



Report of the President & CEO to the Board of Directors

Date: November 2012

First Do No Harm

On November 15 and 16, 2012 Windsor Regional Hospital is hosting a truly remarkable individual who is going to share with us the impact our healthcare system can have on individuals.

We have talked a lot about the harm the healthcare system does to individuals that come through our doors to be healed. Some estimate as high as one in three individuals are harmed by us rather than healed.

We have done a lot at Windsor Regional to reduce the incident of harm to patients and enhancing our clinical care as well. It is a journey and we cannot stop or slow down our efforts.

On November 15 and 16, Mr. Ridley Barron is going to share with us how our healthcare system impacted his family. How the system responded to his family in a time of need and how his remarkable courage will help all of us along our journey to patient safety and quality of care.

I am confident that Mr. Barron will leave a life long impact upon you. He will challenge all of us to not slow down on our journey and, if anything, to double our efforts.

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AWARDED EXEMPLARY STATUS 2012



Strategic Direction - Excel in patient safety and quality

HEAR A REAL LIFE STORY OF THE RESULTS OF A MEDICAL ERROR

All staff, board members and volunteers are invited...

RIDLEY BARRON

A story of Hope, Healing and Forgiveness

November 15 2012

11:00am to 12:30pm

(Tayfour Rehab Room video-conferenced to Met Auditorium)

November 15 2012

3:00pm to 4:30pm

(Met Auditorium video-conferenced to Tayfour Rehab Room)

November 16 2012

7:00am to 8:30am

(Met Auditorium video-conferenced to Tayfour Rehab Room)



Please RSVP to:
**ext. 5RSVP
(57787)**

Ridley's story is a call for
continued improvement in patient safety.



Strategic Direction - Champion accountability and transparency

Patient Harm Index

- This past year Windsor Regional Hospital created a Patient Harm Index to create a better focus and avoid drift.
- The Patient Harm Index focuses on Hospital Acquired Infections, Falls (with and without injury), Irreplaceable Lab Specimens and Medication Incidents.

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AWARDED EXEMPLARY STATUS 2012



Patients Harmed Last Week

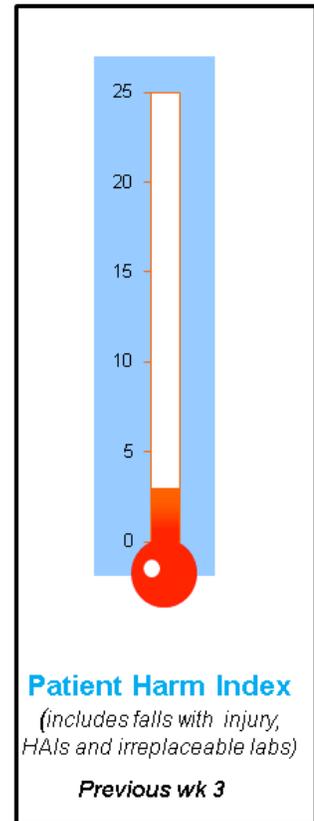
(dated week of Oct 22, 2012)

HAI	3
Falls	
Total Falls (no injury)	14+1 <small>near misses</small>
Falls With Injury	0
Irreplaceable Lab	
Corrected – Yes	0
Corrected - No	0
Patient Harm Index	3

Reported Medication Incidents

13 (includes 6 near misses)

- Overall: reaching pt 7 Harm 0
- High alert: reaching pt 1 Harm 0



- This Index is tracked daily and reviewed at our weekly morning huddles and Executive Committee meetings.
- Individually and collectively, with metrics like the Patient Harm Index, we can make proactive changes to avoid harm coming to patients that come to us to be healed.

