Measure - Dimension: Timely

Indicator #3	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)	4.77	4.53	5% reduction (percent improvement to longer term OH target of 4.0h)	

Change Ideas

Change Idea #1 1. Rapid Assessment Fast Track (RAFT) Optimization (Net new at OTMH, MDH & GH optimization)

Methods	Process measures	Target for process measure	Comments
a. Develop working group for RAFT Optimization (MDH & GH) & RAFT Model Implementation (OTMH) b. Develop strategies that would most impact each ED post cross-site ED observations & review of OH ED COP PIA Best Practice Toolkit (for release Apr 1) c. Define processes d. Determine communication plans to RAFT frontline team members e. Implement defined strategies (will vary by site) f. Evaluate and monitor	1. Obtain baseline data on PIA by zone for each RAFT area in each ED. 2. Number of ED PIA Working group meetings held prior to June 30, 2025. 3. Number of RAFT strategies implemented by each site by July 7, 2025 (OTMH - Open RAFT) 4. Percentage of RAFT staff/physicians confirming understanding of new RAFT processes. (Denominator = # for staff/physicians working in these zones for each site)	1. Complete 2. 5 meetings 3. Minimum 1 RAFT process change initiative per ED 4. 80% staff/physicians reached via communication plan: GH 29 MDH 129 OTMH 156	

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 / Apr 1 to Sep 30, 2024 (Q1 and Q2)	22.69	21.56	5% reduction (percent improvement toward longer term goal of OH target - 20%)	

Change Ideas

Change Idea #1 Create a new pathway for Halton@Home from the Emergency Department to avoid admission.

Methods	Process measures	Target for process measure	Comments
a. Define and design patient-centered pathway - including criteria for program b. Co-design with patients and caregivers c. Communicate and launch updated pathways d. Monitor and evaluate impact e. Iterate and refine strategies	1. Number of patients / week referred through the pathway. 2. 30 day admission rate of those referred to the pathway. 3. Reduction in overall admission rate.	1. 20/week 2. < 10% 3. 5% decrease	

Change Idea #2 Increase referrals to outpatient clinics from the Emergency Department to avoid admission.

Methods	Process measures	Target for process measure	Comments
a. Form cross-sector working group include physician representation b. Create catalogue of available clinics for referral c. Communicate and launch the catalogue to ED provider d.Implement additional appointments in AIM and GIM clinics e. Monitor use of clinic resources	1. Completion of Resource Catalogue 2. Number of referrals to Internal Medicine clinic(s) 3. Reduction in overall admission rates.	1. Complete 2. Increase by 5% 3. 5%decrease in admission rates	

Safety

Measure - Dimension: Safe

Indicator #1	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 1 to September 30, 2024 (Q1 and Q2), based on the discharge date	1.12	1.34	20% increase (efforts focused on improving recognition and reporting of hospital acquired delirium)	

Change Ideas

Change Idea #1 Determine and address recognition of delirium and prescribing patterns for medications which are known to increase the risk of hospital acquired delirium in acute care.

Methods	Process measures	Target for process measure	Comments
a. Obtain baseline prescribing / administration data from Performance Analytics / Pharmacy including understanding patterns and medications prescribed most frequently for sleep b. Enrollment of MDH and GH hospitalists into GEMINI study c. Interprofessional Medicine Program retreat to review data and develop action plan focused on delirium recognition in alignment with OH DASH campaign over the coming year(s).	1. % of eligible hospitalists at each site who confirm receipt of GEMINI MyPractice Report 2. Number of Interprofessional staff who attend the Medicine Program retreat. 3. Creation of Action Plan with physician / provider engagement addressing prescribing practices and delirium recognition. 4. Implementation of a pilot intervention based on action plan	1. 80% 2. 50 with tri-site representation 3. 100% 4. Complete	

Measure - Dimension: Safe

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Stage 3/4 and unstageable Hospital Acquired Pressure Injury	C	% / Patients	In house data collection / IPUP 2024 results	5.30	4.77	10% improvement (percent improvement towards "theoretical best" of 0%)	

Change Ideas

Change Idea #1 1. Implement quarterly prevalence studies on select units based on rates from 2024 International Pressure Injury Prevalence Survey.

Methods	Process measures	Target for process measure	Comments
a. Establish a Wound Care Steering Committee with interprofessional and interdepartmental representation. b. Develop and implement quarterly pressure injury prevalence surveys on select units, including a corporate communication strategy regarding survey results and progress.	1. Number of Wound Care Steering Committee meetings. 2. Number of prevalence studies completed in FY 25/26	1. Minimum of 9 meetings 2. 4/4 = 100%	

Change Idea #2 2. Implement best practices related to pressure injury prevention interventions.

Methods	Process measures	Target for process measure	Comments
a. Optimize Braden assessment documentation and workflow as it relates to the following key pressure injury prevention interventions, including implementation of changes and a monitoring process: -Repositioning -Dietitian consult -Patient on appropriate surface b. Explore and develop a workflow utilizing the Real Time Locating System to locate specialty bed surfaces.	1. % of patient with a Braden score of 18 or lower with appropriate interventions in place. 2. RTLS workflow established	1. 70% 2. Complete	