Access and Flow

Measure - Dimension: Timely

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile ambulance offload time (Four Counties Health Services Corporation)	P	Minutes / Patients	CIHI NACRS / For ERNI hospitals: Dec 1, 2023, to Nov 30, 2024 (Q1 and Q2)	17.00	17.00	Sustain improvement - we are performing well on this indicator and continue to monitor.	Middlesex - London Paramedic Services, Middlesex - London Paramedic Services
90th percentile ambulance offload time (Strathroy Middlesex General Hospital)	P	Minutes / Patients	CIHI NACRS / For ERNI hospitals: Dec 1, 2023, to Nov 30, 2024 (Q1 and Q2)	59.00	56.00	Continue to improve	Middlesex - London Paramedic Services, Middlesex - London Paramedic Services
90th percentile ambulance offload time	P	Minutes / Patients	CIHI NACRS / For ERNI hospitals: Dec 1, 2023, to Nov 30, 2024 (Q1 and Q2)	58.00	56.00	Continue to improve	Middlesex - London Paramedic Services, Middlesex - London Paramedic Services

Change Ideas

Change Idea #1 Standardization of offload process and staff education			
Methods	Process measures	Target for process measure	Comments
Assess existing processes and make necessary updates to align with the revised workflow. The updated process will be documented and shared with all ED staff through staff meetings.	All ED staff trained in the new process	Sustain current performance	Continue to monitor and optimize processes as opportunity arise. This indicator is monitored by P4R team.

Change Idea #2 Standardization of offload process and staff education			
Methods	Process measures	Target for process measure	Comments
Review the current process and update as required to reflect the updated process. The updated process will be documented and shared with all ED staff through staff meetings.	All ED staff trained in the new process	Meet the target of 56 minutes for 90th P Wait Times for Ambulance offload time	

Measure - Dimension: Timely

Indicator #9	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department wait time to physician initial assessment (Four Counties Health Services Corporation)	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)	3.30	3.00	Continue to improve	

90th percentile emergency department wait time to physician initial assessment (Strathroy Middlesex General Hospital)	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)	3.15	3.00	Continue to improve	
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)	3.15	3.00	Continuous Improvement	

Change Ideas

Change Idea #1 Green Zone Nurse

Methods	Process measures	Target for process measure	Comments
The RN does rapid assessment of the patients who are likely to be in and out (CTAS IV &V) of the ED quickly.	The green zone nurse supports patient flow by reducing wait times and disposition time for non-admitted patients because of more timely assessment and treatment.	Monitor PIA wait times. Our target is 3.0 hrs	We have recognized that our P4R ranking for PIA is very low compared to other hospitals and actively working to continue to improve.

Change Idea #2 ED Tech in the Emergency Department

Methods	Process measures	Target for process measure	Comments
The ED Technician role is a new initiative to support access to timely assessment for patients, support patient care activities including documentation, discharge instructions and improve access to diagnostics as a strategy to reduce PIA. SMGH will recruit two ED technicians in Q1 (April- June).	PIA is P4R indicator which is monitored daily. DART Dashboard is reviewed daily by ED department manager and the team for day-to-day performance. We have developed an internal P4R dashboard which is reviewed monthly by clinical portfolio team, along with Health System Insights Dashboard. Monthly VP Clinical Portfolio presents the P4R Dashboard to Senior leadership.	Sustain performance of 3hrs	

Measure - Dimension: Timely

Indicator #10	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. (Four Counties Health Services Corporation)	P	Number / ED patients	CIHI NACRS / Apr 1 to Sep 30, 2024 (Q1 and Q2)	0.27	0.00	Continue to improve	Home and Community Care Support Services, Home and Community Care Support Services
Daily average number of patients waiting in the emergency department for an inpatient bed at 8 a.m. (Strathroy Middlesex General Hospital)	P	Number / ED patients	CIHI NACRS / Apr 1 to Sep 30, 2024 (Q1 and Q2)	1.19	1.00	Continue to improve	Home and Community Care Support Services, Home and Community Care Support Services
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)	1.19	1.00	Continuous improvement	Home and Community Care Support Services, Home and Community Care Support Services

