2013 - 14 QIP Plan for Windsor Regional Hospital

AIM		MEASURE					CHANGE			
Quality Dimension	**Objective**	**Measure/Indicator**	**Current Performance**	**Target for 2013/14**	**Target Justification**	**Priority level**	**Initiative Number**	**Planned Improvement Initiative (change ideas)**	**Methods and Process Measures**	**Goal for change ideas (2013/14)**
Access	Reduce wait times in the ED	**ER Wait times**: 90th Percentile ER length of stay for Admitted patients. **Data:** Q4 2011/12 – Q3 2012/13, iPort	**26.5 hrs**	**20.8 hrs**	Aiming for 90th percentile among peers or better. Based on (Erie St Clair Local Health Integration Network) ESCLHIN Pay for Performance targets.	1	1 2	● Continue with focus on maintaining ED admission rates at 10% or lower ●Implement every two (2) hours "Patient Flow Huddles"	● Daily tracking of admission rates with weekly and monthly reporting hospital wide	10% ED admission rate each month
		ED Length of Stay - Complex Non admitted 90th percentile ER Length of Stay for Complex conditions. **Data**: Q4 2011/12 – Q3 2012/13, iPort	**7.4 hrs**	**6.9 hrs**	Aiming for 90th percentile among peers or better. Based on (Erie St Clair Local Health Integration Network) ESCLHIN Pay for Performance targets.	2	1	●ED Physician Triage (PIT) a minimum of four (4) hours per day	●Track and report daily number of high acuity non-admitted patients discharged within established target	6.9 hours target met each month
		ED Length of Stay - UnComplex ; Non admitted 90th percentile ER Length of Stay for Uncomplex conditions. **Data**: Q4 2011/12 – Q3 2012/13, iPort	**3.9 hrs**	**3.8 hrs**	Aiming for 90th percentile among peers or better. Based on (Erie St Clair Local Health Integration Network) ESCLHIN Pay for Performance targets.	2	1	●Sustain the Nurse Practitioner focus on CTAS 4/5	●Track and report results daily, weekly, and monthly	3.8 hours target sustained each month
	Improve admitted patient flow	**% Discharged by 1100 :** average % Med Surg inpatients discharges that occur before 1100 /month. **Data (Internal)**: Average for April-Dec. 2012	**30.50%**	**32%**	Target is based on IHI literature and is internally set to effectively manage patient flow and based on discharge and admission patterns at WRH.	2	1	●Ensure that standardization of care/bullet rounds and elements documented on board on the Medicine and Surgical Units ie. Estimated Date of Discharge (EDD) and length of stay (LOS)	●Medicine Redesign team will evaluate and assess care boards for standardization ● New patient summary too for reporting at care rounds will be piloted and rolled out to Surgical units	●100% compliance with key documentation elements ie EDD, ELOS, discharge destination and CCAC involvement ● 100% of units will be utilizing the Patient summary tool as part of the care round process
		% Discharged by 1400 : average % Med Surg inpatients discharges that occur before 1400 /month. **Data (Internal)**:Average for April-Dec. 2012	**69%**	**70%**			2	● Engage Family Medicine team physicians to work with Utilization team to participate in new process in Medworxx for assigning Case Mix Group (at 25%tile length of stay)	● Work with Chief and Physician led for Utilization to present and pilot process	● Achievement of the Average LOS for CMGs at the > 50 %percentile
Effectiveness	Improve organizational financial health	**Actual vs Expected Cost Per Equivalent Weighted Case:** is the Ratio of Actual to Expected Cost per Equivalent Weighted Case and is calculated as the total Acute Inpatient and Newborn expenses divided by total Acute Inpatient and Newborn cases divided by our Peer groups expected the total Acute Inpatient and Newborn expenses divided by total Acute Inpatient and Newborn cases **Data: Ministry's Cost/Weighted Case Rpt, Q1-3 2012-13**	**0.6**	**-1**	Theoretical best is between 0%-2% based on the slight variation that may exist between peer hospitals. Our goal is to achieve better performance than our expected.	2	1 2 3 4	● Maintain cost control on operations ● Length of Stay (LOS) performance comparisons both internal and external ● External consultant review of Acuity Summary Form (ASF) ● Identification of documentation drivers related to case weights	● Accurate and timely financial reports and monitoring of variances ● Provide services and physicians with LOS comparisons, tracking monthly ● Improved ASF forms and monitoring of completion and accuracy ● Improved clinical documentation (e.g. new discharge summary templates completed)	● Balanced budget and actual results ● Improve LOS to 40th percentile of peers ● Increase ASF compliance to 80-85% ● Increase use of new discharge summary templates by 50%
