Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 31, 2025

Brockville General Hospital

Ontario Health

OVERVIEW

Brockville General Hospital is your community hospital. Together, we are dedicated to the health and wellbeing of our friends, families and neighbours. Our hospital has a long history of rising to the challenge when the community is in need. Whether pioneering local access to care, building modern diagnostic, surgical, and healing spaces, or tackling the pressures facing our healthcare system, we are here to serve you.

Through teamwork, partnership, and the support of our community, we proudly achieved many of the ambitious goals we have set for ourselves over the past year.

We implemented our regional Health Information System (HIS) - a transformative project which will contribute to building a stronger, more connected healthcare system for our patients and community. We opened new MRI and Mammography and Emergency Mental Health and Addictions spaces. Among our other quality improvement initiatives, we implemented the use of thrombolytics in our emergency department for patients experiencing stroke. We also introduced a variety of back-office technology systems to support our staff with scheduling, learning and accessing information they need to work effectively. These improvements are critical to meeting the needs of our community, implementing patient and family-centred care best practices and moving our quality strategy forward.

Our 2025-26 Quality Improvement Plan (QIP) is organized in the four priority categories set out by Ontario Health (access and flow, equity, experience, and safety). This aligns well with our local priorities which move us forward with our strategic goals. We are

proud to include indicators which are important to our patients and their family members while addressing the priority indicators identified by Ontario Health. Other indicators include external or regulatory requirements, such as our service accountability agreements and opportunities identified in our Accreditation Report. The QIP reflects our continued pursuit of excellence on behalf of our friends, family and neighbours.

ACCESS AND FLOW

This QIP recognizes the interconnections and teamwork needed between all areas of the hospital. Flow in other parts of the hospital can significantly impact the emergency department. This includes inpatient bed availability, discharge processes, and specialty consultations. We have included change ideas intended to address these factors, and improve overall patient flow, reduce ED crowding, and enhance the quality of care provided to all our patients.

We understand the vital role we play in the healthcare system and have implemented initiatives to enhance outcomes and alleviate system pressures. Our patients and their families depend on us to collaborate effectively with our healthcare partners, ensuring a seamless experience and safe transitions of care. This QIP includes activities intended to have a positive impact on our system partners. For example, we are committed to improving our ambulance offload times because we know it's important for our paramedics to respond to our patients who may be waiting next.

EQUITY AND INDIGENOUS HEALTH

As part of our strategic planning, we conduct community needs assessments to understand demographic trends, social determinants of health, and risk factors. We have implemented processes to reduce health disparities, such as cultural competency training, health promotions, accessibility plans, and support through social workers and mental health programs.

This QIP builds on the development and roll out of our Equity, Diversity and Inclusion framework in 2024-25. We are committed to addressing systemic racism, discrimination, and inequalities in healthcare, creating a culture of belonging for all. To meet this commitment, we first need to understand the current experience of our staff and physicians and the challenges they face. This will support moving the framework into an actionable plan with that will be lead and monitored by our Accessibility, Inclusion, Diversity and Equity.

PATIENT/CLIENT/RESIDENT EXPERIENCE

Brockville General continues to engage with our patients and their families as partners in a variety of ways. We hear feedback through our patient relations processes, surveys and through experience advisors.

Patient and family advisors contribute meaningful input in design, planning, implementation, and evaluation of our services. We are privileged to have a dedicated group of advisors partner with us at our Patient and Family Advisory Council, program planning tables and on special projects. We are honoured when our patients and families are willing to share their stories with our Board members, staff and physicians so that we can understand their perspective.

Our patient and family advisors have contributed to the development of this QIP. Specifically, they are piloting our patient portal and continuing to work with us to evolve our Essential Care Partner (ECP) Program. As a member of the Lanark Leeds and Grenville Ontario Health Team, we look forward to collaborating more broadly with our OHT partners as well as the Ontario Caregiver Organization to create a common understanding and approach among our respective ECP Programs.

PROVIDER EXPERIENCE

We know that our friends, families, and neighbours are counting on us for their healthcare. We need to be here for our community. Brockville General has put considerable focus on the well-being of our team and creating a safe and supportive environment, so that we can give our best to our patients. This includes looking at care models so that our healthcare workers can fully contribute their skills and abilities while they partner with patients and families to deliver the best healthcare experience.

Hospital leadership also makes communication with staff a priority to ensure transparency in decision making. This includes maintaining a robust intranet with specific pages for new projects, bi-weekly newsletters and a monthly Staff Forum moderated by our President and CEO.

Like most Ontario hospitals, Brockville General has seen some staff turnover in the past few years. The work we have done to ensure a safe, healthy, positive and professional work culture has led to better retention rates than most of our peers. We are proud of our partnership with the City of Brockville to develop a recruitment campaign that showcased both what our hospital offers professionally with the quality of life that comes with living in our beautiful and vibrant community.

SAFETY

While Brockville General performs well on patient safety indicators, we recognize that patient safety events do occur in healthcare. How we respond and learn from them is crucial to creating a culture of safety. The priorities set out in this QIP are informed by the analysis supported by our patient safety reporting system as well as learnings from patient safety related incidents and near misses. We are targeting improvements in workplace violence, hand hygiene and patient falls.

