Access and Flow

Measure - Dimension: Timely

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile ambulance offload time	P	Minutes / Patients	CIHI NACRS / For ERNI hospitals: Dec 1, 2023, to Nov 30, 2024 (Q1 and Q2)	17.00	15.00	We perform very well on this indicator with a current performance of 17 minutes. We have additional change ideas we are going to implement so have set our target lower to 15 minutes.	

Change Ideas

Change Idea #1 Assess the feasibility and impact of introducing an offload nurse to improve patient flow.

Methods	Process measures	Target for process measure	Comments
Responsibility: ED leadership Team/ FLIP team Tasks: Conduct feasibility study. Develop a proposal for the offload nurse role in correlation with Oxford County Emergency Medical Services (EMS). Submission of application to Ministry of Health for consideration	Time from patient arrival to triage time. Review per shift, days, evening and night.	Our target is for 15 minutes or less	

Change Idea #2 Increase Nursing Participation and enrollment in Triage Course

Methods	Process measures	Target for process measure	Comments
Responsibility: ED Educator Tasks: Identify staff eligible for initial and refresher triage training. Schedule and conduct triage courses. Monitor and report on course completion.	"Number of new staff completing the triage course. " "Number of current staff completing the triage refresher course. " Percentage of staff qualified to perform triage duties.	We are going to collect baseline data for these measures.	

Change Idea #3 Explore Utilization of OH Triage Platform Electronically			
Methods	Process measures	Target for process measure	Comments
Responsibility: IT Department and Nursing Leadership Tasks: Train staff on using the OH platform. Implement electronic documentation processes. Monitor usage and troubleshoot issues.	Number of staff trained on triage using the OH platform.	Collecting baseline data.	We are experiencing some turnover with our ED educator role and our new educator will require training on the train the trainer CTAS triage course leading to a delay in certifying our nursing staff. We hope to leverage the electronic version and evaluate its effectiveness.
Change Idea #4 Develop LMS education of triage to bridge those staff not due this year but who required training on the new platform			
Methods	Process measures	Target for process measure	Comments
Responsibility: Education Department Tasks: Create bridging education modules. Integrate modules into the LMS. Monitor and report on completion rates.	Percentage of staff that completed bridging education. Number of staff completed over number of staff that not due for full training this year.	Completing baseline numbers on new electronic platform	

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 / For ERNI hospitals: Dec 1, 2023, to Nov 30, 2024 (Q1 and Q2)	3.65	1.50	We were successful in keeping our TTIB to under 1.5 hours prior to the pandemic. We are hoping to bring this number back down with the addition of new change ideas.	

Change Ideas

Change Idea #1 Working Group with Housekeepers discuss resource allocation of staff including schedules and breaktimes.

Methods	Process measures	Target for process measure	Comments
"Responsibility: FLIP, Housekeeping Director and supervisor Tasks: Form a working group with housekeeping. Schedule regular meetings to discuss workflow and resource allocation. Identify opportunities for floating housekeepers and managing discharges. Implement new staff allocation plan. "	Number of recommendations implemented.	Aiming for three new recommendations from the group.	

Change Idea #2 Review housekeeping cleans and bed availability on inpatient units.

Methods	Process measures	Target for process measure	Comments
"Responsibility: Housekeeping Supervisor, Patient Flow Coordinator Tasks: Ensure cleans are started within 30 minutes of request. Monitor and report on bed availability delays due to unclean beds.	Percentage of cleans started within 30 minutes of request.	Overall percentage of clean requests started within 30 minutes we are aiming for 90%	

Change Idea #3 Explore Physio and Occupational Therapy schedules and roles.

Methods	Process measures	Target for process measure	Comments
Responsibility: Director of Physiotherapy, Occupational Therapy Tasks: Explore changing PT/OT hours to meet patient flow needs. Collect data on delays related to PT/OT assessments.	Number of discharges delayed due to unavailability of PT/OT assessment	We are aiming for no discharges delayed due to unavailability of PT/OT assessment.	

Change Idea #4 Reeducation to nursing staff of time to next bed indicator			
Methods	Process measures	Target for process measure	Comments
Responsibility: Patient Flow, FLIP team Provide reeducation on TTNB for all inpatient unit staff. Ensure compliance with TTNB protocols.	Number of staff completing the re-education of TTNB " Time from transfer order to arrival on transfer unit	95% nursing staff complete re-education. Time to next bed target is 1.5 hours	We have noticed this rate increase over this fiscal year due to sending units delayed in sending.

