Access and Flow

Measure - Dimension: Timely

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department wait time to inpatient bed	O	Hours / ED patients	CIHI NACRS / December 1, 2024, to November 30, 2025, in alignment with the Pay for Results program	26.40	20.00	The provincial average is 27.3 hours. BCHS has seen an improvement in wait time over the past fiscal year. A target of 20 hours aligns with the top 25% large community hospitals (19.78 hours) and places our performance above the provincial average (27.3 hours) by 7.3 hours. This target is also 12 hours lower than our 2025/26 target of 32 hours.	

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	Reduce the number of admitted patients in the ED at 8:00am by optimizing inpatient discharge processes and reviewing surge plan thresholds to maintain ED as an outpatient-focused unit.		
Methods	Process measures	Target for process measure	Comments
1. Early discharge prioritization by inpatient units through the identification and preparation of patients who are likely to be discharged by 0800-1000hr night prior 2. Review and revise current surge plan triggers and thresholds (e.g., # of ED patients, time admitted) to align with organizational flow demands	1. Time from “discharge ready” to actual departure (percentage of patients identified who leave early) 2. Implementation of the revised Surge Plan within the BCHS Emergency Management System (GetReady)	1. Achieve discharge of 80% of patients (who were identified for discharge night prior) by 1000am. 2. Completion.	

Change Idea #2	Conduct a structured observational study of the inpatient admission process from the decision to admit in the ED through physical transfer to an inpatient bed to identify delays, inefficiencies, and opportunities for process improvement.		
Methods	Process measures	Target for process measure	Comments
1. Observe a representative sample of admitted patients across different days, shifts, and services 2. Map the end-to-end admission workflow, including decision-making, bed assignment, environmental services, transport, and handover 3. Collect timestamps for key process milestones 4. Engage frontline staff to validate observations and identify perceived barriers	Finalized observational study report completed and presented to both the Clinical Operations Steering Committee and the Patient Flow Steering Committee.	Achieve endorsement and roll out of recommendations	

Change Idea #3	Reduce acute ALC rate by developing ongoing partnerships with retirement homes to collaboratively address barriers, prevent avoidable hospital transfers, and support timely, safe return or admission of residents.		
Methods	Process measures	Target for process measure	Comments
1. Establish a process for regular engagement to review trends in transfers and delayed discharges and generate solutions to reduce avoidable ED transfers and/or admissions, and reduce avoidable delays at time of discharge 2. Identify patients at high risk of discharge delays early in admission a) Leverage Clinical Frailty Scale to identify patients requiring early supportive discharge planning	1. Implementation of engagement process within 6 months 2. Percentage of patient screened by trained team members for high risk of discharge delays	1. Completion 2. Achieve screening of 90% of patients	

Measure - Dimension: Timely

Indicator #6	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	7.00	5.00	The 90th percentile wait time to Physician Initial Assessment for high-volume hospitals across Canada is approximately five hours. Setting a target aligned with this national benchmark represents a realistic and measurable improvement goal. Achieving performance close to this average will establish a strong foundation for subsequent improvement and support progression toward the provincial target of 3.4 hours or less in the 2027–2028 Quality Improvement Plan.	

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	Implement an evening physician flex shift to reduce time to Physician Initial Assessment (PIA) and length of stay (LOS) for non-admit low-acuity patients by prioritizing early assessment—supporting already assigned bed patients to relieve backlog, then focusing on triage using existing nursing capacity to improve throughput and wait times.		
Methods	Process measures	Target for process measure	Comments
1. Maximize evening flex shift coverage 2. Enhance physician recruitment via partnership with McMaster University for EM residents completing both community rotations at BCHS and Point of Care Ultrasound (POCUS) rotations. 3. Maintain afternoon physician assistant shift	1. Number of evening physician flex shifts filled 2. Monitor time to Physician Initial Assessment (PIA) 3. Monitor length of stay (LOS) for non-admitted patients triaged as low acuity 4. Number of physician assistant shifts filled	1. Achieve minimum of 10 filled physician flex shifts per month 2. Reduce time to Physician Initial Assessment (PIA) to 5 hours or less 3. Reduce length of stay (LOS) for non-admitted patients triaged as low acuity to 6 hours or less 4. Achieve a minimum of 50% physician assistant shifts filled per month	

