Access and Flow | Timely | Optional Indicator

Indicator #2

90th percentile emergency department wait time to inpatient bed (Queensway-Carleton Hospital)

Last Year		This Year		
28.83	25.94	23.17	19.63%	22
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Improve the compliance with the documentation of entering a Predicted Discharge Date (PDD) within 48 hours of admission.

Process measure

- Percent of medical inpatients who have a PDD listed within 48 hours of admission

Target for process measure

- By December 2024, 95% of medical inpatients will have a PDD documented within 48 hours.

Lessons Learned

Stakeholder engagement is crucial when introducing change in practices. Bringing representation from all aspects of the inter-professional team together to work towards the solution was impactful to gain buy-in and increase receptiveness to change.
Investing the time to complete a literature review, best-practice analysis and engage with colleagues on their process, challenges and learnings is important to bring to the table to inform the project, next steps and overall implementation. Data collection methods can be challenging and time consuming with current IT systems. Recommend to consider data collection process with new electronic medical record implementation next year to support enhanced data tracking and inform next steps.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Reduce the amount of time that patient porters experience delays.

Process measure

- The number of minutes of delay in a month.

Target for process measure

- By December 31, 2024, a reduction of 15% in porter delay minutes, to 4,700 minutes will be realized.

Lessons Learned

Variable results creates instability for patient transports, where there are increased wait times, the transport completion times increase.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Develop a patient flow model to facilitate the flow of patients seeking mental health support through the emergency department.

Process measure

- Creation of the patient flow model.

Target for process measure

- The patient flow model to facilitate the flow of patients seeking mental health support through the emergency department is created by August 31, 2024.

Lessons Learned

Daily conversations with Regional MH hospitals to promote flow across the region which supported internal and regional pressures. Off-service MH patients identified for appropriateness with decreased risk factors that could be supported on medicine units - patients with highest risk factors prioritized to come to the inpatient unit during times of surge. Innovative solutions to enhance patient flow through using Full Capacity Beds (virtual beds)

Change Idea #4 ☑ Implemented ☐ Not Implemented

Standardization of the inpatient rounds process.

Process measure

- Implementation of the project plan related to standardization of the inpatient rounds process.

Target for process measure

- By December 31, 2024, one test of change related to the standardization of inpatient rounds has been implemented, utilizing a model such as the Plan-Do-Study-Act (PDSA) approach.

Lessons Learned

Early stakeholder engagement across all members of multidisciplinary team supported the success of the pilot.

Change Idea #5 ☑ Implemented ☐ Not Implemented

Increase the number of patient transportation jobs of patients transferred from the emergency department that are completed within 17 minutes.

Process measure

- Number of porter transport jobs completed within the target timeframe.

Target for process measure

- By December 31, 2024, increase the number of porter transport jobs related to patient transport that are completed within 17 minutes by 15%.

Lessons Learned

Both wait times affect the completion times for porters. data collection has been ongoing. All data is posted on the CPI board for all. All porters are receiving their monthly performance with supervisor review. We continue to track porter pick up times (aimed at 10 mins - this target was met).

Comment

QCH will continue to track and measure work on this effort into 2025-2026 through our 'Time to inpatient bed' Project. The 90th percentile of time to inpatient bed is a corporate key performance indicator to ensure a seamless system of care. Along with the number of admitted patients in the ED, it is a strong marker for overall access to care within the hospital and the emergency department. A Time to Inpatient Bed Steering Committee has been established at QCH to identify key issue such as delayed discharges, Predicted Date of Discharge (PDD) Compliance and the variability in bed assignment processes.

Additionally, Logistics ULT is working on the wait time issues for the next quarter. They have completed the investigation of current state and are working towards bringing teams together to problem solve challenges getting to the porters for improved transport completion times and reduction of wait time.

