24/25 Workplan

24/25 QIP Indicator Description (Measures)

QIP Indicator Name	Description
90th Percentile ED Wait Time to Inpatient Bed	90th percentile wait time (hours) for patients admitted from the ED to an inpatient bed or operating room, where wait time is from Disposition Date/Time until the Date/Time Patient Left Emergency Department for admission.
Discharge Summaries within 2 Days	Percentage of patients (who have a Family Provider noted in their Health Record) discharged from hospital for which discharge summaries are sent to their primary care provider within 2 days of discharge.
Patient Experience	Percentage of respondents answering 9 or 10 when asked to rate their hospital experience/care/ stay, where 0 is the worst and 10 is the best.
Workplace Violence Incidents Resulting in Lost Time or Healthcare	Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period, that result in Lost Time or Healthcare
Hospital Acquired Pressure Injuries at Prevalence	Percentage of patients with a new stage 2+ hospital acquired pressure injury (HAPI) identified during the quarterly pressure injury prevalence study.
Inpatient Falls Resulting in Moderate+ Harm	Percentage of reported inpatient falls that result in moderate or higher harm (as a proportion of all inpatient falls and near-miss falls reported in SafePoint).
Equity	Percentage of leaders who completed relevant equity, diversity, inclusion, and antiracism education

2024/25 Indicators and Targets

Strategic Goal	Quality Dimension	Indicator	20/21	21/22	22/23	Current YTD (23/24) Performance	23/24 Target	24/25 Target
Own our role to improve the system	Timely	90th Percentile ED Wait Times	23.9hrs	23.4hrs	34.5hrs	39.5hrs	31.5	31.5
Champion a culture of exemplary care and deliver clinical excellence	Patient Centred	Discharge Summaries in 2 Days	85%	87%	86%	88.3%	90%	90%
	Effective	Patient Experience	67%	66%	N/A	68.3%	67%	67%
	Safe	Workplace Violence Incidents resulting in lost time or employee needing to seek healthcare	N/A	26	32	31	26	26
		New HAPI (Hospital Acquired Pressure Injuries) at Prevalence	9.2%	9.5%	7.3%	4.6%	7.0%	5.0%
		Inpatient Falls with MOD+ Harm	2.0%	2.2%	1.6%	1.6%	1.6%	1.4%
Create an environment where the best experiences happen	Equitable	Equity (Percentage of leaders who completed relevant diversity, equity, inclusion, and antiracism education)	New Indicator N/A					100%

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Executive Summary

Indicator	Change Ideas	Indicator Lead(s)
90th Percentile ED Wait Time to Inpatient Bed	• Implement an electronic transfer of Accountability (TOA)	Katrina Scott
Discharge Summaries within 2 Days	• Physician Leader-Driven Performance Improvement Program	Dr. John Randle/Puneet Sandhu
Patient Experience	• Establish an Essential Care Partner (ECP) Program • Dashboard will be implemented in 2024-25 for standardized analysis • Leadership Rounding	Sarah Alisch
Workplace Violence Incidents Resulting in Lost Time or Healthcare	• Develop a Workplace Violence Prevention awareness campaign	Menka Anand
Hospital Acquired Pressure Injuries at Prevalence	• Improve patient safety by optimizing current and new capital resources • Provide education to Essential Care Partners • Seek opportunities to improve documentations through education to staff	Sarah Alisch
Inpatient Falls Resulting in Moderate+ Harm	• Provide education to Essential Care Partners • Implement improvements to information shared related to falls risk during Transfer of Accountability (TOA)	Sarah Alisch
Equity	• Provide training and education opportunities for leaders to build foundational knowledge in Diversity, Equity and Inclusion (DEI) • Provide an unconscious bias training module to all leaders	Chantelle Vernon

Lead: Katrina Scott

90th Percentile ED Wait Time to Inpatient BED

Definition: 90th percentile wait time (hours) for patients admitted from the ED to an inpatient bed or operating room, where wait time is from Disposition Date/Time until the Date/Time Patient Left Emergency Department (ED) for admission.

Change Ideas	Methods	Process Measures	Target for Process Measure	Comments
Implement an electronic Transfer of Accountability (TOA) to streamline patient handoffs while minimizing or eliminating the need for multiple phone calls. By implementing an electronic TOA system, the hospital can significantly enhance the safety and efficiency of patient transfers from the ED to inpatient units. This method focuses on creating a standardized, integrated, and user-friendly system, supported by thorough training and continuous monitoring, thereby reducing the reliance on phone calls while ensuring a high standard of patient care.	• Implement steps to ensure a smooth, reliable, and efficient transfer of information. • Integrate the electronic TOA process into the existing workflows of both the ED and inpatient units to ensure it complements and enhances current practices. • Automate notifications within Meditech to alert inpatient staff when a patient is ready for transfer and when the TOA is complete.	• Percentage of steps taken to implement the electronic TOA	• Percentage of steps taken to implement the electronic TOA	

Discharge Summaries in 2 Days

Definition: Percentage of patients (who have a Family Provider noted in their Health Record) discharged from hospital for which discharge summaries are sent to their primary care provider within 2 days of discharge.

