Access and Flow | Efficient | Optional Indicator

	Last Year		This Year		
Indicator #1 Alternate level of care (ALC) throughput ratio (Windsor Regional Hospital)	**0.97** Performance (2024/25)	**1** Target (2024/25)	**1.05** Performance (2025/26)	**8.25%** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

• Ongoing collaboration with Home and Community Care (HCC) for Intensive Hospital to Home (IHH) services • Daily, provide timely, patient level data tracking ALC's at the Patient Flow/Systems Huddles • Continue to develop and apply targeted strategies to individualized discharge plans to decrease ALC lengths of stay across all medical, surgical and critical care areas • ALC escalation meetings with Hospital and Home and Community Care (HCC) leadership

Process measure

• • Daily, the number of patients designated ALC by most appropriate discharge destination • Weekly and monthly average number of patients designated as ALC

Target for process measure

• • Reduce the overall number of patients designated as ALC • 100% of patients and/ families provided education regarding the level of care provided in acute care and the availability of Home & Community Care Services to help facilitate most appropriate discharge destination

Lessons Learned

WRH's overall ALC rate (7%) remains well below the provincial average. Key ALC prevention strategies include: a dedicated patient flow team that focuses on discharge planning; daily patient flow and command center huddles that include EMS; and ongoing collaboration with community partners with enhanced community service plans.

Access and Flow | Timely | Optional Indicator

Indicator #3

Percent of patients who visited the ED and left without being seen by a physician (Windsor Regional Hospital)

Last Year		This Year		
10.51	**10**	**8.87**	**15.60%**	**8**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

• Reduce the number of Admit No Bed patients and the ED Length of Stay (LOS) • Emergency Department Flow strategies to reduce wait times and improve Physician Initial Assessment (PIA) time • Root cause analysis on the left without being seen (LWBS) patients • Continued collaboration with Windsor Police Services, EMS and Erie Shores Healthcare for diversion initiatives • Expansion of partnership initiatives with Windsor Police Services

Process measure

• • Daily tracking of percentage of patients admitted to an inpatient bed • Daily tracking of ED wait time for admitted patients • Daily tracking of Admit No Bed (ANB) times • Monthly tracking of Physician Initial Assessment (PIA) times • Daily tracking of the number of discharges by 1100 and 1400 by unit • Daily monitoring of outcome metrics for diversion/ wait time initiatives to reduce the number of those left without being seen (LWBS)

Target for process measure

• • Total length of stay for admitted patients • Admit to bed time for admitted patients • 0 ANB waiting greater than 3 hrs. in the Emergency Department • Discharges by 1100 (32%); by 1400 (70%) • Reduced number of LWBS per day with 5% improvement target established at 10%

Lessons Learned

Ongoing monitoring of metrics with daily, weekly and monthly reporting of results through various teams and committees

Experience | Patient-centred | Optional Indicator

Indicator #4

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? (Windsor Regional Hospital)

Last Year		This Year		
70.66	**74**	**79.22**	**12.11%**	**83**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ **Implemented** ☐ **Not Implemented**

• Monthly reporting of results from patient satisfaction surveys (interim paper based model still in place as a result of delay in Qualtrics implementation due to criminal cyber-attack) • Standardized Leadership Rounding on all in-patient units with leaders asking about any concerns or needs patient has about going home and information received • In-room white boards designed to provide communication to those involved in the circle of care • Leverage the electronic health information management system and the Discharge Huddle process to ensure the care team has provided the appropriate health information to patient

Process measure

- • % of patients who respond "completely" to this question

Target for process measure

- • % improvement establishes target of 74.0% or greater

Lessons Learned

The electronic Qualtrics patient experience survey will be introduced in 2025. Leadership Rounding further demonstrates our commitment to patient centered care with a focus on standard work and intentional conversations with patients, and the goal to visit every patient at some point during their stay.

Safety | Safe | Optional Indicator

Indicator #2

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. (Windsor Regional Hospital)

Last Year		This Year		
91.10	**96**	**90.40**	**-0.77%**	**96**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

• Standardized medication reconciliation process at both sites utilizing the new electronic health information system which identifies reporting responsibilities for nursing, physicians (ED and MRP) and pharmacists/pharmacist technicians

Process measure

- • % of patients with medication reconciliation completed at discharge.

Target for process measure

- • % improvement establishes target at 96% or greater

Lessons Learned

Continuous monitoring of the medication reconciliation process at both campuses for accuracy and compliance utilizing Cerner.

Comment

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Indicator #5

Rate of workplace violence incidents resulting in lost time injury (Windsor Regional Hospital)

Last Year		This Year		
0.23	**0.22**	**0.14**	**39.13%**	**0.13**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

• Safe workplace Elearn emphasizes code white policy, safe workplace policy, domestic violence /intimate partner protocol, professional staff conduct and flagging patients/visitors • Workplace violence results including those incidents resulting in lost time injury reported weekly at Monday Morning Huddle with clinical and operations leaders • Code White/de-escalation training provided to all staff in high risk areas • Safe Workplace Indicator Team has cross department representation including high risk areas e.g. Emergency Department and Mental Health • EVOLV Detection System installed in WRH's two Emergency Departments to detect the presence of weapons attempting to be brought into the ED.

Process measure

• • Monthly rate of E-learn compliance • % of incidents reported and reviewed by care team and leadership • % reduction in the number of incidents resulting in lost time injury • % completing code white training from high-risk areas • Number of weapons detected and the weapon type from the EVOLV Detection System.

Target for process measure

• • 90-95% of staff completed Safety in the Workplace Elearn • 100% of incidents reported are reviewed by care team and leadership • % improvement establishes target at .22% or better • 95% of staff from high-risk areas completing Code White training • 100% detection of the presence of weapons using the new EVOLV Detection system.

Lessons Learned

Ongoing monitoring of incidents. Continue conducting post-incident debriefs with involved staff and leadership to identify improvement opportunities.

Comment

As a result of the criminal cyber-attack in 2023 that impacted our data, this target was changed from .22 to .14 post QIP submission. An even more ambitious target of .13 is set for 2025/2026.