Access and Flow | Timely | Custom Indicator

Indicator #1

90th percentile emergency department length of stay for admitted patients. (Weeneebayko Area Health Authority)

Last Year		This Year		
29.00	**24.65**	**NA**	**--**	**NA**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Identify root cause of delays.

Process measure

- We will conduct a total of 6 meeting to identify the trends and opportunity for improvement.

Target for process measure

- By October 1st, 2025, we will have 6 meetings.

Lessons Learned

Root causes of delays were not consistently identified early, highlighting the need for more proactive monitoring and escalation processes.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

Improve accuracy of documentation by providing staff education.

Process measure

- Measure number of staff who have completed the education in surge.

Target for process measure

- 50% of ED staff will have completed the education by August 2025.

Lessons Learned

Documentation accuracy impacts reporting and decision-making, reinforcing the importance of ongoing staff education.

Change Idea #3 ☑ Implemented ☐ Not Implemented ☐ In Progress

Education for IPD and facility services on the importance timely bed availability.

Process measure

- Number of meetings held.

Target for process measure

- 2 meeting held before the end of August 2025.

Lessons Learned

Timely bed availability is critical to patient flow, and increased education for IPD and Facility Services is needed to support efficient bed turnover and readiness.

Comment

Overall, improved coordination, documentation, and awareness across teams are essential to reduce delays and improve patient flow.

Experience | Patient-centred | Optional Indicator

	Last Year		This Year		
Indicator #2 Do patients/clients feel comfortable and welcome at their primary care office? (Weeneebayko Area Health Authority)	**CB** Performance (2025/26)	**CB** Target (2025/26)	**0.00** Performance (2026/27)	**--** Percentage Improvement (2026/27)	**90** Target (2026/27)

Change Idea #1 ☐ Implemented ☐ Not Implemented ☑ In Progress

Implement a patient survey.

Process measure

- Measure the implementation of the system.

Target for process measure

- 1 primary care patient experience survey implemented by July 2025.

Lessons Learned

Implementation of the patient experience survey was delayed due to contract finalization and Qualtrics setup. The WAHA survey was successfully launched on March 23, 2026, while the OHA-required survey remains pending.

The target reflects a phased approach, with initial rollout completed and full implementation expected once remaining requirements are finalized.

Progress will continue to be monitored, with a focus on increasing response rates and using results to inform quality improvement.

Change Idea #2 ☐ Implemented ☐ Not Implemented ☑ In Progress

Educate staff on the survey process so they can help do the reminders to complete.

Process measure

- % of staff who have completed the education.

Target for process measure

- 30% of the staff will have completed the education by the end of March 2026.

Lessons Learned

Implementation of the patient experience survey was delayed due to contract finalization and Qualtrics setup. The WAHA survey was successfully launched on March 23, 2026, while the OHA-required survey remains pending.

To support uptake, the survey is being actively promoted through Communications, newsletters, leadership meetings, and the Quality of Care Committee.

The target reflects a phased approach, with full implementation expected once all requirements are finalized and results used to inform quality improvement.

Change Idea #3 ☐ Implemented ☐ Not Implemented ☑ In Progress

Communication via social media to the communities about completing

Process measure

- Number of social media posts per year.

Target for process measure

- A total of 3 social media posts by the end of March 2026.

Lessons Learned

early involvement and continuous messaging.

Change Idea #4 ☐ Implemented ☐ Not Implemented ☑ In Progress

Create posters with QR codes to post.

Process measure

- Number of posters created.

Target for process measure

- 6 posters (1 for each community) will be created/posted by December 2025.

Lessons Learned

early involvement and continuous messaging.

Comment

Delays in survey implementation highlighted the importance of early contract finalization and timely setup within Qualtrics.

Key lessons include:

Initiating procurement and approvals earlier in the process
Allowing additional time for system configuration and testing
Ensuring clear coordination between vendor, IT, and internal teams

These learnings will support smoother implementation and reduce delays in future survey rollouts.

Safety | Safe | Optional Indicator

Indicator #3

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. (Weeneebayko Area Health Authority)

Last Year		This Year		
CB	**74**	**37.63**	**--**	**34**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☐ Implemented ☐ Not Implemented ☑ In Progress

Staff education on completing the BPMH at the time of admission.

Process measure

- The percentage measures % of BPMH's completed within 24 hours.

Target for process measure

- The percentage measured %.

Progress on Process Measure

- Improved but not met

Lessons Learned

Staff education on completing BPMH at admission
In Progress and ongoing.

