Access and Flow

Measure - Dimension: Timely

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Daily average number of patients waiting in the emergency department for an inpatient bed at 8 a.m.	P	Number / ED patients	CIHI NACRS / April 1, 2024, to March 31, 2025 (i.e., FY 2024)	0.23	0.19	20% reduction based on ALC throughput	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1 Implement a daily "Bed Ahead" Coordination Huddle between the ED Charge Nurse, Inpatient Unit (IPU) Charge Nurses, and the House Supervisor to pre-assign beds for anticipated admissions before they are officially requested.

Methods	Process measures	Target for process measure	Comments
Every weekday morning, a rapid-cycle huddle will occur to review the current ED "admit" list against predicted discharges on the inpatient floors.	The percentage of audited weekdays where a "Bed Ahead" plan was documented with participation from ED, IPU, and Supervision.	60% of audited days	

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	11.86	35.00	Focusing on front facing staff during this implementation phase, expanding organizationally until 80% of all FT/PT staff have completed education.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1 Enhance staff awareness of unconscious bias and foster a culture that actively promotes equity, diversity, inclusion, and anti-racism.

Methods	Process measures	Target for process measure	Comments
Diagnostic Imaging Staff are to be trained in Anti-Racism Indigenous Cultural Safety Training Program.	80% of the Diagnostic Imaging Department will have registered and completed corporate's endorsed Indigenous Cultural Safety Training program within the 2026-2027 fiscal year.	80% of staff will confirm completion of the program.	

Change Idea #2 Enhance staff awareness of unconscious bias and foster a culture that actively promotes equity, diversity, inclusion, and anti-racism.

Methods	Process measures	Target for process measure	Comments
Laboratory Staff are to be trained in Anti-Racism Indigenous Cultural Safety Training Program.	80% of the Laboratory Department will have registered and completed corporate's endorsed Indigenous Cultural Safety Training program within the 2026-2027 fiscal year.	80% of staff will confirm completion of the program.	

Change Idea #3 Enhance staff awareness of unconscious bias and foster a culture that actively promotes equity, diversity, inclusion, and anti-racism.

Methods	Process measures	Target for process measure	Comments
Patient Registration Staff are to be trained in Anti-Racism Indigenous Cultural Safety Training Program.	80% of the Patient Registration Department will have registered and completed corporate's endorsed Indigenous Cultural Safety Training program within the 2026-2027 fiscal year.	80% of staff will confirm completion of the program.	

Experience

Measure - Dimension: Patient-centred

Indicator #2	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	52.00	70.00	Canadian Institute for Health Information (CIHI) Top Box data Patient Satisfaction with Nursing Care Quality Questionnaire (PSNCQQ)	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1 Enhance the Readiness Assessment to include a collaborative approach to pre-discharge planning session involving the multidisciplinary Team, the patient, and their designated support network to identify post-hospitalization education and support needs.

Methods	Process measures	Target for process measure	Comments
A Transition Planning Circle will be triggered 48 hours before the expected discharge date. This assessment involves Physiotherapy, Occupational Therapy, Pharmacy, and Nursing collaborating with the patient's family to identify specific "worry points" (e.g., wound care, red-flag symptoms, or medication side effects). A personalized "What If" Action Plan will be co-created, providing the patient with clear, written instructions and a direct contact number for concerns, ensuring they feel "completely" informed before leaving.	The percentage of audited complex patient files that contain a completed Multidisciplinary Readiness Assessment involving at least one family member or support person.	60% of complex patient discharges will have a documented Collaborative Readiness Assessment completed prior to discharge.	Total Surveys Initiated: 50 Complex Patient is defined as an individual 60 years or older who also presents with a low Braden score (indicating skin integrity risk), a high frailty score (indicating significant functional impairment), and is unattached (lacking a primary care provider).

Change Idea #2 Develop and implement a standardized "Transition Toolkit," including a physical Discharge Envelope for patients and a formal Discharge Standard Operating Procedure (SOP).

Methods	Process measures	Target for process measure	Comments
To eliminate variability in what patients receive, the team will design a "Discharge Envelope" that acts as a central hub for all education materials, prescriptions, and follow-up dates. Simultaneously, a Discharge SOP will be created to reflect these new steps. To ensure successful adoption, a mandatory "Transition Excellence" education module will be rolled out to all unit staff, covering the new SOP and the use of the standardized templates.	Percentage of unit staff who have completed the "Transition Excellence" training and demonstrated competency in the new SOP.	80% of staff will have completed the training and have access to the standardized toolkit.	

Change Idea #3 Hardwire patient education into the clinical workflow by making the "Education Reviewed" section on the Discharge Summary.

Methods	Process measures	Target for process measure	Comments
The Discharge Summary will be modified to include an "Education Provided" section. This forces a pause in the workflow to reflect on the patient’s understanding. The categories will correspond to the gaps identified during the earlier Collaborative Readiness Assessment.	Percentage of 'complex patient' discharge summaries audited where the "Education Reviewed" section is completed with specific, relevant categories documented.	60% of audits will show that the education section has been appropriately selected and documented.	

Safety

Measure - Dimension: Safe

Indicator #3	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	0.00	0.00	Maintain zero harm	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1 Establish a standardized, psychologically safe approach to post-incident recovery following incidents of workplace violence.

Methods	Process measures	Target for process measure	Comments
Formal Post-Incident Debrief Training will be provided to leadership to establish a standardized, psychologically safe approach to post-incident recovery following incidents of workplace violence.	The percentage of Directors who have completed the Formal Post-Incident Debrief training module.	80% of Directors complete training.	

Change Idea #2	Standardize the use of the Violence and Aggression Assessment Tool (VAAT) across ED, and inpatient unit to proactively identify and flag patients with a high risk for aggressive behavior upon admission or change in status.		
Methods	Process measures	Target for process measure	Comments
All ED and inpatient Registered Nurses and Registered Practical Nurses will receive education on how to integrate the VAAT into their baseline assessments. This tool scores dynamic risk factors (e.g., confusion, irritability, verbal threats). When a high-risk score is identified, it triggers an immediate Behavioral Care Plan, which may include increased rounding, specialized signage, or early multidisciplinary intervention. By "flagging" risk early, staff can apply de-escalation techniques before a physical assault occurs, preventing injuries that lead to lost time.	The percentage of ED and inpatient staff who have completed the VAAT Competency Education.	80% of staff complete the training.	

Change Idea #3	Strengthening the escalation chain by ensuring Directors possess the clinical competency to translate VAAT data into actionable oversight and resource allocation.		
Methods	Process measures	Target for process measure	Comments
VAAT training will be completed by all Clinical Directors by to ensure leadership competency in the identification, escalation, and oversight of patient aggression risk.	Percentage of Clinical Directors that complete competency training.	100% of all Clinical Directors will complete education.	