Report of the President & CEO to the Board of Directors

Date: December 2011

One of the most glorious messes in the world is the mess created in the living room on Christmas day. Don't clean it up too quickly. ~Andy Rooney

I want to wish all of you an amazing Holiday Season. I am hopeful you will be able to spend time with family and friends and celebrate this past year and look forward to the future.

I want to thank all of you for the compassion and outstanding care you provide to our community. I am proud to say I work with all of you at Windsor Regional Hospital.

Have a great Holiday Season and Happy New Year!

Strategic Direction – Embed Patient Quality and Safety in Our Culture

Windsor Regional Hospital Recognized as Best of Best at OHA International Conference and Minister of Health Innovations Expo

- Windsor Regional Hospital has been achieving Leading Practice recognition for several years now. The current Ontario Hospital Association (OHA) International HealthAchieve Leading Practice Award for "Polarizing MRI Wait Times" is just another in a series of recognitions.

- The MRI initiative was led by Director of Diagnostic Imaging Ralph Nicoletti who, through his motivation and leadership, got his team together to discuss a growing issue: long wait times for MRIs. In April 2009, Windsor Regional Hospital had 1,424 unprocessed MRI requests and the reported wait time for non-emergent scans was 117 days.

- So the team came up with solutions. It applied LEAN methodologies, which improved efficiencies and sustained change. By engaging front-line staff and a lead Radiologist, who in this case was Dr. Dan Gill, the team achieved standardization while ensuring maximum efficiency of the MRI unit. Also, special modifications were made to streamline bookings, protocolling, and examination processes.

- It did this by utilizing a patient messaging process that reduced telephone calls yet maintained patient satisfaction. It also booked exams on a first-in, first-out basis for each priority level and developed checklists to track items necessary for protocolling.

- Radiologists agreed to standard protocols and examination times, and ensured protocolling was completed by 10:00 a.m. each day. They created "spine Fridays," which minimized frequent coil changes. The nursing staff agreed to 10-hour shifts to increase efficiencies of pediatric sedations. There was a rigid evaluation and tracking of daily and monthly MRI reports related to volumes and efficiency.

- The result: a wait time improvement from 117 to 29 days and the unprocessing of MRI requests dropped from 1,424 to 156. At the same time, volumes increased by 11 percent and radiologist protocolling time decreased from 120 to 45 minutes daily. It was a total team effort and the public was the winner!

- Another milestone for us is capturing yet another *People's Choice Award* presented at the OHA's Annual Summit and Ministry of Health and Long-Term Care Innovations Expo following the OHA HealthAchieve Conference and Exhibition. This year's award for "A Problem With Parts Was Part Of Our Problem: A Specimen Safety Initiative" was the third won by Windsor Regional Hospital in the last four years.

- Specimen handling is an error prone process. Irreplaceable specimen errors are defined as specimens that would be difficult or impossible to recollect, and in rare cases, would place the patient in danger if recollected. The purpose of the initiative was to standardize processes for specimen handling in the Operating Room (OR).

- To address gaps in the process, Windsor Regional Hospital created a multidisciplinary specimen safety committee, re-wrote irreplaceable specimen policies and procedures, developed training modules to increase competencies, created a root cause analysis tool, and defined a standardized reporting structure. Data was collected and monitored via electronic reports and manual data collection.

- The result was a more than 50 percent reduction in OR irreplaceable specimen error rates.

- Windsor Regional Hospital has clearly created a culture that, when a patient safety issue is identified, the only way to solve it is by being transparent, working as a team, and breaking down every part of the process to determine what improvements can and should be made.

- Congratulations to all of you – we are truly living our Mission of providing Outstanding Care with Compassion !!

Strategic Direction – Cultivate an Environment of Accountability and Transparency

Don Drummond Appointed to Aid Ontario Government in Addressing its Deficit and Debt

- The Ontario Government pays $10.3 billion in annual interest payments on its debt ($241.4 billion at the end of 2011-2012 fiscal year) that has accumulated as a result of its annual deficits. In order to address not only the current projected $16.3 billion dollar deficit for 2011-2012, Ontario is working on revamping its public services by appointing respected economist Don Drummond to lead the effort.