Change Ideas

Change Idea #1 Continuous monitoring and proactive surge planning

Methods	Process measures	Target for process measure	Comments
Since the pandemic we have seen exponential rise in ED volumes, compounded by larger volumes of ALC patients causing on average 1 patients waiting for bed at 8am. Daily Bed huddle meetings with ED, Inpatient and OR managers. Weekly ALC Bullet Rounds to review ALC discharges. Review discharge planning for all admitted patients i.e. set discharge date for all patients on admission. Use of flex beds when volumes are high. Reinforce "pull" from ED rather than "push" culture.	Proactive planning at daily bed huddle (discharges & admissions) meeting with all the departments.	We continue to work hard to improve patient flow and achieve pre-COVID levels which was zero.	Continue to improve, but ALC patients is a barrier impacting patient flow.

Change Idea #2 CT and x-ray 24/7 availability

Methods	Process measures	Target for process measure	Comments
In FY -24/25 we piloted 24/7 diagnostic services for ED. We found encouraging results positively impacting patient flow and overall, ED length of stay.	Finalize and implement the process for ED and Diagnostic team for ED patients needing late night diagnostic services.	Tracking of all cases and turnaround times and their impact of LoS indicators.	

Equity

Measure - Dimension: Equitable

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of MHA Board Executive Members, MHA Leaders including Physician Leads who have completed mandatory Indigenous training (Four Counties Health Services Corporation)	C	% / Staff	In house data collection / 2025	0.00	100.00	We had remarkable success with the implementation of our other JEDI education to all staff. Building on learning and successful implementation of JEDI strategy we are embarking on multiyear education strategy for Indigenous training.	
Percentage of MHA Board Executive Members, MHA Leaders including Physician Leads who have completed mandatory Indigenous training (Strathroy Middlesex General Hospital)	C	% / Staff	In house data collection / 2025	0.00	100.00	We had remarkable success with the implementation of our other JEDI education to all staff. Building on learning and successful implementation of JEDI strategy we are embarking on multiyear education strategy for Indigenous training.	
Percentage of MHA Board Executive Members, MHA Leaders including Physician Leads who have completed mandatory Indigenous training	C	% / Staff	In house data collection / 2025	0.00	100.00	We had great success with the implementation of our other JEDI education to all staff. Building on learning and successful implementation of JEDI strategy we are embarking on multiyear education strategy for Indigenous training.	

Change Ideas

Change Idea #1 Provide online training to all MHA Board Members, MHA Leaders, including Physician Leads.			
Methods	Process measures	Target for process measure	Comments
Online training will be offered to all MHA Board Members, MHA Leaders, including Physician Leads. Indigenous Committee will track learning events and attendees.	% of Board members and MHA Leaders completed the mandatory Indigenous training	We aim to achieve 100% compliance for this indicator.	Our commitment to Truth and Reconciliation is to listen and learn to make meaningful action to support the specific health needs and experience of Indigenous Peoples.

Change Idea #2 Conduct Indigenous education learning events and webinars.			
Methods	Process measures	Target for process measure	Comments
Invite Indigenous leaders for education learning events.	100% staff attendance for education events	We had great success with the implementation of our other JEDI education to all staff. Building on learning and successful implementation of JEDI strategy we are embarking on multiyear education strategy for Indigenous training.	

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? (Four Counties Health Services Corporation)	O	% / Survey respondents	Local data collection / Most recent consecutive 12-month period	86.36	90.00	Continue to improve	
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? (Strathroy Middlesex General Hospital)	O	% / Survey respondents	Local data collection / Most recent consecutive 12-month period	81.42	90.00	Continuous Improvement	
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	82.88	90.00	Continuous Improvement	

Change Ideas

Change Idea #1 Staff education on diversity and inclusion to accommodate different cultural, language, and accessibility needs.			
Methods	Process measures	Target for process measure	Comments
Learning from patient feedback we are conducting a diversity and inclusion webinars to treat all patients with respect. Continue to share monthly patient feedback with staff	All staff attend the training	Meet the target of 90% completed surveys.	Total Surveys Initiated: 229 Multi Year Strategy (Year 2) Continue to improve to reach the target of 100%.