Strategic Direction - Strengthen and sustain a proactive approach to health care funding reform

Expected versus Actual Length of Stay

- One of the main drivers of the new patient-based funding formula is the expected length of stay versus actual length of stay.
- In effect the new funding formula will pay a hospital a fixed amount of monies for a certain procedure regardless of how long the patient actually stays in the hospital. The payment is based on the expected length of stay for that type of procedure. Needless to say, the longer the stay the more expenses are incurred and thereby possibly/probably not being covered by the fixed payment.
- Expected Length of Stay (ELOS) is the average of acute length of stay in hospital for patients with the same case mix group (CMG), age category, comorbidity level and intervention factors. Resource Intensity Weights (RIW) is a relative value measuring total patient resource use compared to average typical acute inpatients.
- The goal is to get the actual length of stay (ALOS) as close to or better than the ELOS while at the same time ensuring documentation captures the appropriate RIW. A longer hospital stay than their ELOS is NOT in the best clinical interests of a patient.
- Although a lot of focus and effort has been placed on both ELOS, ALOS and RIW, we still have more work to do. On any given day our statistics have identified that we have 30 more beds in the acute programs in use than is necessary because our ALOS exceeds are ELOS. This is even after taking into the account the average of 25 daily alternative level of care patients (ALC) at the Met campus.
- Just imagine this scenario: We have 100,000 patient days per year for 20,000 patient admissions. Therefore, each patient, on average stays 5 days. Everyone's ALOS equals their ELOS. If each of those stays were just ½ day more than expected we would have to accommodate an extra 10,000 patient days. With 300 acute care beds, this is 33 more beds needed PER DAY PER YEAR.
- If we are to ensure our clinical results continue to get better and we have the necessary financial resources available for our patients, we need to continue to address this issue. Otherwise, our financial funding will continue to be reduced and in effect force us to have the ALOS at or better than the ELOS.

- One way we are doing this is an enhancement to our current software program.
- WRH's Utilization Team has now begun using the physician's provisional diagnosis and a new electronic-based tool within the Medworxx UMS software to assign ELOS for inpatient stays. The tool consists of a table of ELOS averages at the 25th-percentile for the top 100 Case mix groups within the ESCHLIN.
- The information will serve as a guide when staff and physicians are planning the care of our patients. It will be used to more consistently communicate ELOS to physicians, nursing and support staff at daily Care rounds and estimated dates of discharge to our patients. Using the Medworxx UMS software, this information will now be tracked in real-time fashion and will assist WRH to improve our LOS targets to the 25th percentile.

Strategic Direction - Create a vibrant workplace

New Strategic Plan and Posters

- On behalf of the Board of Directors, I am pleased to share with you the *Strategic Plan of Windsor Regional Hospital for 2012-2016*. Visit: http://www.wrh.on.ca/webbuild/site/wrh-internet-upload/file_collection/StrategicDirections/index1.html.
- This plan will allow us to continue our journey to Outstanding Care...No Exceptions!
- Shortly we will be meeting to operationalize the Strategic Plan and achieve the strategic directions and initiatives.
- In addition, you will start seeing posters similar to the one on the next page outlining our Vision, NEW Mission and Values.



Our Vision: Outstanding Care – No Exceptions !



Our Mission: Deliver an outstanding care experience driven by a passionate commitment to excellence.

Our Values:

<p>C – COMPASSIONATE</p> <ul style="list-style-type: none"> • Keeping the patient at the center of all we do; • Demonstrating compassion for patients and their families; • Supporting staff, physicians and volunteers so they are able to care for patients and each other; and • Operating as a team, within WRH and with our partners, to provide exemplary care. 	<p>A – ACCOUNTABLE</p> <ul style="list-style-type: none"> • Striving for accountability and transparency to those we serve and to ourselves; • Driving fiscal responsibility; • Stimulating effective two-way communication at all levels; and • Facilitating timely access to care and service. 	<p>R – RESPECTFUL</p> <ul style="list-style-type: none"> • Treating those we serve and each other with empathy, sensitivity, and honesty; • Upholding trust, confidentiality and teamwork; • Communicating effectively; and • Welcoming individuality, creativity and diversity. 	<p>E – EXCEPTIONAL</p> <ul style="list-style-type: none"> • Promoting a culture of quality and safety; • Embracing change, innovation, and evidence-based practice; • Encouraging learning, discovery, and knowledge sharing; and • Fostering dynamic partnerships.
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 David Musy
 PRESIDENT & CEO