	Reduce unnecessary deaths in hospitals	**HSMR:** Number of observed deaths/number of expected deaths x 100 - **Data:** FY 2011/12, as of December 2012, CIHI	**95*** *based on previous calculation methodology	**95**	A value of 100 represents an average value for hospital mortality. Our goal is to perform better than the average by 5%.	2	1 2	● Continue with established auditing process for patient mortality and morbidity . ● Monitor and track established MD documentation compliance indicators established by Medical Quality Assurance Committee monthly	● Each MD service to complete quarterly chart reviews and report findings to Medical Quality Assurance Committee ● As per Health Record monthly auditing process - Compliance with Acuity Summary sheets completion and Dictated discharge summary (within 7 days) and completion of chart deficiencies	● 100% compliance /service with quarterly audits ● 80% completion of Acuity Summary tool/service ● 90% completion of Dictated discharge summary/service ● 0 deficiencies beyond 30 day per MD
	Reduction of unplanned and incidental sick time	**Sick Time:** Sick time is any unplanned absence, due to illness, not related to a medical leave of absence. Calculated monthly by taking the overall incidental hours for top 5 ONA department with highest unplanned and incidental sick time hours: **Data (Internal)** : June -Dec 2012	**457.07 hrs/month**	**345 hrs/month**	Based on a 25% performance improvement over current baseline and compared to best performing hospitals average paid sick time	2	1	● Identify and remove barriers for sustained and consistent counseling for RN staff with incidental sick time in accordance with policy ● Develop apporpriate escalation plan to ensure consistency ● Review and revise existing tools and templates.	● Monitor and report monthly number of incidental sick time hours by department. ● Track ongoing compliance with counseling and escalate accordingly. ● Trial revised tools amongst indicator team and then rollout corporately.	25% reduction in incidental sick time

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Integrated	Reduce unnecessary time spent in acute care	**Percentage ALC days:** Total number of inpatient days designated as ALC, divided by the total number of inpatient days. **Data**: Q3 2011/12 – Q2 2012/13, DAD, CIHI	**13.10%**	**9%**	Better than provincal target for acute ALC for hospital type and in alignment with ESC LHIN target	2	1	● Continue collaboration with CCAC- ESCHLIN in the implementation of Home First strategies and options to facilitate placement of ALC patients	● Daily monitoring and trending of patients being discharged home, Readiness for Discharge (RFD) and number of ALC patients	● # of patients discharged per day ● # of patients meeting RFD ● # of patients per ALC destination/ day
	Reduce unnecessary hospital readmission	**Readmission within 30 days for selected CMGs to any facility:** The number of patients with select CMGs **(ie CHF, COPD, stroke)**readmitted to any facility for non-elective inpatient care within 30 days of discharge, compared to the number of expected non-elective readmissions - **Data**: 2011 DAD, CIHI	**15.12%** **22.7 %** CHF	**12%** **12 %** CHF	This is based on the Erie St. Clair LHIN Quality and Safety Committee targets. The goal is to reduced 30 day re-admits for COPD and CHF patients to a 3 year target of 12%. These are the 2 CMG's with the largest readmission rate and hence the target produced for the overall.	2	1 2 3	● Implementation of a revised standardized care pathway to guide care from admission to discharge and beyond ● LACE tool implementation ● Education of staff on the entire process	● Audit key steps in the pathway to ensure adherence eg. Order set utilization, CCAC on discharge, follow-up appointment ● Electronic LACE tool implemented for every CHF patient on the pilot unit ● Roll-out of LACE tool to other areas as appropriate ● Educational Program developed and to be provided to all staff on the pilot unit and roll-out to other unit as appropriate ● Develop a methodology for communication of LACE score on handoff to other care providers ie. Rapid Response Nurse Program (CCAC)	● 50% of order set utilized;95% of patients received CCAC consult and/or referral; 100% of CHF patients will have a follow-up appointment with MD ● 100% of patients on the pilot unit will have a LACE score on admission and discharge ● 75% of staff on pilot unit receive education program
Patient Centered	Improve patient satisfaction	NRC Picker: "Overall, how would you rate the care and services you received at the hospital?" (add together percent of those who responded "Excellent, Very Good and Good") **Data:** NRC Picker, Oct 2011-Sep 2012	**94.8 (Inpatient)** **86.18 (ED)**	**96.4 (Inpatient)** **91.8% (ED)**	This is based on the established benchmark for Pt Satisfaction Indicators- 80th percentile NRC Picker data (fiscal 2010-11)	2	1	●Sustain existing overall patient satisfaction scores	●Reporting monthly and quarterly NRC Picker results	Sustain 95% or greater overall satisfaction ***also refer to emotional support indicator below
