2014/15 Quality Improvement Plan for Ontario Hospitals
"Improvement Targets and Initiatives"

Windsor Regional Hospital 1995 Lens Avenue

AIM		Measure								Change			
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Priority level	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas
Access	Reduce wait times in the ED	ED Wait times: 90th percentile ED length of stay for Admitted patients.	Hours / ED patients	CCO iPort Access / Q4 2012/13 – Q3 2013/14	1079	25.68	20.9	Provincial target is 25 hours. This target is very important to funding. Push to be better than peers as staying stagnant will result in loss of funding	Improve	1)•Focus on maintaining ED admission rates at 10% or lower to increase ED capacity and performance and improved bed utilization. •Standardize reporting across both sites due to October 1, 2013 realignment •Creation of Short Stay Medical Unit for patients with an expected LOS of less than 72 hours. • Improve overall flow with increase in percentage of patients discharged before 1100 and 1400. •Improved coordination with CCAC of complex patients designated ALC.	•Daily tracking of admission rates with weekly and monthly reporting and tracking hospital wide with dedicated indicator team monitoring progress daily and reporting weekly. •Monitor flow across all inpatient units and increase percentage of discharges before 1100 and 1400 with targeted discharges/day/unit. •Monitor admissions to Short Stay Medical Unit to ensure expected LOS is less than 72 hours and patients admitted to unit within 90 minutes (from decision to admit to the time they leave the ED). •Maintain newly introduced weekly Complex Discharge Rounds with CCAC to discuss ALC patients and eliminate barriers to discharge.	•Daily tracking of admissions, discharges, ED holds and ALC's. •Weekly tracking of indicator reviewed with leadership and frontline with weekly action items responding to unmet target • Percentage of discharges before 1100 and 1400	•10% ED admissions rate each month •90th % LOS for admitted patients below 20.9 hours. •Increase percentage of discharges before 1100 and 1400
		ED Wait times: 90th percentile ED length of stay for Admitted patients.	Hours / ED patients	CCO iPort Access / Q4 2012/13 – Q3 2013/14	4773	24.32	20.9	Provincial target is 25 hours. This target is very important to funding. Push to be better than peers as staying stagnant will result in loss of funding	Improve	1)•Focus on maintaining ED admission rates at 10% or lower to increase ED capacity and performance and improve bed utilization. Standardize expectations across both acute sites as a result of October 1, 2013 realignment • Improve overall flow with increase in percentage of patients discharged before 1100 and 1400 and targeted discharges. •Improved coordination with CCAC of complex patients designated ALC.	•Daily tracking of admission rates with weekly and monthly reporting and tracking hospital wide. Establishing indicator team monitors progress daily and reports weekly. •Monitor flow across all inpatient units and increase percentage of discharges before 1100 and 1400 with targeted discharges/day/unit. •Maintain newly introduced weekly Complex Discharge Rounds with CCAC to discuss ALC patients and eliminate barriers to discharge.	•Daily tracking of admissions, discharges, ED holds and ALC's. •Weekly tracking of indicator reviewed with leadership and frontline with weekly action items responding to unmet target • Percentage of discharges before 1100 and 1400.	•10% ED admissions rate each month • 90th % LOS for admitted patients below 20.9 hours. •Increase percentage of discharges before 1100 and 1400
Effectiveness	Improve organizational financial health	Total Margin (consolidated): % by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expense, excluding the impact of facility amortization, in a given year.	% / N/a	OHRS, MOH / Q3 2013/14	933*	0.44	2	Requires a balanced budget before net building amortization and is consistent with H-SAA reporting	Improve	1)•Continue annual benchmarking to peer hospitals. • Maintain cost control of operations across both sites as a result of October 1, 2013 realignment. • Continue performance comparisons (LOS, ALC, etc.) both internal and external to ensure no loss in funding. •Analyze QBP cost comparisons to inform strategies, workflow improvements and supply cost reductions	•Ongoing monitoring and tracking of performance targets across departments, services and physicians. •Accurate and timely financial reports and monitoring of variances. • Monthly departmental review with leadership team. •HBAM/QBP monthly/quarterly tracking to ensure that costs are same or better than high performing peers	•Monthly Financial Scorecard. •Provide services and physicians with monthly results on LOS, as well comparisons, and improvements using clinical documentation templates. Standardize reporting across two sites as a result of Oct 1, 2013 realignment. •HBAM/QBP reporting framework to track facility performance on a monthly/quarterly basis	•Balanced budget and actual results. •Improve LOS to 40th percentile of peers. • Among physician group, continued increased compliance overall with clinical documentation tools to 80% for the Metropolitan campus. Introduce physician clinical documentation tools to all services at the Ouellette campus
