Access and Flow

Measure - Dimension: Timely

Indicator #9	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)	117.00	107.00	10% improvement from prior year results	Windsor EMS

Change Ideas

Change Idea #1 • Consult with external Ontario Health expert on quality assurance strategies for ambulance offload time monitoring and escalation plan for ambulance offload time delays • Weekly meetings and ongoing collaboration with EMS leadership to review data (volumes and trends) and the action plans.

Methods	Process measures	Target for process measure	Comments
• Data collection for Pay 4 Results (P4R) reporting • Monitor daily metrics and compliance • In-person mentoring, training and education (face to face) with staff.	Pay 4 Results (P4R) wait time metrics	Target set at 107 minutes	

Measure - Dimension: Timely

Indicator #10	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)	26.65	23.70	~10% improvement from prior year results	

Change Ideas

Change Idea #1 • Physician Initial Assessment (PIA) action plan will improve the total length of stay as well as continuing to work with the inpatient teams and the utilization leadership to improve time to inpatient bed by collaborating with the emergency department patient flow working group and the Utilization Management Committee.

Methods	Process measures	Target for process measure	Comments
Data collection for P4R reporting and monitoring daily metrics and compliance.	Pay 4 Results (P4R) wait time metrics	Target set at 23.7 hours	

Measure - Dimension: Timely

Indicator #11	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 / Apr 1 to Sept 30, 2024 (Q1 and Q2)	8.87	8.00	10% improvement from prior year results	Windsor Police Services, Windsor EMS

Change Ideas

Change Idea #1 • Utilize the Physician Initial Assessment (PIA) action plan to improve left without being seen (LWBS) volume • Create a left without being seen policy with standard work and results of the Emergency Department Return Visit Quality Program (EDRVQP), to help support improvement initiatives • Continue diversion strategies with partner departments and organizations e.g. Nurse Police Team (NPT), Paediatric Emergency Diversion Clinic, Mental Health Assessment Unit (MHAU), and the Nurse Lead Outreach Team (NLOT).

Methods	Process measures	Target for process measure	Comments
• Daily monitoring of emergency department data • Ensure quality assurance through weekly emergency department leadership meetings • Daily/weekly monitoring of diversion strategy metrics	Daily, weekly and monthly reporting of results through various teams and committees	Target set at 8.0%	

Measure - Dimension: Timely

Indicator #12	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department length of stay for nonadmitted patients with low acuity	O	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)	10.75	9.60	10% improvement from prior year results	Erie Shores HealthCare, Windsor Police Services, Windsor EMS

Change Ideas

Change Idea #1	• Improvement in Physician Initial Assessment (PIA) to decrease length of stay • Daily review of the length of stay for all low acuity patients • Review of Emergency Department dashboard data to review practice and delays in disposition and the Emergency Department Return Visit Quality Program (EDRVQP) results for quality improvement opportunities.

Methods	Process measures	Target for process measure	Comments
Data collection for Pay 4 Results (P4R) reporting and monitoring daily metrics and compliance.	Pay 4 Results (P4R) wait time metrics	Target set at 9.6 hours	

Measure - Dimension: Timely

Indicator #13	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department length of stay for nonadmitted patients with high acuity	O	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)	12.88	11.60	10% improvement from prior year results	

Change Ideas

Change Idea #1	• Improvement in Physician Initial Assessment (PIA) will decrease the length of stay overall and for all high acuity patients • Review of Emergency Department dashboard data to review practice and delays in disposition and the Emergency Department Return Visit Quality Program (EDRVQP) results for quality improvement opportunities.

Methods	Process measures	Target for process measure	Comments
Daily monitoring using dashboard and quality assurance through weekly Emergency Department Leadership meetings.	Pay 4 Results (P4R) wait time metrics	Target set at 11.6 hours	

Measure - Dimension: Timely

Indicator #14	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)	8.52	7.70	10% improvement from prior year results	

Change Ideas

Change Idea #1 • Work with the physician leads for recruitment and retention strategies to have a full compliment of physicians on the schedule and modify scheduling practices to fit volume demands • Work with the Medical Affairs department for sustainable human resource plan as well as increase funds for physician hours.

Methods	Process measures	Target for process measure	Comments
• Monthly physician scorecard evaluation of metrics and action plans • Physician leadership mentorship • Medical Affairs human resource development plan for the emergency department physicians	Pay 4 Results (P4R) wait time metrics	Target set at 7.7 hours	

Measure - Dimension: Timely

Indicator #15	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)	25.38	22.80	10% improvement from prior year results	

Change Ideas

Change Idea #1 • Continue to work with the inpatient teams and the utilization leadership to improve time to inpatient bed by collaborating with the emergency department patient flow working group and the Utilization Management Committee.

