September 2019

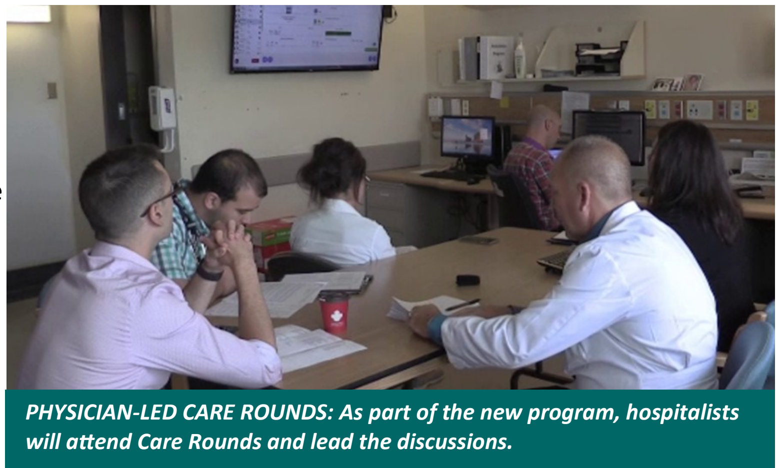
SOP Standardization & Optimization Process | Windsor Regional Hospital — Outstanding Care – No Exceptions!

the Standard

Exciting changes to the Hospitalist Program at the Metropolitan and Ouellette Campuses

Earlier this year, an Optimization Review recommended that WRH make improvements in patient flow, and standardize the Hospitalist programs between the Met and Ouellette Campuses. Hospitalists are physicians whose primary focus is caring for patients while they are in hospital.

Standardizing the program will not only positively impact patient care by providing a more seamless continuum of care, but also assist in the recruitment of new physicians for the program.



PHYSICIAN-LED CARE ROUNDS: As part of the new program, hospitalists will attend Care Rounds and lead the discussions.

The Hospitalist group, led by the Chief of Family Medicine, Dr. Marguerite Chevalier, met several times to review current performance patient-centred metrics for the program and identify strategies for improving and standardizing care. The goal was to develop a model of care for the Hospitalist program that would benefit the patients, and support the physicians and staff. It was fortuitous that the group had the opportunity to look at the processes currently used on the Short Stay Unit (5N) at Met campus as a guide for standardizing the Hospitalist Program. The Short Stay Unit has been very successful in consistently meeting several patient-centred metrics. The new hospitalist program is designed using many of the processes (called standard work) that are already working well for our patients.

The new Hospitalist Program was launched on Friday, August 30, with many exciting changes. Dr. Rob Seski is the Lead Hospitalist for the new program and is working with his colleagues to provide a successful launch.

There are several changes and improvements to the program.

At the Met Campus, the Hospitalist program will remain on both 5N (Short Stay Unit) and 6N (Medical Discharge Unit). The 6N floor was formerly called the Long Stay Unit, but was renamed the Medical Discharge Unit to shift the focus from patients staying a "long" time to a focus on timely discharges.

At the Ouellette Campus, the Hospitalist program, both short stay and medical discharge units, is located on the 7th floor and portions of the 8th floor. A Nurse Practitioner for the Family Medicine Hospitalist patients has also been added, similar to the Met campus. *Continued on next page*

Standardization & Optimization Process

WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE – NO EXCEPTIONS!