Patient falls in hospitals can lead to significant adverse outcomes, including fractures, head injuries prolonged hospital stays, and higher morbidity and mortality rates. Falls also negatively impact patient confidence and satisfaction, potentially leading to a cycle of decreased mobility and further risk of falls. Building on last year's QIP and our falls education strategy, we will focus this QIP on deepening our understanding about preventable falls and meaningful improvements to continue to enhance patient safety.

POPULATION HEALTH MANAGEMENT

Brockville General is an anchor member of the Lanark, Leeds and Grenville Ontario Health Team (OHT). To serve the unique needs of our community, the OHT develops a collaborative QIP which we support and participate in. The focus of the partnership is a strong primary care system. When patients have access to primary care, their health outcomes improve. Primary care is a key partner in supporting patients and families to manage chronic conditions, urgent care needs, and proactive disease prevention. This alleviates pressure on the hospital's emergency and acute care services.

EMERGENCY DEPARTMENT RETURN VISIT QUALITY PROGRAM (EDRVQP)

Brockville General is in the early stages of submitting to participate in the Emergency Department Return Visit Quality Program (EDRVQP). As this will be our first year participating in the program, our initial focus will be on establishing a methodology for audits, understanding patterns in return visits, and utilizing early audit results to further optimize our approach. The team that will be coming together to plan, initiate, and complete our first series of audits will include the Director of our ED, our ED Program Manager, a Physician Lead (Chief of Emergency), a Quality & Risk Lead, a Data Analyst Lead, a Professional Practice Lead, and one ED staff member. The planned audit approach will include auditors looking at both data extracted from the electronic medical record and manually collected information

EXECUTIVE COMPENSATION

Brockville General includes a performance-based component to its executive compensation framework. This framework applies to the Chief Executive Officer, the Chief of Staff, and the executive members of our Executive Leadership Team. A percentage of the executive's compensation (5%) is tied to the achievement of annual goals and objectives aligned to the organization's strategic goals. This includes the quality improvement plan. This approach ensures organizational alignment, as it carries goals through to the individual executive's portfolio. Executive compensation is linked, in part, to the outcomes achieved in our quality improvement plan. The specific performance goals which drive quality and organizational improvement for 2025-26 will be identified and approved by the Board of Directors.

CONTACT INFORMATION/DESIGNATED LEAD

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SIGN-OFF

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan on **March 31, 2025**

Original signed by

James Eastwood, Board Chair

Original signed by

Eleanor Newman, Board Quality Committee Chair

Original signed by

Julie Caffin, Chief Executive Officer

Original signed by

Deanne Henson, EDRVQP lead, if applicable

Access and Flow | Timely | Optional Indicator

Indicator #2

90th percentile ambulance offload time (Brockville General Hospital)

Last Year		This Year		
37.00	**30**	**81.00**	**-118.92 %**	**30**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Continue to secure offload nurse, and review opportunities for improvements.

Process measure

- Ambulance offload time (minutes)(90th P).

Target for process measure

- 30 minutes or less

Lessons Learned

We continue to experience high ambulance offload times (AOT) and are currently meeting with other organizations that have turned their AOT around to identify lessons learned. Based upon what is learned, we will be exploring implementation of changes in Q4, following implementation of our new HIS in Q3.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Utilization of "Fit to Sit" Criteria

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

We are presently exploring updates to our "Fit to Sit" criteria based on lessons learned from other organizations.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Enhancements to offload location

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

A physical location with call bells was established in Q2. There are now five offload locations physically identified in the ED.

Change Idea #4 ☑ Implemented ☐ Not Implemented

Better tracking, with improved ability to pull statistics

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Review of data had supported regular analysis of root causes for offload delays. With a new regional health information system rolled out in Q3, we will continue to explore options within the new HIS for data.

Change Idea #5 ☑ Implemented ☐ Not Implemented

Reach out to high performer hospitals to learn about which approaches have worked well for other hospitals

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Another hospital which has been successful at improving this metric was engaged and has shared lessons learned. Based upon what was learned, we will be exploring implementation of changes in Q4, following the roll out of our new regional health information system in Q3.

Comment

This metric will be carried forward to our organization's 2025/26 QIP. In 2024/25, our organization did not meet Ontario Health's target for ambulance offload and we will looking at new change ideas for 2025/26 to improve ambulance offload times.

Indicator #6

Percent of patients who visited the ED and left without being seen by a physician (Brockville General Hospital)

Last Year		This Year		
9.90	**6**	**12.24**	**-23.64%**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☐ Implemented ☑ Not Implemented

Improve patient flow within the emergency department to support patients with lower acuity (CTAS 4 and 5).

Process measure

- Utilization of chaired spaces.

Target for process measure

- Determine baseline

Lessons Learned

Other hospitals were engaged in 2024/25 and have shared some lessons learned. Change ideas to improve patient flow are presently being planned for 2025/26.