 Gay Wrye
 CHAIR OF THE BOARD OF DIRECTORS

WINDSOR REGIONAL HOSPITAL
 OUTSTANDING CARE – NO EXCEPTIONS! 519-254-5577 • www.wrh.on.ca

Strategic Direction - Distinguish ourselves through superior performance, innovation, and exceptional customer service

Institute for Healthcare Improvement - 24th Annual National Forum

- Once again, Windsor Regional Hospital is having two of its leading practices displayed at the Institute for Healthcare Improvement (IHI) - 24th Annual National Forum taking place from December 9-12, 2012, in Orlando, Florida.
- The IHI National Forum is considered a premier “meeting place”. It unites attendees with thousands of health care leaders from around the world and allows attendees to engage in hundreds of defining moments that will shape the future of health care quality.
- The two leading practices are outlined on the next pages.



REDESIGN OF THE MEDICINE PROGRAM: BLENDING THEORY AND METHOD FOR GROUNDBREAKING RESULTS

The Medicine Program consists of four inpatient units. These units functioned as separate entities which resulted in:

- Lack of standardization;
- Variation in documentation, patient assignment and staffing;
- Inefficiencies in patient care processes and patient flow; and
- Variations in layout from unit to unit.

Ten front-line nursing staff from the Medicine and Emergency Departments worked 12 weeks and applied methodologies to redesign their Medicine program – from the ground up. The scope included phases of the patient journey: Pre-Admission, Admission, Care and Treatment, and Discharge. Staff focused on model of care, patient care processes, and patient flow.

Goal:

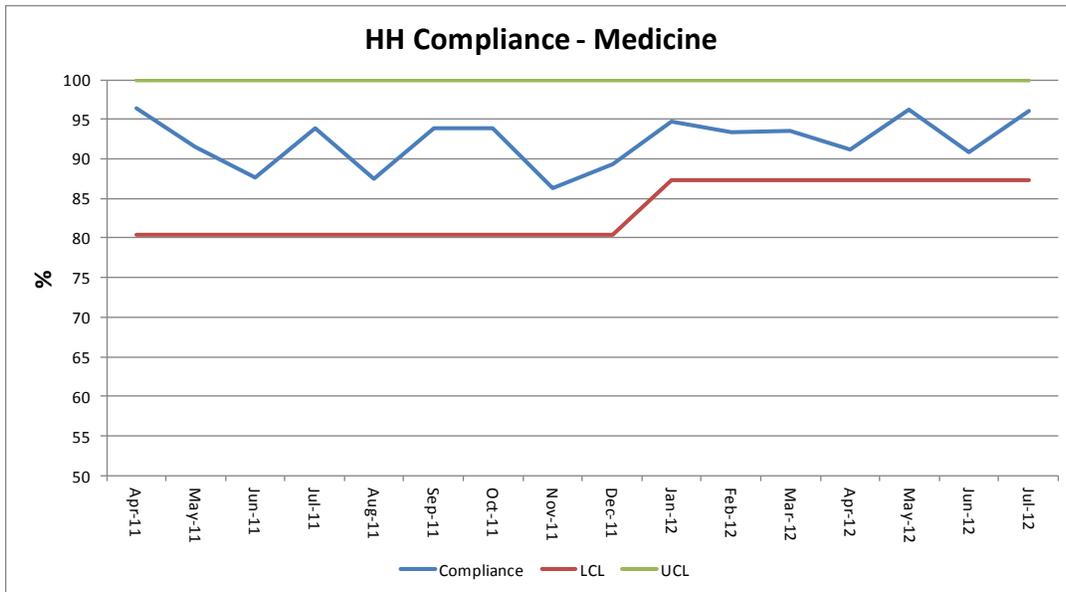
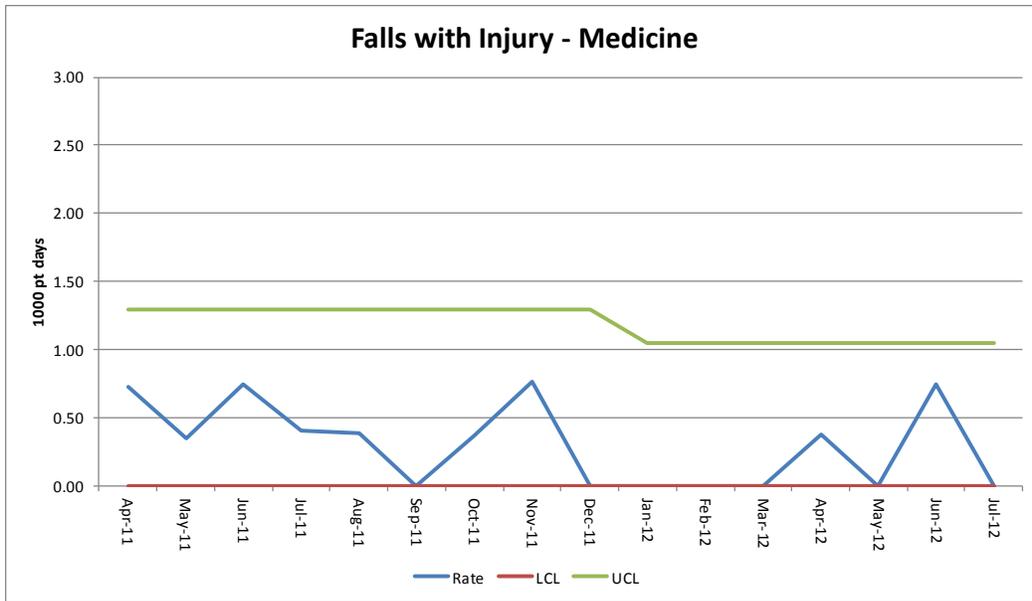
Redesign the entire Medicine Program to improve patient care processes, patient flow, and model of care.

