2017/18 Quality Improvement Plan
"Improvement Targets and Initiatives"

Windsor Regional Hospital 1995 Lens Avenue

AIM		Measure							Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Effective	Effective transitions	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?	% / Survey respondents	CIHI CPES / April - June 2016 (Q1 FY 2016/17)	933*	CB	CB	Continue to collect baseline with 1 full year of data	1)•New standardized satisfaction surveys introduced by NRC Picker in collaboration with OHA. Have recently implemented standardized Leadership Rounding on all in-patient units at the hospital. One third of all patients are engaged in a face to face conversation with a formal nursing leader each day. One of the questions posed to the patients/families asks about any concerns or needs that they may have about going home. •Concurrently WRH is implementing a three component Quality Based Procedure (QBP) package: one component is a Patient Experience Pathway. This pathway is being designed to facilitate verbal and nonverbal communication with patient and family in lay-person terms. It will include face to face conversations about the day to day plan of care and the plans for the patient and family when they return home. In-room white boards have been designed and implemented according to best practices aimed at enhancing communication and understanding of expectations of all involved in the circle of care.	•Monthly reporting of results from NRC Picker. On-going tracking and reporting of the patient satisfaction scores obtained through the daily Leadership Rounding. The scores to be reported each week at the Standard Unit Reporting "huddle". •Action plans to improve on score where appropriate to be provided and reviewed weekly. monthly auditing of completion of in-room patient white boards to sure on going compliance with completion of patient relevant information.	•% of patients who respond positively to this question . •% of patients who rate their stay from 1-5 on the internal Leadership Rounding practice. % of patients who can explain their plan of care following the roll-out of the Patient Experience component of the QBP	•Continue to collect full year of data to establish baseline target. •Daily Leadership Rounding results: 60% of in-patients would rate their stay as good (4) to excellent (5). •70 % of patients with an associated QBP will be able to state their plan for care for the day	.
		Rate of psychiatric (mental health and addiction) discharges that are followed within 30 days by another mental health and addiction admission	Rate per 100 readmissions / Discharged patients with mental health & addiction	CIHI DAD,CIHI OHMRS,MOHTLC RPDB / January 2015 - December 2015	933*	10.4	9.40	Target established is well below the provincial average of 11.3% and we endeavor to continue to make improvements	1)•Re-mapping the flow of patients to community with primary community partners including Canadian Mental Health Association (CMHA). • Continued development of clinical pathways to support relapse prevention post-discharge. 3. Continued re-development of social work discharge model in acute mental health.	•Monthly review of 30-day readmission rate data. Track and monitor referrals to Canadian Mental Health Association. Bi-monthly process review with Canadian Mental Health Association. Chart review of patients re-admitted within 30 days identifying trends and system gaps.	•Monthly tracking of re-admission rates through admitting system data. Program level data tracking referrals to Canadian Mental Health Association.	•Re-admission rate of 6.32% or lower. 70% of discharged patients referred to Canadian Mental Health Association.	.
		Risk-adjusted 30-day all-cause readmission rate for patients with CHF (QBP cohort)	Rate / CHF QBP Cohort	CIHI DAD / January 2015 - December 2015	933*	22.74	21.00	Target represents 7.65% reduction from current performance which is below the provincial expected readmission rate of 21.00%	1)Initiated QBP multidisciplinary team focusing on implementation of best practices for the CHF patient and development of CHF order set, clinical pathway and patient experience pathway. Oversight of project from QBP steering committee and SOP executive sponsors (senior level administrators).	Develop and track key CHF QBP indicators. Weekly tracking of readmissions. Standardization of CHF order sets between campuses. Chart reviews of readmissions of CHF patients (have identified a cohort of patients with 3 or more admissions with CHF per month).	30 day readmission rate; 7 day readmission rate; compliance with initiation of order set; LOS for CHF; in hospital mortality, discharge destination (i.e. home with CCAC, home without services, rehab, etc.)	Meet or exceed provincial target for 30 day readmission rate; less than 10% readmitted after 7 days; 100% compliance with initation of CHF order sets/clinical pathways/patient experience pathway.	
		Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort)	Rate / COPD QBP Cohort	CIHI DAD / January 2015 – December 2015	933*	21.6	20.10	Target represents provincial average readmission rate for COPD of 20.10%	1)•Multidisciplinary team meets weekly 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.	•Our SOP Team is focused on QBPs corporately to standardize order sets, clinical pathways and patient experience pathways. 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. •Working with the ED team to increase ED compliance order set initiation and increasing 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, percentage with CCAC home support post discharge	•Provincial expected rate for COPD - 30 day readmission rate; 0% of 1 to 7 day readmissions; 90% order set utilization; 90% of patients with COPD to have CCAC home support post discharge	

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		Risk-adjusted 30-day all-cause readmission rate for patients with stroke (QBP cohort)	Rate / Stroke QBP Cohort	CIHI DAD / January 2015 - December 2015	933*	7.04	8.00	Current actuals for January to March 2016 is above 14% per MLAA report. As a result, we are maintaining our target at the provincial average of 8.0%.	1)•Initiated QBP multidisciplinary team focusing on implementation of best practices for the Stroke patient and development of Stroke order set, clinical pathway and patient experience pathway. Oversight of project from QBP steering committee and SOP executive sponsors (senior level administrators). •Acute Stroke Unit will be officially launched to ensure that all patients with stroke receive the appropriate expert care in a cohosted setting. Partnered with CCAC to develop and implement an innovative rehab strategy to promote earlier discharge and provide more timely rehab services in the home.	•Develop and track key Stroke QBP indicators. Weekly tracking of readmissions. Standardization of stroke order sets between campuses. All Windsor Essex stroke patients will be admitted to the acute stroke unit when admission criteria is met. Early identification of patients meeting criteria for rehab.	•30 day readmission rate; 7 day readmission rate; compliance with initiation of order set; LOS for stroke; in hospital mortality, proportion of patients admitted to eRehab program, percentage of stroke patients admitted to ASU.	•Meet or exceed provincial target for 30 day readmission rate; less than 5% readmitted after 7 days; 100% compliance with initiation of stroke order sets/clinical pathways/patient experience pathway, 100% of patients meeting ASU admission criteria cared for on ASU for 100% of acute care hospitalization.	
		Hospital Standardized Mortality Ratio (HSMR)	Number of observed deaths divided by the number of expected deaths multiplied by 100. / All patients	CIHI eReporting Tool / CY2016 to Nov	933*	105	95.00	A value of 95 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 105. 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. • Continued physician engagement with acuity summary compliance	•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. • Attend educational sessions with new residents to educate on the use of the Acuity Summary Form	•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 campus.	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	**Access to right level of care**	Total number of alternate level of care (ALC) days contributed by ALC patients within the specific reporting month/quarter using near-real time acute and post-acute ALC information and monthly bed census data	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July – September 2016 (Q2 FY 2016/17 report)	933*	11.67	12.70	Target reflects HSAA agreement of 12.7% which is below provincial average of 15.3% Actual performance for current period is above 12.7% for all medical, surgical and critical care areas.	1)•Continue collaboration with CCAC ESCLHIN in the implementation of Home First Strategies to facilitate placement of ALC patients and reduce barriers to discharge early in their inpatient stay through the continued utilization of WRH's Discharge Planning Policy 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 across all medical, surgical and complex care areas •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. Develop a LHIN wide Surge strategy during times of increased pressure regarding patient flow.	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, timely and 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	Palliative care	Percent of palliative care patients discharged from hospital with the discharge status "Home with Support".	% / Palliative patients	CIHI DAD / April 2015 – March 2016	933*	70.59	84.30	A value of 84.3% is the provincial average and represents patients that are designated palliative care are being discharged from hospital with home support. Current review of patients show that other community services such as palliative care in sub acute care and community residential care at Hospice remain viable options for patients at the end of life.	1)•Continue with established complex discharge reviews with CCAC to ensure the appropriate placement of patients home with services • Conduct regular chart reviews to ensure the right type of patients are being referred that ensures care is focused on patient and caregiver, is safe, equitable and appropriate and is properly resourced. •Erie St. Clair Regional Palliative structure being developed . New multidisciplinary leadership with palliative care experts including three working groups from Sarnia/Lambton, Chatham/Kent, Windsor/Essex being developed . Work plan in progress for Erie St. Clair reflective of OPCN . Flagging palliative patients, embedding symptom management strategies to avoid ED, Continue to work with CCAC and hospice partners to support palliative care patients in community.	•Weekly complex discharge rounds reviewing palliative care patients • Monitor and track discharge destination for palliative care patients • Weekly reviews with CCAC on referrals to palliative e-shift program and readmissions	% of patients designated palliative care reviewed by care and utilization team for possible discharge home with support	100% of palliative patients (excluding those unable to be transferred) are assessed for discharge home with supports. Monthly review of readmissions for palliative patients sent home with CCAC palliative support.	
