Theme I: Timely and Efficient Transitions

Measure

Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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.	P	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / Jul 2019 - Sep 2019	8.69	12.70	Target is based on HSAA agreement of 12.7%. Actual performance is better than HSAA. Goal is continued improvement year over year with the actual results. WRH is among the top Acute Care ALC performers in Ontario	Erie St Clair Local Health Integration Network, Assissted Living Southwestern Ontario, Hotel Dieu Grace Healthcare, Bayshore HealthCare

Change Ideas

Change Idea #1	• Ongoing collaboration with Home and Community Care (HCC) for Intensive Hospital to Home (IHH) and Intensive Hospital to Home Rehab (IHHR) Services to bridge to Long Term Care • Regional Erie St Clair Discharge Planning Policy to be implemented April 2020 reinforcing collaboration between hospital and Home and Community Care (HCC) • Daily, provide timely, patient level data with daily monitoring/ tracking at the Command Center Patient Flow and Systems Level Huddles • Continue to develop and apply targeted strategies to individualized discharge plans to decrease ALC patients lengths of stay across all medical, surgical and critical care areas • Daily leadership attendance at on-unit care rounds and daily at the System and Patient Flow Huddles to review ALC's and Expected Date of Discharge (EDD) at the unit, site and corporate level • Hospital wide escalation of ALC's utilizing a unit specific threshold and standardized ALC escalation meetings when approaching threshold • ALC and EDD escalation meetings where required with Hospital Care Coordinator leadership

Methods	Process measures	Target for process measure	Comments
• Conduct daily ALC and discharge rounds with hospital utilization team, social work, HCC coordinators, and other community support services to identify barriers to discharge and admissions identified as positive screeners for complex discharge issues • Conduct coordinated and timely discharge planning meetings with community providers for patients with complex issues • Daily review of ALC status across all units and across both sites with escalation to senior leadership as required • Address barriers to discharge daily at the patient level with integrated care team at the Patient Flow Daily meetings in the Command Center • Educate patients and families about the appropriateness of acute care services and the Intensive Hospital to Home support services • Daily, weekly and monthly review of ALC's by leadership team • Monthly review of patient flow indicators at Corporate Utilization Committee represented by medical directors and administration.	• On admission, the number of patients that are a Positive Screener for Complex Discharge issues is evaluated daily • Daily assessment on each unit of the patients that have reached their Estimated Date of Discharge and are beyond their EDD beyond five (5) days • The number of patients designated ALC each day by most appropriate discharge destination • The number of ALC patients discharged/day by destination • The average number of ALC patients per day per week.	• % reduction in the overall number of patients declared ALC • 100% of patients and/or families provided education about the appropriateness of acute care services • 100% of coordinated care planning conducted by utilization and Home and Community Care Team	

Measure

Dimension: Efficient

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Unconventional spaces	P	Count / All inpatients	Daily BCS / TBD	CB	CB	The technical specifications are still under development by HQO/(Ontario Health -Quality). Target set at Collecting Baseline during this development phase	Erie Shores Healthcare, Erie St Clair Local Health Integration Network

Change Ideas

Change Idea #1 • Sustainment of positive outcomes with the new Medicine Department Patient Flow Model introduced in 2017 with the reallocation of inpatient beds as assessment bays across all Medicine units as a pull strategy to reduce Emergency Department holds and wait times for admitted patients • New ED and Mental Health Patient Flow Redesign to be introduced in 2020 for improved patient flow • Overflow areas for patients Admitted with No Bed (ANB) created as a temporary location in a conventional space until an appropriate bed is available • Command Center functions as the central hub for patient flow information displaying real time data electronically, which is reviewed by front line staff and leadership at dedicated times each day during the Patient Flow and Systems Huddles • Real time escalation with senior leadership as required.

