Access and Flow

Measure - Dimension: Efficient

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Alternate level of care (ALC) throughput ratio	O	Ratio (No unit) / ALC patients	WTIS / July 1 2023 - September 30, 2023 (Q2)	0.99	1.00	Our current Alternate Level of Care (ALC) throughput ratio stands at 0.99, slightly surpassing the provincial performance of 0.97. This figure signifies a near equilibrium between ALC cases admitted and discharged. Our target of 1.0 aligns with the ratio set by Ontario Health, indicating parity between the number of ALC cases going out and coming in. This objective acknowledges our present performance and underscores the importance of upholding practices that showcase our dedication to continuous improvement within the context of system constraints. This indicator correlates with the QCH Strategic Goal identified as "Seamless System of Care."	

Change Ideas

Change Idea #1 Increase the implementation and enhance the adoption of ALC Leading practices at QCH throughout the 2024/2025 fiscal year.

Methods	Process measures	Target for process measure	Comments
This indicator requires manual tracking. The Director of Geriatrics and Patient Flow will collect this information.	The number of ALC Leading practices fully met according to the defined criteria of ALC Leading practices during the 2024/2025 fiscal year.	By December 31, 2024, 34 out of 48 ALC leading practices will be fully implemented and met.	Currently, 27 of the 48 ALC Leading practices have been fully met at QCH.

Change Idea #2 Improve the efficiency of the Remote Care Monitoring program to facilitate program expansion to additional patient populations.

Methods	Process measures	Target for process measure	Comments
Measured through the Remote Care Monitoring data tracking report.	Number of patients served by the program volumes per month.	By December 31, 2024, the Remote Care Monitoring program will serve a total of 40 patients per month.	

Measure - Dimension: Timely

Indicator #7	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)	12.77	11.50	Reducing the Emergency Department (ED) Length of Stay (LOS) target by 10% is a conservative target, considering the current system pressures and resource constraints. With our current performance at 12.77, this target brings us closer to the provincial benchmark performance and reflects our commitment to optimizing patient flow and care delivery processes. For the 2024-25 FY, the work will focus primarily around the non-admitted patient population, which will impact the overall ED LOS indicator. This indicator is associated with the QCH Strategic Goal identified as "Seamless System of Care".	

Change Ideas

Change Idea #1 Create standard work for the Patient Care Aides (PCAs) and Nurses to support patient flow and the prioritization of patient acuity to support assessment.

Methods	Process measures	Target for process measure	Comments
Self-measure based on the creation of the standard work.	Creation of the standard work document.	By June 30, 2024, the standard work documented will be created for (PCAs) and Nurses.	

Change Idea #2 Develop communications tools customized to facilitate comprehensive information exchange between physicians and nursing staff during handover.

Methods	Process measures	Target for process measure	Comments
Self-measured based on the creation of the communication tools.	Communication tools created.	By August 31, 2024, the communication tools will be created.	

Change Idea #3 Implementation of the short, focused 'mini-huddles' process and communication tools to create situational awareness and collaboration amongst the department leadership.

Methods	Process measures	Target for process measure	Comments
Manual data collection on training completion by the ED leadership team.	Mini-huddle process and use of communication tools are deployed and put in place.	By November 30, 2024, 80% of the staff in the ED will have received training on the communication tools.	

Measure - Dimension: Timely

Indicator #8	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)	28.83	25.94	Analysis of results and peer benchmarks has informed the development of our target for this indicator. In the fiscal year 2022/23, the provincial 90th percentile Emergency Department wait time for an inpatient bed was 34.7 hours, while in Ontario Large Community Hospitals it was 39.0 hours. Although our current performance surpasses that of our peers, our target is grounded in recent quarterly data and accounts for existing system pressures, ensuring it remains both feasible and reflective of ongoing improvement efforts. This indicator is associated with the QCH Strategic Goal identified as "Seamless System of Care".	

Change Ideas

Change Idea #1 Improve the compliance with the documentation of entering a Predicted Discharge Date (PDD) within 48 hours of admission.