Indicator #5	Last Year		This Year		
	7.04	5	8.32	-18.18%	NA
Percent of patients who visited the ED and left without being seen by a physician (Queensway-Carleton Hospital)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☐ Implemented ☑ Not Implemented

Recruitment of a Nurse Practitioner (NP) to the Emergency Department team.

Process measure

- A Nurse Practitioner is recruited to the ED.

Target for process measure

- By July 31, 2024, a NP will be recruited and onboarded in the Emergency Department.

Lessons Learned

Unable to recruit. Strategy removed.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Alignment of physician resources with patient volume patterns.

Process measure

- Adjustments to physician resources to align with patient volume patterns is completed.

Target for process measure

- By September 30, 2024, the process and practice to physician resources to align with patient volume patterns will be in place.

Lessons Learned

Innovative strategies are required to change outcomes above and beyond the existing physician schedule.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Creation and roll-out of standard work for the triage model which includes role clarity and responsibilities for the initial assessment and reassessment of patients.

Process measure

- Percent of triage nurses who have received training.

Target for process measure

- By June 30, 2024, 100% of triage nurses will be trained on the standard work triage model and expectations surrounding assessment and reassessment.

Lessons Learned

Continue to monitor to sustain change. Ongoing education for new staff needs to be consolidated with refreshed model. Staff expressed appreciation for role clarity and clear accountabilities.

Comment

The EDRVQP audit revealed that overall, 12 % of all patients returning to the ED requiring admission, left without being seen on the initial visit, higher than the overall proportion published on the 2023 EDRVQP report.

A countermeasure action plan is in place to improve the flow to an inpatient unit through the Time to inpatient bed indicator. We expect this and the work under ED Xcellence Project to address our left without being seen by improving flow and time to PIA.

Indicator #1

90th percentile ED length of stay (Queensway-Carleton Hospital)

Last Year		This Year		
12.77	**11.50**	**13.70**	**-7.28%**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Create standard work for the Patient Care Aides (PCAs) and Nurses to support patient flow and the prioritization of patient acuity to support assessment.

Process measure

- Creation of the standard work document.

Target for process measure

- By June 30, 2024, the standard work documented will be created for (PCAs) and Nurses.

Lessons Learned

Early team engagement in the planning process improved results with go-live.

Change Idea #2 ☐ Implemented ☑ Not Implemented

Develop communications tools customized to facilitate comprehensive information exchange between physicians and nursing staff during handover.

Process measure

- Communication tools created.

Target for process measure

- By August 31, 2024, the communication tools will be created.

Lessons Learned

Shifts did not align and there was too much flexibility in the unit to support this approach. Strategies need to be vetted to ED Exec and ULT for stakeholder input to ensure applicability.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Implementation of the short, focused 'mini-huddles' process and communication tools to create situational awareness and collaboration amongst the department leadership.

Process measure

- Mini-huddle process and use of communication tools are deployed and put in place.

Target for process measure

- By November 30, 2024, 80% of the staff in the ED will have received training on the communication tools.

Lessons Learned

Manager and CCL have regular daily huddles, manager, CCL and CF have daily status, director joins weekly.

Comment

QCH will continue to address ED length of stay through our ED Xcellence Project. The ED Xcellence Project was implemented in August 2024 with the goal to enhance ED operations and patient care. The project has three areas of focus: Ambulance Offload Optimization, Time to Physician Initial Assessment (PIA), and Innovative Opportunities.
The focus on time to PIA aims to reduce overall wait times, which in turn is expected to decrease the ED length of stay.

Access and Flow | Efficient | Optional Indicator

	Last Year		This Year		
Indicator #3 Alternate level of care (ALC) throughput ratio (Queensway-Carleton Hospital)	**0.99** Performance (2024/25)	**1** Target (2024/25)	**0.99** Performance (2025/26)	**0.00%** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Increase the implementation and enhance the adoption of ALC Leading practices at QCH throughout the 2024/2025 fiscal year.

Process measure

- The number of ALC Leading practices fully met according to the defined criteria of ALC Leading practices during the 2024/2025 fiscal year.