Methods	Process measures	Target for process measure	Comments
• Sustained performance of patient flow indicators • Implementation of Emergency Department and Mental Health Patient Flow Redesign Model in 2020 • Ongoing standardization of Patient Flow and Command Center patient flow processes.	• Number of patients admitted each day as an Admit No Bed (ANB) requiring placement in unconventional spaces.	• Collecting baseline as per HQO (Ontario Health) direction as technical specs are under development	

Measure

Dimension: Timely

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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.	P	% / Discharged patients	Hospital collected data / Most recent 3 month period	25.80	27.10	Target set at 5% improvement over reporting period	

Change Ideas

Change Idea #1	• Health records process in place temporarily at the Met Campus 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. Process will be replaced by a new electronic health information system in November 2020 • Timely completion of the discharge summary by physicians is tracked by the health records department

Methods	Process measures	Target for process measure	Comments
• Discharge summaries auto faxed to community provider • Discharge summary timeliness and compliance monitored by the Medical Quality Committee • New health information system in 2020 will automate reporting hospital-wide.	• % completed of discharge summaries faxed to community provider where a community provider is documented • % compliance of discharge summary completion by physicians	• 27% completed discharge summaries faxed to community provider where provider is identified within 48 hours • 80% or greater compliance with discharge summary completion by physicians	

Measure

Dimension: Timely

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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.	M	Hours / All patients	CIHI NACRS, CCO / Oct 2019– Dec 2019	6.65	6.40	Target set at 5% improvement over reporting period for 90%tile	Windsor Essex Emergency Management System (EMS), Erie Shores Healthcare

Change Ideas

Change Idea #1	• Sustained improvement as a result of New Patient Flow and Bed Allocation Model introduced in October 2017 across all Medicine units to reduce wait time for admitted patients, reduce the number of Admit No Bed patients, and improve the overall patient experience • New Emergency Department and Mental Health Patient Flow Redesign introduced in 2020 to reduce wait times • Command Center functions as the centralized hub for real time data and response to patient flow issues with continued standardization of patient flow processes • Daily root cause analysis on every patient that is an Admit No Bed waiting greater than 3 hours for their inpatient bed • Continued collaboration with Erie Shores Healthcare and EMS for the diversion of CTAS 3, 4 & 5 to low volume emergency departments • EMS leadership attends Command Center Huddles when required

Methods	Process measures	Target for process measure	Comments
• 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• New Patient Flow Model in ED reorganizes patients in the ED by CTAS level.• Hourly tracking of Code 7 holds in the Emergency Department and escalation as needed for diversion to lower volume emergency departments	• Daily tracking of percentage of patients admitted to an inpatient bed • Daily tracking of ED wait time for admitted patients • Daily tracking of Admit no Beds (ANB) times •Monthly tracking of PIA times • Daily tracking of the number of discharges by 1100 and 1400 by unit • Daily monitoring	• Total length of stay for admitted patients • Admit to bed time for admitted patients • 0 ANB waiting greater than 3 hrs. in the Emergency Department • Discharges by 1100 - 32%; by 1400 - 70%.	

Theme II: Service Excellence

Measure

Dimension: Patient-centred

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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?	P	% / Survey respondents	CIHI CPES / Most recent 12 months	53.35	70.00	Target set is consistent with previous year target	

Change Ideas

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 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.

Methods	Process measures	Target for process measure	Comments
• 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.	• % of patients who respond positively to this question • % of patients who rate their stay from 1-5 on the internal Leadership Rounding process • % of patients who can explain their plan of care following the roll-out of the Patient Experience component of the QBP	• 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	Total Surveys Initiated: 373

Measure

Dimension: Patient-centred

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of complaints acknowledged to the individual who made a complaint within five business days.	P	% / All patients	Local data collection / Most recent 12 month period	98.18	100.00	Target set at 100%	

Change Ideas

Change Idea #1 • The patient advocate will follow-up with every individual making a complaint • Real time reporting in Hospital's risk reporting system RL6 to ensure data collection and follow up • Immediate review with parties involved as well as Senior team to ensure resolution • QCIPA reviews initiated in real time that include staff, leadership and physicians involved in the incident.

