Access and Flow | Timely | Optional Indicator

	Last Year		This Year		
Indicator #1 90th percentile ambulance offload time (Humber River Health-Wilson Site)	**33.00** Performance (2024/25)	**30** Target (2024/25)	**36.00** Performance (2025/26)	**-9.09%** Percentage Improvement (2025/26)	**30** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

1. Introducing a fourth nurse at front triage to reduce the number of pre-triage patients waiting to be seen. 2. Standardization of the ED PFM role to optimize bed management strategies to expedite patient admission, discharge, and transfers. 3. Update ramp-down staffing strategies to ensure that SA surge nurse position is always filled, maximizing ED bed capacity. 4. Work with other departmental directors to create surge capacity on the floors when ED admissions surpass 24 hours. 5. Implementation of ScaleAI – queuing technology aimed to improve patient experience by reducing in hospital wait and PIA times. 6. Collaborate with inpatient managers to create a pull culture when transferring patients to the inpatient unit. 7. ED Redesign project – examination of current ED physical layout and potential restructuring (see potential structural changes) a. Evaluate the workflow of triage, O-Zone, EMS triage, Acute and Subacute b. Reallocation of OZ-CDU room to designated TAT room 8. Implement comprehensive care plans, order sets and follow-up protocols for individuals with sickle cell disease.

Process measure

- 90th percentile ambulance offload time (AOT)

Target for process measure

- Target is 30 minutes

Lessons Learned

We have implemented most of the change ideas aimed at improving ED-specific metrics. When comparing 2023/2024 to 2024/2025, we have observed improvements in the majority of these metrics, with additional opportunities for further enhancement. Moving forward, we plan to focus on the physician initial assessment metric and will continue exploring actionable steps to drive improvement in this area.

Lessons Learned:
Working with this ED QIP indicators revealed the importance of identifying and targeting specific metrics to drive meaningful improvements in ED performance. One key learning was that implementing multiple small but focused change ideas can collectively lead to noticeable progress. While many of our change ideas positively impacted ED metrics, we recognized that sustained improvement requires continuous monitoring and adaptability.
The most significant changes were observed when frontline teams were actively engaged in the process, highlighting the value of collaboration and communication across roles. The physician initial assessment metric proved to be a challenging area, emphasizing the need for targeted strategies to address systemic bottlenecks (e.g., DI, consultation, and lab turnaround time).
Impact:
The change ideas implemented did make a measurable difference in several metrics, demonstrating the value of iterative testing and refinement of strategies. However, some metrics, like physician initial assessment, require deeper analysis and a tailored approach to see similar improvements.
Advice for Others:
• Start Small: Begin with manageable, specific changes that are easy to implement and measure. Evaluate and define current process.
• Engage Teams: Collaborate with frontline staff to identify barriers and co-create solutions.
• Stay Adaptive: Be prepared to refine strategies based on feedback and outcomes.
• Focus on Data: Use data-driven insights to prioritize and track progress, ensuring alignment with goals.
This approach fosters a culture of continuous improvement and ensures that efforts are both impactful and sustainable.

Comment

HRH receives the highest number of EMS transfers compared to peers, with the largest proportion of CTAS 1 and 2 patients. This significantly impacts overall ED length of stay (LOS) and access and flow. While we are currently three minutes off target, this variance is explainable given our high EMS volume. We will continue to evaluate and optimize ED/EMS offload workflow processes.