Target for process measure

- By December 31, 2024, 34 out of 48 ALC leading practices will be fully implemented and met.

Lessons Learned

The OH operational direction document for Home First was based on many of the ALC leading practices. This directive from OH was leveraged to support implementation.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Improve the efficiency of the Remote Care Monitoring program to facilitate program expansion to additional patient populations.

Process measure

- Number of patients served by the program volumes per month.

Target for process measure

- By December 31, 2024, the Remote Care Monitoring program will serve a total of 40 patients per month.

Lessons Learned

The RCM project was implement to support ALC leading practices. This supports the directive from OH to improve discharge efficiencies.

Comment

QCH was proud of the achievements in ALC, 36 of 48 ALC leading practices were fully implemented and currently trending with ~30 patients/month being served by the Remote Care Monitoring Program.

Equity | Equitable | Optional Indicator

	Last Year		This Year		
Indicator #7 Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (Queensway-Carleton Hospital)	**CB** Performance (2024/25)	**100** Target (2024/25)	**84.23** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**100** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Targeted training for QCH Leaders on RESPECT training.

Process measure

- Percent of QCH Leaders (management; formal leaders) who have completed the training.

Target for process measure

- By March 31, 2025, 100% of QCH Leaders (management) will have completed the RESPECT training.

Lessons Learned

In Progress. RESPECT Training was recently enhanced with new microaggression modules. By March 31, 2025, we aimed for 100% completion of RESPECT training for all QCH Leaders (management). As of now, we have achieved 90% completion, with efforts ongoing to engage the remaining leaders.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Develop a comprehensive EDIB learning strategy.

Process measure

- Creation of a written strategy.

Target for process measure

- Written strategy created by September 30, 2024.

Lessons Learned

Completed. We developed an EDIB Learning Strategy Roadmap and formed an Education Working Group in Q4 to guide implementation.

Change Idea #3 ☑ **Implemented** ☐ **Not Implemented**

Develop EDIB learning curriculum / training material for all staff to complete.

Process measure

- The learning curriculum is developed.

Target for process measure

- By December 31, 2024, the EDIB learning curriculum and training materia is developed.

Lessons Learned

In Progress – The curriculum was drafted in Q3 with EDIB Advisory Council input. In Q4, we partnered with Carleton University's Centre for Indigenous Support and Community Engagement to create an Indigenous Learning Bundle on Cultural Safety and Humility.

Change Idea #4 ☑ **Implemented** ☐ **Not Implemented**

Ontario Indigenous Cultural Safety (ICS) training for QCH Leaders.

Process measure

- Number of QCH Leaders (management) who have completed training.

Target for process measure

- By March 31, 2025, we will have 100% compliance with Ontario ICS training, based on the number of seats available for training (approximately 25 training spots).

Lessons Learned

Flexible and Tailored Training: Recognizing diverse roles and time constraints, we've adopted adaptable educational strategies to enhance participation and compliance.

Appropriate Training Duration: While comprehensive programs like San'yas Indigenous Cultural Safety Training are valuable, their length can be challenging for frontline staff. To address this, we've implemented:

Leadership Levels (Board, Executive, Director, Management): Require completion of either the San'yas Indigenous Cultural Safety online training or the Wabano-win Indigenous Cultural Safety in-person training, both approximately 8 hours long.

Staff, Physicians, and Volunteers: To accommodate time constraints and resource considerations, we are sourcing a shorter, 90-minute Indigenous Cultural Safety training module for these groups.

Comment

Through ongoing reflection and consultation, we recognized the need to deepen the integration of Indigenous learning and knowledge within our EDIB Learning Strategy and Curriculum. As an enhancement, we are prioritizing this work in 2025/2026, including collaboration with Carleton University's Centre for Indigenous Support and Community Engagement to develop Indigenous Learning Bundles on Cultural Safety and Humility. This approach ensures a more meaningful and sustained commitment to Indigenous cultural safety education.