	Person experience	"Would you recommend this emergency department to your friends and family?"	% / Survey respondents	EDPEC / April - June 2016 (Q1 FY 2016/17)	933*	CB	CB	Continue to collect baseline with 1 full year of data	1)•Patients come to the ED to see a physician or Nurse Practitioner. We need to decrease the wait time for patients to see a healthcare provider and reduce the ED LOS. •Improved communication to patients and families on the plan of care and discharge instructions and follow up and connection with community services as appropriate. •Reducing revisits for ED patients.	•Monthly indicator team meetings and action plan development •Use a multi-discipline team approach, including a patient advocate and a patient. •Connect with the corporate patient experience team for support and proven strategies.	•% of patients that 'Would recommend the emergency department'?	•No target is established for this indicator as one full year of data is not yet available.	
		"Would you recommend this hospital to your friends and family?" (Inpatient care)	% / Survey respondents	CIHI CPES / April - June 2016 (Q1 FY 2016/17)	933*	CB	CB	Continue to collect baseline with 1 full year of data	1)•A number of quality initiatives are being implemented to improve the patient experience at WRH including patient satisfaction surveys, patient experience task force, critical incident reporting and patient flow. One significant source of concern and complaint is that of patient flow: specifically the length of time admitted patients are waiting for their in-patient beds and the number of times a patient is moved from on unit to another during their acute care stay. The goal of the Patient Flow Initiative is to reduce both of the above. Engaging with patients and families at least once during their acute care stay is a required leadership practice. Nursing leaders have 5 standardized questions (Leadership Rounding) they ask each patient in a "real time" effort to determine what, if anything, they can do to make the patient experience as positive as possible. Quality Based Procedures which have been introduced to the organization are being re-examined with the focus being on the impact of the QPB on the patient and their family. A Patient Experience Pathway is being introduced as part of the new QBP approach to providing care to patients. The goal is to better include the patient and family in their journey each and every day and with each and every patient interaction.	•One of the patient flow initiatives is aimed at determining the number of acute care beds required in order to facilitate timely access to beds from the ED. The bed allocations will be made within the existing physical capacity and will support the concept of units being designated for specific patient populations. Real time patient feedback will provide opportunities to identify any issues or concerns a patient may have and to address and resolve these while the patient is still in the hospital.	•% of patients that positively respond to this question. # of Admit No Beds in the ED, average # of patients admitted to off service beds, from Leadership Rounding satisfaction scores	•No target is established for this indicator as one full year of data is not yet available. •Other indicators include: Decrease in the # of ANB in the ED. Decrease # of patient admitted to off service beds and positive scores with Leadership Rounding.	