Change Idea #2 ☐ Implemented ☐ Not Implemented ☑ In Progress

Provider education on the importance of Medication Reconciliation and how to complete it.

Process measure

- Number of demonstrations provided.

Target for process measure

- 1 demonstration provided by June 30,2025.

Progress on Process Measure

- Met target

Lessons Learned

Provider education on Medication Reconciliation
In Progress
1 demonstration.

Change Idea #3 ☐ Implemented ☐ Not Implemented ☑ In Progress

Pharmacy team to help provide reminders.

Process measure

- Percentage of patients who receive reminders withing the recommended time frame.

Target for process measure

- Percentage of patients who engage with reminders, confirming receipt or acting on the reminders, such as by filing prescriptions, or adjusting their medications schedule.

Progress on Process Measure

- Met target

Lessons Learned

newsletter, and quality of care as well as memo's.

Change Idea #4 ☑ Implemented ☐ Not Implemented ☐ In Progress

User friendly checklist for discharges.

Process measure

- the number of checklist created.

Target for process measure

- The checklist completed by June 30, 2025.

Progress on Process Measure

- Improved but not met

Lessons Learned

User-friendly discharge checklist implemented by ipd manager. created later in the year.

Comment

Pharmacy-led education: Implement pharmacy-led education on completing Best Possible Medication Discharge Plans (BPMDP), with a target of 100% delivery to high-volume discharging units within 6 months
Mandatory workshops: Introduce mandatory medication reconciliation workshops for clinical staff
Provider education (MDs/NPs): Provide focused education on the importance of medication reconciliation at discharge and proper documentation in Expanse
Standardized discharge process: Use of implemented a user-friendly discharge checklist to support completion of medication reconciliation,
Pharmacy reminders and support: Strengthen pharmacy involvement through reminders and real-time support, aiming to increase medication reconciliation at discharge
Monitoring and accountability: Monitor completion rates monthly and report quarterly

Safety | Safe | Custom Indicator

Indicator #4

Number of workplace violence incidents reported by hospital workers within a 12 month period (Weeneebayko Area Health Authority)

Last Year		This Year		
46.00	**69**	**NA**	**--**	**NA**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Staff education on the workplace violence and when/what to report

Process measure

- The percentage of staff who completed the module.

Target for process measure

- 30% of staff to have completed the module by the end of December 2025.

Lessons Learned

Education sessions have been initiated to increase staff awareness of workplace violence, including what constitutes violence (verbal, physical, threats, harassment) and when incidents must be reported. Ongoing reinforcement is being provided through team meetings, newsletter, and surge learning modules to support consistent understanding across departments.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

Staff education on how to report workplace violence

Process measure

- % of staff who have completed the education.

Target for process measure

- 30% of staff will have completed education by end of December 2025.

Lessons Learned

Staff have been provided education on the incident reporting process within the system (QRM/Expanse), including when and how to submit reports. Support is also being provided by managers and the Quality team to ensure staff feel confident and supported in reporting incidents.

Change Idea #3 ☑ Implemented ☐ Not Implemented ☐ In Progress

Educate staff on completing a violence risk assessment in Expanse

Process measure

- % of staff who have completed module in surge learning.

Target for process measure

- 30% of staff will complete module in surge learning by the end of December 2025.

Lessons Learned

Education has been provided on the use of the Violence Risk Assessment Tool within Expanse, including when it should be completed and how it supports patient and staff safety. Early monitoring shows increased awareness, with continued education planned to improve completion rates.

Change Idea #4 ☑ Implemented ☐ Not Implemented ☐ In Progress

Educate staff on how to flag a patient chart when there is a risk of violence and the interventions to be put in place.

Process measure

- % of staff who have completed learning module in surge.

Target for process measure

- 30% of staff will have completed module in surge learning by the end of December 2025.

Lessons Learned

Staff are being educated on how to appropriately flag patient charts to indicate potential risk of violence. This includes guidance on documenting risks, implementing safety interventions (e.g., communication strategies, environmental considerations, team awareness), and ensuring this information is clearly communicated during handover.

Comment

Key areas for continued improvement include increasing completion rates of the Violence Risk Assessment Tool, improving the consistency and quality of incident reporting, and strengthening staff confidence in identifying and responding to potential risks. While education has begun, ongoing reinforcement and monitoring will be critical to sustain improvements.

