2015/16 Quality Improvement Plan for Ontario Hospitals
"Improvement Targets and Initiatives"

Windsor Regional Hospital 1995 Lens Avenue

AIM		Measure							Change				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
Access	Reduce wait times in the ED	ED Wait times: 90th percentile ED length of stay for Admitted patients.	Hours / ED patients	CCO iPort Access / Jan 1, 2014 - Dec 31, 2014	1079*	25.17	20.9	Provincial target is 25 hours. This target is very important to funding. Push to	1)•Focus on maintaining ED admission rates at 10% or lower to increase ED capacity and performance and improved bed	•Daily tracking of admission rates with weekly and monthly reporting and tracking hospital wide with dedicated indicator team monitoring progress daily and reporting weekly. •Monitor flow across all inpatient units and increase percentage of discharges	•Daily tracking of admissions, discharges, ED holds and ALC's. •Weekly tracking of indicators reviewed with leadership and frontline with weekly action items responding to unmet target • Weekly tracking of percentage of discharges before 1100 and 1400	•10% ED admissions rate each month •90th % LOS for admitted patients	
		ED Wait times: 90th percentile ED length of stay for Admitted patients.	Hours / ED patients	CCO iPort Access / Jan 1, 2014 - Dec 31, 2014	4773*	28.63	20.9	Provincial target is 25 hours. This target is very important to funding. Push to	1)•Focus on maintaining ED admission rates at 10% or lower to increase ED LOS and capacity and improved bed utilization across both	•Daily tracking of admission rates with weekly and monthly reporting and tracking hospital wide with dedicated indicator team monitoring progress daily and reporting weekly. •Monitor flow across all inpatient units and increase percentage of discharges	•Daily tracking of admissions, discharges, ED holds and ALC's. •Weekly tracking of indicators reviewed with leadership and frontline with weekly action items responding to unmet target • Weekly tracking of percentage of discharges before 1100 and 1400	•10% ED admissions rate each month •90th % LOS for admitted patients	
Effectiveness	Improve organizational financial health	Total Margin (consolidated): % by which total corporate (consolidated)	% / N/a	OHRS, MOH / Q3 FY 2014/15 (cumulative from April 1, 2014 to December 31,	933*	0.56	2	Requires a balanced budget before net building amortization	1)•Continue annual benchmarking to peer hospitals. • Maintain cost control of operations across both sites as a result	•Ongoing monitoring and tracking of performance targets across departments, services and physicians. •Accurate and timely financial reports and monitoring of variances. • Monthly departmental review with leadership team. •HBAM/OBP monthly/quarterly	•Monthly Financial Scorecard. •Provide services and physicians with monthly results on LOS, as well comparisons, and improvements using clinical documentation templates. Standardize reporting across two sites as a result of Oct 1, 2013 realignment.	•Balanced budget and actual results. •Improve LOS to 25th percentile of peers at the Met	
	Reduce unnecessary deaths in hospitals	HSMR: Number of observed deaths/number of expected deaths x 100.	Ratio (No unit) / All patients	DAD, CIHI / April 1, 2013 to March 31, 2014	1079*	84	95	A value of 100 represents an average value of hospital mortality. Our	1)•Continue with established auditing process for patient mortality and morbidity reviews. •Continue to	•Each MD service to complete quarterly chart reviews and report findings to Medical Quality Assurance Committee. •Continue monthly auditing process to review compliance with acuity summary sheet completion and dictated discharge summary	•The number of MD charts reviewed by service • Percent of compliance with completed Discharge Summary and Acuity Summary forms. •Percent of compliance with individual chart reviews with quarterly auditing process.	100% compliance/service with quarterly audits. •80% completion of	
		HSMR: Number of observed deaths/number of expected deaths x 100.	Ratio (No unit) / All patients	DAD, CIHI / April 1, 2013 to March 31, 2014	4773*	95	95	A value of 100 represents an average value of hospital mortality. Our	1)•Continue with established auditing process for patient mortality and morbidity reviews. •Continue to	•Each MD service to complete quarterly chart reviews and report findings to Medical Quality Assurance Committee. •Initiate monthly auditing process to review compliance with acuity summary form and dictated discharge summary (within 7 days)	•The number of MD chart reviews by service • Percent of compliance with completed Discharge Summary and Acuity Summary forms. •Percent of compliance with individual chart reviews with quarterly auditing process.	100% compliance/service with quarterly chart audits. 60% completion of	
