Theme I: Timely and Efficient Transitions

Measure

Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
This indicator measures 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 / ED patients	CIHI NACRS / 2023 2024	380.00	90.00	Numbers were up last year due to increased patient volumes, diminished services in the community and availability of LTC beds. Healthcare is experiencing large human health resource concerns in hospitals, homecare and LTC homes. Our recent time to inpatient rates have started to trend down and we would like to get back into less than or equal to 90minute target we have met for previous fiscal years.	

Change Ideas

Change Idea #1 Review and standardize current patient flow admissions standard.

Methods	Process measures	Target for process measure	Comments
Working with internal teams to standardize admission processes including communication between all ED and inpatient units. Review data on number of STAT cleans and challenges around resource use. Improve standard workflow.	Completion of review of the patient flow admissions standard. Percentage reduction in number of STAT cleans required to accommodate admissions Review data on the turn around times from discharge to admission on the inpatient units	Collect a baseline of the date for turnaround times from last fiscal year to determine target for this fiscal year. Admissions standard reviewed and standardized by all key stakeholders. 25% Percentage reduction in the number of stat cleans	

Change Idea #2 Dedicated year round staffing to Inpatient Surge Unit.

Methods	Process measures	Target for process measure	Comments
Hiring and scheduling of staff on unit 2400 for the entire fiscal year. Ensuring the unit has adequate staff 365 days of the year.	Number of days the Inpatient Surge Unit is staffed appropriately to keep all beds open. Number of instances we do not meet the time to inpatient bed target due to beds not being available in the hospital.	Inpatient Surge unit staffed 365 days of the year to keep all beds open. Review last fiscal years data for the number of instances we do not meet the time to inpatient bed and set target for this fiscal year.	

Change Idea #3 Collaborate with home and community care partners and Retirement Homes to reduce our ALC days

Methods	Process measures	Target for process measure	Comments
Review successful partner models. Collaboration meetings with community partners including retirement homes, home and community cares, including speakers	Review partner models to consider for implementation Attendance at quarterly meetings Meet quarterly with collaboration meetings	Review 5 other organizations models Meet every quarter 100% of the time.	

Change Idea #4 All barriers to admissions reviewed by Flow and FLIP team, strategies discussed with key stakeholders.

Methods	Process measures	Target for process measure	Comments
Daily TTIB times sent out by health records to targeted Charge nurses, Directors, Patient flow and Flip Team. Discuss barriers at daily huddles to keep TTIB awareness for frontline staff. Barriers tracked quarterly and added to scorecards	Measure the number of days the barriers are discussed at huddles. Barrier emails sent to all Directors on daily TTIB report. Number of instances per barrier category recorded on units on scorecards.	100% of barriers identified sent out the Directors on daily TTIB reports. Review number of instances per barrier category for last fiscal year and set target for this fiscal year.	

Theme II: Service Excellence

Measure

Dimension: Patient-centred

Indicator #2	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 consecutive 12-month period	CB	80.00	Current target selected based on target achieved during fiscal year 2021/2022. Unable to collect any data last fiscal year due to no Survey Provider. Starting with Qualtrics April 17, 2023.	

Change Ideas

Change Idea #1 Continue to complete inventory of patient information material and modify patient information with the guidance of the Patient and Family Advisors

Methods	Process measures	Target for process measure	Comments
Ensure that all patient education given to the patient is reviewed by PFAC members. Continue to provide every patient, upon admission, with standard information on admission and have the discharge nurse meet with all planned discharged patients to ensure all education is reviewed with patient and or family using teach back method.	Patient education materials are reviewed by PFAC members. Discharge nurse meets with all patients with planned discharges on the Medicine units using the teach back method.	100% of all patient education materials are reviewed by PFAC members 100% of all patients with planned discharges that are completed by the discharge nurse on the medicine units are provided education using the teach back method.	

Change Idea #2 Patients receive standardized discharge information and frontline staff are educated on standard discharge process.

Methods	Process measures	Target for process measure	Comments
Continue with D/C nurse on medicine to ensure standard information is provided to patients on discharge. Follow up calls completed on all discharges to ensure understanding of all information provided and closing the loop on patient discharge and smooth transitions home. Creation of a Standard Operating procedure for discharge on Medicine units that all frontline staff are educated about.	All patients discharged home from Medicine unit receive follow up discharge call to ensure smooth transition and understanding of information. All staff educated on the Discharge Process Standard Operating Procedure.	100% of all patients discharged from Medicine Unit receive standardized information. 100% of all staff educated on Discharge Process Standard Operating Procedure on Medicine units.	

Change Idea #3 Trial of bedside rounding on the inpatients units to ensure consistent information is shared with patients and involvement of patient in discharge planning.

