Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 30, 2026

Ontario Health

OVERVIEW

Over the past year reviewing and improving resounded as the main theme for the hospital's quality improvement work. The leadership team was newly formed with a combination of experience and the promise of new and fresh outlooks and ideas. With a relatively new team formed the work required going back through processes that have been in place for quite some time and assessing their relevance, which often led to improvements and efficiencies. The energy the board, staff and volunteers put in to ensure the hospital modelled exactly how we wanted to serve the community and how we showed up for our accreditation review was phenomenal. Every department aligned with the strategic vision for the organization and that effort was reflected in our patient's experience. Quality Care - every patient, every time was the north star for the organization in the 25/26 fiscal year and continues to guide the work we have identified for the 26/27 fiscal year. This will be a year of change for the hospital with a new CEO and a new health record on the horizon and the leadership team will be focusing on guiding the team through the change management process while continuing to maintain our high expectations of the care our clients and patients receive.

ACCESS AND FLOW

The Red Lake hospital and the Red Lake Family Health Team (FHT) worked collaboratively with other health service provider organizations in Red Lake and Ear Falls, the North West Regional Seniors' Care Program and the Kiiwetinoong Healing Waters OHT to address the needs of frail seniors in the community. A Frailty Pathway was developed, which includes frailty identification and management pathway, available resources, system gaps and opportunities for strengthening early identification and coordinated care for older adults living with frailty.

The pathway supports early screening, consistent identification, and timely referral to coordinated multidisciplinary supports. The aim is to maintain independence, reduce avoidable emergency visits/hospitalizations and support aging at home.

The plan includes several opportunities, including

- Standardize clinical frailty screening (CFS) across the hospital, family health team, paramedicine and home care
- Integrate CFS in the FHT EMR and ensure automatic referral prompts
- Introduce an OT-Geriatric Assessor role to provide centralized coordination, navigation and oversight across the frailty pathway
- Develop caregiver support resources
- Enhance communication pathways using OCEAN and shared care plan

The Pathway identifies the need for an Occupational Therapy-Geriatric Assessor (OT-GA), as a central coordinating role. This role is essential in rural and remote settings where geriatric expertise is limited. The plan and the role description have been shared with Ontario Health North along with requests for funding.

EQUITY AND INDIGENOUS HEALTH

Red Lake Margaret Cochneour Memorial Hospital recognizes that Indigenous people are facing anti-Indigenous racism at all points in the health care system. Efforts are required to ensure that cultural safety is addressed and is targeted to hotspots, such as emergency departments and inpatient wards. There needs to be more measures and actions taken when Indigenous people face any racism or discrimination in the health system. Improving Indigenous people’s experiences in the Hospital needs to extend to traditional practitioners to ensure they do not face barriers or discrimination. Cultural safety, which includes physical, mental, emotional and spiritual safety, needs to be implemented across the entire organization and health system to ensure safe care from the first point of contact.

To achieve these aims, in partnership with the hospital Indigenous Working Group an action plan was created with a shared vision of partnering to advance Indigenous health. The pillars of the action plan are to build and sustain productive relationships, build and enhance capacity and education, review the physical environment in an effort to continue to make improvements, create equitable access to culturally safe care and report on the progress and next steps for these pillars.

PATIENT/CLIENT/RESIDENT EXPERIENCE

The hospital, during the last quality improvement cycle made the transition from a paper-based survey platform to an electronic format, the transition required a change management project that is still underway. In the emergency department there was a two hundred percent increase in survey responses compared to the previous year. The information on the emergency department survey told us we were continuing to work on the right things in terms of patient experience. Focusing on the patient during discharge and the communication between the care team continues to be a vital part of our success at Red Lake Hospital and will be an area we continue to focus on in the future. Patients report they continue to feel seen and heard and that our concentration on communicating with patients and putting patients in has been successful. Space constraints have led to conversations being overheard and we have begun exploring areas where improvements can be made in the layout of the emergency department. The inpatient survey process did not result in the same level of feedback collected, as a result we will be concentrating on improving the process and results submitted from this population for the upcoming year. This feedback increase is essential to ensure we are accurately capturing the patient voice.