- The Government is also looking at an expanded privatization of its ServiceOntario operations, which now provide documents like birth and marriage certificates, to see if more private-sector innovation could lead to improvements.

- Education and health care, two key priorities for the Government, eat up 62 per cent or $70.8 billion of Ontario's spending on programs.

- This past month Mr. Drummond released a report through the C.D. Howe Institute on the state of Canada's health care system.

- The report found that health care spending in Ontario has been rising 7.6 per cent annually at a time when Drummond is strongly recommending Ontario rein in all spending to no more than 1 per cent per year in order to slash its deficit by 2018. And the reality is that revenues are not projected to increase at a rate sufficient to pay for rising health-related costs, the report claims.

- Drummond argued in a report released last year that if "left unchecked, health-care costs are set to reach between 70 to 80 per cent of total program spending by 2030, up from just over 40 per cent today." 2010 saw over $192B spent on health care costs alone, a total which accounts for just under 12 per cent of the country's GDP.

- In his report, Drummond identifies that many of the hospital beds in Canada are occupied by patients who no longer need acute care services. He uses statistics from 2008/2009, where 5 percent of hospitalizations and 13 percent of all hospital days were ALC. He concludes that the results of this inefficiency include people in hospital beds who could be better cared for elsewhere, crowding of emergency facilities, cancellations of surgeries because beds are not available and a clogging of ambulance services bringing people to and from hospitals. He properly identifies that this is a "classic symptom of a system built for acute care at a time when the needs have shifted more to chronic care".

- Drummond also recommends that a "policy that encourages competition among providers, by emphasizing the important distinction between how we raise money to purchase health services, which should remain largely public, and how we provide services, could result in a more effective system that provides quality care at a low cost (Ruseski 2009). Past reforms in the United Kingdom, which has a much larger public-

purchasing envelope than Canada, have emphasized this purchaser provider split. A carefully designed policy would reward providers based on quality-adjusted price rather than award contracts to the lowest-cost provider. For example, specialized care clinics, such as for cataracts, should also be encouraged as they can enhance quality, promote innovation and lower costs. Special diagnostic clinics should also be encouraged: with coverage under the public-payer model, patients can be sent to the clinics from within a health region. In some cases, clinics could even service patients that come from other regions".

- Drummond also indicated that the system would benefit from seeing fewer people in hospitals, which are "expensive, expose people to contagious diseases and yield poor patient satisfaction" and more people treated in primary care facilities. He also argued for better utilization of TeleHealth Ontario to keep people out of hospitals who don't need to be there, and that more resources be placed into preventative measures. He stated, "The ideal health system would put more emphasis on preventing poor health," the report claims. What better way to treat people than to help prevent them from getting sick in the first place?

- Drummond also does discuss compensation for physicians in his report. He identifies that "other incentives that should be changed to reduce costs include shifting from pay-for-service to pay-for-episode of care in hospitals or to blends of compensation methods for physicians". Drummond identified in his report that "blended payment systems are likely best. In the case of hospitals, that would be a mix of base funding with payment for activities. Such a scheme would encourage specialization in that some hospitals would stop offering treatments they could not deliver within the payment schedule whereas more efficient operations could. For physicians, pay-for-service gives an incentive to over serve but strict capitation gives an incentive to under supply. A mix with something like 70 percent weighting to salary and 30 percent on pay-for-services may be appropriate. Going one step further, the incentive payments should be tied to outcomes rather than interventions. For example, there would be an incentive payment for diabetes patients who did not have complications. The use of alternative payment systems – payments that are not fee for- service – has risen to over 20 percent of all clinical payments in Canada, with a high of 45 percent in Nova Scotia and a low of 12 percent in Alberta in 2005/06" (CIHI 2008).