Integrated	Reduce unnecessary time spent in acute care	Percentage ALC days: Total number of acute inpatient days designated as ALC, divided by the total	% / All acute patients	Ministry of Health Portal / Oct 1, 2013 - Sept 30, 2014	1079*	14.71	12	Province ranges from 10 % to 25%. Aim is to be close to the provincial target	1)•Continue collaboration with CCAC ESCLHIN in the implementation of Home First Strategies to facilitate placement of ALC patients	•Conduct weekly complex discharge rounds with hospital Utilization team, social work and CCAC case managers in identifying barriers to discharge for patients with complex issues. • Conduct coordinated integrated care planning and discharge planning	• The number of patients admitted per day. •The percent of ED admissions per day • The number of discharges each day •The number of patients designated ALC each day by destination • The number of ALC patients discharged/day by destination• The	• Reduction in the # of patients admitted per day • 5% reduction overall in the	
		Percentage ALC days: Total number of acute inpatient days designated as ALC, divided by the total	% / All acute patients	Ministry of Health Portal / Oct 1, 2013 - Sept 30, 2014	4773*	22.07	12	Province ranges from 10 % to 25%. Aim is to be close to the provincial target	1)•Continue collaboration with CCAC ESCLHIN in the implementation of Home First Strategies to facilitate placement of ALC patients	•Conduct weekly complex discharge rounds with hospital Utilization team, social work and CCAC case managers in identifying barriers to discharge for patients with complex issues. • Conduct coordinated integrated care planning and discharge planning	• The number of patients admitted per day. •The percent of ED admissions per day • The number of discharges each day •The number of patients designated ALC each day by destination • The number of ALC patients discharged/day by destination• The	• Reduction in the # of patients admitted per day • 5% reduction overall in the	
	Reduce unnecessary hospital readmission	Readmission within 30 days for Selected Case Mix Groups	% / All acute patients	DAD, CIHI / July 1, 2013 - Jun 30, 2014	1079*		16	Targeting 30 day readmissions for selected CMG's, CHF and COPD supports the	1)•Focusing on and creating unique process to address populations that return to hospital frequently by implementing	Audit key steps in the pathway to ensure adherence i.e. Order set utilization, CCAC on discharge, follow-up appointment •Standardized Order Set in ED •Standardized patient education package developed promoting self-management and providing effective	•% of order set utilized; •% of patients received CCAC consult and/or referral; •% of CHF and COPD patients will have a follow-up appointment with MD •% of staff receiving education program . • Monthly tracking of OBP scorecard.	•90% of order set utilized on pilot unit; •95% of patients received CCAC consult	
		Readmission within 30 days for Selected Case Mix Groups	% / All acute patients	DAD, CIHI / July 1, 2013 - Jun 30, 2014	4773*		16	Targeting 30 day readmissions for selected CMG's, CHF and COPD supports the	1)•Focusing on and creating unique process to address populations that return to hospital frequently by implementing	Audit key steps in the pathway to ensure adherence i.e. Order set utilization, CCAC on discharge, follow-up appointment •Standardized Order Set in ED •Standardized patient education package developed promoting self-management and providing effective	•% of order set utilized; •% of patients received CCAC consult and/or referral; •% of CHF and COPD patients will have a follow-up appointment with MD •% of staff receiving education program . • Monthly tracking of OBP scorecard.	•90% of order set utilized on pilot unit; •95% of patients received CCAC consult	