PROVIDER EXPERIENCE

The hospital Human Resources Plan provides a strategic framework for Red Lake Margaret Cochenour Memorial Hospital (RLMCMH) to attract, hire, engage, and retain a talented, dynamic, and inclusive workforce. The purpose of this plan is to meet the organization's evolving needs and ensure the delivery of high-quality services. The plan will also play a key role in supporting RLMCMH's strategic objective of "fostering a collaborative supportive team".

We acknowledge the challenges facing health human resources across Canada, particularly in the Northern, remote and small regions like Red Lake, where competition for roles such as Registered Nurses, Lab Technicians, and other critical positions is becoming increasingly intense. Addressing these challenges is essential for maintaining our ability to provide excellent care.
The unique demographic and geographic characteristics of the Red Lake create challenges that require tailored and innovative solutions to workforce planning. This plan reflects our commitment to utilizing technology to enhance human resource systems and processes, maintaining our values-based culture of care that prioritizes respect, inclusion, and well-being, and also attracting and supporting the growing number of new immigrants to Canada by offering meaningful opportunities to contribute to our healthcare system
Key deliverables to increasing provider experience include digitizing and automating the performance appraisal process to ensure that feedback was delivered in a timely manner and the information could be utilized to improve provider experience. Concentrating on employee wellness and recognition while ensuring resource needs were met, where possible, to prevent provider burnout, creating a safety-minded workplace culture to prevent and minimize the effects of workplace violence, finally new employees to the organization are provided accommodations up to 8 weeks while they transition into the community.

SAFETY

The hospital maintains a strong reporting culture rooted in “just culture” principles that begins at orientation for each employee. The process for reporting is explained, as well as how each report is reviewed by the Patient Safety Committee with quality improvement actions implemented and each incident is not considered closed until these action items are put in place. The patient safety committee is comprised of an interdisciplinary group that will pull in front line staff, on occasion, to create a better understanding of incidents as they occurred. There is always a back and fourth conversation between those involved in the incident until the incident is considered complete. The Patient Family Advisory Committee and the Quality committee of the board are provided with a monthly “open incident report” as a measure of safety improvement and improvement timelines. Quarterly, both committees receive key safety metric reports where incident themes and outcomes are reported in greater detail for discussion. Severity, or potential for severity, triggers a higher internal rating and a more wholesome review including all staff involved, with an aim of finding root causes and systemic factors that can be changed to ensure improved safety in the future. Learnings from incident reviews are disseminated through follow-up emails, changes to procedures, quality newsletters, and safety spotlight reports for staff.

To prevent the occurrence of “never events” best practices are utilized from Health Quality Ontario and risk assessments are conducted utilizing various sources of data. These risk assessments inform the hospital as to which “never events” require more focus for the organization and result in longer-term improvement projects.

PALLIATIVE CARE

The hospital re-initiated the community palliative care meetings to gather perspectives across the palliative care continuum. The group has focused this past year on membership, ensuring diverse views were captured and in creating a regular meeting schedule. We also sit on the Regional Palliative Care Focus Group to ensure that our goals align with the region as well. The focus for the upcoming year will be on hosting an Advance Care Planning session for the community to increase preparedness and decrease stress for both caregivers and individuals towards end of life. We will also be working with the Regional Palliative Care Group to provide education to our physicians at MAC.

Locally the hospital received several generous donations to improve the Palliative end of life space at the hospital. The hospital is in the planning stages of re-designing a room with end-of-life needs in mind that will sit adjacent to a refurbished patient/family room. The room design will utilize design details aimed at achieving both comfort and convenience for loved ones and patients of both small and large groups.

POPULATION HEALTH MANAGEMENT

The RLMCMH invited all health service partners to a full-day meeting with the purpose of identifying the health and social needs of people in the community, and to identify the gaps in service. The result of that initial meeting and subsequent meetings is the development of the Frailty Pathway.

