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	Target established by HRH	

Change Ideas

No Data Available

Change Idea #1	1. Maintain weekly ALC rounds across all departments utilizing the I-Plan platform. 2. Implement CAM assessment in ED for all admitted patients 64 years of age or older. 3. Provide Standardized ALC designation education to GIM physicians utilizing CIHI ALC guidelines 4. Provide targeted education to managers, Responsible Persons (RPs), and social workers (SWs) on discharge pathways. 5. Optimize RM&R training for all RPs and Team Leads (TLs) in the inpatient units.		
Methods	**Process measures**	**Target for process measure**	**Comments**
Implement initiatives to enhance adherence to the discharge planning pathway process. Explore enhancements in iPlan to support the optimal use of the Discharge Planning Pathway. 1. Maintain weekly ALC rounds across all departments utilizing the I-Plan platform a. Engage interdisciplinary members. b. Built capacity by inviting two more external partners to the ALC meeting. c. Refresh the ALC rounds structure. 2. Implement CAM in ED for all admitted patients 64 years of age or older. a. Build the CAM assessment tool in Meditech. b. Provide CAM assessment education to ED nurses. c. Implement CAM assessment for all admitted patients 64 years or older. 3. Provide standardized ALC Designation Education to GIM physicians utilizing CIHI ALC guidelines. a. Provide ALC designation education to GIM physicians. b. Provide the CIHI ALC guidelines to GIM physicians. 4. Provide targeted education to managers, Responsible Persons (RPs), and social workers (SWs) on discharge pathways. a. Schedule 3 education sessions for RPs, SWs, and managers. 5. Optimize RM&R training for all RPs and Team Leads in the inpatient units a. Schedule 5 education sessions for RPs and TLs.	1. Percent of ED nurses trained in CAM assessment. 2. Percent of CAM assessment completed for admitted patients >64 yrs. 3. Percent of GIM physicians trained on CIHI ALC designation. 4. Percent of SWs trained on discharge planning pathway. 5. Percent of RPs trained on discharge planning pathway. 6. Percent of managers trained on discharge planning pathway. 7. Percent of RPs and TLs trained on RM&R	The target for the process measures is completion of 80% or higher	It is important to note risks and balancing factors that may influence the targets set in the QI plan. There has been a significant rise in ALC rate across Ontario and Central Region. System capacity pressures (e.g., outbreaks, decrease in LTC beds due to LTC closures, limited HSSC capacity) continue to limit the flow of patients from acute care hospitals into post acute and community settings.

Measure - Dimension: Timely

Indicator #10	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)	10.50	9.00	Target established by Health Quality Ontario	

Change Ideas

No Data Available

Change Idea #1	1. Introducing a fourth nurse at front triage to reduce the number of pre-triage patients waiting to be seen. 2. Standardization of the ED PFM role to optimize bed management strategies to expedite patient admission, discharge, and transfers. 3. Update ramp-down staffing strategies to ensure that SA surge nurse position is always filled, maximizing ED bed capacity. 4. Work with other departmental directors to create surge capacity on the floors when ED admissions surpass 24 hours. 5. Implementation of ScaleAI – queuing technology aimed to improve patient experience by reducing in hospital wait and PIA times. 6. Collaborate with inpatient managers to create a pull culture when transferring patients to the inpatient unit. 7. ED Redesign project – examination of current ED physical layout and potential restructuring (see potential structural changes) a. Evaluate the workflow of triage, O-Zone, EMS triage, Acute and Subacute b. Reallocation of OZ-CDU room to designated TAT room 8. Implement comprehensive care plans, order sets and follow-up protocols for individuals with sickle cell disease.