	Last Year		This Year		
Indicator #3	**13.22**	**6**	**6.88**	**47.96%**	**6**
90th percentile emergency department wait time to inpatient bed (Humber River Health-Wilson Site)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

1. Introducing a fourth nurse at front triage to reduce the number of pre-triage patients waiting to be seen. 2. Standardization of the ED PFM role to optimize bed management strategies to expedite patient admission, discharge, and transfers. 3. Update ramp-down staffing strategies to ensure that SA surge nurse position is always filled, maximizing ED bed capacity. 4. Work with other departmental directors to create surge capacity on the floors when ED admissions surpass 24 hours. 5. Implementation of ScaleAI – queuing technology aimed to improve patient experience by reducing in hospital wait and PIA times. 6. Collaborate with inpatient managers to create a pull culture when transferring patients to the inpatient unit. 7. ED Redesign project – examination of current ED physical layout and potential restructuring (see potential structural changes) a. Evaluate the workflow of triage, O-Zone, EMS triage, Acute and Subacute b. Reallocation of OZ-CDU room to designated TAT room 8. Implement comprehensive care plans, order sets and follow-up protocols for individuals with sickle cell disease.

Process measure

- 90th percentile emergency department wait time to inpatient bed

Target for process measure

- Target is 6 hours

Lessons Learned

We have implemented most of the change ideas aimed at improving ED-specific metrics. When comparing 2023/2024 to 2024/2025, we have observed improvements in the majority of these metrics, with additional opportunities for further enhancement. Moving forward, we plan to focus on the physician initial assessment metric and will continue exploring actionable steps to drive improvement in this area.

Lessons Learned:
Working with this ED QIP indicators revealed the importance of identifying and targeting specific metrics to drive meaningful improvements in ED performance. One key learning was that implementing multiple small but focused change ideas can collectively lead to noticeable progress. While many of our change ideas positively impacted ED metrics, we recognized that sustained improvement requires continuous monitoring and adaptability.
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Impact:
The change ideas implemented did make a measurable difference in several metrics, demonstrating the value of iterative testing and refinement of strategies. However, some metrics, like physician initial assessment, require deeper analysis and a tailored approach to see similar improvements.
Advice for Others:
• Start Small: Begin with manageable, specific changes that are easy to implement and measure. Evaluate and define current process.
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• Focus on Data: Use data-driven insights to prioritize and track progress, ensuring alignment with goals.
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Comment

We are meeting the target for admit-to-inpatient bedtime, with current performance exceeding expectations at an average 90th percentile, year to date of 5.2 hours. Efforts to sustain and improve this performance will continue.

Indicator #7

Percent of patients who visited the ED and left without being seen by a physician (Humber River Health-Wilson Site)

Last Year		This Year		
2.50	**2**	**2.34**	**6.40%**	**1.50**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

1. Introducing a fourth nurse at front triage to reduce the number of pre-triage patients waiting to be seen. 2. Standardization of the ED PFM role to optimize bed management strategies to expedite patient admission, discharge, and transfers. 3. Update ramp-down staffing strategies to ensure that SA surge nurse position is always filled, maximizing ED bed capacity. 4. Work with other departmental directors to create surge capacity on the floors when ED admissions surpass 24 hours. 5. Implementation of ScaleAI – queuing technology aimed to improve patient experience by reducing in hospital wait and PIA times. 6. Collaborate with inpatient managers to create a pull culture when transferring patients to the inpatient unit. 7. ED Redesign project – examination of current ED physical layout and potential restructuring (see potential structural changes) a. Evaluate the workflow of triage, O-Zone, EMS triage, Acute and Subacute b. Reallocation of OZ-CDU room to designated TAT room 8. Implement comprehensive care plans, order sets and follow-up protocols for individuals with sickle cell disease.

Process measure

- Percentage of patients who visited the emergency department and left without being seen (LWBS) by a physician

Target for process measure

- Target for process measure is 2.0%

Lessons Learned

We have implemented most of the change ideas aimed at improving ED-specific metrics. When comparing 2023/2024 to 2024/2025, we have observed improvements in the majority of these metrics, with additional opportunities for further enhancement. Moving forward, we plan to focus on the physician initial assessment metric and will continue exploring actionable steps to drive improvement in this area.