The RLMCMH meets monthly with Red Lake and Ear Falls health care partners and regional partners: Ontario Health Team, Ontario Health North, Ontario Health at Home and the Northwest Regional Seniors Care Program. ALC data and patterns of illness are presented and reviewed.

The hospital conducted a full review of data related to CAT scan utilization in this catchment area, the costs related to transfer of patients for diagnostic scanning and the human resource costs associated with those transfers. The data was compiled and an application for approval of a CT scan program was submitted to Ontario Health in August 2025.
The RLMCH is collaborating with Pikangikum First Nation Health Authority (PFNHA) to understand their health and social needs to develop an understanding of how this organization can support their goals. The PFNHA supported the hospital's CAT scan submission as a benefit to their community.

EMERGENCY DEPARTMENT RETURN VISIT QUALITY PROGRAM (EDRVQP)

This year we introduced return visit auditing as part of quality processes. We worked closely as a team with Medical Records, CNE, and Chief of Staff to complete these audits which helped simplify the process. aligning reporting processes created some challenges which we worked to overcome and this process is believed to continue to improve with the introduction of a new medical health record for the region. Signing up for provincial databases and ensuring the right individuals had access proved to be challenging as well. The hospital is happy to report there were no instances of a patient with a Sentinel diagnoses (acute myocardial infarction, subarachnoid hemorrhage and pediatric sepsis) returning to the emergency department and requiring hospital admission within 7 days of an initial visit for the same or related concern during the 25-26 fiscal year. The hospital will continue to monitor care processes to ensure this remains at zero. In the upcoming year the hospital will continue with chart audits with an aim to continue to improve patient care and reduce return ED visits. The hospital will also continue to examine wait times and time to admission in an effort to improve patient access and flow.

EXECUTIVE COMPENSATION

Our Chief Executive Officer and Chief Nursing Executive compensation and targets that the executive team is accountable for achieving is linked to performance in the following way:

Senior Management Team
- President and CEO: 3% of annual base salary
- Chief Nursing Executive: 1% of annual base salary.

Terms: Achievement of all targets would result in 100% payout; partial achievement of targets will result in partial payout, as set out in Table 1.

Quality Dimension	Objective	Target 2026-2027	100%	50%
• 33% Experience	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 you condition or treatment after you left the hospital?	75% of all inpatients answering "completely" to this question at the end of Q3	75% of all inpatients answering "completely" to this question at the end of Q3	70% of all inpatients answering "completely" to this question at the end of Q3
• 33% Safety	Hand hygiene compliance among healthcare providers	86% of healthcare providers observed as performing hand hygiene correctly during the 4 moments of hand hygiene	86% of healthcare providers observed as performing hand hygiene correctly during the 4 moments of hand hygiene	80% of healthcare providers observed as performing hand hygiene correctly during the 4 moments of hand hygiene
• 33% Safety	Decrease in the number of medication errors relating to wrong type/wrong dose	50% reduction in the amount of medication errors relating to wrong type/wrong dose by end of Q3	50% reduction in the amount of medication errors relating to wrong type/wrong dose by end of Q3	40% reduction in the amount of medication errors relating to wrong type/wrong dose by end of Q3

CONTACT INFORMATION/DESIGNATED LEAD

Amanda Kaczmarek
Director of Quality, Risk and Support Services
akaczmarek@redlakehospital.ca
807-727-3804

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 30th, 2026

Board Chair

Board Quality Committee Chair

Chief Executive Officer

EDRVQP lead, if applicable

Access and Flow | Timely | Optional Indicator

Indicator #2

90th percentile emergency department length of stay for nonadmitted patients with low acuity (The Red Lake Margaret Cochenour Memorial Hospital)

Last Year		This Year		
5.75	**5.25**	**6.35**	**-10.43%**	**6**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Implement patient review and assessment for all patients who are nonadmitted with low acuity at the 24 hour mark

Process measure

- Number of patients who stayed in our Emergency Department for 24hrs without admission that were followed up on for further assessment action

Target for process measure

- 60% of all patients reaching the 24hr mark having some standardized follow up implemented by Q3

Lessons Learned

The project was implemented as planned and it is believed that Health Human Resources (HHR) challenges led to increased times in the ED.