Equity | Equitable | Custom Indicator

	Last Year		This Year		
Indicator #5 Percent of new hires with documentation of indigenous cultural awareness and competency training within a 12 months period (Weeneebayko Area Health Authority)	**30.00** Performance (2025/26)	**36** Target (2025/26)	**10.00** Performance (2026/27)	**--** Percentage Improvement (2026/27)	**NA** Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Manager education on running reports.

Process measure

- Number of meetings with presentation provided.

Target for process measure

- This will be done twice a year- due to high turnover of managers.

Lessons Learned

Education and support are being provided to managers on how to access and run reports so they can better monitor compliance, identify gaps, and follow up with staff as needed.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

Providing time at home or at work to complete as soon as employee arrives

Process measure

- The number of staff who are able to complete education within the first two weeks of being assigned.

Target for process measure

- 15% of staff will have the annual education completed 1 month after assigned (determine date).

Lessons Learned

Managers are being encouraged to provide staff with dedicated time, either at work or as arranged, to complete required education as soon as possible after starting or when training is assigned.

Change Idea #3 ☑ Implemented ☐ Not Implemented ☐ In Progress

Manager outreach.

Process measure

- Bi-Annual outreach completed.

Target for process measure

- The Education Department will reach out to 5 individual staff with the most outstanding number of incomplete modules.

Lessons Learned

Ongoing outreach is taking place with managers to reinforce expectations, provide reminders, and support timely completion of education and follow-up activities.

Change Idea #4 ☐ Implemented ☑ Not Implemented ☐ In Progress

Target reminders campaign until target achieved

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

We will continue to strengthen manager accountability and support through regular follow-up, reminders, and education. Future improvement efforts will include clearer tracking of completion rates, more consistent outreach to managers with overdue items, and dedicated time for staff to complete required learning. This will help improve compliance and ensure education is completed in a timely manner.

Comment

1-2 group viewing slots per dept/site per quarter, attendance recorded and sent to education for credit.

Access and Flow | Efficient | Optional Indicator

Indicator #6	Last Year		This Year		
	CB	**CB**	**CB**	**--**	**NA**
Percentage of clients with type 2 diabetes mellitus who are up to date with HbA1c (glycated hemoglobin) blood glucose monitoring (Weeneebayko Area Health Authority)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Establish baseline and data collection methods

Process measure

- we will measure the number of meetings per month.

Target for process measure

- Start of March 2025 2 meeting per month until baseline and data collection measures established. This will be obtained by June 30th, 2025.

Lessons Learned

Baseline data collection has been established using monthly tracking of HbA1c completion rates for clients with type 2 diabetes. Data is being monitored and reported quarterly to support performance improvement.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

Patient reminders on the importance of the HBA1c testing and when it needs to be completed.

Process measure

- 1 social media reminder per quarter (4 per year).

Target for process measure

- We expect to see the post by the last month of quarter (the end June 2025, September 2025, December 2025 and March 2026)

Lessons Learned

Patient reminders are being incorporated into routine care; however, a standardized and consistent reminder process is still being strengthened.

Change Idea #3 ☑ Implemented ☐ Not Implemented ☐ In Progress

Prevention Specialist conversations to encourage goal setting with Clients with type 2 diabetes for updated HBA1C.

Process measure

- We are going to measure the number of clients per month that have had conversations about HBA1C testing.

Target for process measure

- We will have 5 client conversations per month. (there will be 6o conversations by March 2026)

Lessons Learned

Prevention Specialists are engaging clients in discussions related to diabetes management and goal setting. Continued reinforcement and consistency across sites is required.

Change Idea #4 ☑ Implemented ☐ Not Implemented ☐ In Progress

Establish a flagging mechanism/pre-scheduling process

Process measure

- The number of meetings held during the year.

Target for process measure

- We will have at total of 6 meetings by March 31, 2026.

Lessons Learned

Work is underway to develop a flagging or pre-booking process to ensure clients are scheduled for HbA1c testing at appropriate intervals. This will support improved compliance and follow-up.

Comment

Indicator: Percentage of clients with type 2 diabetes mellitus who are up to date with HbA1c testing

Numerator: Clients with type 2 diabetes mellitus who are up to date with HbA1c
Denominator: Clients with type 2 diabetes
Measure: % of clients with type 2 diabetes who are up to date with HbA1c testing
Performance Summary (April – December YTD)
Total Numerator: 930
Total Denominator: 1660
YTD Performance: 56%

Experience | Patient-centred | Optional Indicator

Indicator #7

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?
(Weeneebayko Area Health Authority)

Last Year		This Year		
CB	**CB**	**CB**	**--**	**NA**
Performance (2025/26)	**Target (2025/26)**	**Performance (2026/27)**	**Percentage Improvement (2026/27)**	**Target (2026/27)**

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Implement a patient survey.