- Drummond concluded the report by asking if "Canada's or Ontario's health care system is sustainable" before changing the nature of the question to "why would one want to sustain the status quo?" He states, "For the amount of money spent, the system should surely be delivering better results. It needs to shift from an acute-care model to a chronic-care model. It needs to broaden in purview from health care to health more generally, which brings in prevention and socio-economic factors. It needs to be centered on the patient, with all parts of the system co-ordinated around patient care."

- Drummond also states "in Ontario, reconstituted Local Health Integrated Networks could play this role. Consideration could be given to reducing the number from the current 14, with a commensurate reduction in boards. However, the number of LHINs is of

secondary importance to granting them the appropriate authorities and resources, and establishing clear accountabilities. Alternatively, the co-ordination could be done through the administrations of the large hospitals in a region. The former has the advantage of being neutral to any particular segment of the sector, whereas the latter has the advantage in that hospitals are where the required management expertise is now typically found".

- For a full copy of the report go to: http://www.cdhowe.org/pdf/Benefactors_Lecture_2011.pdf. I would recommend that everyone read it. I would imagine it will form the basis of the work he has undertaken for the Ontario Government.

Strategic Direction – Build and Sustain Financial Health

2012-2013 Budget Process

- We are continuing our Budget process and we should have a completed approved 2012-2013 budget in January/February 2012.

- Windsor Regional Hospital has had only 5 small surpluses in the last 18 years of operation. Three of these have occurred in the last 3 years. As a result of having a limited number of balanced operating years over the past two decades Windsor Regional Hospital is financing a considerable amount of short and long term debt through the payment of principal and interest payments of approximately $5 million dollars per annum. That is $5 million that is not available to be spent on Hospital operations. That CANNOT go any higher.

- The positive development of this budgeting process is the fact we are operating very efficiently and project our actual cost per weighted case as being approximately 1-2% above expected for the 2012-2013 year. As previously discussed cost per weight case is a financial indicator that provides a measure of the cost to provide care to a "standard" hospital patient. It is a relative, average cost calculated by summing the weights assigned to all cases treated by a hospital, and dividing this number into the hospital's total inpatient expenditure. It is used for describing and comparing the cost of care, as it removes the effects of differences in the acuity, severity and complexity of the populations served in different hospitals on the cost of providing care, and permits the assignment of a cost to each case that is discharged from a hospital.`

- At the same time, being so efficient, results in very difficult decisions having to be made to ensure a balanced budget entering 2012-2013.

- Entering 2012-2013, assuming a balanced operating position, we need to find approximately $2.2 million dollars in savings to offset projected expense increases (i.e. volume increases, wage and benefit increases, supply cost increase etc.) even taking into account a 1.5% projected funding increase from the Ministry of Health and Long Term Care.

- We will keep you up to date on the progress we are making in this regard.

Strategic Direction – Enhance our Status as an Employer of Choice

Parking at the Metropolitan Campus

- As previously announced we proceeded with the necessary changes to parking at the Metropolitan campus effective November 1, 2011, to better serve our patients and families. These changes were to convert the existing staff parking lot located at the east end of the Lens lot to a patient/family parking lot.

- Since Windsor Regional Hospital has been informed that it needs to look to an external site within the next 10-15 years, building and operating a parking structure is NOT financially possible.

- Windsor Regional has expanded its offsite parking on Kildare in order to accommodate all staff that wishes to park offsite.

- Overall this change has gone rather smoothly. I want to thank all of the staff for understanding and appreciating the need and rationale for these changes.

Strategic Direction – Distinguish Ourselves through Superior Performance, Innovation and Exceptional Customer Service

Progress in 14 Core Indicators

- In 2008 we commenced a Strategic Planning process that involved hundreds of front line Windsor Regional Hospital team members.

- This resulted in a new Vision, Mission and Values that have driven our daily activities for the benefit of our patients ever since.

- Five (5) Strategic Directions we developed and various Strategic Initiatives were assigned under each Direction.

