Access and Flow

Measure - Dimension: Timely

Indicator #6	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)	13.00	16.00	Ontario Health, in consultation with Emergency Medical Services and Paramedic Services, has set a target of 30 minutes for this indicator. We are aiming to ensure we are less than 16 per quarter (last year's performance) which we feel is reasonable given the seasonal fluctuations in our ED volume and past performance. We have, historically, performed very well in this metric and strive to continue at that level. Past performance numbers for 24/25 are Q1 16min, Q2 17min, Q3 14min. We have questioned the National Ambulatory Care Reporting System (NACRS) figures recorded in the QIP tool that put our current performance at 13 and past performance at 7.	Haliburton County Paramedic Service

Change Ideas

Change Idea #1	HHHS began submitting data for the Pay for Results Program in January 2025. Our major quality improvement initiative for this indicator will be to ensure the accuracy of our coded data and ensure data integrity for this metric.		
Methods	Process measures	Target for process measure	Comments
Comparing data in the EPIC Electronic Medical Record to coded data. Collaboration between Health Information Management and Quality Departments.	Quarterly variation in Electronic Medical Record and National Ambulatory Care Records System (NACRS) data	Zero variability	

Change Idea #2	Discharge planning on admission.		
Methods	Process measures	Target for process measure	Comments
1. Ensure EPIC discharge planning component is completed in admission navigator within 24hrs of admission. 2. Staff Education	Quarterly Audts	Information gathering. Target 100% completion.	

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)	2.77	2.50	The Ontario Health target for this indicator is 4 hours. Our performance in this metric has, objectively, been very good and we will, through several ongoing initiatives, maintain our level.	

Change Ideas

Change Idea #1 HHHS began submitting data for the Pay for Results Program in January 2025. Our major quality improvement initiative for this indicator will be to ensure the accuracy of our coded data and ensure data integrity for this metric.

Methods	Process measures	Target for process measure	Comments
Comparing data in the EPIC Electronic Medical Record to coded data. Collaboration between Health Information Management and Quality Departments.	Quarterly variation in Electronic Medical Record and National Ambulatory Care Reporting System data	Zero variability	

Measure - Dimension: Timely

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Alternate Level of Care (ALC) rate	C	% / All inpatients	EMR/Chart Review / 25/26	26.70	25.00	Being a small community hospital, our rates will fluctuate greatly with each new Alternate Level of Care patient (Small N) but we would like to remain on or near our current levels. This metric is to support our Family Health Team Collaborative Quality Improvement Plan (CQIP).	

Change Ideas

Change Idea #1 1. Admission avoidance strategies

Methods	Process measures	Target for process measure	Comments
1. Process map development 2. Policy revision and approval 3. Educate staff and patients on the policy	1. Process map developed and approved 2. Policy approved 3. Education to staff at huddles. Admission avoidance 1 pager/poster	Completion by Q3	

Change Idea #2 Discharge planning on admission

Methods	Process measures	Target for process measure	Comments
1. Ensure EPIC discharge planning component is completed in admission navigator within 24hrs of admission. 2. Staff Education	1. Staff Education 2. Quarterly Audits	Target - gathering data	

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	100% Management/Executive Leadership Team	

Change Ideas

Change Idea #1 LGBTQS2+ theme focusing on Trans Health

Methods	Process measures	Target for process measure	Comments
Develop education through the engagement of and collaboration with community partners such as Point in Time Centre for Youth and Children. Roll out initially to management and Executive Leadership Team, then staff.	Completion of course development. Completion of education by management and Executive Leadership Team. Roll out to staff	Educational development completed by Q2. 100% completion by Executive Leadership Team and management by end of Q3 and availability to staff by Q4.	

Experience

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (Highland Wood)	O	% / LTC home residents	In house data, NHCAHPS survey / Most recent consecutive 12-month period	81.82	85.00	Our 2024/25 Resident Satisfaction Survey was designed in collaboration with the Residents and Families of Hyland Crest and Highland Wood. This group voted against a 1-10 scale and rather chose a three point scale - Yes, No, Sometimes. This will be reviewed this year. At Hyland Crest, 9 indicated "Yes," 1 indicated "Sometimes," 1 indicated "No" 9/11=81.8%	
Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (Hyland Crest)	O	% / LTC home residents	In house data, NHCAHPS survey / Most recent consecutive 12-month period	83.33	85.00	Our 2024/25 Resident Satisfaction Survey was designed in collaboration with the Residents and Families of Hyland Crest and Highland Wood. This group voted against a 1-10 scale and rather chose a three point scale - Yes, No, Sometimes. This will be reviewed this year. At Hyland Crest, 10 indicated "Yes" and 2 indicated "Sometimes." No-one indicated "No" 10/12=83%	

Change Ideas

Change Idea #1	Build on Resident Focused Care Model - to make the home less institutionalized. Programs and Care lead by residents. All staff - everyone who comes into the home - responsible for and incorporated into care. Staff will introduce themselves, everyone helps. Assuring residents that they do not live in a business but in a home.		
Methods	Process measures	Target for process measure	Comments
Staff Education	Completion Rate	100% by end of Q3	Total Surveys Initiated: 62 Total LTCH Beds: 62