Lessons Learned:
Working with this ED QIP indicators revealed the importance of identifying and targeting specific metrics to drive meaningful improvements in ED performance. One key learning was that implementing multiple small but focused change ideas can collectively lead to noticeable progress. While many of our change ideas positively impacted ED metrics, we recognized that sustained improvement requires continuous monitoring and adaptability.
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Impact:
The change ideas implemented did make a measurable difference in several metrics, demonstrating the value of iterative testing and refinement of strategies. However, some metrics, like physician initial assessment, require deeper analysis and a tailored approach to see similar improvements.
Advice for Others:
• Start Small: Begin with manageable, specific changes that are easy to implement and measure. Evaluate and define current process.
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Comment

We are 0.5% above provincial target, and 1 % above HRH target for LWBS metric. Despite having a robust policy for managing LWBS patients, the increased ED patient volume has contributed to this variance.

	Last Year		This Year		
Indicator #2 90th percentile ED length of stay (Humber River Health-Wilson Site)	**10.50** Performance (2024/25)	**9** Target (2024/25)	**9.70** Performance (2025/26)	**7.62%** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

1. Introducing a fourth nurse at front triage to reduce the number of pre-triage patients waiting to be seen. 2. Standardization of the ED PFM role to optimize bed management strategies to expedite patient admission, discharge, and transfers. 3. Update ramp-down staffing strategies to ensure that SA surge nurse position is always filled, maximizing ED bed capacity. 4. Work with other departmental directors to create surge capacity on the floors when ED admissions surpass 24 hours. 5. Implementation of ScaleAI – queuing technology aimed to improve patient experience by reducing in hospital wait and PIA times. 6. Collaborate with inpatient managers to create a pull culture when transferring patients to the inpatient unit. 7. ED Redesign project – examination of current ED physical layout and potential restructuring (see potential structural changes) a. Evaluate the workflow of triage, O-Zone, EMS triage, Acute and Subacute b. Reallocation of OZ-CDU room to designated TAT room 8. Implement comprehensive care plans, order sets and follow-up protocols for individuals with sickle cell disease.

Process measure

- 90th percentile emergency department length of stay (LOS)

Target for process measure

- Target is 9 hours

Lessons Learned

We have implemented most of the change ideas aimed at improving ED-specific metrics. When comparing 2023/2024 to 2024/2025, we have observed improvements in the majority of these metrics, with additional opportunities for further enhancement. Moving forward, we plan to focus on the physician initial assessment metric and will continue exploring actionable steps to drive improvement in this area.

Lessons Learned:
Working with this ED QIP indicators revealed the importance of identifying and targeting specific metrics to drive meaningful improvements in ED performance. One key learning was that implementing multiple small but focused change ideas can collectively lead to noticeable progress. While many of our change ideas positively impacted ED metrics, we recognized that sustained improvement requires continuous monitoring and adaptability.
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Impact:
The change ideas implemented did make a measurable difference in several metrics, demonstrating the value of iterative testing and refinement of strategies. However, some metrics, like physician initial assessment, require deeper analysis and a tailored approach to see similar improvements.
Advice for Others:
• Start Small: Begin with manageable, specific changes that are easy to implement and measure. Evaluate and define current process.
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This approach fosters a culture of continuous improvement and ensures that efforts are both impactful and sustainable.

Comment

We successfully reduced the admit-to-inpatient time, positively affecting overall ED LOS. Moving forward, we will focus on reducing LOS for non-admitted ED patients.

Access and Flow | Efficient | Optional Indicator

	Last Year		This Year		
Indicator #4 Alternate level of care (ALC) throughput ratio (Humber River Health-Wilson Site)	**0.99** Performance (2024/25)	**1** Target (2024/25)	**0.98** Performance (2025/26)	**-1.01%** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 ☑ **Implemented** ☐ **Not Implemented**

1. Maintain weekly ALC rounds across all departments utilizing the I-Plan platform. 2. Implement CAM assessment in ED for all admitted patients 64 years of age or older. 3. Provide Standardized ALC designation education to GIM physicians utilizing CIHI ALC guidelines 4. Provide targeted education to managers, Responsible Persons (RPs), and social workers (SWs) on discharge pathways. 5. Optimize RM&R training for all RPs and Team Leads (TLs) in the inpatient units.