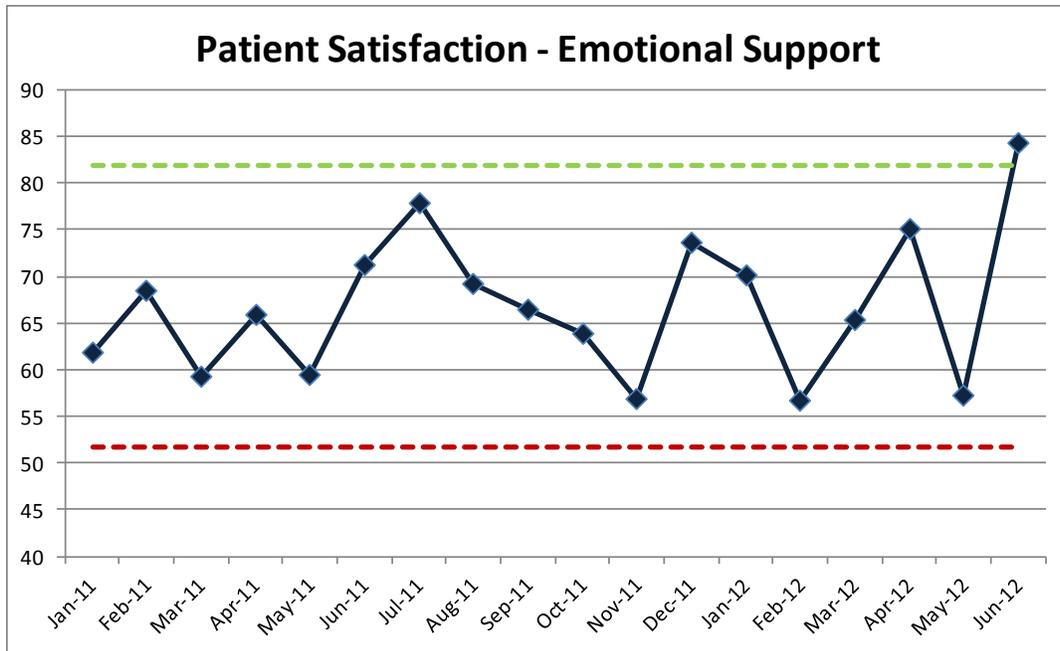
Various changes were tested including:

- Standard format/process for Patient care rounds, including use of a patient summary tool, focused on barriers to discharge on admission, and used during shift handoffs;
- Standardizing and sustaining Comfort rounds to reduce patient falls;
- Major changes to the physical environment of the nursing units including decentralized nursing stations, distributed and quiet medication rooms, bedside chart locations, new sinks to improve infection control processes; and
- Development of the “We Care Framework” to guide patient interactions and improve patient emotional support.

Results:

The result of this intensive project included a structured rollout of interventions directed toward falls prevention, patient satisfaction, alternatives to the current model of care, and improved methods for discharge planning. Within 3 months, a 50% reduction in falls was identified. Hand hygiene compliance and patient satisfaction has also increased.





Sustainability:

The ground has been broken for a new world for the WRH Medicine Program. Fueled by new knowledge and an enhanced process improvement “tool kit”, nursing staff continue to meet monthly to build a program focused on providing Outstanding Care, No Exceptions! Planned changes include:

- More improvements in nursing documentation;
- Adoption of call bell communication devices that will allow patients to connect directly with the nurse;
- Introduction of a Medicine Concierge who will act as a patient liaison; and
- Changes to support staff model to assist nurses with non-nursing tasks and allow nurses more time at the bedside.

Project Team Members

Karen Hazzard	4N
Holly Brunelle	6N
Crystal Allison	4N
Michelle Gagne	Emergency
Marty Gagne	Float pool
Renee Hamlin	5N
Jennifer Shepley	4W



Elisaveta Jovanoski 5N
Kristie Tasevski-Moy 5N
Linda Morrow Manager, Learning and Workplace Development
Jaime Furtado 4W
Karen Wells 6N
Corry O'Neil Director, Organizational Effectiveness

CHRONIC DISEASE MANAGEMENT: A STAFF DRIVEN EVIDENCE-BASED CARE MODEL AT WINDSOR REGIONAL HOSPITAL

Background:

Nursing staff of WRH within the Complex Continuing Care (CCC) program identified that current standardized care plans and documentation of patient education do not reflect standards of evidence-based care or an inter-professional approach. In addition the tools are:

- Time intensive and task oriented;
- Rarely kept up to date due to their inaccessibility to the nurse and to the rest of the inter-professional team; and
- Rarely developed in collaboration with the patient and family, which results in poor survey satisfaction results.

The development and implementation of an evidence-based inter-professional care plan and patient education model was funded, with a focus on diabetes, heart failure, and COPD. In addition we included urinary tract infection prevention and management as a sub project and engaged a Master's of Nursing student for development.

Aim:

The goals of this project included:

- improved staff engagement, leadership opportunities in quality improvement, and staff satisfaction with quality of work-life;
- Promotion of a culture of patient-centered care and collaboration with the inter-professional staff, and increased productivity of the workforce;
- Reduced staff stress, conflict and increased team work;
- Increased patient and family satisfaction; and
- Reduction in transfers and admissions to Acute Care.

Our timeline for this improvement project was January 2012 to March 31st, 2012.

Strategy:

A team of nursing staff representing all CCC units participated, with the guidance and support of senior and clinical management and were responsible for research and development, staff/patient/family engagement, data collection, measurement, staff education, and implementation of the care plans.

Changes Tested and Implemented:

1. Evidence-Based Plans of Care:

- Patients, families, and nursing staff were engaged in provision of feedback into priorities and goals through satisfaction surveys, pre and post implementation.
- An inter-professional approach to research and identification of best practices for inclusion in plans of care was undertaken with involvement of all disciplines.
- Piloting of documentation tools to ensure end user satisfaction with usability and application to the practice setting.
- Three new plans of care were implemented in April 2012 for Heart Failure, COPD and Diabetes.
- Additional supporting tools for documenting assessments of the respiratory system and foot exam were also developed.