- Each department then operationalized these Initiatives. We collectively created work plans to ensure the achievement of these Initiatives and Directions. However, we kept in mind the fact – if we cannot measure it we cannot manage it. Therefore, if you could not measure what you wanted to pursue it was not worth it.

- At the end of the day we created approximately 100 indicators that we could measure and manage with the goal of bringing the Strategic Directions to life !

- Out of these 100 indicators, fourteen (14) of them rose to the surface as being ones that cut across the whole organization. They are our 14 core indicators. These 14 core indicators are found on the Internet site, tracked, monitored and acted upon daily, discussed weekly at Monday Morning Huddles and monthly at our Quality of Care/Medical Advisory Committee and Board meetings.

- The following is a brief outline of the progress we have made with each of the 14 Core indicators since 2008.

Hand Washing Compliance

- ✓ WRH has been monitoring and tracking Hand Hygiene (HH) compliance since **early 2008** with corporate rates ranging from **49**% weekly in the beginning.
- ✓ Windsor Regional Hospital was the first Hospital in the Province to report handwashing compliance on the Internet for the world to see. The OHA and MoH followed suit a year later.
- ✓ Windsor Regional Hospital kicked off a campaign "Wash Hands Saves Lives" 2 years before the MoH campaign.
- ✓ Auditing is conducted through ***self reporting*** results and through ***spot audit*** processes conducted by IPAC- all disciplines and departments/services staff, physicians, students and volunteers can be audited.
- ✓ Auditing is based on observation for all 4 moments of hand hygiene: (i) Before initial patient/patient environment contact; (ii) Before aseptic procedure; (iii) After body fluid exposure risk; and (iv) After patient/patient environment contact.
- ✓ 2010-11 HH results indicated we exceeded Provincial averages with **91% compliance** before and **94%** compliance after patient contact. A total of **3,495** HH audits were completed throughout the year 2010-11. Additional outpatient services such as the Cancer Clinic and RCC are now participating in audits.
- ✓ To the end of Oct 2011 **3,829 audits have been completed -** New peer to peer auditing and feedback processes are being piloted.
- ✓ Weekly results are communicated at the Monday Morning Huddle- we have a predictable pattern that when our weekly HH drops below 85% hen the subsequent week there is an increase in Hospital Acquired Infections.

Hospital Acquired Infections (HAI)

- ✓ WRH began monitoring and tracking HAIs **in Apr 2008** through weekly reporting of new acquired infections of VRE, MRSA (infections or colonization) and C diff. Weekly rates varied from **5 to 15** cases. This reporting goes beyond public reporting requirements of reporting bacteremia.
- ✓ Multiple measures have been piloted and established to address our practices: follow the yellow dot processes, electronic flagging, use of Personal Protective Equipment, new screening tools, communication tools; new signage and point prevalence studies.
- ✓ Improvement teams have been used to improve areas that have increased incidents: Critical Care and now one of the Medical Units.

- ✓ Our 2010-11 overall improvement target was set at 1.40 /1000 patient days, with our average at 0.756 last year.
- ✓ For **2011-12** our goal/target was set even lower at **.875/1000** patient days.

Patient Falls (with Injury)

- ✓ In 2009/2010 WRH reported a total of 685 falls and falls with injury; 632 (92%) were falls and 53(8%) were falls with injury.
- ✓ Acute care accounted for 52% of falls and 49% of falls with injury; 54% were on Medical units.
- ✓ Complex Continuing Care accounted for 29% of falls and 42% of falls with injury. Rehab accounted for 19% of falls and 9% of falls with injury.
- ✓ WRH's Risk Monitor Pro reporting system captures falls and falls with injury. Falls with injury are categorized as a level E to I. Category E is a fall with injury that results in temporary harm requiring intervention. Category F is temporary harm to the patient requiring initial or prolonged hospitalization. Category G is permanent patient harm. Category H is intervention required to sustain life. Category I is patient death.
- ✓ In 2010-11 the corporate falls with injury improvement target is 0.25 per 1000 patient days. Corporate performance for 09/10 rate was 0.7/1000 patient days and for 10/11 the rate was 0.25. For the first quarter of 2011-12 the result was .24 /1000 patient days.
- ✓ Multiple measures have been piloted and established to improve our falls with injury rate investigating Best Practice Literature; trialing various fall risk assessment tools, standardizing fall interventions, establishing comfort round processes monitoring and auditing of falls and conducting root cause analysis.
- ✓ Windsor Regional Hospital was honoured to be asked to present its work on tracking and preventing patient falls at the Mayo Clinic in 2010.

