Quality Improvement Plan (QIP)

# Narrative for Health Care Organizations in Ontario

March 31, 2025


## OVERVIEW

Land Acknowledgement

We acknowledge that Brant Community Healthcare System (BCHS) is located on land that has been the traditional territories of Indigenous peoples for at least 10,000 years. Today, their descendants – the Haudenosaunee and Mississauga nations – continue to reside in the Grand River region. Several centuries ago, these two groups entered into a social and political agreement known as the Dish with One Spoon wampum, which called upon people to help one another and commit to ensuring that the natural environment would be cared for so that future generations would benefit from what the land provided. This ancient philosophy, based upon mutual respect and a shared responsibility to put aside differences to ensure human and social wellness, are values that BCHS will continue to uphold and to strive for when working with Indigenous patients, families, and staff.

Programs & Services

BCHS is a large, two-site community hospital system serving Brantford, Brant County, Six Nations of the Grand River, Mississaugas of the Credit First Nation, and surrounding communities. With 330 beds, BCHS is an affiliated teaching site of McMaster University's Michael G. DeGroote School of Medicine. Brantford General Hospital is a regional acute health centre, while The Willett, Paris provides urgent care and transitional beds. Brantford General Hospital:

- Ambulatory Care
- Cancer Treatments

- Complex Care
- Critical Care
- Diabetes Education
- Diagnostic Imaging
- Emergency Care
- Geriatric Services
- Indigenous Health
- Inpatient Medicine
- Rehabilitation
- Integrated Stroke
- Laboratory Medicine
- Labour & Delivery
- Mental Health
- Neonatal Intensive Care
- Palliative Care
- Pediatrics
- Pharmacy
- Surgery

The Willett, Paris:

- Urgent Care
- Transitional Beds

BCHS is proud to have earned Accreditation with Exemplary Standing from Accreditation Canada. We are a high-performing healthcare organization responding to our community's rapid growth, rising demands, and increasing expectations for healthcare services.
Strategic Plan 2025-2030: "Leading Beyond Care"
As we look to the future, our commitment remains to deliver high-quality, person-centered care to improve patient experience and outcomes.

2025/2026 Quality Improvement Plan Goal Summary:

•Reducing Emergency Department (ED) wait times: Improve physician initial assessment time by 2.1 hours, from 7.3 to 5.2 hours.

•Improving ambulance offload time: Reduce ED ambulance offload time by 55 minutes, from 115 to 60 minutes or less.

•Increase access to timely surgery: Improve access to hip fracture surgery rates within 48 hours from by from 57.8% to 80.9%, a 23.1 percentage point improvement.

•Prevent hospital-acquired pressure injuries: Reduce hospital-acquired stage 3 and 4 pressure injury rates to 0.0%.

•Improve patient experiences: Increase positive survey responses regarding receiving adequate information at discharge from 54% to 59%, a 5 percentage point improvement.

•Reduce patient occupancy challenges: Decrease Alternate Level of Care (ALC) Rate from 19.9% to 17.3%, a 2.7 percentage point improvement.

•Shorten ED wait times for inpatient beds: Reduce the time patients wait for an inpatient bed by 6.9 hours, from 38.9 to 32.0 hours.

•Advance equity and inclusion: Ensure 100% of BCHS leaders

complete diversity, equity, inclusion and anti-racism training.

## ACCESS AND FLOW

To support the community's growing population and healthcare needs, BCHS is committed to ongoing improvement to promote access to the care and services our patients need, while also supporting a safe work environment for the delivery of quality patient care. Efficient patient access and flow is essential to meeting the increasing demand for timely and appropriate care.

BCHS has implemented several strategies to enhance the patient experience within the Emergency Department (ED), while also supporting admission avoidance and improving patient flow. The ED Navigator connects patients with Community Support Services (CSS), while Ontario Health at Home and Community Services collaborate in the ED to identify patients who may benefit from home-based care. The expansion of our Geriatric Program within the ED and the launch of our BCHS@Home program enhances these established processes, creating additional pathways to allow BCHS to uphold the Home First philosophy.

When patients are admitted to the hospital, effective bed management processes ensure that patients are placed in the most appropriate available bed. This includes daily bed meetings where leaders from each program collaborate to optimize patient flow and ensure timely bed availability. The "Bed Ahead" strategy helps to proactively plan for specialty bed availability, facilitating smoother transitions and ensuring ongoing access to emergent care.

Post-acute care is coordinated from a person-centred lens through our interprofessional team to ensure patients receive the right care at the right time, in the right place, by the right provider. Our Coordinators triage referrals in a timely manner and assess eligibility for internal and external programs, while collaborating with the interprofessional team to ensure safe and timely transitions. These initiatives reflect BCHS' ongoing commitment to enhancing access to care, improving service delivery, and optimizing patient flow, ensuring care is provided to those who need it.

## EQUITY AND INDIGENOUS HEALTH

In BCHS' 2025-2030 Strategic Plan, Champion Equity is identified as an organizational value, and each Strategic Pillar includes a key objective that describes our commitment to equity.

Our 2025/2026 QIP goals recognize that we are serving some of the most vulnerable people in our communities and therefore, we have developed goals that are aimed at improving access, enhancing safety, providing diversity, equity, inclusion and anti-racism education, and connecting patients with services to both treat and prevent illness.

In 2023, we welcomed a Director of Diversity, Equity, Inclusion, and Belonging (DEI-B) and launched a DEI-B Engagement Survey. The findings provided valuable insight into understanding the experiences, perspectives, and needs of our BCHS employees, professional staff, and volunteers and influenced the development of our Current State Report and DEI-B Roadmap, setting the priorities of leaders for the next three years.

