Access and Flow

Measure - Dimension: Timely

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percent of patients who visited the ED and left without being seen by a physician	O	% / ED patients	CIHI NACRS / Apr 1 to Sept 30, 2024 (Q1 and Q2)	3.69	3.69	Target set for accountability in patient quality.	

Change Ideas

Change Idea #1 Increase patient follow up for patients who visited the emergency department and left without being seen by a physician and where there is a discrepancy related to care initiated by a medical directive

Methods	Process measures	Target for process measure	Comments
Create a discrepancy follow up process for the ED nurse to initiate patient follow up phone calls under physicians direct oversight	Transition current physician led process to nurse led process.	Implement a nurse led discrepancy process by July 31, 2025	

Change Idea #2 Increase patient follow up for patients who visited the emergency department and left without being seen by a physician and where there is a discrepancy related to care initiated by a medical directive

Methods	Process measures	Target for process measure	Comments
Create a discrepancy follow up process for the ED nurse to initiate patient follow up phone calls under physicians direct oversight	Create patient follow up criteria and documentation requirements.	Contact 100% of patients who have left the ED without seeing a physician and who have a discrepancy by Dec 31, 2025	

Measure - Dimension: Timely

Indicator #7	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)	3.17	2.00	Indicator proves to be a constant challenge, requiring focus by STEGH.	

Change Ideas

Change Idea #1 Improve wait time to ED physician initial assessment (PRIORITY)

Methods	Process measures	Target for process measure	Comments
Evaluate current workflow and management of increased patient volumes in ED focusing on PIA	Launch a working group to review P4R, volume and staffing trends current metrics quarterly to support Quality Improvements.	Establish a monthly working group with first meeting scheduled by April 30, 2025	

Change Idea #2 Improve wait time to ED physician initial assessment (PRIORITY)

Methods	Process measures	Target for process measure	Comments
Evaluate current workflow and management of increased patient volumes in ED focusing on PIA	Realign nursing assignments to support the physician at triage to provide timely initiation of physician orders and medical directives.	Complete a comprehensive review of nursing realignment initiative by October 1, 2025	

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	CB	CB	STEGH wanting to improve its DEI training.	

Change Ideas

Change Idea #1	Increase ED staff awareness of diversity equity and inclusion issues in healthcare to address potential stigma within the Emergency Department related to visible minorities and vulnerable populations		
Methods	Process measures	Target for process measure	Comments
Invite community partners to engage with identification of best practice education and training	Facilitate collaborative meetings with community partners.	Meet with identified stakeholders by September 30, 2025	This change plan is expected to inform future year improvements

Change Idea #2	Increase ED staff awareness of diversity equity and inclusion issues in healthcare to address potential stigma within the Emergency Department related to visible minorities and vulnerable populations		
Methods	Process measures	Target for process measure	Comments
Utilize current validated stigma and diversity training tools.	Identify and implement validated stigma and diversity training tool(s)	Obtain endorsement of the validated training tool by ED Clinical Care Connect team by September 30, 2025	This change plan is expected to inform future year improvements

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	65.54	90.00	Target set to hold high accountability in patient quality.	

Change Ideas

Change Idea #1 Increase the percentage of patients who received adequate information about their health and care at discharge.

Methods	Process measures	Target for process measure	Comments
Increase distribution of discharge summary and patient education at the time of discharge from ED and all acute units.	Complete a review of current discharge process to identify improvements.	Complete a review of discharge processes by March 31, 2025.	Total Surveys Initiated: 591

Change Idea #2 Increase the percentage of patients who received adequate information about their health and care at discharge.

Methods	Process measures	Target for process measure	Comments
Increase distribution of discharge summary and patient education at the time of discharge from ED and all acute units.	Implement new process to all staff.	Provide a patient centred discharge summary and patient specific health education using Healthwise content to 85% of acute unit patients upon discharge and 60% of ED patients from hospital by December 31, 2025.	

Safety

Measure - Dimension: Safe

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of delirium onset during hospitalization	O	% / Hospital admitted patients	CIHI DAD / April 1 to September 30, 2024 (Q1 and Q2), based on the discharge date	0.14	0.00	STEGH wanting to improve patient safety and aligning with provincial safety priorities.	

Change Ideas

Change Idea #1 Reduce the rate of delirium during hospitalization

Methods	Process measures	Target for process measure	Comments
1A: Engage in evaluation of rates of delirium during hospitalization through review of retrospective data	A: Enroll STEGH in DASH regional registry. B: Participate in regional meetings. C: Complete delirium data analysis on a quarterly basis.	A: STEGH will be an active participant on at the Ontario Health DASH regional group by April 1, 2025. B: STEGH will participate in monthly regional meetings beginning May 1, 2025 C: We will engage in a review of hospital data to inform future opportunities by December 31, 2025	This change plan is expected to inform future year improvements

Measure - Dimension: Safe

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of workplace violence incidents resulting in lost time injury	O	% / Staff	Local data collection / Most recent consecutive 12-month period	CB	CB	Target set to collect baseline for this indicator.	

Change Ideas

Change Idea #1 Improve employee awareness of Work Place Prevention and mitigation strategies

Methods	Process measures	Target for process measure	Comments
#1 Mock Code white in each clinical unit	1A: Create a schedule for a minimum of one mock code white per clinical unit (9 mocks covering 10 units)	1A: 100% of clinical units completed a mock code white by December 31, 2025	

Change Idea #2 Improve employee awareness of Work Place Prevention and mitigation strategies

Methods	Process measures	Target for process measure	Comments
#1 Mock Code white in each clinical unit	1B: Create and implement evaluation method	1B: Create and implement an evaluation form by February 6, 2025	

Change Idea #3 Improve employee awareness of Work Place Prevention and mitigation strategies

Methods	Process measures	Target for process measure	Comments
#2 Increase percent of staff who have completed required CIT training	2A: Expand availability of CIT training into after hours	2A: 75% of active staff who require CIT with Pinels training compliant by December 31, 2025	

Change Idea #4 Improve employee awareness of Work Place Prevention and mitigation strategies			
Methods	Process measures	Target for process measure	Comments
#2 Increase percent of staff who have completed required CIT training	2B: Increase the number of CIT Trainers	2B 95% of active staff who require CIT without Pinels training compliant by December 31, 2025	

Change Idea #5 Improve employee awareness of Work Place Prevention and mitigation strategies			
Methods	Process measures	Target for process measure	Comments
#2 Increase percent of staff who have completed required CIT training	2C: Promote newly developed low risk CIT Training	2C 90% of active staff who require low risk CIT training by December 31, 2025	

Measure - Dimension: Safe

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Reduce the number of opioids prescribed in hospital	C	Count / All patients	Hospital collected data / Jan 1 - Dec 31st	CB	CB	Recognizing a need to improve patient safety, developing a culture of safety and accountability for patients. Developing strategies to prevent and reduce the risk of drug diversion and opioid related harm.	

Change Ideas

Change Idea #1 Reduce the number of opioids prescribed in hospital

Methods	Process measures	Target for process measure	Comments
Develop a hospital Opioid Stewardship program	Develop a framework including terms of reference, reporting structure and program monitoring metrics Launch an Opioid Stewardship committee	Create Opioid Stewardship Committee Terms of Reference (TOR) by June 30, 2025 Approval of TOR at P&T by June 30, 2025 Develop Opioid Stewardship Committee Framework by December 31, 2025	This change plan is expected to inform future year improvements