Exciting changes to the Hospitalist Program

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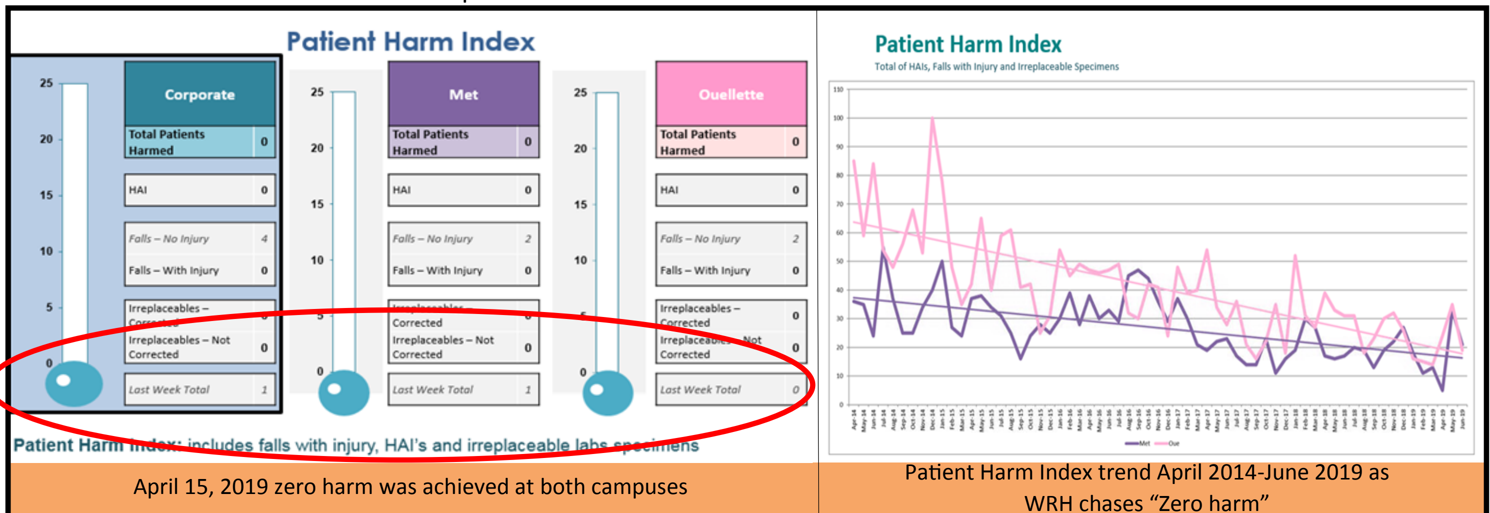
At both campuses, Hospitalist Physicians are now present on the units for the entire day/shift. This will increase the opportunity for nursing and allied staff to access and collaborate with the Physicians and monitor the patient's plan of care. Best practice strategies such as placement in assessment bays, Physician-led Care Rounds, and standardized discharge huddles have been implemented.

The new Hospitalist Program is designed to improve both care and outcomes for patients. The Hospitalist Group at both campuses and the entire multidisciplinary team will be closely monitoring the results of these improvements and are looking forward to working together to provide optimal care.

Making the impossible happen as we chase "Zero"

Each week, Windsor Regional Hospital reports the Patient Harm Index at Monday Morning Huddle. This measures the number of preventable harm incidents that occur in our organization including, Falls with Injury, Hospital Acquired Infections and Irreplaceable Lab Specimens. A Zero Harm Index means that none of these occurred during the past week. This remarkable achievement occurred four times in 2018 and has occurred five times in 2019 so far. In April, BOTH campuses achieved zero harm the same week proving it can be done!

Supplemental to this commitment to "Outstanding Care – No Exceptions!" was the addition of "Scrub Thursdays", an opportunity for our clinical leaders to don their scrubs and offer experiential support, develop stronger relationships, and get feedback from frontline staff. Experiences are then shared during monthly "Journey to Zero" sessions with all clinical leaders to address barriers to patient care.



April 15, 2019 zero harm was achieved at both campuses

Patient Harm Index trend April 2014-June 2019 as WRH chases "Zero harm"

"Do not waste a day of my life!"

Patients who are in hospital are eager to get well and eager to get home. Sometimes the healthcare journey requires that they receive additional services well past their acute care stay. It is difficult for patients to stay in hospital waiting for a bed at another facility so they can receive rehabilitative services. Every day waiting is a precious day wasted for patients and their families, and it also reduces the number of beds available for other patients with acute care conditions.