Guided by our "Celebrate, Educate, Engage" model, we have made significant progress across eight key pillars: DEI-B Leadership and Governance, Data Gathering and Insights, Communication and

Awareness, Training and Education, Inclusive Practices and Cultural Awareness, Community Engagement and Allyship, Accountability and Transparency, and DEI-B Progress and Future Focus. Major highlights include honouring and celebrating culturally specific dates, expanding inclusive and accessible practices and programming, and committing to training and education through e-Learning modules and in-person sessions.

Moving forward, we remain focused on fostering a culture where everyone feels fully seen, heard, and respected, as well as aligning our 2025-2030 Strategic Plan to address existing systemic barriers. We also welcomed the addition of an Indigenous Health Manager, and Indigenous Patient Navigators to the Indigenous Health Services Team. These roles work collaboratively with leadership, staff, and physicians to improve the Indigenous patient experience at BCHS and advance cultural safety.

## PATIENT/CLIENT/RESIDENT EXPERIENCE

BCHS has established a Patient and Family Advisory (PFA) Program to enable the community and patients and families to assist us in the co-design of our services. PFAs assist us in the design of key processes that impact patients in the hospital.

Our CEO's Patient and Family Advisory Committee meets monthly, and all Program Councils have a PFA sitting at the table, bringing the patient and family voice to each discussion and decision.

To support the 2025/2026 QIP planning, all QIP working groups included a PFA to provide input and support in setting ideas and targets. This QIP was presented to the CEO’s Patient Family Advisory Committee to solicit input on whether:

• The goals and planned improvement initiatives selected address key patient concerns
• Our incremental approach to target setting was reasonable given our current environment
• How best to communicate this plan and our progress externally

Notably, our PFAs developed BCHS' "People-Centered Framework". People-centered care at BCHS is an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families. As part of this framework, BCHS offers patients the opportunity to share their experiences and feedback through patient experience surveys, or through the Patient Experience Office. Our framework defines how we partner with patients, people with lived experiences, and the community to drive a person-centered care approach.

To learn more about our Patient and Family Advisor Program, visit www.bchsys.org/pfa.

## PROVIDER EXPERIENCE

At BCHS, we continue to prioritize the provider experience, as we know caring for those who care for others is essential to ensure we are proving high-quality and safe care to patients.
We continuously strive to focus on supporting and empowering our staff. Our BCHS Peer Support Program is an emotional support program that works to improve the psychological health and safety, resiliency, well-being, and sustainability of all employees, volunteers, and learners at BCHS. As we continue to enhance the Peer Support Program at BCHS, the next phase of development

includes the launch of a Physician Peer Support Program. This initiative aligns with our ongoing commitment to fostering a culture of health, safety, and well-being across our organization.

Our Wellness and Recognition Committees also provide much appreciated resources to our frontline staff, including wellness and staff, professional staff and volunteer recognition events. This past year, we were happy to continue our Annual Recognition Awards Night, where we could celebrate and recognize the dedication and successes of our exceptional healthcare workers. Additionally, BCHS has committed to the monthly circulation of the Wellness Wagon, designed to encourage staff to take a moment for personal well-being by providing light snacks and other wellness-enhancing items. Further reinforcing our dedication to employee wellness, we are excited to announce the opening of a new wellness space in Spring 2025. This space will be available to all staff, professional staff, volunteers, and learners and will feature two new massage chairs to support relaxation and stress relief.

Staff safety and well-being remain key priorities in our efforts to enhance the provider experience. As part of this commitment, we are implementing Safety Talk Huddles—regular discussions aimed at reinforcing workplace safety measures and identifying opportunities for continuous improvement to ensure BCHS remains a safe and supportive environment. Recognizing the critical role of mental health in overall well-being, we have also partnered with our Peer and Outpatient Mental Health Social Workers to introduce a Skills Education Series for staff. This initiative is designed to provide valuable tools and resources that support mental wellness and resilience among our team members.

A cornerstone of BCHS' engagement plan with staff includes the "BCHS Culture Survey". The culture survey includes the full Accreditation Canada Patient Safety Culture Survey. We utilize this information to inform what we are doing well, and where opportunities lie to enhance all aspects of the quintuple aim of healthcare: improving patient experience, population health, reducing costs, care team well-being and health equity. The data from this survey is analyzed and shared back with all levels of the organization. Additionally, we hear from our staff and physicians through Quality & Safety Huddles, Senior Leader Rounding, Manager Rounding, Town Halls, and our Virtual Suggestion Box.

## SAFETY

Advancing quality and safety is our top priority at BCHS. Incident reporting of patient/visitor safety events (including near misses/good catches) is crucial to the continuous quality improvement process and is intended to improve the overall system of safety. As such, all BCHS staff and physicians must report all patient and visitor safety incidents in the incident management system (Safety Incident Management System/"SIMS").

BCHS promotes a ‘just culture’ and utilizes a ‘systems’ approach to incident reviews. We have chosen to adopt the Canadian Incident Analysis Framework (Canadian Patient Safety Institute) as a best practice tool for reviewing and learning from incidents at BCHS. We have developed algorithms and decision-making tools and resources to support team members and leadership in managing, disclosing, and reviewing incidents.

Learning from patient safety incidents and preventing recurrences drive continuous quality improvement at BCHS. Incident reports for

each program are reviewed by leaders and the quality and risk team to monitor for trends or concerns. Any identified trends or concerns are shared with the Program's Quality Council and brought to the attention of Quality & Operations Committee, Senior Team and/or the Quality Committee of the Board as per the established reporting schedule. Quality & Patient Safety Learning Stories are circulated in staff newsletters on a regular basis (quarterly) to support organizational learning from incidents and share improvement initiatives. Learning from incidents and actions for improvement are also shared at Program Quality Councils and at team Quality & Safety Huddles.

