Access and Flow

Measure - Dimension: Timely

Indicator #6	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)	13.00	16.00	Based on last year's performance the target has been set to maintain at 16 min. Emergency Medical Services and Paramedic Services has set a target of 30 minutes for the 90th percentile ambulance offload time. Reducing this time can improve patient flow, reduce wait times in the emergency department, and enhance the overall accessibility of healthcare services	

Is this indicator related to:	
Emergency Department Return Visit Audits	Yes
Executive Compensation	Yes
Pay-for-Results Action Plan	Yes

Change Ideas

Change Idea #1	Continue collaboration with EWEMS to view their real-time patient flow dashboard to prepare for and mitigate any potential bottlenecks. Optimize communication with EMS, CACC and both WRH ED's to plan for volume surges and evenly distribute EMS trucks based on bed availability. Create a dedicated Admission Discharge Unit (ADU) to streamline patient transitions for those awaiting admission or discharge, alleviating pressure on the emergency department in order to prevent delayed EMS offloads.

Methods	Process measures	Target for process measure	Comments
Launch a Power Bi-Dashboard that is visible and reviewed at daily huddles with the ED team that includes ALL P4R metrics including Ambulance Offload times. Daily meetings with WRH ED managers, Paramedic Patient Navigator and EMS DC to ensure real time information sharing regarding the flow of each of the ED's in the region and the call volume for EMS. Communicate throughout the day via text with this working group. Having steady patient flow throughout the department will help to ensure the availability of beds for patients arriving by EMS to be offloaded to. Continuous patient flow is the goal.	Time to physicians intimal assessment. Monitor time to physician initial assessment during PIT time. Monitor turnaround times from time of order to time of test results for lab and DI.	Reduction from current 6hr time by 10% to 5.4hr Maintain our average of 3.12 hrs. from time of exam to time of result.	

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)	5.33	5.45	Based on last fiscal year's target. our performance was 6 hours an the goal is to reduce by 10%.ED overcrowding can lead to treatment delays, compromised patient safety, and increased staff stress. Extended wait times in the ED can negatively impact patient experience and outcomes. By aiming to reduce the 90th percentile PIA time, hospitals can improve the patient experience, reduce patient anxiety, and potentially improve health outcome Establishing a target serves as a tangible measure to track progress in alleviating overcrowding.	

Is this indicator related to:	
Emergency Department Return Visit Audits	Yes
Executive Compensation	Yes
Pay-for-Results Action Plan	Yes

Change Ideas

Change Idea #1	Optimize physician scheduling. Using data on patient arrival and ED LOS, schedule physicians coverage during peak times. Physician in Triage during peak arrival times to ensure patients are being assessed by a physician in a timely manner. Monitor lab and DI turnaround times to ensure patient flow is at its optimal. Improving overall patient flow will help to positively impact the ability for physicians to continue to see patients in a timely manner.

Methods	Process measures	Target for process measure	Comments
Collaborate with the physician group for data sharing so they can use it to help support physician coverage at peak times. Chief of Emergency Department is scheduling physicians to work in triage based on patient arrival times and physician availability to ensure patients are seen by a provider in a timely manner. Power BI to monitor lab and DI turnaround times to help identify areas where improvements are needed. Collaborate with Lab and DI Managment for process improvements where needed.	Time to physicians intimal assessment. Monitor time to physician initial assessment during PIT time. Monitor turnaround times from time of order to time of test results for lab and DI.	Reduction from current 6hr time by 10% to 5.4hr Maintain our average of 3.12 hrs. from time of exam to time of result.	

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	100.00	75.00	We accomplished leadership and the board in the first year of DEII training; our goral is to have 75% of frontline teams trained in DEII; hence the lower target.The goal is to move the organization toward a workplace culture that values inclusivity, equity, and respect for all individuals. Training contributes to creating a culturally safe environment for both patients and staff. It fosters understanding and respect for different cultures, backgrounds, and experiences.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	Yes
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1	Identification of most appropriate times and formats for all departments to engage in EDII training, embedding EDII education wherever possible. FNIMUI Cultural Sensitivity and Traditional Medicine Training at HWO with CFN.

