Access and Flow

Measure - Dimension: Efficient

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Time from initial assessment to disposition/discharge.	C	Minutes / ED patients	CIHI NACRS / 2024-2025	CB	CB	CB	

Change Ideas

Change Idea #1 Continue to utilize NP Clinic for low urgency patients to enhance patient flow through the Emergency Department (ED) and support more responsive care for high urgency and low urgency patients.

Methods	Process measures	Target for process measure	Comments
The NP Clinic will be seeing CTAS 3, 4, and 5 patients. Continue to review ED wait time data for high and low acuity patients. Monitor length of stay for NP Clinic patients.	Patients seen by a Nurse Practitioner (NP) and average length of stay for NP patients.	Patients seen by NP: 95 patients/month Average LOS for NP patients: 95 minutes/month	

Change Idea #2 Enhanced Diagnostic Imaging requisitioning process from ED to reduce delays and reduce errors.

Methods	Process measures	Target for process measure	Comments
Monitor wait time data for patients referred to Diagnostic Imaging from ED (time from test entry to time of service completion).	Reduced wait times for imaging.	Completed by April 2024.	

Change Idea #3 Additional staffing complement in the Emergency Department (ED) (Day Shift Team lead and additional staff on night shifts).

Methods	Process measures	Target for process measure	Comments
Complete chart audits to determine percentage of patients reassessed according to CTAS standards.	Percentage of ED patients reassessed in according with CTAS standards for triage.	All patients are reassessed according to CTAS standards.	

Change Idea #4 Implement recently developed Safe Discharge Checklist to identify risk factors, reduce readmissions, and enhance patient flow.

Methods	Process measures	Target for process measure	Comments
A Safe Discharge Checklist will be completed for all patients discharged from the ED.	% completion of Safe Discharge Checklist at time of patient discharge.	Completion of Safe Discharge Checklist for 80% of discharged patients.	

Measure - Dimension: Timely

Indicator #9	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Average time patients waited for first assessment in emergency department (ED)	C	Hours / ED patients	CIHI NACRS / 2024-2025	CB	CB	CB	

Change Ideas

Change Idea #1 Implement recently developed Safe Discharge Checklist to identify risk factors, reduce readmissions, and enhance patient flow.

Methods	Process measures	Target for process measure	Comments
A Safe Discharge Checklist will be completed for all patients discharged from the ED.	% completion of Safe Discharge Checklist at time of patient discharge.	Completion of Safe Discharge Checklist for 80% of discharged patients.	

Measure - Dimension: Timely

Indicator #10	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percent discharge summaries sent from hospital to community care provider within 48 hours of discharge	C	% / All inpatients	Local data collection / 2024-2025	81.00	90.00		

Change Ideas

Change Idea #1 Use of Fluency Flex Dictation to facilitate timely completion of discharge summaries.

Methods	Process measures	Target for process measure	Comments
Monitor use of Fluency Flex and encourage all physicians to use dictation to enhance timely completion of discharge summaries.	Number of active users and use of Fluency Flex.	100% of discharge summaries completed using front-end dictation.	

Change Idea #2 Audit charts to identify lack of physician follow-up and charting dificiencies.

Methods	Process measures	Target for process measure	Comments
Coders enter deficiencies in Meditech. Review reports of deficiencies.	Percentage of deficiencies related discharge summaries.	10% reduction in deficiencies.	

Equity

Measure - Dimension: Equitable

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of complaints received which are related to diversity, equity, and inclusion.	C	% / N/a	Hospital collected data / 2024-2025	23.00	10.00	We anticipate a decrease in patient complaints relating to issues around diversity, equity, and inclusion.	

Change Ideas

Change Idea #1 Offering of San'yas Indigenous Cultural Safety Training to all staff.

Methods	Process measures	Target for process measure	Comments
Identify rate of completion through HR reporting.	Percentage of staff who completed training.	50% of front line staff and 75% of management to complete San'yas training.	

Change Idea #2 Collaboration with Indigenous Patient Relations Department (IPRD) on accessibility of LWDH's Indigenous Client Navigation resources.

Methods	Process measures	Target for process measure	Comments
Patient Experience Survey question "If you are First Nations, Metis, or Inuit, were you aware of the following cultural services provided in the hospital to meet your needs: Traditional Healing, Interpreter Services, and Cultural Support," and an increased uptake of client navigation services.	Increased utilization of Indigenous Client Navigation services and number of Indigenous Client Navigation referrals.	10% increase in utilization of Indigenous Client Navigation services and number of Indigenous Client Navigation referrals.	