Patient-centred	Improve patient satisfaction	From NRC Canada: "Overall, how would you rate the care and services you received at the hospital	% / All patients	NRC Picker / October 2013 - September 2014	1079*	94.13	96.4	This target is based on the established benchmark set for Select QIP	1)Improve on existing overall patient satisfaction scores by engaging and working with patients to help deliver health care	●Report monthly and quarterly NRC Picker results •'WellCome Mat' Program allows volunteers to meet with newly admitted patients to orient them and their loved ones to the hospital •Introduce exit survey on the patient television's to provide immediate	•% or greater overall satisfaction •Measure response rate to NRC Picker● % completion of AIDET training by staff and volunteers ●Patient advocate office to track and monitor all patient complaints and acknowledgments to ensure follow-up ● %	95 % or greater overall satisfaction •10% increase in response rate with TV prompting	

		From NRC Canada: "Overall, how would you rate the care and services you received at the hospital	% / All patients	NRC Picker / October 2013 - September 2014	4773*	91.63	96.4	This target is based on the established benchmark set for Select QIP	1)Improve on existing overall patient satisfaction scores by engaging and working with patients to help deliver health care	●Report monthly and quarterly NRC Picker results •'WellCome Mat' Program allows volunteers to meet with newly admitted patients to orient them and their loved ones to the hospital •Introduce exit survey on the patient television's to provide immediate	•% or greater overall satisfaction •Measure response rate to NRC Picker● % completion of AIDET training by staff and volunteers ●Patient advocate office to track and monitor all patient complaints and acknowledgments to ensure follow-up ● %	•95 % or greater overall satisfaction •10% increase in response rate with TV prompting	
		From NRC Canada: "Overall, how would you rate the care and services you received at the ED?" (add	% / ED patients	NRC Picker / October 2013 - September 2014	1079*	79.4	91.8	This target is based on the established benchmark set for Select QIP	1)●Sustain and improve on existing overall patient satisfaction scores •As a result of realignment on October 1, 2013, continue	●Report monthly and quarterly NRC Picker results •WellCome Mat Program allows volunteers to meet with newly admitted patients to orient them and their loved ones to the hospital •Introduce exit survey on the patient TY's to provide immediate feedback on	•% or greater overall satisfaction •Measure response rate to NRC Picker	• 91.8% or greater overall satisfaction •10% increase in response rate with TV prompting	
		From NRC Canada: "Overall, how would you rate the care and services you received at the ED?" (add	% / ED patients	NRC Picker / October 2013 - September 2014	4773*	81.56	91.8	This target is based on the established benchmark set for Select QIP	1)●Sustain and improve on existing overall patient satisfaction scores •As a result of realignment on October 1, 2013, continue	Report monthly and quarterly NRC Picker results •WellCome Mat Program allows volunteers to meet with newly admitted patients to orient them and their loved ones to the hospital •Introduce exit survey on the patient TY's to provide immediate feedback on	•% or greater overall satisfaction •Measure response rate to NRC Picker	• 91.8% or greater overall satisfaction •10% increase in response rate with TV prompting	
Safety	Increase proportion of patients receiving medication reconciliation upon admission	Medication reconciliation at admission: The total number of patients with medications	% / All patients	Hospital collected data / most recent quarter available	1079*	24.1	55	Baseline being established with data for Q3 2013 to be able to determine	1)• Introduce aligned process/documentation across both campuses to increase compliance by ensuring the	•Pharmacists will lead Medication Reconciliation for all newly admitted patients to Med/Surg units. •Audit results with monthly documentation of medication reconciliation completions per program and educate staff who are under target	•% of med Surg patients assessed by a pharmacist •% of patients with a documented BPMH	•2 MedRecs per day per pharmacist to achieve 55% consults on all	
		Medication reconciliation at admission: The total number of patients with medications	% / All patients	Hospital collected data / most recent quarter available	4773*	44.2	50	Baseline being established with data for Q3 2013 to be able to determine	1)• Introduce aligned process/documentation across both campuses to increase compliance by ensuring the	•Pharmacists will lead Medication Reconciliation for all newly admitted patients to Med/Surg units. •Audit results with monthly documentation of medication reconciliation completions per program and educate staff who are under target	•% of med Surg patients assessed by a pharmacist •% of patients with a documented BPMH	•2 MedRecs per day per pharmacist to achieve 55% consults on all	
