Access and Flow

Measure - Dimension: Efficient

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Average Ambulance offload Time (Four Counties Health Services Corporation)	C	Minutes / ED patients	Hospital collected data / FY 24/25 (Q1-Q3)	CB	CB	This is year 1 of collecting data for Average Ambulance Offload Time. Initial internal data audits have shown data discrepancies and incomplete data. We are focused on finding the root cause and fix the process.	
Average Ambulance offload Time (Strathroy Middlesex General Hospital)	C	Minutes / ED patients	Hospital collected data / FY 24/25 (Q1-Q3)	CB	CB	Data collection Year 1	
Average Ambulance offload Time	C	Minutes / ED patients	Hospital collected data / FY 24/25 (Q1-Q3)	CB	CB	We measure average ambulance offload time for both the MHA sites. Internal data audits revealed data discrepancies and errors. Hence this year we are working on improving data quality	

Change Ideas

Change Idea #1 Working collaboratively with Clinical Informatics, Decision Support, Registration staff and Nurses to improve data accuracy and quality.

Methods	Process measures	Target for process measure	Comments
1. Establish a working group, complete current state analysis followed by Root Cause Analysis (RCA) for lack of accurate data (Q1). 2. Share the outcomes of RCA with all stakeholder, review current process and create future state 3. Establish action plan, implement new processes, test change/PDSA (Q3) 4. Monitor weekly/monthly data and share the results with all key stakeholders.	Monitor weekly/monthly data and share the results with all key stakeholders	N/A working on collecting baseline data.	

Measure - Dimension: Timely

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile ambulance offload time (Strathroy Middlesex General Hospital)	O	Minutes / Patients	CIHI NACRS / ERNI hospitals: December 1st 2022 to November 30th 2023. Non-ERNI hospitals: April 1st 2023 to September 30th 2023 (Q1 and Q2)	70.00	60.00	No patient should wait for more than 60 mins	Middlesex-London Emergency Medical Services, Middlesex-London Emergency Medical Services

90th percentile ambulance offload time	O	Minutes / Patients	CIHI NACRS / ERNI hospitals: December 1st 2022 to November 30th 2023. Non-ERNI hospitals: April 1st 2023 to September 30th 2023 (Q1 and Q2)	70.00	60.00	Our current performance is better than OH West and Ontario Health. Our aim is no patient waits more than 60 mins (90th P)	Middlesex-London Emergency Medical Services, Middlesex-London Emergency Medical Services

Change Ideas

No Data Available

Change Idea #1 Working collaboratively with Clinical Informatics, Decision Support, Registration staff and Nurses to improve data accuracy and quality.

Methods	Process measures	Target for process measure	Comments
1. Establish a working group, complete current state analysis followed by Root Cause Analysis (RCA) for lack of accurate data (Q1). 2. Share the outcomes of RCA with all stakeholder, review current process and create future state 3. Establish action plan, implement new processes, test change/PDSA (Q3) 4. Monitor weekly/monthly data and share the results with all key stakeholders.	Monitor weekly/monthly data and share the results with all key stakeholders	90th Percentile target is 60 min.	

Equity

Measure - Dimension: Equitable

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
JEDI (Justice, Equity, Diversity and Inclusion Training)- Percentage of (new & returning) staff who have completed relevant equity, diversity, inclusion, and antiracism education. (Four Counties Health Services Corporation)	C	% / Other	Local data collection / FY-24/25 (Q1-Q3)	0.00	100.00	All new and returning staff members attend in house training before resuming work.	
JEDI (Justice, Equity, Diversity and Inclusion Training)- Percentage of (new & returning) staff who have completed relevant equity, diversity, inclusion, and antiracism education. (Strathroy Middlesex General Hospital)	C	% / Other	Local data collection / FY-24/25 (Q1-Q3)	0.00	100.00	All new and returning staff members attends the in-house training before resuming work.	
JEDI (Justice, Equity, Diversity and Inclusion Training)- Percentage of (new & returning) staff who have completed relevant equity, diversity, inclusion, and antiracism education.	C	% / Other	Local data collection / FY-24/25 (Q1-Q3)	0.00	100.00	All new and returning staff members attends in-house training before resuming work.	