Patient stories serve as catalysts for change across our organization. These stories, sourced from feedback received by the Patient Experience Office—be it compliments, complaints, or inquiries—are shared at the onset of various meetings throughout the organization. The Patient Experience Office shares stories from emails or telephone conversations that recount concerns, positive experiences, or inquiries. These stories, carefully selected based on prevalent trends, provide a platform to highlight areas for improvement. The profound impact of patient stories resonates throughout the organization, propelling us toward continuous improvement in quality, safety, and patient experience.

## PALLIATIVE CARE

We deliver high-quality care through a dedicated palliative care unit staffed by designated palliative care physicians, nurses, and personal support workers (PSWs). Every patient admitted to our palliative care beds has a palliative care physician responsible for their care. Nurses and PSWs working in this unit have recent experience in a palliative care setting and/or have completed or are working toward their palliative care certificate.

To ensure excellence in care, all nurses and PSWs are supported in obtaining further certification in palliative care within six months to one year of hire. We are fortunate to have support from the Hamilton Niagara Haldimand Brant Regional Cancer Program, which provides opportunities for employees to participate in Pallium Canada's Learning Essential Approaches to Palliative Care (LEAP™) training. Completing this training is a requirement for our team within their first year of hire.

Our approach to care is patient- and family-centered. The program features eight private suites designed to support end-of-life care, providing patients and their families with privacy during their final days and weeks. Our program has a great partnership with Ontario Health at Home to work with our patients and families whose wish is to return home for palliative care.

The Palliative Quality Care Council meets monthly to review our program. This committee includes physicians, nurses, PSWs, support staff, and a patient and family advisor. Together, we assess our processes and identify opportunities for improvement, incorporating feedback and insights from employees and the patient and family advisor.

## POPULATION HEALTH MANAGEMENT

Since 2021, BCHS has proudly been one of the 19 signatory agencies which form the Brantford Brant Norfolk Ontario Health Team (BBNOHT). Collectively the BBNOHT provides information, support and access to health services in the Brantford, Brant and Norfolk communities.

BCHS is committed to advancing population health in partnership with the BBNOHT. In alignment with the BBNOHT strategic priorities, BCHS has set QIP goals aimed at reducing the Alternative Level of Care (ALC) rate to align with provincial metrics. Working in together with BBNOHT to meet these targets will help maximize local health system resources, ensuring patients receive the right care, in the right place, at the right time.

BCHS also participates in the BBNOHT's Collaborative Quality Improvement Plan which this year is focused on hospitalizations for ambulatory care sensitive conditions and the admission rate for persons with chronic obstructive pulmonary disease and heart failure. BCHS will work to enhance the continuum of care, particularly in supporting primary care and community-based services to ensure acute care resources are available to those who need it most.

Advancing the continuum of care and services for specific communities through collaboration with community partners is essential to supporting priority populations with pressing health needs. A multi-organizational approach to an integrated care model is grounded in a shared vision of improving health outcomes, providing more patient centred care and enhancing the patient experience for our region's priority populations.

## EMERGENCY DEPARTMENT RETURN VISIT QUALITY PROGRAM (EDRVQP)

Large-Volume Site EDRVQP Submission

1. Status Update on Quality Improvement Priorities

LWBS Rates

Reducing patients who Leave Without Being Seen (LWBS) remains a key focus. In 2022-2023, our LWBS rate was 6.3%. This past year, we improved it to 6.0%. Contributing factors include ED boarding and physician staffing challenges, which drive up Physician Initial Assessment (PIA) times and, in turn, LWBS rates.
In July 2024, we launched an LWBS Result Review Process. Physician Assistants (PAs) review abnormal results from all LWBS patients daily and contact them for follow-up. This standardized, well-documented process has been effective, with patients successfully recalled for care. We plan to continue this initiative as a core quality process.
To better understand LWBS cases, we purposefully audited 15 cases this year, identifying key themes explored further below.

PIA Time

The 90th percentile PIA time was 7.5 hours in 2023-2024. This year, it has improved modestly to 6.8 hours. We expanded PA coverage in high-acuity areas and directed mid-acuity zone physicians to use the last hours of their shifts to assess waiting patients, initiate testing, and discharge simple cases. Physicians have used unconventional spaces, such as the triage bay and Quiet Room, to increase flow.
Despite improvements, high PIA times persist due to ED boarding, staffing, and space constraints. We are exploring the possibility of adding an Initial Assessment Physician (IAP) shift to further reduce PIA times, pending recruitment efforts.

2. Quality Issues Identified and Planned Initiatives

Sentinel Diagnosis Analysis

Of 11 acute myocardial infarction (AMI) cases audited, 4 patients LWBS and another 4 left against medical advice (LAMA). Proactive use of the Chest Pain Medical Directive at triage and our LWBS result recall system helped mitigate harm. Half of the LWBS patients were recalled after abnormal cardiac enzyme results and treated appropriately.
We will continue proactive ECG screening, rapid physician review, and result recall processes, but acknowledge system pressures driving LAMA/LWBS are largely outside ED control.

LWBS Analysis

Among 20 LWBS cases reviewed, a key theme was patients with substance use disorder, particularly alcohol withdrawal. These patients often left early and had risky behaviors between visits. The current Clinical Institute Withdrawal Assessment (CIWA) protocol requires intensive resources and is challenging to implement in the waiting room setting.
We aim to develop an Alcohol Withdrawal Medical Directive for early recognition and treatment at triage. This initiative will involve multidisciplinary collaboration and is expected to reduce LWBS rates and improve patient outcomes in this vulnerable group.

