Theme I: Timely and Efficient Transitions

Measure

Dimension: Timely

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Acute medicine discharges with conservable bed days (i.e. number of days patients remain in hospital when they could have been discharged or cared for elsewhere).	C	% / All acute patients	In house data collection / April 1 to march 31	23.00	19.00	We would like a reduction in conservable bed days to ensure a bed is available for acute care patients when it is needed. Our current performance is 23% compared to target of less than 19%.	Home and Community Care, Family Practitioner Group

Change Ideas

Change Idea #1 Improve pathway process, early engagement with Home and Community Care, weekly meetings with Leadership to review discharge plans, early engagement with the multidisciplinary team including OT/PT, Bedside rounding, inclusion of patient and family in early discussions of discharge planning

Methods	Process measures	Target for process measure	Comments
1) Increase training and support for medicine nurses with these pathways, discuss at huddles, discharge planner role to spread to other units 2) weekly meetings with Home and Community care to review those at risk of complex discharges 3) Early engagement with multidisciplinary team including OT/PT - referrals entered on admission 4) bedside rounding on the medicine units - early engagement with the patient and review of plan of care	Number of referrals entered upon admission for OT 117 avg per month. PT avg inpt 209. Increase OT/PT as appropriate, Current number of ALC's 12.25 for fiscal year 2021/22Total number of ALC patients on acute care. Current number is 17	Number of conservable beds days reduced to less then 19% by fiscal year 2023. Increased number of referrals to OT/PT referrals by 10%. Maintaining number of ALC under 12.	

Measure

Dimension: Timely

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
The time interval between the Disposition Date/Time (as determined by the main service provider) and the Date/Time Patient Left Emergency Department (ED) for admission to an inpatient bed or operating room.	C	Minutes / All patients	CIHI NACRS / April 1 to March 31	88.00	90.00	TTIB set at 90 minutes which is a 50% reduction from when we first embarked on Pay for Performance in 2014. Presently ranking # 2 in the province out of 74 hospitals; 90 minutes is our Pay for Results target, targets to align	

Change Ideas

Change Idea #1 1)Dedicated staffing to surge unit on medicine year round. Initiatives with Home and Community Care partners and Retirement Homes to reduce ALC patients waiting for nursing home in hospital: review successful partner models; collaboration with RH to reduce admissions for long term care and to increase increased service plans.

Methods	Process measures	Target for process measure	Comments
Daily TTIB times sent out by health records to targeted individuals ie. Directors, patient flow, CN's. All barriers to admissions reviewed by Flow and FLIP team, strategies discussed with key stakeholders. Discussed at daily Huddles to keep at forefront to of frontline staff	Monitor 90% TTIB for 90 minutes, as well as, % TTIB meeting less than 75 minutes and 60 minutes to continuously monitor progress	April 2022 - 90 minutes	Pre-existing quality indicator for Pay for Results initiative; currently ranking 2nd out of 74 Ontario hospitals

Theme II: Service Excellence

Measure

Dimension: Patient-centred

Indicator #3	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?	P	% / Survey respondents	CIHI CPES / Most recent 12 mos	70.00	75.00	Previous fiscal year target was >=70% therefore target increased to >=75%	

Change Ideas

Change Idea #1 Survey patients on how they would like to receive information. Consider for some emailing instructions, discharge phone calls in some areas increased. Standardized education to be provided to all patients on discharge by the discharge nurse. All patient education is vetted through PFAC team to ensure content is patient centered and level appropriate

Methods	Process measures	Target for process measure	Comments
Discharge nurse spread to other departments Discharge instructions provided by ED consistent for all discharged. Discharge follow up call completed within 24-48 hours post discharge to ensure understanding of information.	Monitor Patient Satisfaction Survey results monthly, number of patients surveyed per month by Leadership team, number of patients that received discharge instructions from ED per audits	Percentage of respondents that respond completely is 75% by the end of the fiscal year 2023 number of patients surveyed per month by the leadership team is increased by 10%	Total Surveys Initiated: 124

Theme III: Safe and Effective Care

Measure

Dimension: Effective

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percent of unscheduled repeat visits falling within 30 days following a substance abuse visit	C	% / ED patients	In house data collection / April 1 to march 31	26.40	22.40	LHIN Target	