Methods	Process measures	Target for process measure	Comments
1. Funding has been secured to accommodate a 4th triage nurse at the front, staffing model changes have been implemented. 2. ED Director to work alongside Command Center Director to perform a workflow analysis on ED PFM role. 3. Staffing contingency plan to be generated and shared amongst ED PFM group, ED manager, ED director (and admin on call if necessary). 4. Daily Bed Meetings to include patients over 24 hours and plan for transfer to floors. 5. Complete – continue to monitor effects of additional bed capacity. 6. Several working groups in existence, (clinical working group, operational working group, executive committees), AI model being generated alongside Deloitte. 7. UofT student capstone initiative in progress, working alongside HRH project management team. 8. ED Managers to work alongside ED PFMs to generate a template with ED and Command Center director approval.	90th percentile emergency department length of stay (LOS)	Target is 9 hours	

Measure - Dimension: Timely

Indicator #11	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile ambulance offload time	O	Minutes / 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)	33.00	30.00	Target established by HRH	

Change Ideas

No Data Available

Change Idea #1 1. Introducing a fourth nurse at front triage to reduce the number of pre-triage patients waiting to be seen. 2. Standardization of the ED PFM role to optimize bed management strategies to expedite patient admission, discharge, and transfers. 3. Update ramp-down staffing strategies to ensure that SA surge nurse position is always filled, maximizing ED bed capacity. 4. Work with other departmental directors to create surge capacity on the floors when ED admissions surpass 24 hours. 5. Implementation of ScaleAI – queuing technology aimed to improve patient experience by reducing in hospital wait and PIA times. 6. Collaborate with inpatient managers to create a pull culture when transferring patients to the inpatient unit. 7. ED Redesign project – examination of current ED physical layout and potential restructuring (see potential structural changes) a. Evaluate the workflow of triage, O-Zone, EMS triage, Acute and Subacute b. Reallocation of OZ-CDU room to designated TAT room 8. Implement comprehensive care plans, order sets and follow-up protocols for individuals with sickle cell disease.

Methods	Process measures	Target for process measure	Comments
1. Funding has been secured to accommodate a 4th triage nurse at the front, staffing model changes have been implemented. 2. ED Director to work alongside Command Center Director to perform a workflow analysis on ED PFM role. 3. Staffing contingency plan to be generated and shared amongst ED PFM group, ED manager, ED director (and admin on call if necessary). 4. Daily Bed Meetings to include patients over 24 hours and plan for transfer to floors. 5. Complete – continue to monitor effects of additional bed capacity. 6. Several working groups in existence, (clinical working group, operational working group, executive committees), AI model being generated alongside Deloitte. 7. UofT student capstone initiative in progress, working alongside HRH project management team. 8. ED Managers to work alongside ED PFMs to generate a template with ED and Command Center director approval.	90th percentile ambulance offload time (AOT)	Target is 30 minutes	

Measure - Dimension: Timely

Indicator #12	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)	13.22	6.00	Target recommended by Auditor General/Canadian Association of Emergency Physicians/National Emergency Nurses Affiliation	

Change Ideas

No Data Available

Change Idea #1 1. Introducing a fourth nurse at front triage to reduce the number of pre-triage patients waiting to be seen. 2. Standardization of the ED PFM role to optimize bed management strategies to expedite patient admission, discharge, and transfers. 3. Update ramp-down staffing strategies to ensure that SA surge nurse position is always filled, maximizing ED bed capacity. 4. Work with other departmental directors to create surge capacity on the floors when ED admissions surpass 24 hours. 5. Implementation of ScaleAI – queuing technology aimed to improve patient experience by reducing in hospital wait and PIA times. 6. Collaborate with inpatient managers to create a pull culture when transferring patients to the inpatient unit. 7. ED Redesign project – examination of current ED physical layout and potential restructuring (see potential structural changes) a. Evaluate the workflow of triage, O-Zone, EMS triage, Acute and Subacute b. Reallocation of OZ-CDU room to designated TAT room 8. Implement comprehensive care plans, order sets and follow-up protocols for individuals with sickle cell disease.