Process measure

- 1. Percent of ED nurses trained in CAM assessment. 2. Percent of CAM assessment completed for admitted patients >64 yrs. 3. Percent of GIM physicians trained on CIHI ALC designation. 4. Percent of SWs trained on discharge planning pathway. 5. Percent of RPs trained on discharge planning pathway. 6. Percent of managers trained on discharge planning pathway. 7. Percent of RPs and TLs trained on RM&R

Target for process measure

- The target for the process measures is completion of 80% or higher

Lessons Learned

Yes. Twice weekly Joint Discharge Rounds were maintained, with additional rounds during times when ALC #'s were above 100. Training for physicians on accurate ALC designation was completed, Two comprehensive training sessions were provided to allied health, RP's and managers on the Discharge Planning Pathway. ED CAM training was completed. RP's and TL's will receive refresher education sessions for RM&R in Q4.

Engagement of all managers and allied health disciplines vs. just social workers in discharge planning pathway training has optimized engagement in the discharge planning pathway and process. We have also seen improvement in accuracy of ALC designation by physicians at appropriate times in the patient care journey, resulting in decreased Acute LOS. RCC leadership have also been instrumental in pre-planning patient transfers to minimize bed empty times at RCC and decreasing ALC patient LOS in acute beds.

Comment

HRH continues to perform well in this metric and is within 1% of target for FY to date.

Equity | Equitable | Optional Indicator

	Last Year		This Year		
Indicator #10	**82.22**	**100**	**100.00**	**21.62%**	**100**
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (Humber River Health-Wilson Site)	**Performance (2024/25)**	**Target (2024/25)**	**Performance (2025/26)**	**Percentage Improvement (2025/26)**	**Target (2025/26)**

Change Idea #1 ☑ **Implemented** ☐ **Not Implemented**

#1): Evaluate module completion rates at the leadership level #2) Provide leaders with educational tools and resources generate awareness and increase uptake

Process measure

- Module Completion Rate. Number of Group Training Sessions Offered.

Target for process measure

- 75% by March 31st, 2024 and 100% March 31st, 2025. 10 Group Training Sessions offered between November-December 2023.

Lessons Learned

The Introduction to Anti-Black Racism e-learning module was well received by staff, physicians and volunteers. With any roll-out of education it is important to provide a variety of delivery options to support with uptake and with this module we learned that championing this at a local level by the leadership team was essential. A few strategies that supported our ability to meet our target but also make an impact included the following:

• Dedicated time during our monthly Leadership Forum for our leaders to collectively engage in the learning module together. When this was done in a large group setting, it was important to break for discussion and allow leaders to reflect and share their insights throughout the module.

• Development of huddle scripts for unit managers so they could help promote the module with their staff

• Share uptake statistics with the leadership team on % of individual teams who have completed the training so leaders could appropriately support the remaining staff to dedicate time to complete the training

• Allowed for pre and post surveys when we conducted large group learning sessions, this allowed us to evaluate the impact the content had with the participants around their understanding of Anti-Black Racism within a Canadian context

• Imbedding the training as part of New Staff Orientation and in this format allowing participants to participate and read aloud section of the module to ensure active engagement.

Comment

Supported the organization and leadership team with the rollout and completion of the Introduction to Anti-Black Racism module. Embedding the training as part of New Staff Orientation starting in February 2024.