	Reduce unnecessary deaths in hospitals	HSMR: Number of observed deaths/number of expected deaths x 100.	Ratio (No unit) / All patients	DAD, CIHI / 2012/13	1079	102	80	A value of 100 represents an average value of hospital mortality. Our goal is to continue to perform better than the national/provincial (89) average. More recent data (based on CIHI results) is 83 and therefore better than the ratio identified in 'current performance'	Improve	1)•Continue with established auditing process for patient mortality and morbidity reviews. •Continue to monitor and track physician documentation compliance indicators established by Medical Quality Assurance Committee monthly. •Ensure timely response to care •Decrease rates of infection	•Each MD service to complete quarterly chart reviews and report findings to Medical Quality Assurance Committee. •Continue monthly auditing process to review compliance with acuity summary sheet completion and dictated discharge summary completion of chart deficiencies. •Do to realignment on Oct 1, 2013, amalgamation of the two medical quality committees and standardizing processes across the Met and Ouellette sites. •Monitor and track performance and quality indicators and report back to committees.	•The number of MD charts reviewed by service • Percent of compliance with completed Discharge Summary and Acuity Summary forms. •Percent of compliance with individual chart reviews with quarterly auditing process.	100% compliance/service with quarterly audits. •80% completion of Acuity Summary across all services. •80% completion of dictated discharge summary across all services. •0 deficiencies beyond 60 days for each physician
		HSMR: Number of observed deaths/number of expected deaths x 100.	Ratio (No unit) / All patients	DAD, CIHI / 2012/13	4773	104	80	A value of 100 represents an average value of hospital mortality. Our goal is to perform better than the national/provincial average (89). More recent data (based on CIHI results) reports HSMR at 89, therefore better than ratio reported under current performance	Improve	1)•Due to October 1, 2013 realignment, amalgamate Ouellette Campus Morbidity and Mortality Committee with Met Campus Medical Quality Assutance Committee and standardize auditing and case review processes across both sites •Monitor and track physician documentation compliance indicators •Ensure timely response to care •Decrease rates of infection	•Each MD service to complete quarterly chart reviews and report findings to Medical Quality Assurance Committee. •Continue monthly auditing process to review compliance with acuity summary sheet completion and dictated discharge summary (within 7 days) completion of chart deficiencies. •Do to realignment on Oct 1, 2013, amalgamation of the two medical quality committees and standardizing processes. •Monitor and track performance and quality indicators	•The number of MD chart reviews by service • Percent of compliance with completed Discharge Summary and Acuity Summary forms. •Percent of compliance with individual chart reviews with quarterly auditing process.	60% compliance/service with quarterly chart audits. 60% completion of clinical documentation tools across select services. •0 deficiencies beyond 90 days for each physician

Integrated	Reduce unnecessary time spent in acute care	Percentage ALC days: Total number of acute inpatient days designated as ALC, divided by the total number of acute inpatient days.	% / All acute patients	Ministry of Health Portal / Q3 2012/13 – Q2 2013/14	1079	24.7	12	Aim is to be close to provincial target (9.45%)	Improve	1)•Continue collaboration with CCAC ESCLHIN in the implementation of Home First Strategies including newly created rest home 6 week pilot program to facilitate placement of ALC patients. •Recognize value of timely, patient level data to reduce wait times and provide ongoing monitoring and tracking of indicators • Develop and apply targeted strategies to continuously decrease ALC patients lengths of stay ••Implement escalation planning when needed exceeds	•Conduct weekly complex discharge rounds with hospital Utilization team and social work and CCAC case managers in identifying barriers to discharge for patients with complex issues. • Conduct coordinated care planning and discharge planning • Address barriers to discharge at the patient level • Educate patients and families about the appropriateness of services	• The number of patients admitted per day. • The number of patient designated ALC. • The number of ALC patients discharged/day • Percentage of patients receiving coordinated care planning	• Reduction in the # of patients admitted per day • 10% 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