Comment

HHR has become more stable and the hospital will utilize this tactic for another cycle to determine its effectiveness.

Indicator #1

90th percentile emergency department length of stay for nonadmitted patients with high acuity (The Red Lake Margaret Cochenour Memorial Hospital)

Last Year		This Year		
16.67	**15**	**13.30**	**20.22%**	**NA**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Implement patient review and assessment for all patients who are nonadmitted with high acuity at the 24 hour mark

Process measure

- Number of patients who stayed in our Emergency Department for 24hours without admission that were followed up on for further assessment or action

Target for process measure

- 60% of all patients reaching the 24 hour mark having some standardized follow up implemented by Q3

Lessons Learned

The charts reviewed showed the patient's care was appropriate, transfer to another facility was the main factor that increased patient times in the ED.

Comment

This assessment will continue, it was noted that some patients were moved to a room with a bed but left as in the Emergency department, focus will be on completing the admission process for this population.

Access and Flow | Timely | Priority Indicator

Indicator #3

90th percentile emergency department wait time to physician initial assessment (The Red Lake Margaret Cochenour Memorial Hospital)

Last Year		This Year		
2.27	**2.20**	**2.40**	**-5.73%**	**2**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Data entry assessment

Process measure

- Number of charts without discrepancies Percentage increase in current performance based on new standardized procedure

Target for process measure

- awaiting baseline data to insert results

Lessons Learned

The discrepancies were often tied to locums who would assist for a very brief period of time, such as a weekend and health records would not be able to follow up as they did not have the physician schedule until the locum had already left town. Calendar sharing began in Q4.

Comment

The issues related to chart discrepancies will be eliminated with Meditech Expanse so we will not be continuing this change idea in the upcoming quality improvement plan.

Equity | Equitable | Optional Indicator

Indicator #6

Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (The Red Lake Margaret Cochenour Memorial Hospital)

Last Year		This Year		
25.00	**90**	**92.59**	**270.36 %**	**100**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Indigenous cultural training for all staff members who are in a leadership position or who fill "charge" roles at the hospital.

Process measure

- percentage of supervisors on site receiving Indigenous Cultural training

Target for process measure

- 100% of all supervisors on site receiving relevant Indigenous Cultural training by end of Q4 2026

Lessons Learned

This is just a start and the hospital has created an action plan to work towards through its Indigenous Working Group.

Change Idea #2 ☐ Implemented ☐ Not Implemented ☑ In Progress

Creation of a palliative end of life care space better suited to patient needs

Process measure

- Co-design of project with from patients and families to include family/caregiver space, a dedicated room washroom, literature for families

Target for process measure

- Completion of project by Q4

Lessons Learned

Currently undergoing design phase with patient family advisors.

Comment

A training focus on equity, diversity and inclusion, as well as Indigenous cultural safety will continue in the next improvement cycle.

Experience | Patient-centred | Optional Indicator

Indicator #5

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? (The Red Lake Margaret Cochenour Memorial Hospital)

Last Year		This Year		
51.85	**60**	**66.67**	**28.58%**	**75**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Create an interdisciplinary working group to conduct a mapping exercise for our current discharge process and it will include the information sharing with patient process

Process measure

- Completion of this process with at least one improvement project implemented as a result

Target for process measure

- Improvement project identified as part of mapping implemented by the end of Q3

Lessons Learned

There are some issues identified that will be resolved through the hospital's transition to Meditech Expanse. Monitoring and Auditing kept the process in focus.

Change Idea #2 ☐ Implemented ☑ Not Implemented ☐ In Progress

Compile data and conduct a discharge focus group

Process measure

- Take data from Q1 and Q2, review to identify discharge focus group Conducting a focus group with that population and creating an improvement plan from the results

Target for process measure

- Completed data review by end of Q3 and completed focus group by end of Q4

Lessons Learned

The hospital intended to identify the focus group through the new inpatient survey process, it quickly became apparent that focusing on increasing response rates to the inpatient survey was the greater priority.

