Access and Flow

Measure - Dimension: Timely

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile ED LOS for Admitted Patients	C	Other / ED patients	In house data collection / 2025	14.90	14.60	Year 1 will focus on a deeper dive into the factors involved in the interval of time from PIA to Disposition, with support from the Analytics Hub. In addition, we will continue to drive further improvements in the other 2 intervals of Time to PIA and Time to Inpatient Bed. With a better understanding of current and trend performance with TAT for lab test and diagnostic imaging, consult response times and time from initial consult to disposition decision, Year 2 will focus on implementation of improvement initiatives to target this longest time interval to drive greater reductions in overall ED LOS for admitted patients.	

Change Ideas

Change Idea #1 Continue to reduce Time to PIA			
Methods	Process measures	Target for process measure	Comments
Continue to build the advanced care provider model of care in the ED (PA & NP) Continue to employ capacity-demand scheduling Employ HeroAI for back-up MD deployment, introduce new patient flow flares	Average and 90th percentile Time to PIA	2% reduction in 90th percentile Time to PIA	

Change Idea #2 Investigate PIA to Disposition Decision time interval factors			
Methods	Process measures	Target for process measure	Comments
Collaborate with Analytics Hub to develop a data measurement strategy Investigate long-stay admissions in the ED to understand root cause Continue to employ the Escalation Protocol Consult policy refresh Continue to leverage the impact of the Emergency DI Service	Development of KPIs for Disposition Decision factors Consult response times Time from initial consult response to disposition decision DI turnaround time Impact of Emergency DI Service Lab turnaround time # of times Escalation Protocol was used # of long-stay case reviews completed	Baseline data collection	Enablers: Engagement with key stakeholders with improvement PDSAs

Change Idea #3 Continue to reduce Time to Inpatient Bed			
Methods	Process measures	Target for process measure	Comments
Continue data-driven bed management strategies SRAT Patient Flow Escalation status for situation awareness Nursing Workforce Optimization	Average and 90th percentile Time to Inpatient Bed	2% reduction in 90th percentile Time to Inpatient Bed	Risk: Physical space challenges through surge, renovation projects

Measure - Dimension: Timely

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Surgical Waitlist Reduction	C	Number / Patients	In house data collection / 2025	3538.00	3184.00	10% reduction in surgical waitlist cases for all high-volume services (>100 patients) except Urology This target represents all the services with >100 patients on the current waitlist (excluding Urology) For these services, we have realistic community options for treatment of some conditions. For some of these services, we have opportunities for expansion of community access. SickKids has identified numerous strategies to reduce our surgical wait list.	

Change Ideas

Change Idea #1 Community Partnership Program			
Methods	Process measures	Target for process measure	Comments
Re-route high-volume, lower-acuity cases resulting in capacity-building and the delivery of high-quality care to more children and families. SickKids has partnered with Humber River Health, Scarborough Health Network, Trillium, Unity Health (St Joseph's) and Michael Garron to transfer low-acuity daycare patients on our existing waitlist. This will ensure that pediatric surgeries and procedures are done at the right centre, closer to home, and within clinically acceptable access targets.	Number of cases removed from SickKids Waitlist and referred directly to community partners. Number of cases directly referred to the community without being added to the Sickkids surgical waitlist.	Expand inclusion criteria and expand the scope of cases to be done at our community partners resulting in additional patients being referred. Directly re-routing cases to community partners before adding patients to the SickKids surgical wait list SickKids surgeons work in community partnership sites allowing expanded capacity to treat an increased volume of mid-complexity cases.	Exhaust pool of low acuity daycare patients from SickKids waitlist Low acuity patients may be directly re-routed to community partners in future reducing the volume referred to SickKids. This is a desirable future state.

Change Idea #2 Integrated Sedation Team Expansion			
Methods	Process measures	Target for process measure	Comments
Increasing procedure capacity with the Integrated Sedation Service to support EUA for Ophthalmology patients in ambulatory clinic. Anesthesia Assistants provide care to support cases that would otherwise be supported in the operating room. This will allow increased capacity in the operating room for children who require general anesthesia for surgical cases. Increase the capacity for sedation cases on 8C Sedation Unit. Reroute based on patient criteria	Number of cases removed from SickKids Waitlist and completed in Ophthalmology Clinic. Number of cases completed on 8C.	Clinical review of surgical cases on the waitlist to be supported by an Anesthesia Assistant with procedural sedation in/on 8C or in clinic. Exclusion criteria to be followed.	Exhaust pool of sedation supported patients from the surgical wait list

Change Idea #3 Waitlist Clean up

Methods	Process measures	Target for process measure	Comments
The surgical waitlist “cleanup” identifies patients who may be removed from the waitlist after clinically reviewing each patient in EPIC. Remove patients from the waitlist who: Had surgery completed elsewhere No longer need surgery Duplicate entries on waitlist No contactable as per new SOP Re-education of Surgical Wait List related to Decision to Treat Date and Dates Affecting Readiness to Treat. This will include administrative staff and surgeons, plus new onboarding orientation for new surgeons related to surgical wait list.	Estimated number of patients removed from waitlist for administrative reasons	Clinical review of surgical cases on the waitlist. Removal criteria are based on surgery completed, and the patient no longer requires surgery. Standard Operating Procedure to remove non-contactable patients from surgical waitlist Contact all families of long-waiting patients (> 2years on waitlist) to confirm if surgery still indicated/desired	

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	63.57	85.00	To continue building foundational EDI knowledge among SickKids leadership while a new Health Equity and Inclusion Strategy is in planning phase.	