Change Idea #5 Explore use of Blaylock discharge planning tool for patients admitted 65 years or older upon admission.			
Methods	Process measures	Target for process measure	Comments
"Responsible: Admission Team, Cerner Team, Nursing Staff. Tasks: Configure the Blaylock tool in Cerner to be used upon admission. Train staff on the use of the tool and its importance in discharge planning. Ensure the tool is used consistently for all eligible patients.	a. Percentage of times Blaylock tool completed for patients 65 years and older upon admission. b. Percentage of staff trained on use of Blaylock tool.	Our target for each process measure is 95%	This is a new initiative we just started to roll out in Q4 of this fiscal year.

Change Idea #6 Establish a committee to oversee the implementation and monitor the effectiveness of the Blaylock tool.			
Methods	Process measures	Target for process measure	Comments
Responsible: Quality Improvement Team, Nursing Leadership, IT Team. Tasks: Form a multidisciplinary committee including representatives from nursing, IT, and quality improvement. Hold regular meetings to review progress and address any issues. Collect feedback from staff and patients to refine the process.	a. Attendance for Committee meeting members. b. Percentage of actions items completed by due date.	Target for percentage of attendance is 90% Target for percentage of actions is 80%	

Change Idea #7 Conduct a pilot test of the Blaylock tool on unit 2200 to evaluate its effectiveness and gather data for broader implementation.

Methods	Process measures	Target for process measure	Comments
"Responsible: Unit 2200 and M200 Staff, Committee. Tasks: Implement the tool on unit M200. Collect data on patient outcomes and staff feedback. Make necessary adjustments based on pilot results.	a. Percentage of patients 65 and over identified Blaylock score 0-19 that are readmitted.	Our target for this indicator is 10%. A lower score is better.	

Measure - Dimension: Timely

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department wait time to physician initial assessment	P	Hours / ED patients	CIHI NACRS / ERNI hospitals: Dec 1, 2023, to Nov 30, 2024/Non-ERNI hospitals: Apr 1, 2024, to Sept 30, 2024 (Q1 and Q2)	3.38	3.30	We were successful in keeping our TTIB to under 1.5 hours prior to the pandemic. We are hoping to bring this number back down with the addition of new change ideas.	

Change Ideas

Change Idea #1 Extra physician hours scheduled during peak times			
Methods	Process measures	Target for process measure	Comments
"Responsibility: FLIP Team, ED Chief and MD Scheduler Tasks: Review with team what hours physicians are most needed. MD scheduler offers available extra shifts to physicians Track and record the number of shifts available and the number of shifts filled per month."	Percentage of physician extra shifts filled per month PIA wait times per shift days, evenings, nights	Target for percentage of shifts filled is 90%. Our targets for PIA waits for each shift are 3.3.	We have now secured our hospitalists as casual physicians to assist in filling these open shifts.

Change Idea #2 Provide information of physician coverage hours on the hospital website			
Methods	Process measures	Target for process measure	Comments
"Responsibility: ED Leadership Team Develop and update educational content on the website regarding physician coverages. Ensure all relevant staff are aware of and access the information."	Feedback on the usefulness of information provided on website from staff and patients Number of visits on website that view this information	Collecting baseline for these process measures with the introduction of our new website platform.	

Change Idea #3 Evaluation of mid shift physician change over from one ED area to another.			
Methods	Process measures	Target for process measure	Comments
"Responsibility: ED Leadership Team Tasks: Complete environmental scan of other hospitals physician scheduling and PIA times. Determine measures that will identify delays in physician initial assessments times during mid shift change over. Track Measures identified, Communicate the change to all relevant staff. Share measures with physician group displaying delays in care. Measures: Adjust change over schedule based on decisions made with physician group."	Number of hospitals whose physicians change over mid shift to another area in the ED. Physician initial assessment during mid shift change over times	We will be benchmarking changeover times with other large community hospitals.	

Change Idea #4 Continue with implementation of physician assistant (PA)program			
Methods	Process measures	Target for process measure	Comments
"Responsibility: Flip team Task: Submit government grant, new grad recruited, Created policy, workflow and medical directives Implement policy, workflow and medical directives Recruited and roll out new role supported by mentors. Monitor and review implementation "	90th percentile emergency department length of stay for non-admitted patients with low acuity during hours PA worked. 90th percentile emergency department length of stay for non-admitted patients with low acuity	Our target for the LOS is 5 hours	We just started this program in late December, early January of 2025 with a new grad PA so we are still in the process of evaluating.