Change Idea #3 Working with the IPRD on a more culturally sensitive feedback process for Indigenous patients and clients, which includes an update to our external site.

Methods	Process measures	Target for process measure	Comments
Review of RL6 Feedback submissions (complaints, concerns, and compliments).	Percentage of complaints received regarding diversity, equity, and inclusion.	A 5% increase in the reporting of any feedback (complaint, concern, and compliment) regarding diversity, equity, and inclusion.	

Experience

Measure - Dimension: Patient-centred

Indicator #6	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	75.69	80.00	Achievable target based on previous years performance and implementation of change ideas.	

Change Ideas

Change Idea #1 Develop and post QR code access to the Patient Experience Surveys in key areas throughout the hospital.

Methods	Process measures	Target for process measure	Comments
Patient Experience Survey for Inpatients and Outpatients.	Increased rate of completion.	10% increase in response rate to the previous year on each survey (inpatient and outpatient).	Total Surveys Initiated: 328

Change Idea #2 Emergency Department (ED) to join with a hospital or obtain a platform for a repository of educational sheets specific to a patient's condition that would be provided upon discharge from the ED.

Methods	Process measures	Target for process measure	Comments
Working as a team to select a hospital(s) to partner with, or obtain a platform, for a repository of educational sheets that can be utilized by the LWDH ED.	Hospital(s) partnership or platform obtained for a repository.	Repository for educational sheets has been sourced, established, and is operational.	

Change Idea #3 Evaluate the completion of a PODS for each discharged inpatient.

Methods	Process measures	Target for process measure	Comments
Audit by the Discharge Transitions Nurse.	Percentage of patients indicating "yes" to the survey question.	85% on both inpatient and outpatient survey results.	

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	75.56	80.00	Achievable target based on previous years performance and implementation of change ideas.	

Change Ideas

Change Idea #1 Dedicated BPMH Pharmacy Technician to complete BPMH for all admitted patients starting on April 1, 2024.

Methods	Process measures	Target for process measure	Comments
Pharmacy Technician will complete audit of charts from each department.	Percentage of completed BPMH.	80% completion.	

Measure - Dimension: Effective

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of patients readmitted to hospital within 30 days of discharge after hospitalization for mental illness or addiction	C	% / Mental health patients	CIHI DAD,CIHI OHMRS,MOH TLC RPDB / 2024-2025	5.00	3.00	We will continue to work towards reducing the number mental health readmissions within 30 days.	

Change Ideas

Change Idea #1 Providing each discharged inpatient with a Safety Plan and PODS.

Methods	Process measures	Target for process measure	Comments
Every discharged inpatient receives a Safety Plan and PODS upon discharge. This information is shared with community partners with the patient's consent.	Rate of Safety Plan and PODS completion.	100% of discharged inpatients to receive a Safety Plan and PODS.	

Change Idea #2 To provide care closer to home, clinics within the region/district have been restarted. Psychiatrists travel to each district to see patients. The current wait list is six (6) to nine (9) months.

Methods	Process measures	Target for process measure	Comments
Evaluate the effectiveness of the clinics by reviewing the number of patients seen at each clinic.	Number of clients attending appointments through the District Clinics and a decrease in the current wait list.	Decrease in the current wait list of six (6) to nine (9) months. At each district clinic, either three (3) new consults or six (6) follow ups.	

Change Idea #3 Collaborate with community partners to ensure continuity of care and availability of services.

Methods	Process measures	Target for process measure	Comments
With patient consent, utilizing the Complex Care Table to review applicable patients (1% of the population that uses 99% of services). This table meets monthly.	Number of LWDH patients referred to the Complex Care Table.	Fewer readmissions from clients discussed at the Complex Care Table.	

Measure - Dimension: Effective

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Repeat ED visits with 30 days for mental health and addictions	C	% / ED patients	CIHI NACRS / 2024-2025	34.00	25.00	We will continue to work towards reducing repeat ED visits for mental health and addictions within 30 day.	

Change Ideas

Change Idea #1 Partnership with Kenora Chiefs Advisory to embed social workers in ED.