Change Ideas

Change Idea #1 Reminder at Monthly Leadership Forums

Methods	Process measures	Target for process measure	Comments
Planned reminders will be conducted at the following forums: Quality Management Council Clinical Operations Management Team Forum Joint Director/Manager Forum Other existing forums	# of presentations that target expected participants (i.e., People Leaders)	A minimum of 10 presentations	

Change Idea #2 Monthly reminder emails

Methods	Process measures	Target for process measure	Comments
Monthly reminder to be sent to individuals who have yet to complete the 3 modules	# of individuals being emailed each month	A minimum of 6 monthly email blasts in 2025	

Experience

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Inpatient PFX survey: Provider told how to care for health after leaving (% answering "yes, definitely")	C	% / Survey respondents	In house data collection / 2025	84.00	88.00	Stakeholders closest to this process suggested that moving the needle on this metric will require a lot of effort Assuming the same response rate as last fiscal, requires 64 families to change their answer from “no” or “yes, somewhat” to “yes, definitely” which: Based on our analysis, should result in less ED bounce backs Has been deemed feasible based on a targeted and enterprise-wide action plans	

Change Ideas

Change Idea #1 Targeted discharge-related process improvements			
Methods	Process measures	Target for process measure	Comments
Data already stratified by service area, identifying “hot spots” for discharge improvement -Assess current state analysis through interviews and observation with patients and clinical teams involved in discharge -Define problem + design solutions	(will be dependent upon proposed solutions)	(will be dependent upon proposed solutions)	Buy-in from targeted clinical areas

Change Idea #2 Enterprise-wide push to improve digital discharge summaries			
Methods	Process measures	Target for process measure	Comments
MyChart feedback has already highlighted a need for improved After Visit Summaries -Align with MyChart team to define more clearly, how the AVS can be optimized to best meet the needs of patients and families	-# of staff completing improved AVS -Patient/Family reported satisfaction with new AVS	Baseline	Limitations to customizing the AVS within Epic/MyChart

Safety

Measure - Dimension: Safe

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Total number of staff events resulting in first aid, lost time, and healthcare, following a workplace violence incident.	C	Count / Staff	In house data collection / 2025	103.00	98.00	Target represents a 5% decrease from the 2024 rate of 103. With the utilization of the Comfort & Safety Bundle in all inpatient units, we anticipate that high risk patients will be identified and supportive plans will be put in place for patients, mitigating risk and severity of injury to staff. In addition, continued review of agitation events leading to staff injury will lead to ongoing awareness and recommendations to mitigate risk and severity of injury for staff.	

Change Ideas

Change Idea #1	Increase Utilization of Comfort & Safety Bundle.		
Methods	Process measures	Target for process measure	Comments
Chart Reviews & EPIC Reports	% of behavioural health screening tools completed = Number of behavioural health screening tools completed / number of new patient admissions (age 5 and older).	85% of patients (age 5 and older) will be screened for behavioural health risks within 24 hours of admission to an inpatient unit.	When high risk patients are identified, staff are prompted to obtain consults for CL Psychiatry, Child Life, Social Work, or Developmental Paeds as required. Staff are provided with a list of supportive tools and assessments to collect more information about patient triggers to mitigate risk. PPLs offer support with rounding on the units and JITT related to the completion of the CSB. Comfort and Safety scenarios are being integrated into preceptor training.
Change Idea #2	Review all employee safety reports related to aggressive/ violent action to ensure contributing factors and preventative measures are identified and implemented.		
Methods	Process measures	Target for process measure	Comments
Data on employee incidents that have resulted in harm to staff will be collected through the Safety Reporting System.	% of employee safety reports reviewed= number of aggressive/ violent action employee incidents reviewed / total number of aggressive/ violent action employee incidents	95% of employee incidents will be reviewed by the prevention of workplace violence program to ensure mitigation strategies are identified and implemented to prevent further escalations. Check-ins will occur with each affected staff member and available supports will be reviewed. Prevention measures will be collected and prioritized to identify trends and hospital wide issues for targeted interventions	Data collection and identified trends will help to understand the root cause of these events and offer insight to future interventions aimed at preventing escalations.

Measure - Dimension: Safe

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of potentially preventable Hospital Acquired Conditions (HACs)	C	Other / Patients	In house data collection / 2025	0.92	0.88	Eliminating potentially preventable harm continues to be a priority at SickKids. Work to reduce HAC rates is ongoing at requires shifts in attention as rates change. An increase in PIVIE rates has resulted in such a change. A moderate reduction is proposed as there has been a significant decrease in several HACs over the past years.	

Change Ideas

Change Idea #1 Increase CAUTI observation audit and coaching interactions

Methods	Process measures	Target for process measure	Comments
Continue to have Nursing Practice Observation Leads engage in audit and coaching moments for CAUTI prevention bundle. Track total observation using the CAUTI Status board dashboard.	CAUTI observation audits	Increase by 30% by December 2025.	CAUTI observations may be done by the Central HAC Team NPOLs or local QLs to provide practice coaching and support opportunities.

Change Idea #2 Reduce PIVIEs by 10%

Methods	Process measures	Target for process measure	Comments
Utilize current method of identifying events through safety reporting and having subject matter expert follow and classify injuries	Establish PIVIE apparent cause analysis process	50% of all PIVIE injuries analyzed using ACA and use findings to drive improvements	Establishing a PIVIE action group seen as drive of this work

Change Idea #3 Continue to support and strengthen leadership engagement in supporting reductions of HACs

Methods	Process measures	Target for process measure	Comments
Initiate HAC action groups for HACs that do not have one and continue current action group actives Continue to communicate metrics and benchmarking results and improvement activities to leaders for us when engaging with staff (CIP huddles, walk arounds, other)	Action groups continue to meet as decided by each HAC lead/team. Establish PIVIE action group by December 2025	HAC updates presented to Quality Management Council at least 2/year	SickKids Caring Safely program is a multifaceted safety program that supports HAC reduction.