Change Ideas

Change Idea #1	Launch JEDI online resources for Staff - Learning Management System. MHA-JEDI staff expectations are introduced on day 1 of orientation for new and returning staff members.		
Methods	Process measures	Target for process measure	Comments
Internal data collection following the completion of orientation and LMS training.	All new and returning staff has completed the training. Outcome of the staff survey shared with staff. Learning from the survey incorporated in Learning Management System	100% new and returning staff members completed the training. LMS course available to all staff members.	This is multiyear strategy. We expect by the end of next two fiscal years all employees of the MHA have completed the training. MHA implemented the JEDI strategy in FY 23/24. In year 1 all senior management staff completed the training. In year two FY-24/25 we are offering mandatory training to all new and returning staff members.

Change Idea #2	Conduct staff survey to understand staff's current knowledge and gaps about JEDI principles.		
Methods	Process measures	Target for process measure	Comments
Electronic survey sent to all staff members.	All staff members completed the survey. Survey results evaluated and outcomes shared with the staff. Outcome of the staff survey shared with staff. Learning from the survey incorporated in Learning Management System refresh.	100% staff participation	

Experience

Measure - Dimension: Patient-centred

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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	% / All inpatients	Hospital collected data / FY-24/25 (Q1-Q3)	56.00	70.00	Multi Year Strategy. Continue to improve to achieve - 100%	
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	% / All inpatients	Hospital collected data / FY-24/25 (Q1-Q3)	54.46	65.00	Multi Year Strategy. Continue to improve to achieve - 100%	

Change Ideas

No Data Available

Change Idea #1 Conduct 4 learn and lunch session Inpatient nurses/clerks re: patient feedback.

Methods	Process measures	Target for process measure	Comments
o Create monthly patient feedback dashboard to share with staff o Engage PFAC to increase social medical visibility and develop plan to share patient feedback with patients and general public.	Increase in number of fully completed surveys. Increase in number of respondents completing survey responding positively for this question.	Meet the target of 65% completed surveys.	

Change Idea #2 Implement - Patient oriented discharge summaries (PODS).

Methods	Process measures	Target for process measure	Comments
Implementation of Patient Oriented Discharge Summaries and discharge planning at the time admission. Monthly data presented and discussed at applicable Service meetings to identify trends and opportunities for improvement.	Weekly count of PODS for inpatients	Meet target of 65% completed surveys.	Year 1 PODS rolled out for all medicine patients.

Measure - Dimension: Patient-centred

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Emergency Department - Patient Experience. 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	Hospital collected data / FY-24/25 (Q1-Q3)	43.00	60.00	Multi- year strategy, continue to improve towards the target of 100%.	
Emergency Department - Patient Experience. 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	Hospital collected data / FY-24/25 (Q1-Q3)	49.00	60.00	Multi- year strategy, continue to improve towards the target of 100%.	

Emergency Department - Patient Experience. 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	Hospital collected data / FY-24/25 (Q1-Q3)	47.00	60.00	Multi Year Strategy Continue to improve to achieve -100%	

Change Ideas

Change Idea #1 Retrain ED nurses-discharge documentation. Retrain ED registration staff re: customer care.

Methods	Process measures	Target for process measure	Comments
• Provide standardized scripting for staff to use at triage and registration. • Continue to improve the process of capturing emails. Educate/Train all new and returning staff on email collection process. • Monthly monitor number of emails gathered and number of emails declined.	1.Number of fully completed surveys. 2. Increase in email address collection 3. Decrease in email bounce backs.	i. Meet target of 60% completed surveys.	Multi Year Strategy (Year 1) Continue to improve to reach the target of 100%.

Change Idea #2 Conduct 4 learn and lunch session with ED nurses re: patient feedback. Share improvements with patients/general public.

Methods	Process measures	Target for process measure	Comments
• Create monthly patient feedback dashboard to share with staff • Engage PFAC to increase social medical visibility and develop plan to share patient feedback with patients and general public. • Develop and implement action plan for ED team appreciation, personal and team accountability for patient satisfaction • Share improvements with patients/general public	Increase in number of fully completed surveys.	Meet the target of 60% completed surveys.	