Non-Sentinel Diagnosis Analysis

A recurring theme was admission avoidance in elderly patients and those with borderline needs. While avoiding unnecessary admissions helps reduce ED boarding, it requires balancing patient safety and system capacity. Cross-functional teams, including navigation, physiotherapy/occupational therapy, dementia support, and LHIN services, support safe discharges. Recently, we added a Geriatric Nurse to assist with navigation 12 hours per day, which we expect to enhance discharge planning further.

Despite ongoing system challenges, our ED team remains resilient and committed to quality improvement through innovation and teamwork.

## EXECUTIVE COMPENSATION

Subject to compliance with the Broader Public Sector Executive Compensation Act (BPSECA), 2014, a percentage of an executive's base salary is linked to the achievement of a defined number of performance improvement indicators set out in the Quality Improvement Plan.

## CONTACT INFORMATION/DESIGNATED LEAD

If you have any questions, comments or concerns about our QIP or the hospital in general you can reach at us at the following contact points:

The Brantford General
200 Terrace Hill Street
Brantford, ON
N3R 1G9
519-751-5544

The Willett, Paris
238 Grand River St. North
Paris, ON
N3L 2N7
519-442-2251

You can also learn more about us at our website at:
www.bchsys.org or follow us on social media.

## 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 28, 2025**

Dave Diegel

**Dave Diegel**, Board Chair

**Dr. Mackenzie Slifierz**, Board Quality Committee Chair

**Bonnie Camm**, Chief Executive Officer

**Melissa Hayward**, EDRVQP lead, if applicable

# 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) | 140.00 | 60.00 | In Q3 of 2024/25, the Emergency Department (ED) made significant progress in reducing ambulance offload times, reaching 79 minutes. The 60-minute target reflects our commitment to continuous improvement and alignment with the provincial average. This will position us to set our next target to the top decline performance of 23 minutes in the 2026/2027 QIP. | Brant-Brantford Paramedic Services,<br>Six Nations Paramedics |

### Change Ideas

Change Idea #1 Human Resources: Sustain position of dedicated Ambulance Offload Nurse – Currently funded by Emergency Medical Services (EMS) and will need to demonstrate improvement of Ambulance Offload (AOL) Time for sustainability

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1. Prioritize filling the dedicated AOL time assignment per shift | 1. ED Scheduler and manager to audit rotor prior to publishing to ensure EMS Offload nurse assignment are filled 2. Daily assignments sheets to be reviewed in advance of shift to ensure EMS offload nurse is identified | 95% of Dedicated Offload Nurse shifts are assigned | |

| Change Idea #2 Process Improvement: Improved utilization of in-patient capacity, surge spaces and ED flow | | | |
|---|---|---|---|
| Methods | Process measures | Target for process measure | Comments |
| 1. Maintain flow within the back hall of the ED a. Maximizing utilization of the fit to sit criteria – Broadening criteria to allow more patients to be offloaded from EMS stretcher to waiting room | 1. Number of days of 15 admitted patients or less in the department at 0800h - Indicator of how many of the admit no bed patients are still in the ED from overnight) 2. Utilize PulseCheck to view number of hours admitted patients are in back hall a. Dashboard currently being created in PowerBi by Decision Support | 1. Decrease number of hours admitted patients are in back hall by 15% 2. Improved and sustained AOL time to 60 minutes | |

| Change Idea #3 Documentation Improvement: Transfer of Care (TOC) Initiative – In collaboration with EMS to align off-load times. | | | |
|---|---|---|---|
| Methods | Process measures | Target for process measure | Comments |
| 1. Improve documentation for accuracy of data collected – Ensure no missing fields in the patient data record 2. Work with EMS for sign off to align off-load times - eliminate discrepancy between EMS offload data and BCHS offload data | 1. ED Supervisor to randomly audit 15 charts per month to ensure data completion and accuracy – Chart review findings to be reviewed with staff at huddles on a weekly basis 2. Alignment of data with EMS AOL time – Creation of shared documentation tool in progress and will be part of the chart audit review | Improved AOL time to 60 minutes | |

## Measure - Dimension: Timely

| Indicator #5 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| 90th percentile emergency department wait time to inpatient bed | O | Hours / ED patients | CIHI NACRS / For ERNI hospitals: Dec 1, 2023, to Nov 30, 2024 (Q1 and Q2) | 39.07 | 32.00 | The proposed target of 32.0 hours reflects the current provincial performance of 32.9 hours (April to November) and aligns with both our historical and current performance, while offering realistic and attainable improvement opportunities. Past performance metrics indicate that the previously projected target of less than 28 hours was difficult to achieve given our current infrastructure challenges. Our year-to-date (April to December) performance is 38.9 hours, with historic performance of 33.4 hours in 2023-24 and 35.5 hours in 2022-23. The target of less than 28 hours was achieved less than 10% of the time. Setting a target of 32.0 hours will position us to work toward achieving the provincial target of 28 hours or less in the 2026/2027 QIP. | |

