2016/17 Quality Improvement Plan
"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
Effective	**Reduce 30 day readmission rates for select HIGs**	Percentage of acute hospital inpatients discharged with selected HBAM Inpatient Grouper (HIG) that are readmitted to any acute inpatient hospital for non-elective patient care within 30 days of the discharge for index admission.	% / All acute patients	DAD, CIHI / July 2014 – June 2015	933*	15.01	14.26	Targeting 30 day readmissions for selected CMG's: Acute Myocardial Infarction, Cardiac conditions, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Pneumonia, Diabetes, Stroke and Gastrointestinal Disease. These also support the ESCLHIN chronic disease management initiatives overall. Our target is a 5% reduction from the current performance and is below the expected target identified for CY2014 at 17.72%.	1)•Focusing on and creating unique process to address populations that return to hospital frequently by implementing a standardized care pathway to guide care from admission in the Emergency Department to discharge and beyond for selected HIG's • Utilize appropriate risk assessment to prospectively identify patients who might benefit from more intense post discharge care • Conduct coordinated individualized discharge planning • Ensure collaboration with the CCAC to ensure community nursing support for patient once discharged from acute care. • Standardization of processes across both acute care sites continues with realignment of programs and services	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 education to the patient and caregiver (used for inpatients and community patient education for continuity) • Provide training for nurses on the new care pathway and patient education materials on selected units•Automatic referral to CCAC for follow-up post discharge • Appointment with Primary Care Provider scheduled for the patient prior to discharge . • QBP oversight and multidisciplinary select committees to oversee monthly progress for all QBP's	•% 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 volume, LOS, and selected quality indicators across all QBP's	•90% of order set utilized on pilot unit; •95% of patients received CCAC consult and/or referral; •100% of CHF and COPD patients will have a follow-up appointment with MD •100% of staff on designated units to receive education program	
	Reduce readmission rates for patients with CHF	Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with CHF (QBP cohort)	% / CHF QBP Cohort	DAD, CIHI / January 2014 – December 2014	933*	22.96	21.81	Target represents 5% reduction from current performance which is below the provincial expected readmission rate CY 2014 at 23.45%	1)Multidisciplinary team meets monthly to review readmission rates and overall CHF QBP scorecard and indicators. QBP senior level oversight committee reviews monthly.	Monthly tracking of key QBP indicators. Weekly tracking of crude readmissions and chart review by multidisciplinary team and physician for any 1 to 7 day readmission for CHF. Standardization of order sets between campuses.	30 day readmission rate; weekly 1 to 7 day readmission review; order set utilization; LOS for CHF, in hospital mortality, post discharge physician follow-up, CCAC home support with telemedicine post discharge	Provincial expected rate for CHF; 0% of 1 to 7 day readmissions; 90% order set utilization;	
	Reduce readmission rates for patients with COPD	Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with COPD (QBP cohort)	% / COPD QBP Cohort	DAD, CIHI / January 2014 – December 2014	933*	22.94	21.24	Target represents provincial expected readmission rate for COPD CY 2014 at 21.24%	1)Multidisciplinary team meets monthly to review readmission rates and overall COPD QBP scorecard and indicators. QBP senior level oversight committee reviews monthly. Physician representation includes Family Medicine, Internal Medicine and Respirology and multidisciplinary team includes nursing, respiratory therapy, CCAC, and decision support.	Monthly tracking of key QBP indicators. Weekly tracking of crude readmissions and chart review by multidisciplinary team and physician for any 1 to 7 day readmission for COPD. Standardization of order sets between campuses. Increase ED compliance with Respiratory Therapy support. CCAC ongoing monitoring of telemedicine utilization and Rapid Response Team	30 day readmission rate; weekly 1 to 7 day readmission review; order set utilization; BIPAP utilization in the Emergency Department; LOS for COPD, in hospital mortality, post discharge physician follow-up, CCAC home support with telemedicine post discharge	Provincial expected rate for COPD; 0% of 1 to 7 day readmissions; 90% order set utilization;	
