Access and Flow

Measure - Dimension: Efficient

Indicator #1	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)	CB	CB	ALC throughput ratio calculation: ALC patients discharged in a given time period divided by the number of ALC patients designated in a given time period. Through put ratio above 1 indicates reduction in number of ALC patients.	

Change Ideas

Change Idea #1 Early identification of patients with potential discharge barriers at time of admission.

Methods	Process measures	Target for process measure	Comments
Creation and implementation of a tool to capture the ability to early identify patients with potential discharge barriers leading to alternative level of care needs.	% of audits where tool was utilized appropriately prior to admission.	20% of audits where tool was utilized appropriately prior to admission.	

Measure - Dimension: Timely

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Emergency Department wait time to inpatient bed	C	Hours / ED patients	CIHI NACRS / April 1, 2023 to June 30th 2023 (Q1)	15.40	12.00	90th percentile	

Change Ideas

Change Idea #1 Reduction in Physician Initial Assessment (PIA) Wait Times

Methods	Process measures	Target for process measure	Comments
Incorporate new staffing model to include a Nurse Practitioner	Hour to when patient is initially seen by MRP (MD or NP)	3hr wait time to be seen by MRP	

Change Idea #2 Reduction in wait times for bed to be cleaned on In patient unit

Methods	Process measures	Target for process measure	Comments
Prioritization of bed cleans after patient discharged	% of audits showing bed space clean completed within 60 minutes of discharged patients bed being unoccupied	60% of audits indicate bed space clean within 60 minutes of being unoccupied	

Change Idea #3 Improve bed ahead strategies through the utilization of standardized discharge expectations

Methods	Process measures	Target for process measure	Comments
Physicians to identify discharges by 10am on the inpatient unit	% of discharges that had discharge ordered before 10am	60% of discharges had discharge ordered before 10am	

Equity

Measure - Dimension: Equitable

Indicator #2	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	0.00	90.00	Theoretical best	

Change Ideas

Change Idea #1 Educate Executive team using SAN'YAS Anti-racism Indigenous Cultural Safety Training

Methods	Process measures	Target for process measure	Comments
All members to register for on-line-self directed program	% of executive team with course completion	100% of executive team with course completion	

Change Idea #2 Educate Management team using SAN'YAS Anti-racism Indigenous Cultural Safety Training

Methods	Process measures	Target for process measure	Comments
All members to register for on-line, self directed program	% of management team with course completion	100% of management team with course completion	

Change Idea #3 Educate Trustees using SAN'YAS Anti-racism Indigenous Cultural Safety Training

Methods	Process measures	Target for process measure	Comments
All members to register for on-line, self directed program	% of trustees with course completion	100% of trustees with course completion	

Change Idea #4 Educate all staff using SAN'YAS Anti-racism Indigenous Cultural Safety Training			
Methods	Process measures	Target for process measure	Comments
All staff to register for on-line, self directed program.	% of staff with course completion	90% of staff with course completion	

Change Idea #5 Educate management and clinical chiefs using the Inclusion, Diversity, Equity and Anti-Racism IDEA principles			
Methods	Process measures	Target for process measure	Comments
Management and clinical chiefs to participate in education sessions occurring throughout the year	% of management and Clinical Chiefs that have completed required # of sessions	90% of management and Clinical Chiefs that have completed required # of sessions	

Experience

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of respondents who report inequities in care	C	% / All patients	Local data collection / April 1, 2023-December 31, 2023	1.00	0.00	Theoretical best. We do not want any patient to experience inequities in care.	

Change Ideas

Change Idea #1 Elevate staff understanding of individual patient's life experiences in order to deliver effective care and improve patient engagement, treatment adherence, health outcomes and provider and staff wellness

Methods	Process measures	Target for process measure	Comments
Provide Trauma informed care education	% of clinical staff that complete education	40% of clinical staff complete education	

Change Idea #2 Increase opportunities to hear the patients voice to reduce concerns in the moment

Methods	Process measures	Target for process measure	Comments
Create a Patient and Family Advisory Council (PFAC) Patient Rounding Program	# of patient rounding experiences performed by the end of the year	30 patients will have been rounded on by PFAC members	

Change Idea #3 Increase accessibility to electronic patient health records.

Methods	Process measures	Target for process measure	Comments
Implement the utilization of Dragon Medical One (DMO) for electronic documentation by medical staff.	% of providers trained to utilize Dragon Medical One device for electronic documentation.	80% of providers trained to utilize Dragon Medical One device for electronic documentation.	

Safety

Measure - Dimension: Safe

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Reduction in Work Place Violence incidents resulting in injury, severity level 3 or higher.	C	Count / Staff	Local data collection / April 1, 2023-December 31, 2023	5.00	4.00	20% reduction	

Change Ideas

Change Idea #1 Incorporate employee input Corporate management of Workplace Violence strategies

Methods	Process measures	Target for process measure	Comments
Implement actionable strategies determined by the senior team as identified by responses from the clinical employee workplace violence survey	% of actionable strategies actioned by the end of the year	80% of actionable strategies actioned by the end of the year	