Change Idea #2 ☐ Implemented ☑ Not Implemented

Explore opportunities for waiting room supports from ED team including (PSP/Volunteer/Crisis)

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

This work has been delayed as we navigate a change in model with our Crisis Workers in our Emergency Mental Health Assessment and Care area (EMAC) implementation. Preliminary discussions on the use of volunteers to support a reduction in left without being seen volumes are planned for Q4 of 2024/25.

Change Idea #3 ☐ Implemented ☑ Not Implemented

Determine the reasons that patients leave without being seen to better understand root causes

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

We are currently reviewing the information that can be leveraged from our new regional health information system to develop a custom report that would support this analysis

Comment

Our organization saw the percent of ED patients who left without being seen by a physician progressively increase in 2024/25. This metric will continue to be monitored in 2025/26 in concert with planned change ideas for 2025/26 to improve access and flow.

Access and Flow | Efficient | Optional Indicator

	Last Year		This Year		
Indicator #3 Alternate level of care (ALC) throughput ratio (Brockville General Hospital)	**0.95** Performance (2024/25)	**1** Target (2024/25)	**0.97** Performance (2025/26)	**2.11%** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 ☐ Implemented ☑ Not Implemented

The home first philosophy was reviewed and updated last year. This year will focus on promoting and the philosophy.

Process measure

- Total number of all ALC patients at the end of each week (average).

Target for process measure

- Ten to sixteen patients by the end of each week (average)

Lessons Learned

In Q1, there was preparation to utilize the new Learning Management System (LMS) to deliver education on the Home First philosophy to all front line staff. However, there are still some functionality issues with the new LMS that need to be worked through before it can be used to disseminate this education to staff.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Continue to explore ways to build upon the success of the Early Intervention Outreach Team in preventing some hospital admissions

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

In 2024/25 BGH continued to build partnerships with the nurse practitioner clinic and other community providers with consistent referrals. In this fiscal year we focused on strengthening our partnership with the iCART program, which proactively identifies high risk seniors. The iCART coordinator for our region has come to the hospital to provide additional education to various teams/departments and assisted with screening patients for this program given our HHR challenges and patient volumes. In Q3 of 2024/25 we also focused on partnering with care coordinators in collaboration with Ontario Health at Home, to support patients with activities considered important for maintaining the ability to live independently.

Comment

This metric will not be carried forward onto the organization's 2025/26 QIP. We did observe some modest improvement in ALC throughput ratio in 2024/25, however we must acknowledge system-wide pressures beyond our control that account for the greatest share of performance on this metric.

Access and Flow | Timely | Custom Indicator

Indicator #4

Implement thrombolytics for stroke during 2024-25 Q1 (Brockville General Hospital)

Last Year		This Year		
CB	**CB**	**NA**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Implement thrombolytics in ED for stroke and expand CT services to 24/7

Process measure

- Median door to needle time for thrombolytics for qualifying patients presenting with stroke

Target for process measure

- <30 minutes as this is the provincial target.

Lessons Learned

In early Q2 of 2024/25, BGH became part of Ontario's Telestroke program and the first patient received stroke thrombolytic treatment in early July. Through Telestroke, Emergency Department physicians, the patient and their family, and an interprofessional health care team now have 24/7 access to a neurologist through a dedicated Ontario Telehealth Network connection. Activities in Q1 included implementation of equipment for Ontario Telehealth Network and completion of protocols, policies, and order sets. Going forward, utilization of Telestroke will be monitored by reviewing patient volumes.

Comment

Our organization successfully implemented thrombolytics in the ED for stroke in 2024/25. While this metric will not be carried forward to our 2025/26 QIP, we are continuing to monitor utilization of Telestroke on an ongoing basis to inform future approaches.

Equity | Equitable | Optional Indicator

Indicator #8	Last Year		This Year		
	CB	75	83.11	--	NA
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (Brockville General Hospital)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Implementation of education related to our new EDI framework.

Process measure

- Completion of modules by newly hired staff and physicians. Completion of new education module by all staff and physicians.

Target for process measure

- 100% and 50% respectively.

Lessons Learned

In Q3, the training module on the EDI framework was posted on the LMS and disseminated to all managers and chiefs with direction to support staff and physicians in completing this education within the fiscal year. The module includes links to applicable BGH policies that support EDI. People Services will be tracking completion rates and sharing this data with program managers and chiefs to monitor progress. With respect to physician completion of EDI framework education, the modules have not yet been sent to individual physicians. Dissemination of the education to physicians and tracking of completion will occur in Q4, alongside planned dissemination of other modules to physicians.

Comment

The target was met

Experience | Patient-centred | Custom Indicator

Indicator #7

Percentage of respondents who responded positively to the following question: "Would you recommend this hospital to your friends and family?" (Brockville General Hospital)

Last Year		This Year		
CB	**CB**	**CB**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Partner with patient and family advisors to roll out program specific patient facing materials.

Process measure

- Number of patients / families who receive guides. 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?

Target for process measure

- All patients will receive guides. We will need to determine a baseline for the survey results.

Lessons Learned

The Mental Health pilot is complete, although patients didn't have much feedback one way or the other to provide. It was agreed to move forward with broader roll-out the next fiscal.

