Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2014/15 QIP

The Progress Report is a tool that will help organizations make linkages between change ideas and improvement, and gain insight into how their change ideas might be refined in the future. The new Progress Report is mostly automated, so very little data entry is required, freeing up time for reflection and quality improvement activities.

Health Quality Ontario (HQO) will use the updated Progress Reports to share effective change initiatives, spread successful change ideas, and inform robust curriculum for future educational sessions.

ID	Measure/Indicator from 2014/2015	Current Performance as stated on QIP14/15	Target as stated on QIP 14/15	Current Performance 2015	Comments
1	ED Wait times: 90th percentile ED length of stay for Admitted patients. Hours ED patients Q4 2012/13 – Q3 2013/14 CCO iPort Access	24.32	20.90	28.63	Continued improvement at the Ouellette Campus. Focus on maintaining ED admission rates at 10% or lower to increase ED capacity and performance and improved bed utilization across both sites. •Hospital is 1 year post realignment of two major acute sites which has allowed for integration of medical and administrative leadership to further reinforce standardization of practices. •Maintain 16 bed Short Stay Medical Unit for unattached family medicine patients with an expected LOS of less than 72 hours at the Met site to impact ED flow • Improve overall flow with increase in percentage of patients discharged before 1100 and 1400. •Improved coordination with CCAC of complex patients designated ALC and returning home.• Track discharge and referral rate of Geriatric Emergency Department Nurse.

Realizing that the QIP is a living document and the change ideas may fluctuate as you test and implement throughout the year, we want you to reflect on which change ideas had an impact and which ones you were able to adopt, adapt or abandon. This learning will help build capacity across the province.

Change Ideas from Last Years QIP (QIP 2014/15)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?

•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.	Yes
Focus on maintaining ED admission rates at 10% or lower to increase ED capacity and performance and improved bed utilization across both sites. •Hospital is 1 year post realignment of two major acute sites which has allowed for integration of medical and administrative leadership to further reinforce standardization of practices. •Maintain 16 bed Short Stay Medical Unit for unattached family medicine patients with an expected LOS of less than 72 hours at the Met site to impact ED flow • Improve overall flow with increase in percentage of patients discharged before 1100 and 1400. •Improved coordination with CCAC of complex patients designated ALC and returning home.• Track discharge and referral rate of Geriatric Emergency Department Nurse	Yes

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2	ED Wait times: 90th percentile ED length of stay for Admitted patients. Hours ED patients Q4 2012/13 – Q3 2013/14 CCO iPort Access	25.68	20.90	25.17	Continued improvement at the Metropolitan Campus. Focus on maintaining ED admission rates at 10% or lower to increase ED capacity and performance and improved bed utilization across both sites. •Hospital is 1 year post realignment of two major acute sites which has allowed for integration of medical and administrative leadership to further reinforce standardization of practices. •Maintain 16 bed Short Stay Medical Unit for unattached family medicine patients with an expected LOS of less than 72 hours at the Met site to impact ED flow • Improve overall flow with increase in percentage of patients discharged before 1100 and 1400. •Improved coordination with CCAC of complex patients designated ALC and returning home.• Track discharge and referral rate of Geriatric Emergency Department Nurse

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•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.	Yes	

Focus on maintaining ED admission rates at 10% or lower to increase ED capacity and performance and improved bed utilization across both sites. •Hospital is 1 year post realignment of two major acute sites which has allowed for integration of medical and administrative leadership to further reinforce standardization of practices. •Maintain 16 bed Short Stay Medical Unit for unattached family medicine patients with an expected LOS of less than 72 hours at the Met site to impact ED flow • Improve overall flow with increase in percentage of patients discharged before 1100 and 1400. •Improved coordination with CCAC of complex patients designated ALC and returning home.• Track discharge and referral rate of Geriatric Emergency Department Nurse	Yes

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3	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 Q3 2013/14 OHRS, MOH	0.44	2.00	0.56	Requires a balanced budget before net building amortization and is consistent with H-SAA reporting.

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•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	Yes	
•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	Yes	

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4	HSMR: Number of observed deaths/number of expected deaths x 100. Ratio (No unit) All patients 2012/13 DAD, CIHI	102.00	80.00	84.00	Continued improvement at the Met Campus. 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. •Conduct QCIPA's with physician, administration and front line staff participation to review unusual events .• Conduct and track daily leadership rounding and comfort care rounds to ensure patient needs are being met and timely response to deteriorating condition.

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•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	Yes	
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. •Conduct QCIPA's with physician, administration and front line staff participation to review unusual events .• Conduct and track daily leadership rounding and comfort care rounds to ensure patient needs are being met and timely response to	Yes	

deteriorating condition.