Patient Specimen Incidents

- ✓ The specimen process includes: an ordering phase, a collection phase (includes identification and labeling), a transportation phase, receipt of specimen by lab and the analysis and reporting of results.
- ✓ "***Acceptable"*** specimens are those that have followed a "perfect" process: correct order, correct name, correct test, correct container, correct preservative, etc.
- ✓ Although the potential for error exists in all steps of the process, based on WRH data, most occur in either the interpretation of orders, specimen collection and transportation of patient specimen phases. Such process errors result in a specimen being considered "***Unacceptable***". Although many specimens can be replaced, some specimens cannot be retrieved again from the patient or cannot be retrieved without causing considerable risk to the patient. These specimens are considered "***Irreplaceable****"* and may include (as defined by the Laboratory's "Irreplaceable Specimen Protocol"):
    - Bone Marrow Specimens
    - Body Fluids
    - Surgical Specimens
    - Specimens from autopsies

- ✓ Areas of high risk for irreplaceable specimens include areas such as the Operating Room, Diagnostic Imaging and Endoscopy.

- ✓ In 2009, there were 11,018 unacceptable patient specimens at WRH, 67 of which were irreplaceable. A process review of the 67 incidents revealed:
  - 54 involved 'Incorrect or Missing Identification',
  - 7 involved 'Inappropriate Conditions of Preservation',
  - 2 involved 'Specimens that Pose Hazardous Handling Conditions',
  - 1 involved a 'Wrong Container Used', and
  - 2 were 'Other' (no specimen received in the container).

- ✓ At WRH our goal is that all patient specimens are handled as if they were irreplaceable
  Target: 0 unacceptable specimens - Target: 0 irreplaceable specimens.
- ✓ Last month WRH was presented the People's Choice Award by the Minister of Health at the recent Innovations Expo for its work in this indicator.

High Alert Medication Incidents

- ✓ High alert medications are most likely to cause significant harm to the patient, even when used as intended.
- ✓ Based on reports submitted to the Institute of Safe Medication (ISMP), literature reviews and experience from hospitals that have participated in the IHI Collaborative, the following four groups of high alert medications represent areas of greatest harm and greatest opportunity for improvement:
  - Anticoagulants (e.g. heparin),
  - narcotics and opiates,
  - insulins, and
  - sedatives.
- ✓ The most common types of harm associated with these medications include hypotension, bleeding, hypoglycaemia, delirium, and bradycardia.
- ✓ For the fiscal year 2009/2010 the total number of medication incidents reported at WRH was **337.** Of the total WRH incidents reported, 139 (41%) were incidents generated from the high alert medications: anticoagulant (27), chemotherapy (26), insulin (28) and narcotics (58).
- ✓ For fiscal 2010/2011 year to date WRH has reported **134** incidents with 52 (39%) incidents generated from the high alert medications: anticoagulants (10); chemotherapy (8); insulin (15) and narcotics (18).

Medication Reconciliation Errors Resulting in Medication Errors

- ✓ Most systems for measuring medication incidents rely on voluntary reporting of errors and near miss events. Studies have shown that even in good systems, voluntary reporting only captures the 'tip of the iceberg'. At WRH Risk Monitor Pro software is utilized to report medication incidents.