	Last Year		This Year		
Indicator #5	**109.87**	**15**	**145.16**	**-32.12%**	**15**
Average ED wait time to physician initial assessment (PIA) for individuals with sickle cell disease (CTAS 1 or 2) (Humber River Health-Wilson Site)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

1. Introducing a fourth nurse at front triage to reduce the number of pre-triage patients waiting to be seen. 2. Standardization of the ED PFM role to optimize bed management strategies to expedite patient admission, discharge, and transfers. 3. Update ramp-down staffing strategies to ensure that SA surge nurse position is always filled, maximizing ED bed capacity. 4. Work with other departmental directors to create surge capacity on the floors when ED admissions surpass 24 hours. 5. Implementation of ScaleAI – queuing technology aimed to improve patient experience by reducing in hospital wait and PIA times. 6. Collaborate with inpatient managers to create a pull culture when transferring patients to the inpatient unit. 7. ED Redesign project – examination of current ED physical layout and potential restructuring (see potential structural changes) a. Evaluate the workflow of triage, O-Zone, EMS triage, Acute and Subacute b. Reallocation of OZ-CDU room to designated TAT room 8. Implement comprehensive care plans, order sets and follow-up protocols for individuals with sickle cell disease.

Process measure

- Average emergency department wait time to physician initial assessment (PIA) for individuals with sickle cell disease (CTAS 1 or 2)

Target for process measure

- CTAS level 1 – immediate (e.g., within 5 minutes) CTAS level 2 – within 15 minutes

Lessons Learned

We have implemented most of the change ideas aimed at improving ED-specific metrics. When comparing 2023/2024 to 2024/2025, we have observed improvements in the majority of these metrics, with additional opportunities for further enhancement. Moving forward, we plan to focus on the physician initial assessment metric and will continue exploring actionable steps to drive improvement in this area.

Lessons Learned:
Working with this ED QIP indicators revealed the importance of identifying and targeting specific metrics to drive meaningful improvements in ED performance. One key learning was that implementing multiple small but focused change ideas can collectively lead to noticeable progress. While many of our change ideas positively impacted ED metrics, we recognized that sustained improvement requires continuous monitoring and adaptability.
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Impact:
The change ideas implemented did make a measurable difference in several metrics, demonstrating the value of iterative testing and refinement of strategies. However, some metrics, like physician initial assessment, require deeper analysis and a tailored approach to see similar improvements.
Advice for Others:
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Comment

The ED Sickle Cell Disease (SCD) quality improvement (QI) project is ongoing, focusing on staff education, SCD triage flagging, SCD order set, and determining the SCD referral process. These initiatives aim to improve the SCD-related QI metrics. We have applied and received funding from Ontario Health and North York General (SCD site Hub) to support the implementation of SCD initiatives.

Indicator #12

Rate of ED 30-day repeat visits for individuals with sickle cell disease (Humber River Health-Wilson Site)

Last Year		This Year		
40.63	**30**	**28.81**	**29.09%**	**30**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

1. Introducing a fourth nurse at front triage to reduce the number of pre-triage patients waiting to be seen. 2. Standardization of the ED PFM role to optimize bed management strategies to expedite patient admission, discharge, and transfers. 3. Update ramp-down staffing strategies to ensure that SA surge nurse position is always filled, maximizing ED bed capacity. 4. Work with other departmental directors to create surge capacity on the floors when ED admissions surpass 24 hours. 5. Implementation of ScaleAI – queuing technology aimed to improve patient experience by reducing in hospital wait and PIA times. 6. Collaborate with inpatient managers to create a pull culture when transferring patients to the inpatient unit. 7. ED Redesign project – examination of current ED physical layout and potential restructuring (see potential structural changes) a. Evaluate the workflow of triage, O-Zone, EMS triage, Acute and Subacute b. Reallocation of OZ-CDU room to designated TAT room 8. Implement comprehensive care plans, order sets and follow-up protocols for individuals with sickle cell disease.

Process measure

- Rate of emergency department 30-day repeat visits for individuals with sickle cell disease

Target for process measure

- Target is 30.0%.

Lessons Learned

We have implemented most of the change ideas aimed at improving ED-specific metrics. When comparing 2023/2024 to 2024/2025, we have observed improvements in the majority of these metrics, with additional opportunities for further enhancement. Moving forward, we plan to focus on the physician initial assessment metric and will continue exploring actionable steps to drive improvement in this area.