Methods	Process measures	Target for process measure	Comments
1. Funding has been secured to accommodate a 4th triage nurse at the front, staffing model changes have been implemented. 2. ED Director to work alongside Command Center Director to perform a workflow analysis on ED PFM role. 3. Staffing contingency plan to be generated and shared amongst ED PFM group, ED manager, ED director (and admin on call if necessary). 4. Daily Bed Meetings to include patients over 24 hours and plan for transfer to floors. 5. Complete – continue to monitor effects of additional bed capacity. 6. Several working groups in existence, (clinical working group, operational working group, executive committees), AI model being generated alongside Deloitte. 7. UofT student capstone initiative in progress, working alongside HRH project management team. 8. ED Managers to work alongside ED PFMs to generate a template with ED and Command Center director approval.	90th percentile emergency department wait time to inpatient bed	Target is 6 hours	

Measure - Dimension: Timely

Indicator #13	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)	2.50	2.00	Target established by HRH	

Change Ideas

No Data Available

Change Idea #1	1. Introducing a fourth nurse at front triage to reduce the number of pre-triage patients waiting to be seen. 2. Standardization of the ED PFM role to optimize bed management strategies to expedite patient admission, discharge, and transfers. 3. Update ramp-down staffing strategies to ensure that SA surge nurse position is always filled, maximizing ED bed capacity. 4. Work with other departmental directors to create surge capacity on the floors when ED admissions surpass 24 hours. 5. Implementation of ScaleAI – queuing technology aimed to improve patient experience by reducing in hospital wait and PIA times. 6. Collaborate with inpatient managers to create a pull culture when transferring patients to the inpatient unit. 7. ED Redesign project – examination of current ED physical layout and potential restructuring (see potential structural changes) a. Evaluate the workflow of triage, O-Zone, EMS triage, Acute and Subacute b. Reallocation of OZ-CDU room to designated TAT room 8. Implement comprehensive care plans, order sets and follow-up protocols for individuals with sickle cell disease.

Methods	Process measures	Target for process measure	Comments
1. Funding has been secured to accommodate a 4th triage nurse at the front, staffing model changes have been implemented. 2. ED Director to work alongside Command Center Director to perform a workflow analysis on ED PFM role. 3. Staffing contingency plan to be generated and shared amongst ED PFM group, ED manager, ED director (and admin on call if necessary). 4. Daily Bed Meetings to include patients over 24 hours and plan for transfer to floors. 5. Complete – continue to monitor effects of additional bed capacity. 6. Several working groups in existence, (clinical working group, operational working group, executive committees), AI model being generated alongside Deloitte. 7. UofT student capstone initiative in progress, working alongside HRH project management team. 8. ED Managers to work alongside ED PFMs to generate a template with ED and Command Center director approval.	Percentage of patients who visited the emergency department and left without being seen (LWBS) by a physician	Target for process measure is 2.0%	

Equity

Measure - Dimension: Equitable

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Average ED wait time to physician initial assessment (PIA) for individuals with sickle cell disease (CTAS 1 or 2)	O	Minutes / ED patients	CIHI NACRS / April 1st 2023 to September 30th 2023 (Q1 and Q2)	109.87	15.00	Target established by Health Quality Ontario	

Change Ideas

No Data Available

Change Idea #1 1. Introducing a fourth nurse at front triage to reduce the number of pre-triage patients waiting to be seen. 2. Standardization of the ED PFM role to optimize bed management strategies to expedite patient admission, discharge, and transfers. 3. Update ramp-down staffing strategies to ensure that SA surge nurse position is always filled, maximizing ED bed capacity. 4. Work with other departmental directors to create surge capacity on the floors when ED admissions surpass 24 hours. 5. Implementation of ScaleAI – queuing technology aimed to improve patient experience by reducing in hospital wait and PIA times. 6. Collaborate with inpatient managers to create a pull culture when transferring patients to the inpatient unit. 7. ED Redesign project – examination of current ED physical layout and potential restructuring (see potential structural changes) a. Evaluate the workflow of triage, O-Zone, EMS triage, Acute and Subacute b. Reallocation of OZ-CDU room to designated TAT room 8. Implement comprehensive care plans, order sets and follow-up protocols for individuals with sickle cell disease.