Change Idea #2	Optimize utilization of the Clinical Decision Unit (CDU) to reduce length of stay for high-acuity patients, thereby improving patient flow, increasing emergency department bed availability, and supporting reduced wait times to Physician Initial Assessment.		
Methods	Process measures	Target for process measure	Comments
1. Increase utilization of Clinical Decision Unit (CDU) 2. Improved education and shared understanding of Clinical Decision Unit (CDU) criteria and documentation among emergency department staff to enable earlier Clinical Decision Unit (CDU) identification during ED visit 3. Monthly Clinical Decision Unit (CDU) audit to monitor and ensure compliance with Ontario Health West	1. Monitor Clinical Decision Unit (CDU) utilization 2. Review length of stay (LOS) on non-admitted patient triaged as high acuity 3. Review Clinical Decision Unit (CDU) data and documentation monthly	1. Achieve a 25% increase in Clinical Decision Unit (CDU) volume 2. Reduce length of stay (LOS) of non-admitted patients triaged as high acuity to 8 hours or less 3. Complete 100% review of monthly data and documentation	

Change Idea #3	Review Canadian Triage and Acuity Scale (CTAS) documentation and data coding to identify improvement opportunities and support reduced ambulance off-load times.		
Methods	Process measures	Target for process measure	Comments
1. Review of Triage and Acuity Scale (CTAS) 1 Physician Initial Assessment (PIA) data to ensure improved documentation. 2. Establish a standardized process to improve documentation by ensuring progress sheets are available at triage, as well as support registration staff through education to promptly provide charts to physicians for Triage and Acuity Scale (CTAS) Level 1 patients within moments of arrival.	1. Monthly audit of Triage and Acuity Scale (CTAS) 1 data to ensure accuracy 2. Review ambulance offload times that are greater then 30 minutes 3. Improved documentation for Triage and Acuity Scale (CTAS) 1 patients	1. Complete 100% review of monthly data 2. Improve ambulance offload times to 30 minutes or less 3. Within monthly review: 50% or more of Triage and Acuity Scale (CTAS) 1 patients are seen less than 5 minutes	

Measure - Dimension: Timely

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Access to Hip Fracture Surgery within 48 Hours	C	% / Candidates for hip fracture surgery	CIHI DAD, NACRS / 2026-2027	70.10	80.90	In 2026/2027, Brant Community Healthcare System (BCHS) will improve the rate of patients who receive hip fracture surgery within 48 hours of first inpatient admission to 80.9% This target aligns with the large community hospital average (2025/2026). Additionally, this target positions the organization well to achieve and/or exceed the provincial average, large community top 25% average, and large community top 10% average in 2027/2028.	

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 Develop a process to assess patients in a timely manner to identify and mitigate potential medical barriers to surgery.

Methods	Process measures	Target for process measure	Comments
1. Implement a Peri-Operative Assessment Team that includes Internal Medicine and Anesthesia	1. Percentage of patients seen and medically cleared by Peri-Operative Assessment Team	1. Achieve a 10% reduction in cases that are not medically cleared from 2025-26 base data set	

Change Idea #2 Expand anesthesia support at Brant Community Healthcare System.

Methods	Process measures	Target for process measure	Comments
1. Expand the Anesthesia Assistant program 2. Develop a process for anesthesia consult for hip fracture patients pain management	1. Business plan prepared for the expansion of the Anesthesia Assistant program 2. Number of Hip Fracture patients seen by Anaesthesia within 18 hours of admission	1. Completion and endorsement of business plan 2. 90% of acute hip fracture patients will be seen by Anaesthesia within 18 hours of admission	

Change Idea #3 Work with Norfolk General Hospital and West Haldimand General Hospital to strategize new access to care process for hip fracture patients.

