Access and Flow

Measure - Dimension: Timely

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile ED length of stay	O	Hours / ED patients	CIHI NACRS / ERNI hospitals: December 1st 2022 to November 30th 2023. Non-ERNI hospitals: April 1st 2023 to September 30th 2023 (Q1 and Q2)	5.80	5.50	We have set the target for 2024/25 the same as our current target. Setting lower targets for length of stay is not realistic due to larger volumes of ED patients.	

Change Ideas

Change Idea #1 Adding 6 hour physician shift on evenings four days a week on the days that currently have the highest volume.

Methods	Process measures	Target for process measure	Comments
Decision support wil be tracking PIA times for all three shifts. Compare PIA times on extra coverage days to days with regular coverage.	PIA for hours on all three shifts evening shifts during certain days.	Target for process measures is 3 hours	We have partnered with the MD group to discuss what time of day to add on these extra shifts and are actively recruiting for more ED physicians. We have recognized that our P4R ranking for PIAs is very low compared to other hospitals and actively working to improve this metric.

Change Idea #2	RPN float nurse assigned into RAZ assessment area to improve patient flow in the department and work with the additional MD to reduce CTAS 3-5 patient wait times		
Methods	Process measures	Target for process measure	Comments
FLIP team will track the CTAS 3 data and report it to the Chief of ED, Director, Frontline staff and ED Committee meeting.	Average number of hours all CTAS 3 levels have waited to see a doctor..	Our target for PIA of CTAS is 3.0 hours	Data collection and analysis on PIA times revealed that the CTAS3 patients have prolonged wait times. We implemented a fast track area years ago to assist with our CTAS 4 and 5 and now recognize the CTAS 3 patients are experiencing some of the longest wait times. We have moved the RPN to assist the additional MD to expedite the flow for these patients.

Change Idea #3	Dementia Resource Consultants will start to consult on frail elderly patients living with dementia who have been admitted less then 5 days to attempt to provide services for discharge.		
Methods	Process measures	Target for process measure	Comments
Tracked by decision support and reviewed and analyzed by FLIP team.	A decrease in Conservable bed days pre and post implementation of this program.	Target for conservable bed days for frail elderly patients post implementation is 18.9	ED Resource team has had good success in the ED assessing and avoiding admissions for frail elderly patients and those patients living with dementia. The team currently has the capacity to assess some inpatients therefore able to start this initiative to assist with patient discharge post admission.

Measure - Dimension: Timely

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department wait time to inpatient bed	O	Hours / ED patients	CIHI NACRS / ERNI hospitals: December 1st 2022 to November 30th 2023. Non-ERNI hospitals: April 1st 2023 to September 30th 2023 (Q1 and Q2)	3.13	1.30	Like other hospitals in Ontario, our time to inpatient rates have increased since the pandemic. We have still set our target to 1.5 hours, looking for our change ideas to help lower our current performance. We have also set this target as 1.5 hours, the same as our Pay for Results program target.	

Change Ideas

Change Idea #1 Create frontline working group to review barriers to getting patients to unit including patient representatives

Methods	Process measures	Target for process measure	Comments
This group will be initiated by the FLIP team to engage frontline workers to understand the experiences of other workers and the importance of having a patient in the right place getting the right care at the right time.	Successful implementation of a working group to review barriers and create actionable items to be followed up on.	Successful implementation of a TTIB working group end of Q2	Increase in pushback from inpatient areas delaying admissions. Employees siloed in their understanding of the barriers experienced by one another and understanding workflows specific to ED and inpatients. When the P4R TTIB project was initiated years ago this was a successful tool in decreasing TTIB times.

Change Idea #2 Review and standardize current patient flow admissions standard			
Methods	Process measures	Target for process measure	Comments
Review of stat clean data and turn around times (TAT).	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	10% reduction in TAT	still working on this initiative for the next fiscal year, only staff permitted to call for stat clean is patient flow, evening coordinators and after hours charge nurse.

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 partner models to consider for implementation Attendance at quarterly meetings. Meet quarterly with collaboration meetings. Share successes and challenges to work as a team to ensure patient receive the right care in the right place.	Include community LTC homes in membership of Collaborative meetings by the end of Q2 fiscal year 2024/25.	the target is to have at least 3 LTC homes join the Collaborative	in progress for 2-3 years but focus was on RH now inviting LTC homes. The need for their participation was recently identified when a concern was brought forward by a local LTC home and they were then invited to join the team. We also identified we had the same flow issues with LTC homes as we did with RH.

Measure - Dimension: Timely

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percent of patients who visited the ED and left without being seen by a physician	O	% / ED patients	CIHI NACRS / April 1st 2023 to September 30th 2023 (Q1 and Q2)	4.20	3.75	We have set this target for left without being seen to be lower than our current performance.	

Change Ideas

Change Idea #1	Addition of second triage nurse for peak times in the Emergency department. Address staffing levels to meet demands of peak times.		
Methods	Process measures	Target for process measure	Comments
Data will be collected by the FLIP team on what the Peak hours are in the department as well as the data on when most patients leave without being seen	Implementation of an additional triage nurse in the ED during peak times by the end of fiscal year 2024/25	Target is set for completion by the end of fiscal year 2024	Increased ED visits has led to delayed triage of patients during peak busy times

Change Idea #2	Implementation of Geriatric Emergency Nurse in the ED for assessments on seniors, navigate care and link them up to community resources to avoid re-admissions to ED.		
Methods	Process measures	Target for process measure	Comments
The implementation and number of referrals seen is tracked by the GEM nurse and reported to the FLIP team	Number of referrals seen by GEM nurse	Collecting baseline data	limitations include that there is only one GEM nurse therefore unable to cover 7 days per week. This is off set by Alzheimer's resource staff in ED and Home and Community Care supports.