Change Idea #5 Working Group Review Process with DI: Collaboration between both departments to create and review workflow, establish targets for DI turnaround times and prioritization of DI tests ordered. We will work together to create solutions to meet our targets.			
Methods	Process measures	Target for process measure	Comments
"Responsibility: ED Frontline Working Group/FLIP Team Tasks: Develop a strategy to create a faster pathway (""fast track"") for patients who need to return for imaging. The goal is to reduce wait times for diagnosis, treatment, interventions, transfers, or admission by streamlining the process specifically for these patients. Re-allocating Human Resources: Review current schedules and availability within the US departments. The goal is to offer more flexible hours, including evenings. We will measure this by tracking DI turnaround times. "	Success will be measured by tracking data on the PIA for patients who return for imaging, the number of safety events related to this issue, and patient experience surveys.	PIA target for this measure is 2 hours. Our other measures are collecting qualitative data.	Our EDRVQP audits showed a high number of return visits for imaging results where these patients also received long wait times to be reassessed. We are looking to reallocate some US hours to the evening shift.

Measure - Dimension: Timely

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Daily average number of patients waiting in the emergency department for an inpatient bed at 8 a.m.	P	Number / ED patients	CIHI NACRS / Apr 1 to Sep 30, 2024 (Q1 and Q2)	0.45	0.45	We do well on this indicator currently. We realize patients may experience some waits in the ED, so we are keeping our target the same.	Ontario Health at Home

Change Ideas

Change Idea #1 Explore change of Patient Flow start time from 0800 to 0700.

Methods	Process measures	Target for process measure	Comments
"Responsibility: Access and Flow Committee Tasks: Track data on number of patients waiting in ED with no bed assignment at 0700 and 0800. Review data on reasons patients waiting for a bed assignment after 0800. Review data on number of inpatient beds not cleaned at 0800 Review data on number of patients admitted to hospital between the hours of 0600 - 0800 from ED to evaluate batching. Make recommendations based on findings. Monitor and evaluate the impact of recommendations on patient flow."	Number of admitted patients in ED at 0700 with no bed assignment. Number of admissions from 0600-0800 in ED Number of inpatient beds that are not cleaned by 0800	Our targets for the number of admitted patients will be set once we collect a baseline.	

Change Idea #2 Geriatric Emergency Management (GEM) Nurse and Ontario Health at Home Admission Avoidance

Methods	Process measures	Target for process measure	Comments
"Responsibility: GEM (Geriatric Emergency Management) Nurse Tasks: Identify patients who can avoid admission through GEM interventions. Implement appropriate interventions to prevent unnecessary admissions. Track and report on admission avoidance cases."	Number of admissions avoided through GEM interventions.	We will start tracking this data to collect a baseline in fiscal 2025/26.	Our EDRVQP noted that we have many return visits for patients aged 65 and older who are experiencing frailty, weakness and mobility concerns. The GEM nurse and our Ontario Health at Home Team will be available for these patients to avoid admissions and therefore not have patients in the ED waiting for a bed.

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	97.99	98.00	Our equity education will be targeted towards Intimate Partner Violence Education for All Staff. IPV and GBV education equips our team members to more effectively identify and address the health and social consequences of IPV to ensure that everyone, regardless of background, has access to essential resources and support.	Oxford Domestic Abuse Resource Team

Change Ideas

Change Idea #1 Mandatory in person education on IPV for Management Group

Methods	Process measures	Target for process measure	Comments
"Responsibility: VP patient Care/CNE and Director of MCWH Tasks: Engage with Domestic Abuse Resource Team (DART) to provide IPV education Schedule and conduct training sessions. Monitor and report on completion rates."	Percentage of management group staff that have completed education on IPV	Our target is set at 100%	

Change Idea #2 Gender-Based Violence Specialist Training for 6 employees including all members of the Occupational Health department			
Methods	Process measures	Target for process measure	Comments
"Responsibility: VP Patient Care/CNE, Director of MCWH Tasks: Identify and train specialists in gender-based violence. Engage with companies who train on Gender based violence. Track and report on specialist training completion."	Number of employees trained on gender based violence	We have set our target for this process measure to 6. This includes all of our Occupational Health team.	