Change Idea #2 ☐ Implemented ☑ Not Implemented

Review and update Essential Care Partner Program

Process measure

- ~Track project milestones, implementation and performance metrics to be developed project team ~Were your family or friends involved as much as you wanted in decisions about your care?

Target for process measure

- ~Milestones completed ~baseline for survey question will need to be determined

Lessons Learned

Due to operational responsibilities of Lumeo, work on the ECP process has been limited to bringing about awareness. We have met with the Hospitalist Physician Group and are currently planning to meet with the ED Physician Group which aligns with strategies for 2025/26.

Comment

Multiple change ideas are under consideration for QIP 2025/26. Rollout of patient and family guides to take place in April 2025. Communication and education is continuing for the ECP program.

Safety | Effective | Custom Indicator

	Last Year		This Year		
Indicator #10	**21.00**	**19.95**	**36.00**	**--**	**NA**
Rate of violent incidents that result in physical harm (Brockville General Hospital)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Review Code White protocol: Education - NVCI and pinnel restraint training offered to all clinical units (mandatory for ED & MH). Encourage gentle persuasive techniques and de-escalation strategies, reporting of incidents.

Process measure

- Compliance for the mandatory training. Debriefs on code calls.

Target for process measure

- Track and increase the number of training sessions attended. 100% of code white calls to have a debrief

Lessons Learned

Code white is slated for review March 2025, to prepare those who will be working in the Emergency Mental Health Assessment & Care area, there has been increased training delivered to team members who will be working in this newly re-designed space, The Medical Surgical program is presently looking at how best to support their staff with gentle persuasive techniques and de-escalation strategies. Reporting of incidents is always encouraged by Occupational Health, Safety and management, in addition to education completed on upon hire

Change Idea #2 ☑ Implemented ☐ Not Implemented

Education - NVCI and pinnel restraint training offered to all clinical units (mandatory for ED & MH)

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

To prepare those who will be working in the Emergency Mental Health Assessment & Care area, there has been increased training delivered to team members who will be working in this newly re-designed space

Comment

Workplace violence will continue to stay on the organization's quality improvement plan with new change ideas for 2025/26 recognizing more can be done to improve the state of violence employees endure and encounter while on tours of duty.

Indicator #1

% of staff compliance with hand hygiene before patient environment contact (Brockville General Hospital)

Last Year		This Year		
64.00	**85**	**89.10**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☐ Implemented ☑ Not Implemented

1. Hand hygiene observations 2. Enhance Messaging to staff 3. Auditors to give on-the-spot-feedback

Process measure

- 1. # of observer and self-audits 2. # Communications per month 3. % of audits with feedback given

Target for process measure

- 1. 450 moments per month 2. 2 per month 3. 50%

Lessons Learned

1) Hand hygiene audits are almost 100% conducted by modified workers. Given the inconsistency of staff being injured, and their ability to work as an auditor during said injury, increasing the number of completed audits is impractical in our current model 2) This was successfully completed 3) Auditors were modified staff with no formal training in IPAC and did not feel empowered to provide in the moment feedback.

Comment

Hand hygiene will continue on the 2025/26 quality improvement plan with new initiatives to continue to improve performance and practice within the organization.

Indicator #5

Inpatient falls resulting in harm: The number of reported falls (mild, moderate, severe and death) resulting in harm in inpatient areas as a proportion of 1000 patient days (Brockville General Hospital)

Last Year		This Year		
1.56	**1.40**	**1.38**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Deployment of new beds with falls prevention features.

Process measure

- Total falls reported

Target for process measure

- decrease by 2% in that area.

Lessons Learned

New beds were deployed within our inpatient medicine floors where count of falls is one of the highest in the organization. The yearly trend quarter over quarter was a decrease each quarter in number of falls reported with an overall decrease in the number of falls that resulted in some degree of patient harm per 1000 patient days. Training also coincided with deployment of the new beds.

Comment

The indicator absolute target was surpassed. Inpatient falls will remain on the 2025/26 quality improvement plan with a focus on root cause analysis.

	Last Year		This Year		
Indicator #9	**CB**	**CB**	**NA**	**--**	**NA**
Positive Patient Identification: Percentage of times Two Patient Specific Identifiers are used before medication administration, treatments, tests, and procedures. (Brockville General Hospital)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Develop audit including tracer and feedback mechanism.

Process measure

- #audits completed Rate of reported patient safety incidents related to patient identification.

Target for process measure

- Reduction in positive patient identification misses in Q4 as compared to baseline developed during first audit. We may see increased reporting of incidents with education.

Lessons Learned

A new audit mechanism utilizing armband scanning data reports in Lumeo/armband compliance is planned for Q4, following implementation of the new HIS at the end of Q3.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Professional Practice will observe practice and provide feedback in real time

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Informal spot checks, looking for the presence of an armband on BGH patients, have continued to be conducted periodically by the Lab. Instances of armbands not being present on patients continue to be observed. It is recognized that more work needs to be done in this area. Barriers include the ease with which armbands can be removed and some cases of skin irritation associated with armbands. A new style of armband constructed of softer material was rolled out at the end of Q3 and is hoped to address some of these barriers.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Education and reinforcement for staff on the importance of positive patient identification

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

When lab staff identify a patient without an armband during their spot checks, they provide on the spot feedback to their colleagues for a learning opportunity and ensure that these patients are given an armband.

