The concrete sidewalk at the outer end of the front canopy was ramped to allow wheelchair access from the payment up to the sidewalk
17. The entrance into the emergency department from the previous drive through had an asphalt ramp installed to eliminate one step into the hospital
18. The addition of the day hospital to the hospital included barrier free washrooms, tub room and shower; entrance and exits from their exterior tranquility garden had sloped concrete walks to make them wheelchair accessible
19. Accessible washroom installed in the waiting room area of the emergency/out-patient department when department was renovated
20. Automatic swing door operators, complete with accessible activation buttons, installed on the entrances to the operating rooms, imaging department, laboratory and the west wing first floor corridor door
21. Two close proximity disability parking spaces created in the hospital's front visitor parking lot; Six additional disability parking spaces added when the parking lot reorganized for the new medical clinic; hospital patrols these reserved spaces to ensure compliance and availability
22. The patient room numbers lowered to wheelchair level in all of the nursing units and the number enlarged from one-inch number to two-inch numbers

23. The shine of the finish used on sheet resilient flooring removed so the floors would have a non-shine surface to assist people with depth perception when walking on these floors
24. Re-development of the obstetrics unit, which included patient room accessible washrooms
25. Accessible washroom constructed in palliative care unit's family rooms 206 and 209
26. Carpet replaced in Emergency department waiting area with safety flooring
27. Handrails on both sides of corridor from Day Hospital entrance to Diagnostic Imaging Department entrance installed
28. A "No Scent" policy implemented and signage posted
29. Accessible washroom installed on the second floor for patients and the Public
30. CNIB and Hearing Impaired Phones are available
31. Education for staff on CNIB needs
32. The addition of four accessible parking spots adjacent to the buildings and strategically located in high volume areas
33. Installation of new signage for direction and flow pedestrian traffic
34. Stop blocks and speed bumps at cross walks to slow traffic around accessible entrances and access points
35. New Lab renovations – completion fall 2013
    - installation of a phone/video display for patient identification
    - installation of automatic door openers in Laboratory renovations for completion
    - installation of accessible washroom
36. Installed an automatic door leading into the dialysis unit.
37. Retrofitted the fire alarm system so that the alarm signals are both audible and visual throughout the building
38. Purchased some "raised" toilet seats and began a program to evaluate the seats in patient room washrooms; they did not prove to be a satisfactory solution
39. Replace compact fluorescent lamps that were slower to brighten with newer lamps that brighten quicker
40. Retrofitted both elevators to meet current codes and standards and installed new safety system on the doors (meets current accessibility codes); buttons are at wheelchair height and include braille to assist persons with vision impairment
41. Retrofit the lighting in the Pediatric Speech room so that is not as bright as when the main room lighting is currently on; Installation of incandescent fixtures to offer an alternate level of lighting
42. Developed a policy to accommodate a caseworker to be with a mental health patient in the ER department rather than the waiting room whenever possible
43. Doctors' entrance had a ramp installed to facilitate wheelchairs and the transfer of air ambulance stretchers
44. Investigated the feasibility and costs associated with constructing one accessible washroom using the space or portion of the space now occupied by the female staff and male public washrooms at switchboard and the housekeeping janitor closet located across from the hospital's boardroom; construction project awarded & completed
45. The carpet has been replaced in the Emergency department waiting area with non-slip flooring

46. The female staff washroom on the second level renovated to make one large accessible public washroom
47. Installed a second automatic door push plate at the main entrance door to Diagnostic Imaging department to accommodate people who approach from the Emergency department
48. Installed twin level water drinking fountain to accommodate wheelchair height and children
49. Purchased speakerphones
50. Purchased a wheelchair accessible weight scale

ACCESSIBILITY PLAN APPENDIX B:

Five (5) Year Plan

2021-22

☑ Temporary Wayfinding Signage posted during COVID-19
☑ Wheelchair accessible washroom & Shower on Acute Care
☑ Ceiling Lift Installed in Room 121 & 122 for improved transfers for patients with disabilities
☑ Staff training on ceiling lift provided by vendor
☑ Wheelchair accessible washroom (Diagnostic Imaging)
☑ Installed LED lighting on first floor
☑ Implemented QR Codes on the Patient Feedback Surveys
☑ Added a comment line under the accessibility question to patient feedback survey
☑ Ongoing monitoring of accessibility comments on patient feedback survey
☑ Implemented "Boogie" board to enhance patient communication
☑ Ongoing staff education at Brain Train
❒ Wayfinding Project - Directional Signage (on hold due to COVID-19)
❒ Wooden railing replacement
❒ Evaluate entrances into the building and make suggestions to increase accessibility
❒ Investigate Interpreter Resources to remove language barriers

2022-23 & 2023-24

☑ Wheelchair accessible door installed on the Quiet Room on the second floor
☑ Purchased clear masks for staff to wear for hearing impaired patients, as needed
☑ Purchased a Pocket Talker for hearing impaired patients
☑ Ongoing staff education at Brain Train
☑ Installed LED lighting on second floor
☑ Review accessibility comments from Patient Feedback Surveys
☑ Wooden railing replacement
☑ Investigate Interpreter Resources to remove language barriers
☑ Implemented interpreter resource utilizing iPads
☑ Staff Education: implemented AODA online training for new hires at orientation
☑ Monitor Accessibility comments on Patient Feedback Surveys; present quarterly at Health Equity
☑ Health Equity Committee AODA training
❒ Wayfinding Project - Directional Signage (on hold due to COVID-19)
❒ Evaluate entrances into the building and make suggestions to increase accessibility
❒ Automatic Door on ER washroom outside Treatment #1 and in waiting room

2024-25

❒ Wheelchair accessible washroom
❒ Ongoing staff education at Brain Train

- ❒ Monitor Accessibility comments on Patient Feedback Surveys; present quarterly at Health Equity
- ❒ Implement Self-Service Kiosks
- ❒ Continuing training: communicating with individuals with hearing loss/impairment
- ❒ Evaluate entrances into the building and make suggestions to increase accessibility
- ❒ Automatic Door on ER washroom outside Treatment #1 and in waiting room
- ❒ Wayfinding Project - Directional Signage
- ❒ Installation of third elevator – pending HIRF funding approval

2025-26

- ❒ Wheelchair accessible washroom
- ❒ Ongoing staff education at Brain Train
- ❒ Monitor Accessibility comments on Patient Feedback Surveys; present quarterly at Health Equity

Ongoing Projects:

- ❒ Changing faucets in washrooms (being changed to lever handles or motion activated) as repairs and replacement of old ones required.
- ❒ Changing door knobs (being changed to lever handles) as repairs and replacement required.
- ❒ Higher toilet in washrooms (on going). Short term solution purchase seat adjusters.

Future Projects:

- ❒ E.R. Accessible washroom.
- ❒ E.R. treatment rooms (5-9) larger, more accessible.
- ❒ Switchboard and Registration accessible.
- ❒ Sharps containers in Public Washrooms (Unable to source proper size container)
- ❒ Elevator sound to identify arrival at floor/ when door is opening or closing (to be completed when elevator has to be replaced)