Access and Flow

Measure - Dimension: Timely

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile ED length of stay	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)	9.55	8.59	Represents a 10% reduction.	

Change Ideas

Change Idea #1 Complete necessary diagnostics and assessments prior to initial physician assessment so that information is available when the physician arrives and reduce the wait time for treatment decision.

Methods	Process measures	Target for process measure	Comments
Inclusion of a PA at triage to initiate appropriate diagnostics and assessments earlier.	Percentage of days that a PA is scheduled in triage.	A PA is scheduled in triage 85% of the time.	

Change Idea #2 Generate an improved understanding of the data and contributors to ED LOS. The initiative will be to use this data to identify 2-3 target groups for which improvement work could be initiated.

Methods	Process measures	Target for process measure	Comments
Work with business intelligence to dig into the data and create an in depth understanding.	ED LOS data analysis is complete and target groups identified	The analysis will be completed by the end of Q2.	

Measure - Dimension: Timely

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile ambulance offload time	O	Minutes / 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)	42.00	35.00		HPE Paramedic Services

Change Ideas

Change Idea #1 Increased focus on sustaining an offload nurse each day in Belleville to expedite transfer of accountability from EMS to the ED team.

Methods	Process measures	Target for process measure	Comments
During scheduling and day to day operational staffing activities the offload nurse will be considered part of baseline staffing.	Percentage of days with a scheduled offload nurse.	There will be an offload nurse scheduled in the Belleville ED 50% of the time.	

Change Idea #2 Offload data is not currently visible to staff and the quality of that data is often questioned.

Methods	Process measures	Target for process measure	Comments
Work with our business analytics team to ensure reliable offload data by hospital ED and post this data on huddle boards for discussion and monitoring	Reliable offload data is posted at all four ED's on their huddle board.	Data will be posted routinely by the end of Q2.	

Change Idea #3 Review of the Fit2Sit agreement with EMS and ensuring that the process established in that agreement is followed consistently.

Methods	Process measures	Target for process measure	Comments
Review of the agreement with EMS and ED staff and together identifying the key process elements for consistent application.	Percentage of Fit2Sit patients with 100% of key process elements completed.	85% of Fit2Sit patients will have all key process elements followed by ED and EMS staff.	

Measure - Dimension: Timely

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of CTAS 2 and 3 patients who visited the ED and left without being seen by a physician.	C	% / Patients	CIHI NACRS / April 1 2023 to December 31 2023 (Q1 to Q3)	7.20	3.00	Pre-pandemic we were averaging 3.0% and this amounts to more than a 50% reduction over a year.	

Change Ideas

Change Idea #1 Complete a comprehensive exploration of the data to understand contributing factors and impact of recent coding changes.

Methods	Process measures	Target for process measure	Comments
Work with business intelligence to obtain and analyze the available data.	Data exploration is completed.	Data exploration is completed by the end of Q2.	

Change Idea #2	During peak times have a physician assistant assigned to triage to support early assessment and intervention where appropriate.		
Methods	Process measures	Target for process measure	Comments
Schedule a PA in triage during peak volume times.	Percentage of days that a PA is assigned to triage.	85% of the time a PA is assigned to triage between the hours of 1100-2300.	

Change Idea #3	Increase transparency about anticipated wait times to better manage expectations and supplement the information currently provided.		
Methods	Process measures	Target for process measure	Comments
Display an anticipated wait time clock in the ED waiting room.	Clock will be visible to all those who present to the ED and who remain in the waiting room.	A wait time clock will be visible in the ED by the end of Q1.	

Change Idea #4	Creation of a policy and process to guide organizational response and efforts to reduce the volume of patients who present to triage but leave before seeing a physician.		
Methods	Process measures	Target for process measure	Comments
Work with the emergency team, professional practice, and quality/risk to create a policy.	Creation of a policy that provides direction around LWBS prevention and response.	Policy will be created by the end of Q1.	

Equity

Measure - Dimension: Equitable

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	O	% / Staff	Local data collection / Most recent consecutive 12-month period	100.00	85.00	We will expand the target group to include all SLT, Directors and Managers. It is also expected that ongoing leadership turnover may prevent us from meeting the 100% target we are aiming for.	

Change Ideas

Change Idea #1 Creation of an EDI plan for the organization.