Methods	Process measures	Target for process measure	Comments
1. Develop resources to support medical clearance for surgery prior to transfer 2. Develop a process to ensure communication between and within facilities to ensure physician transfer of accountability is completed in a timely manner 3. Timely patient repatriation post-operatively	1. Development of resources for external organizations 2. Percentage of delays due to transfer of accountability between facilities 3. Percentage of patients repatriated within 48 hours post-operatively	1. Completion of resource development 2. Achieve a 15% reduction in cases that are not medically cleared from 2025-26 base data set 3. Achieve a 15% reduction in hip fracture patients who have been repatriated within 48 hours	

Equity

Measure - Dimension: Equitable

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of staff who have completed relevant equity, diversity, inclusion, and anti-racism education	C	% / Staff	Local data collection / Most recent consecutive 12-month period	79.98	90.00	Based on current BCHS staff education compliance rates (approximately 80% year-to-date), setting a target of 90% completion for relevant equity, diversity, inclusion, and antiracism education by March 31, 2027, is both achievable and meaningful. A 100% completion rate is not feasible due to factors such as staff turnover, casual and temporary employment, and other operational considerations, making 90% a realistic and appropriate target.	

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	Promote completion of e-learning modules on Halogen (BCHS learning management system) among all staff, including Cultural Humility: Understanding Equity and Inclusivity in Healthcare, Unconscious Bias, Microaggressions, Inclusive Language, and Allyship.		
Methods	Process measures	Target for process measure	Comments
1. Distribute quarterly reports to leaders on learning module completion rates for all staff 2. Send staff a monthly reminder of incomplete modules 3. Include relevant Halogen modules in new staff onboarding	1. Percentage of staff who have completed the learning modules on Halogen	1. Achieve an 90% completion rate for relevant equity, diversity, inclusion, and antiracism education among all staff by March 31, 2027	

Change Idea #2	Promote completion of e-learning modules among all active and associate professional staff, including Cultural Humility: Understanding Equity and Inclusivity in Healthcare, Unconscious Bias, Microaggressions, Inclusive Language, and Allyship.		
Methods	Process measures	Target for process measure	Comments
1. Promote module completion at departmental and division meetings 2. Send professional staff a monthly reminder of incomplete modules 3. Assign relevant Halogen modules as part new professional staff onboarding	1. Measure medical leadership completion rates of training modules 2. Measure active and associate professional staff completion rates of training modules	1. Achieve 80% of medical leadership completing relevant equity, diversity, inclusion, and antiracism training 2. Achieve 70% of active and associate professional staff completing relevant equity, diversity, inclusion, and antiracism training	

Change Idea #3	Launch an Indigenous Cultural Training e-learning module in Halogen, developed in collaboration with the Indigenous Health and Traditional Medicine Teams for all staff and professional staff.		
Methods	Process measures	Target for process measure	Comments
1. Conduct equity, diversity, inclusion, and antiracism panel discussions in collaboration external community partners on Indigenous Cultural Training 2. Engage frontline staff in Cultural Awareness training through unit huddles. 3. Include the Indigenous Cultural Training module as part of the equity, diversity, inclusion, and antiracism training education package for new staff 4. Send staff a monthly reminder regarding incomplete Indigenous Cultural Training modules.	1. Number of panel discussions conducted 2. Number of unit huddles conducted	1. Conduct two panel discussions: one in June for Indigenous Peoples Month and one in September 2026 for Truth and Reconciliation Day 2. Indigenous Health Team to hold monthly huddles with all clinical units	

Experience

Measure - Dimension: Patient-centred

Indicator #4	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	62.53	67.00	Based off our current year-to-date (YTD) performance of 62%, we feel that 5% increase is a realistic and achievable target for the percentage of patients who only responded “completely” to the survey question. This target will be achieved through efforts to increase survey response volumes and streamlining discharge practices. BCHS would like to note that a significant proportion of patients respond “quite a bit” to the survey question, which also indicates that they receive sufficient information at discharge regarding their health.	