Lessons Learned:
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Impact:
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Comment

The ED Sickle Cell Disease (SCD) quality improvement (QI) project is ongoing, focusing on staff education, SCD triage flagging, SCD order set, and determining the SCD referral process. These initiatives aim to improve the SCD-related QI metrics. We have applied and received funding from Ontario Health and North York General (SCD site Hub) to support the implementation of SCD initiatives.

	Last Year		This Year		
Indicator #8	**71.88**	**75**	**79.49**	**-10.59%**	**75**
Percentage of ED visits for individuals with sickle cell disease triaged with high severity (CTAS 1 or 2) (Humber River Health-Wilson Site)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

1. Introducing a fourth nurse at front triage to reduce the number of pre-triage patients waiting to be seen. 2. Standardization of the ED PFM role to optimize bed management strategies to expedite patient admission, discharge, and transfers. 3. Update ramp-down staffing strategies to ensure that SA surge nurse position is always filled, maximizing ED bed capacity. 4. Work with other departmental directors to create surge capacity on the floors when ED admissions surpass 24 hours. 5. Implementation of ScaleAI – queuing technology aimed to improve patient experience by reducing in hospital wait and PIA times. 6. Collaborate with inpatient managers to create a pull culture when transferring patients to the inpatient unit. 7. ED Redesign project – examination of current ED physical layout and potential restructuring (see potential structural changes) a. Evaluate the workflow of triage, O-Zone, EMS triage, Acute and Subacute b. Reallocation of OZ-CDU room to designated TAT room 8. Implement comprehensive care plans, order sets and follow-up protocols for individuals with sickle cell disease.

Process measure

- Percentage of emergency department visits for individuals with sickle cell disease triaged with high severity (CTAS 1 or 2)

Target for process measure

- Target is 75.0%

Lessons Learned

We have implemented most of the change ideas aimed at improving ED-specific metrics. When comparing 2023/2024 to 2024/2025, we have observed improvements in the majority of these metrics, with additional opportunities for further enhancement. Moving forward, we plan to focus on the physician initial assessment metric and will continue exploring actionable steps to drive improvement in this area.

Lessons Learned:
Working with this ED QIP indicators revealed the importance of identifying and targeting specific metrics to drive meaningful improvements in ED performance. One key learning was that implementing multiple small but focused change ideas can collectively lead to noticeable progress. While many of our change ideas positively impacted ED metrics, we recognized that sustained improvement requires continuous monitoring and adaptability.
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Impact:
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Advice for Others:
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Comment

The ED Sickle Cell Disease (SCD) quality improvement (QI) project is ongoing, focusing on staff education, SCD triage flagging, SCD order set, and determining the SCD referral process. These initiatives aim to improve the SCD-related QI metrics. We have applied and received funding from Ontario Health and North York General (SCD site Hub) to support the implementation of SCD initiatives.

Experience | Patient-centred | Optional Indicator

Indicator #9

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? (Humber River Health-Wilson Site)

Last Year		This Year		
70.18	**65**	**89.43**	**27.43%**	**75**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

1) Provide specific performance indicators to respective areas within Medicine Inpatient Units and Critical Care areas to understand if patient felt they received adequate information about their health and their care at discharge. 2) Advance patient and family engagement in order to improve the patient/family satisfaction scores within the Medicine Inpatient Units and Critical Care Areas.

Process measure

- • Monitor PDCC unit results (reflective in results of PDCC questions - staff/doctors listen carefully; explained things in a way patient can understand; information given about condition and treatment) with the addition of these questions to the current PDCC quality improvement action plan. • QIP initiatives as standing agenda items for Medicine and ICU Portfolios.

Target for process measure

- • Noted that current performance for this QIP for 2022/23 – at 65.5 % • Ongoing performance improvement – target > 65%. • 100% process compliance (monthly reporting) • Sharing survey (PDCC / FSICU) results with staff, display on quality boards and staff discussions within daily huddles and RPCC

Lessons Learned

Specific targets were set, with monitoring related to patient rounding. In addition, rounding was tailored on each unit to better engage patients and families on those units and to improve satisfaction scores.