Methods	Process measures	Target for process measure	Comments
Continue to enhance Charge nurse/Physician and interdisciplinary rounding on patients to encourage engagement of patients in determining what information they require to meet their discharge needs. Bedside rounding will be completed on all patients on medical units on a rotating basis. Discharge plan and discharge requirements will be entered into CERNER to ensure all staff aware of patient's needs and what was shared with the patient.	Successful implementation and education of nurses on how to document discharge plans and education provided in CERNER. Successfully implement bedside rounding on all medicine units.	100% of medicine units implemented bedside rounding, 100% of units implemented and educated on discharge documentation in CERNER	

Theme III: Safe and Effective Care

Measure

Dimension: Effective

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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.	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / Oct–Dec 2022 (Q3 2022/23)	87.53	88.00	This years data revealed an 88% completion rate for BPMH. New target kept the same to ensure physicians complete the BPMH.	

Change Ideas

Change Idea #1 Provide timely and understandable data to physician and to directors to indicate performance around this metric.

Methods	Process measures	Target for process measure	Comments
Performance results to be sent to physician and directors for review and follow up with appropriate teams on a quarterly basis.	Number of physicians and directors to receive quarterly audit and compliance reports	100% of all physicians and directors will receive quarterly audit and compliance reports that will be used to guide follow up and performance opportunities.	

Measure **Dimension:** Safe

Indicator #4	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 / Jan 2022–Dec 2022	99.00	100.00	We want to see an increase in the number of reported workplace violence incidents to establish a better baseline. Workplace Violence incidents are under reported. We also want to see a reduction in the number of workplace violence harmful incidents from 45 to less then 40.	

Change Ideas

Change Idea #1 Implementation of RNAO Best Practice Guidelines Preventing Violence, Harassment and Bullying against Healthcare workers.

Methods	Process measures	Target for process measure	Comments
Development of workplace harassment and violence prevention working group. Develop and implement a survey for all staff at Woodstock Hospital (WH) complete gap analysis of recommendations from BPG to current practice at WH	Numbers of respondents on survey that are victims of workplace harassment, number of respondents on survey that are victims of workplace violence	We need to establish baseline data on this survey and then compare to the data we receive via RL6 and repeated survey.	FTE=1000

Change Idea #2 Access the toolkits from Public Services Health and Safety Association (PSHSA) to enhance workplace violence prevention and management processes.

Methods	Process measures	Target for process measure	Comments
Focus on the five responsive tools by PSHSA (workplace violence risk assessment, individual client assessment, risk communication flagging, security gap analysis, personal safety response system, emergency responses.	Number of toolkits successfully implemented within the hospital at the end of the fiscal year	All 6 toolkits successfully implemented	

Change Idea #3 Improve verbal de-escalation training for employees

Methods	Process measures	Target for process measure	Comments
Provide further verbal de-escalation training for all employees in high risk frontline units. Provide verbal de-escalation training for leaders at Woodstock Hospital	Percentage of employees on high risk area units that received further de-escalation training and percentage of leaders that receive further de-escalation training	100% of employees in high risk areas to receive training and 100% of Management team to receive training	

Equity

Measure

Dimension: Equitable

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Indigenous Truth and Reconciliation and Sikh education for all employees of Woodstock Hospital.	C	% / Worker	In house data collection / 2023 2024	0.00	100.00	Our community has seen a large increase in our Sikh population. We want to bring cultural safety and awareness to our workers on traditions and practices. In response to the Truth and Reconciliation Commissions call to action, we will be providing education to all of our safety on the history, experiences and stories of Indigenous peoples in Canada.	

Change Ideas

Change Idea #1 Implementation of Sikh cultural awareness and safety for all staff at Woodstock Hospital.

Methods	Process measures	Target for process measure	Comments
Lunch and learn with member of Sikh community, LMS education created on Sikh cultural awareness and safety for all staff. Presentation and celebration of Sikh Heritage month at Woodstock Hospital	Number of employees who attend the lunch and learn, number of employees who complete LMS education on Sikh awareness	80 staff members present at lunch and learn for Sikh cultural awareness and safety and 100% of employees complete the LMS for Sikh awareness and safety.	

Change Idea #2 Implementation of Indigenous Truth and Reconciliation training for all staff at Woodstock Hospital

Methods	Process measures	Target for process measure	Comments
Lunch and Learn for staff at Woodstock Hospital provided by South West Ontario Aboriginal Health Access Centre on Indigenous social determinants of health and issues, Truth and Reconciliation. LMS Education provided to employees of Woodstock Hospital on Indigenous social determinants of health and issues, Truth and Reconciliation.	Number of staff who attend the lunch and learn presented on Indigenous issues. Number of employees who complete the LMS education on Indigenous issues and Truth and Reconciliation.	80 staff attend the lunch and learn 100% employees complete the LMS education	