We have established that San'yas Indigenous Cultural Safety (ICS) Training or Wabano-Win ICS Training will be mandatory for all Executive, Directors, and Managers. Leaders must complete either the 8-hour in-person or online training. Additionally, we are exploring a shorter module for all staff. In 2025/2026, we will identify an Inuit-specific ICS Training to further strengthen cultural safety education.

We will also be looking at how to best engage Physicians in training and compliance and how best to include New Board and QCH Leadership to maintain our commitment to EDIB and compliance, it is imperative that all new Board members and Executive Level leaders complete anti-racism and ICS training.

Experience | Patient-centred | Optional Indicator

Indicator #6

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? (Queensway-Carleton Hospital)

Last Year		This Year		
61.26	**67.40**	**66.60**	**8.72%**	**67.40**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Increase the compliance of completing the Discharge Transition tool/ Guidelines Applied to Practice (GAP) discharge tool as part of discharge planning.

Process measure

- Number of patients who receive the completed Discharge Transition tool/ GAP discharge tool at discharge.

Target for process measure

- 95% of all medicine inpatients will receive the completed Discharge Transition tool / GAP discharge tool (whichever is applicable) at time of discharge.

Lessons Learned

Data collection proved to be challenging, as the GAP / Discharge Tool remains a paper-based process, which limited the options available for data capture and interpretation. While we are maintaining this practice with current resources, longer-term evaluation to reduce paper-based/ hybrid processes with the electronic medical record should be considered.

Change Idea #2 ☐ Implemented ☑ Not Implemented

Increase the number of surveys distributed to patients discharged from an inpatient medicine or surgery visit.

Process measure

- The number of surveys distributed to patients post-discharge compared to the survey response rate.

Target for process measure

- Baseline collection year. By December 31, 2024, we will have evaluated the response rate and distribution patterns with the electronic patient experience survey to optimize and inform the next steps.

Lessons Learned

There are many factors impacting the measure that will need to be better understood. Identification and engagement of all stakeholders was key to gather a comprehensive initial data report that can be maintained monthly.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Create a dashboard within the business intelligence platform to share patient experience survey results with QCH leadership.

Process measure

- A patient experience survey results dashboard is created.

Target for process measure

- By September 30, 2024, a digital dashboard will be created in DataShark for QCH leaders to access patient experience survey results.

Lessons Learned

As patient experience survey data can be inconsistent, ensuring cleaning and standardization is crucial for meaningful analysis. Implementing a thorough data cleansing process helps in improving the reliability of this dashboard.

Change Idea #4 ☑ Implemented ☐ Not Implemented

Dissemination of standard work process and education related to discharge practices to inpatient units

Process measure

- Standardized language has been developed and training material has been developed to facilitate the effective dissemination of information related to strong discharge practices.

Target for process measure

- The remaining units (A4 and D4) will deploy the training materials and provide education to the care team by September 30, 2024.

Lessons Learned

Variations in workflows across departments can be a limitation in full adoption of practices. Developing standard work or materials that are able to be utilized as templates/ guides/ or resources and integrated into the sector-specific workflows is optimal.

Comment

QCH will continue to work towards better understanding survey processes to pinpoint areas of continued improvement in response rates. Additional efforts will be undertaken by specific units in standardizing discharge processes and educating and training staff.

Safety | Safe | Optional Indicator

Indicator #4

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. (Queensway-Carleton Hospital)

Last Year		This Year		
85.00	**90**	**84.95**	**-0.06%**	**90**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☐ Implemented ☑ Not Implemented

Creation of Discharge Medication Reconciliation educational tip sheet for surgeons and the department workflow.

Process measure

- Creation of tip sheet about discharge medication reconciliation

Target for process measure

- The tip sheet is created and distributed to 100% of Surgeons by August 31, 2024.

Lessons Learned

Validating the data is important at the start. Though education was provided to Surgeons, we were unable to provide one to one feedback to those with low rates of Discharge Med Rec completion. We will continue this item into next year.