	Improve overall patient with emotional support providing during inpatient and ED visits	**Emotional Support** NRC Picker survey questions evaluate how well WRH program address anxieties/fears and confidence/trust in service providers and the ease of finding someone to talk to. This indicator combines positive scores for all the questions that fall under the Emotional Support Dimension of Care. **Data:** NRC Picker, Oct 2011-Sep 2012	**70.64% (Inpatient)** **62.92% (ED)**	**78% (Inpatient)** **70% (ED)**	10% improvement for Emotional Support.	2	1	●Initiate Corporate "World Class Service" training	●House-wide training over the next twelve (12) months with monitoring and reporting of impact on NRC Picker emotional support scores	● 10%improvement/program
Safety	Reduce clostridium difficile associated diseases (CDI)	**CDI rate per 1,000 patient days:** Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1,000 - Acute Care only **Data**: Average for Jan-Dec. 2012	**0.27/1000pt days**	**0.25/1000pt days**	Benchmark - based on the 10th percentile performance for hospitals with >300 beds.	2	1	●Continue to roll out the use of clorox products for cleaning CDI patient rooms and equipment corporate wide	● Establish daily and terminal cleaning process (through housekeeping) for the use of clorox based products in CDI cases ● Ensure that all clinical units are utilizing clorox based products for cleaning equipment in CDI cases- presently process is being rolled out corporately	●100% compliance with the use of clorox in CDI cases as per tracer audits/month ●100% of the units have implemented clorox products in CDI cases
	Reduce rates of deaths and complications associated with surgical care	**Rate of in-hospital mortality following major surgery**: This indicator measures the rate of in-hospital deaths due to all causes occurring within five days of major surgery. **Data**: FY 2011/12, CIHI CHRP eReporting tool	**4.85**	**4.06**	Target is based on the hospital adjusted rate for the high performer in the Province of Ontario. Fiscal year 2010-2011.	2	1	See HSMR change/improvement content - will be monitored by Medical Quality Assurance audits		
	Sustain health care provider hand hygiene compliance	**Overall HH compliance (based on 4 moments of HH):** % of observed staff who wash their hands appropriately according to the MoHLTC moments of hand hygiene criteria. **Data (Internal)**: average April- Dec 2012	**95.90%**	**> 95%**	Close to Theoretical best	3	1 2	●Ensure Hand hygiene auditing process are resulting in true picture of hand hygiene (ie reliable and valid) ●Standardize the patient and family education re HH performance expectations at WRH on all unit	●Research best practice literature and determine best process for auditing ●Retrain auditors to new process and standardize methodology ●Process to be developed for patient/ family/visitor education	● 90%of those conducting audits will be trained ● Reduction in HAI rate to below target (.875/1000pt days)
	Eliminate incidence of Hospital acquired infections and colonizations	**Hospital Acquired Infections (HAI):** the number of hospital acquired infections expressed as a rate per 1000 patient days/mon. The infections included are: Multiple-Resistant Staph Aureus (MRSA), Vancomycin-Resistant Enterococci (VRE) Clostridium Difficile (C diff). **Data (Internal):** average April- Dec 2012	**0.92**	**0.875/1000 patient**	Target is based on >10% improvement of Windsor Regional Hospitals current average monthly performance.	2	1	● Evaluate and eliminate gaps in screening patients for infections on ED visit ; in patient admission and on transfer to unit	● Research best practice hospitals and redevelop the documentation on the IPAC screening tool for infections. ● Determine ongoing accountabilities for documentation on the patient screening tool and patient record	● 75% accurate completion of the screening tool and ongoing documentation on pilot /target units
	Avoid incidences of patient falls with injury	**Patient Falls with Injury:** the number of reported inpatient falls with injury expressed as a rate per 1000 patient days/month. **Data (Internal):** average April- Dec 2012	**0.08/1000 pt days**	**0.07/1000 pt days**	Target is based on > 10% improvement of Windsor Regional Hospitals most recent fiscal performance.	3	1	● Create a "falls" and "comfort round" bundle focused on evidenced based practice on assessment of risk and implementation of interventions.	● Introduce best practice to staff ● Provide staff education and training. ● Modify practice . ● Track and report fall with injury rate weekly and monthly	● 80% of staff having completed Falls and Comfort Round Bundle Training & Education. ●5% overall reduction of fall with injury rate.