		Percentage ALC days: Total number of acute inpatient days designated as ALC, divided by the total number of acute inpatient days.	% / All acute patients	Ministry of Health Portal / Q3 2012/13 – Q2 2013/14	4773	23.65	12	Aim is to be close to the provincial target (9.45%)	Improve	1)•Continue collaboration with CCAC ESCLHIN in the implementation of Home First Strategies including the rest home 6 week pilot program to facilitate placement of ALC patients. •Recognize value of timely, patient level data to reduce wait times and provide ongoing monitoring and tracking of indicators • Develop and apply targeted strategies to continuously decrease ALC patients length of stay • Implement utilization team on site to better coordinate discharges and care planning for ALC patients	•Conduct weekly complex discharge rounds with hospital Utilization team, social work and CCAC case managers in identifying barriers to discharge for patients with complex issues. • Conduct coordinated care planning and discharge planning is implemented • Address barriers to discharge at the patient level •Educate patients and families about the appropriateness of services	• The number of patient admitted per day. • The number of patient designated ALC. • The number of ALC patients discharged/day • Percentage of patients receiving coordinated care planning	• Reduction in the # of patients admitted per day • 10% 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
	Reduce unnecessary hospital readmission	Readmission to any facility within 30 days for selected CMGs for any cause: The rate of non-elective readmissions to any facility within 30 days of discharge following an admission for select CMGs.	% / All acute patients	DAD, CIHI / Q2 2012/13-Q1 2013/14	1079	16.41	13	Targeting 30 day readmissions for selected CMG's, CHF and COPD supports the ESCLHIN chronic disease management initiatives overall.	Improve	1)•Implementation of a revised standardized care pathway to guide care from admission to discharge and beyond : Value stream process mapping was utilized to outline current state care processes and to identify gaps/barriers to delivering best-practice care for both CHF and COPD patients at the Met campus. • A pilot unit was selected to test the future state processes for CHF patients and the same protocol will be followed for COPD patients	•Audit key steps in the pathway to ensure adherence i.e. Order set utilization, CCAC on discharge, follow-up appointment •Pilot unit selection and Educational Program developed and provided to all staff on the pilot units •Standardized Order Set to start in ED •Standardized patient education package developed (used for inpatients and community patient education for continuity) •Training for nurses on the new care pathway and patient education materials •Automatic referral to CCAC for follow-up post discharge • Appointment with Primary Care Provider scheduled for the patient prior to discharge • Auditing compliance with the future state processes to ensure adherence to standardized processes	•% of order set utilized; •% of patients received CCAC consult and/or referral; •% of CHF and COPD patients will have a follow-up appointment with MD •% of staff on pilot unit receiving education program	•90% of order set utilized on pilot unit; •95% of patients received CCAC consult and/or referral; •100% of CHF and COPD patients will have a follow-up appointment with MD •100% of staff on pilot unit receive education program
		Readmission to any facility within 30 days for selected CMGs for any cause: The rate of non-elective readmissions to any facility within 30 days of discharge following an admission for select CMGs.	% / All acute patients	DAD, CIHI / Q2 2012/13-Q1 2013/14	4773	15.32	13	Targeting 30 day readmissions for selected CMG's, CHF supports the ESCLHIN chronic disease management initiatives overall.	Improve	1)•Utilize appropriate risk assessment to prospectively identify patients who might benefit from more intense post discharge care •Implement coordinated discharge planning communication and documentation • Begin standardization of processes across both acute care sites	•Utilization of readmission tool for CHF patients • Coordinate discharge planning communication and documentation	% compliance with readmission tool and associated post discharge interventions on all CHF patients • % compliance on coordinated care planning on all CHF patients	•90% compliance with readmission tool and associated post discharge interventions on all CHF patients • 100 % compliance on coordinated care planning on all CHF patients