Methods	Process measures	Target for process measure	Comments
Measured on the patient flow card as part of the Time to Inpatient Bed corporate initiative.	Percent of medical inpatients who have a PDD listed within 48 hours of admission	By December 2024, 95% of medical inpatients will have a PDD documented within 48 hours.	The predicted discharge date allows the patient and family to plan for discharge. This year, the focus will be on complying with a documented PDD within the medical record.

Change Idea #2 Reduce the amount of time that patient porters experience delays.

Methods	Process measures	Target for process measure	Comments
Transport Tracking system provides a report on transport wait times in minutes.	The number of minutes of delay in a month.	By December 31, 2024, a reduction of 15% in porter delay minutes, to 4,700 minutes will be realized.	This quality improvement initiative is an extension of the 2023-2024 quality improvement plan. The reduction of overall delays, measured in minutes, will enhance porter transportation services for admitted patients, thereby streamlining the transfer process from the Emergency Department to the inpatient location.

Change Idea #3 Increase the number of patient transportation jobs of patients transferred from the emergency department that are completed within 17 minutes.

Methods	Process measures	Target for process measure	Comments
Report from Teletracking that captures dispatch times.	Number of porter transport jobs completed within the target timeframe.	By December 31, 2024, increase the number of porter transport jobs related to patient transport that are completed within 17 minutes by 15%.	On average, 68% of patient transport jobs are completed within 17 minutes. Reducing the pending dispatch completion wait time for porters for admitted patients in the emergency department who require transportation should increase the percentage of transports completed within the 17-minute target and create efficiencies with timely transfers out of the emergency department to the inpatient location.

Change Idea #4 Standardization of the inpatient rounds process.

Methods	Process measures	Target for process measure	Comments
Self-measured based on the progress of project plan and timelines.	Implementation of the project plan related to standardization of the inpatient rounds process.	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.	A LEAN Greenbelt project will review the rounds process and implement changes to standardize the rounds process and create efficiencies.

Change Idea #5 Develop a patient flow model to facilitate the flow of patients seeking mental health support through the emergency department.

Methods	Process measures	Target for process measure	Comments
Self-measure based on the creation of the patient flow model.	Creation of the patient flow model.	The patient flow model to facilitate the flow of patients seeking mental health support through the emergency department is created by August 31, 2024.	

Measure - Dimension: Timely

Indicator #9	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percent of patients who visited the ED and left without being seen by a physician	O	% / ED patients	CIHI NACRS / April 1st 2023 to September 30th 2023 (Q1 and Q2)	7.04	5.00	This target reflects our commitment to enhancing access to timely and effective emergency care. It has been informed by program-level review and benchmarking against peer organizations, as well as provincial performance for FY Q1/Q2, which currently stands at 5.36%. This indicator is associated with the QCH Strategic Goal identified as "Seamless System of Care".	

Change Ideas

Change Idea #1 Recruitment of a Nurse Practitioner (NP) to the Emergency Department team.

Methods	Process measures	Target for process measure	Comments
To be tracked by the Director of the Emergency Department, when an NP has been onboarded into the Emergency Department.	A Nurse Practitioner is recruited to the ED.	By July 31, 2024, a NP will be recruited and onboarded in the Emergency Department.	The integration of a Nurse Practitioner into the Emergency Department aims to enhance the efficiency of patient assessments, thereby improving the department's capacity to promptly evaluate individuals seeking care. By facilitating earlier assessment (PIA), the NP's presence is anticipated to mitigate the occurrence of patients leaving without being seen (LWBS), consequently contribution to a reduction of the LWBS rate.

Change Idea #2 Alignment of physician resources with patient volume patterns.

Methods	Process measures	Target for process measure	Comments
Self-measure based on the implementation of change(s) to the physician schedule/ resources.	Adjustments to physician resources to align with patient volume patterns is completed.	By September 30, 2024, the process and practice to physician resources to align with patient volume patterns will be in place.	While the target of September 30, 2024, guides the work of instituting a process to adjust physician resources to align with the volume patterns of patients presenting to the emergency department, the richness will be in the ongoing process of evaluating volume patterns and adjusting physician resources to support care needs.