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Safety	Eliminate irreplaceable specimen incidents and Reduce unacceptable specimen incidents	**Patient Specimen Incidents- Irreplaceable:** the total number of irreplaceable specimens (those which would be difficult or impossible to recollect) rec'd by the lab per month. **Data (Internal):** average April- Dec 2012	**2.6**	**0 irreplaceable specimens**	Aiming for Theoretical Best	2	1 2	● Monitor and trend all irreplaceable specimens by Patient Care Areas. ● All incidents to be reviewed and specific improvement plans identified and implemented.	● Patient Specimen process audits for all areas on escalation. ● A Just Culture review will be undertaken as required. ● Areas specific education and engagement strategies also available if deemed helpful.	● 100% compliance with zero repeat incidents
		Patient Specimen Incidents-Unacceptable : the total number of unacceptable specimens due to collection and labeling errors rec'd by the lab per month. **Data (Internal):** average April- Dec 2012	**246 per month**	**123/month**	Target is based on a 50% improvement of Windsor Regional Hospitals most recent fiscal performance.	2		● Criteria established for what constitutes an unacceptable specimen resulting in patient harm. ● Unit-specific report developed for Clinical Practice leaders to follow-up on all unacceptable specimens. ● Staff awareness of unacceptable specimens and contributing factors. ● Track & trend factors and implement improvement processes. ● Identify an "owner" for Order Entry processes and required improvement initiatives (e.g. Ward Clerk orientation, use of the navigational tool, technology improvements, etc.)	● Monthly review of unit-specific unacceptable specimen incidents by Clinical Practice leaders to the staff ● Weekly review of unacceptable specimen incidents by the Pt. Specimen team and identification to trends ● Standardized best-practice processes developed to address contributing factors.	● 100% compliance with a monthly review of all unacceptable specimen incidents by each area ● Increased staff awareness of the importance of appropriate specimen labeling and collection practices
	Eliminate all medication incidents that harm patients and reduce the incidents that reach the patient	**Reported Medication Incidents (Reached Patient and Harm):** The total number of medication incidents/ month occurring that reach the patient involving temporary or permanent harm and require intervention or prolonged hospitalization. **Reported in Risk Monitor Pro Data (Internal):** average April- Dec 2012	**0.55 incidents*** *ranges from 0-2/month	**0 medication incidents that cause harm**	Aiming for Theoretical Best	1	1 2 3	● Create awareness of the need to report near misses to learn about gaps in our medication system before they reach the patient ● Improve the detection of high alert medication incidents that harm patients ● Track specific action plans for implementation to ensure medication process improvements	● Percentage of reported incidents that are near misses ● Monitor & track 'trigger' medications (e.g. naloxone, glucose, vitamin K, etc.) to increase documentation of med. Incidents ● Follow up on all medication incidents within 48 hours	● Increase reporting of near misses by 10% ● Decrease # incidents medication incidents reaching patients of targeted medications by 10% ● 100% compliance with root cause analysis method for Category E (and above) incidents
		Reported Medication Incidents (Reached Patient Harm+No Harm): The proportion of all medication incidents reported/month that reached the patient including those that caused harm and or no harm. The remaining proportion of medication incidents represent the reported near misses/month **Reported in Risk Monitor Pro Data (Internal):** average April- Dec 2012	**46%** **54%** (near miss)	**40%**	Based on a >10% reduction in the proportion of medication incidents reaching the patient	1	1 2 3	● Create awareness of the need to report near misses to learn about gaps in our medication system before they reach the patient ● Improve the detection of high alert medication incidents that harm patients ● Track specific action plans for implementation to ensure medication process improvements	● Percentage of reported incidents that are near misses ● Monitor & track 'trigger' medications (e.g. naloxone, glucose, vitamin K, etc.) to increase documentation of med. Incidents ● Follow up on all medication incidents within 48 hours	● Increase reporting of near misses by 10% ● Decrease # medication incidents reaching patients by 10% as a proportion
	Reduce patient harm	The **Patient Safety Culture** indicator includes total number of patients harmed per month due to a fall with injury an HAI or an irreplaceable specimen. Variability in the result signals drift in a culture that supports safety **Data (Internal):** average Jan- Dec 2012	**17.2 pt/month**	**8 pt /month**	Target is based on a 15% improvement of Windsor Regional Hospitals average monthly performance.	1	1 2 3	● Implement Patient Safety 101 Curriculum ● Development and distribution of corporate communication related to patient safety to reduce "drift" i.e. patient safety newsletter ● Leadership rounding	● % of staff completing curriculum; ● % of professional staff completing curriculum ● # of people submitting for reward/draws ● 100% compliance in leadership rounding per established protocols	● Reduction in number of patients harmed as indicated by the Patient Harm index (reduction to 8 per month) ● Improvement in Quality of Worklife survey results related to leadership support of patient safety to 4.0 ● Reduction in # of patient complaints; improvement in patient satisfaction scores of 15% for select programs