Change Ideas

Change Idea #1 All MH patients assessed by Crisis team member. Patients offerred appointments right from ED for further assessment by addictions or MH. Addition of full time hospital and community Addictions Response Resource. Engagement with RAAM clinic for ongoing community support, establish working group with community resources to ensure community supports in place

Methods	Process measures	Target for process measure	Comments
Track crisis assessments in ED and those not offered. Track number of referrals from ED to addictions or MH assessments. Follow up phone calls to patients seen with higher CTAS levels and addiction issues. Engagement with Addictions Response Resource	Number of visits of MH patients offered crisis assessment and or Addictions Response Resource	100% of MH patients are offered crisis assessment or addictions response resources by the end of fiscal year 2023	

Measure

Dimension: Safe

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.	P	Count / Worker	Local data collection / January - December 2021	50.00	45.00	We have set the target incidents reported by hospital workers that resulted in harm(actual event severity level from 2-5)within a 12 month period as a 10% decrease in incidents for the fiscal year 2022-2023. We have been tracking violent incidents and seen an increase in reporting from workers. We still want to encourage reporting of all workplace violence incidents but want to see a decrease in the number of incidents that have caused harm to the worker demonstrating the mitigation strategies the hospital has put in place to reduce harm are effective.	

Change Ideas

Change Idea #1 1)All Workplace Violent Incidents reviewed and investigated, rates reported at huddles on each unit and management group weekly.

Methods	Process measures	Target for process measure	Comments
Risk Manager, Directors and Employee health reviews all incidents of workplace violence with debrief and a ongoing support process standardized throughout the organizations and ensures follow up occurs as required.	number of incidents that occurred per severity level per department shared at unit and weekly management group huddles number of incidents that occurred shared at JH&S committee yearly reporting of incidents to unions	100% of incidents to be reviewed and analysis completed by either Risk manager, Director or Employee health with data shared at management group huddles weekly and unit huddles monthly, JH&S and unions.	FTE=1000

Change Idea #2 Provide prevention strategies for workplace violence including NVCI training, MOAB, Emotional intelligence course, coaching.

Methods	Process measures	Target for process measure	Comments
Additional educators trained to provide NVCI with more flexible hours and classes, Training of Security and super users in MOAB training, more mock drills on Code whites and how to de-escalate a patient Provide education on De-escalation techniques,	number of employees completed NVCI training in high risk areas, number of management group completed emotional intelligence to assist with coaching employees	100 % of staff in high risk areas to receive training within 3 months of commencing position in high risk areas, 100% of Directors complete emotional intelligence course	

Change Idea #3 3) Workplace Violence Week at Hospital every year during Code of the Month(Code White) to bring attention to issue and prevention

Methods	Process measures	Target for process measure	Comments
Create signs on zero tolerance on Workplace violence for waiting areas, patient rooms, ensure behavioural safety alerts in CERNER are applied for every incident of workplace violence. Review Code Of Conduct Workplace Violence Policy and Code White policy at Patient Family Advisory Committee	number of workers that feel the education and mitigation strategies provided are effective in reducing number of harmful workplace violence number of Code Whites called in hospital	95% of Workers feel that the education and mitigation strategies in place are effective in reducing the number of harmful workplace violence by the end of fiscal year	

Equity

Measure

Dimension: Equitable

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
LGBT2S+ education provided for all workers at Woodstock Hospital with mandatory completion by the March 31, 2023.	C	% / Worker	In house data collection / April 1 to March 31	91.00	100.00	Last fiscal year Diversity, Equity and Inclusion education was provided for all workers with a 91% completion rate. This was not mandatory	

Change Ideas

Change Idea #1 Diversity Equity and Inclusion Committee to provide education and awareness to all workers on LGBT2SQ+

Methods	Process measures	Target for process measure	Comments
LMS will be created and distributed that is mandatory for all workers	number of completions of the mandatory LMS in percentages reported to Quality Committee every fiscal quarter	100% of workers at Woodstock Hospital will have completed the LGBTQ2S+ education LMS by March 31, 2023	