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 a revised Discharge Process Checklist across inpatient units to standardize discharge practices and support patients receiving adequate information at discharge.		
Methods	Process measures	Target for process measure	Comments
1. Implement a structured education plan, informed by an evidence-based framework in collaboration with clinical educators to support consistent use of the revised Discharge Process Checklist. 2. Conduct manual spot audits to ensure are inpatients are using the revised Discharge Process Checklist. 3. Use Plan–Do–Study–Act (PDSA) cycles to refine and improve the revised Discharge Process Checklist based on staff feedback.	1. Number of huddles dedicated to new Discharge Process Checklist education. 2. Number of manual spot audits.	1. Complete 2 huddles per quarter per unit facilitated by clinical educators. 2. Achieve 100% of inpatient units using the revised Discharge Process Checklist.	Total Surveys Initiated: 855

Change Idea #2	Consolidate patient experience feedback from multiple avenues to identify common themes and gaps in discharge practices, and use these insights to refine discharge processes.		
Methods	Process measures	Target for process measure	Comments
1. Conduct thematic analysis of patient experience feedback related to discharge practices, categorized by key areas such as medications, follow-up care, and patient education. 2. Incorporate targeted questions into patient experience rounding program to gather real-time feedback on discharge information needs and opportunities to clarify instructions, treatment plans, and follow-up care with providers.	1. Patient feedback is systematically reviewed and categorized by discharge themes. 2. Targeted discharge information questions are integrated into patient experience rounding program and consistently asked during interactions.	1. Develop actionable recommendations for respective committees and programs to improve hospital discharge practices.	

Change Idea #3	Engage frontline staff in reviewing patient experience feedback (Qualtrics data) during huddles to highlight the value of patient experience surveys in improving discharge practices and ensuring patients receive clear and complete information at discharge.		
Methods	Process measures	Target for process measure	Comments
1. Review patient experience data to identify unit-specific themes, including both quantitative and qualitative feedback, related to discharge practices.	1. Frontline staff actively participate in huddles to review patient experience survey data and feedback.	1. Patient experience survey results and identified themes are shared with frontline staff by the unit manager at least once per quarter.	

Safety

Measure - Dimension: Effective

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of inpatients who experience a stage 2, 3, 4 or unstageable Hospital Acquired Pressure Injury	C	% / All inpatients	EMR/Chart Review / 2026-2027	2.38	2.00	The 2025/26 year to date documented HAPI rate was 2.38%. The targeted reduction to 2.00% reflects a deliberate and balanced approach that recognizes both the vulnerability of the population we serve, and the significant improvements achieved through our previous Quality Improvement Plan. Over the past fiscal year, substantial investments in staff education, standardized risk assessment, and prevention practices have contributed to availability of information to support identification and management of pressure injury risk. As we build on this foundation, ongoing efforts to enhance data quality – through improved assessment, staging, and documentation – will ensure that performance is measured accurately and consistently. Aligning the aim with the provincial benchmark allows the organization to sustain momentum, factoring the complex needs of our community, and continue advancing pressure injury prevention while data maturity continues to improve.	

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	Use patient safety incident reporting data (from Safety Incident Management System [SIMS]) to identify recurring practice gaps and develop monthly Huddle Helpers that provide focused, actionable communication for frontline teams.		
Methods	Process measures	Target for process measure	Comments
1. Review monthly Safety Incident Management System (SIMS) qualitative data to identify trends and recurring practice gaps. 2. Prioritize one key safety theme per month based on frequency, severity, and learning potential. 3. Develop a monthly Huddle Helper that includes: a. A summary of the incident trends b. Identified practice gaps c. Clear expectations for evidence-informed practice d. Discussion prompts for team huddles 4. Reinforce messaging through leadership support and follow-up communication	1. Implementation of Huddle Helpers	1. Develop and share 10 Huddle Helpers	

