Access and Flow

Measure - Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Alternate level of care (ALC) throughput ratio	O	Ratio (No unit) / ALC patients	WTIS / July 1 2023 - September 30, 2023 (Q2)	0.92	1.00	Target aligns with provincial best practice.	

Change Ideas

Change Idea #1 Implement ALC rounds.

Methods	Process measures	Target for process measure	Comments
ALC rounds implemented, occurring twice weekly.	(1) Number of ALC rounds held per week. (2) Number of ALC case presentations held per week.	(1) ALC rounds held twice a week. (2) 4-7 case presentations per week.	

Change Idea #2 Revise ALC-LTC designation process and embed approval within the ALC rounds.

Methods	Process measures	Target for process measure	Comments
Create a process whereby the care team undertakes a systematic and exhaustive review of community discharge options prior to ALC-LTC designation. Embed new process within the ALC rounds.	The number of patients designated as ALC-LTC that were presented at an ALC Round.	100% of patients designated as ALC-LTC that were presented at an ALC Round.	

Change Idea #3	Implement leading practices to improve risk identification and early access to intervention for patients at risk for cognitive and functional decline during hospitalization.		
Methods	Process measures	Target for process measure	Comments
Implement the AGS CoCare® Hospital Elder Life Program (HELP) on the Medicine Units.	(1) HELP program implemented, (2) Number of admitted medicine patients 65 years of age or older, screened within 72 hours of admission for HELP eligibility and (3) Number of patients enrolled in HELP	(1) Program implemented by 31 March 2024. (2) 80% of admitted medicine patients 65 years of age or older, screened within 72 hours of admission for HELP eligibility. (3) 15-20 per month over 6 months.	

Safety

Measure - Dimension: Safe

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Fall Prevention - Number of reported inpatient falls per 1000 inpatient days.	C	Rate / All inpatients	Hospital collected data / Q3	4.90	4.90	Reviewed international literature shows that the rate of inpatient falls per 1000 inpatient days ranges between 2.6 – 7. In FY25 Q3 over 600 workflows at KHSC will change because of the implementation of an electronic medical record. Our goal is to ensure that these changes do not result in an increased number of inpatient falls and that KHSC does not fall below the baseline of 4.9%.	

Change Ideas

Change Idea #1 Implement the MORSE Fall Risk Assessment Tool into current nursing practice in preparation for implementation of electronic medical record (Lumeo).

Methods	Process measures	Target for process measure	Comments
(1) Education delivered to point of care staff as a monthly “hot topic”. (2) Implement pocket cards (by Nursing Practice Council) for nursing, allied health and unregulated staff with the MORSE tool and recommended interventions based on patient risk.	(1) Random chart audits to confirm completion of the MORSE Falls Tool. (2) # of pocket cards disseminated to staff	(1) 80% of inpatients have MORSE Fall Risk Assessment completed. (2) 80% of nursing, allied health and unregulated staff receive pocket cards.	

Change Idea #2 Provide a refresher course for all inpatient patient care assistants (PCAs) that includes falls assessment and prevention as a topic.

Methods	Process measures	Target for process measure	Comments
4 hour refresh course with a 1-hour education session on completing inpatient falls assessment, MORSE Falls Tool and implementing/documenting falls interventions delivered to PCAs.	# of inpatient PCA staff who attend the refresher education.	80% of PCA staff attend education refresher	

Measure - Dimension: Safe

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Hand Hygiene Compliance	C	% / Staff	In-home audit / Q3	76.00	80.00	Pragmatic target that focuses on empowering front-line teams in quality improvement projects directed to improve hand hygiene.	

Change Ideas

Change Idea #1 A unit-level quality improvement initiative will be completed on all inpatient units and the ED, UCC and COPC to address local gaps/opportunities for improvement.

Methods	Process measures	Target for process measure	Comments
Unit managers will identify local unit-level opportunities for improvement and develop changes ideas.	(1) One QI initiative completed on each inpatient unit and the ED, UCC and COPC by 31 March 2025. (2) Each unit to complete one or more manager led hand hygiene huddles aligned with the QI initiative per month.	(1) 100% (23 projects complete by 31 March 2025). (2) 100% of units hold monthly huddles.	

Change Idea #2 Implement a fun and engaging annual hand hygiene event called March Madness to engage staff on all inpatient units. This event will foster positive competition with staff using competition and rewards to boost hand hygiene rates.

Methods	Process measures	Target for process measure	Comments
(1) March Madness game designed and staff trained on game strategy. (2) Targeted hand hygiene education and awareness delivered to all inpatient units, ED and UCC. (3) Increase the number of HH observations by volunteers to a minimum of 20 per day per unit.	(1)Number of units participating in March Madness (2) Percent of units who received targeted HH education and awareness. (3) Number of hand hygiene audits completed per unit/ per day during March Madness.	(1) 100% of units participating in March Madness. (2) Targeted hand hygiene education and awareness is delivered to 100% of inpatient units, including ED, UCC and COPC.	