Comment

The focus for discharge in the upcoming improvement cycle will include the physician role in the process and the communication between nurses and physicians.

Safety | Safe | Optional Indicator

	Last Year		This Year		
Indicator #7 Rate of delirium onset during hospitalization (The Red Lake Margaret Cochenour Memorial Hospital)	**X** Performance (2025/26)	**0** Target (2025/26)	**0.00** Performance (2026/27)	**--** Percentage Improvement (2026/27)	**NA** Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

process mapping of patient journey for vulnerable populations

Process measure

- completion of mapping session with identification of gaps

Target for process measure

- Gaps identified with working plan created for improvements by Q3

Lessons Learned

This was completed in partnership with the Ontario Health Team.

Comment

Delirium screening was implemented in the ED and will be monitored in the upcoming improvement cycle.

Indicator #8

Rate of workplace violence incidents resulting in lost time injury (The Red Lake Margaret Cochenour Memorial Hospital)

Last Year		This Year		
0.00	**0**	**1.00**	**--**	**0**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Conduct Code White Skills drills for staff to enhance Code white knowledge and response

Process measure

- % of FT and PT staff having received a skills drill training session

Target for process measure

- 60% of all FT and PT staff undergoing a skills training session for Code White

Lessons Learned

This target was met through a combination of formats, staff preferred the "choose your own adventure" approach to training over acting out scenario's in small groups

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

We will continue to offer Non-Violent Crisis intervention to the staff

Process measure

- % of FT and PT staff who have current training in NVCI

Target for process measure

- 60% of all FT and PT staff current with NVCI course by end of Q4

Lessons Learned

This course was offered quarterly, but staffing availability and turnover created a constantly fluctuation in "trained" staff affecting our ability to hit 60%

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

Continue with Gentle Persuasive Approach training

Process measure

- % of staff current in GPA course

Target for process measure

- 60% of patient care staff current in GPA by end of Q4

Lessons Learned

This course was offered annually in February but was not part of the mandatory training requirements for staff. The voluntary sign-up did not add up to 60% of staff being trained.

Comment

The training is now apart of the annual curriculum offered to staff, the hospital is changing focus to concentrate on staff who work in the community.

Safety | Safe | Custom Indicator

Indicator #4

Achievement of Exemplary status during the Accreditation Canada process (The Red Lake Margaret Cochenour Memorial Hospital)

Last Year		This Year		
CB	CB	NA	--	NA
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Achievement of exemplary status during the hospitals accreditation cycle.

Process measure

- Achievement rating provided after onsite visit

Target for process measure

- Exemplary status achieved

Lessons Learned

Staff rallied and came together with constant check-ins and huddles to make sure we aligned with standards in a very short time frame. Utilizing frequent check-ins was the key to our success achieving "Accredited with Commendation".

Comment

We are moving to a continual assessment format with Accreditation Canada and, as such will not include this metric in the upcoming improvement cycle.

Access and Flow

Measure - Dimension: Timely

Indicator #7	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 / April 1, 2024, to March 31, 2025 (i.e., FY 2024)	2.10	1.00	This is staged approach with a plan to achieve consistent improvement over multiple Quality Improvement Cycles aimed at achieving a theoretical best of zero.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	Yes

Change Ideas

Change Idea #1 Monthly data review to look for trends in patient population leaving without being seen

Methods	Process measures	Target for process measure	Comments
1) Run monthly report on LWBS 2) Record diagnosis categories 3) Remove outliers based on data criteria 3) Review charts for trends and commonalities	% of charts reviewed monthly and data compiled Data indicators to guide improvement project for next QIP cycle	75% of LWBS charts reviewed/month Improvement project created for next QI cycle	The hospital will utilize data collected to inform future quality improvement projects

Measure - Dimension: Timely

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department length of stay for nonadmitted patients with low acuity	P	Hours / ED patients	CIHI NACRS / December 1, 2024, to November 30, 2025, in alignment with the Pay for Results program	6.35	6.00	This is a percentage improvement with aim at matching or exceeding provincial targets over multiple years.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1 Conduct review and assessment for all patients who are non-admitted with low acuity at the 24 hour mark

Methods	Process measures	Target for process measure	Comments
1) Collect patient listing of all 4's and 5's in ED 2) Review time since arrival for LOS greater than 24hrs 3) Review care plan to ensure appropriate 4) Follow up with care providers for next steps	% of triage level 4's and 5's receiving further assessment	75% of triage 4's and 5's receiving care plan review after 24hr mark by Nurse Manager on weekdays.	This assessment plan has been working and the hospital believes the increase in length of stay is a reflection of staffing shortages. The intent is to review this initiative when staffing is at more stable levels.