Patient-centred	Improve patient satisfaction	From NRC Picker: "Overall, how would you rate the care and services you received at the hospital (inpatient care)?" (add together % of those who responded "Excellent, Very Good and Good").	% / All patients	NRC Picker / Oct 2012- Sept 2013	1079	94.35	96.4	This target is based on the established benchmark set for Select QIP Core Indicators.	Improve	1)●Sustain and improve on existing overall patient satisfaction scores •Well-come"" Program piloted in 2013 on one unit will be rolled out to remaining medical units •Seek immediate feedback from patients •As a result of realignment on October 1, 2013, ongoing efforts to standardize practices across both campuses to increase the patients overall experience	●Report monthly and quarterly NRC Picker results •Well-come Program allows volunteers to meet with newly admitted patients to orient them and their loved ones to the hospital •Introduce exit survey on the patient TY's to provide immediate feedback on emotional support component of care	•% or greater overall satisfaction •Measure response rate to NRC Picker	•95 % or greater overall satisfaction •10% increase in response rate with TV prompting introduced
		From NRC Picker: "Overall, how would you rate the care and services you received at the hospital (inpatient care)?" (add together % of those who responded "Excellent, Very Good and Good").	% / All patients	NRC Picker / Oct 2012- Sept 2013	4773	91.38	96.4	This target is based on the established benchmark set for Select QIP Core Indicators.	Improve	1)●Sustain and improve on existing overall patient satisfaction scores •As a result of realignment on October 1, 2013, ongoing efforts to standardize practices across both campuses to increase the patients overall experience •Introduce AIDET Training to the Ouellette Campus	●Report monthly and quarterly NRC Picker results •Conduct AIDET Training Seminars for Leadership and frontline staff reinforcing 5 processes: Acknowledge, Introduce, Duration, Explanation< Thank you	•% or greater overall satisfaction •Measure response rate to NRC Picker	•95 % or greater overall satisfaction •10% increase in response rate with TV prompting introduced
		From NRC Picker: "Overall, how would you rate the care and services you received at the ED?" (add together % of those who responded "Excellent, Very Good and Good").	% / ED patients	NRC Picker / 2013	1079	85.86	91.8	This target is based on the established benchmark set for Select QIP CoreIndicators.	Improve	1)●Sustain and improve on existing overall patient satisfaction scores •Well-come"" Program piloted in 2013 on one unit will be rolled out to remaining medical units •Seek immediate feedback from patients •As a result of realignment on October 1, 2013, ongoing efforts to standardize practices across both campuses to increase the patients overall experience	●Report monthly and quarterly NRC Picker results •Well-come Program allows volunteers to meet with newly admitted patients to orient them and their loved ones to the hospital •Introduce exit survey on the patient TY's to provide immediate feedback on emotional support component of care	•% or greater overall satisfaction •Measure response rate to NRC Picker	•95 % or greater overall satisfaction •10% increase in response rate with TV prompting introduced
		From NRC Picker: "Overall, how would you rate the care and services you received at the ED?" (add together % of those who responded "Excellent, Very Good and Good").	% / ED patients	NRC Picker / 2013	4773	87.79	91.8	This target is based on the established benchmark set for Select QIP CoreIndicators.	Improve	1)●Sustain and improve on existing overall patient satisfaction scores •As a result of realignment on October 1, 2013, ongoing efforts to standardize practices across both campuses to increase the patients overall experience •Introduce AIDET Training to the Ouellette Campus	●Report monthly and quarterly NRC Picker results •Conduct AIDET Training Seminars for Leadership and frontline staff reinforcing 5 processes: Acknowledge, Introduce, Duration, Explanation< Thank you	•% or greater overall satisfaction •Measure response rate to NRC Picker	•95 % or greater overall satisfaction •10% increase in response rate with TV prompting introduced
Safety	Increase proportion of patients receiving medication reconciliation upon admission	Medication reconciliation at admission: The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital.	% / All patients	Hospital collected data / Most recent quarter available (e.g. Q2 2013/14, Q3 2013/14 etc)	1079	52.4	55	Baseline being established with data for Q3 2013 to be able to determine percentage increase for following year.	Improve	1)• Introduce process to increase compliance by ensuring the standardization of practice to Best Possible Medication History (BPMH), a precursor to effective medication reconciliation compliance •Increase compliance with medication reconciliation education •Unit-based re-design (RPH + tech pair) assigned to Med/Surg units to support timely Med Rec completion (current pilot on one unit to spread to other medical	•Pharmacists will lead Medication Reconciliation for all newly admitted patients to Med/Surg units. •Audit results with weekly documentation of medication reconciliation completions and immediately educate staff who are under target	•% of med Surg patients assessed by a pharmacist •% of patients with a documented BPMH	•2 MedRecs per day per pharmacist to achieve 55% consults on all Med/Surg patients admitted.