2. Staff Education:

- Staff provided feedback on required education for increased understanding of best practices.
- Education developed in multiple formats to address various learner needs, including e-learn checks for understanding, self learning modules, didactic sessions and direct mentoring and coaching at the bedside.
- Project team nursing staff provided education to their peers utilizing a unit champion approach.
- All nursing, allied health staff and physicians within CCC received training on the new approaches.

3. Patient and Family Engagement:

- Patients and their families were surveyed both pre and post implementation regarding their satisfaction levels.
- This information was utilized to develop the plans of care and determine content required for staff education.

- Patients and their families participated in evaluation of the various iterations of the tools while under development providing feedback into the process throughout.

Measurement and Improvement:

Baseline data was collected in January 2012 and post implementation data was collected between April and June 2012. Our measures included patient and nurse satisfaction and transfers and admissions to Acute Care from CCC were measured.

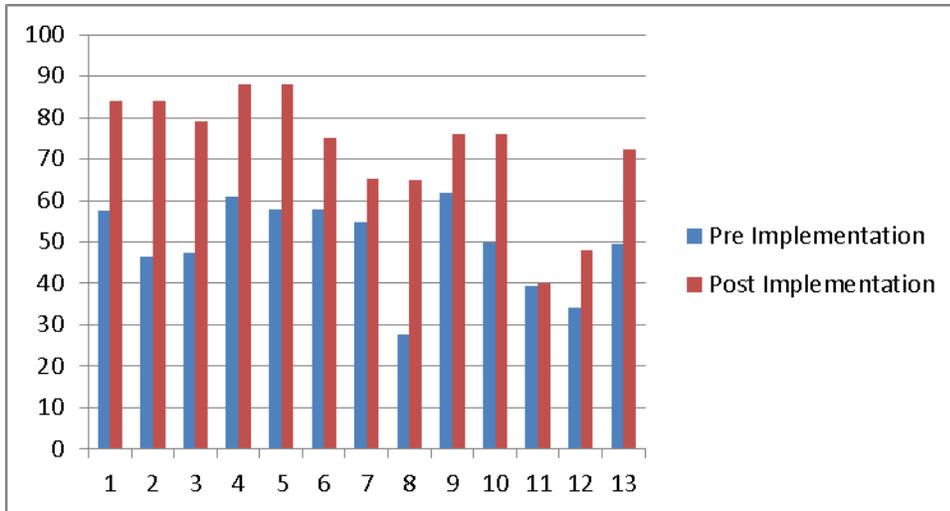
Results:

Post implementation measurement was collected between April 2012 and June 2012.

Nursing Satisfaction:

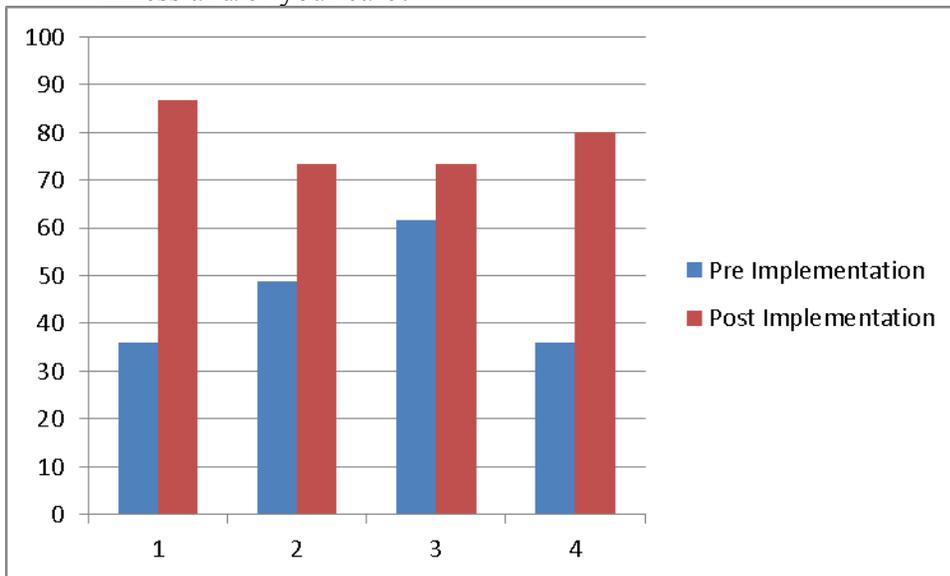
- 1 Reflect the current patient needs in a clear fashion.
- 2 Are developed in collaboration with the inter-professional team.
- 3 Are developed in collaboration with the patient/family/SDM.
- 4 Are evidence-based, incorporating best practices into the plan of care.
- 5 Guide the care delivered to the patient.
- 6 Assist you in planning your care delivery.
- 7 Provide a mechanism for evaluating your patients response to the care delivered.
- 8 Are reviewed and updated regularly based on changes in the patient condition.
- 9 Are accessible to you when providing care.
- 10 Assist in planning and delivery of patient/family/SDM education.
- 11 I am satisfied with the amount of time that I spend in provision of bedside care for my patient(s).
- 12 I am satisfied with the amount of time that I spend in provision of patient education.
- 13 Overall





Patient Satisfaction

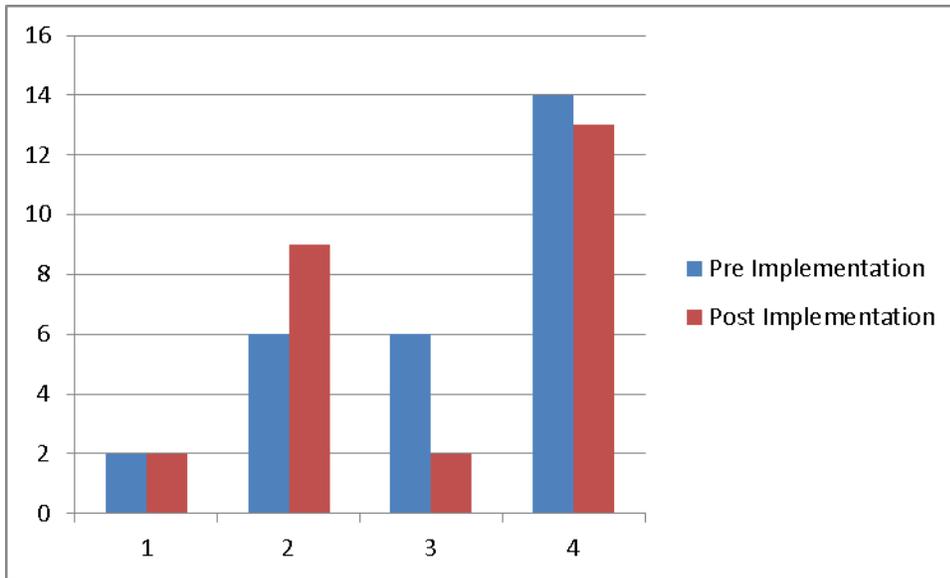
- 1 Has someone asked you what your goals are for treatment?
- 2 Do you know what goals have been established for treatment?
- 3 Does your treatment plan meet your needs and goals?
- 4 During hospitalization you/your family member have received education related to your illness and/or your care?