Methods	Process measures	Target for process measure	Comments
1. Funding has been secured to accommodate a 4th triage nurse at the front, staffing model changes have been implemented. 2. ED Director to work alongside Command Center Director to perform a workflow analysis on ED PFM role. 3. Staffing contingency plan to be generated and shared amongst ED PFM group, ED manager, ED director (and admin on call if necessary). 4. Daily Bed Meetings to include patients over 24 hours and plan for transfer to floors. 5. Complete – continue to monitor effects of additional bed capacity. 6. Several working groups in existence, (clinical working group, operational working group, executive committees), AI model being generated alongside Deloitte. 7. UofT student capstone initiative in progress, working alongside HRH project management team. 8. ED Managers to work alongside ED PFMs to generate a template with ED and Command Center director approval.	Average emergency department wait time to physician initial assessment (PIA) for individuals with sickle cell disease (CTAS 1 or 2)	CTAS level 1 – immediate (e.g., within 5 minutes) CTAS level 2 – within 15 minutes	

Measure - Dimension: Equitable

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of ED 30-day repeat visits for individuals with sickle cell disease	O	% / ED patients	CIHI NACRS / Index visits from April 1st 2023 to September 30th 2023 (Q1 and Q2)	40.63	30.00	Target established by HRH	

Change Ideas

No Data Available

Change Idea #1 1. Introducing a fourth nurse at front triage to reduce the number of pre-triage patients waiting to be seen. 2. Standardization of the ED PFM role to optimize bed management strategies to expedite patient admission, discharge, and transfers. 3. Update ramp-down staffing strategies to ensure that SA surge nurse position is always filled, maximizing ED bed capacity. 4. Work with other departmental directors to create surge capacity on the floors when ED admissions surpass 24 hours. 5. Implementation of ScaleAI – queuing technology aimed to improve patient experience by reducing in hospital wait and PIA times. 6. Collaborate with inpatient managers to create a pull culture when transferring patients to the inpatient unit. 7. ED Redesign project – examination of current ED physical layout and potential restructuring (see potential structural changes) a. Evaluate the workflow of triage, O-Zone, EMS triage, Acute and Subacute b. Reallocation of OZ-CDU room to designated TAT room 8. Implement comprehensive care plans, order sets and follow-up protocols for individuals with sickle cell disease.

Methods	Process measures	Target for process measure	Comments
1. Reinforce triage education by placing a greater focus on sickle cell-related content, ensuring the inclusion of proper triage classification. 2. Work in collaboration with the HRH pain service, hematology, and other healthcare providers to develop an Emergency Department Order Set specifically designed for the effective management of Sickle Cell Crisis. 3. Utilize Meditech's special indicators to generate individualized care plans for patients with sickle cell disease. 4. Overhaul the sickle cell follow-up process to incorporate UMCC referrals, aiming to minimize Emergency Department revisits among sickle cell patients. 5. Collect data regarding patient who present in ED with sickle cell disease.	Rate of emergency department 30-day repeat visits for individuals with sickle cell disease	Target is 30.0%.	

Measure - Dimension: Equitable

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of ED visits for individuals with sickle cell disease triaged with high severity (CTAS 1 or 2)	O	% / ED patients	CIHI NACRS / April 1st 2023 to September 30th 2023 (Q1 and Q2)	71.88	75.00	Target established by HRH	

Change Ideas

No Data Available

Change Idea #1 1. Introducing a fourth nurse at front triage to reduce the number of pre-triage patients waiting to be seen. 2. Standardization of the ED PFM role to optimize bed management strategies to expedite patient admission, discharge, and transfers. 3. Update ramp-down staffing strategies to ensure that SA surge nurse position is always filled, maximizing ED bed capacity. 4. Work with other departmental directors to create surge capacity on the floors when ED admissions surpass 24 hours. 5. Implementation of ScaleAI – queuing technology aimed to improve patient experience by reducing in hospital wait and PIA times. 6. Collaborate with inpatient managers to create a pull culture when transferring patients to the inpatient unit. 7. ED Redesign project – examination of current ED physical layout and potential restructuring (see potential structural changes) a. Evaluate the workflow of triage, O-Zone, EMS triage, Acute and Subacute b. Reallocation of OZ-CDU room to designated TAT room 8. Implement comprehensive care plans, order sets and follow-up protocols for individuals with sickle cell disease.