Change Idea #2	Build on Resident Focused Care Model - to make the home less institutionalized. Programs and Care lead by residents. All staff - everyone who comes into the home - responsible for and incorporated into care. Staff will introduce themselves, everyone helps. Assuring residents that they do not live in a business but in a home.		
Methods	Process measures	Target for process measure	Comments
Homelike Spaces in the home - lounges, nooks, etc. Wall colours - unique - working on Highland Wood. Completed at Hyland Crest. Remove nursing station, creating more resident spaces	Creation of new spaces and repurposing of old	Completion by end of Q3	

Change Idea #3	Build on Resident Focused Care Model		
Methods	Process measures	Target for process measure	Comments
Painting/Esthetics - Unique colours for each space. Murals, getting rid of uniforms - everyone is a unique individual.	Completion of Murals and Painting. Roll out of new staff dress code	Completion by end of Q3	

Change Idea #4	Review of satisfaction survey with residents and families		
Methods	Process measures	Target for process measure	Comments
Direct collaboration with residents and families (Resident's Council, 1:1, etc)	Revision of survey	Completion by Q3 25/26	

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	55.32	70.00	Though a significant increase, we feel that this metric is of sufficient importance that it warrants a lofty but achievable target.	

Change Ideas

Change Idea #1 Develop an Emergency Department Discharge Process

Methods	Process measures	Target for process measure	Comments
Collaboration with physicians, nurses, patients and other stakeholders	Process Development, Level of stakeholder buy in	Completion by start of Q2	Total Surveys Initiated: 329

Change Idea #2 Increase After Visit Summary (AVS) distribution to patients upon discharge.

Methods	Process measures	Target for process measure	Comments
Education, Collaboration with physicians, nurses, patients and other stakeholders	EPIC COGITO Report - times printed.	Beginning Q2 25/26	

Safety

Measure - Dimension: Safe

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Highland Wood)	O	% / LTC home residents	CIHI CCRS / July 1 to Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average	18.52	16.50	Target for Hyland Crest and Highland Wood set at 16.5%	
Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Hyland Crest)	O	% / LTC home residents	CIHI CCRS / July 1 to Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average	19.91	16.50	Target for Hyland Crest and Highland Wood 16.5%	

Change Ideas

Change Idea #1 Safety Committee monthly meeting - reviews 30 days falls			
Methods	Process measures	Target for process measure	Comments
Multi disciplinary review including nursing, Personal Support Worker (PSW), activation, physio, dietary, behavioural support (BSO), Infection Prevention and Control (IPAC), pharmacy and family. All care plans are reviewed and revised. Environmental factors such as clutter, lighting, matts, alarms, checks, toileting, Trending is discussed. Post fall huddle checklists reviewed for each fall.	Completion Attendance	100% completion monthly for all falls	

Change Idea #2 Move to hourly/purposeful rounding for PSWs targeting night shift.			
Methods	Process measures	Target for process measure	Comments
Currently, rounding is every 2 hours. We would increase our rounding frequency to every hour on nights and introduce purposeful rounding.	PSW documentation - POC	High level POC completion	

Change Idea #3 Falls Prevention Education - Falling Star/Leaf Program - Standard Precautions for EVERYONE - Multi disciplinary Pain, position, personal needs			
Methods	Process measures	Target for process measure	Comments
Program development - education, posters, stakeholder engagement	Staff completed education. Total falls - falls with harm Periodic review with staff	100% completion, lower falls rates	

Change Idea #4 Personalized care plans			
Methods	Process measures	Target for process measure	Comments
Personalized care plans are updated after each fall and are reviewed and updated after every fall	All falls are reviewed on a monthly basis by the Safety Committee	100% completion	

Measure - Dimension: Safe

Indicator #5	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	0.00	0.00	Maintenance goal - Last year we achieved zero lost time due to workplace violence. We will focus on reducing overall incidents involving workplace violence.	

Change Ideas

Change Idea #1 Evaluate number of staff trained in gentle persuasive techniques (GPT)

Methods	Process measures	Target for process measure	Comments
Document number of staff already Gentle Persuasive Technique (GPT) trained Training to additional staff	% trained in Gentle Persuasive Technique (GPT)	Increase base number trained in Gentle Persuasive Technique (GPT) by 10% across the organization	

Change Idea #2 Develop peer support teams

Methods	Process measures	Target for process measure	Comments
Role model Share best practices Ensure care plan completion	Incident reporting system - violence	Reduction in overall RL6 reported incidents involving violence	

Change Idea #3 HR risk assessment for care in the community setting

Methods	Process measures	Target for process measure	Comments
Enhanced client screening	Violent incidents reporting in RL6 Incident Reporting System	Overall reduction in the number of violence incidents reported in RL6 Incident Reporting System	