### Change Ideas

| Change Idea #1 | Reduce the number admitted patients requiring less than 48 hours of acute inpatient care. | | |
|---|---|---|---|
| Methods | Process measures | Target for process measure | Comments |
| 1. Review access to ambulatory and community clinics, services, and resources. 2. Review organizational resources available at time of decision to admit. | 1. Conduct an environmental scan of ambulatory and community clinics, services, and resources. 2. Conduct an environmental scan of the organizational resources available at time of decision to admit | 1. Development of an index of the established relationships with ambulatory and community clinics, services, and resources available 2. Development of guidelines to support admission diversion using internal and external resources. | |

| Change Idea #2 | Improve consistency in meeting discharge timeline of 1100h from inpatient post-acute programs (i.e., rehabilitation, medically complex, and Alternate Level of Care [ALC]). | | |
|---|---|---|---|
| Methods | Process measures | Target for process measure | Comments |
| 1. Complete discharge orders the day prior (orders to be date and time-stamped). 2. Streamline communication and planning of weekly discharges to ensure effective post-acute movement. 3. Develop and integrate a virtual communication tool to summarize current readiness for discharge to support proactive patient flow planning. | 1. Engage in stakeholder (physician) education and discussion regarding proper completion of discharge orders day prior. a. Conduct spot audit checks on patients who are predicted and/or confirmed to be discharged within the next 24 hours. 2. Provide stakeholders (Charge/Shift Lead, Senior Clinical Operations Manager [SCOM], Clinical Managers, Patient Access and Flow office) education regarding discharge readiness and discharge orders 3. Successful roll out and uptake of the virtual communication tool by key stakeholders. | 1. 100% of discharge orders accurately completed (date and time-stamped) 2. 80% of patients discharged from post-acute program by 1100h 3. 100% compliance with use of virtual communication tool | |

| Change Idea #3 Improve the accuracy of discharge predictions across the organization (all services and programs). | | | |
|---|---|---|---|
| Methods | Process measures | Target for process measure | Comments |
| 1. Develop an interprofessional discharge readiness checklist (e.g., OT, PT, community supports, transportation, pick up time, etc.) to facilitate discharge orders. a. Establish a process for Senior Clinical Operations Manager (SCOM) to review interprofessional discharge readiness checklist prior to (48hrs and 24 hrs) Estimated Date of Discharge (EDD) to identify risks/barriers to meeting EDD 2. Streamline the process for reviewing, communicating, and acknowledging daily discharge plans. 3. Develop and integrate a virtual communication tool to summarize current readiness for discharge to support proactive patient flow planning. | 1. Establish a working group to help facilitate the development and implementation of the discharge readiness checklist. a. Conduct compliance audit for discharge readiness checklist completion (48hr and 24hr) for patients with predicted and/or confirmed discharges 2. Implement a discharge triage process 3. Successful rollout and uptake of the virtual communication tool by key stakeholders | 1. Launch and integration of interprofessional discharge checklist by July 2025 o 100% compliance with use of discharge readiness checklist 2. Successful integration of discharge triage process 3. 100% compliance with use of virtual communication tool. | |

| Change Idea #4 Refresh current Bed Management process to avoid unnecessary delays and avoid periods of decreased or no flow due to person-dependent processes. | | | |
|---|---|---|---|
| Methods | Process measures | Target for process measure | Comments |
| 1. Review current patient flow processes (input, throughput, and output) within the organization to identify opportunities to streamline process 2. Streamline process for Transfer of Accountability (TOA) and develop template for “No Delay TOA” between ED and Inpatient Units | 1. Review and update current organizational Bed Management policy 2. Engage in education sessions, huddles, and organizational communication to support the launch of updated TOA process | 1. Successful implementation of updated Policy with notification and education roll out to support any changes in process by September 2025 2. Integration of updated TOA process | |

## Measure - Dimension: Timely

| Indicator #6 | 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) | 7.13 | 5.20 | Average 90th percentile is 4.5 hours for hospitals across Canada with high volumes, so we are aiming to meet close to this average. This will position us to set our next goal of meeting the provincial target of 4 hours or less in the 2026/2027 QIP. | |

### Change Ideas

Change Idea #1 Documentation review: Canadian Triage and Acuity Scale (CTAS) 1 data coding and documentation improvement opportunities

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1. Review of CTAS 1 physician initial assessment (PIA) data to ensure improved documentation 2. Support improved documentation with access to progress sheets at Triage and education to registration to provide charts to physicians for CTAS 1 patients | 1. Monthly audit of CTAS 1 data to ensure accuracy 2. Improved documentation for CTAS 1 patients | 1. Monthly data review at 100% 2. Within review: 85% or more of CTAS 1 patients are seen less than 5 minutes | |

| Change Idea #2 Practice Improvement: Implementing strategies to enhance support for patients being assessed near the end of shift hours | | | |
|---|---|---|---|
| Methods | Process measures | Target for process measure | Comments |
| Prioritize patients in the main department by providing initial assessments on patients with bed assignments: • Managing patients with pain • Assessing patients with C-collar for potential clearance • Assessing patients to initiate testing such as imaging or labs | Improvement of PIA towards target | Improved PIA time to target of 5.2 hours | |

| Change Idea #3 Human Resources: Utilize Flex nurse to support assessments in the waiting room to decrease time to physician initial assessment (PIA) | | | |
|---|---|---|---|
| Methods | Process measures | Target for process measure | Comments |
| Utilizing the flex nurse when there are many patients waiting in non-traditional spaces such as beds available without nurse capacity | 1. Reduction in cases of Left Without Being Seen (LWBS) 2. Reduction of flex nursing shift vacancies | 1. Reduction of LWBS to 5% 2. Vacancy of flex shift less than 10% 3. Improved PIA time to target of 5.2 hours | |

## Measure - Dimension: Timely

| Indicator #7 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Alternate Level of Care (ALC) Rate | C | Rate / ALC patients | CIHI DAD / 2024-2025 | 19.90 | 17.30 | The provincial average is 17.3% and our YTD performance is 20% so we are targeting to align with the provincial metrics. We will be working collaboratively with our community partners, and maximizing our internal resources, to ensure patients receive the right care in the right place at the right time. This will position us to set our next target of achieving top quartile performance at 13.3% in the 2026/2027 QIP. | |