Measure - Dimension: Timely

Indicator #9	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 / December 1, 2024, to November 30, 2025, in alignment with the Pay for Results program	2.40	2.00	This is a percentage improvement, recognizing challenges faced by rural hospitals.	

Is this indicator related to:	
Emergency Department Return Visit Audits	Yes
Executive Compensation	No
Pay-for-Results Action Plan	Yes

Change Ideas

Change Idea #1 Implementation of daily checks of locum charts to ensure Physician time of assessment has been written

Methods	Process measures	Target for process measure	Comments
1) Continue to reinforce this task during locum orientation 2) Health records to be sent Physician calendar in order to see locum shifts 3) Any locum shifts that occur during the week will trigger a chart assessment to ensure Physician time of assessment has been written. 4) missed charts will be communicated to the Nurse Manager for same day follow up with locum	Physician time to assessment	Sustain 80% or higher compliance with completing the physician time to assessment audit on patient charts	

Measure - Dimension: Timely

Indicator #10	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department length of stay for admitted patients	O	Hours / ED patients	CIHI NACRS / December 1, 2024, to November 30, 2025, in alignment with the Pay for Results program	23.00	19.50	This is a percentage improvement with planned incremental improvements over several years.	

Is this indicator related to:	
Emergency Department Return Visit Audits	Yes
Executive Compensation	No
Pay-for-Results Action Plan	Yes

Change Ideas

Change Idea #1 Fulsome review of current program and staff knowledge of the processes/tools to assess for process and/or knowledge gaps.

Methods	Process measures	Target for process measure	Comments
1)review and improve current organizational process (policy review, patient input, current gaps or trends in the data, admission process review) 2) Physician KPI's brought to MAC monthly for review by physician group 3) Campaign on detriments of long ED length of stay 4) Daily review by charge nurse or nurse manager 5) Empower charge nurse to take a greater role in the admission process 6) KPI's for nursing/Nurse Practitioners brought to professional practice committee	Time for triage levels 2-5 to be admitted.	19.5% decrease in time to admission and completion of project steps.	This is a multi-faceted approach involving the physician group at the hospital.

Equity

Measure - Dimension: Equitable

Indicator #2	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	92.59	100.00	This is a priority indicator for the organization and the theoretical best is 100%.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	Yes
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1 Provide education and training on DEI and respect in the workplace for all new hires.

Methods	Process measures	Target for process measure	Comments
Update the onboarding process by utilizing the surge online training platform in partnership with Canadian Centre for Diversity and Inclusion (CCDI).	Training completion tracked digitally through the surge platform	100% completion rate for all new hires	

Change Idea #2 Provide mandatory DEI fundamentals training to all the management and executive-level staff.

Methods	Process measures	Target for process measure	Comments
Utilizing partnership with CCDI to deliver DEI fundamentals training at the leadership retreat.	Attendance recorded during the session	100% completion rate for all the management staff and executive-level staff.	

Change Idea #3 Educating all staff on DEI and respect in the workplace training sponsored by CCDI.

Methods	Process measures	Target for process measure	Comments
Annual in-person education session	In person attendance	60% completion rate for all FT/PT staff	

Experience

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of respondents who responded “completely” to the following question: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?	O	% / Survey respondents	Local data collection / Most recent consecutive 12-month period	66.67	75.00	This is a corporate target for the organization.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	Yes
Pay-for-Results Action Plan	Yes

Change Ideas

Change Idea #1 Implementation of PODS toolkit as a new way of discharging patients from the ED.