Change Idea #4 ☑ Implemented ☐ Not Implemented

Develop workflows in Lumeo to strengthen positive patient identification

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

For lab specimens, the use of "positive accession ID" (PAID) is under consideration as an additional safeguard for potential future implementation. This is presently being piloted with blood bank specimens.

Comment

Given the deployment of a regional electronic health information system, patients will now be scanned using a bar code for medication administration, blood procurement, and administration of blood products. This change in practice is embedded into new workflows and data can be collected electronically and is readily available. This data however, is not accurate current state but will continue to be monitored to determine adoption of practice. As such, it will not carry forward on the 2025/26 quality improvement plan but will be considered for the 2026/27 plan depending on performance.

Access and Flow

Measure - Dimension: Timely

Indicator #7	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)	81.00	30.00	Provincial standard	United Counties of Leeds and Grenville EMS

Change Ideas

Change Idea #1 Maximize utilization of designated offload nurse to full potential

Methods	Process measures	Target for process measure	Comments
1. Daily review of record level ambulance arrivals data to identify contributors to offload delays 2. Organize regular cross-program huddles for front line staff and physicians to review data and identify any barriers to ability to place patients in offload 3. Routinely meet with LLG EMS to review offload times and opportunities 4. Review designated offload nurse role with team lead daily and communicate this with Paramedic supervisor	1. Number of patients admitted to offload location 2. Number of hours patients cared for in offload 3. % of days designated offload nurse in place 4. Hours of designated offload nurse per month	Collect baseline	

Change Idea #2 Review and revise Fit to Sit criteria and maximize utilization

Methods	Process measures	Target for process measure	Comments
1. Daily review of record level ambulance arrivals data to identify contributors to offload delays 2. Organize regular cross-program huddles for front line staff and physicians to review data and identify any barriers to ability to place patients in offload 3. Routinely meet with LLG EMS to review offload times and opportunities 4. Review opportunities to track 'fit to sit' utilization with new data reports from new regional health information system	1. Number of patients admitted to offload location 2. Number of hours patients cared for in offload	Collecting baseline	

Measure - Dimension: Timely

Indicator #8	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)	5.52	4.00	Provincial target	

Change Ideas

Change Idea #1	Explore development of RAZ/Fast Track space purposefully designed to expedite time to physician initial assessment and non-admitted patient length of stay		
Methods	Process measures	Target for process measure	Comments
Re-purpose former PR room for utilization as a quick one procedure or privacy space (< 30 mins) for patients safe to return to waiting room	90th percentile LOS for non-admitted ED patients	Collecting baseline	

Change Idea #2	Assess and improve lab and diagnostic imaging turnaround times		
Methods	Process measures	Target for process measure	Comments
1. Examine patterns in blood collection by medical lab assistants for ED patients to determine if there is opportunity for greater utilization of MLAs in ED 2. Explore having urine drug screen done as a point of care test within ED, for more rapid turnaround 3. Examine patterns in data (ex. times, ordering dept, triaging of referrals) to better understand consistency of triaging for DI referrals and impact on DI turnaround for ED patients 4. Examine patterns in radiology turnaround data to determine if there are areas that can be targeted for improvement initiatives 5. Explore options for reducing time DI staff spend waiting in ED for patients not yet ready to be brought over to DI, including feasibility of DI-specific portering 6. Explore the feasibility of having low acuity ED patients requiring imaging return as an outpatient for imaging	1. Time from ED lab test ordered to specimen collection (breakdown MLA vs nurse collected) 2. Time from ED specimen collection to accessioned by lab 3. Time from ED specimen accessioned by lab to results reported (breakdown by specific test) 4. % of ED specimens collected by MLA vs nurse (filtered by time of day) 5. Breakdown of DI referrals by assigned triage/priority level, time of day, ordering department, modality 6. Time from DI exam complete to radiology report available for ED patient (breakdown by time of day, RTR vs in-house radiology, modality) 7. Time from entry of order for imaging to DI exam start time (breakdown by time of day, modality) 8. Balancing Measure: Unscheduled ED Returns within 72 hours & admitted 9. Balancing Measure: Outpatient wait times for diagnostic imaging	Collecting baseline	

Measure - Dimension: Timely

Indicator #9	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)	4.49	4.00	Provincial Standard	

Change Ideas

Change Idea #1 Revise applicable staff and physician workflows to expedite patient admissions from the ED to the accepting inpatient program.