	Reduce readmission rates for Stroke patients	Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with Stroke (QBP cohort)	% / Stroke QBP Cohort	DAD, CIHI / January 2014 – December 2014	933*	9.67	8.76	Target used represents provincial expected readmission rate for CY2014 at 8.76%	1)Multidisciplinary team meets monthly to review readmission rates and overall Stroke QBP scorecard and indicators. QBP senior level oversight committee reviews monthly. Collaboration with inpatient stroke unit to help prevent complications and prevent readmission as well as support access to appropriate rehab programming (inpatient or in the community).	Monthly tracking of key QBP indicators. Weekly tracking of crude readmissions and chart review by multidisciplinary team and physician for any 30 day readmission for Stroke. Standardization of order sets between campuses. Reduce unnecessary time in acute care.	30 day readmission rate; order set utilization; LOS for Stroke, in hospital mortality, post discharge sub acute care; CCAC home support with telemedicine post discharge	Provincial expected rate for Stroke	
	Reduce unnecessary deaths in hospital	Hospital Standardized Mortality Ratio (HSMR)	Number of observed deaths divided by the number of expected deaths multiplied by 100. / All patients	CIHI / CY2015	933*	104	96.00	A value of 96 represents an average value of hospital mortality. Our goal is to continue to perform better than the national/provincial average. More recent data (based on CIHI results) is 102. This is an important indicator to WRH and therefore remains on this year's QIP	1)•Continue with established auditing process for patient mortality and morbidity reviews. •Continue to monitor and track physician documentation compliance indicators established by Medical Quality Assurance Committee monthly. •Conduct QCIPA's with physician, administration and front line staff participation to review unusual events .• Conduct and track daily leadership rounding and comfort care rounds to ensure patient needs are being met and timely response to deteriorating condition.	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 completion of chart deficiencies. Continue with standardizing process and practice across the two campuses. •Monitor and track performance and quality indicators and report back to committees.• Review record level data (internal and CIHI level data)and compare departmental, diagnostic and physician variances.	•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. Monthly comparison of HSMR results by department, diagnosis and physician. Conduct record level reviews as needed	100% compliance/service with quarterly audits. •80% completion of Acuity Summary across all services across two sites. •80% completion of dictated discharge summary across all services. •0 deficiencies beyond 60 days for each physician. 5% improvement in overall HSMR	
Efficient	**Reduce unnecessary time spent in acute care**	Total number of ALC inpatient days contributed by ALC patients within the specific reporting period (open, discharged and discontinued cases), divided by the total number of patient days for open, discharged and discontinued cases (Bed Census Summary) in the same period.	% / All acute patients	WTIS, CCO, BCS, MOHLTC / July 2015 – September 2015	933*	19	12.70	Province ranges from 10 % to 25%. Aim is to be close to the provincial target (12.7%).	1)•Continue collaboration with CCAC ESCLHIN in the implementation of WRH' New Discharge Planning Policy that reinforces Home First Strategies to facilitate placement of ALC patients and reduce barriers to discharge early in their inpatient stay through the implementation of the Complex Discharge Screener that introduces a CCAC response time within 48 hours of admission and sees an overall ALC reduction strategy and a reduction of ALC to LTC across both sites • Provide timely, patient level data to reduce wait times and provide ongoing daily monitoring and daily tracking of indicators focusing on patient flow across the organization • Develop and apply targeted strategies to individualized discharge planning to continuously decrease ALC patients lengths of stay •Implement regional escalation planning when need exceeds bed capacity.