- ✓ Medication reconciliations have been in process for four years. We were relying on audits done by Pharmacists after the admission and we were tracking the number of errors per audit. For two years we consistently found 2.2 errors per audit on average.
- ✓ We are now in the process of rolling out a new CMAR and with that a discharge and transfer form that will extend medication reconciliation to the discharge and transfer process, as well as on admission.
- ✓ We are starting to do medication reconciliation in the Cancer Clinic Outpatient area also.
- ✓ We are developing a campaign and working with the Paramedics to educate the public on the importance of a "Best Possible Medication History (BPMH)" on admission to prevent medication errors and to help with plans for discharge and transfer.
- ✓ The errors that are found due to medication reconciliation are now counted in the indicator above to prevent double counting as they all still go through the Risk Monitor Pro system.
- ✓ This work takes a very committed team of Physicians, Pharmacists, Pharmacy Techs and Nursing staff.

HSMR

- ✓ The WRH 2007 HSMR results of 133 showed Windsor Regional Hospital at an uncharacteristically high number of actual deaths compared to expected deaths and the response was to make excuses: "Our patients are sicker than others", "we have a cancer program and the formula is faulty".
- ✓ The high HSMR was a signal that inpatient deaths, and the processes that affect it, needed to be reviewed.
- ✓ It became our goal to create a distinctive approach to mortality that would not only impact our HSMR but our overall quality of care. We began by creating awareness for all staff about HSMR, what the results meant and how the hospital was going to address mortality moving forward.
- ✓ Decision Support, Health Records, Physicians and all Clinical Leadership were brought together to establish working groups for improvement, strengthen accountabilities of the MQA members and facilitate collaborative relationships between services and departments.
- ✓ Over the past two years, we have achieved the following successes: • Implementation of concurrent mortality reviews for all deaths; • Ongoing education sessions for Clinicians; • Roll-out of Acuity Summary Form, which is a multi-disciplinary, multi-service, documentation tool to aid in communication of inpatient cases; • Ongoing provision of real inpatient examples with both optimal and suboptimal outcomes; • Improved protocols for end of life care, advanced directives and sepsis management; and • Bi-annual mortality and morbidity rounds.
- ✓ Overall, our actions have shown an increase in documentation compliance, improvement of mortality-related outcomes, and ultimately a decrease in the HSMR for both 2009-2010 at 101 and 2010-2011 at 81.

Patient Satisfaction Rating

- ✓ Windsor Regional Hospital has been engaged with the collection and reporting of NRC Picker data since 2006. The data from the survey conducted serves as one of the primary sources of information related to how our patients view their hospital experience.
- ✓ Results over the years have improved as we compare ourselves to other large community hospitals. WRH's overall patient satisfaction scores have improved from the high 80's to the most recent score of 95.7.
- ✓ Improvements have been noted in each of the clinical areas including: Emergency, Surgery, Medicine, Paediatrics, Maternal Newborn and Rehabilitation
- ✓ The Patient Satisfaction results are reported monthly as part of the Quality of Care scorecard.
- ✓ The most recent work has been aimed at identifying those episodes of care, as reported by NRC Picker, that are below the overall corporate average of 95% .
- ✓ Based on this analysis, the top three areas for improvement in descending order are: emotional support, patient preferences and physical comfort.
- ✓ The target for the next 12 months is to improve the emotional support being provided to our patients by a minimum of 15% for each clinical program. The goal is to attain perfection with 100% patient satisfaction with the emotional support they have received.
- ✓ The key to making the improvements being targeted will be the engagement of patients and families during their stay to better meet their emotional needs in "real time".