Change Idea #2	Implement structured pressure injury prevention rounds to support knowledge translation of the SSKIN+ education campaign into clinical practice.		
Methods	Process measures	Target for process measure	Comments
1. Complete the pressure injury prevention rounds trial on Medical Inpatient units. a. Develop a standardized pressure injury rounding tool aligned with the SSKIN+ framework b. Use pressure injury rounds to verify that at-risk patients are on a pressure-redistributing surface and reinforce staging documentation 2. Use Medicine Inpatient trial data to determine readiness and feasibility for implementation of pressure injury prevention rounds on additional clinical inpatient units.	1. Completion of trial on Medical Inpatient units a. Percentage of patients on a pressure-relieving surface b. Percentage of patients with pressure injury staging documentation 2. Create a report of findings and recommendations from Medicine Inpatient trial to determine transferability and potential risks/benefits of expanding the rounding format to additional inpatient units at BCHS	1. Successful completion of trial where units demonstrate: a. Increased compliance with documented surfaces for patients with a Braden Score of 15 and under (target on medicine units with new surfaces to be 100%) b. Increased compliance with documentation of pressure injury staging (target on medicine inpatient trial units will be 100% of patients) 2. Endorsement and roll out of pressure injury prevention rounds to identified additional clinical inpatient units if trial benefits demonstrated	

Change Idea #3	Enhance staff competence in completing a comprehensive wound assessment through targeted education, building on existing training (SSKIN+) to improve accuracy of assessment and monitor efficacy of pressure injury interventions.		
Methods	Process measures	Target for process measure	Comments
1. Provide education and validate knowledge translation for wound assessment	1. Percentage of full-time and part-time nursing staff who have completed the required education	1. Achieve 80% completion	

Measure - Dimension: Effective

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Hand Hygiene Moment #1 Compliance	C	% / Health providers in the entire facility	Crede / 2026-2027	75.50	90.00	In 2026/2027, Brant Community Healthcare System (BCHS) will achieve 90% compliance with Hand Hygiene Moment #1. This target exceeds both the large community hospital average (2025/2026) and the provincial average (2025/2026). Additionally, the target of 90% aligns with BCHS's corporate goal for hand hygiene (inclusive of Moments 1 through 4). Achieving the target of 90% compliance with Hand Hygiene Moment #1 in 2026/2027 will build the foundation to achieve and/or exceed the large community hospital top 25% average and large community hospital top 10% average in 2027/2028.	

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 Refine the current hand hygiene auditing process at Brant Community Healthcare System (BCHS) to be a standardized process for auditing.

Methods	Process measures	Target for process measure	Comments
1. Conduct current state gap analysis in hand hygiene including addressing and managing low compliance rates of hand hygiene moment #1 2. Standardize the process of hand hygiene auditing across the organization. 3. Create educational materials and resources to support hand hygiene auditors in providing constructive feedback in the moment 4. Develop a template for hand hygiene auditors to provide summary reports to managers in a timely manner	1. Upon completion, bring forward the summary and recommendations to Joint Health and Safety Committee for endorsement 2. Develop and implement the new auditing process among the active hand hygiene auditors in the organization. 3. The percentage of auditors who receive the required educational materials and resources. 4. The number of hand hygiene summary reports shared with clinical managers	1. Attend one Joint Health and Safety Committee meeting to present the recommendations based on the current state gap analysis in collaboration with Infection Prevention and Control 2. Implementation of standardized auditing process 3. 100% of auditors receive the educational materials and resources 4. Hand hygiene summary reports shared with clinical managers at least once a month	

Change Idea #2 Develop an organization-specific campaign for hand hygiene

Methods	Process measures	Target for process measure	Comments
1. Operationalize an organization wide campaign that addresses gaps in practice as identified during hand hygiene auditing 2. Develop recognition awards to recognize teams and individuals who consistently model best practice while promoting hand hygiene awareness	1. Percentage of audited gaps that had a corresponding intervention implemented	1. A minimum of 80% of audited gaps have a corresponding intervention implemented	

Change Idea #3 Refine the reporting structure for organizational hand hygiene compliance at Brant Community Healthcare System.

Methods	Process measures	Target for process measure	Comments
1. Report organizational compliance rates and any proposed interventions to Joint Health and Safety Committee 2. Report organizational compliance rates and any proposed interventions to Quality Steering Committee	1. Attend Joint Health and Safety Committee to present data and action plans 2. Attend Quality Steering Committee to present data and action plans	1. Attend and present at 12 Joint Health and Safety meetings per year 2. Attend and present at 4 Quality Steering Committee meetings per year	