Transfers to Acute Care

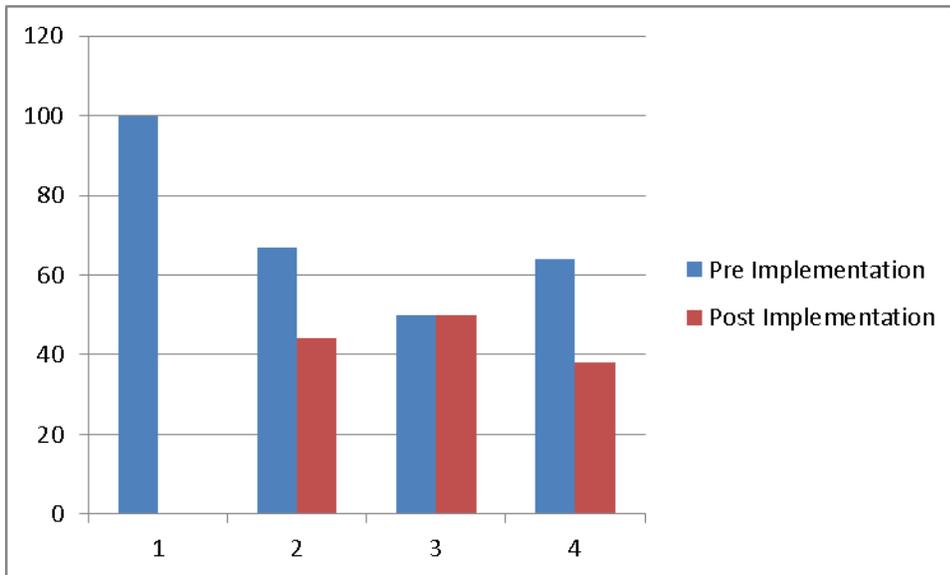
- 1 Cardiac
- 2 Respiratory
- 3 Urinary Tract
- 4 Total





Admissions to Acute Care

- 1 Cardiac
- 2 Respiratory
- 3 Urinary Tract
- 4 Total



Project Team Members:

Karen Riddell, RN, MBA
Caroline Bothamley, RN
Sarah Picco, RN
Marianne Gilbert, RPN
Shelley Farrand, RPN
Maria Feloniuk, RN
Grace Ramos, RPN
Pat Scalia, RPN
Danielle Souci, RN
Danielle Vukosavljevic, RN (UTI Lead).

Many experts from disciplines including Physiotherapy, Occupational Therapy, Clinical Nutrition, Medicine, Endocrinology, Respiratory Medicine, Cardiology, Podiatry and Recreational Therapy were consulted throughout the course of this project. Fifty-four patients participated in provision of feedback during this process in the early evaluation, during testing of changes and in post implementation evaluation. Eighty-seven staff nurses provided feedback in all phases of the project.

Sustainability:

The new plans of care along with the supporting education have been incorporated into our CCC orientation. Audits are being completed on a weekly basis by the Charge Nurses on all units, and on a quarterly basis by the Clinical Practice Managers to ensure the changes are sustained in practice.

An audit conducted in the summer of 2012, 3 months after implementation, showed that 32 of 33 patients in CCC with one of either Heart Failure, COPD or Diabetes had active and up-to-date plans of care on their chart. A subsequent audit is planned for October 2012. Transfers and admissions to Acute Care are monitored on an ongoing basis.

Lessons Learned:

Increasing staff, patient and family participation in quality improvement initiatives yields great rewards not only in measurable results such as satisfaction and admissions, but also in morale, sense of team, and inter-professional collaboration.

Strategic Direction - Strategically engage with external partners

New Face, New Name BUT same Amazing Staff

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- Starting in early 2013, we will be renovating the existing Palliative Care Unit on the 3rd floor of the Tayfour Campus, Malden Park building.
- With the leadership of our Windsor Regional Hospital Foundation, the amazing creations and architectural designs from Robert Gauthier and the philanthropic support from T2B the new Supportive Care Unit will match the amazing staff we already have in the program.



- As we all know the transition to this part of one's life is stressful and difficult both physically and emotionally for patients, families and staff. Windsor Regional Hospital wanted to design a project that reduced that stress and allowed people to focus on taking care of their loved ones and not be worried about their physical environment.
- The end result will be magic. We will have created a home like environment for the patients, families and staff.
- I cannot thank enough the WRH Foundation, Robert Gauthier and T2B. The project is aptly entitled *From Rooms to Wings*. We are going to end up with a project that will be a model for others to follow.