ER Length of Stay
EDLOS – Admitted

- ✓ The process improvement team leading this initiative stated it best, "We need to put the passion back into compassion" as stated in our Mission Statement. The demand for Emergency Room services has increased by 16% since 2007/08, leading to long wait times and potentially unsafe situations. During 2010/11, 72,000 patients were seen in the ED at WRH with approximately 15% of these patients being admitted. The average Physician Initial Assessment (PIA) time during 2010/11 was 288 minutes (4.8 hours). This reflects the average time it takes for a patient to see a Physician or Practioniers. Currently (April 1 to August 31, 2011), the PIA time is at 4.9 hours at WRH.
- ✓ For high acuity patients with an ED wait time of six or more hours, the risk of death was 79% higher and of hospitalization 95% higher when compared to a wait time of one hour. Even for low acuity, less sick patients, the relative risk of death was 71% higher and of hospitalization 66% higher for ED shifts that had wait times of six hours or more. Reducing adverse events attributable to long wait times among patients who go home is probably best achieved by reducing the overall length of stay in EDs for all patients, rather than targeting for review or follow-up those patients who leave without being seen. (www.ices.on.ca).
- ✓ At the 90th percentile, average EDLOS for admitted patients at WRH was 21.90 hours. This is significantly higher than the established 8 hour benchmark. We need to get the right patient in the right bed since patients that are held in the ED often don't have a Physician caring for them and the Nursing staff are focused on the emergent patients. As described by IHI, unnecessary delays can contribute to poor medical outcomes, frustrated

and unhappy patients, increased cost from waste and rework, increased harm and a lower quality of work life for staff. Currently at WRH, from April 1 to August 31, 2011, the EDLOS for admitted patients is 22.6 hours. Reducing the length of time that patients spend in the ED is a complex, systems issue that can't be solved by focusing solely on the ED.

- ✓ The high acuity (CTAS 1-3) patient volumes during 2010/11 accounted for 72% of the patients seen through the ED. During 2010/11, at the 90th percentile, the high acuity, non-admitted patients had an average EDLOS of 7.7 hours. Currently (from April 1 to August 31, 2011), the EDLOS for this patient type is 8.0 hours. This leads to a lack of proper flow for patients through the Emergency Room and can often lead to the sickest patients waiting to be seen, with only minimal level of care initiated. These patients often require multiple, time consuming investigations.
- ✓ The low acuity (CTAS 4-5) patient volume has increased by 16% from 2009/10 to 2010/11. During this time, WRH had an average EDLOS for these patients, at the 90th percentile of 4.2 hours. Currently (from April 1 to August 31, 2011), the EDLOS for this patient type is 4.5 hours. The ambulatory hall is meant to be a fast paced, high patient turnover area for 'treat and release' type of concerns. Increasing complaints and patient dissatisfaction are being received as patients are experiencing increasing wait times for non-complicated interventions. The most recent ED satisfaction scores (January to March 2011) have dropped to 55.7% (positive scores) from 64.6% the previous period. The majority of the comments make reference to the wait as a source of dissatisfaction.
- ✓ Our overall goals are :
    1. To create a 'pull' system for ED admitted patients with zero delay from ED to any unit.
    2. To ensure a PIA time that is within 30 minutes of any patient's arrival time.
    3. To improve patient satisfaction scores to 100%.

Discharge by 1100 and 1400 hours

- ✓ On average, Windsor Regional Hospital requires at least twenty two (22) discharges per day to facilitate planned patient admissions; accommodate Emergency Room patient admissions and quality of stay. Ensuring that adequate numbers of patients are discharged before 1100 and 1400 is designed to support patient flow and ensure our patient's safety. For their safety, it is important to have ***patients in the right place and at the right time and ensure they are cared for by the right staff.***
- ✓ In April 2010 the overall proportion of Windsor Regional patients discharged before 1100 is 20% and by 1400 is 68%. As of December 2010 the proportion of Windsor Regional patients discharged before 1100 is 28% and by 1400 is 63%. This continues to be inadequate to support and facilitate flow and capacity at peak time and is resulting in:

    - Increased lengths of stay for acutely ill patients in ED waiting for an inpatient bed,
    - Increased waits for ED patients to be seen in the ED,
    - Greater than ED Holds > 5 each day,
    - Patient dissatisfaction,
    - Poses a risk of postponing inpatient surgeries,

- Patient quality and safety concerns such as increased mortality and morbidity,
- Potential financial impact for not meeting ED P4P, and
- Increased numbers of patients waiting for an alternative level of care discharge destination.

