Access and Flow

Measure - Dimension: Efficient

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Alternate level of care (ALC) throughput ratio	O	Ratio (No unit) / ALC patients	WTIS / July 1 2023 - September 30, 2023 (Q2)	0.97	1.00	WRH HSAA rate is 1.00 and reflects continuous improvement from prior period results	Hotel Dieu Grace Healthcare, Home and Community Care Support Services Erie St. Clair

Change Ideas

Change Idea #1 • 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

Methods	Process measures	Target for process measure	Comments
• Conduct daily ALC/discharge huddles with hospital utilization team, social work, HCC coordinators, and other community services to identify barriers to discharge. Review at Patient Flow and System Huddles • Provide education to patients and families about the appropriateness of acute care services and Home and Community Care services • Daily, weekly and monthly review of ALC's • Monthly review at Corporate Utilization Committee represented by medical directors and administration.	• Daily, the number of patients designated ALC by most appropriate discharge destination • Weekly and monthly average number of patients designated as ALC	• 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	

Measure - Dimension: Timely

Indicator #5	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)	10.51	10.00	Provincial benchmark is 5.36%. WRH target reflects a 5% improvement from prior period results.	Windsor Police Services, Essex-Windsor EMS

Change Ideas

Change Idea #1 • 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

Methods	Process measures	Target for process measure	Comments
• Daily tracking of compliance to ED LOS (length of stay) and the number of admissions, Admit No Beds and wait times •Dedicated indicator teams monitor progress daily with weekly and monthly reporting and the development of action plans • Track and monitor corporate LOS by program, and the number of discharges by 1100 and 1400 by individual unit • Daily tracking and root cause analysis of LWBS patients • Daily/weekly monitoring of Windsor Police Services and EMS diversion initiatives (e.g. new Nurse Police Team (NPT))	• 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)	• 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%	

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	70.66	74.00	Provincial & National Average is 59% (CIHI FY 21/22) data. WRH target is 5% improvement from prior period results	

Change Ideas

Change Idea #1 • 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

Methods	Process measures	Target for process measure	Comments
• Monthly reporting of results from patient satisfaction surveys and leadership rounding across the organization ensuring that appropriate contact information including email address has been collected from patients • On-going monitoring of completion of in-room patient white boards • Leverage new electronic information management system and discharge huddle process to confirm that appropriate health information has been provided to patient prior to discharge	• % of patients who respond "completely" to this question	• % improvement establishes target of 74.0% or greater	Total Surveys Initiated: 501

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	91.10	96.00	Cerner results from Canadian Hospitals average 50% to 60%. WRH target is 5% improvement from prior period results	

Change Ideas

Change Idea #1 • 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

Methods	Process measures	Target for process measure	Comments
• Audit the compliance and accuracy monthly	• % of patients with medication reconciliation completed at discharge.	• % improvement establishes target at 96% or greater	

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	0.23	0.22	New indicator: WRH target is 5% improvement from prior period results	

Change Ideas

Change Idea #1	• 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.

Methods	Process measures	Target for process measure	Comments
• Ongoing monitoring of E-learn compliance • Standard work created for prevention, investigation and debriefing • Weekly monitoring of workplace violence results with clinical leadership team at Monday Morning Huddle and the review of every incident in real time with leadership, the process improvement team and the bargaining unit leadership, as required • Monitoring staff completion of Code White/de-escalation training program • Ongoing monitoring of detection volumes and weapon type from EVOLV Detection System.	• 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.	• 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.	