Access and Flow

Measure - Dimension: Timely

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department wait time to physician initial assessment	P	Hours / ED patients	CIHI NACRS / ERNI hospitals: Dec 1, 2023, to Nov 30, 2024/Non-ERNI hospitals: Apr 1, 2024, to Sept 30, 2024 (Q1 and Q2)	5.00	4.60	Target develop in collaboration with physician colleagues and based on development and implementation of process measure.	

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

Change Ideas

Change Idea #1 Develop and implement Rapid Assessment Zone (RAZ) with ED

Methods	Process measures	Target for process measure	Comments
Lead by ED Leadership, with oversight from Quality and Practice Committee	% of patients assessed through the RAZ	Collecting Baseline	

Change Idea #2 Explore and optimize ED patient flow.			
Methods	Process measures	Target for process measure	Comments
Lead by ED and Access and Flow leadership, oversight from ED Quality and Practice Committee.	Workflow pathway for booked appointments completed.	Pathway 100% completed.	

Change Idea #3 Co - develop plan to improve ED patient workflow with physicians and NPs.			
Methods	Process measures	Target for process measure	Comments
Oversight ED Quality and Practice Committee.	Workflow pathway for booked appointments completed.	Pathway 100% completed.	

Measure - Dimension: Timely

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Community Mental Health: Counselling Waitlist (average days waited) (#)	C	Days / Clients	In house data collection / Q1-Q3	45.30	45.30	Target based on current performance and improvement plans in place.	

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 Optimize internal and external referral pathway workflow.			
Methods	Process measures	Target for process measure	Comments
Oversight by Mental Health Quality and Practice Committee	Referral pathway workflow framework completed.	100% completed.	

Change Idea #2 Analyze current workflow for referral pathways for mental health in EMR (EPIC).			
Methods	Process measures	Target for process measure	Comments
Oversight by Mental Health Quality and Practice Committee	Current state analyzed and data validated.	100% completed.	

Change Idea #3 Optimize workflow for referral pathway in EMR (EPIC).			
Methods	Process measures	Target for process measure	Comments
Oversight by Mental Health Quality and Practice Committee	Workflow standardized.	100% completed.	

Equity

Measure - Dimension: Equitable

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of staff (mandatory); Percentage of volunteers, physicians and midwives (voluntary) who have completed the voluntary EDI training	C	% / Staff	In house data collection / Q1-Q3	CB	CB	New indicator.	

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 training and awareness education for 2025/26.

Methods	Process measures	Target for process measure	Comments
EDIAC oversight and organizational development.	% of staff, physicians, midwives, and volunteers reached.	Collecting Baseline	

Change Idea #2 Track and trend completion rates.

Methods	Process measures	Target for process measure	Comments
EDIAC oversight and organizational development.	# of engagement activities.	Collecting Baseline	

Change Idea #3 Implement planned engagement activities to increase completion rate.

Methods	Process measures	Target for process measure	Comments
EDIAC oversight and organizational development.	Evaluation of engagement activities completed.	Evaluation 100% completed.	

Experience

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Positive responses to, “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?”	C	% / Survey respondents	In house data collection / Q1 - Q3	CB	CB	New survey tool.	

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 Qualtrics patient experience survey in 1 areas of the hospital (ED).

Methods	Process measures	Target for process measure	Comments
Oversight by Patient Experience Working Group(s), reporting to Senior Leadership Team	Percentage of surveys completed.	Collecting Baseline	

Change Idea #2 Track, trend, and analyze responses to this survey question on a quarterly basis.

Methods	Process measures	Target for process measure	Comments
Oversight by Patient Experience and Decision Support.	Complete Quarterly Survey Results Reports to be shared broadly.	100% completion.	

Change Idea #3 Develop action plans to address result trend.

Methods	Process measures	Target for process measure	Comments
Oversight by Patient Experience in conjunction with the QPCs	Action plans developed to address results trend for at least one hospital program.	100% plan developed.	

Safety

Measure - Dimension: Safe

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Barcode Medication Administration (BCMA) Completion Rate	C	% / Patients	In house data collection / Q1-Q3	91.60	90.00	Based on current performance and improvement opportunities.	

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 Track and trend non-scanning medication issues.

Methods	Process measures	Target for process measure	Comments
Oversight by the Quality, Clinical Informatics, and Professional Practice Committee.	Build non-scanning medication issues report.	One hundred percent of reports built.	NHH looks forward to monitoring this work.

Change Idea #2 Manager and/or department monitoring of BCMA compliance.

Methods	Process measures	Target for process measure	Comments
Oversight by QCIPP	BCMA compliance monitoring	One hundred percent complete.	NHH looks forward to monitoring this work.

Measure - Dimension: Safe

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
In-patient falls with injury rate	C	% / Of all falls	In house data collection / Q1-Q3	3.10	2.80	Based on current performance.	

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 Develop and implement: Staff education and training related to falls prevention strategies, documentation and patient assessment.

Methods	Process measures	Target for process measure	Comments
Oversight by Falls Quality Aim Committee.	Percentage of applicable staff completing Falls survey.	Eighty percent of applicable staff complete falls survey.	NHH looks forward to monitoring this work.

Change Idea #2 Develop and implement: Patient and family engagement and education resources.

Methods	Process measures	Target for process measure	Comments
Oversight by Falls Quality Aim Committee	% of patients who attend education sessions.	collecting baseline	

Change Idea #3 Develop and implement: Staff education and training related to falls prevention strategies, documentation.			
Methods	Process measures	Target for process measure	Comments
Oversight by Falls Quality Aim Committee	% of staff who attend education activities.	collecting baseline.	

Change Idea #4 Develop and implement: Staff education and training related to falls prevention strategies, documentation and patient assessment.			
Methods	Process measures	Target for process measure	Comments
Oversight by Falls Quality Aim Committee	% of patients identified as high risk for falls having visual aid applied within 24 hours of admission.	collecting baseline.	