Methods	Process measures	Target for process measure	Comments
1. Increase flexibility in which beds particular types of patients can be admitted to, re-assess policies that restrict where patients can go, and streamline policies/criteria for this. Update surge protocol to explore new options 2. Facilitate having transfer of care communication occur soon after the decision to admit 3. Explore physically sending patients to the accepting unit as soon as is practicable 4. Strengthen staff understanding, comfort, and adherence to new health information system workflows for quickly completing all necessary actions to fully change an ED patient to an admitted patient 5. For the most commonly overlooked aspects of health information system sections to be completed in preparation for admission, deliver targeted education or optimize	1. 90th percentile wait for inpatient bed (hrs) 2. Time from entry of internal medicine consult request to time consultant arrived to see patient 3. Time from admission order entered to time transfer of care documented 3. Time from transfer of care documented to patient received on inpatient unit 4. Time from admission order entered to bed assigned in Capacity Management	Collecting baseline	

workflow to avoid time wasted obtaining clarity from physicians for sections accidentally missed 6. Look at response time for internal medicine consult requests for ED patients, to determine if there are modifiable factors that can be targeted for improvement 7. Review number of patient room moves during same encounter to look for opportunities to decrease movement. Assess whether our isolation requirements exceed those of other hospitals. When bed moves are necessary, optimize timing to minimize negative impact on patient flow 8. Regular analysis of record level data to determine the relative contribution of different factors towards time admitted patients wait in ED for an inpatient bed			
Change Idea #2	Revise applicable staff and physician workflows to optimize early proactive discharge planning and prioritize discharge orders, along with associated next steps		
Methods	Process measures	Target for process measure	Comments
1. Refreshers on Homefirst policies, full scope of home care services available, and legislation changes re equipment to support proactive discharge planning 2. Proactive identification of patients with mobility concerns who may benefit from mobility optimization to help safely prepare them for discharge, such that needed consults are requested as soon as patient becomes medically stable 3. Structure rounds discussions to facilitate very streamlined, focused, and efficient discussion on readiness for discharge and factors affecting readiness for discharge (no more than 1 min per	1. Avg number of bed moves (during same inpatient encounter) 2. Breakdown of discharge orders by time of day order inputted and location 3. Time from discharge order entry to time discharged patient physically leaves building (breakdown by time of day) 4. Time patient physically leaves building to completion of EVS discharge clean task (breakdown by time of day) 5. Actual LOS vs expected LOS for discharged patients 6. Balancing Measure: Rate of unplanned readmissions within days of discharge 7. Balancing Measure: Number of instances where a patient	Collecting baseline	

patient). Explore increasing the frequency of discharge planning rounds, shortening duration, and changing timing from afternoons to mornings. Feed info/trends coming out of rounds back to managers, who may be able to assist with overcoming particular barriers. Explore development of tracking board including expected discharge date within Lumeo 4. Designated staff member on inpatient units consistently available every day for proactive/early identification of patients safe for discharge, in consultation with MRP. To also monitor progress on pending discharges and assist with overcoming any barriers to timely discharge. 5. Explore development of role for discharges that is analogous to what the admissionist does - To the extent possible, target discharge orders being inputted before 11:00 am daily and entry of discharge orders in a planned state prior to the day of anticipated discharge 6. Review number of patient room moves during same encounter to look for opportunities to decrease movement. When bed moves are necessary, optimize timing to minimize negative impact on patient flow 7. Review patterns in data for time of discharge ordered to time patient discharged to time EVS requests completed, and explore barriers to decreasing times at each interval 8. Reduce discharge delays associated with extended wait for ride home - ex. clear and proactive discussions with families re expectations for timely

decompensates/rapidly deteriorates within hours of being brought to inpatient unit

transportation, exploration of alternate options for transportation home when families not available until end of day, determine if there are other transportation options available in community that can be utilized, consider having a discharge lounge			
Change Idea #3	Expedite greater utilization of outpatient clinics (e.g. Ambulatory Care Unit, internal medicine clinic) to prevent avoidable admissions and facilitate safe patient discharges sooner with appropriate supports.		
Methods	Process measures	Target for process measure	Comments
1. Explore greater utilization of outpatient clinics as part of discharge plans to facilitate safely discharging patients sooner, when appropriate, and feasibility of expedited outpatient appointments for newly discharged patients 2. Look at ways to more frequently involve within discharge planning patients' primary care provider, FHT role that follows their patients, and NP from internal medicine clinic, to expedite safe discharges. Look at including these roles in discharge planning rounds. 3. Review data of inpatients admitted with ambulatory sensitive conditions. 4. Review patterns in data for discharged patients with very short LOS (1-2 days) to asses whether some patients may not have needed admission/could have been safety managed in community with the right supports	1. % of patients admitted with ambulatory sensitive conditions 2. % of admissions with LOS between 1-2 days	Collecting baseline	

Equity

Measure - Dimension: Equitable

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percent of front-line staff and physicians in the past 12 months who have experienced or witnessed unfair treatment or discrimination at work based on personal characteristics.	C	% / Staff	Staff survey / April 1, 2025 to March 31, 2026	CB	CB	This is a new indicator and question in our staff / physician surveys.	

Change Ideas

Change Idea #1 Create standardized EDI language to be utilized and approved throughout the organization.

Methods	Process measures	Target for process measure	Comments
EDI language will go through various committees and governance for awareness and finalization in order to be approved.	Completion of EDI workplan.	By April 30, 2025, standardized EDI language will be ready for utilization.	

Change Idea #2 Implementation of Accessibility, Inclusion, Diversity and Equity (AIDE) Committee to combine EDI and Accessibility.