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Safe	Medication safety	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	Rate per total number of admitted patients / Hospital admitted patients	Hospital collected data / Most recent 3 month period	933*	41.7	50.00	SOP Med Rec working group initiated with purpose of review of current med rec processes in the ED and development of standardized, simplified process. Identify roles and responsibilities of care providers in med rec process. Revise form to ensure best practices in med rec are being captured. Standardize process across both campuses.	1)•Engage physicians, ED staff and pharmacy staff to review current state. Research best practices. Design future state process and revise med rec form with clearly identified roles and responsibilities of nursing, physicians (ED and MRP) and pharmacists/pharmacist techs.	•Pharmacist/pharmacy tech located in ED during week days to perform med rec on newly admitted patients. •Pharmacists will review and complete Medication Reconciliation for all newly admitted patients to Med/Surge units. Education for ED staff on appropriate methodology for conducting a medication reconciliation interview as well as roles and responsibilities for medication reconciliation. Form revision. •Audit compliance and accuracy monthly.	•% of Medical Surgical patients with medication reconciliation completed. •Number of medication reconciliations completed in ED and by a pharmacist on the inpatient unit. •% of patients with a documented BPMH completed in ED. •Number of medication errors as a result of incomplete or inaccurate medication reconciliation.	•2-3 MedRecs per day per pharmacist to achieve 45% consults on all Med/Surg patients admitted. 100% BPMH completed in ED for admitted patients	
		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.	Rate per total number of discharged patients / Discharged patients	Hospital collected data / Most recent quarter available	933*	CB	CB	SOP Med Rec working group initiated with purpose of review of current med rec processes in the ED and development of standardized, simplified process. Identify roles and responsibilities of care providers in med rec process. Revise form to ensure best practices in med rec are being captured. Standardize process across both campuses.	1)•Engage physicians, ED staff and pharmacy staff to review current state. Research best practices. Design future state process and revise med rec form with clearly identified roles and responsibilities of nursing, physicians (ED and MRP) and pharmacists/pharmacist techs.	•Pharmacist/pharmacy tech located in ED during week days to perform med rec on newly admitted patients. •Pharmacists will review and complete Medication Reconciliation for all newly admitted patients to Med/Surge units. Form revision and standardize across both campuses. •Audit compliance and accuracy monthly.	•% of Medical Surgical patients with medication reconciliation completed at discharge. •Number of medication errors as a result of incomplete or inaccurate medication reconciliation.	•2-3 MedRecs per day per pharmacist to achieve 45% consults on all Med/Surg patients discharged.	
	Safe care	Reduce Hospital Acquired Infections: The number of reported hospital acquired infections (MRSA, Cdiff, VRE) expressed as a rate per 1,000 patient days/month for all acute inpatients	Rate per 1,000 patient days / All inpatients	Hospital collected data / CY2016	933*	4.6	3.82	Internally established target based on using best practices, proven interventions and continued standardization across both sites.	1)•Continue with 7 day a week Leadership Walk About that are aimed at supporting staff at the beside to perform the 4 moments of hand hygiene and to don and doff personal protective equipment as required. •Continue with Monday Morning Huddle weekly report out on HAI's but with a focus on those units that have higher numbers than target and have a written action plan to address and resole the root cause(s) observed. •Use the newly installed electronic performance boards on each unit to give staff and patients the results of efforts the week prior to reduce/eliminate health care acquired infections. Continue to reinforce with leaders and staff the best methods of escalating their concerns related to patient safety including immediate steps to be taken and using the RL6 risk reporting software to capture the issues for the purposes of trending.	•Continue to report unit, program and campus HAI results on a weekly and monthly basis to recognize both positive and not so positive results. Provide hand hygiene audit training quarterly to ensure sufficient numbers of staff are trained in proper technique AND can coach peers at the bedside.	•Unit level HAI's reported weekly at Monday Morning Huddle and displayed on performance boards. 4 hand hygiene audit sessions conducted each year, monthly audit re: the use of the performance boards	•All HAI's reported by campus, by unit on a weekly basis. 100% of new clinical leaders to attend hand hygiene audit sessions.	

