2019/20 Quality Improvement Plan
"Improvement Targets and Initiatives"

Windsor Regional Hospital 1995 Lens Avenue

AIM		Measure									Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
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Theme I: Timely and Efficient Transitions	**Efficient**	Average number of inpatients receiving care in unconventional spaces or ER stretchers per day within a given time period.	P	Count / All patients	Daily BCS / October - December 2018	933*	16.55		Collecting Baseline Target as this is the first year of this indicator		1)•New Medicine Bed Allocation 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 • Overflow areas created for patients Admitted with No Bed (ANB) as a temporary location in a conventional space until an appropriate bed is available • 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• Surgical patient flow under development with launch in 2019 • Command Center launched in 2017 as the central hub for patient flow information displayed electronically, 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.	• Sustainment of performance of patient flow indicators •Roll out Surgical Patient Flow Bed Allocation Model in 2019 • Ongoing development of Command Center patient flow processes.	• Number of patients admitted each day as an Admit No Bed (ANB) requiring placement in unconventional spaces.	• % reduction in the number of patients receiving care in unconventional spaces	.
		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 / July - September 2018	933*	8.67	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.	Erie St. Clair Local Health Integration Network	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.	•Conduct weekly complex discharge rounds with hospital utilization team, social work, LHIN care coordinators, and other community support services to identify barriers to discharge for patients with complex issues • Conduct coordinated and timely discharge planning meetings with the LHIN and community providers • Address barriers to discharge daily at the patient level with integrated care team (SW, LHIN, Utilization) • Educate patients and families about the appropriateness of acute care services and Intensive Hospital to Home support services• Monthly review of patient flow indicators at Corporate Utilization Committee represented by medical directors and administration	•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	• 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	.
	Timely	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	933*	CB	CB	New indicator. Collecting baseline (CB) for 2019/2020.		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.	• 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.	• Percent completed of discharge summaries faxed to community provider where a community provider is documented • % compliance of discharge summary completion by physician • % completed of community provider documented on patient chart	• 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.	.

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		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 A N D A T O R Y	Hours / All patients	CIHI NACRS / October 2018 – December 2018	933*	11.3	10.74	Oct provincial avg 26.4. 5% better than our performance would be 10.74.	Erie Shores Healthcare, Windsor Essex EMS	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	• 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 • Reduced wait time for patients admitted to an inpatient bed with standardized processes • Daily monitoring of ambulance availability and Emergency Department Capacity across Windsor Regional hospital and Erie Shores Health Care	• 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.	• LOS 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	**Patient-centred**	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	933*	CB	CB	New indicator. Collecting baseline (CB) for 2019/20.		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.	• 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	•% of patient complaints compared to % response.	Collecting Baseline as first year of indicator	.
		Percentage of respondents who responded positively 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 consecutive 12-month period	933*	52.83	70.00	Ontario Inpatient Community Hospital Average is 53.7%. Target set is consistant with previous year target		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	• 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	•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	.
Theme III: Safe and Effective Care	**Effective**	Medication reconciliation at discharge: Total number of discharged patients for whom	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / October - December 2018	933*	57.87	59.00	Consistent with FY18/19 QIP target as well as 2019 Non-Union Compensation		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	•Audit compliance and accuracy monthly	•% of Medical Surgical patients with medication reconciliation completed at discharge.	•5% improvement is 60.8% from previous year results for medication reconciliation compliance at discharge	.

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		Proportion of hospitalizations where patients with a progressive, life-threatening illness have their palliative care needs identified early through a comprehensive and holistic assessment.	P	Proportion / at-risk cohort	Local data collection / Most recent 6 month period	933*	CB	CB	New indicator. Collecting baseline (CB) for 2019/20.		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.	• 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	• Individuals designated palliative care reviewed daily at care rounds	• 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.	.
		Rate of mental health or addiction episodes of care that are followed within 30 days by another mental health and addiction admission.	P	Rate per 100 discharges / Discharged patients with mental health & addiction	CIHI DAD,CIHI OHMRS,MOHTLC RPDB / January - December 2017	933*	14.49	11.30	Target based on achieving provincial average of 11.3% as identified by HQO		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	•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.	•Monthly tracking of raw re-admission rates • Program level data tracking referrals to Canadian Mental Health Association.	•Re-admission rate at or below provincial target; 70% of discharged patients to be referred to Canadian Mental Health Association for community support.	.
	Safe	Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.	MANDATORY	Count / Worker	Local data collection / January - December 2018	933*	256	243.00	5% improvement over reporting period		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.	• 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	• Monthly rate of Elearn 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=3193