

Access and Flow

Measure - Dimension: Timely

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile ambulance offload time	P	Minutes / Patients	CIHI NACRS / December 1, 2024, to November 30, 2025, in alignment with the Pay for Results program	68.00	60.00	The goal is to achieve 60 minutes ambulance offload time in the 90th percentile by March 2027. This will allow us to implement the change ideas in collaboration with the community partners and test the pilot program before expanding the ideas to other community programs	Frontenac Paramedics

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 Collaborate with Frontenac Paramedics and Kingston Central Ambulance Communication Centre (CAAC) to implement a joint Fit2Sit pilot program to support appropriate patient disposition and improve ED flow.

Methods	Process measures	Target for process measure	Comments
Develop a joint Fit2Sit Criteria Provide joint education to staff	% of eligible patients placed on paramedic Fit2Sit pathway Time from ED arrival to Transfer of Care completion for Fit2Sit patients	80% by Q3 Less than 30 minutes	

Change Idea #2 Optimize EMR documentation fields and reporting logic to improve accuracy of "Transfer of Care" capture.

Methods	Process measures	Target for process measure	Comments
Weekly audit for highest "Transfer of Care" times for each CTAS to ensure early flagging of discrepancies to HIS team to support accurate coding Identify opportunities for EMR to automate the "Transfer of Care" capture based on the nursing handover	Reduce discrepancies in the actual and reported transfer of care times Submit and escalate the ticket for creating the logic to capture transfer of care	>80% accuracy by Q3 Completed by Q4	

Change Idea #3 Enhance the ED front-end clinical model by expanding the Waiting Room Nurse role and adding Nurse Practitioner support to improve early assessment, treatment initiation, and patient flow.

Methods	Process measures	Target for process measure	Comments
Evaluation of ED Offload, waiting room nurse's role to maximize resources for waiting room flow Optimization of Nurse Practitioner role in ED to support workflow	Utilization of Medical Directive and CTAS re - assessment time Percentage of eligible patients seen by NP at the top of their scope within 120 minutes	>70% compliance starting Q2 >70% compliance starting Q2	

Equity

Measure - Dimension: Equitable

Indicator #1	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	74.65	75.00	Building on the work from FY 26 the organization will now focus on education and learning that in addition to focusing on base level understanding related to diversity, equity and inclusion, will also focus on indigenous cultural safety. A new course - the Foundations: Working Toward Indigenous Cultural Safety course will be introduced by assigning it not only to new hires, but also all employees with a goal of 75% completion.	

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 Assign the Foundations: Working Toward Indigenous Cultural Safety training to all KHSC staff as a part of their annual training

Methods	Process measures	Target for process measure	Comments
On demand e-Learning course will be assigned through the Learning Management System which alerts via email to each employee that a mandatory training is required.	Percentage of eligible employees that are assigned the course	Above 80% every quarter	

Change Idea #2 Follow up with leaders to ensure completion of training for their staff

Methods	Process measures	Target for process measure	Comments
Reminders are given directly via email with a timeline for completion. Communication broadly and to leaders regarding the initiative will also occur. Completion reports will be conducted monthly and broken down by department and individuals. The rate captures a moment in time and will inform leaders of their staff completion	Percentage of employees that complete the mandatory training in assigned time frame, including grace period	Above 50% starting Q2	

Change Idea #3 Improve staff awareness (leaders/front line) of the available resources that can be offered

Methods	Process measures	Target for process measure	Comments
Creating awareness of available resources for patients identifying as Indigenous	Number of education sessions for staff and leaders completed to share the information	2 sessions offered by Q4	

Safety**Measure - Dimension: Safe**

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
<p>Percentage of admitted patients in top three high prevalence areas for Hospital Acquired Pressure Injury who have:</p> <p>A documented pressure injury risk assessment completed within 24 hours of admission and daily thereafter</p> <p>An individualized pressure injury prevention plan of care for patients identified as at risk (e.g. Braden ≤ 18) and/or with an existing pressure injury</p>	C	% / All inpatients	Hospital collected data / Collecting Baseline	CB	60.00	<p>Routine completion of pressure injury risk assessments on admission and daily thereafter is an evidence-based practice that supports early identification of skin integrity changes, timely escalation of care, and prevention of hospital-acquired pressure injuries.</p> <p>Establishing a target of >60% compliance reflects a balance between high reliability expectations for patient safety practices and the operational realities of clinical environments. This target aligns with provincial best practices, accreditation expectations, and organizational priorities to reduce preventable harm, standardize care delivery, and improve documentation reliability. Improving compliance with daily reassessment and prevention planning is expected to contribute to earlier interventions, improved patient outcomes, and sustained reductions in pressure injury incidence across the organization.</p>	

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

Change Ideas

Methods	Process measures	Target for process measure	Comments
Standardize expectations for pressure injury risk assessment completion and documentation Conduct monthly point-prevalence or focused chart audits - Provide unit-level audit feedback and CLS "hot topic" education Huddles - identification of patients at risk	Education/awareness of nursing staff regarding documentation expectation by CLS hot topics % of admitted patients with completed and documented admission and daily skin assessment	>60% compliance by Q2 for top 3 high risk areas, sustained quarterly thereafter	

Change Idea #2 Increase compliance with documented pressure injury prevention plans for patients identified as at risk

Methods	Process measures	Target for process measure	Comments
Standardize documentation requirements for pressure injury prevention plans of care Conduct monthly chart audits with targeted feedback to units and leadership	Percentage of patients with Braden ≤ 18 who have a documented pressure injury prevention plan of care. Percentage of patients with an existing pressure injury who have a documented pressure injury prevention plan of care.	>60% compliance by Q3 for top 3 high risk areas, sustained quarterly thereafter	