• Monthly monitoring of patient flow indicators across the organization with Medical Directors, senior leadership and Utilization Team.	Conduct weekly complex discharge rounds with hospital Utilization team, social work, CCAC leadership and case managers, and other community support services in identifying barriers to discharge for patients with complex issues. • Conduct coordinated integrated care planning and discharge planning meetings with CCAC and others for those with complex discharge needs• Address barriers to discharge at the patient level with integrated team (SW, CCAC, Utilization) • Educate patients and families about the appropriateness of acute level of services • Monthly review of flow indicators at Corporate Utilization Committee represented by medical Directors, Administration and Utilization	• % of patient seen by CCAC within 48 hours of admission • 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 most appropriate discharge destination • The number of ALC patients discharged/day by destination• The LOS compared to the 25th percentile •Percentage of patients receiving coordinated care planning	• 80% response time by CCAC within 48 hours of admission• Reduction in the # of patients admitted per day • 5% reduction overall in the number of patient declared ALC •100% of patients and/or families provided education about the appropriateness of acute care services •100% of coordinated care planning conducted • 80% attendance at monthly Utilization Committee	

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Patient-centred	Improve patient satisfaction	"Overall, how would you rate the care and services you received at the ED?", add the number of respondents who responded "Excellent", "Very good" and "Good" and divide by number of respondents who registered any response to this question (do not include non-respondents).	% / ED patients	NRC Picker / October 2014 - September 2015	933*	CB	CB	establishing baseline due to utilization of new survey tools	1)utilizing new tools and new methodology	x	x	x	Reporting at the corporate level utilizing the EPES-IC and EDPEC Surveys as new tool.
		"Overall, how would you rate the care and services you received at the hospital?" (inpatient), add the number of respondents who responded "Excellent", "Very good" and "Good" and divide by number of respondents who registered any response to this question (do not include non-respondents).	% / All patients	NRC Picker / October 2014 – September 2015	933*	CB	CB	establishing baseline due to utilization of new survey tools	1)utilizing new tools and new methodology	x	x	x	Reporting at the corporate level utilizing the EPES-IC and EDPEC Surveys as new tool.
		Overall, how would you rate the care and services you received at the ED?	% / ED patients	EDPEC / Oct 2014- Sep 2015	933*	CB	CB	Current performance is 80.10 and is based on previous NRC survey results. As this measurement has changed for 16/17, no direct comparison can be made between the previous results and the new calculation as we are collecting baseline for next year	1)•Improve on existing overall patient satisfaction scores •Continue to standardize practices across both campuses to increase the patients overall experience, such as the Well-come Mat program; the AIDET Training; the service recovery program; the T2B Concierge Program; and patient testimonials; Improved patient flow process introduced at both sites to reduce wait times	•Report monthly and quarterly NRC Picker results •Well-come 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 emotional support component of care ● Continue AIDET Training Seminars for Leadership and frontline staff reinforcing 5 processes: Acknowledge, Introduce, Duration, Explanation, Thank you ● Track each patient complaint and acknowledgment received and the follow-up	•% or greater• overall satisfaction •Measure response rate to NRC Picker	• 91.8% or greater overall satisfaction •10% increase in response rate with TV prompting introduced	Reporting at the corporate level utilizing the EPES-IC and EDPEC Surveys as new tool.
