Access and Flow

Measure - Dimension: Timely

Indicator #4	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)	4.37	3.00		

Change Ideas

Change Idea #1 Optimize discharge scheduling by prioritizing morning discharges to increase bed availability for afternoon and evening ED admissions

Methods	Process measures	Target for process measure	Comments
Refresh the patient discharge readiness assessment process and patient board	Patients are accurately identified for discharge readiness at the bed meeting	60% of predicted discharge occur	

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 11 a.m.	C	Number / ED patients	CIHI NACRS / April 1, 2024-December 31, 2024	3.00	2.00	Internal reporting occurs at 11 a.m.	

Change Ideas

Change Idea #1 Implement a standardized, real-time bed turnover communication system to ensure timely bed availability, reducing total turnaround time from patient discharge to bed readiness.

Methods	Process measures	Target for process measure	Comments
Establish a real-time bed turnover notification process to ensure timely communication between nursing, Environmental Services (EVS), and bed management.	Time from patient discharge and vacating bed to the bed being available for the next patient.	60% of audits will indicate that beds met the 60-minute turnaround time standard.	

Measure - Dimension: Timely

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile ambulance offload time	C	Minutes / Patients	CIHI NACRS / April 1, 2024-Novemeber 30, 2024	40.00	30.00	90% percentile	

Change Ideas

Change Idea #1 Enhance communication and process to expedite patient flow.

Methods	Process measures	Target for process measure	Comments
Review and revise the gridlock policy for additional efficiencies.	Gridlock policy is reviewed and approved for escalation processes.	Grid lock policy has been approved, and circulated.	

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	5.23	25.00	The target is to reach a 25% staff education completion rate during the 2025-2026 fiscal year, and an additional 25% the following year, working towards a goal of 80% of NGH staff having completed Anti-Racism Indigenous Cultural Safety Training Program.	

Change Ideas

Change Idea #1 Enhance staff awareness of unconscious bias and foster a culture that actively promotes equity, diversity, inclusion, and anti-racism.

Methods	Process measures	Target for process measure	Comments
Emergency Department Staff are to be trained in Anti-Racism Indigenous Cultural Safety Training Program.	80% of Emergency Department staff will have registered and completed corporate's endorsed Indigenous Cultural Safety Training program within the 2025-2026 fiscal year.	80% of staff will confirm completion of the program.	The total goal will be to reach 80% of all clinical staff, this initiative will continue into the following years.

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	54.00	61.00	Canadian Institute for Health Information (CIHI) Top Box data Patient Satisfaction with Nursing Care Quality Questionnaire (PSNCQQ)	

Change Ideas

Change Idea #1 Patients identified through evidence based criteria, frailty score of 5+ without a primary care provider attached will receive an assessment to determine care needs and readiness for transition in care.

Methods	Process measures	Target for process measure	Comments
Patients with a frailty score of 5+ without a primary care provider will have a meeting with supports and care team to co-collaborate to determine care needs and readiness for transition in care.	% of patients who meet criteria have met to review care needs and readiness for transition in care.	60% of identified patients will have had a meeting	Total Surveys Initiated: 101 RNAO BPSO Transitions in Care action plan

Safety

Measure - Dimension: Safe

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of workplace violence incidents (severity level 3 or higher)	C	Number / Staff	Hospital collected data / April 1, 2024-December 31, 2024	4.00	3.00	This indicator measures the number of reported workplace violence incidents by hospital workers within a 12 month period.	

Change Ideas

Change Idea #1 Review of all 2024/2025 incident reports regardless of severity if the contributing factor indicates 2 or more reported incidents by the same patient (inpatients only)

Methods	Process measures	Target for process measure	Comments
80% of chart audits for admitted patients who contributed to 2 or more reported incidents in 2024/2025 are completed	Action Plan generated from audits to determine program enhancements and education requirements for staff by September 2025	80% of program enhancements identified are implemented as a result of the Action Plan	