Change Idea #3	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.		
Methods	Process measures	Target for process measure	Comments
Manual data collection by the emergency department leadership.	Percent of triage nurses who have received training.	By June 30, 2024, 100% of triage nurses will be trained on the standard work triage model and expectations surrounding assessment and reassessment.	Initial and reassessment at triage. Audit methodology Standard work development is underway and is slated to be completed by April 30, 2024. This will support the education and roll-out of the triage model and role expectations.

Equity

Measure - Dimension: Equitable

Indicator #3	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	100.00	The target is focused on all staff completing the relevant Equity, Diversity, Inclusion, and Belonging (EDIB) training that is part of onboarding with corporate orientation. We are in the process of collecting baseline data, as this is a relatively new education offering. Setting a target of 100% for all staff to complete EDIB training aligns with our organization's commitment to comprehensively rolling out the EDIB strategy. This target underscores our dedication to fostering a culture of inclusivity from the top down, ensuring that all executives have the necessary knowledge and skills to champion EDIB initiatives effectively. This indicator is associated with the QCH Strategic Goal identified as "Positive Work Life".	

Change Ideas

Change Idea #1 Targeted training for QCH Leaders on RESPECT training.

Methods	Process measures	Target for process measure	Comments
Completion rate of the RESPECT training module tracked through VIP application.	Percent of QCH Leaders (management; formal leaders) who have completed the training.	By March 31, 2025, 100% of QCH Leaders (management) will have completed the RESPECT training.	

Change Idea #2 Develop a comprehensive EDIB learning strategy.

Methods	Process measures	Target for process measure	Comments
Self-measure based on the creation of strategy.	Creation of a written strategy.	Written strategy created by September 30, 2024.	

Change Idea #3 Develop EDIB learning curriculum / training material for all staff to complete.

Methods	Process measures	Target for process measure	Comments
Self-measure based on the creation of the EDIB learning curriculum.	The learning curriculum is developed.	By December 31, 2024, the EDIB learning curriculum and training materia is developed.	

Change Idea #4 Ontario Indigenous Cultural Safety (ICS) training for QCH Leaders.

Methods	Process measures	Target for process measure	Comments
Training is tracked through the ICS report via their website.	Number of QCH Leaders (management) who have completed training.	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).	For 2024-25, we should have approximately 25 seats available for training, and the goal is to ensure that all openings available for training are utilized by the end of the 2024-25 FY.

Experience

Measure - Dimension: Patient-centred

Indicator #4	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	61.26	67.40	Our current performance for this indicator stands at 61.3%. Building on our recent strides and sustained enhancements in this area, we aim to achieve a 10% improvement over the upcoming year. Notably, we observed a 5% increase in performance during the 2023-2024 FY, marking a significant departure from previous years of stagnation. Looking ahead, we are eager to engage in benchmarking initiatives facilitated by the Ontario Hospitals Association. This presents an opportunity to align our practices with industry standards and further enhance our patient experience initiatives. This indicator is associated with the QCH Strategic Goal identified as "Exceptional Care Experience".	

Change Ideas

Change Idea #1 Increase the compliance of completing the Discharge Transition tool/ Guidelines Applied to Practice (GAP) discharge tool as part of discharge planning.

Methods	Process measures	Target for process measure	Comments
Manual tracking of this data is required. This is to be collected through the standardized electronic collection form.	Number of patients who receive the completed Discharge Transition tool/ GAP discharge tool at discharge.	95% of all medicine inpatients will receive the completed Discharge Transition tool / GAP discharge tool (whichever is applicable) at time of discharge.	Total Surveys Initiated: 555 This initiative will focus on the medicine patients initially and will look to scale the process to other departments once the process is stabilized.

Change Idea #2 Increase the number of surveys distributed to patients discharged from an inpatient medicine or surgery visit.