Methods	Process measures	Target for process measure	Comments
Data collection for Pay 4 Results (P4R) reporting and monitoring daily metrics and compliance.	Pay 4 Results (P4R) wait time metrics	Target set at 22.80 hours	

Measure - Dimension: Timely

Indicator #16	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department length of stay for admitted patients	O	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)	35.83	31.90	10% improvement from prior year results	

Change Ideas

Change Idea #1	• Physician Initial Assessment (PIA) action plan will improve the total length of stay • Continue to work with the inpatient teams and the utilization leadership to improve time to inpatient bed by collaborating with the Emergency Department patient flow working group and the Utilization Management Committee.

Methods	Process measures	Target for process measure	Comments
Data collection for P4R reporting, monitoring daily metrics and compliance.	Pay 4 Results (P4R) wait time metrics	Target set at 31.9 hours	

Equity

Measure - Dimension: Equitable

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Average ED wait time to physician initial assessment (PIA) for individuals with sickle cell disease (CTAS 1 or 2)	O	Minutes / ED patients	CIHI NACRS / April 1 to September 30, 2024 (Q1 and Q2)	109.44	109.44	As this is a new indicator for WRH, will use baseline data to set target for improvement	

Change Ideas

Change Idea #1	• Collaborate with professional staff and physician leads/champions to provide sickle cell education and information to the emergency department staff to improve assessment and treatment times and outpatient follow-up • Physician Initial Assessment (PIA) electronic medical record time stamp improvements, Code Medical initiation and overall physician initial assessment improvements will support CTAS 1 and 2 Physician Initial Assessment times.

Methods	Process measures	Target for process measure	Comments
Daily, weekly and monthly reporting of results to establish baseline	Daily, weekly and monthly reporting of results to establish baseline	Baseline year for collection of data and initiation of services	

Measure - Dimension: Equitable

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of ED 30-day repeat visits for individuals with sickle cell disease	O	% / ED patients	CIHI NACRS / Index visits from April 1 to September 30, 2024 (Q1 and Q2)	X	18.20	As this is a new indicator for WRH, will use baseline data to set target for improvement	

Change Ideas

Change Idea #1	• Collaborate with professional staff and physician leads/champions to provide sickle cell education and information to the Emergency Department staff to improve assessment and treatment times and outpatient follow-up, to reduce 30-day repeat visits to the emergency department • Review the Emergency Department Return Visit Quality Program (EDRVQP) results for quality improvement opportunities • Where possible, refer paediatric patients to the Paediatric Emergency Department Diversion Clinic or to appropriate paediatric specialist (hematology-oncology) offices.

Methods	Process measures	Target for process measure	Comments
Daily, weekly and monthly reporting of results to establish baseline	Daily, weekly and monthly reporting of results to establish baseline	Baseline year for collection of data and initiation of services	

Measure - Dimension: Equitable

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of ED visits for individuals with sickle cell disease triaged with high severity (CTAS 1 or 2)	O	% / ED patients	CIHI NACRS / April 1 to September 30, 2024 (Q1 and Q2)	74.07	74.07	As this is a new indicator for WRH, will use baseline data to set target for improvement	

Change Ideas

Change Idea #1 • Collaborate with professional staff and physician leads/champions to provide sickle cell education and information to the Emergency Department staff to improve assessment and treatment times and outpatient follow up

Methods	Process measures	Target for process measure	Comments
Daily, weekly and monthly reporting of results to establish baseline	Daily, weekly and monthly reporting of results to establish baseline	Baseline year for collection of data and initiation of services	

Measure - Dimension: Equitable

Indicator #4	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	100.00	100.00	Maintain 100% compliance for executive; achieve 80% compliance for directors and 50% compliance for managers, and collecting baseline for front-line staff	

Change Ideas

Change Idea #1 • Provide EIDAR e-learn education & training to leadership: Track compliance and the progress of leadership completing required EIDAR training and education • Provide Indigenous cultural safety training and disseminate to leadership (executive and directors) • Develop EIDAR education to be included in staff orientation and through e-learn • Regional Indigenous Navigator to support development of content across Erie St. Clair hospitals.

Methods	Process measures	Target for process measure	Comments
• All senior leadership to complete EIDAR and Indigenous cultural safety training • Include EIDAR and Indigenous cultural safety training in staff orientation process to improve patient experience • Utilize working groups and/or committees to plan education roll-out and strategies	Monthly reporting of results	Targets set based on staffing group: 100% compliance for executives; 80% compliance for directors, 50% compliance for managers and CB for frontline staff.	

