Access and Flow

Measure - Dimension: Timely

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percent of patients who visited the ED and left without being seen by a physician	O	% / ED patients	CIHI NACRS / April 1, 2024, to March 31, 2025 (i.e., FY 2024)	14.87	10.00	The LWBS rate increased from 12.31% (2023/24) to 16.97% (2024/25) and remains elevated at 14.87% in 2025/26 YTD. Patient feedback consistently identifies long waits, lack of check-ins, and unclear communication while waiting as key drivers of dissatisfaction and early departure. A target of ≤10% reflects a realistic but meaningful improvement that aligns with provincial expectations and focuses on early engagement, improved flow, and proactive communication to reduce avoidable departures.	

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 Rapid Medical Assessment (RMA) During Peak Hours: Establish a dedicated RMA block during peak times where a provider quickly evaluates low-acuity patients early. This aims to reduce patient backlog and improve Emergency Department flow. Implementation will be discussed alongside planned physician FTE and opportunities to create appropriate space for low-acuity patient assessment.

Methods	Process measures	Target for process measure	Comments
Create an RMA block schedule during peak hours once physician FTE and appropriate space are available. Use historical ED data to identify peak LWBS hours for scheduling guidance.	Percentage of ED waiting room patients with documented nursing check-ins.	Sixty percent of CTAS 4–5 patients are evaluated within 60 minutes of arrival.	Change ideas emphasize early patient engagement and communication, which have been identified through patient feedback as key contributors to LWBS.

Change Idea #2 Standardize ED waiting room rounding and check-in procedures, including scheduled nursing check-ins (e.g., every 60–90 minutes) and documentation in the ECTAS platform to monitor patients and facilitate communication during wait times.

Methods	Process measures	Target for process measure	Comments
Implement scheduled nursing check-ins every 60–90 minutes, documenting in the ECTAS platform, and provide staff orientation on rounding and documentation expectations.	Percentage of ED waiting room patients with documented nursing check-ins.	At least 80% of patients in the ED waiting room have documented check-ins during their stay.	

Change Idea #3 Triage Liaison Role for High-Risk LWBS Assign staff during busy times to identify and engage patients at risk of leaving without being seen (LWBS) and provide updates on wait times and next steps in care.

Methods	Process measures	Target for process measure	Comments
Establish a triage liaison role during peak ED times to identify and connect with patients at risk of leaving without being seen (LWBS). Staff will provide updates, reassessments, and communicate about wait times and next steps.	LWBS rate during peak ED hours.	Lower the LWBS rate during peak ED hours by 30% within a year.	

Measure - Dimension: Timely

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th Percentile Emergency Department Wait Time for Inpatient Bed (length of stay for inpatient bed waiting as an ED inpatient until physically transferred to an inpatient bed)	C	Hours / ED patients	EMR/Chart Review / 2025FY	77.00	48.00	The current 90th percentile ED wait time to get an inpatient bed is 77 hours, indicating extended boarding and delays in physically moving patients to inpatient units. The average ED length of stay for admitted patients is about 32 hours, emphasizing ongoing issues with bed availability and patient flow. Setting a goal of ≤48 hours supports a realistic and achievable reduction in wait times, aligning with patient safety priorities and improving access to care.	

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 Focused Early Week Discharge Planning: Encourage inpatient units to start discharge planning and coordination earlier in the week, aiming to increase the number of discharges when appropriate.

Methods	Process measures	Target for process measure	Comments
Collaborate with inpatient unit managers and care teams to initiate discharge planning earlier in the week (e.g., Monday/Tuesday focus). Implement daily review of patients with anticipated discharge within 24–48 hours. Monitor discharge patterns by day of week and identify opportunities to increase early-week discharges. Reinforce communication through daily bed huddles and interdisciplinary rounds to support timely discharge decisions.	Percentage of patients with a documented estimated discharge date within 48 hours of admission, and the number of discharges that occur early in the weekdays.	=80% of admitted patients have an estimated discharge date documented within 48 hours	This initiative supports improved patient flow by increasing inpatient bed availability earlier in the week, thereby reducing ED boarding and admission delays. Early discharge planning is a key strategy to address access and flow challenges and improve patient experience.

Experience

Measure - Dimension: Patient-centred

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of Emergency Department patients receiving initial nursing pre-triage contact upon arrival	C	% / ED patients	In house data collection / 2026FY	CB	90.00	This is a new process measure introduced to enhance early patient assessment and flow in the Emergency Department. Establishing baseline data will help understand current performance and guide future target setting. Quick pre-triage contact is expected to improve patient experience, support care prioritization, and reduce delays in the initial assessment.	

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 Establish pre-triage nursing contact for all ED patients upon arrival.

Methods	Process measures	Target for process measure	Comments
Train staff on the pre-triage process and ensure compliance.	Percentage of ED patients receiving initial nursing pre-triage contact upon arrival	Collect baseline data.	Facilitates early patient assessment and enhances patient flow.

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of Emergency Department patients reassessed within the recommended timeframes according to ECTAS score.	C	% / ED patients	Hospital collected data / 2026fy	CB	CB	This is a new process measure to track patient reassessment in the ED. Baseline data will be gathered to understand current performance and enable future improvements.	

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 Implement ECTAS-based reassessment for emergency department patients

Methods	Process measures	Target for process measure	Comments
Train staff and track reassessment compliance.	Percentage of ED patients reassessed within ECTAS timeframes	Gather initial baseline data	Supports patient safety during wait times in the ED.