Process measure

- Measure the implementation of the system.

Target for process measure

- 1 patient experience survey implemented by July 2025.

Progress on Process Measure

- Unclear/Not Available

Lessons Learned

Implementation experienced major delays; however, the WAHA patient experience survey was successfully launched in the last week of March 2026. The OHA Emergency Department Short-Form Survey is still pending final setup.

Change Idea #2 ☐ Implemented ☐ Not Implemented ☑ In Progress

Educate staff on the survey process so they can help do the reminders to complete

Process measure

- % staff who have completed the education.

Target for process measure

- 30% of staff will have completed the education by the end of March 2026.

Progress on Process Measure

- Unclear/Not Available

Lessons Learned

Staff education has started, but final completion rates are not yet available.

Change Idea #3 ☐ Implemented ☐ Not Implemented ☑ In Progress

Communication via social media to the communities about completing

Process measure

- Number of social media post per year.

Target for process measure

- A total of 3 social media posts by the end of March 2026.

Progress on Process Measure

- Unclear/Not Available

Lessons Learned

Promotion planning is underway, but final confirmation of the number of posts completed is not yet available.

Change Idea #4 ☐ Implemented ☐ Not Implemented ☑ In Progress

Create posters with QR codes to post

Process measure

- Number of posters created.

Target for process measure

- 6 posters (1 for each community) will be created/posted by December 2025.

Progress on Process Measure

- Unclear/Not Available

Lessons Learned

Poster development is underway to support survey awareness and access across communities.

Change Idea #5 ☐ Implemented ☐ Not Implemented ☑ In Progress

Finalize and implement the OHA Emergency Department Short-Form Survey alongside the WAHA patient experience survey to support standardized provincial reporting and local patient experience improvement.

Process measure

- No process measure entered

Target for process measure

- No target entered

Progress on Process Measure

- Unclear/Not Available

Lessons Learned

There were significant delays in implementing the survey process; however, the WAHA patient experience survey was successfully launched in the last week of March 2026. The OHA survey remains pending and will be implemented once setup is finalized. Next steps include continuing staff education, expanding communication through social media and posters with QR codes, and monitoring participation and response rates to improve patient feedback collection across WAHA communities.

Comment

There were significant delays in implementing the survey process; however, the WAHA patient experience survey was successfully launched in the last week of March 2026.Next steps include continuing staff education, expanding communication through social media and posters with QR codes, and monitoring participation and response rates to improve patient feedback collection across WAHA communities.

Equity | Equitable | Optional Indicator

Indicator #8

Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (Weeneebayko Area Health Authority)

Last Year		This Year		
27.01	**33.80**	**106.93**	**295.89 %**	**143.30**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Manager education on running reports.

Process measure

- Number of meetings with presentation provided.

Target for process measure

- This will be done twice a year- due to high turnover of managers.

Progress on Process Measure

- Met target

Lessons Learned

no issues

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

Providing time at home or at work to complete as soon as employee arrives.

Process measure

- The number of staff who are able to complete education within the first two weeks of being assigned.

Target for process measure

- 15% of staff will have the annual education completed 1 month after assigned (determine date).

Progress on Process Measure

- Met target

Lessons Learned

no issues

Change Idea #3 ☑ Implemented ☐ Not Implemented ☐ In Progress

Manager outreach.

Process measure

- Bi-Annual outreach completed.

Target for process measure

- The Education Department will reach out to 5 individual managers with the most outstanding number of incomplete modules.

Progress on Process Measure

- Met target

Lessons Learned

no issues

Change Idea #4 ☑ Implemented ☐ Not Implemented ☐ In Progress

Start incentives like early bird raffle prizes.

Process measure

- Number of raffles held.

Target for process measure

- 1 Raffle held per year.

Progress on Process Measure

- Met target

Lessons Learned

held March 31.

Change Idea #5 ☑ Implemented ☐ Not Implemented ☐ In Progress

secure 1-2 group session quarterly and have education apply credit to staff.

Process measure

- No process measure entered

Target for process measure

- No target entered

Progress on Process Measure

- Unclear/Not Available

Lessons Learned

this is new.

Comment

continue ongoing outreach