Theme I: Timely and Efficient Transitions | Efficient | Priority Indicator

Indicator #9

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. (Windsor Regional Hospital)

Last Year		This Year	
8.67	**12.70**	**8.69**	**12.70**
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

•Ongoing collaboration with the ESC LHIN in the implementation of Intensive Hospital to Home (IHH) Services to bridge to Long Term Care • Implementation of the Rehab Intensive Hospital to Home Services for patients awaiting an inpatient rehab bed or as an alternative to inpatient care • WRH's Discharge Planning Policy utilizes a Complex Discharge Screening process at admission to identify discharge barriers • Provide timely, patient level data with daily monitoring/tracking at the Command Center Patient Flow and Systems Level Huddles • Develop and apply targeted strategies to individualized discharge plans to decrease ALC patients lengths of stay across all medical, surgical and critical care areas • Senior leadership attendance on unit daily care rounds and daily System and Patient Flow Huddles to review ALC's at the unit, site and corporate level • Participate in regional escalation planning when need exceeds bed capacity • Participate in the development of a LHIN wide ALC Planning Policy.

Target for process measure

• • 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

Lessons Learned

Sustainment of performance of patient flow indicators and ongoing development of Command Center patient flow processes.

Theme I: Timely and Efficient Transitions | Timely | Priority Indicator

Indicator #4

Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital. (Windsor Regional Hospital)

Last Year		This Year	
CB	CB	25.80	27.10
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

• Health records process created where once the physician completes the discharge summary and it is transcribed, the dictated report is released from the dictation system and auto faxed to any community partners attached to the patient record • Ensure timely completion of discharge summary by physicians • MRP to ensure community provider documented on patient record where applicable.

Target for process measure

• • 100% completed discharge summaries faxed to community provider where provider is identified • 80% or greater compliance with discharge summary completion • 100% compliance with community provider documented on chart where applicable.

Lessons Learned

Discharge summaries auto faxed to community provider • Discharge summary timeliness and compliance monitored by the Medical Quality Committee • Conduct chart audits to ensure community provider documented on chart where applicable.

Theme I: Timely and Efficient Transitions | Timely | Mandatory Indicator

Indicator #8

The time interval between the Disposition Date/Time (as determined by the main service provider) and the Date/Time Patient Left Emergency Department (ED) for admission to an inpatient bed or operating room. (Windsor Regional Hospital)

Last Year		This Year	
11.30	**10.74**	**6.65**	**6.40**
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #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, including standard order sets, clinical pathways and patient experience pathways will decrease overall LOS • Reduce provider initial assessment (PIA) times with introduction of ED wait time tracker from Oculys • Patient Flow and Bed Allocation Model introduced October 2017 and the introduction of assessment bays across all Medicine units to reduce wait time for admitted patients, reduce the number of Admit No Bed patients, and improve patient experience • Process improvements identified in collaboration with Diagnostic Imaging to ensure timely access to required imaging and reports including Radiologist real time reporting for the ED from 0600 to 2400 daily • New Patient Flow Model Surgery to be rolled out in 2019 • EMS diversion protocol established between Windsor Essex Emergency Management Service, Windsor Regional Hospital and Erie Shores Health Care to divert CTAS 4 and 5 to low volume Emergency Department

Target for process measure

• • LOS for admitted patients • 0 ANB waiting greater than 3 hrs. in the Emergency Department • Discharges by 1100 - 32%; by 1400 - 70%.

Lessons Learned

Daily tracking of compliance to ED LOS (length of stay) and the number of admissions, Admit No Beds and wait time to inpatient bed• Dedicated indicator teams monitors progress daily with weekly and monthly reporting and the development of action plans • Command Center provides centralized hub for patient flow indicators in real time action and resolution • Track and monitor corporate LOS by program, and the number of discharges by 1100 and 1400 by individual unit• Increased number of physicians in the ED allows for earlier assessment and intervention and increased capacity.

Theme II: Service Excellence | Patient-centred | Priority Indicator

Indicator #5

Percentage of respondents who responded “completely” to the following question: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital? (Windsor Regional Hospital)

Last Year		This Year	
52.83	**70**	**53.35**	**70**
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

• Monthly reporting of satisfaction results • Standardized Leadership Rounding on all in-patient units where daily, one-third of patients are engaged in a face to face conversation with a formal nursing leaders. One of the questions posed asks about any concerns or needs patient has about going home • Implementing the Quality Based Procedure (QBP) package: one component is a Patient Experience Pathway. Pathway 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 discharge 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. Physician led rounds across all Medicine units ensures entire care team is involved in Plan of Care.