Safety

Measure - Dimension: Safe

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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.	O	% / Discharged patients	Local data collection / Most recent consecutive 12-month period	20.00	90.00	Medication reconciliation at discharge is a necessary patient safety practice and an expectation set by Accreditation Canada. Local chart audits show that while about 95% of charts include a Seamless Care Form with admission medication reconciliation completed, only 21% show completion of discharge medication reconciliation (Part C and/or Part D). Pharmacy leadership has confirmed that physicians are responsible for completing the Seamless Care Form as the discharge prescription, and that rotating hospitalist coverage poses continuity challenges. Setting a goal of ≥90% supports safer care transitions, reduces medication discrepancies, and aligns with provincial QIP standards.	

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 Establish a clear and documented process to notify the pharmacy of anticipated patient discharges to support medication reconciliation and discharge readiness.

Methods	Process measures	Target for process measure	Comments
Collaborate with pharmacy, discharge planning team, and unit leadership to establish a standardized workflow for notifying pharmacy of upcoming discharges. Determine the appropriate timing for notification (e.g., 24–48 hours before discharge, when feasible). Share the workflow with clinical teams and integrate it into existing discharge planning procedures. Track implementation through regular chart audits.	Percentage of planned discharges with prior pharmacy notification.	Establish baseline in Q1 and achieve =80% pharmacy notification for anticipated discharges by year end.	Baseline informed by December 2025 random chart audit. Pharmacy leadership confirmed documentation locations and workflow context,

Change Idea #2 Implement a medication list review process for repatriated patients prior to transfer to SLMHC.

Methods	Process measures	Target for process measure	Comments
"Develop a process to request a medication list or recent MAR from sending hospitals once repatriation is accepted. Share the medication list with the pharmacy before patient arrival for review. Ensure the required medications are available before transfer, or coordinate with the sending facility if needed. Monitor through periodic review of repatriation cases."	Percentage of repatriated patients where a medication list or MAR is received and reviewed by pharmacy prior to arrival.	Establish baseline and achieve =90% medication list review before repatriation, where documentation is available.	

Change Idea #3 Track medication transition issues using Risk Pro reporting and pharmacy feedback to find improvement opportunities.

Methods	Process measures	Target for process measure	Comments
Review Risk Pro reports related to medication transitions and discharge medication issues. Share findings with pharmacy leadership and clinical teams. Identify recurring issues and implement targeted workflow improvements where needed.	Number of medication transition issues identified through Risk Pro review.	Completed quarterly review and implemented improvement actions based on identified trends.	

Measure - Dimension: Safe

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of Emergency Department (ED) patients initially undiagnosed with blastomycosis but later confirmed to have blastomycosis (ICD-10 codes B40.0–B40.9) during admission or within 48 hours after discharge.	C	Number / ED patients	Hospital collected data / 2026FY	CB	CB	Blastomycosis is a rare but clinically significant fungal infection that has a higher regional occurrence in Northwestern Ontario. Tracking ED and inpatient cases helps with early detection, timely treatment, and regional surveillance. Because of low case numbers and yearly variation, a monitoring-only goal is appropriate, while also focusing on increasing clinical awareness, screening, and documentation efforts.	

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 Clinical Awareness & Education – Regional Infectious Disease Awareness Provide education and awareness to Emergency Department and inpatient nursing staff during orientation about region-specific diseases like blastomycosis.

Methods	Process measures	Target for process measure	Comments
Include information on regional infectious diseases, such as blastomycosis, in staff orientation and educational materials to support early recognition and proper clinical awareness. Create educational posters and awareness messages emphasizing regional blastomycosis risk factors.	Percentage of ED and inpatient nursing staff receiving regional infectious disease awareness training during orientation.	Over 90% of ED and inpatient nursing staff receive regional infectious disease awareness training during orientation.	Indicator promotes regional infectious disease surveillance and early detection, not volume reduction.

Change Idea #2 Case Tracking & Review Create a straightforward log to track suspected and confirmed blastomycosis cases for quarterly review.

Methods	Process measures	Target for process measure	Comments
Create a straightforward tracking log for suspected and confirmed blastomycosis cases and review these cases quarterly during Quality and Infection Prevention & Control meetings.	Number of suspected and confirmed blastomycosis cases recorded in the tracking log and reviewed quarterly.	Quarterly review of blastomycosis cases.	

Measure - Dimension: Safe

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of ED patients initially misdiagnosed but later confirmed to have sepsis (ICD-10 codes A40, A41, R65.2, etc.) either during admission or within 48 hours after discharge.	C	% / ED patients	CIHI NACRS / 2026FY	CB	CB	Early recognition of sepsis is vital for patient survival and outcomes. This indicator has been chosen to establish a baseline measure of potential sepsis misdiagnosis and to support the implementation of standardized screening and early warning procedures in the Emergency Department. Setting a baseline performance in 2025/26 will guide future improvement goals and help reduce diagnostic delays and preventable harm.	

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 Standardized Sepsis Screening at Triage Implement uniform sepsis screening during triage using validated tools (e.g., qSOFA, NEWS2) for patients showing infection-related symptoms to enable earlier detection of potential sepsis.

Methods	Process measures	Target for process measure	Comments
Adopt validated sepsis screening tools at triage and provide staff orientation and onboarding education to support consistent use.	Percentage of ED patients presenting with infection-related symptoms who are screened for sepsis at triage.	=95% of infection-related presentations screened for sepsis at triage.	Year 1 focus is on establishing reliable baseline measurement and standardized screening processes.

Change Idea #2	Sepsis Case Review Process Conduct quarterly reviews of confirmed sepsis cases to identify missed early warning signs, treatment delays, and opportunities for improvement.		
Methods	Process measures	Target for process measure	Comments
Maintain a sepsis case tracking log and hold quarterly multidisciplinary case reviews to identify missed early signs, treatment delays, and opportunities for improvement.	Number of confirmed sepsis cases reviewed.	Completed quarterly review of sepsis cases.	