		Medication reconciliation at admission: The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital.	% / All patients	Hospital collected data / Most recent quarter available (e.g. Q2 2013/14, Q3 2013/14 etc)	4773	44.5	50	Baseline being established with data for Q3 2013 to be able to determine percentage increase for following year.	Improve	1)• Introduce process to increase compliance by ensuring the standardization of practice to Best Possible Medication History (BPMH), a precursor to effective medication reconciliation compliance •Increase compliance with medication reconciliation education • Unit-based re-design (RPH + tech pair) assigned to Med/Surg units to support timely Med Rec completion (in place at Ouellette in 3 areas and spreading to Met this year – pilot on 6N currently)	•Pharmacists will lead Medication Reconciliation for all newly admitted patients to Med/Surg units. •Audit results with weekly documentation of medication reconciliation completions and immediately educate staff who are under target	•% of med Surg patients assessed by a pharmacist •% of patients with a documented BPMH	•2 MedRecs per day per pharmacist to achieve 50% consults on all Med/Surg patients admitted.
	Reduce hospital acquired infection rates	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 - Average for Jan-Dec. 2013, consistent with publicly reportable patient safety data.	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / 2013	1079	0.24	0.21	Current performace exceeds 10th percentile (0.25/1000 pt days) MoHLTC. Target is based on 10% reduction of current performance	Improve	1)●Use of Clorox products for cleaning CDI patient rooms and equipment corporate wide •Continue hand hygiene auditing process and ensure true reflection of hand hygiene practice by utilizing best practice process for auditing. •Educate patients and visitors regarding hand hygiene performance expectations on all units. •Conduct prevalence testing on any unit with higher than expected Hospital Acquired Infections (HAI's) •Thoroughly investigate every incident of hospital acquired infection	●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	●% compliance with the use of Clorox in CDI cases as per tracer audits/month ●% of the units have implemented Clorox products in CDI cases	●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
		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 - Average for Jan-Dec. 2013, consistent with publicly reportable patient safety data.	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / 2013	4773	0.46	0.25	Current performace is at the Median (.50/1000 pt days). Target is to meet the 10th percentile (.25/1000 pt days) MoHLTC	Improve	1)●Use of Clorox products for cleaning CDI patient rooms and equipment corporate wide •As a result of hospital realignment on October 1, 2013, IPAC team to be established and standardize practice across both campuses. •Ensure that alcohol based hand sanitizer is available in all patient care areas and at all entrances. •Educate leadership on auditing practices. •Introduce HH auditing best practice processes across all areas. "	● 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"	●% compliance with the use of Clorox in CDI cases as per tracer audits/month ●% of the units have implemented Clorox products in CDI cases "	●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
		Hand hygiene compliance before patient contact: The number of times that hand hygiene was performed before initial patient contact divided by the number of observed hand hygiene indications for before initial patient contact multiplied by 100 - consistent with publicly reportable patient safety data.	% / Health providers in the entire facility	Publicly Reported, MOH / 2013	1079	97.78	95	Close to theoretical best (100%) as WRH tracks and reports all 4 moments of hand hygiene. Provincial average for large hospital is 74%	Maintain	1)•Continue hand hygiene auditing process and ensure true reflection of hand hygiene practice by utilizing best practice process for auditing. •Educate patients and visitors regarding hand hygiene performance expectations on all units. •Conduct prevalence testing on any unit with higher than expected Hospital Acquired Infections (HAI's) •Thoroughly investigate every incident of hospital acquired infection	● Conduct hand hygiene audits weekly based on best practice process for auditing ●Ongoing patient/ family/visitor education •% compliance with Root Cause Analysis conducted on all newly acquired Hospital Acquired Infections	● Reduction in HAI rate to below target • % compliance overall with the 4 moments of hand hygiene •# of hand hygiene audits conducted weekly •% compliance with Root Cause Analysis conducted on every new Hospital Acquired Infection"	● % Reduction in HAI rate to below target • >95% compliance overall with the 4 moments of hand hygiene •# of hand hygiene audits conducted weekly •100% compliance with Root Cause Analysis conducted on every new Hospital Acquired Infection