Experience

Measure - Dimension: Patient-centred

Indicator #5	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	79.22	83.00	5% improvement from prior year results; WRH results are better than the provincial average (71.2%)	

Change Ideas

Change Idea #1	• Monthly reporting of results from patient satisfaction surveys ensuring appropriate contact information including email address has been collected • Ongoing education to registration staff on consent and email collection process • Standardized Leadership Rounding on all in-patient units with leaders asking about concerns or needs • In-room white boards to provide communication to those involved in the circle of care • Utilize the electronic health information management system and discharge huddle process to ensure the care team has provided the appropriate health information to the patient • Roll-out Qualtrics electronic patient experience survey to inpatient areas, select outpatient areas, and the Emergency Department.

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 • Use the electronic information management system and the discharge huddle process to confirm the appropriate health information has been provided to patient prior to discharge	% of patients responding completely to this question.	Target set at 5% improvement from prior year results. Target of 83% is better than the provincial average of 71.2%	Total Surveys Initiated: 765

Safety

Measure - Dimension: Safe

Indicator #6	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	90.40	96.00	Keep target at 96%; results (90.40%) are better (above) than the provincial average (83.4%)	

Change Ideas

Change Idea #1 • Continue to monitor the medication reconciliation process at both campuses utilizing Cerner (electronic health information system), with identified reporting responsibilities for nursing, professional staff (physicians in the Emergency Department and Most Responsible) and pharmacists/pharmacist technicians

Methods	Process measures	Target for process measure	Comments
• Audit the compliance and accuracy of medication reconciliation monthly	% of patients with medication reconciliation completed at discharge	Target set at 96%, which is better than the provincial average of 83.4%	

Measure - Dimension: Safe

Indicator #7	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	1.11	1.03	Target set at provincial average	

Change Ideas

Change Idea #1 • Review hospital acquired delirium documentation with the physician teams in the Departments of Medicine and Family Medicine • Establish and review hospital acquired delirium case studies with the Departments of Medicine and Family Medicine physician teams • Review hospital acquired delirium cases through the Departmental Quality Review (DQR) process where applicable • Ensure the on-site Behavioral Nursing Specialist continues delirium education and training with frontline staff.

Methods	Process measures	Target for process measure	Comments
• Monthly review of coded data related to hospital acquired delirium • Audit the Confusion Assessment Method (CAM) screening completion through the senior friendly initiative • Monthly review of cases at the Departmental Quality Review Committee • Behavioral Nursing Specialist to incorporate delirium information in staff education and training sessions.	% of patients diagnosed with hospital acquired delirium	Target set at 1.03%, which is the provincial average	

Measure - Dimension: Safe

Indicator #8	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	0.14	0.13	Target is a 7% improvement from prior year results; WRH results (0.14%) are better than the provincial average (4.8%) and the Ontario Health West average (0.7%).	Windsor Police Services, Windsor EMS

Change Ideas

Change Idea #1	• Safe Workplace e-learn: Continue with enforcement of Safe Workplace e-learns as part of training protocol for all staff • Workplace Violence Weekly Reports: Highlight incidents resulting in harm at Monday Morning Huddles • Continue to provide Code White/De-escalation training to all staff • Safe Workplace Indicator Team: Maintain cross-department representation • Enhanced Flagging Protocol: Enhance and implement patient/visitor flagging with known risks • Incident Follow-Up Process: Introduce a standardized approach to follow-up on workplace violence incidents with debriefings and actionable recommendations • Environment Safety Audits: Conduct monthly safety audits in high-risk areas to identify potential hazards and ensure compliance with safety standards • Staff Support Resources: Expand availability of support resources for staff exposed to workplace violence • Risk Assessment Tools: Integrate risk assessment tools into workflows to proactively identify and mitigate potential workplace violence threats • Department specific safety working groups.

Methods	Process measures	Target for process measure	Comments
• Monitor completion rates of Safe Workplace e-learn through the Learning Management System (LMS) • Weekly incident reporting and analysis • Track staff participation in Code White and De-escalation training sessions • Develop and distribute monthly workplace violence trending reports, including actionable insights • Use patient flagging systems in electronic health record to identify and communicate risks to staff effectively • Continue conducting post-incident debriefs with involved staff and leadership to identify improvement opportunities • Ensure all flagged patients are reviewed at safety huddles • Promote the use of incident reporting systems and provide feedback to staff about changes made based on reporting and results.	• % of staff completing Safe Workplace e-learn monthly • % of incidents reported and reviewed by the care team and leadership within 48 hours • % of staff from high-risk areas completing Code White training • % of Post-Incident Debrief completed with involved staff and leadership • the number of workplace violence incidents reported compared to total number of incidents observed or flagged	• 95% of staff complete the Safe Workplace e-learn • 100% of reported incidents reviewed by care teams and leadership within 48 hours • 95% of staff in high-risk areas complete Code White training • 100% of incidents resulting in lost time injury or harm hold post incident debrief sessions • 100% of high risk areas complete environmental safety audits monthly with actionable follow-up within two weeks of incident • Workplace Violence Trends Report distributed monthly to 100% of leadership teams.	