✓ Effective discharge and planning for admissions are key priorities of Windsor Regional Hospital in order to:
- Provide the best possible patient outcomes and experiences,
- Ensure patient safety,
- Promote appropriate bed utilization, and
- Ensue effective use of our resources.

✓ Windsor Regional Hospital is committed to ensuring that patients are **discharged safely and in a timely fashion**, once medically fit, to an appropriate location.

Cost Per Weighted Case

✓ Windsor Regional Hospital was in a very poor position as it related to cost per weighted case as far back as 2006 where the hospital results were between 13% and 14% above the provincial average.

✓ There were multiple reasons/excuses for this poor performance including the belief that our patients were sicker and needed more hours of care and testing.

✓ There was also an underlying lack of knowledge and understanding about the concept of cost per weighted case and how, as an organization, it could take hold of the issue and resolve it.

✓ Key to turning the situation around was the sharing of the impact of our poor results when working with the LHIN and/or MOHLTC and how, as an organization, we were viewed as inefficient. We cost more money to deliver the services than almost every other hospital in the Province.

✓ We partnered with an external organization (HealthCare Management) to provide education sessions with the Board of Directors, Senior Leadership, Directors, Managers and Physicians to ensure a common understanding of the issues and to develop a common plan to address and resolve these issues.

✓ A number of decisions were made and strategies implemented. The most significant strategy was was the corporate investment in a Utilization Management Team composed of utilization review nurses and a Physician Advisor whose primary responsibility it is to ensure patients are admitted appropriately, have their acute care managed efficiently and are discharged within expected lengths of stay.

✓ A number of tools were developed for use across the organization including the Acuity Summary Sheet, a tool also used to improve HSMR, and multiple Length of Stay tracking tools.

✓ WRH now has an electronic UM tool that was implemented in April 2010. The Hospital was instrumental in having the tool adopted by all 5 hospitals within the ESC LHIN.

✓ WRH's cost per weighted case percentages decreased from this point forward and steadily over the past 5 years.

✓ As a result of ensuring acute care services and treatment are being provided as required and in a timely fashion, the 2010 – 2011 fiscal years results show WRH at slightly under 1% cost per weighted case.

Patient Safety Culture

- ✓ WRH strives to have a patient safety culture embedded in its daily activities knowing that every patient, at any time, any day will be safe and receive the same level of outstanding care.
- ✓ The team administered a Patient Safety Culture survey to several units during 2010/2011 to determine areas of strength and where improvement initiatives should be focused.
- ✓ Results of this survey showed where improvement is required. One identified area was the impact and presence of Senior Leadership in providing a work climate that promotes patient safety and shows that patient safety is a top priority (37% positive response rate).
- ✓ Currently the team is completing their examination of data and feedback from various sources including results from the recent Accreditation Patient Safety Culture Survey.
- ✓ Next steps: Conduct a gap analysis and then develop action plans based on priorities.
- ✓ It is likely that initial actions will focus on strategies related to Senior Leadership support including focused rounding/leadership walkabouts.

To view WRH's current results in the above indicators go to http://www.wrh.on.ca/Site_Published/wrh_internet/RichText.aspx?Body.QueryId.Id=39608&LeftNav.QueryId.Categories=736

Strategic Direction – Strengthen our Relationships with External Partners

Toldo Specialized Mental Health Hospital Opening

- ➢ Commencing November 15, 2011 we started to accept the transfer of patients from London to the Toldo Specialized Mental Health Hospital.

- ➢ Windsor Regional Hospital will continue to increase admissions to the Hospital on a systematic/preplanned basis, to ensure the safety of the patients and staff is paramount. Immediately staffing and populating the facility to 59 beds is not in the best interests of the patients or staff.

- ➢ I want to thank all of our partners – Hôtel-Dieu Grace Hospital, Leamington District Memorial Hospital and Chatham Kent Health Alliance in understanding this process and working in partnership to ensure a safe transition.