		Hand hygiene compliance before patient contact: The number of times that hand hygiene was performed before initial patient contact divided by the number of observed hand hygiene indications for before initial patient contact multiplied by 100 - consistent with publicly reportable patient safety data.	% / Health providers in the entire facility	Publicly Reported, MOH / 2013	4773	70.31	95	Close to theoretical best and increased target from 90% that was set in 2012/2013. WRH tracks and reports all 4 moments of hand hygiene. Provincial average is 71% for large hospitals.	Improve	1)"•As a result of hospital realignment on October 1, 2013, IPAC team to be established and standardize practice across both campuses. •Ensure that alcohol based hand sanitizer is available in all patient care areas and at all entrances. •Educate leadership on auditing practices. •Introduce HH auditing best practice processes across all areas. "	"● Conduct hand hygiene audits weekly based on best practice process for auditing ●Ongoing patient/ family/visitor education •% of leadership trained in auditing practices"	"● Reduction in HAI rate to below target • % compliance overall with the 4 moments of hand hygiene •# of hand hygiene audits conducted weekly"	"● % Reduction in HAI rate to below target • >95% compliance overall with the 4 moments of hand hygiene •# of hand hygiene audits conducted weekly"
		VAP rate per 1,000 ventilator days: the total number of newly diagnosed VAP cases in the ICU after at least 48 hours of mechanical ventilation, divided by the number of ventilator days in that reporting period, multiplied by 1,000 - consistent with publicly reportable patient safety data.	Rate per 1,000 ventilator days / ICU patients	Publicly Reported, MOH / 2013	1079		0	Achieve 100% reduction in VAP incidence and achieve theroetical best (0%). Provincial average is 0.75 for large hospitals. Data is suppressed (as numerator is between 1-4 and therefore does not appear in current performance. Current performance is .42/1000 vent days.	Improve	1)• Ensure Safer Health Care Now (SHCN) best practices for VAP have been implemented • Ongoing audits for compliance to best practice. • Ensure best practices are followed with hand hygiene	•Ensure compliance with the 5 key components of the VAP bundle •Ensure hand hygiene compliance •Ensure compliance with practices that promote patient mobility and autonomy •Ensure compliance with the use of venous thromboembolism prophylaxis	•% compliance with VAP Bundle •% compliance with hand hygiene •% compliance with practices that promote mobility and autonomy	100% compliance with VAP Bundle > 95% compliance with Hand Hygiene 100% compliance with practices that promote mobility and autonomy
		VAP rate per 1,000 ventilator days: the total number of newly diagnosed VAP cases in the ICU after at least 48 hours of mechanical ventilation, divided by the number of ventilator days in that reporting period, multiplied by 1,000 - consistent with publicly reportable patient safety data.	Rate per 1,000 ventilator days / ICU patients	Publicly Reported, MOH / 2013	4773	0	0	Maintain established target of best achieved in Ontario (0%).	Maintain	1)• Ensure Safer Health Care Now (SHCN) best practices for VAP have been implemented •Ongoing audits for compliance to best practice. • Ensure best practices are followed with hand hygiene	Ensure compliance with the 5 key components of the VAP bundle •Ensure hand hygiene compliance •Ensure compliance with practices that promote patient mobility and autonomy •Ensure compliance with the use of venous thromboembolism prophylaxis	•% compliance with insertion bundle guidelines •% compliance with Hand Hygiene •% compliance with practices that promote mobility and autonomy	100% compliance with VAP Bundle > 95% compliance with Hand Hygiene 100% compliance with practices that promote mobility and autonomy
		Rate of central line blood stream infections per 1,000 central line days: total number of newly diagnosed CLI cases in the ICU after at least 48 hours of being placed on a central line, divided by the number of central line days in that reporting period, multiplied by 1,000 - consistent with publicly reportable patient safety data.	Rate per 1,000 central line days / ICU patients	Publicly Reported, MOH / 2013	1079		0	Achieve best to date in Ontario (0%). 0.40 is provincial average for large hospitals. Current performance has been suppressed when numerator is between 1-4. Current performance is 0.66/1000 line days.	Improve	1)•Ensure Safer Health Care Now (SHCN) best practices for central line insertion and maintenance have been implemented and are followed. •Ongoing auditing for compliance to best practice. •Flow sheet used for documentation.	• Insertion Bundle Guidelines • Central Line Maintenance Guidelines Implementing "scrub the hub" competency for insertion, maintenance and documentation of the central line.	• % compliance with insertion bundle guidelines •% compliance with Central Line Maintenance Guidelines	• 100% compliance with insertion bundle guidelines • 100% compliance with Central Line Maintenance Guidelines