### Change Ideas

Change Idea #1 Commence early screening and implement intervention of adult patients at-risk for ALC.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1. Collaboratively identify and implement a standardized Frailty Tool (to be used across all sectors internally and externally) 2. Identify the key stakeholders who will use the standardized Frailty Tool and those who contribute to designating patients as ALC. 3. Create and implement a robust Geriatric program to optimize organizational senior-friendly initiatives | 1. Launch the standardized Frailty Tool (incorporate into standard practice and policy) a. Conduct quarterly audits for compliance with use of Frailty Tool 2. Utilize the standardized Frailty Tool to guide recommendations for interventions at time of admission a. % of identified at risk patients with documented intervention plan within first 48hrs of admission 3. Fill the funded Geriatric Emergency Medicine (GEM) nursing roles | 1. 100% implementation and compliance with use of the standardized Frailty Tool 2. 80% patients with documented intervention plan at time of admission 3. 2 funded GEM nursing roles filled | |

| Change Idea #2 | Maximize referral to the funded Hospital to Home (BCHS@Home) program to support admission avoidance for patients presenting in the ED and those patients who are designated ALC or at-risk of becoming ALC. | | |
|---|---|---|---|
| Methods | Process measures | Target for process measure | Comments |
| 1. Streamline referral process to increase opportunity for admission avoidance and ALC designation. 2. Leverage expertise of the interprofessional team for early identification of functional goals and restorative potential to support seamless transitions (with Home First lens). | 1. Utilize the pre-existing BCHS@Home Coordinator to streamline the referral process by providing in-time support and education. 2. Increase the number of patients admitted to the program. | 1. 21 patient admissions (at minimum) to program per month | |

| Change Idea #3 | Incorporate clear accountabilities and deadlines for follow-up within the bi-weekly ALC rounds to support a reduction in delays by increasing the overall efficiency of the collaborative team. | | |
|---|---|---|---|
| Methods | Process measures | Target for process measure | Comments |
| 1. Update the Terms of Reference for ALC Rounds to define the purpose and expectations of Rounds and establish clear accountabilities. 2. Formalize collaboration with community partners (i.e., OH@H, retirement homes, community support services) to ensure alignment with Home First guiding principles. 3. Review escalation and approval process to align with Ontario Health's Home First operational direction (i.e., all opportunities are exhausted prior to application to LTC) | 1. Develop anonymous team feedback survey to evaluate the effectiveness of ALC rounds prior to change and after change. 2. Pass a signed Memorandum of Understanding (MOU) to further streamline the process of partnership. 3. Develop standardized ALC checklist to establish and enhance accountability. | 1. Full completion of team feedback survey. 2. Implementation of the signed MOU and stakeholder education, including those involved in ALC designation and our community partners, as well as high level information to support knowledge transfer within the organization. 3. Implementation of the ALC checklist with stakeholder education to support use. | |

## Measure - Dimension: Timely

| Indicator #8 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Access to Hip Fracture Surgery within 48 Hours | C | % / All patients | CIHI NACRS / 2024-2025 | 57.80 | 80.90 | Match with current provincial performance. This will position us to set our next goal of meeting the provincial target of 85% in the 2026/2027 QIP. | Norfolk General Hospital, West Haldimand General Hospital |

### Change Ideas

**Change Idea #1** Internal Improvement: Conduct a review of the urgent/emergent booking policy for impact on meeting targets, and create an internal process to review Hip Fracture Surgeries that have missed targets for improvement opportunities

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1. Create audit form to assess emergent case classification for hip fractures 2. Review all hip fracture cases that have missed targets 3. Develop process for reviewing failed hip fractures a. Data review to be shared with Perioperative Quality Council and Orthopedic surgeons | 1. Performance improvement toward provincial target 2. Established process to review factors associated with hip fracture patient that have failed to reach target time. Recommendations and next steps for each review | 90% of hip fracture patients that missed access target time will be reviewed annually | |

**Change Idea #2** System Improvement: Internal audit to review barriers and factors that impact BCHS's ability to complete Hip Fracture Surgery within 48 Hrs of first inpatient admission

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1. Compare dashboard provided by Decision Support, add to additional factors that impact ability to meet the 48 hours timeline 2. Review utilization of OR time to determine if there is an opportunity to realign OR Grid 3. Complete case reviews to identify additional barriers to access | 1. Collect and review new data elements to track real time admission to the OR a. Identify barriers to access b. Liaison with physicians and MRP surgeons to investigate c. Tracking mechanism to identify trends and reporting out | Performance improvement toward target of 80.9% | |

| Change Idea #3 | Process Improvement: Develop a process to get external hip fracture patients to BCHS in a timelier manner. Mitigate the changing function of the Express Admission Unit (EAU). | | |
|---|---|---|---|
| Methods | Process measures | Target for process measure | Comments |
| 1. Identify potential inpatient areas that could be used to admit hip fractures into BCHS 2. Identify process improvement opportunities with space change 3. Establish a new plan on getting externally fractured hip patients to BCHS to offset the EAU closure | 1. Performance improvement toward provincial target (Specific to external referrals) 2. The creation of a plan to offset the EAU Closure and identified inpatient areas to admit hip fractures to BCHS | Performance improvement toward target of 80.9% | |

| Change Idea #4 | (External Improvement) Discussion with external sites (Norfolk General Hospital & West Haldimand General Hospital) to standardize a process for flow of access to care patients | | |
|---|---|---|---|
| Methods | Process measures | Target for process measure | Comments |
| 1. Work with Norfolk General Hospital & West Haldimand General Hospital to strategize new access to care process for hip fracture patients a. Medical clearance for surgery prior to transfer b. Develop a process to ensure communication between and within facilities to ensure physician TOA’s have been completed in a timely manner | 1. Completion of meeting with external collaborators 2. Establish a baseline to understand transportation delays for Hip Fracture Surgery | Established baseline data for transportation delays by Q2 | |