Change Idea #2 ☐ Implemented ☑ Not Implemented

Create and distribute a Discharge Medication Reconciliation educational tip sheet specific to obstetricians and the department workflow.

Process measure

- Creation and distribution of tip sheet about discharge medication reconciliation.

Target for process measure

- The tip sheet is created and distributed to 100% of the Obstetricians by August 31, 2024.

Lessons Learned

We will continue into next year but, the initiative will change from Obstetric and Genecology specific to standardization of documentation for the hospital as a whole. The expectation is the standard documentation changes will be built by end of March. It will take the first two quarters of FY 25/26 to gauge improvement.

Change Idea #3 ☐ Implemented ☑ Not Implemented

The Medication Reconciliation Policy is updated to support the Medication reconciliation practice.

Process measure

- The Medication Reconciliation Policy is updated.

Target for process measure

- By June 30, 2024, the Medication Reconciliation Policy is updated, including the addition of the medication reconciliation workflows.

Lessons Learned

Delay in acuity scoring and document standardization changes which delayed movement of the policy through the approval process. Continue into next year for the approval process of the policy.

Comment

(Q3 Data submitted) Substantial work is underway to better understand and action change ideas to reach our target. Our policy is drafted, however, awaiting finalization of two subprojects: Acuity Scoring for Emergency Patient BPMH and Standardization of Documentation for BPMH. These are to be completed by end of March 25. The policy will then be able to proceed through the approval process.

Surgery overall 01 Mar 24 to 28 Feb 25 is at 78%. Work is ongoing with CHAMP to confirm aspects of Discharge Med Rec completion report, this report will provide increased awareness on areas to focus on for continued improvement with respect to Surgical Med Rec.

Obstetrics and Gynocology overall 01 Mar 24 to 28 Feb is at 60%. Review of the data shows that 5/6 of the non-completed Discharge Med Recs are due prenatal vitamin not being addressed. In 2025-2026, we will focus on standardizing admission BPMH documentation across all units which will ideally move prenatal vitamins to a PCS documentation, removing the need to action on discharge. This will substantially increase the Discharge Med Rec completion rates for this service.

Indicator #8

Rate of delirium onset during hospitalization (Queensway-Carleton Hospital)

Last Year		This Year		
1.91	**2**	**1.60**	**16.23%**	**2**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Create a delirium management documentation intervention in the electronic medical record (EMR).

Process measure

- Creation of delirium management intervention.

Target for process measure

- By March 31, 2025, a delirium management intervention for documentation within the EMR will be created.

Lessons Learned

Protocol is aligned with the QCH corporate policy which staff can refer back to.
Implementation of new EMR (Epic) will support further opportunities to improve on care planning with patients with delirium.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Develop standard of work for delirium recognition and flagging for all patient-facing staff.

Process measure

- Creation of standard work.

Target for process measure

- By March 31, 2025, the standard work for delirium recognition (including the ability to flag for all patient-facing staff) will be created.

Lessons Learned

Corporate delirium policy implemented outlining the process for staff to follow when a patient is flagged as CAM positive.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Staff education on delirium prevention, recognition, and management.

Process measure

- Number of staff trained through education sessions.

Target for process measure

- 150 staff trained by March 31, 2025.

Lessons Learned

Use of various education opportunities including SharePoint, staff huddles, education days, GPA, corporate education module, nursing orientation, etc. was key in educating staff in various ways and extending reach.

Change Idea #4 ☑ **Implemented** ☐ **Not Implemented**

Quarterly chart audits on compliance with the Confusion Assessment Method (CAM) documentation.

Process measure

- Number of chart audits completed per quarter.

Target for process measure

- By March 31, 2025, 80 chart audits are completed (20 audits per quarter).

Lessons Learned

Chart audits have identified that CAM screening is continuing to not be completed accurately. Opportunity for continued staff education in the year ahead.