Methods	Process measures	Target for process measure	Comments
Patient relations / Decision Support can provide a report from the Qualtrics patient experience survey platform.	The number of surveys distributed to patients post-discharge compared to the survey response rate.	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.	QCH implemented the new survey solution through Qualtrics, disseminating patient experience surveys via email in October 2023. We are in the process of understanding this new workflow and optimizing the distribution of surveys to a diverse patient group.

Change Idea #3 Create a dashboard within the business intelligence platform to share patient experience survey results with QCH leadership.

Methods	Process measures	Target for process measure	Comments
Creation of a digital dashboard displaying patient experience survey results for QCH leaders.	A patient experience survey results dashboard is created.	By September 30, 2024, a digital dashboard will be created in DataShark for QCH leaders to access patient experience survey results.	Establishing a digital platform for QCH leaders to access patient experience data will streamline the dissemination process of survey results throughout the organization. This initiative will empower leaders to promptly analyze feedback and identify areas for improvement, fostering a culture of continuous improvement in response to patient input.

Change Idea #4 Dissemination of standard work process and education related to discharge practices to inpatient units

Methods	Process measures	Target for process measure	Comments
Manual tracking of this indicator is required. This will be collected by the discharge practice champion project lead.	Standardized language has been developed and training material has been developed to facilitate the effective dissemination of information related to strong discharge practices.	The remaining units (A4 and D4) will deploy the training materials and provide education to the care team by September 30, 2024.	This quality improvement work was associated with the 2023-24 quality improvement plan within the medicine team. The team successfully implemented the materials and program in the inpatient medicine units. This change idea will support the finalization of the rollout with the remaining units in 2024-25 FY to support discharge practices and enhance communication and the patient experience.

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	85.00	90.00	QCH demonstrates consistent performance in discharge medication reconciliation practices, with numerous departments achieving compliance rates exceeding 90%. However, targeted efforts in specific services to enhance overall compliance rates and achieve targeted improvements will drive continued improvement work in this area. With an overarching target of 90% (and a stretch goal of 95%), this initiative aligns with our commitment to ensuring patient safety and quality care throughout the discharge process. This indicator aligns with the QCH Strategic Goal identified as "Exceptional Care Experience".	

Change Ideas

Change Idea #1 Creation of Discharge Medication Reconciliation educational tip sheet for surgeons and the department workflow.

Methods	Process measures	Target for process measure	Comments
Self-measure based on the creation and distribution of the tip sheet.	Creation of tip sheet about discharge medication reconciliation	The tip sheet is created and distributed to 100% of Surgeons by August 31, 2024.	

Change Idea #2 Create and distribute a Discharge Medication Reconciliation educational tip sheet specific to obstetricians and the department workflow.

Methods	Process measures	Target for process measure	Comments
Self-measure based on the creation and distribution of the tip sheet.	Creation and distribution of tip sheet about discharge medication reconciliation.	The tip sheet is created and distributed to 100% of the Obstetricians by August 31, 2024.	

Change Idea #3 The Medication Reconciliation Policy is updated to support the Medication reconciliation practice.

Methods	Process measures	Target for process measure	Comments
Self-measured by the Policy MRP (Director of Pharmacy) that the policy has been updated and approved for circulation.	The Medication Reconciliation Policy is updated.	By June 30, 2024, the Medication Reconciliation Policy is updated, including the addition of the medication reconciliation workflows.	

Measure - Dimension: Safe

Indicator #5	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)	1.91	2.00	Setting a target of 2.0% for the rate of delirium onset during hospitalization aligns with our commitment to enhancing patient care and safety. While our current performance stands at 1.91%, our focus this year is on improving the identification and reporting of delirium cases, which may result in a slight increase in reported incidents. This target reflects our dedication to proactive monitoring and intervention, ensuring early detection and appropriate management of delirium to improve patient outcomes and overall quality of care. This indicator is associated with the QCH Strategic Goal identified as "Exceptional Care Experience".	