# 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 | 100.00 | 100.00 | Based on the current compliance rates of BCHS staff education, setting a target for a 100% completion among all leaders by March 31, 2026, for relevant equity, diversity, inclusion, and antiracism education is both an achievable and valuable goal. | |

### Change Ideas

Change Idea #1 Promote completion of e-learning modules among leadership, including Cultural Humility: Understanding Equity and Inclusivity in Healthcare, Unconscious Bias, Microaggressions, Inclusive Language, and Allyship.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1. Distribute quarterly reports on learning module completion rates for leaders 2. Send leaders a monthly reminders of incomplete modules 3. Include relevant Halogen modules in new leadership onboarding | 1. Percentage of leaders who have completed the learning modules on Halogen (BCHS learning management system). | 1. Achieve a 100% completion rate for relevant equity, diversity, inclusion, and antiracism education among all leaders by March 31, 2026 | Rationale: Process measure target is inclusive of leaders that have access to the Halogen learning management system |

| Change Idea #2 | Implement relevant equity, diversity, inclusion, and antiracism training access for all professional staff and have 100% of medical leadership (inclusive of Medical Directors and Chiefs and Heads of Service) to complete the online training in Halogen | | |
|---|---|---|---|
| Methods | Process measures | Target for process measure | Comments |
| 1. Explore training platforms for professional staff to access training modules 2. Investigate opportunities to accredit relevant equity, diversity, inclusion, and antiracism education for professional staff | 1. Measure number of medical leaders that have been granted access to training modules 2. Measure medical leadership completion rates of training modules | 1. 100% of medical leadership to access training module 2. A 100% of medical leadership to complete relevant equity, diversity, inclusion, and antiracism training | |

| Change Idea #3 | Provide opportunities for all staff to engage in understanding the theoretical components of the relevant equity, diversity, inclusion, and antiracism Halogen learning modules through webinars and panel discussions, incorporating lived experience discussions. | | |
|---|---|---|---|
| Methods | Process measures | Target for process measure | Comments |
| 1. Hold 5-6 panel discussions featuring subject matter experts and staff on a range of equity, diversity, inclusion, and antiracism topics 2. Disseminate insights from panel discussions to staff members to supplement their understanding of the relevant Halogen learning modules. | 1. Measure staff engagement through participation in future related activities or discussions, indicating how much staff are continuing to engage with the topic after the webinars/panels. | 1. Attendance of at minimum 50 staff members per virtual panel discussion/webinar | Rationale: Difficult to measure leadership attendance currently as such events are new to the organization. However, will supplement leader's understanding of relevant modules |

## 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 | 59.00 | Based off our current YTD performance of 54%, we feel that 5% increase is a realistic and achievable target for the percentage of patients who only responded “completely” to the survey question. This target will be achieved through efforts to increase survey response volumes and streamlining discharge practices. BCHS would like to note that a significant proportion of patients respond “quite a bit” to the survey question, which also indicates that they receive sufficient information at discharge regarding their health. | |

**Change Ideas**

| Change Idea #1 Evaluation of current state of organizational discharge practices and processes. | | | |
|---|---|---|---|
| Methods | Process measures | Target for process measure | Comments |
| 1. Review current state and conduct gap analysis on discharge practices and discharge process checklist, and related policies. 2. Gather Patient Family Advisors (PFA) perspectives and input on discharge process. | 1. Develop a working group of subject matter experts to conduct current state analysis and revision of discharge process checklist 2. Hold 3-5 sessions at PFA coffee houses and PFA committee meetings to consolidate feedback on discharge checklist recommendations | 1. Formalize an analysis on discharge practices and implement amendments to discharge process checklist. 2. Ensure at least 50% of PFAs provide feedback and/or recommendations on the discharge checklist | Total Surveys Initiated: 518 |

| Change Idea #2 Conduct auditing of the patient discharge summary forms and information that is provided during discharge | | | |
|---|---|---|---|
| Methods | Process measures | Target for process measure | Comments |
| 1. Conduct discharge summary rounding quarterly across all adult inpatient units to ensure consistent discharge forms for patients 2. Post staff education clinical educators and/or managers to conduct regular spot audits 3. Develop one-page information guide for unit managers and clerks on accessing appropriate discharge summaries | 1. Review each unit's discharge form to ensure most updated form is utilized across BCHS 3. Standardize seamless access to printing vendor portal for all unit clerks by ensuring updated log in credentials and cost centers | 1. Standardize appropriate discharge forms across all adult inpatient units across BCHS 3. 100% of unit clerks to have access to printing vendor portal | |

| Change Idea #3 Optimize current clinical staff education channels and platforms to standardize discharge practices. | | | |
|---|---|---|---|
| Methods | Process measures | Target for process measure | Comments |
| 1. Dedicated education booth at nursing skills day to emphasize the importance of collecting and utilizing patient experience survey data 2. Leverage standard unit huddles for clinical managers and educators to reinforce the importance of patient feedback and highlighting patient experience survey at discharge | 1. Host educational booth at each quarterly nursing skills day with support from clinical educators 2. Conduct at least two huddle blitzes per inpatient unit to ensure maximum outreach to all staff | 1. Complete two huddle blitzes per quarter | |

Change Idea #4 Increase inpatient survey response with volunteer and Patient & Family Advisor (PFA) rounding support