		Overall, how would you rate the care and services you received at the Hospital?	% / All patients	CIHI portal / Oct 2014 - Sep 2015	933*	CB	CB	Current performance is 92.90 and is based on previous NRC survey results. As this measurement has changed for 16/17, no direct comparison can be made between the previous results and the new calculation as we are collecting baseline for next year	1)Improve on existing overall patient satisfaction scores by engaging and working with patients to help deliver health care that is linked to their needs and create a culture where 'compassion is our passion'. •As a result of realignment on October 1, 2013, continue to standardize practices across both campuses to increase the patients overall experience . •Continue roll-out of the 'Well-come program to all medical units • Ongoing communication with patients and visitors using elevator signage, hospital television monitors and patient televisions, Brahms' Lullaby and Lean on Me Songs, volunteers posted at key entrance areas to help with way finding and the President's Welcome Letter to every admitted patient.• Seek immediate feedback from patients through patient advocate office and the above and beyond program• Continue the service recovery program where we make things right after something has gone wrong with the patient's experience. • Continue AIDET Training for all staff . •Invite patients to bring their story to the monthly Quality of Care Meeting of the Board and Leadership	Report monthly and quarterly NRC Picker results •Well-come 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 emotional support component of care ● AIDET Training Seminars for Leadership and frontline staff reinforcing 5 processes: Acknowledge, Introduce, Duration, Explanation and Thank you. Expand to include volunteers, patients and their families	•% 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 acknowledgements to ensure follow-up ● % participation of patients at Quality of Care Meeting	95 % or greater overall satisfaction •10% increase in response rate with TV prompting introduced ●10% of staff to receive AIDET training in one year ●100% compliance with follow-up on patient complaints.	Reporting at the corporate level utilizing the EPES-IC and EDPEC Surveys as new tool.
Safe	Increase proportion of patients receiving medication reconciliation upon admission	Medication reconciliation at admission: The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital	% / All patients	Hospital collected data / most recent quarter available	933*	44.2	50.00	Baseline established with post realignment results using medical surgical patient group and identifying a percentage increase for the following year.	1)• Introduce aligned process/documentation across both campuses due to realignment to increase compliance by ensuring the standardization of practice to obtain the Best Possible Medication History (BPMH), a precursor to effective medication reconciliation compliance •Increase compliance with medication reconciliation education using annual e-learn and new physician orientation •Expand unit-based re-design across both campuses (RPH + tech pair) assigned to Med/Surg units to support timely Med Rec completion •Increase documentation of Med Rec incidents in RL6 (incident reporting program) by pharmacists and nurses •Implement (electronic) transfer orders to improve medication information sent to receiving institution	• Pharmacist located in ED during week days to capture all newly admitted patients •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 Medical Surgical patients assessed by a pharmacist •% of patients with a documented BPMH	2 MedRecs per day per pharmacist to achieve 45% consults on all Med/Surg patients admitted.	
	Reduce hospital acquired infection rates	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI during the reporting period, divided by the number of patient days in the reporting period, multiplied by 1,000.	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / January 2015 – December 2015	933*	0.34	0.25	Current performance exceeds 25th percentile (0.42/1000 pt. days) MoHLTC. Target is based on 25% reduction of current performance	1)Monitor use of Clorox products for cleaning CDI patient rooms and equipment corporate wide •Continue investigations of every incident of hospital acquired infection • Standardize human waste management procedures, i.e. bedpan, commode usage and reprocessing	●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	● % 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 Leadership Rounding ●100% of the units have implemented Clorox products in CDI cases	