Change Ideas

Change Idea #1 Create a delirium management documentation intervention in the electronic medical record (EMR).

Methods	Process measures	Target for process measure	Comments
Self-measure based on the creation of a delirium management intervention within the EMR.	Creation of delirium management intervention.	By March 31, 2025, a delirium management intervention for documentation within the EMR will be created.	

Change Idea #2 Develop standard of work for delirium recognition and flagging for all patient-facing staff.

Methods	Process measures	Target for process measure	Comments
Self-measured based on completion of standard work creation (completed Yes / No).	Creation of standard work.	By March 31, 2025, the standard work for delirium recognition (including the ability to flag for all patient-facing staff) will be created.	

Change Idea #3 Staff education on delirium prevention, recognition, and management.

Methods	Process measures	Target for process measure	Comments
Manual tracking for this indicator is required. This is to be collected by the Geriatrics team.	Number of staff trained through education sessions.	150 staff trained by March 31, 2025.	

Change Idea #4 Quarterly chart audits on compliance with the Confusion Assessment Method (CAM) documentation.

Methods	Process measures	Target for process measure	Comments
Manual tracking of this indicator is required. This is to be collected by those responsible for the chart audits.	Number of chart audits completed per quarter.	By March 31, 2025, 80 chart audits are completed (20 audits per quarter).	

Measure - Dimension: Safe

Indicator #6	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	0.18	0.17	This indicator is associated with the QCH Strategic Goal identified as "Positive Work Life".	

Change Ideas

Change Idea #1 Expand Behaviour Support Ontario (BSO) education sessions beyond nursing to allied health, support services (e.g. security, environmental services and others)

Methods	Process measures	Target for process measure	Comments
Advanced Practice Nurse in Geriatrics manually tracks all staff trained.	Number of staff trained through BSO education sessions.	15 staff trained in Behaviour Support by Q4 2024-2025.	Providing education assoicated with Behaviour Support gives staff additional tools to de-escalate situations that can arise with patients experiencing dementia, with a goal to avoiding a violent interaction.

Change Idea #2 Increase capacity in each training session for Gentle Persuasive Approach (GPA) techniques.

Methods	Process measures	Target for process measure	Comments
The Advanced Practice Nurse in Geriatrics manually tracks all sessions offered.	Number of people in each session and number of sessions provided.	120 staff will be trained by Q4 2024-2025.	The team is planning to have up to 20 people trained in each of 6 education sessions planned.

Change Idea #3 Update the Handling Aggressive Behaviour e-learning module.

Methods	Process measures	Target for process measure	Comments
Updates to the Handling Aggressive Behaviour e-learning module is completed.	The e-module is updated.	By December 31, 2024, the Handling Aggressive Behaviour e-learning module will be updated.	

Change Idea #4 Conduct Occupational Health & Safety Management Systems audit using the Canadian Standards Association (CSA) standard Z45001.

Methods	Process measures	Target for process measure	Comments
Completion of the audit is tracked manually through an internal process by the Safety Officer.	The audit is completed.	By March 31, 2025, the audit is completed.	ISO/CSA Z45001 standard specifies the requirements and provides guidance to enable organizations to provide safe and healthy workplaces by preventing work-related injury and ill health, as well as by proactively improving their OHS performance.

Change Idea #5 Implement the Public Services Health and Safety Association (PSHSA) Workplace Violence Risk Assessment (VRA) Tool.

Methods	Process measures	Target for process measure	Comments
Self-measure based on the implementation of the PSHSA VRA Tool.	PSHSA VRA Tool implemented (Completion Yes / No).	By September 30, 2024, the PSHSA VRA Tool will be implemented.	

Change Idea #6 Implement the agreed upon Violence Risk Assessment (VRA) action items within the Mental Health and Park Place departments.

Methods	Process measures	Target for process measure	Comments
Self-measure based on the implementation and completion of the action items from the VRA actionable items.	Percent of actions implemented from the total number of VRA action items.	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.	