Change Idea #3 Intimate Partner Violence(IPV) Education for All Staff via LMS			
Methods	Process measures	Target for process measure	Comments
Responsibility: Education Department Tasks: Develop and upload educational content to the LMS. Include survey on LMS before content on current awareness Include survey on LMS after content on new awareness Ensure all staff complete the required training. Monitor and report on completion rates.	Percentage of all staff completed educated on IPV via LMS Average number of staff who scored higher on post survey knowledge versus pre survey knowledge.	Our target for this education completion is 98%	

Change Idea #4 Provide education to the Board of Directors on IPV			
Methods	Process measures	Target for process measure	Comments
"Responsibility: Education Department Tasks: Develop LMS for the Board on IPV (Intimate Partner Violence). Ensure board members complete the training. Monitor and report on completion rates."	Percentage of board members who have completed the IPV training.	Our target for this change idea is 100% of board members.	

Change Idea #5 Explore and review Ryan Inquest Recommendations 2, 8, 18, 19, 20, 21 and 29.			
Methods	Process measures	Target for process measure	Comments
"Responsibility: Quality and Risk Specialist and VP Patient Care/CNE Tasks: Review remaining Ryan inquest recommendations. Determine what recommendations will be implemented. Work with key stakeholders to implement recommendations. Monitor and report on the implementation progress."	Number of recommendations implemented	We aim to review all six of the hospital requests.	

Change Idea #6 Review and update worker and patient abuse policies to ensure IPV is included.			
Methods	Process measures	Target for process measure	Comments
"Responsibility: Human Resources and Clinical Practice Committee Tasks: Review and update the current worker and patient abuse policies to ensure IPV is included. Communicate policy changes to all staff."	Number of policies updated	Our Target is to get all three policies updated.	

Change Idea #7 Join the DART Network with Community Partners			
Methods	Process measures	Target for process measure	Comments
"Responsibility: Director of MCWH Tasks: Attend meetings Develop and maintain partnerships within the DART network. Monitor and report on partnership activities."	Percentage of meetings attended by WH representative	We aim to have WH attend 90% of the committee meetings.	

Experience

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?	O	% / Survey respondents	Local data collection / Most recent consecutive 12-month period	72.81	80.00	We aim to improve this score using some additional change ideas. We are also looking forward to benchmarking this Qualtrics Survey question with other organizations. This will allow us to reach out to those who are doing really well to learn how to improve.	

Change Ideas

Change Idea #1 Discharge nurse completes follow up phone calls on all acute inpatient patients who were discharged asking them: • 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? • If no, what information do you still need?"

Methods	Process measures	Target for process measure	Comments
"Responsibility: Discharge nurse Tasks: Place follow up phone calls to all acute patients who are discharged to home. Document information still required. Ensure information is provided."	Percentage of discharged patients from acute medicine that have received a follow up phone call Percentage of patients who were asked during the follow up phone call who rate completely they have received enough information about what to do if you were worried about your condition.	We aim to have all patients who are discharged to home receive a follow up phone call from the discharge nurse. We have set our target for the completely score to 75%.	Total Surveys Initiated: 242

Change Idea #2 Develop a process to roll out follow up discharge phone calls

Methods	Process measures	Target for process measure	Comments
"Responsibility: Acute Inpatient Medicine Tasks: Determine a platform to use to collect relevant information. Create a process for completing discharge phone calls. Analyze data to determine gaps in information provided to focus quality improvements on"	Process successfully implemented	Our target is that all stakeholders are satisfied with the roll out of this initiative.	

Safety

Measure - Dimension: Safe

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of delirium onset during hospitalization	O	% / Hospital admitted patients	CIHI DAD / April 1 to September 30, 2024 (Q1 and Q2), based on the discharge date	X	0.20	The current provincial value is at 1.03%. We would like to set ours to our current performance of 0.2% to ensure our rate does not rise.	

Change Ideas

Change Idea #1 Develop and implement a standardized delirium order set in Cerner.

Methods	Process measures	Target for process measure	Comments
Responsible: Senior Friendly Committee Create the order set in Cerner. Ensure the order set includes evidence-based interventions for delirium.	Measure: Percentage of patients with positive CAM scores who have a delirium Powerplan initiated. Percentage of patients with a CAM completed within 24 hours of admission.	Our target for the percentage with positive CAM score to have a delirium Powerplan initiated is set at 85%. The target for percentage of patients with a CAM score completed within 24 hours of admission is 100%.	