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		Reduce patient falls: Falls with Injury for patients admitted to the hospital	Rate per 1,000 patient days / All acute patients	Hospital collected data / CY2016	933*	0.05	0.05	Maintain ambitious target of 0.05 across all inpatient medical/ surgical/ critical care areas. Continue to reduce falls with injury across both campuses based on sustaining best practices and proven interventions.	1)•Continue Corporate Fall Prevention Program including Fall Prevention and Comfort Round Bundles through reinforcing best practice evidence on assessment of risk and implementation of strategies/ interventions • Roll out of Model of Care training to all inpatient medical surgical nursing units. • Standard unit working groups integrate standardized best practices through standard work to achieve quality care and outcomes.	?Comfort round working groups for the Standard Unit project rolled out with the Standardization and Optimization Team (SOP) ? Provide ongoing staff education and training regarding Fall Prevention and Comfort Round Bundle methodology ?Track and report fall with injury weekly and monthly and ensure Root Cause Analysis conducted on all high risk incidents ? going regular reporting of incidents and follow-up to front line, leadership, Quality Report and public reporting.	•% complete of Standard work Comfort Round Bundles through the SOP project •% completion of Root Cause Analysis with leadership and front line staff on all falls with injury	• Maintain fall with injury target • Weekly tracking of falls and falls with injury per unit •100% of patients are assessed at admission using the Morse Falls Risk Assessment •100% compliance on comfort round bundle compliance •Conduct Root Cause Analysis 100% of the time on all falls with injury	
		Use of Surgical Safety Checklist: 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 Exclusions are minor surgical procedures that are done under local anesthetic; Inclusions are surgical procedures such as: major surgery, cataracts, dental procedures, and emergency surgeries	% / All patients with major surgery	Publicly Reported, MOH / 2016	933*	99.9	100.00	Achieve theoretical best at 100%	1)•Ongoing auditing of compliance with use of surgical safety checklist during all three phases: briefing; timeout; and debriefing. Compliance with the surgical safety checklist reduces the number of communication failures, promotes proactive and collaborative team communication and identify patient safety problems and concerns	•Daily auditing of all three phases of the checklist to ensure 100% completion compliance • Ensure members of the interprofessional team share in auditing experience	•% compliance with all three (3) phases of surgical safety checklist	•100% compliance with all three (3) phases of the surgical safety checklist • Daily audit ensures 100% compliance with all procedures conducted and provides real time feedback to surgical team to ensure completion	
Timely	**Timely access to care/services**	Total ED length of stay (defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ED) where 9 out of 10 complex patients completed their visits	Hours / Patients with complex conditions	CIHI NACRS / January 2016 – December 2016	933*	12.3	8.00	Target is from HSAA agreement which is 8.0%, which is very ambitious and well below the provincial average of 10.30%.	1)•Focus on maintaining or improving ED admission rates at 10% at Met Campus and 13% at the Ouellette Campus. The corporate focus on QBPs, led by the SOP Team, by rolling out standard order sets, clinical pathways and patient experience pathways will assist. •Implement improvements to the 'zones' where patients move through for assessment, testing, treatment and monitoring to improve flow. WRH continues to strive to reduce the provider initial assessment (PIA) times. •Continue to focus on the mental health patients at the Ouellette Campus by redesigning the patient experience and flow through the ED. A team has been established to improve on the current MH processes. This may include continuing to admit MH patients to a short stay unit as appropriate. •The SOP Team (standardization and optimization) will focus on corporate patient flow as one of its main projects for 2017/18. Once implemented, this should allow the ED to benefit from improved patient flow on the inpatient units, thus improving ED flow. • Collaborating with Diagnostic Imaging to ensure timely access to required imaging and reports. Radiologist real time reporting in support of the ED is from 6a until midnight daily.	•Daily tracking of compliance to ED LOS (length of stay) and the number of admissions. •Dedicated indicator teams monitors progress daily with weekly and monthly reporting and the development of action plans. •Track and monitor daily wait times within the new 'zones'. •Track and monitor monthly wait times for MH patients through the Ouellette Campus ED and for those admitted to the MH short stay unit. •Track and monitor corporate LOS , by program, and the number of discharges by 1100 and 1400 by individual unit.	•Daily tracking of ED wait times for CTAS I, II and III patients. •Daily tracking of admissions, with review of all <24 hour admissions. •Monthly tracking of PIA times. •Monthly tracking of MH wait times in the ED and MH short stay unit. •Weekly tracking of the number of discharges by 1100 and 1400 by unit.	•The total ED length of stay where 9 out of 10 complex patients completed their visits (Admitted and non admitted patients CTAS 1, 2, 3) within 8 hours. •Admission rates: 10% for Met Campus & 13% for Ouellette Campus •Wait times for high acuity, non admitted patients in the ED should be 6.9 hours or less •Discharges by 1100 - 32%; by 1400 - 70%.	