Methods	Process measures	Target for process measure	Comments
1. Reinforce triage education by placing a greater focus on sickle cell-related content, ensuring the inclusion of proper triage classification. 2. Work in collaboration with the HRH pain service, hematology, and other healthcare providers to develop an Emergency Department Order Set specifically designed for the effective management of Sickle Cell Crisis. 3. Utilize Meditech's special indicators to generate individualized care plans for patients with sickle cell disease. 4. Overhaul the sickle cell follow-up process to incorporate UMCC referrals, aiming to minimize Emergency Department revisits among sickle cell patients. 5. Collect data regarding patient who present in ED with sickle cell disease.	Percentage of emergency department visits for individuals with sickle cell disease triaged with high severity (CTAS 1 or 2)	Target is 75.0%	

Measure - Dimension: Equitable

Indicator #6	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	82.22	100.00	Target established by HRH	

Change Ideas

No Data Available

Change Idea #1 #1): Evaluate module completion rates at the leadership level #2) Provide leaders with educational tools and resources generate awareness and increase uptake

Methods	Process measures	Target for process measure	Comments
Review completion rates and encourage leaders to engage staff who remain outstanding in LIME. Provide leaders with the Introduction to Anti-Black Racism Manager Huddle Script and FAQ to support with answering questions and/or concerns from staff.	Module Completion Rate. Number of Group Training Sessions Offered.	75% by March 31st, 2024 and 100% March 31st, 2025. 10 Group Training Sessions offered between November-December 2023.	The Introduction to Anti-Black Racism eLearning Module launched to all Leaders on August 10, 2023 and all Staff, Physicians and Volunteers on October 16. 2023.

Experience

Measure - Dimension: Patient-centred

Indicator #7	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	70.18	65.00	Target established by Health Quality Ontario	

Change Ideas

No Data Available

Change Idea #1 1) Provide specific performance indicators to respective areas within Medicine Inpatient Units and Critical Care areas to understand if patient felt they received adequate information about their health and their care at discharge. 2) Advance patient and family engagement in order to improve the patient/family satisfaction scores within the Medicine Inpatient Units and Critical Care Areas.

Methods	Process measures	Target for process measure	Comments
Medicine Inpatient Units • Identify specific quality indicators and regularly track and measure the implementation's success, with the ability to adjust strategies based on ongoing evaluation. • Ensure utilization and distribution of patient discharge package to all patients on admission (primary nursing teams to review and ensure all information present and any specific patient information prn – based on patient medical condition and treatment during hospital stay. • Incorporate as Priority Question for IP units Leader Rounding on Patient Log for Managers/RPs. • Collaborate with Patient Relations to address any concerns and/or issues with patients/families in a timely manner. Critical Care Services • Monitor FS-ICU results and solicit feedback from patients/families using survey for ICU admission with ability to adjust strategies to address feedback based on ongoing evaluation. • Incorporate as Priority Question for IP units Leader Rounding on Patient Log for Managers/RPs.	• Monitor PDCC unit results (reflective in results of PDCC questions - staff/doctors listen carefully; explained things in a way patient can understand; information given about condition and treatment) with the addition of these questions to the current PDCC quality improvement action plan. • QIP initiatives as standing agenda items for Medicine and ICU Portfolios.	• Noted that current performance for this QIP for 2022/23 – at 65.5 % • Ongoing performance improvement – target > 65%. • 100% process compliance (monthly reporting) • Sharing survey (PDCC / FSICU) results with staff, display on quality boards and staff discussions within daily huddles and RPCC	Total Surveys Initiated: 5390

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	75.91	81.00	Target established by Health Quality Ontario	

Change Ideas

No Data Available

Change Idea #1 1. Trial or pilot pharmacist driven preparation and access to Meditech functionality of the Best Possible Medication Discharge Plan for physician review and conversion. 2. Explore access for pharmacists to access med rec discharge module and training to assist physicians at point of care at any time with med rec at discharge. 3. Explore future change ideas from Capstone (UofT Engineering) project.

Methods	Process measures	Target for process measure	Comments
1. Trial or pilot pharmacist driven preparation and access to Meditech functionality of the Best Possible Medication Discharge Plan for physician review and conversion. 2. Explore access for pharmacists to access med rec discharge module and training to assist physicians at point of care at any time with med rec at discharge. 3. Explore future change ideas from Capstone (UofT Engineering) project.	Number of discharged patients for whom a Best Possible Medication Discharge Plan was created out of the total number of patients discharged. Compare pilot care area rates to control care area rates for the aforementioned.	Target for 2024/25: 81%	

Measure - Dimension: Safe

Indicator #8	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)	0.26	0.20	Target established by HRH	

Change Ideas

No Data Available

Change Idea #1 Medicine: Sustain and improve the results achieved from previously implemented delirium initiative. Extend the delirium prevention initiate to the ED. Sustain CAM assessment compliance within 24 hours of admission in inpatient medicine units. Sustain and improve the initiation of CHASM intervention in inpatient medicine units. Initiate Delirium order set for all patients who screen CAM positive.