Change Idea #3	Adding 6 hour physician shift on evenings four days a week on the days that currently have the highest volume.		
Methods	Process measures	Target for process measure	Comments
Decision support wil be tracking PIA times for all three shifts. Compare PIA times on extra coverage days to days with regular coverage.	PIA for hours on all three shifts evening shifts during certain days.	Target for process measures is 3 hours	We have partnered with the MD group to discuss what time of day to add on these extra shifts and are actively recruiting for more ED physicians. We have recognized that our P4R ranking for PIAs is very low compared to other hospitals and actively working to improve this metric.

Equity

Measure - Dimension: Equitable

Indicator #2	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	CB	95.00	Last years target for equity, diversity, inclusion and anti-racism target was 100%. We achieved 95.6% for 2023/24. Realizing this is a more realistic target when considering turnover rates, we set our target at 95% for the 2024/25 Fiscal year QIP.	

Change Ideas

Change Idea #1 Anti-Black Racism Education to all staff

Methods	Process measures	Target for process measure	Comments
TAHSN module on Anti-Black racism has been already branded for Woodstock so we can launch it through our LMS.	percentage of staff completing the LMS module by the end of 2024/25	the target for this process measure is 95%	we had great success with implementation of our other EDIB education to all staff. We will also continue incorporating education on unconscious bias for all staff.

Experience

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?	O	% / Survey respondents	Local data collection / Most recent consecutive 12-month period	75.00	80.00	We set our target as 80% same as last year	

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
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 and the reviewed materials..	Number of discharge materials that will be reviewed by our Patient and Family Advisors	the target process measure is 10	Total Surveys Initiated: 517 Challenges with maintaining education materials at a grade 6 level of education even with our current patient and family advisors.

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
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.	Percentage of acute medicine nurses receiving education on standardized discharge education	target for this process measure is 90%	Staff receive education on the PODS discharge tool from the FLIP team. Challenges in implementing this is the current high turnover employment rate on these units.

Safety

Measure - Dimension: Effective

Indicator #1	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.	O	% / Discharged patients	Local data collection / Most recent consecutive 12-month period	83.38	88.00	Target was set at 88% last year and only achieved 83% but we are confident we can raise this with our new change ideas.	

Change Ideas

Change Idea #1 Implementation of scorecards for all physicians with continued focus on the surgeons due to lower compliance. Review of metric at Medical audit committee to promote compliance and completion.

Methods	Process measures	Target for process measure	Comments
scorecards provided to all physicians and Directors by decision support and pharmacy team for review and follow up on a quarterly basis. Data is shared at Medical Audit Committee quarterly.	Number of physicians and Directors to receive quarterly audit reports and improvements in statistics	100% of all physicians will receive quarterly scorecards and compliance will be reviewed with the physician by the Chief and Assistant Chief of Staff.	

Change Idea #2 Add 1FTE pharmacist to support under-supported areas like our 2500 unit (inpatient Surgical unit) and L500 unit (inpatient psychiatry).

Methods	Process measures	Target for process measure	Comments
The priority for the surgical unit will be to support the surgeons to complete discharge med rec since our monthly metrics indicate that this unit is a poor performer.	Percentage of medication reconciliations completed by surgeons on 2500 unit	Target for completion is 80%	If we can improve compliance in the surgical program then this will overall improve the hospital average.

Measure - Dimension: Safe

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of workplace violence incidents resulting in lost time injury	O	% / Staff	Local data collection / Most recent consecutive 12-month period	1.00	0.00	For the past two year we have had 2 incidents of lost time per year therefore will be reducing to target of 1 incident in calendar year	

Change Ideas

Change Idea #1 Revision of our Non Violent Crisis intervention training completed at the end of fiscal year 2023/24 with full roll out in 2024/25. This includes improved verbal de-escalation strategies based on staff feedback into training needs

Methods	Process measures	Target for process measure	Comments
Providing further verbal de-escalation strategies training to all front line staff. Revision of NVCI training to online module for low risk areas which also includes increased verbal de-escalation strategies.	Percentage of staff that complete both the online module and in person NVCI training with verbal de-escalation.	100% of staff both in high risk and low risk areas trained with revised training modules	This was identified on our 2023/2024 QIP revision occurred in previous year with further rollout this year and evaluation

Change Idea #2 Completion of root cause analysis of workplace violence incidents causing injury.

Methods	Process measures	Target for process measure	Comments
Root cause analysis of workplace violence incidents causing injury. Review any incidents and root cause with Directors, Senior leadership and security within the organization. Increased completion of mock code whites within the organization ensuring each unit is provided the training and opportunity to participate in mock code whites.	% of recommendations completed based on root cause analysis of incident. %compliance of staff wearing personal alarms. % of mock code whites completed	100% staff compliance in wearing electronic personal alarms. Staff education completes mock code white on every unit within the organization on regular basis	