Excellent Care for All – Windsor Regional Hospital

Quality Improvement Plans (QIP): Progress Report for 2013/14 QIP

The following template has been provided to assist with completion of reporting on the progress of your organization's QIP. Please review the information provided in the first row of the template which outlines the requirements for each reporting parameter.

Priority Indicator	Performance	Performance Goal	Progress to date	Comments
ED Wait times: 90th percentile ED length of stay for Admitted patients. Hours ED patients Q4 2011/12 – Q3 2012/13 CCO iPort Access Improve	26.50	20.80	25.68	High acuity and an increase in ALC patients has affected timely access to inpatient beds and increased number of ED holds daily. Planned improvements include: Continue to decrease wait times with utilization nurses rounding on inpatient units to mitigate discharge barriers and leading complex discharge rounds with CCAC case managers to assess complex discharge issues for ALC patients waiting to be placed; Continue to work with physicians and ED group to ensure the use of established pathways and consultant arrival times; and, Opened a 20 bed Short Stay Medical Unit (SSU)in July 2013 at the Metropolitan campus where decision to admit in ED and arrival on unit does not exceed 90 minutes and length of stay on the SSU unit does not exceed 72 hours.
ED Length of Stay - Complex Non admitted 90th percentile ER Length of Stay for Complex conditions. Data: Q4 2011/12 – Q3 2012/13, iPort Hours Population Period Source Maintain	7.40	6.90	6.60	Continue to track and monitor this indicator weekly with real time action plans. Continue to work with CCAC and sub acute hospital services to facilitate discharge of patients destined for Long Term Care, Complex Continuing Care, Rehabilitation and Palliative care services. Emergency physician and team to conduct formalized huddles to identify high volume/high acuity areas and realign physician assignment.
ED Length of Stay - UnComplex ; Non admitted 90th percentile ER Length of Stay for Uncomplex conditions. Data: Q4	3.90	3.80	3.60	Continue to track and report weekly and develop real time action plans. Continue to make progress and address process issues in ambulatory area. Broadcast CDU capacity every 2 hours. Reassignment of nursing staff depending on volume/acuity (eg. ensuring 2

2011/12 – Q3 2012/13, iPort Hours Population Period Source Maintain				nurses are present in ambulatory hall). Continue daily tracking of admissions and discharges.
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 incidents Population Period Source Improve	0.55	0.00	0.90	Strategies to reduce medication incidents that reached the patient and caused harm include: The development of a pain order set and algorithm to decrease narcotic medication incidents; Reporting of trigger drugs (e.g. Narcan) into RMP as adverse events to better analyze trends in prescribing/administration that result in adverse outcomes to patients; Aligning and updating IV medication guidelines between sites to clearly outline how to administer IV medications; Implementing Hazardous Cytotoxic and Non-Cytotoxic Drug Policy across all sites; Conduct Root Cause Analysis of every incident that caused harm immediately following the incident and report results to the leadership team; Alignment and monitoring of corporate Medication Use policy across both sites; and, Implementation of unit medication tracer audits (to observe practices pertaining to Medication Use Policy) and provide proactive feedback to front line staff.
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	46.00	40.00	50.70	Continue to decrease medication incidents that reached the patient - no harm by: investigating every medication incident to determine contributing factors; weekly monitoring of Risk Reporting system and trending of results reported weekly to leadership and frontline staff through the Monday Morning Huddle

% Population Period Source Improve				
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 pts/month Population Period Source Improve	7.20	8.00	16.00	This indicator includes falls with injury, patient specimen incidents and Hospital Acquired Infections and an increase reflects drift in a culture that supports safety. Progress for this overall indicator is dependant on each indicator reaching their target. Each indicator is monitored separately and supported by an indicator team that tracks and monitors each indicator weekly across both the Metropolitan and Ouellette sites. Poor performance is attributed to an increase in hospital acquired infections and patient specimen incidents - irreplaceable, specifically as Falls with injury has successfully achieved a fall with injury rate of .07/1000 patient days. For hospital acquired infections the "back to basics" approach is the focus with full attention on HH and the proper use of PPE. Leadership to work with the frontline to ensure they are completing the four moments of HH and donning and doffing PPE correctly and appropriately. Audits will be completed with a nursing focus and with real time feedback. With patient specimens, the focus is on conducting a Root Cause Analysis on every irreplaceable specimen incident with the department that is impacted. Standardized Safety/Specimen Procurement Checklist is being finalized.