Access and Flow

Measure - Dimension: Timely

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department wait time to inpatient bed	C	Hours / ED patients	Local data collection / YTD Q3 23/24 (April 2023-December 2023)	21.93	16.00	FY 23/24 target was not reached, maintain target at 16 hours	

Change Ideas

Change Idea #1 Implement Length of Stay and Conservable Bed Hospitalist Initiative

Methods	Process measures	Target for process measure	Comments
Identify units within scope of project i.e. Medicine and Stroke; Establish change ideas to reduce LOS and conservable bed days for patients under Hospitalist service; Test change ideas on select units using PDSA cycles	Hospitalist service acute ALOS; Conservable beds; % of change ideas tested	5 days ALOS; 18 conservable beds; 80% of change ideas tested	

Change Idea #2 Implement initiatives to improve ALC rates

Methods	Process measures	Target for process measure	Comments
Identify approach for early assessment of older adults visiting the ED; Develop screening and preventative care management process for inpatients at risk of functional decline; Develop screening and preventative care management process for inpatients at risk of delirium	Percent of assessment approach identified; Percent of screening processes developed; Percent of care management processes developed	100% of approaches identified; 100% of screening processes developed; 100% of care management processes developed	

Equity

Measure - Dimension: Equitable

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Completion of sociodemographic data collection	C	% / Patients	In house data collection / YTD Q3 23/24 (April 2023-December 2023)	CB	80.00	In the absence of baseline data and since a new process needs to be developed to capture these components, target set at 80% completion rate	

Change Ideas

Change Idea #1 Implement data collection within Cerner using the Measuring Health Equity (MHE) data set

Methods	Process measures	Target for process measure	Comments
Identify specific heath equity fields required in Cerner; Build required fields in the electronic health record; Determine workflow for data collection with consideration for use of patient portal for self reporting prior to planned visits; Identify priority areas for rollout of workflow	Percent of required fields built in Cerner; Percent of staff following workflow; Percent of data completion in patient portal	100% of fields built; 80% of staff following workflow; 80% of data complete in patient portal	Currently at GRH only gender is collected in Cerner upon registration. All other fields in the MHE data set would need to be added and a process identified for completion.

Experience

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Communication with Physicians and Nurses (%) - Composite Metric	C	% / Survey respondents	Local data collection / YTD Q3 23/24 (April 2023-December 2023)	67.91	80.00	FY 23/24 target was not reached, maintain target at 80%	

Change Ideas

Change Idea #1 Continue implementation of customer service training in priority areas

Methods	Process measures	Target for process measure	Comments
Co-design and deliver AIDET training in high priority and self-selected areas; Sustain AIDET practice in areas which have already completed training (e.g. Emergency Department)	Percent of staff in priority areas that have completed AIDET training; Percent of providers in priority areas that have completed AIDET training; Percent of new ED staff that have completed AIDET training	90% of staff who have completed training; 90% of providers who have completed training; 90% of new ED staff who have completed training	Patient experience surveying resumed at GRH in September 2023, using a phased-in approach as we adopted organization-wide patient email collection. Patient surveying in the Emergency Department and select adult inpatient programs began in December 2023 and included customized questions related to communications between physicians, nurses and patients to allow monitoring of these key metrics.

Change Idea #2 Implement patient communication boards in select pilot area(s)			
Methods	Process measures	Target for process measure	Comments
Identify pilot area(s); engage staff, patients and families on design and components of board; develop process for using and updating boards	Percent of pilot areas identified; Percent of engagement completed; Percent of process developed	100% of pilot area(s) identified; 100% of engagement completed; 100% of process for updating boards developed	

Safety

Measure - Dimension: Safe

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of Hand Hygiene Compliance Before Patient/Patient Environment Contact	C	% / Other	In house data collection / YTD Q3 23/24 (April 2023-December 2023)	61.53	87.00	FY 23/24 target was not reached, increase target to 87%	

Change Ideas

Change Idea #1 Strengthen shared accountability for hand hygiene compliance between clinical, enabling teams and patients and families.

Methods	Process measures	Target for process measure	Comments
Meetings and planning with shared accountability for improvement interventions including education, clinical leadership, quality, and IPAC; Increasing direct care provider awareness of patient impact through shared patient stories, case studies, and reminders to staff to increase visibility of hand cleaning for patient comfort; Identification and prioritization in reviewing workflows to maximize hand hygiene compliance with WOWs and mobile equipment integration	Percent of leadership meetings that include hand hygiene performance as a standing agenda item; Percent of units utilizing staff-facing patient reminders in patient spaces, such as white-boards, tray liners, table top notices; Percent of units reviewed for workflow prioritization	100% of leadership meetings with hand hygiene performance as standing agenda item; 100% of inpatient units develop staff-facing reminders related to patient impact; 100% of clinical units reviewed for prioritization of workflows	

Change Idea #2 Increase visibility of hand hygiene and current trends through the use of huddle boards

Methods	Process measures	Target for process measure	Comments
Utilization of huddle boards, and associated discussion, to celebrate progress to create trends and awareness; Utilization of huddle discussions to share potential risks to patients	Percent of huddle boards that include current hand hygiene results; Percent of huddle boards that indicate trend (increasing or decreasing) of hand hygiene performance in the before moment	Inclusion of hand hygiene results, for program or individual units, on 100% of organization huddle boards	

Measure - Dimension: Safe

Indicator #4	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.	C	% / Discharged patients	Local data collection / YTD Q3 23/24 (April 2023-December 2023)	64.10	77.50	20% improvement over FY23/24 YTD Nov Performance.	

Change Ideas

Change Idea #1 Provide education to physicians on the medication reconciliation process within Cerner

Methods	Process measures	Target for process measure	Comments
Identify priority areas that need additional training; Deliver training on the workflow required within Cerner for medication reconciliation on discharge; Continue monitoring BPMH compliance as an important step in the overall medication reconciliation process; Continue monitoring admission medication reconciliation as an important step in the overal medication reconciliation process	Percent of providers in priority areas that have completed Cerner medication reconciliation training; Percent of time BPMH completed within 24 hours of admission; Percent of medication reconciliation completed on admission	90% of providers who have completed training; 83% of BPMH completed within 24 hours; 80% of medication reconciliation completed on admission	Excludes newborns, childbirth and admissions with LOS<24 hours

Measure - Dimension: Safe

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of workplace violence incidents resulting in lost time injury	C	Rate / Other	Local data collection / YTD Q3 23/24 (April 2023-December 2023)	0.29	0.15	50% reduction	

Change Ideas

Change Idea #1 Continue implementation of recommendations from workplace violence program audit.

Methods	Process measures	Target for process measure	Comments
Update workplace violence and respectful workplace policies; Complete remaining workplace violence program audit recommendations; Continue code white/de-escalation training in high risk areas; Update violence risk assessments in priority clinical areas	Percent of relevant policies updated; Percent of recommendations implemented; Percent of staff in high risk areas current with training; Percent of violence risk assessments in high risk areas completed	100% of policies updated; 100% of recommendations implemented; 100% of staff in high risk areas with initial code white training; 100% of priority violence risk assessments completed	Rate calculation based on current methodology used for OHA reporting