Access and Flow

Measure - Dimension: Timely

Indicator #5	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 / For ERNI hospitals: Dec 1, 2023, to Nov 30, 2024 (Q1 and Q2)	23.35	22.00	Achieved target for 2 quarters prior year, continuing to work on initiatives to meet target	

Change Ideas

Change Idea #1 Continued focus on ICU and Mental Health Time to inpatient bed

Methods	Process measures	Target for process measure	Comments
This change idea will be monitored and tracked at the Emergency Department Care Team, and Quality and Utilization Committee	Time to inpatient bed measured in minutes	90% patient are admitted to ICU within 30 minutes of being assessed by intensivist and 90% of patients are admitted to the Inpatient Mental Health Unit within 30 minutes when a bed is available	Confirm the time utilized for this metric; to reflect the time that the intensivist assesses the patient, rather than the time that the ED physician has ordered the consult

Change Idea #2 Improve attendance at and consistency of weekend/STAT holiday bed meetings

Methods	Process measures	Target for process measure	Comments
This change idea will be monitored by the Director of Critical Care & Mental Health Services and Director of Patient Flow	Number of units attending after hours bed meetings	100% of all units to attend weekend bed meetings, and pre-populate information into the daily bed meeting form	Record weekend bed meetings (review Monday mornings by Director CC/MH and/or Director Pt. Flow) - director to follow up with managers of units that do not attend.

Measure - Dimension: Timely

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of potential admissions avoided with utilization of the CHaH Program	C	Number / ED patients	CIHI NACRS / The period will be the fiscal year April 1 2025 to March 31 2026	248.00	260.00	Current performance based on manual data collection, due to this, aiming for a 5% target increase due to risk of reliability in data.	Couchiching OHT

Change Ideas

Change Idea #1 Promotion and education on the use and importance of the Couchiching Health at Home program through visual cues in the emergency department.

Methods	Process measures	Target for process measure	Comments
Manual data collection initially through the data analytics team. Monitored quarterly through quarterly reporting. Will be led by the QIP indicator lead.	Number of patients who are referred to CHaH from the emergency department and are not admitted.	Increase by 3 patients referred per quarter.	Current data is manual collection therefore risk to data quality.

Change Idea #2 Leverage coordinators to support education of admission avoidance strategies through referral to CHaH

Methods	Process measures	Target for process measure	Comments
Number of education sessions provided to staff. Training records will be tracked through the coordinators. This change idea will be led by the QIP lead	6 education sessions will be provided to emergency department staff.	This will be completed by the end of Q2	

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	CB	75.00	Target represents a commitment to training, the target has been set at 75% with the understanding that training can be impacted by availability and competing priorities.	

Change Ideas

Change Idea #1 Offer equity, diversity, inclusion and accessibility training directed to the need of the recipient (audience). We will engage partners with expertise (indigenous health circle for example) to develop an education plan geared towards indigenous cultural safety using the KTA framework wherein training opportunities are offered in different ways for different levels of learning In order to ensure meeting the widest group of people, and to accommodate timing and resourcing, we will plan in advance.

Methods	Process measures	Target for process measure	Comments
Training records will be kept within the human resources department and reported quarterly as a part of QIP reporting through the quality and safety committee of the board.	Number of leaders who have received training.	50% of the desired target audience will be trained by the end of the second quarter.	

Change Idea #2 Offer IDI training to leadership (senior team and directors) for self-reflective learning. DEIRB committee will guide the use of a platform called the IDC to support individual learning journeys in cultural competence.

Methods	Process measures	Target for process measure	Comments
Training will be tracked manually through the Human Resources and people services team.	Number of directors receiving training.	25% of directors will have an IDI facilitator by the end of Q4	

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" or "quite a bit" 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?	C	% / Survey respondents	Local data collection / Most recent consecutive 12 month period	84.00	80.00	Increased the target to 80% as continuing to improve as measured in last year's data.	

Change Ideas

Change Idea #1 Improve consistency in discharge documentation to ensure standardization in alignment with our policy and accreditation standards. 20 patients per quarter will be surveyed post roll out of discharge brochure and policy via phone.

Methods	Process measures	Target for process measure	Comments
There will be a sampling of discharged patients through the test and trial phase of the rollout. In addition, we will obtain and monitor Qualtrics survey data.	Number of patients that received adequate discharge documentation	80% of surveyed patients will have received discharge documentation in alignment with hospital policy.	

Change Idea #2 Improve the depart tool by completing a fishbone, 5W 2H analysis and a prioritization matrix with the multidisciplinary working group and physician leads to further understand root cause related to the depart tool.

Methods	Process measures	Target for process measure	Comments
This initiative will be led by the QIP joint leads for this indicator.	Number of root cause analysis activities completed	3 root cause analysis activities will be completed by the end of Q1, 1 scheduled per month.	

Safety

Measure - Dimension: Safe

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of delirium onset during hospitalization	O	% / Hospital admitted patients	CIHI DAD / April 1 to September 30, 2024 (Q1 and Q2), based on the discharge date	1.08	1.50	Current performance is higher than provincial average, initiatives this year will be focused on recognition of delirium, anticipated that this indicator might increase	

Change Ideas

Change Idea #1	Improve accurate completion of the CAM tool, delirium standard of care and prevention protocol through education on use. Collaborate with Specialized geriatric services in the development of education related to delirium identification and prevention.		
Methods	Process measures	Target for process measure	Comments
Tracked attendance for staff training	Number of staff trained	60% of frontline staff will receive education by end of Q3	

Change Idea #2	Assess current structures where similar delirium initiatives are currently being worked on and reformat delirium working group to include all delirium initiatives		
Methods	Process measures	Target for process measure	Comments
The delirium working group will complete an assessment and will monitor progress.	Number of similar initiatives	Based on assessment, reduce similar initiatives by 20% by the end of Q2	

Measure - Dimension: Safe

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of workplace violence incidents resulting in lost time injury	O	% / Staff	Local data collection / Most recent consecutive 12-month period	2.00	5.00	Current performance is not end of fiscal year, anticipating performance will be near target. Target set based on performance over 3 years.	

Change Ideas

Change Idea #1 Delineation and customization of SMG, GPA and civility training to the right audience at the right time.

Methods	Process measures	Target for process measure	Comments
Internal assessment to determine needs and value of SMG and GPA; external benchmarking with peer hospitals on utilization of SMG or GPA training, or other programs. Identify list of training that requires adaptation.	Number of courses assessed	SMG, GPA and civility training alignment with organization and staff needs will be completed by end of Q2	

Change Idea #2 Provide education and awareness for workplace violence and joint health and safety committees for utilization of SBAR framework (ethical decision making) related to specific and/or generalized workplace violence cases. Develop and deliver an SBAR education session focused on case specific workplace violence incidents to the workplace violence committee and joint health and safety committee

Methods	Process measures	Target for process measure	Comments
Education and training will be tracked through the people services team	Number of staff trained	80% of workplace violence and joint health and safety committees by the end of Q3	

Change Idea #3	Review and evaluate the current reporting process and tools to ensure adequate response measures in alignment with the workplace violence policy. A root cause analysis on current data from both the incident management system and HR investigation will be completed		
Methods	Process measures	Target for process measure	Comments
This review will take place within the people strategy portfolio	Number of root cause analysis activities	Two root cause analysis activities will be completed by the end of Q2	