Methods	Process measures	Target for process measure	Comments
1. Combine committees 2. Confirm ToR and Workplan 3. Ensure a diverse membership	Collection of meeting minutes	The AIDE Committee will be in place with a Approved ToR and workplan by September 1, 2025.	

Change Idea #3	EDI language will be incorporated in 20 policies across the organization including Human Resources, Emergency Preparedness, Governance, and Patient and Family Experience.		
Methods	Process measures	Target for process measure	Comments
1. EDI language will be incorporated and tested amongst stakeholders 2. Policies will be tested amongst stakeholders 3. PDSA's will be implemented if improvements are needed to ensure the language is meaningful.	Monitor against baseline indicator.	By March 31, 2026, twenty policies will include EDI language.	

Experience

Measure - Dimension: Patient-centred

Indicator #3	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	75.00	Target maintains collected baseline	

Change Ideas

Change Idea #1 Leveraging the successful pilot in Mental Health, spread the use of the Patient and Family Guidebooks across at least 1 more program. the admitting nurse from the first program of inpatient admission will provide each patient with a guidebook.

Methods	Process measures	Target for process measure	Comments
1. Educate staff on the value of the guidebooks and how to speak with patients and families about the guidebooks and how to use them. 2. Ensure there are processes for staff to easily access guidebooks The admitting nurse will provide the patient/family with a guidebook at admission.	Number of guidebooks provided based on numbers printed and QR code access.	60% of patients within the piloted program have been provided with a guidebook.	

Change Idea #2 The new Patient Portal is scheduled to be released in June of 2025. We want to help get as many patients on the portal as possible.

Methods	Process measures	Target for process measure	Comments
Develop a workflow to support patients at registration and inpatients to access the patient portal.	# patients admitted who access the Patient Portal, # of patients who do not wish to access the patient portal.	By March 31, 2026, BGH will have helped 1000 patients to access the Patient Portal.	

Measure - Dimension: Patient-centred

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% of respondents who responded positively (Always, I did not want them to be involved, I did not have family or friends to be involved) to the following question: Were your family or friends involved as much as you wanted in decisions about your care and treatment?	C	% / Other	Local data collection / Apr 1 to Mar 31	CB	75.00	Target reflects maintaining the baseline collected	

Change Ideas

Change Idea #1 Find an appropriate place to document the Essential Care Partner(s) in Electronic Health Record.

Methods	Process measures	Target for process measure	Comments
1. Request regional/local change request in Electonic Health Record. 2. Find an appropriate place to document ECP name, contact information and level of participation in care. 3. Ensure this documentation is front facing throughout the patient journey in the Electronic Health Record.	Patients who want an essential care partner, have an essential care partner.	Ability to measure baseline will be in place.	Healthrecord is regional. If the change requires regional intervention, it may be more complex to implement.

Change Idea #2 2)Pilot the Essential Care Partner Program in at least one program.

Methods	Process measures	Target for process measure	Comments
Leverage the current ECP program and build onto that with: 1. Update handover strategies, point of care workflows, and transition planning to integrate the ECP. 2. Educate staff on the role of ECP's and practical ways to include and support them. 3. Essential Care Partner program is proactively communicated to patients and families of the designated unit.	Project milestones and uptake of education within the designated unit.	By March 31, 2026, 80% of the staff within the pilot program have completed the Essential Care Partner education.	

Safety

Measure - Dimension: Effective

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Inpatient falls resulting in harm: The number of reported falls (mild, moderate, severe, and death) resulting in harm in inpatient areas as a proportion of 1000 patient days.	C	Number / All inpatients	Local data collection / April 1, 2025 to March 31, 2026	1.40	1.37	When compared year over year, the target continues the trend of a 2% reduction in performance as further mitigation and prevention strategies are employed to address inpatient falls resulting in harm.	

Change Ideas

Change Idea #1 Conduct chart audits in the electronic health records system to determine staff compliance in completing the Morse Falls Risk Assessment upon admission to hospital as an inpatient.

Methods	Process measures	Target for process measure	Comments
Develop standardized chart auditing workflow and checklist	Number of Morse Falls Risk Assessments being completed upon admission by percentage	95% of inpatients admitted to Hospital will have a Morse Falls Risk Assessment completed upon admission.	This is a new falls risk assessment that was part of the regional EHR project (LUMEO) involving Cerner. As such, no current baseline data exists current state for completion rate.

Change Idea #2 Conduct chart audits to determine activation of fall prevention independent plans of care in patients who score high on the Morse Falls Risk Assessment.

Methods	Process measures	Target for process measure	Comments
Develop standardized chart auditing workflow and coordination with Data Analysts to pull monthly reports.	The number of system generated interdisciplinary plans of care being accepted and initiated in the electronic health record as it relates to fall precautions.	85% of inpatients admitted to Hospital that are identified as a high risk of falls in accordance with the Morse Falls Risk Assessment will have an interdisciplinary plan of care documented in the electronic medical record.	Interdisciplinary plans of care being documented in the electronic health record is a new workflow and practice that was part of the regional EHR project (LUMEO) involving Cerner. As such, no current baseline data exists current state for completion rate.