Change Idea #2 Utilizing results of surveys to improve patient experience and overall rating			
Methods	Process measures	Target for process measure	Comments
• Continue to share monthly patient feedback dashboard with staff • Review negative feedback with staff, identify improvement opportunities and test one improvement idea every quarter. • Through service of medicine and staff meetings share positive, appreciative comments.	• Increase in number of fully completed surveys. • Increase in number of respondents completing survey responding positively for this question.	Meet target of 90% completed surveys	We met the target in FY 24/25 and continue to improve.

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Day Surgery - 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? (Strathroy Middlesex General Hospital)	C	% / Other	In-house survey / 2025	97.00	97.00	Sustain improvement	

Day Surgery - 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?	C	% / Other	In-house survey / 2025	97.00	97.00	Sustain improvement	

Change Ideas

Change Idea #1 Utilizing results of surveys to improve patient experience and overall rating

Methods	Process measures	Target for process measure	Comments
• Continue to share monthly patient feedback dashboard with staff • Continue to engage PFAC to increase social media visibility and patient engagement. • Review negative feedback with staff, identify improvement opportunities and test one improvement idea every quarter. • Continue to improve the process of capturing emails. Educate/Train all new and returning staff on email collection process.	Increase in number of fully completed surveys. Increase in number of respondents completing survey responding positively for this question.	Sustain current performance	Multi Year Strategy (Year 1) Continue to improve to reach the target of 100%.

Measure - Dimension: Patient-centred

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Emergency Department - 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? (Four Counties Health Services Corporation)	C	% / ED patients	In-house survey / 2025	72.00	80.00	Continue to improve	
Emergency Department - 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? (Strathroy Middlesex General Hospital)	C	% / ED patients	In-house survey / 2025	75.00	80.00	Continue to improve	
Emergency Department - 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?	C	% / ED patients	In-house survey / 2025	74.00	80.00	Continue to improve	

Change Ideas

Change Idea #1 Utilizing results of surveys to improve patient experience and overall rating

Methods	Process measures	Target for process measure	Comments
•Continue to share monthly patient feedback dashboard with staff • Continue to engage PFAC to increase social media visibility and patient engagement. • Review negative feedback with staff, identify improvement opportunities and test one improvement idea every quarter.	•Increase in number of fully completed surveys. •Increase in number of respondents completing survey responding positively for this question.	Meet target of 80% completed surveys	Multi Year Strategy (Year 1) Continue to improve to reach the target of 100%.

Safety

Measure - Dimension: Safe

Indicator #5	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. (Four Counties Health Services Corporation)	O	% / Discharged patients	Local data collection / Most recent consecutive 12-month period	80.75	90.00	Continue to improve	
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. (Strathroy Middlesex General Hospital)	O	% / Discharged patients	Local data collection / Most recent consecutive 12-month period	90.63	91.00	Sustain performance	
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	81.10	90.00	Sustain current performance and continue to improve	

Change Ideas

Change Idea #1	Working with Clinical Informatics to provide education to providers, and audit incomplete med recs at discharge in timely manner provide regular reporting to providers on performance and education support.		
Methods	Process measures	Target for process measure	Comments
1) Ongoing monitoring and review of statistical data available through Electronic Patient Record (EPR). Each occurrence of a medication administration is tracked 2) Continue to track and optimize the number of patients who have the best possible medication history (BPMH) completed at the time of admission as it impacts the medication reconciliation at discharge. 3) Track quarterly compliance rates share it with the managers to follow up with staff to support the process. 4) Quarterly review of unit/program performance with focus on areas with lowest compliance	Daily audits or completion of admitted patient BPMH by Nurse Practitioners. Regular evaluation of reviews by pharmacists.	100% of all physicians will receive quarterly scorecards and compliance will be reviewed with the physician by the Chief of Staff.	Sustain current performance and continue to improve