		Rate of central line blood stream infections per 1,000 central line days: total number of newly diagnosed CLI cases in the ICU after at least 48 hours of being placed on a central line, divided by the number of central line days in that reporting period, multiplied by 1,000 - consistent with publicly reportable patient safety data.	Rate per 1,000 central line days / ICU patients	Publicly Reported, MOH / 2013	4773	0	0	Maintain established target of best to date in Ontario and theoretical best (0%).	Maintain	1)"• Ensure Safer Health Care Now (SHCN) best practices for central line insertion and maintenance have been implemented •Ongoing audits for compliance to best practice. • Utilize flow sheet for documentation."	"• Insertion Bundle Guidelines • Central Line Maintenance Guidelines Implementing "scrub the hub" competency for insertion, maintenance and documentation of the central line."	"• % compliance with insertion bundle guidelines •% compliance with Central Line Maintenance Guidelines"	"• 100% compliance with insertion bundle guidelines • 100% compliance with Central Line Maintenance Guidelines"

	Avoid Patient falls	Falls The number of reported inpatient falls with injury expressed as a rate per 1000 patient days/month DATA (Internal): Average April to December 2013	Rate per 1,000 patient days / All acute patients	Hospital collected data / Q2 FY 2013/2014	1079	0.07	0.06	Continue to improve on target which was based on yearly incremental improvements using best practices and proven interventions	Maintain	1)•Continue with Fall Prevention Program including Fall Prevention And Comfort Round Bundles developed in 2012/2013 that was based on best practice evidence on assessment of risk and implementation of interventions. •Continue to reinforce Fall Prevention Back to Basics methodology that is well established. •Target Emergency Department for roll out of best practice prevention guidelines. •Ongoing tracking and monitoring of this indicator with real time data and response to incidents	●Continue to educate best practice to new staff and students ● Provide ongoing staff education and training regarding Back to Basics methodology and Fall Prevention and Confront Round Bundle ● Track and report fall with injury rate weekly and monthly and ensure high risk incidents are discussed at safety huddles and Falls Road Show •Reinforce escalation planning as needed for higher than average rates of falls or 1 fall with injury	• Educate the majority of nursing staff having completed Falls and Comfort Round Bundle Training & Education. • Conduct Falls Road Show on all of units with a fall with injury •Conduct Root Cause Analysis with management and front line staff on all falls with injury	Overall reduction by .08% in fall with injury rate at the Metropolitan campus 90% of nursing staff having completed Falls and Comfort Round Bundle Training & Education. • Conduct Falls Road Show on 100% of units with a fall with injury •Conduct Root Cause Analysis with management and front line staff on 100% of falls with injury
		Falls The number of reported inpatient falls with injury expressed as a rate per 1000 patient days/month DATA (Internal): Average April to December 2013	Rate per 1,000 patient days / All acute patients	Hospital collected data / Q2 FY 2013/2014	4773	0.79	0.7	Baseline established with data from Oct 2013 to Jan 2014. 10% improvement for newly introduced prevention program and process improvement program to campus.	Improve	1)•Introduce well established Fall Prevention Program from Metropolitan campus to Ouellette Campus. •Utilize pilot unit as a ""learning unit"" to test interventions and run PDSA cycles.	Introduce Back to Basics Methodology for the Fall Prevention Program that addresses prevention strategies and monitor and track unit based data weekly	•Roll out Fall Prevention Program from pilot unit to all Medicine programs •Weekly tracking and monitoring of fall indicators •Audit patient charts to ensure compliance with completion of Morse Risk Assessment at admission	•Percentage decrease in fall with injury rate overall • Weekly tracking of falls and falls per injury per unit •100% of patients are assessed at admission using the Morse Falls Risk Assessment