Change Idea #3	When conditions of an inpatient's bed are identified as a mitigation to prevent falls through the interdisciplinary plan of care, conduct an audit to determine staff compliance actively managing both the height of the bed and number of bed rails up in an optimized position for patient safety.		
Methods	Process measures	Target for process measure	Comments
Create bed auditing check sheets to allow for tracking and trending of compliance.	Number of bed audits demonstrating compliance to the interdisciplinary plan of care as it relates to prescribed bed rail positioning and height positioning for the bed.	90% of bed audits will yield compliance to the interdisciplinary plan of care as it relates to prescribed bed rail positioning and height positioning for the bed.	The Hospital has recently purchased new Hill-Rom beds having deployed them in almost all clinical areas (the remaining areas will see beds deployed fiscal year 2025). This will allow for whole-hospital audits in all clinical areas with beds that were designed with patient safety as a focus.

Change Idea #4	Comprehensive electronic health records analysis to determine the top 3 contributing factors of inpatient falls in Hospital.		
Methods	Process measures	Target for process measure	Comments
Develop standardized chart auditing workflow, coordinate with Data Analysts to pull monthly reports, interview staff members and debrief post-fall where harm occurs to patient	Percentage of falls risk assessment completed; percentage of mitigations initiated; count of mitigations initiated; percentage of bed positioning being in the lowest setting; percentage of confusion assessments completed; percentage of restraint application; percentage of interdisciplinary care plans being activated.	95% of core and common strategies with the Hospital's falls risk policy and protocol will be implemented and documented in the patient's electronic medical record.	There are a multitude of factors that may contribute to a fall in hospital. A comprehensive list in audits will afford the organization ample data to drive decision-making on changes to further reduce inpatient falls in Hospital.

Measure - Dimension: Safe

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of staff compliance with hand hygiene before and after patient/patient environment contact	C	% / Other	Local data collection / 2025-26	92.00	95.00	The absolute target reflects continued marginal improvement in performance and practice. Before = 92% After = 95%	

Change Ideas

Change Idea #1 Determine feasibility of purchasing and implementation of an artificial intelligence solution to monitor hand hygiene compliance.			
Methods	Process measures	Target for process measure	Comments
Engage with vendors to examine products, conduct demonstrations, secure finances, and develop a project plan to roll out a pilot program with project stakeholders.	1) Vendor demonstrations 2) Product selection 3) Training and education 4) Number of hand hygiene observations completed by the AI	1) Completed 2) Completed 3) 100% of staff in the respective pilot area 4) 5000/quarter	Based on historical organizational issues with data accuracy, reliability, and consistency, a needs assessment has already been completed with AI identified as a viable change idea. 5000 moments is an estimated target based on quarterly average across the entire hospital current state.

Change Idea #2 Leadership engagement in hand hygiene compliance monitoring (Develop a standard and consistent process to evaluate performance)			
Methods	Process measures	Target for process measure	Comments
Enhanced accountability through IPAC leadership to create a schedule for observations, role modeling behaviours by IPAC team, targeted monitoring in areas with lesser observed moments, and focused continuous improvement.	1) Managers and Directors will be trained on how to complete hand hygiene audits 2) Increased hand hygiene audits across the organization 2) Count of hand hygiene audits completed	1) 100% of managers and directors within the organization will be trained on how to conduct hand hygiene audits 2) Count of hand hygiene audits completed per quarter will increase by 33%	This change idea reflects a proposed change idea from the previous fiscal year but with a project plan in place. Past change ideas were limited by resources, level of comfort, inter-rater reliability, training, and the types of observers which were almost 100% modified staff workers.

Measure - Dimension: Safe

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of violent incidents that result in lost time claims	C	Number / Staff	Local data collection / 2025-26	1.00	1.00	This prioritizes worker well-being ensuring the health and safety of all employees while providing reasonable modifications and accommodations that minimizes lost time	

Change Ideas

Change Idea #1 Actively monitor and maintain staff NVCI training in mandatory areas and expand NVCI Lite. And Gentle Persuasive Approach into the Transitional Care Program.

Methods	Process measures	Target for process measure	Comments
Professional Practice and clinical learning specialists will take an active roll in routinely schedule in-house training sessions with support from leadership.	Percentage of mandatory staff that have completed their NVCI training	95% of mandatory staff will have completed the necessary NVCI training respective to their clinical area.	Previously the organization had reviewed gentle persuasive approach as an idea to reduce the number of workplace violence incidents that result in harm but this was not a practical nor feasible option

Change Idea #2 Provide staff training on when to call security for assistance and what criteria is required to transition into a Code White

Methods	Process measures	Target for process measure	Comments
The Security Supervisor and Emergency Preparedness Coordinator will conduct training sessions with staff across the organization to inform staff on proper process and protocol; Code White review and analysis will transition from the EP Coordinator to the Security Supervisor to better align with their portfolio and normal duties.	Percentage of security activation and/or Code White	There will be a 5% increase in the total number of security activations and/or Code Whites	This was identified as a gap during hot debriefs that there is often a delay in securing resources (human capital) during workplace violence events.