In February, 2019 WRH joined with the Erie St. Clair LHIN and Hotel-Dieu Grace Healthcare for a collaborative program called Intensive Home from Hospital Rehab Services (IHH). This program allows patients who require additional rehabilitative services to be discharged from hospital so they can receive these service at home, rather than waiting in hospital for an inpatient rehab bed at another facility. Patients can continue to receive rehabilitative services in their own home with the support of their family and friends.

Since March, 2019, WRH has referred 52 patients from both campuses to the IHH Program. The program has proven to be so successful that the ESC-LHIN plans on expanding the program to other hospitals in our region. The IHH program has been effective in helping to reduce the number of patients who are deemed Alternative Level of Care because they no longer require acute care services and are just waiting for a rehab bed, and has also helped create capacity and flow in the hospital by reducing the length of stay for rehab patients. The program is also designed to decrease re-admissions to hospital, increase patient satisfaction, and achievement of the patient rehab goals.

Marie Colarossi, Utilization Manager at the Ouellette Campus, commented, “Patients’ needs are being met in their own home. It is a collaborative service plan that is very patient centred and allows people the opportunity to see that they can function and heal in their own homes.”

Movement Matters—One Step at a Time

Windsor Regional’s Mobility Team has been working with certain “at risk” patients to keep them active while in hospital. The goal is to assist and maintain baseline function during their recovery process.

Information taken from MOVE ON (Mobilization of Vulnerable Elders in Ontario) tells us that ‘One-third of older adults develop a new disability in an activity of daily living (ADL) during hospitalization; half are unable to recover function.’

Identifying a patient’s mobility needs early is essential. It has been proven that early mobilization strategies have positive impacts on length of stay, delirium, independent functional status, risk of depression, rates of discharge to home, and hospital costs. Often our vulnerable elder patients remain in bed in the hospital.

Patients who are most “at risk” for complications are the ones who need assistance to get up and moving. On admission, the primary care nurse is responsible for identifying a patient’s mobility level, barriers to mobility, and setting daily mobility goals. When appropriate, the nurse will make a referral to the ambulation team using Ambulation Assistant referral criteria. Individual daily goals are established and discussed with the patient and caregiver team.

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Movement Matters—One Step at a Time

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Mobility is now being discussed daily during care rounds and barriers are escalated in real time. The Utilization Nurse is asked at the daily patient flow huddle if there are any patients over their Estimated Discharge by 5 Days and if so, if the barrier for discharge is mobility. All of these elements promote team work that includes everyone who is involved in the patient's care.

LET'S GET MOVING: *Ambulation assistants Erika and Tarra assisting a patient as she walks around the unit*

Tara Corra-Pella, Ambulation Assistant, a member of the mobility team since it began, shares, "As an ambulation assistant it is very rewarding to be part of a program that provides an opportunity for the patients to maintain or strengthen their abilities to mobilize and give them the confidence to reach successful outcomes." Often patients need encouragement, especially when they are not feeling well." The ambulation team will often say to patients, "Practice makes progress" or "Every day you try to do a little more than the day before."

Measuring Success: the team is looking at the number of hospital acquired pressure injuries and how many patients are identified as having mobility as the barrier to discharge. These patient outcome metrics are in the early stages. Ongoing education around identifying, preventing and reporting pressure injuries continues at the unit level. Capturing and discussing barriers to mobility are shared daily during the patient flow huddles with the Director of Medicine and Utilization Nurses.

You can see mobility information everywhere in the hospital. Look for the 'Movement Matters, Family and Friends can help too!' flyer in the elevators and patient information booklets. If patients are interested in keeping track of their daily walking distance, they can ask their nurse or ambulation assistant for a patient log.

Coming in September: We are preparing for an exciting corporate initiative 'Movement Matters – One Step at a Time' travelling across Windsor/Essex county. How far can W/E go?

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