Methods	Process measures	Target for process measure	Comments
An EDI plan will be created that aligns with our strategy and that will guide our EDI efforts in the coming years.	An EDI plan is created.	The EDI plan will be completed by the end of Q1.	

Change Idea #2 Provide ongoing DEI education opportunities within the organization.

Methods	Process measures	Target for process measure	Comments
The DEI Committee will identify and arrange lunch and learn sessions for staff, leaders, and physicians.	The DEI Committee will delivery lunch and learn sessions each quarter.	A minimum of one DEI lunch and learn session will be delivered each quarter.	

Experience

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of respondents who responded “completely” to the following question: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?	O	% / Survey respondents	Local data collection / Most recent consecutive 12-month period	61.14	68.20	Represents a 10% increase on current performance.	

Change Ideas

Change Idea #1 Update PODS and review process for distribution and review at discharge on all acute medicine units.

Methods	Process measures	Target for process measure	Comments
Involve HEPP in the review and revision of existing PODS, re-educate staff on the process and timing of PODS distribution to patients who are being discharged.	Percentage of patients who receive a PODS at discharge.	80% of patients receive a PODS at discharge.	Total Surveys Initiated: 422

Change Idea #2 Follow-up with discharged patients to understand what may have been missing from their discharge teaching that left them feeling it was inadequate.

Methods	Process measures	Target for process measure	Comments
Discharge follow-up phone calls to evaluate experience and that ask for feedback specifically on discharge preparation.	Process for completing and capturing feedback from discharge phone calls is in place.	Discharge preparation phone calls will begin by the end of Q1.	

Safety

Measure - Dimension: Safe

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of delirium onset during hospitalization	O	% / Hospital admitted patients	CIHI DAD / April 1st, 2023, to September 30th, 2023 (Q1 and Q2)	0.67	0.50		

Change Ideas

Change Idea #1 Creation of a delirium prevention and management program.

Methods	Process measures	Target for process measure	Comments
Create a policy that outlines the organizations approach and commitment to delirium prevention and management.	Delirium prevention and management policy will be approved at Leadership Committee.	The policy will be approved by the end of Q1.	

Change Idea #2 Improve compliance with q shift CAM assessment.

Methods	Process measures	Target for process measure	Comments
Provide education refreshers for staff on delirium and its link to the CAM assessment and resultant care planning.	Percentage of med/surg patients with a CAM assessment completed every shift.	100% of med/surg patients have a CAM assessment completed each shift.	

Change Idea #3 Improve awareness of the risk factors for delirium and staff understanding of how to address or mitigate those risk factors.

Methods	Process measures	Target for process measure	Comments
Create internal PIECES instructors and make PIECES training available to staff.	Percentage of acute med/surg nursing staff who have received PIECES training.	20% of acute med/surg nursing staff have received PIECES training by the end of Q4.	

Measure - Dimension: Safe

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of workplace violence incidents resulting in injury.	C	Number / Staff	Local data collection / April 1 to December 31 (Q1-Q3)	34.00	24.00	In our current quarterly baseline data 8 is the fewest number of events resulting in injury and if sustained each quarter would result in a 30% reduction in overall number of WPV events resulting in harm.	

Change Ideas

Change Idea #1 Creation of a standard report, inclusive of trends and recommendations, that is posted internally and review by Leadership Committee on a regular basis.

Methods	Process measures	Target for process measure	Comments
Work with Business Intelligence and Communications to develop an infographic report for posting and to communicate Key WPV findings with organizational leadership.	Creation of an infographic report on WPV for Leadership Committee.	Report created and being sent a minimum of quarterly to Leadership Committee by the end of Q1.	

Change Idea #2	Increase the number of units and staff who have current NVCI training.		
Methods	Process measures	Target for process measure	Comments
Leverage the additional NVCI instructors we have created to deliver NVCI courses on a scheduled basis to that managers can schedule staff accordingly.	Percentage of staff on units requiring NVCI who have current certification.	75% of staff working regularly in units that require NVCI have current certification.	

Change Idea #3	Put forward a request, based on Risk Assessments performed by managers and Occupational Safety, to increase the number of units requiring NVCI certification for nurses.		
Methods	Process measures	Target for process measure	Comments
Create a proposal for approval at Leadership Committee.	Proposal created and presented to Leadership Committee for decision.	Proposal presented to Leadership Committee for decision by the end of Q1.	