Access and Flow

Measure - Dimension: Timely

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile ambulance offload time	P	Minutes / Patients	CIHI NACRS / For ERNI hospitals: Dec 1, 2023, to Nov 30, 2024 (Q1 and Q2)	36.00	30.00		Northumberland County Paramedic Services

Change Ideas

Change Idea #1 Reduce Ambulance Offload time to 30 mins or less at the 90th percentile

Methods	Process measures	Target for process measure	Comments
monthly review of AOT via EPIC	audit number of ED visits with a longer AOT than 30 minutes	30 min at the 90th percentile	

Change Idea #2 Create daily awareness of AOT

Methods	Process measures	Target for process measure	Comments
utilize EPIC reports to monitor and share with the team	# of staff aware of target time for reduction	100 % of the ED team will be aware of the 30 min or less target	

Measure - Dimension: Timely

Indicator #5	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)	3.51	2.00		Ontario Health @ Home East Region

Change Ideas

Change Idea #1 ALC reduction

Methods	Process measures	Target for process measure	Comments
Geriatric Emergency Management specialist to review patients waiting for a bed at 8 am	# of patients meeting criteria for GEM referral to be reviewed for ED and Admission diversion	100 % of patients will be reviewed	

Change Idea #2 CMH Leadership collaboration on TRAC meetings

Methods	Process measures	Target for process measure	Comments
Clinical IPU Manager or VP CNE or designate attendance at weekly TRAC meetings	Meetings will be attended by CMH leadership in collaboration with community partners focusing on ALC designation	100 % attendance of CMH leadership at TRAC meeting	

Change Idea #3 Establish process for daily prioritizing of patients with longest LOS waiting in ED

Methods	Process measures	Target for process measure	Comments
Creation of daily monitoring tool to be utilized at bed capacity meeting	reduction in LOS	reduction in TTIPB by 5% at the 90th percentile	

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	50.00	90.00		CCO Ontario Health

Change Ideas

Change Idea #1 Continue with targeted education for the Executive and Leadership team

Methods	Process measures	Target for process measure	Comments
Delivery of 2-day onsite workshop that will enhance the education already provided in previous year	% of learners attending the workshop	80 % of Leadership team will attend the workshop	

Change Idea #2 Established plan of EDI and anti-racism education will be planned for the 25/26 year.

Methods	Process measures	Target for process measure	Comments
Jedi committee will prioritize and plan EDI and or antiracism education for the leadership team	4 education sessions will be presented at Leadership Committee	80 % of Leadership team will attend identified education sessions by March 31st, 2026.	

Change Idea #3 Collaborate with community partners to develop education and training programs related to gender/inclusion.

Methods	Process measures	Target for process measure	Comments
The JEDI committee will continue to leverage existing community partnerships to bring education and awareness to the Leadership team and various committees at CMH	# of collaborative education sessions	4 gender/inclusion related education sessions will be delivered by March 31st, 2026.	

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	CB	90.00		

Change Ideas

Change Idea #1 Increase uptake of current electronic ED survey tool to gather baseline data

Methods	Process measures	Target for process measure	Comments
monthly audit of number of surveys completed monthly tracking of 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?	% completion of patient experience surveys for the ED	50 % increase in completed surveys Baseline data determined and reported monthly at leadership and quality committee	

Change Idea #2 Expand ways for Patients and families to access current electronic format for patient experience

Methods	Process measures	Target for process measure	Comments
Add multiple ways to access the patient experience survey using email, social media, external websites and onsite access to survey link	the number of reach outs per quarter	50 reach outs by end of Q2 with an expected increase by 25 in Q3 and Q4	

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	1.00	0.00		

Change Ideas

Change Idea #1

Methods	Process measures	Target for process measure	Comments
		0 workplace injuries resulting in lost time	