Methods	Process measures	Target for process measure	Comments
Monitor use of social work services in ED to determine impact on patient flow.	Percentage of ED patients who utilized social work services in ED.	Collecting baseline.	

Change Idea #2 Utilize Indigenous Client Navigators to support clients with access to follow-up/community supports.

Methods	Process measures	Target for process measure	Comments
Extend availability of Indigenous Client Navigators to include evenings and weekends.	Increase rate of Indigenous patients connected with Indigenous Client Navigators.	10% increase in referral to Indigenous Client Navigators.	

Change Idea #3 Implement ED Safe Discharge Checklist to identify risk factors, reduce readmissions, and enhance patient flow.

Methods	Process measures	Target for process measure	Comments
A Safe Discharge Checklist will be completed for all patients discharged from the ED.	Percent completion of Safe Discharge Checklist for all patients discharged from the ED.	Completion of Safe Discharge Checklist for 80% of discharged patients.	

Change Idea #4 As Safety Plan is created by the ED Social Worker for each patient seen, when applicable.

Methods	Process measures	Target for process measure	Comments
A chart audit to ensure a Safety Plan is being created by the ED Social for each MH&A patient seen by them in the ED.	Number of Safety Plans completed by the ED Social Worker for each MH&A patient seen by them in the ED.	90% completion of a Safety Plan for a MH&A patient discharged from the ED.	

Change Idea #5 Work with community partners to develop an MOU for when a patient is brought into the Emergency Department (ED) and requires follow-up following discharge/AMA (with the patient's consent).

Methods	Process measures	Target for process measure	Comments
This change idea is currently in discussions as to whether it is feasible, but is being explored as more help is sometimes required for certain patients following discharge or leaving the ED.	Regular meetings with the Social Work in the ED Working Group and community partners to further this discussion.	Monthly meetings are held if everyone agrees this MOU is worthwhile, feasible, and should be implemented.	

Measure - Dimension: Safe

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of workplace violence incidents (Overall)	C	Number / Worker	Local data collection / 2024-2025	72.00	72.00	Target set using previous year results. Goal is to enhance reporting culture for incidents of workplace violence while implementing strategies aimed to reduce the overall number of incidents.	

Change Ideas

Change Idea #1 Continue to encourage and monitor reporting practices.

Methods	Process measures	Target for process measure	Comments
RL6 Incident Monitoring Sytem.	Total number of reported Safety/Security incidents relating to violence.	5% increase in reporting.	

Change Idea #2 JOHSC will repeat formal violence/risk assessments.

Methods	Process measures	Target for process measure	Comments
PSHSA Violence/Risk Assessment Tool.	Completion of the violence/risk assessments.	100% completion for all departments.	

Change Idea #3 Increased training and awareness on workplace violence prevention, including in-house CPI training.

Methods	Process measures	Target for process measure	Comments
Newsletters, department in-service education, and mandated CPI training for specific departments but open to all staff.	Percentage of CPI completion for mandatory departments.	90% CPI completion for mandated staff and 50% CPI completion for other staff.	

Measure - Dimension: Safe

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of incidents reported related to issues in management of medications	C	% / N/a	Hospital collected data / 2024-2025	CB	CB	Collecting baseline to determine rate of incidents relating to potential narcotic diversion.	

Change Ideas

Change Idea #1 Roll-out education on updated Narcotic and Controlled Drugs - Administration, disposal, and inventory management on wards policy and procedure with the goal of increasing awareness and reporting of medication incidents from nurses.

Methods	Process measures	Target for process measure	Comments
Review of medication incidents reports from RL6 incident management system.	Percentage of medication incidents related to narcotic and controlled medication issues.	10 % increase in reporting from nurses.	

Change Idea #2 Regular auditing of Med order, Med Dispense reports, MAR, and wasting.

Methods	Process measures	Target for process measure	Comments
Pharmacy audits of Med Dispense reports and reconciling to patient charts. Discrepancies entered into RL6 incident monitoring system.	RL6 medication incident reports.	Collecting baseline. Target set to 10% of medication issues.	

Change Idea #3 Adhere to newly developed formal investigation process for staff follow-up when a medication discrepancy is identified.

Methods	Process measures	Target for process measure	Comments
Pharmacy flags all identified discrepancies in RL6 incident monitor. Review medication incident reports.	Percentage of medication incidents related to narcotic and controlled medications.	100% incident follow-up and investigation.	