Target for process measure

- •Previous year established baseline for new methodology •Daily internal 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 of care for the day

Lessons Learned

Monthly reporting of results from NRC across the organization • On-going tracking and reporting of the patient satisfaction scores obtained through the daily Leadership Rounding. Scores to be reported each week at the Standard Unit Reporting "huddle" •Monthly auditing of completion of in-room patient white boards to ensure on going compliance with completion of patient relevant information.

Indicator #3

Percentage of complaints acknowledged to the individual who made a complaint within five business days. (Windsor Regional Hospital)

Last Year		This Year	
CB	CB	98.18	100
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

• Patient advocate follow-up with every individual making a complaint • Real time reporting in Hospital's risk reporting system RL6 • Immediate review with parties involved as well as Senior team to ensure resolution • QCIPA reviews initiated including staff, leadership and physicians involved in the incident.

Target for process measure

- Collecting Baseline as first year of indicator

Lessons Learned

Patient advocate responds to individual making a complaint immediately and then records complaint and follow-up in the Risk Reporting system • Patient advocate department ensures timely follow-up and resolution

Theme III: Safe and Effective Care | Effective | Priority Indicator

Indicator #1

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. (Windsor Regional Hospital)

Last Year		This Year	
57.87	59	59.07	62
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

•Revise med rec form with clearly identified roles and responsibilities of nursing, physicians (ED and MRP) and pharmacists/pharmacist techs; •Standardize med rec process/tool at both sites

Target for process measure

- •5% improvement is 60.8% from previous year results for medication reconciliation compliance at discharge

Lessons Learned

Audit compliance and accuracy monthly;

Indicator #6

Proportion of hospitalizations where patients with a progressive, life-limiting illness, are identified to benefit from palliative care, and subsequently (within the episode of care) have their palliative care needs assessed using a comprehensive and holistic assessment. (Windsor Regional Hospital)

Last Year		This Year	
CB	CB	CB	CB
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

• Conduct regular chart reviews to ensure early identification of documented assessment of palliative care needs • Review daily status of palliative care assessments at Patient Flow Huddle in the Command Center • Erie St. Clair Regional Palliative multidisciplinary team includes palliative care experts across the Erie St. Clair LHIN • Flag palliative patients, embedding symptom management strategies to avoid ED and inpatient admission • Continue to work with the LHIN and Hospice partners to support palliative care patients in community.

Target for process measure

• • 100% of palliative patients are assessed for palliative care needs with daily review at unit care rounds and escalation (if necessary) in Command Center at Patient Flow Huddle •Monthly review of readmissions for palliative patients sent home with LHIN palliative care support.

Lessons Learned

Daily review at unit care rounds • Monitor and track documented assessment of needs of palliative care patients • Weekly review with the LHIN on referrals to palliative care home support services and readmissions

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Indicator #7

Rate of mental health or addiction episodes of care that are followed within 30 days by another mental health and addiction admission. (Windsor Regional Hospital)

Last Year		This Year	
14.49	**11.30**	**10.34**	**--**
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

• Post-Discharge Clinic in mental health for a 7 day follow up appointment post discharge with a psychiatrist and optional 2nd visit at 14 days post discharge • Identification of 7 day, 30 day and 90 day readmits of patients during care rounds to develop targeted care plans •Monthly reporting of 30 day readmissions with MRN to do a clinical review of the case

Target for process measure

- •Re-admission rate at or below provincial target; 70% of discharged patients to be referred to Canadian Mental Health Association for community support.

Lessons Learned

Monthly review of 30-day readmission rate data • Track and monitor referrals to Canadian Mental Health Association with bi-monthly process review with Canadian Mental Health Association. Chart review of patients re-admitted within 30 days identifying trends and system gaps.

Theme III: Safe and Effective Care | Safe | Mandatory Indicator

Indicator #2

Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period. (Windsor Regional Hospital)

Last Year		This Year	
256	**243**	**217**	**206**
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

•Process Improvement Team ensures safety as a dimension of quality including both patient and workplace safety: safe workplace Elearn emphasized code white policy, safe workplace policy, domestic violence /intimate partner protocol, professional staff conduct and flagging patients/visitors •Created Safe Workplace Program Bundles • Results reported weekly at Monday Morning Huddle utilizing RL6 incident reporting system• New Code White training program continues to be provided to all staff in high risk areas • Process improvement team includes cross department representation including high risk areas, to review incidents in real time for incident resolution.

Target for process measure

- • 90-95% of staff completed Safety in the Workplace Elearn •100% of inpatient unit rolling out Safe Workplace Program Bundles •100% of incidents reported reviewed by care team and leadership • 95% of staff from high risk area completing new Code White training program

Lessons Learned

Ongoing monitoring of E-learn compliance • Standardized safe workplace bundles for prevention, investigation and debriefing •Weekly monitoring of results and review of every incident in real time • Staff completion of Code White training program