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		Number of times that hand hygiene was performed before initial patient contact during the reporting period, divided by the number of observed hand hygiene opportunities before initial patient contact per reporting period, multiplied by 100.	% / Health providers in the entire facility	Publicly Reported, MOH / Jan 2015 - Dec 2015	933*	94.5	95.00	Close to theoretical best (100%) as WRH tracks and reports all 4 moments of hand hygiene.	1)•Continue best practice hand hygiene auditing with real-time feedback to staff/visitors/etc. •Educate patients and visitors regarding hand hygiene performance expectations on all unit- 2x4 campaign, brochures, teaching. •Continue to implement Electronic HH Auditing Software, i.e. use of hand held devices, report distribution • continue Just Clean Your Hands Hand Hygiene Audit training for all HH Auditors to ensure validity of HH results • Increase number of frontline staff trained in JCYHs, teaching. •Continue to implement Electronic Hand Hygiene Software	● Conduct hand hygiene audits target 30 audits per week per unit ● Continue 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 automated report distribution	● Reduce MRSA, VRE and C diff rates to below target • >95% compliance overall with the 4 moments of hand hygiene •95% of target audits completed ● 100% of programs with automated report distribution ● 100% of programs with trained frontline auditors	
	Reduce rates of deaths and complications associated with surgical care	Number of times all three phases of the surgical safety checklist were performed ('briefing', 'timeout' and 'debriefing') during the reporting period, divided by the total number of surgeries performed in the reporting period, multiplied by 100.	% / All surgical procedures	Publicly Reported, MOH / Jan 2015 - Dec - 2015	933*	99.96	100.00	Achieve theoretical best at 100%	1)Ongoing monitoring of compliance with use of surgical safety checklist during all three phases: briefing; timeout; and debriefing to ensure interprofessional practice reduces the number of communication failures, promotes proactive and collaborative team communication and identifies patient safety problems.	Daily monitoring of all three phases of the checklist	% compliance with all three phases	100%compliance with all 3 phases of the surgical safety checklist	
	Reduce patient falls	Falls with injury for acute inpatients	Rate per 1000 patient days/month / Acute Inpatient	Hospital collected data / 2015	933*	0.06	0.05	Continue to improve on target which was based on yearly incremental improvements using best practices and proven interventions. Standardize target across both sites due to major improvement in performance at Ouellette Campus in past 2 years	1)•Continue with Fall Prevention Program including Fall Prevention And Comfort Round Bundles developed in 2012/2013 updated in Feb/16 that was based on best practice evidence on assessment of risk and implementation of interventions. • Education conducted with all CPMs re: comfort rounds and how to roll out in depts. Including sustainability plan	●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 incidents	%of nursing staff to complete education on Fall Prevention with focus on Comfort Rounds. •Conduct Root Cause Analysis with leadership and front line staff on all falls with injury	•.01% decrease in fall with injury rate overall • Weekly tracking of falls and falls per injury per unit •100% of patients are assessed at admission using the Morse Falls Risk Assessment • 100% of nursing of staff to complete education on Fall Prevention with focus on Comfort Rounds.•Conduct Root Cause Analysis 100% of the time on all falls with injury	
Timely	**Reduce wait times in the ED**	ED Wait times: 90th percentile ED length of stay for Admitted patients.	Hours / ED patients	CCO iPort Access / January 2015 - December 2015	933*	28.7	20.90	Provincial target is 25 hours. This target is important to funding. Work toward achieving better results than peers in order to be better than provincial average and target.	1)•Focus on maintaining ED admission rates at 10% at Met Campus and 13% at Ouellette Campus, or lower to increase ED capacity and performance and improved bed utilization across both sites. Hospital is 2 years post realignment of two major acute sites which has allowed for integration of medical and admin leadership to further reinforce standardization of practices. • Implement ' Zones' where patients move through for assessment, testing, treatment and monitoring to improve patient flow •Maintain a 16 bed Short Stay Medical Unit for unattached family medicine patients with an expected LOS of less than 72 hours at the Met site to impact ED flow • Improve overall flow with increase in percentage of patients discharged before 1100 and 1400. •Improved coordination with CCAC of complex patients designated ALC and returning home.• Track discharge and referral rate of Geriatric Emergency Department Nurse	Daily tracking of admission rates with weekly and monthly reporting and tracking hospital wide with dedicated indicator team monitoring progress daily and reporting weekly. • Track and monitor daily wait times with new ZONE areas •Monitor flow across all inpatient units and increase percentage of discharges before 1100 and 1400 with targeted discharges/day/unit. •Monitor admissions to Short Stay Medical Unit to ensure expected LOS is less than 72 hours and patients admitted to unit within 90 minutes (from decision to admit to the time they leave the ED). • Utilize GEM nurse and CCAC support services for complex discharges to eliminate barriers	• Daily tracking of admissions, discharges, ED holds and ALC's. • Daily tracking of ZONE wait times and overall wait time performance •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% and 13% ED admissions rate each month •90th % LOS for admitted patients below 20.9 hours. •Increase percentage of discharges before 1100 (32%) and by 1400 (70%).	