Access and Flow

Measure - Dimension: Timely

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile ED length of stay: non-admit high-acuity (CTAS 1-3)patients.	C	Hours / ED patients	CIHI CCRS, CIHI NACRS / FY 2023/24 YTD Jan	6.30	5.80	7.9% (0.5 hours) decrease based on current performance.	

Change Ideas

Change Idea #1 Identify bottlenecks that have the greatest impact on ED length of stay and implement strategies to eliminate barriers.

Methods	Process measures	Target for process measure	Comments
Conduct a value-stream analysis (from triage/registration to departure).	Measures to be identified once improvement opportunities are confirmed.	Targets to be identified once process measures confirmed.	Reducing the time from triage in the emergency department to when a patient is discharged is crucial for enhancing patient experience and outcomes. Our objective for the next year is to find ways to decrease this time for our patients.

Measure - Dimension: Timely

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department wait time to inpatient bed.	C	Hours / ED patients	CIHI CCRS, CIHI NACRS / FY 2023/24 YTD Jan	30.40	27.50	Maintain target based on current performance.	

Change Ideas

Change Idea #1 Streamline and optimize discharge processes across the Medicine Program.

Methods	Process measures	Target for process measure	Comments
Conduct a LEAN event to identify efficiencies and eliminate waste in the discharge process.	Indicator to be identified when interventions confirmed.	Target to be identified when indicator confirmed.	Reducing the volume of admitted patients in ED requires a long-term approach. Our goal for the upcoming year is to streamline discharge processes across our medicine units to ensure that admitted patients who no longer require emergency care are transferred to a nursing unit as soon as possible.

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	Based on current performance.	

Change Ideas

Change Idea #1 Determine equity, diversity, inclusion, and antiracism training expectations to promote health equity.

Methods	Process measures	Target for process measure	Comments
1. Establish a working group to identify and determine education/training and expectations. 2. Implement education/training and monitor completion.	1. Working group established, and education/training determined 2. % SLT, Directors, and Managers who have completed the education.	1. Completed by June 30, 2024 2. 100% of targeted participants.	Our aim for the next year is to ensure all of our executive and management staff complete equity, diversity, inclusion and antiracism education and training. This is to promote an inclusive workplace and minimize disparities in staff and patient experiences.

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% of patients who select the top-box answer for courtesy and respect.	C	% / ED patients	Local data collection / April-December	79.30	86.00	Maintain - high performer (stretch target to support patient experience strategies).	

Change Ideas

Change Idea #1 Implement a communication bundle to improve communication between patients and providers.

Methods	Process measures	Target for process measure	Comments
1. Continue to roll-out "patient communication bundle" - virtual reality experience, simulation, quick bites, & LiME module in the ED (ED staff, ED Registration clerks). 2. Conduct staff self-efficacy assessment post education to evaluate staff self-reported effectiveness of the education provided.	1. % of individuals who complete the education 2. % increase in staff self-efficacy assessment scores.	1. >80% of full/part time staff. 2. >10%.	Enhancing the patient experience involves improving communication between patients and providers. This year our focus will be to expand empathy communication education/training to staff across our hospital sites.

Change Idea #2 Establish a patient ambassador program in the ED to support compassionate communication and meaningful engagement.

Methods	Process measures	Target for process measure	Comments
1. Co-design program with ED Leadership team, Volunteer Services, and front-line staff. 2. Pilot in high need areas (Yellow, Orange, Red, and Blue zones). 3. Establish evaluation framework to determine effectiveness of program and the ability to spread and scale.	1. % of shifts where patient ambassadors are scheduled. 2. % of patients, staff, and volunteers who complete the survey. 3. Evaluation is completed, and opportunities to spread and scale are identified.	1. 100% of scheduled shifts. 2. >80%. 3. Completed by the end of Q2.	The Patient Ambassador program utilizes volunteers to assist the team with various duties that will enable clinicians to carry on with their clinical responsibilities whilst providing comfort to patients and their families who may be waiting in the Emergency Department.