The change idea clearly had an impact. Lessons learned related to the communication of expectations to all levels of leadership and the need for early engagement of front-line managers to solicit ideas that will assist with success.

Comment

Significant effort has occurred in all inpatient areas to ensure patients leaving the hospital have sufficient information regarding their condition or treatment. This has led to surpassing our target. Efforts included:

- Formalizing Patient Rounding and tracking of encounters with clear targets
- Increasing family meetings to plan for discharge
- Engagement with SMART Discharge package with patient and family on admission

Safety | Safe | Optional Indicator

Indicator #6

Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged. (Humber River Health-Wilson Site)

Last Year		This Year		
75.91	**81**	**81.09**	**6.82%**	**81**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☐ Implemented ☑ Not Implemented

1. Trial or pilot pharmacist driven preparation and access to Meditech functionality of the Best Possible Medication Discharge Plan for physician review and conversion. 2. Explore access for pharmacists to access med rec discharge module and training to assist physicians at point of care at any time with med rec at discharge. 3. Explore future change ideas from Capstone (UofT Engineering) project.

Process measure

- Number of discharged patients for whom a Best Possible Medication Discharge Plan was created out of the total number of patients discharged. Compare pilot care area rates to control care area rates for the aforementioned.

Target for process measure

- Target for 2024/25: 81%

Lessons Learned

The change ideas outlined above were not fully implemented. However, the data collection methodology for discharge medication reconciliation was reviewed and improved to ensure accuracy in tracking rates. This will provide a more reliable foundation for future performance assessments.

Key Learnings:
• Accurate data collection is critical for monitoring progress and aligning initiatives with organizational goals.
• Engaging multidisciplinary teams early in the process can help identify and address feasibility issues before implementation.

Impact of Change Ideas:
• Although not implemented, the reviewed functionalities highlighted opportunities for future improvements, particularly around workflow optimization and resource allocation.

Advice to Others:
• Ensure robust data collection and validation processes to build trust in reported metrics.
• Conduct feasibility assessments for proposed changes, focusing on both operational constraints and strategic benefits.
• Foster collaboration across teams to identify scalable solutions that align with broader organizational objectives.

Indicator #11

Rate of delirium onset during hospitalization (Humber River Health-Wilson Site)

Last Year		This Year		
0.26	**0.20**	**0.17**	**34.62%**	**0.20**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Medicine: Sustain and improve the results achieved from previously implemented delirium initiative. Extend the delirium prevention initiate to the ED. Sustain CAM assessment compliance within 24 hours of admission in inpatient medicine units. Sustain and improve the initiation of CHASM intervention in inpatient medicine units. Initiate Delirium order set for all patients who screen CAM positive.

Process measure

- Quarterly CAM compliance rate. Quarterly CHASM intervention compliance rate. Quarterly CAM + rate. Quarterly order set use for CAM positive patients.

Target for process measure

- Quarterly CAM compliance rate of 90%. Quarterly CHASM intervention compliance rate of 85%. Quarterly order set use rate for CAM positive patient rate of 80%. Delirium rate of less than 0.20%.

Lessons Learned

Yes, the planned initiative to initiate the CAM in the ED was completed and we sustained our CAM assessment compliance within 24 hours of admission (improved by 1%) from FY 23/24) - FY 24./25 Q2 YTD is 97% through ongoing new nursing orientation and delirium education huddles.
We were also able to improve our initiation of CHASM interventions in inpatient medicine units by 3%TY4 – 24/25Q2 YTD 82%.
We have also improved our Delirium order set initiation by 7% from Q1 to Q2 (and by a total of 2% over FY 23/24)

- Our Q3/Q4 change ideas to be implemented include:
  - o Reduction of Sedative-Hypnotics
  - o Optimizing Sleep Friendly Environment
  - o Daily Delirium Huddle strategy implementation

Change Idea #2 ☑ **Implemented** ☐ **Not Implemented**

ICU: Sustain and improve the results achieved from previously implemented ICU delirium initiatives. Sustain and improve early identification of ICU delirium using CAM-ICU tool on admission and every 4 hours while admitted to the ICU. Improve methods of preventing delirium in the ICU.