Change Idea #2	Refresh BPMH and Medication Reconciliation LMS and introduction to Medication reconciliation in orientation.		
Methods	Process measures	Target for process measure	Comments
Refresh BPMH Learning Module. On revieing our BPMH LMS we found it outdated. We will refresh BPMH to reflect the current process. All clinical staff are expected to complete the refreshed BPMH course. We will be introducing medication reconciliation processes in orientation for clinical staff.	No of staff members who have completed the LMS	We aim to achieve 100% compliance for this indicator	Meet or exceed performance expectations.

Measure - Dimension: Safe

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Hand Washing Compliance - Moment 1 (before entering patient environment) by Hospital Care Provider. (Strathroy Middlesex General Hospital)	C	% / All patients	In-home audit / Most recent consecutive 12-month period	73.00	80.00	Continuous improvement	

Change Ideas

Change Idea #1 Continue learning opportunities, implement teaching based on staff needs.

Methods	Process measures	Target for process measure	Comments
1.Issue surveys to staff to gain understanding of their value, perception and use of the 4 moments of hand hygiene. Use results to provide targeted education to highlight the importance of achieving at least 80% compliance. 2. In survey address barriers to hand hygiene and personal perception of importance of hand hygiene.	• Count of weekly completed audits • Regularly scheduled meeting with IPAC nurse and unit staff to review the results.	Completed audits.	In FY 24/25 SMGH met the target. Hand Hygiene Compliance is a Multi-Year Strategy, we continue to improve to achieve -100%.

Change Idea #2 Provide hand hygiene results feedback to targeted groups and units (ex. Physicians, ICU) throughout the year.

Methods	Process measures	Target for process measure	Comments
1.Assess if hand hygiene specific to one group (physicians, nurses, other) or department (1S, 2S, ACNU, ED, ICU, AMB) is of sufficient quantity 2. If not sufficient quantity for the group or department, do focused Hand Hygiene audits 3. Provide results and education.	• Count of weekly completed audits • Regularly scheduled meeting with IPAC nurse and unit staff to review the results.	Completed audits	

Measure - Dimension: Safe

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Hand Washing Compliance - Moment 1 (before entering patient environment) by Hospital Care Provider (Four Counties Health Services Corporation)	C	% / All inpatients	In-home audit / Most recent consecutive 12-month period	89.00	90.00	Continuous improvement	
Hand Washing Compliance - Moment 1 (before entering patient environment) by Hospital Care Provider	C	% / All inpatients	In-home audit / Most recent consecutive 12-month period	81.00	85.00	Continuous improvement	

Change Ideas

Change Idea #1 Continue learning opportunities, implement teaching based on staff needs.

Methods	Process measures	Target for process measure	Comments
1.Issue surveys to staff to gain understanding of their value, perception and use of the 4 moments of hand hygiene. Use results to provide targeted education to highlight the importance of achieving at least 80% compliance. 2. In survey address barriers to hand hygiene and personal perception of importance of hand hygiene.	• Count of weekly completed audits • Regularly scheduled meeting with IPAC nurse and unit staff to review the results.	Completed audits.	In FY 24/25 FCHS met the target. Hand Hygiene is a Multi-Year Strategy, we continue to improve to achieve -100%.

Change Idea #2 Provide hand hygiene results feedback to targeted groups and units (ex. Physicians, ICU) throughout the year.

Methods	Process measures	Target for process measure	Comments
1.Assess if hand hygiene specific to one group (physicians, nurses, other) or department (1S, 2S, ACNU, ED, ICU, AMB) is of sufficient quantity 2. If not sufficient quantity for the group or department, do focused Hand Hygiene audits 3. Provide results and education.	• Count of weekly completed audits • Regularly scheduled meeting with IPAC nurse and unit staff to review the results.	Completed audits	Hand Hygiene Compliance is a Multi-Year Strategy, we continue to improve to achieve -100%.