	Reduce rates of deaths and complications associated with surgical care	Rate of 5-day in-hospital mortality following major surgery: The rate of in-hospital deaths due to all causes occurring within five days of major surgery.	Rate per 1,000 major surgical cases / All patients with major surgery	CIHI eReporting Tool / 2012/13	1079	4.85	4.06	"Maintain previous years target which was based on the hospital adjusted rate for the high performer in the Province of Ontario. National Peer Group (8.58), Region Average (9.46)"	Improve	1)•Continue with established auditing process for patient mortality and morbidity. •Continue to monitor and track physician documentation compliance indicators established by Medical Quality Assurance Committee monthly. •Ensure timely response to care •Decrease rates of infection •Ensure Surgical Safety Checklist continues as standard practice	•As specified above for HSMR: Each MD service to complete quarterly chart reviews and report findings to Medical Quality Assurance Committee. •Continue monthly auditing process to review compliance with clinical documentation tools and completion of chart deficiencies. •Do to realignment on Oct 1, 2013, amalgamation of the two Medical Quality Committees and standardizing processes. •Add indicator to monthly Medical Quality Assurance Scorecard to track performance •maintain high performance with surgical Safety Checklist	•The number of MD chart reviews by service • Percent of compliance with completed clinical documentation tools. •Percentage compliance with individual chart reviews with quarterly auditing process. •% of patients admitted to the SSU within 90 minutes (decision to admit to time left the ED) •Percentage patients with Hospital Acquired Infection •Percentage compliance with Surgical Safety Checklist	100% compliance/service with quarterly audits. •80% completion of Acuity/ Summary tool across all services. •80% completion of dictated discharge summary across all services. •0 deficiencies beyond 60 days for each physician • 100% of patients admitted to SSU within 90 minutes •0 hospital acquired infections • 100 % compliance with Surgical Safety Checklist
		Rate of 5-day in-hospital mortality following major surgery: The rate of in-hospital deaths due to all causes occurring within five days of major surgery.	Rate per 1,000 major surgical cases / All patients with major surgery	CIHI eReporting Tool / 2012/13	4773	11.88	8.58	Improvement needed to achieve hospital adjusted National Peer Group Rate (8.58). Region average us slightly higher at 9.46	Improve	1)•Continue with established auditing process for patient mortality and morbidity. •Continue to monitor and track physician documentation compliance indicators established by Medical Quality Assurance Committee monthly. •Ensure timely response to care •Decrease rates of infection •Ensure Surgical Safety Checklist continues as standard practice	•As specified above for HSMR: Each MD service to complete quarterly chart reviews and report findings to Medical Quality Assurance Committee. •Continue monthly auditing process to review compliance with acuity summary sheet completion and dictated discharge summary (within 7 days) completion of chart deficiencies. •Do to realignment on Oct 1, 2013, amalgamation of the two medical quality committees and standardizing processes. •Add indicator to monthly Medical Quality Assurance Scorecard to track performance •maintain high performance with surgical Safety Checklist	•The number of MD chart reviews by service • Percent of compliance with completed Discharge Summary and Acuity Summary forms. •Percent of compliance with individual chart reviews with quarterly auditing process. •Percentage patients with Hospital Acquired Infection •Percentage Compliance with Surgical Safety Checklist	60% compliance/service with quarterly audits. •60% completion of clinical documentation tools across select services. •0 deficiencies beyond 90 days for each physician •0 hospital acquired infections •100% compliance with Surgical Safety Checklist
	Reduce use of physical restraints	Physical Restraints: The number of patients who are physically restrained at least once in the 3 days prior to a full admission divided by all cases with a full admission assessment.	% / Mental health/addiction patients	OMHRS, CIHI / Q4 2010/12 - Q3 2012/13	4773	2.7	2.5	Stay below provincial target of 4%.	Maintain	1)•Enforce current least restraint policy	•Utilize least restrictive treatment modality and use physical restraint only as a last resort when patient is unable to control their behavior and becomes a threat to either self or others.	% of physical restraint use in selected time period.	Reduction in restraint application