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1. Launch a volunteer support pilot in medical cardiology unit to increase awareness of patient experience surveys and assist patients in filing out survey. 2. Leverage PFA patient experience rounding to highlight patient experience surveys and encourage patient participation 3. Gather feedback from patients via PFA patient experience rounding on what information they find valuable when leaving the hospital | 1. Track number of surveys completed via volunteer support on BCHS iPads (over number of patients to be discharged) 2. Educating PFAs on best practices to support patient survey completion and track the proportion of PFAs who receive training and participate in rounding 3. Compile patient responses to questions and relay leaders to evaluate gaps and opportunities for effective discharge practices | 1. Successful volunteer support pilot program will be extended to applicable inpatient units and Qualtrics survey response will be tracked quarterly in respective units 2. Develop and recruit for a specific volunteer role to support patient experience rounding 3. Consolidated patient feedback and translate to key stakeholders | |

# Safety

## Measure - Dimension: Safe

| Indicator #3 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Percentage of Inpatients Who Experience a Stage 3 or 4 Hospital Acquired Pressure Injury | C | % / All inpatients | EMR/Chart Review / 2024-2025 | 0.86 | 0.00 | Current situation of pressure injuries at BCHS are not reflected in reported data. Results from a September 2024 pressure injury prevalence survey demonstrated a HAPI rate of 9.6% (for all pressure injury stages) compared internal rate of 0.86%. Therefore, improving pressure injury prevention practices and increasing accurate documentation will help achieve the prevalence of Hospital Acquired Pressure Injuries of stage 3 and 4 to 0.0% | |

**Change Ideas**

| Change Idea #1 | Launch and monitor compliance of care planning tool SSKIN+ in BCHS's electronic medical record (EMR) system to support the reduction of hospital acquired pressure injuries. Parallel to launch of new tool launch is staff education on skin and wound assessment standards of documentation to support early identification and prevention of pressure injuries. | | |
|---|---|---|---|
| Methods | Process measures | Target for process measure | Comments |
| 1. Launch revised Braden Scale and SSKIN+ tool within the EMR & corresponding education (i.e. modules on BCHS's learning management system Halogen and "Wound Care Wednesdays") 2. Monitor compliance of Braden scale/SSKIN+ tool completion with interventions charted (Moderate to high-risk patients) 3. Monitor documentation of pressure injuries upon admission to inpatient units | 1. Review completion rate of Halogen learning modules and manager support to monitor compliance inclusive of nursing staff, personal support workers (PSWs), and clinical externs 2. Improvement in compliance with interventions charted for patients with moderate to high risk on the Braden Scale (18 and below) 3. Document proportion of patients with pressure injury wound presence on admission to inpatient unit | 1. 90% completion of Halogen training for pressure injuries 2. 90% of patients with moderate to high-risk scores denoted on the Braden Scale will have charted surface and interventions. 3. 90% of patients will have a skin and / or wound assessment documented on admission to an inpatient unit" | |

| Change Idea #2 | Implementation of appropriate staff compliance with revised Braden/SSKIN+ tool will support the generation of reliable and accurate hospital acquired pressure injury prevalence data | | |
|---|---|---|---|
| Methods | Process measures | Target for process measure | Comments |
| 1. Ongoing BI tool HAPI data comparison to pressure injury prevalence survey HAPI rate and upcoming March 2025 and Fall 2025 prevalence study results 2. Investigate options for optimize of documentation of skin and wound assessments in the EMR and the emergency department rapid documentation system (PulseCheck) by nurses and unregulated care providers 3. Continuous monitoring of Pressure Injury Dashboard on the PowerBI tool at monthly Pressure Injury Prevention Steering Committee (PIPSC) meetings | 1. Comparison of PowerBI tool HAPI data and prevalence survey HAPI results after each prevalence study 2. Develop sub-working group with Information Communication Technology (ICT) specialists, clinical educators, decision support and wound care experts to investigate the inclusion of skin assessment in the PulseCheck documentation system upon admission to ED and daily wound documentation in inpatient units by nurses and unregulated care providers 3. Link BI tool dashboard review as standing agenda in PIPSC meeting | 3. Results from PowerBI tool HAPI data and prevalence study results should gradually reduce HAPIs of stage 3 and 4 to 0.0% | Rationale: there is a discrepancy between reported frequency of hospital acquired pressure injuries and results of SPIP study (add to comments section of QIP submission) |

Change Idea #3 Update current BCHS policies related to pressure injury prevention, monitoring and reporting.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1. In collaboration with subject matter experts and stakeholder create comprehensive policies related to: a. Visibility flagging frailty flagging b. Safety Incident Management System (SIMS) reporting c. Patient and family education d. Transfer of Information (TOI) expectations for frailty care planning e. Escalation process for surfaces 2. Educational rollout to support awareness of BCHS pressure injury prevention policies among all clinical teams (i.e. Halogen learning modules). | 1. Create subject matter experts working group and develop draft policies for review as per criteria outlined in BCHS policy management policy 2. Measure completion of Halogen learning modules on policy education | 1. Updated pressure injury prevention policies reviewed and approved by appropriate policy approval committee (s) 2. 75% completion rate of halogen learning modules on policy education | |

Change Idea #4 Reviewing and advancing continence care practices among staff to reduce risks of pressure injuries

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1. In collaboration with unit leadership, change practices for double briefing for continence care as it leads to higher risk of HAPIs 2. Implement Nursing, PSW and Clinical Extern education from product representative on dangers of double briefing practice on patients 3. Conduct huddle blitzes on best practices for double briefing for continence care | 1. Conduct unit audits to assess double briefing use post staff education 2. Review and analyze trends in orders for incontinence liners post product representative education 3. Proportion of Nursing, PSW and Clinical Extern who attend education huddle | 1. Reduction in double briefing usage post staff education 2. Anticipating reduction in orders for incontinence liners post product representative education 3. 80% of Nursing, PSW and Clinical Externs that complete huddle education | |