Methods	Process measures	Target for process measure	Comments
1) Review and implement applicable, to our hospital, steps from the toolkit 2) Create discharge summary on EHR for physicians 3) Teach new expectations 4) Monitor use of discharge instruction template 5) Add discharge to Physician onboarding process	percentage of discharge summaries being used by the physician group	25% of patients receiving discharge instructions from Physician by end Q3	Total Surveys Initiated: 5 This is a multi-year project involving a new discharge process, in year one the concentration will be on education and training.

Safety

Measure - Dimension: Effective

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Preparation and implementation of a documentation project plan for the hospital's upcoming electronic health record renewal.	C	% / pre-requisite completion	In house data collection / Q4	CB	100.00	The region is currently updating it's electronic health record which will create multiple process changes for care pathways for the nursing department. The goal of this phase of the project will be to implement known changes ahead of time to ease the go-live transition for staff.	Thunder Bay Regional Health Sciences Centre

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1 Implementing the SOAPE (Subjective, Objective, Assessment, Plan, Evaluation) notes process for patient charting

Methods	Process measures	Target for process measure	Comments
In conjunction with Thunder Bay Regional Health Sciences Centre, utilize a change management strategy to change nurse charting to a SOAPE style of assessment for patients.	Adherence of nursing staff utilizing the SOAPE note method of charting for patients in the ED and Inpatients.	70% of charts utilizing the SOAPE method by Q4	By implementing some of the larger process changes ahead of go-live for the EHR we will improve compliance with with the new EHR system

Change Idea #2 Change in current process to where patient height and weight being entered before physician orders are created for ED patients

Methods	Process measures	Target for process measure	Comments
PDSA change management process in collaboration with Thunder Bay Regional Health Sciences Centre. 1) Add height to ER Face Sheet	% of ED charts that have patient height and weight entered	60% of ED patients having height and weight entered on chart by Q3	This is part of a change management process that will need to occur to transition staff to the new Electronic Health Record, Meditech Expanse.

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	1.00	0.00	The theoretical best target for this indicator is zero.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1 Create and Implement offsite procedures for our hospital based community programs.

Methods	Process measures	Target for process measure	Comments
1) Review current employee safety policies and procedures against PSHSA best practices 2) Conduct needs assessment and gap analysis 3) Implement targeted initiatives based on results from gap analysis.	Implementation of new community violence prevention framework	Completion of re-vised violence framework for hospital based community programs by Q4	The hospital has added another community based organization to its umbrella.

Measure - Dimension: Safe

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Hand hygiene compliance among health care providers	C	% / Worker	Hospital collected data / 4	57.00	86.00	Target setting based on achieving provincial average.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	Yes
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1 Implement the Alberta Health Services Hand Hygiene improvement toolkit

Methods	Process measures	Target for process measure	Comments
1) Assess the environment and improve the environmental design 2) Provide training and education for staff 3) Conduct evaluation and feedback exercises 4) Implement workplace reminders 5) Build a supportive culture for staff that encourages hand hygiene	Number of steps considered fully implemented by Q4	Implementation of steps 1 through 4 with step 5 started.	The Hospital's hand hygiene compliance has dropped below the provincial benchmark and the intent is to achieve provincial average or better.

Measure - Dimension: Safe

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of medication errors relating to wrong type/wrong dose	C	Number / All patients	In house data collection / Q3	16.00	8.00	The goal is to improve by 50% each year, working toward the theoretical best target of 0% of patients experiencing medical errors related to wrong dose/type	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	Yes
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1 Conduct multi-faceted incident review process to look for systemic improvements in the delivery of medication

Methods	Process measures	Target for process measure	Comments
1) Debrief with staff involved in wrong dose/type medication errors 2) Conduct root cause analysis for incident 3) classification of causal factors involved 4) Examination and implementation of systemic improvements 5) Incident added to "Safety Spotlight" for staff knowledge	Completion of 5-step incident review process	100% of incidents involving wrong dose/type receiving multi-faceted review and improvement implementation plan	The focus will be on finding systemic fixes to prevent future errors