Methods	Process measures	Target for process measure	Comments
Sustain and improve the results achieved from previously implemented delirium initiative by reviewing and sharing quarterly data. Extend the delirium prevention initiate to the ED by implementing the CAM assessment for all admitted patient 64 years or older.	Quarterly CAM compliance rate. Quarterly CHASM intervention compliance rate. Quarterly CAM + rate. Quarterly order set use for CAM positive patients.	Quarterly CAM compliance rate of 90%. Quarterly CHASM intervention compliance rate of 85%. Quarterly order set use rate for CAM positive patient rate of 80%. Delirium rate of less than 0.20%.	

Change Idea #2	ICU: Sustain and improve the results achieved from previously implemented ICU delirium initiatives. Sustain and improve early identification of ICU delirium using CAM-ICU tool on admission and every 4 hours while admitted to the ICU. Improve methods of preventing delirium in the ICU.		
Methods	Process measures	Target for process measure	Comments
Sustain CAM-ICU compliance on admission and every 4 hours. Improve and sustain methods to decreased delirium in the ICU including the ICU Early. Mobility Protocol, daily SAT/SBT compliance and the About Me RPCC initiatives. Encourage family involvement to improve or avoid delirium. Sustain education to newly hired and existing staff on CAM-ICU through ICU Skills days and ICU Orientation days.	Quarterly ICU PAD documentation compliance rates. Quarterly ICU CAM + rate.	Quarterly CAM compliance rate of 90%.	

Change Idea #3	Surgery: Sustain and improve the results achieved from previously implemented delirium initiative. Sustain CAM assessment compliance in inpatient surgery units. Sustain and improve the initiation of CHASM intervention in inpatient surgical units. Initiate Delirium order set for all patients who screen CAM positive.		
Methods	Process measures	Target for process measure	Comments
Sustain use of regional anesthesia where appropriate for operative procedures. Review data quarterly at program quality meetings. Sustain compliance with continued education to existing and new nurses. Initiate order set for patients who screen CAM positive.	Quarterly CAM compliance rate. Quarterly CHASM intervention compliance rate. Quarterly CAM + rate. Quarterly order set use for CAM positive patients.	Quarterly CAM compliance rate of 90%. Quarterly CHASM intervention compliance rate of 85%. Quarterly order set use rate for CAM positive patient rate of 80%. Delirium rate of less than 0.20%.	

Measure - Dimension: Safe

Indicator #9	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	0.24	0.20	Target established by HRH	

Change Ideas

No Data Available

Change Idea #1 Improve process for conducting root cause analysis of all HC and LT incidents.

Methods	Process measures	Target for process measure	Comments
Development of a root cause analysis form to be completed by managers/key players for all HC or LT. Enhancing data analytics for WPV to provide visibility for leadership.	Completion of rootcause analyses for all HC and LT incidents. Completion of unit workplace violence risk assessments after HC or LT incidents.	100% completion of root cause analyses for all HC and LT incidents within 5 business days of the incident. 100% completion of workplace violence risk reassessments within 7 business days of the incident.	

Change Idea #2 Rollout of Meditech outpatient violence special indicator – improvement of communication to staff to inform them of violent patients.

Methods	Process measures	Target for process measure	Comments
Training of all CPLs, Managers and Supervisors on placing violence special indicator.	Number of reported workplace violence incidents that result in a violence special indicator.	100% of workplace violence incidents resulting in FA, HC and LT have a violence special indicator reviewed on a monthly basis.	Improvement initiative #2 will be included as part of the WSIB Health and Safety Excellence Program - Workplace Violence Policy and Program topic for 2024 to assist in meeting our goals and objectives outlined above.