Measure - Dimension: Patient-centred

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Inpatients - 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	% / All inpatients	Hospital collected data / FY-24/25 (Q1-Q3)	45.00	65.00	Multi Year Strategy. Continue to improve to achieve - 100%	

Change Ideas

No Data Available

Change Idea #1 Conduct 4 learn and lunch session Inpatient nurses/clerks re: patient feedback.

Methods	Process measures	Target for process measure	Comments
Create monthly patient feedback dashboard to share with staff o Engage PFAC to increase social medical visibility and develop plan to share patient feedback with patients and general public.	Increase in number of fully completed surveys. Increase in number of respondents completing survey responding positively for this question.	Meet the target of 60% completed surveys.	

Change Idea #2 Implement - Patient oriented discharge summaries.

Methods	Process measures	Target for process measure	Comments
Implementation of Patient Oriented Discharge Summaries (PODS) and discharge planning at the time admission. Monthly data presented and discussed at applicable Service meetings to identify trends and opportunities for improvement.	Weekly count of PODS for inpatients	Meet target of 60% completed surveys.	Year 1 PODS rolled out for all medicine patients.

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. (Four Counties Health Services Corporation)	O	% / Discharged patients	Local data collection / Most recent consecutive 12-month period	72.64	90.00	Multiyear strategy - continue to improve to achieve - 100%.	Neighbourly Pharmacy
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	88.37	92.00	Multi Year strategy - Continue to improve towards target.	Neighbourly Pharmacy
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	85.84	90.00	Multi Year strategy - continue to improve towards target of 100%	Neighbourly Pharmacy

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) Track and optimize the number of patients who have a best possible medication history (BPMH) completed at the time of admission as it impact the medication reconciliation at discharge. 3) Track quarterly compliance rates and managers to follow-up with staff to support the process. 4) BPMH working group to provide recommendations for improvement and standardization and to develop resources to support quality improvement. 5) 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 pharmacist.	Monthly completed Medication Reconciliation at discharge.	

Change Idea #2	Engagement with providers (physicians & NPs) to provide monthly reporting to providers on performance. Communication and awareness campaign for providers		
Methods	Process measures	Target for process measure	Comments
Establish working group and action plan for improvement to be developed to review current process/reports/dashboard.	Daily audits or completion of admitted patient BPMH by Nurse Practitioners. Regular evaluation of reviews by pharmacist.	Timely distribution of monthly reports and quarterly dashboard	

Measure - Dimension: Safe

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Hand Washing Compliance - Moment 1 (before touching a patient) by Hospital Care Provider (Four Counties Health Services Corporation)	C	% / All inpatients	In house data collection / FY 24/25 (Q1-Q3)	CB	CB	Not applicable - collecting baseline data.	
Hand Washing Compliance - Moment 1 (before touching a patient) by Hospital Care Provider (Strathroy Middlesex General Hospital)	C	% / All inpatients	In house data collection / FY 24/25 (Q1-Q3)	47.00	60.00	Continue to improve. Multi-year strategy to achieve 100%	
Hand Washing Compliance - Moment 1 (before touching a patient) by Hospital Care Provider	C	% / All inpatients	In house data collection / FY 24/25 (Q1-Q3)	47.00	60.00	Multi Year Strategy Continue to improve to achieve -100%	

Change Ideas

Change Idea #1 A) Recruit and train 4 MHA Hand Hygiene Champions. B) Conduct 4 Lunch and Learn sessions.

Methods	Process measures	Target for process measure	Comments
1) Identify existing high performers and learn strategies used. Working with high performers develop a plan using the influencer model to increase audit frequency and conduct lunch and learn sessions. 2) Engage health care workers in determining optimal ways of communicating/disseminating audit outcomes (rates) with them and implement the recommendations.	• Count of weekly completed audits • Regularly scheduled meeting with IPAC nurse and unit staff to review the results.	Completed audits.	Last year we had Health Human Resources challenges resulting audits not completed consistently. This year we have recruited another IPAC nurse with key responsibility of consistently completing monthly audits.

Change Idea #2 Conduct consistent monthly 100 audits.

Methods	Process measures	Target for process measure	Comments
1)Develop unit level reporting mechanisms and share results with the unit managers and all staff members. 2)Evaluate access to hand hygiene agents at the point of care. Implement required recommendations.	• Count of weekly completed audits • Regularly scheduled meeting with IPAC nurse and unit staff to review the results.	Completed audits.	