	Reduce hospital acquired infection rates	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / Jan 1, 2014 - Dec 31, 2014	1079*	0.44	0.25	Current performance exceeds 10th percentile (0.25/1000 pt.	1)● Monitor use of Clorox products for cleaning CDI patient rooms and equipment corporate wide •Continue investigations of	●Daily leadership rounding by ops/CPM/c's for appropriate supplies/cleaning of equipment ● Housekeeping audits conducted by supervisors-(tracer audits)● Conduct HAI investigation meetings weekly ● Roll out aligned Corporate Human Waste	● % compliance with Leadership Rounding reported weekly on MMH (include Clorox and HWM)● % compliance Clorox patient room cleaning reported on tracer audits● % compliance with c diff HAI investigations	●100% compliance with the use of Clorox in CDI cases as per tracer audits/month and	
		CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / Jan 1, 2014 - Dec 31, 2014	4773*	0.56	0.25	Current performance exceeds 10th percentile (0.25/1000 pt.	1)● Monitor use of Clorox products for cleaning CDI patient rooms and equipment corporate wide •Continue investigations of	●Daily leadership rounding by ops/CPM/c's for appropriate supplies/cleaning of equipment ● Housekeeping audits conducted by supervisors-(tracer audits)● Conduct HAI investigation meetings weekly ● Roll out aligned Corporate Human Waste	● % compliance with Leadership Rounding reported weekly on MMH (include Clorox and HWM)● % compliance Clorox patient room cleaning reported on tracer audits● % compliance with c diff HAI investigations	●100% compliance with the use of Clorox in CDI cases as per tracer audits/month and	
		Hand hygiene compliance before patient contact: The number of times that hand hygiene was	% / Health providers in the entire facility	Publicly Reported, MOH / Jan 1, 2014 - Dec, 31, 2014	1079*	97	97	Close to theoretical best (100%) as WRH tracks and reports all 4	1)●Continue best practice hand hygiene auditing with real-time feedback to staff/visitors/etc. ●Educate patients and visitors	● Conduct hand hygiene audits target 30 audits per week per unit ● 2x4 campaign, leadership rounding verification knowledge re: HH requirements ● Support provided by IPAC for use of HH Devices and reports ● Monthly training available for JCYH HH	● Reduction in MRSA, VRE and C diff rates ● % compliance overall with the 4 moments of hand hygiene ●# of hand hygiene audits conducted weekly ● % of HH Auditors with access to an electronic hospital device set up ● % of programs with	● Reduce MRSA, VRE and C diff rates to below target ● >95% compliance overall	
		Hand hygiene compliance before patient contact: The number of times that hand hygiene was	% / Health providers in the entire facility	Publicly Reported, MOH / Jan 1, 2014 - Dec, 31, 2014	4773*	90	95	Close to theoretical best and increased target from 90% that was set in	1)●Continue best practice hand hygiene auditing with real-time feedback to staff/visitors/etc. ●Educate patients and visitors	● Conduct hand hygiene audits target 30 audits per week per unit ● 2x4 campaign, leadership rounding verification knowledge re: HH requirements ● Support provided by IPAC for use of HH Devices and reports ● Monthly training available for JCYH HH	● Reduction in MRSA, VRE and C diff rates ● % compliance overall with the 4 moments of hand hygiene ●# of hand hygiene audits conducted weekly ● % of HH Auditors with access to an electronic hospital device set up ● % of programs with	● Reduce MRSA, VRE and C diff rates to below target ● >95% compliance overall	
		VAP rate per 1,000 ventilator days: the total number of newly diagnosed VAP cases in the ICU after	Rate per 1,000 ventilator days / ICU patients	Publicly Reported, MOH / Jan 1, 2014 - Dec 31, 2014	1079*	X	0	Achieve 100% reduction in VAP incidence and achieve theoretical best	1)•Ensure Safer Health Care Now (SHCN) best practices for VAP maintained• Ongoing audits for compliance to	•Ensure compliance with the 5 key components and additional evidence based components of the VAP bundle	•% compliance with VAP Bundle	100% compliance with VAP Bundle	