Change Idea #2 Develop a clear process for ordering and utilizing the delirium Powerplan.			
Methods	Process measures	Target for process measure	Comments
Responsible: Form a committee including representatives from the Cerner Team, MDs, and nursing staff. Tasks: Establish a workflow for ordering the delirium Powerplan. Train staff on the new process. Monitor and adjust the process based on feedback and performance data.	Percentage of of nursing staff be educated on the new process.	We set our target for 100% of inpatient nurses being educated on the new delirium Powerplan.	

Change Idea #3 Conduct a pilot test of the delirium order set on unit M200.			
Methods	Process measures	Target for process measure	Comments
"Responsible: Committee, Unit M200 staff. Tasks: Implement the order set on unit M200. Collect data on the effectiveness and efficiency of the order set. Make necessary adjustments based on pilot results."	Measure: Percentage of patients with positive CAM scores who have a delirium Powerplan initiated. Other measures will be qualitative feedback from nursing staff on the process to make changes.	Our target is for 100% of the patients on M200 have this initiated.	

Change Idea #4 Explore adjusting time of auto fire of CAM screening tool to align with current nursing workflow.			
Methods	Process measures	Target for process measure	Comments
"Responsible: Senior Friendly Committee Tasks: Survey staff to determine what time they believe the CAM tool auto fire should be adjusted too. Reeducate staff on CAM tool completion. Audit number of times CAM tool completed inaccurately before and after time changed. Explore if the task allowed time can be adjusted so nursing does not rush to complete if marked a late task. Clinical informatics team make necessary adjustments based on results."	Percentage of CAM screens completed accurately after task fire time changed. Number of delirium cases identified before and after time adjustment. Number of nurses satisfied with new time fire.	Our targets for the first two measures is set at 100%. We also aim to have 85% of nursing staff rate the new auto fire times as improved.	

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	0.00	0.00	We had no incidents last year of Workplace Violence (WPV) incidents resulting in lost time injury and have set our target the same for this fiscal year.	

Change Ideas

Change Idea #1 Conduct quarterly simulation exercises on workplace violence prevention for low risk areas to ensure staff are regularly practicing and refining their skills.

Methods	Process measures	Target for process measure	Comments
Responsible: Occ health, Staff Development Tasks: Create committee to determine scheduling and responsibility for the simulations, methods (VR, insitu etc) and exercise content. Create a schedule for quarterly simulations in low risk areas. Make necessary adjustments to schedule after reviewing effectiveness of simulation ex	Number of simulations completed in low risk areas per quarterly.	We have set our target at 4 simulations to be completed in low risk areas per quarter.	

Change Idea #2	Conduct monthly simulation exercises for workplace violence prevention in high risk areas (ED, L500, CCU, 2100, Outpatient MH), to ensure staff are regularly practicing and refining their skills.		
Methods	Process measures	Target for process measure	Comments
Responsible: Occ health, Staff Development Tasks: Create committee to determine scheduling and responsibility for the simulations, methods (VR, insitu etc) and exercise content. Create a schedule for quarterly siumlations in low risk areas. Make necessary adjustments to schedule after reviewing effectiveness of simulation exercises.	Number of simulations completed in high risk areas per month.	Our target for this measure is to have one simulation completed in each of the high risk areas (ED, L500, CCU, 2100, Outpatient MH) per month.	We are rolling out our Code of Conduct for Patients and Visitors policy with hospital wide in person education planned. This will help us achieve our initiative as the education includes de-escalation of a patient and/or visitor.

Change Idea #3	Foster a Supportive Culture by encouraging open communication by debriefing/reviewing of all WPV incidents at safety huddles determining root causes, possible solutions and mitigation strategies.		
Methods	Process measures	Target for process measure	Comments
Responsible: Safety Huddle Team, Directors Tasks: Meet with Safety huddle team to determine best method for providing reports for Directors on WPV incidents. Ensure each incident is discussed as a huddle ticket with review of root causes, possible solutions for prevention. Create a follow up section in RL6 where Director can input huddle debrief. including mitigation strategies. Audit percentage of WPV incidents that have been debriefed. Collect and review data on WPV incidents in RL6 to improve safety protocols by implementing new interventions.	Percentage of WPV incidents that have been debriefed including root causes and solutions at department huddles. Numbers of new interventions or safety protocols introduced from department level WPV debriefs/reviews.	We have almost completed implementation of hospital wide Safety and QI Huddles. The debriefs of these incidents will be completed during these huddles as a huddle ticket concern for staff to evaluate contributing factors and solutions. We aim to have 100% of all incidents debriefed as huddle tickets.	