Change Ideas	Methods	Process Measures	Target for Process Measure	Comments
Physician Leader-Driven Performance Improvement Program	• Involve physician leaders in actively monitoring, guiding, and supporting Most Responsible Physicians (MRPs) in low-performing programs. The focus is on personalized intervention, feedback, and continuous improvement.	• Measure the regularity of interventions or meetings between physician leaders and MRPs in low-performing programs.	• Minimum of 1 interventions or meeting between physician leader and MRP with the low performing program.	

Workplace Violence Incidents with LT/HC

Definition: Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period, that result in Lost Time ("LT") or Healthcare ("HC").

Change Ideas	Methods	Process Measures	Target for Process Measure	Comments
Develop a Workplace Violence Prevention awareness campaign Workplace Violence Prevention (WPVP) program helps increase understanding and appreciation for the importance of the program across the organization. Increased understanding of hospital protocols and policies on workplace violence helps create a safer and more resilient work environment. In addition, the program also helps increase accountability by building capacity across the organization to make it more reliable.	• Review and revamp the WPVP program in collaboration with key stakeholders to increase engagement. • Engage with the WPVP committee and corporate communications to develop an awareness campaign to communicate key elements and resources of the WPVP. • Actively involve hospital leadership in promoting and participating in WPVP program activities to support buy-in. • Ensure that all resources related to the WPVP are easily accessible to staff. This can include digital resources, printed materials, and direct contacts for immediate assistance. .	• % Completion of the awareness campaign	• 100% completion of the campaign by Q4 2024/25	Our objective is to enhance awareness of the Workplace Violence Prevention (WPVP) program and our zero-tolerance policy in the workplace, while also increasing familiarity with the training and resources available to staff.

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Workplace Violence Incidents with LT/HC (Cont'd)

Definition: Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period, that result in Lost Time or Healthcare.

Change Ideas	Methods	Process Measures	Target for Process Measure	Comments
Increase the frequency of Public Services Health and Safety Association (PSHSA) Risk Assessments Completing frequent and timely risk assessments is essential in minimizing the number of workplace violence incidents reported by hospital workers, as defined by OSHA, over a 12-month period that lead to lost time or healthcare needs. These assessments proactively identify and mitigate potential hazards, ensuring a safer environment for employees. By thoroughly analyzing and addressing risks, hospitals can implement effective strategies to prevent violent incidents, thereby safeguarding workers and minimizing disruptions in healthcare delivery due to lost time or injuries. This proactive approach not only enhances the safety and well-being of hospital staff but also contributes to a more stable and efficient healthcare system.	• Engage with leaders to gain strong support and endorsement for the completion of proactive risk assessments • Provide comprehensive training on how to conduct risk assessments at Clinical Services Huddle. • Use the PSHSA Risk Assessment Tool to complete proactive risk assessments for all clinical units. • Incorporate risk assessments into regular workflows and protocols to enable annual completion of risk assessment and following any changes to the use of the physical workspace. • Develop measuring and monitoring methodology	• Number of units requiring risk assessments • % of leaders who have completed the necessary training • Number of programs with up-to-date risk assessment • Number of units/programs that complete the risk assessments per month. • % of completion month by month	• 100% of units or clinical units that complete at least one risk assessment in fiscal 24/25 • 100% completion of risk assessment training for clinical leaders.	Our current risk assessments were completed for each program in 2018, they require updating.

Patient Experience

Definition: Percentage of respondents answering 9 or 10 when asked to rate their hospital experience/care/ stay, where 0 is the worst and 10 is the best.

Change Ideas	Methods	Process Measures	Target for Process Measure	Comments
Initiate and implement an Essential Care Partner (ECP) Program.	• Integrate and enhance ECPs role in the patients care team, allowing them to participate in care planning of their loved ones to support decision-making, and daily care activities with guidance of healthcare professionals. • Establish clear communication channels and protocols between ECPs, patients, and healthcare teams to ensure coordinated care and shared decision-making. • Provide resources and support to ECPs, including educational materials, access to care plans, and guidance on best practices in patient support.	• % of ECP initiatives identified that are implemented • Regularly collect and analyze feedback from staff, patients and families, caregivers, and physicians to assess satisfaction with the ECP Program and identify areas of improvement.	100% of ECP initiatives by end of fiscal 2024/25.	Patients with an active ECP are more likely to be engaged in their overall care. This engagement can lead to better health outcomes and increased patient satisfaction.