Comment

Delirium will remain a focus for QCH into 2025-2026. Setting targets to further facilitate staff training and focus on engagement and education of Family and Care Partners by offering education about delirium to people at risk for delirium or who have delirium, and their family and caregivers.

Indicator #9

Rate of workplace violence incidents resulting in lost time injury (Queensway-Carleton Hospital)

Last Year		This Year		
0.18	**0.17**	**0.47**	**-161.11%**	**0.24**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Expand Behaviour Support Ontario (BSO) education sessions beyond nursing to allied health, support services (e.g. security, environmental services and others)

Process measure

- Number of staff trained through BSO education sessions.

Target for process measure

- 15 staff trained in Behaviour Support by Q4 2024-2025.

Lessons Learned

Interdisciplinary focus identified this year which has expanded the ability to build capacity across all care teams.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Increase capacity in each training session for Gentle Persuasive Approach (GPA) techniques.

Process measure

- Number of people in each session and number of sessions provided.

Target for process measure

- 120 staff will be trained by Q4 2024-2025.

Lessons Learned

Opening opportunity to QCH support staff was important to build capacity across various departments. Improved collaboration and knowledge sharing. Supports staff retention.

Change Idea #3 ☐ Implemented ☑ Not Implemented

Update the Handling Aggressive Behaviour e-learning module.

Process measure

- The e-module is updated.

Target for process measure

- By December 31, 2024, the Handling Aggressive Behaviour e-learning module will be updated.

Lessons Learned

Due to competing priorities the module was reviewed for suitability and the module remained appropriate - the plan for update for FY 2025 2026 will be to enhance user experience with added video footage of simulations of actual events. These events will be filmed in collaboration with the Mental Health Team. This will create a more real experience and help further demonstrate the use of de-escalation techniques.

Change Idea #4 ☐ Implemented ☑ Not Implemented

Conduct Occupational Health & Safety Management Systems audit using the Canadian Standards Association (CSA) standard Z45001.

Process measure

- The audit is completed.

Target for process measure

- By March 31, 2025, the audit is completed.

Lessons Learned

Undertaking a Health and Safety Management System audit can be a daunting task. QCH is now ready to start the Audit as of April 1 2025. The audit preparation has been the focus for the last quarter as the timeline was interrupted due to an Auditor unavailability. QCH is excited to embark on this journey as previous audits laid a foundation for a best practice Safety Program. We look forward to success in FY 2025 2026 and are confident that a solid Continuous Improvement Plan will once again position QCH as a leader in the occupational health and safety community.

Change Idea #5 ☑ Implemented ☐ Not Implemented

Implement the Public Services Health and Safety Association (PSHSA) Workplace Violence Risk Assessment (VRA) Tool.

Process measure

- PSHSA VRA Tool implemented (Completion Yes / No).

Target for process measure

- By September 30, 2024, the PSHSA VRA Tool will be implemented.

Lessons Learned

Although some customization was required , the PSHSA VRA Tool is proving to be successful and will remain in use for all VRA going forward. This change idea was a success and will contribute to the effectiveness of our health and safety program.

Change Idea #6 ☑ Implemented ☐ Not Implemented

Implement the agreed upon Violence Risk Assessment (VRA) action items within the Mental Health and Park Place departments.

Process measure

- Percent of actions implemented from the total number of VRA action items.

Target for process measure

- By March 31, 2025, 100% of the agreed-upon action items from the VRA related to Mental Health and Park Place will be fully implemented and completed.

Lessons Learned

All controls in both risk assessments were completed- some are ongoing and are continuously monitored to ensure they reach completion in acceptable timeframes. A very successful approach to our VRA aided by the PSHSA validated Tool and diligence from management ensured controls were adequately addressed.

Comment

QCH will maintain this indicator into future years with goals to align with our target through implementing an interdisciplinary focus. The future approach will focus on areas of elevated risk to allocate resources effectively.