Methods	Process measures	Target for process measure	Comments
E-Learning Policy Review -- training as needed In-Person Training Partner Organization in-kind Training Continue to enhance training on Gender Diversity -- last year was 100% leadership, now 75% frontline.	# Policies Reviewed to identify training needs # Training provided on policy # E-Learning provided # E-Learning completed # Partners providing education # Staff attending	Above information will support the development of a DEII e-learning tool once an environmental scan has been completed	New indicator focused on frontline teams

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	C	% / Staff	In house data collection / 2024/2025	83.00	75.00	The target justification was 83% of Leadership. The goal is to move the frontline organization toward a workplace culture that values inclusivity, equity, and respect for all individuals. Training contributes to creating a culturally safe environment for both patients and staff. It fosters understanding and respect for different cultures, backgrounds, and experiences.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	Yes
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1	Identification of most appropriate times and formats for all departments to engage in EDII training, embedding EDII education wherever possible. FNIMUI Cultural Sensitivity and Traditional Medicine Training at HWO with Caldwell First Nations.		
Methods	Process measures	Target for process measure	Comments
E-Learning Policy Review -- training as needed In-Person Training Partner Organization in-kind Training Continue to enhance training on Gender Diversity -- last year was 100% leadership, now 75% frontline.	# Policies Reviewed to identify training needs # Training provided on policy # E-Learning provided # E-Learning completed # Partners providing education # Staff attending	There is no target set for our reviews as we will gather our learnings from the number of policies and utilize it to generate our E-learning to educate frontline teams	

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	90.02	92.00	Our goal is to improve patient experience and patient outcomes as research shows if patients are discharged with appropriate information and resources they are less likely to have a return visit.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	Yes
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1	Expanding role of patient family liaison by embedding a Social Worker into the planning for complex D/C Launching a new Essential Care Partner (ECP) program		
Methods	Process measures	Target for process measure	Comments
Patient family liaison are embedded into the patient experience to enhance service. They connect with patients and families on admission and prior to discharge to collect their feedback. A new policy to support essential care partner at the bedside is included as part discharge planning Dedicated admission discharge nurse to support targeted standardized discharge instructions to all patients	# of surveys # of ECP supported # of D/C that received dedicated	"30-50/month new metric will collect qualitative data"	Total Surveys Initiated: 982

Safety

Measure - Dimension: Safe

Indicator #4	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	98.74	99.00	Medication errors during discharge in care can lead to serious adverse events and potential readmissions. Our organization is currently achieving a medication reconciliation at discharge. Based on evidence-based best practices, our goal is to ensure that all patients continue to have a Best Possible Medication Discharge Plan from specialized discharge unit.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	Yes
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1	Implement a standardized process for medication reconciliation within 24hours of discharge, including clear roles and responsibilities for all involved Engage patients and families in the medication reconciliation process, where possible, to ensure accuracy and completeness of information

Methods	Process measures	Target for process measure	Comments
A team consisting of nurses, pharmacists, and physicians will develop a standardized process for medication reconciliation within twelve hours of admission and within 24 hours of discharge Training sessions for staff will be conducted by a designated trainer within the hospital, and will involve interactive education and training modules Patient education materials will be developed to encourage active participation in the process	% of e-learning modules completed # of Med recs completed on admission targeted timeframe and within 12 hours # of medication reconciliation withing 24hours of D/C	E-learning - 90% # of Med Recs within 12 hours - 60% # of med recs within 24 hours of D/C- 99%	Goal to capture all d/c through our pilot program- Admission Discharge Unit (ADU)

Measure - Dimension: Safe

Indicator #5	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	0.51	1.70	New metric for the organization recognizing that delirium can lead to longer hospital stays, increased risk of complications, and higher healthcare costs. ESHC focus on delirium is important because it is a significant issue that impacts patient safety and well-being.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	Yes
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1	Implement a standardized screening process for delirium for all patients at risk of developing delirium, using a validated assessment tool Provide education and training to all relevant staff on the risk factors, identification, and management of delirium Implement a GEM nurse in the Emergency department to support early identification of frail seniors that may be at risk for developing delirium		
Methods	Process measures	Target for process measure	Comments
The team will create a delirium care pathway that is based on best practices and fits with existing clinical workflows Training sessions will be conducted by the multidisciplinary team to educate staff on delirium identification and management, using resources from Quorum	90% of at-risk patients screened for delirium using a validated tool within 24 hours of admission Number of medical/surgical staff trained on delirium identification, prevention and management	Goal is to screen all patients at risk for delirium with a goal of achieving 90% recognizing not all patients may be able to vocalize and be part of their plan of care if no family available.	