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% of patients who select the top-box answer for courtesy and respect	C	% / Patients	Local data collection / April - December	88.00	90.00	Maintain - high performer (stretch target to support patient experience strategies)	

Change Ideas

Change Idea #1 Implement a communication bundle to improve communication between patients and providers.

Methods	Process measures	Target for process measure	Comments
1. Spread and scale "patient communication bundle" - (virtual reality experience, simulation, LiME module, and quick bites) across the organization 2. Conduct staff self-efficacy assessment post education to evaluate staff self-reported effectiveness of the education provided 3. Implement the Patient Communication module for Support/Allied Service areas (Facilities, Diagnostic Imaging, Lab, Registration, Pharmacy).	1. % of individuals from each unit who complete the education. 2. % increase in staff self-efficacy assessment scores. 3. % of individuals who complete/participate in education.	1. >80% of full/part time staff in each area. 2. >10%. 3. >80% of full/part time staff in each selected area.	

Safety

Measure - Dimension: Safe

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of workplace violence incidents that result in reportable and non-reportable injury as defined by WSIB (health care/lost time injuries/illnesses).	C	Number / Other	Local data collection / 2023	1.38	1.17	15% reduction.	

Change Ideas

Change Idea #1 GPA training for Registered Practical Nurses/Personal Support Workers in the Medicine Program.

Methods	Process measures	Target for process measure	Comments
Target groups will attend Gentle Persuasive Approach (GPA) training to prevent or safely avoid escalating interactions.	% target groups that complete education.	80% by March 31, 2025.	To reduce injury from workplace violence incidents we will implement comprehensive training that supports staff safety and well-being, and establish clear protocols for preventing and addressing incidents of workplace violence and minimizing injury.

Change Idea #2 Reinforce Risk Assessment knowledge sharing in Medicine units.

Methods	Process measures	Target for process measure	Comments
Implement knowledge sharing activities to increase staff awareness of violence risks within and across teams.	Completion of projects to integrate content.	The target is 100%.	

Change Idea #3 Review of personal alarm (duress tag) use.

Methods	Process measures	Target for process measure	Comments
Review and evaluate staff use of personal alarms (duress tags) and identify opportunities to optimize and/or improve utilization.	Use of alarms as percent of total code white initiation.	The target is 100%.	

Measure - Dimension: Safe

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Reduction in falls that result in harm	C	Rate / Other	Local data collection / 12 month period	0.66	0.58	5.0% reduction based on current performance	

Change Ideas

Change Idea #1 Implement a tele-monitoring program to reduce falls with harm in high risk areas identified through our incident report data.

Methods	Process measures	Target for process measure	Comments
Identify phase 2 units to spread and scale the Halo program.	1) Percent of phase 2 units where Halo Tele-monitoring has been implemented 2) Percent falls with harm for patients enrolled in Halo program.	1) 100%. 2) To be determined.	Falls in hospitals can lead to serious injuries and complications, prolong recovery and impact patient outcomes. Our focus for the upcoming year is to reduce falls resulting in harm for our patients.

Change Idea #2 Implement a validated falls risk assessment tool to better support clinical decision making and identification of falls risk and the development of individualized care plans.

Methods	Process measures	Target for process measure	Comments
1) Provide education and training to clinical teams on refreshed approach and supportive tools 2) Identify clinical champions to support the implementation and sustain change 3) Launch falls risk assessment policy and tool 4) Create education rollout plan for Patient/Family Education bundle.	1a) Percent of high-risk patients who are appropriately identified. 1b) Percent of high-risk patients who have appropriate interventions in place. 2) Number of clinical champions to support change 3) Launch completed 4) Percent of moderate & high risk patients/family who have recieved the education bundle.	1a) Collect baseline. Target TBD. 1b) Collect baseline. Target TBD. 2) >1 clinical champion per unit. 3) Aim: March 27, 2024. 4) >80%.	