Process measure

- Quarterly ICU PAD documentation compliance rates. Quarterly ICU CAM + rate.

Target for process measure

- Quarterly CAM compliance rate of 90%.

Lessons Learned

Removing systemic barriers to choosing the correct order set has a greater impact than educating, in isolation. When we changed the keyword search function for finding the delirium order set, we found greater compliance with using the order set.

Provision of transparent order set use to physicians is also a valuable way to increase awareness of the issue.

Change Idea #3 ☑ **Implemented** ☐ **Not Implemented**

Surgery: Sustain and improve the results achieved from previously implemented delirium initiative. Sustain CAM assessment compliance in inpatient surgery units. Sustain and improve the initiation of CHASM intervention in inpatient surgical units. Initiate Delirium order set for all patients who screen CAM positive.

Process measure

- Quarterly CAM compliance rate. Quarterly CHASM intervention compliance rate. Quarterly CAM + rate. Quarterly order set use for CAM positive patients.

Target for process measure

- Quarterly CAM compliance rate of 90%. Quarterly CHASM intervention compliance rate of 85%. Quarterly order set use rate for CAM positive patient rate of 80%. Delirium rate of less than 0.20%.

Lessons Learned

Removing systemic barriers to choosing the correct order set has a greater impact than educating, in isolation. When we changed the keyword search function for finding the delirium order set, we found greater compliance with using the order set.

Provision of transparent order set use to physicians is also a valuable way to increase awareness of the issue.

Comment

Performance on hospital acquired delirium was above target by .06%

Indicator #13

Rate of workplace violence incidents resulting in lost time injury (Humber River Health-Wilson Site)

Last Year		This Year		
0.24	**0.20**	**0.06**	**75.00%**	**0.20**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Improve process for conducting root cause analysis of all HC and LT incidents.

Process measure

- Completion of rootcause analyses for all HC and LT incidents. Completion of unit workplace violence risk assessments after HC or LT incidents.

Target for process measure

- 100% completion of root cause analyses for all HC and LT incidents within 5 business days of the incident. 100% completion of workplace violence risk reassessments within 7 business days of the incident.

Lessons Learned

Yes this change was implemented, OHSW ensures the loop is closed on all WPV incidents by completing audits of both our internal follow up to mitigate lost time via prompt follow up and modified work offers if necessary as well as Manager Follow up to ensure root cause is determined to mitigate risk for future staff.

Change Idea #2 ☐ Implemented ☑ Not Implemented

Rollout of Meditech outpatient violence special indicator – improvement of communication to staff to inform them of violent patients.

Process measure

- Number of reported workplace violence incidents that result in a violence special indicator.

Target for process measure

- 100% of workplace violence incidents resulting in FA, HC and LT have a violence special indicator reviewed on a monthly basis.

Lessons Learned

This change has not been marked as completed as of yet. Organizational re-structuring of our various Workplace Violence Task Forces is in the process of amalgamating into the “Violence Free Task Force” which is currently at its call to members stage and this change idea will be a focus of this committee in future.

To add, it was determined that discretion needs to be exercised cautiously in this process as once a flag is initiated, what would constitute it being removed. These are bigger questions that need to be addressed by the task force before the next stages can roll out.

Comment

In review of the projected target and current performance, this can be attributed to the following:
- Potential under reporting in the past of workplace violence incidents.
- Increased emphasis and education on how and when to report all types of incidents including Workplace Violence and Workplace Harassment.
- Increased De-escalation training which increased awareness on what constitutes workplace violence and how and when to initiate a code white, submit a staff incident report and emphasis on resources available to staff involved in Workplace violence incidents.