Methods	Process measures	Target for process measure	Comments
• Patient advocate responds to individual making a complaint immediately and then records complaint and follow-up in the Risk Reporting system RL6 • Patient advocate department ensures timely follow-up and resolution	• % of patient complaints compared to % response.	• Expected target is 100% compliance	

Theme III: Safe and Effective Care

Measure

Dimension: Effective

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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.	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / Oct 2019–Dec 2019 (Q3 2019/20)	59.07	62.00	Target set at 5% improvement over reporting period	

Change Ideas

Change Idea #1 • Continued utilization of new medication reconciliation form with clearly identified roles and responsibilities of nursing, physicians (ED and MRP) and pharmacists/pharmacist techs •Standardize medication reconciliation process/tool at both sites

Methods	Process measures	Target for process measure	Comments
• Audit the compliance and accuracy monthly	• % of Medical Surgical patients with medication reconciliation completed at discharge.	• 5% improvement establishes target at 62.0%	

Measure

Dimension: Effective

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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.	P	Proportion / All patients	Local data collection / Most recent 6 month period	CB	CB	Target set as Collecting Baseline as indicator is under development with the implementation of the electronic Health Information System (HIS) in 2020.	Hospice Windsor - Essex, Hotel-Dieu Grace Healthcare, Erie St Clair Local Health Integration Network

Change Ideas

Change Idea #1 • New Health Information System (HIS) in 2020 will electronically capture the early identification of documented assessment of needs for palliative patients and Goals of Care as documented on the health record • Currently, daily status review of palliative care needs and palliative care team consults for all palliative patients occurs at Unit Care Rounds and documented in patient health record

Methods	Process measures	Target for process measure	Comments
• Daily review at unit care rounds to ensure early identification of palliative care needs and Goals of Care discussion • Monitor and track documented assessment of needs of palliative care patients at care rounds • Daily review with care team and community partners at Hospice, Home and Community Palliative Care Team and Palliative Inpatient Care Team to ensure palliative care needs are being met	• Individuals designated palliative care reviewed daily at care rounds to ensure palliative care assessment conducted and interventions completed	• Collecting baseline target as indicator and process is being developed with the new HIS system to ensure all palliative patients to be assessed for palliative care needs with daily review at unit care rounds with care team	

Measure

Dimension: Effective

Indicator #9	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percent of unscheduled repeat emergency visits following an emergency visit for a mental health condition.	P	% / ED patients	CIHI NACRS / April - June 2019	20.89	19.85	5% percentage improvement from current performance	Hotel Dieu Grace Healthcare, Erie Shores Healthcare, Erie St Clair Local Health Integration Network, Canadian Mental Health Association (CMHA) Windsor-Essex

Change Ideas

Change Idea #1 • Post-Discharge Clinic in mental health for a 7 day follow up appointment following discharge with a psychiatrist and optional 2nd visit at 14 days post discharge • Emergency Department and Mental Health Patient Flow Redesign Model introduced in 2020 to facilitate improved patient flow in the Emergency Department and in the Mental Health department.

Methods	Process measures	Target for process measure	Comments
• Track and monitor referrals to Canadian Mental Health Association with bi-monthly process reviews • Monthly chart reviews conducted on all repeat emergency visits identifying trends and system gaps.	• Program level data tracking referrals to Canadian Mental Health Association • Monthly tracking of emergency department re-visit rates	• 70% of discharged patients to be referred to Canadian Mental Health Association for community support • Collecting baseline target for first year as a new and developing indicator	

Measure

Dimension: Safe

Indicator #10	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.	M	Count / Worker	Local data collection / Jan - Dec 2019	217.00	206.00	5% improvement over reporting period.	

Change Ideas

Change Idea #1 • Process Improvement Team ensures safety as a dimension of quality including both patient and workplace safety: safe workplace Elearn emphasizes 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 such as the Emergency Department and Mental Health to review incidents in real time for incident resolution.

Methods	Process measures	Target for process measure	Comments
• 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 • Monitoring staff completion of Code White training program.	• Monthly rate of E-learn compliance• % of units with standardized safety unit bundles rolled out • % of incidents reported and reviewed by care team and leadership • % completing code white training from high risk areas	• 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	FTE=3134