Patient Experience (Cont'd)

Definition: Percentage of respondents answering 9 or 10 when asked to rate their hospital experience/care/ stay, where 0 is the worst and 10 is the best.

Change Ideas	Methods	Process Measures	Target for Process Measure	Comments
Improving the patient experience through increased access to real time data to inform improvement strategies.	• Engage with decision support and clinical programs, to understand how to extract data from Qualtrics to help inform strategies for patient experience improvement. • Establish mechanisms to share real time data at all levels of the organization.	% of clinical leaders to have access to real time data from Qualtrics.	100% of all leaders to have access to their own Qualtrics dashboards by end of Q2 .	Empowering leaders to share real time data with their teams to help monitor the impact of their initiatives and to improve patient satisfaction.
Improve the patient experience with leader rounding.	• Implement a standardized leadership rounding program. • Patient Experience Office to conduct regular check-ins with leaders to support any concerns. • Patient Relation Office to create a standardized toolkit to support the sustainability of roundings.	• % of clinical leaders rounding daily (Inpatient) • Completion date of standardized toolkit	• 100% of clinical leaders rounding daily • Develop Tool kit by end of Q1	Clinical leader rounding improves communication with patients and families and enables leaders to promptly engage in service recovery.

HAPI (Hospital Acquired Pressure Injuries) at Prevalence

Definition: Percentage of patients with a new stage 2+ hospital-acquired pressure injury (HAPI) identified during the quarterly pressure injury prevalence study.

Change Ideas	Methods	Process Measures	Target for Process Measure	Comments
Improve patient safety by optimizing current and new capital resources.	• Optimize equipment to enhance patient care as it relates to pressure injury prevention.	• Monitor the availability of pressure injury prevention equipment in patient care areas and allocate appropriately.	• 100% of patients with pressure injuries or at high risk for pressure injuries.	Relieving surfaces on beds and stretchers will help prevent pressure injuries.
Provide education to Essential Care Partners (ECPs)	• Develop and provide education to ECPs on their role in preventing pressure injuries.	• Create formal education materials. • Provide education to interested ECPs.	• Formal education materials created by Q3 • 100% by end of fiscal 24/25	Educating ECPs about prevention strategies, such as regular repositioning, skin care, nutrition, and hydration for the prevention of pressure injuries.
Seek opportunities to improve documentation through education to staff.	• Improve the quality and thoroughness of pressure injury documentation by educating healthcare staff on best practices. This includes recognizing the stages of pressure injuries, accurately charting their progression, and noting preventive measures taken.	• Education materials created and available to nurse educators by the beginning of Q3, with education provided by the end of Q3.	• 100% of project completion by Q3	Standardized documentation can help with detection and early assessment of pressure injuries. There is a greater ability to learn from standardized data about our ongoing opportunities for pressure injury reduction when we have accurate and complete data in the patient record.

Lead: Sarah Alisch

Inpatient Falls Resulting in Serious Harm

Definition: Percentage of reported inpatient falls that result in moderate or higher harm (as a proportion of all inpatient falls and near-miss falls reported in SafePoint)

Change Ideas	Methods	Process Measures	Target for Process Measure	Comments
Provide education to Essential Care Partners (ECPs)	• Develop and provide education to ECPs on their role in preventing inpatient falls • Investigate flexible and accessible training Formats.	• Create formal education materials. • Provide education to interested ECPs.	• Formal education materials created by Q3 • 100% by end of fiscal 24/25	Educating ECPs about prevention strategies, such as using call bells to ambulate, wearing shoes, making a safe environment, empowers them to actively participate in the prevention of falls.
Implement improvements to information shared related to falls risk during Transfer of Accountability (TOA)	• Create a standardized process for TOA from ED to inpatient units	Create the standardized process for TOA and establish necessary tools for support by end of Q2 and implement process and tool by the end of Q3.	100%	Standardized communication about falls risk is essential at care transitions to best support patients and reduce the risk of falls.

Equity

Definition: Percentage of leaders who completed relevant diversity, equity, inclusion, and antiracism education.

Change Ideas	Methods	Process Measures	Target for Process Measure	Comments
Provide training and education opportunities for leaders to build foundational knowledge in Diversity, Equity and Inclusion (DEI).	Implement DEI module in core-curriculum	Creation and integration of DEI module into core curriculum	Module available in core curriculum in the next fiscal year (24/25).	
Provide an unconscious bias training module to all leaders.	• Engage in a procurement process to identify a vendor for the implementation of a unconscious training module. • Integrate the unconscious training module into SOLS.	Procurement and integration of a unconscious training module.	100 % of all Leaders by end of fiscal year 2024/2025.	