		VAP rate per 1,000 ventilator days: the total number of newly diagnosed VAP cases in the ICU after	Rate per 1,000 ventilator days / ICU patients	Publicly Reported, MOH / Jan 1, 2014 - Dec 31, 2014	4773*	0	0	Maintain established target of best achieved in Ontario (0%).	1)•Ensure Safer Health Care Now (SHCN) best practices for VAP maintained• Ongoing audits for compliance to	•Ensure compliance with the 5 key components and additional evidence based components of the VAP bundle	•% compliance with VAP Bundle	100% compliance with VAP Bundle	
		Rate of central line blood stream infections per 1,000 central line days: total number of	Rate per 1,000 central line days / ICU patients	Publicly Reported, MOH / Jan 1, 2014 - Dec 31, 2014	1079*	X	0	Achieve best to date in Ontario (0%). 0.40 is provincial average for large	1)•Ensure Safer Health Care Now (SHCN) best practices for central line insertion and maintenance are maintained.	• Ensure compliance with all components of insertion and maintenance bundles	• % compliance with insertion bundle guidelines •% compliance with Maintenance Bundle Guidelines	• 100% compliance with insertion bundle guidelines • 100% compliance with	
		Rate of central line blood stream infections per 1,000 central line days: total number of	Rate per 1,000 central line days / ICU patients	Publicly Reported, MOH / Jan 1, 2014 - Dec 31, 2014	4773*	X	0	Maintain established target of best to date in Ontario and theoretical	1)•Ensure Safer Health Care Now (SHCN) best practices for central line insertion and maintenance are maintained.	• Ensure compliance with all components of insertion and maintenance bundles	• % compliance with insertion bundle guidelines •% compliance with Maintenance Bundle Guidelines	• 100% compliance with insertion bundle guidelines • 100% compliance with	

	Avoid Patient falls	This is not an indicator identified for acute care. WRH has identified this as a priority and has	Rate per 1,000 patient days / All acute patients	Hospital collected data / F2014/15 Q2	1079*	0.08	0.07	Continue to improve on target which was based on yearly	1)•Continue with Fall Prevention Program including Fall Prevention And Comfort Round Bundles developed in	●Continue to educate best practice to new staff and students ● Provide ongoing staff education and training regarding Fall Prevention and Confront Round Bundle methodology● Track and report fall with injury rate weekly and monthly and ensure high risk	• Educate the majority of nursing staff by completing the Falls and Comfort Round Bundle Training & Education. • Conduct Falls Road Show on all of units with a fall with injury •Conduct Root Cause Analysis with management and front line staff on all falls with	Sustain fall with injury rate to .07. At the Metropolitan campus 90% of	
		This is not an indicator identified for acute care. WRH has identified this as a priority and has	Rate per 1,000 patient days / All acute patients	Hospital collected data / F2014/15 Q2	4773*	0.17	0.12	Continue to improve on target which was based on yearly	1)•Continue with Fall Prevention Program including Fall Prevention And Comfort Round Bundles developed in	●Continue to educate best practice to new staff and students ● Complete staff education and training regarding Fall Prevention and Comfort Round Bundle methodology to staff on all Surgery and Medicine Units● Roll out specialized Fall Prevention Assessment	• Monitor and track fall and fall with injury rate in all Surgical and Medicine units pre and post Fall Prevention and Comfort Round Bundle education and training •Weekly tracking and monitoring of fall indicators •Audit patient charts to ensure compliance	•Percentage decrease in fall with injury rate overall • Weekly tracking of falls	
	Reduce use of physical restraints in Mental Health	Physical Restraints: Number of admission assessments where restraint use occurred in last 3	% / All patients	OMHRS, CIHI / Oct 1, 2013 - Sep 30, 2014	4773*	3.98	2.3	Stay below provincial target of 4.7% (2012 provincial data). Current	1)●Enforce least restraint policy for psychiatric patients	●Select and implement a standardized admission risk assessment tool in the Mental Health Program. ●develop and implement multidisciplinary care plans ●implementation of multidisciplinary care rounds to review patient risk factors ●review and update crisis	Tracking of restraint application in daily nursing flow charting, % of physical restraint use in the selected time frame	100% of patients to be assessed upon admission with standardized assessment tool,	