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5	HSMR: Number of observed deaths/number of expected deaths x 100. Ratio (No unit) All patients 2012/13 DAD, CIHI	104.00	80.00	95.00	Continue improvement at the Ouellette Campus. 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. •Conduct QCIPA's with physician, administration and front line staff participation to review unusual events .• Conduct and track daily leadership rounding and comfort care rounds to ensure patient needs are being met and timely response to deteriorating condition.

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•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	Yes	
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. •Conduct QCIPA's with physician, administration and front line staff participation to review unusual events .• Conduct and track daily leadership rounding and comfort care rounds to ensure	Yes	

patient needs are being met and timely response to deteriorating condition.

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6	Percentage ALC days: Total number of acute inpatient days designated as ALC, divided by the total number of acute inpatient days. % All acute patients Q3 2012/13 – Q2 2013/14 Ministry of Health Portal	24.70	12.00	14.71	Continue improvement at the Metropolitan Campus. Continue collaboration with CCAC ESCLHIN in the implementation of Home First Strategies to facilitate placement of ALC patients and reduce barriers to discharge early in their inpatient stay. •Recognize value of timely, patient level data to reduce wait times and provide ongoing daily monitoring and daily tracking of indicators focusing on patient flow across the organization • Develop and apply targeted strategies to individualized discharge planning to continuously decrease ALC patients lengths of stay •Implement regional escalation planning when need exceeds bed capacity.• Monthly monitoring of patient flow indicators across the organization with Medical Directors, Senior leadership and Utilization.

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•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	Yes	

••Implement escalation planning when needed exceeds	
Continue collaboration with CCAC ESCLHIN in the implementation of Home First Strategies to facilitate placement of ALC patients and reduce barriers to discharge early in their inpatient stay. •Recognize value of timely, patient level data to reduce wait times and provide ongoing daily monitoring and daily tracking of indicators focusing on patient flow across the organization • Develop and apply targeted strategies to individualized discharge planning to continuously decrease ALC patients lengths of stay •Implement regional escalation planning when need exceeds bed capacity.• Monthly monitoring of patient flow indicators across the organization with Medical Directors, Senior leadership and Utilization.	Yes

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7	Percentage ALC days: Total number of acute inpatient days designated as ALC, divided by the total number of acute inpatient days. % All acute patients Q3 2012/13 – Q2 2013/14 Ministry of Health Portal	23.65	12.00	22.07	Continue improvement at the Ouellette Campus. Continue collaboration with CCAC ESCLHIN in the implementation of Home First Strategies to facilitate placement of ALC patients and reduce barriers to discharge early in their inpatient stay. •Recognize value of timely, patient level data to reduce wait times and provide ongoing daily monitoring and daily tracking of indicators focusing on patient flow across the organization• Develop and apply targeted strategies to individualized discharge planning to continuously decrease ALC patients lengths of stay • Implement regional escalation planning when need exceeds bed capacity. •Roll out Utilization Model at the Ouellette Campus in February 2015 • Monthly monitoring of patient flow indicators across the organization with Medical Directors, senior leadership and Utilization.		

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•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	Yes	
Continue collaboration with CCAC ESCLHIN in the implementation of Home First Strategies to facilitate placement of ALC patients and reduce barriers to discharge early in their inpatient stay. •Recognize value of timely, patient level data to	Yes	

reduce wait times and provide ongoing daily monitoring and daily tracking of indicators focusing on patient flow across the organization• Develop and apply targeted strategies to individualized discharge planning to continuously decrease ALC patients lengths of stay • Implement regional escalation planning when need exceeds bed capacity. •Roll out Utilization Model at the Ouellette Campus in February 2015 • Monthly monitoring of patient flow indicators across the organization with Medical Directors, senior leadership and Utilization.

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8	Percentage of acute hospital inpatients discharged with selected Case Mix Groups (CMGs) that are readmitted to any acute inpatient hospital for non-elective patient care within 30 days of the discharge for index admission. % All acute patients Q2 2012/13-Q1 2013/14 DAD, CIHI	16.41	13.00	23.30	Continue improvement strategies for the Metropolitan Campus. Focusing on and creating unique process to address populations that return to hospital frequently by implementing a standardized care pathway to guide care from admission in the Emergency Department to discharge and beyond for both CHF and COPD patients . • Utilize appropriate risk assessment to prospectively identify patients who might benefit from more intense post discharge care • Conduct coordinated individualized discharge planning • Ensure collaboration with the CCAC to ensure community nursing support for patient once discharged from acute care. • Standardization of processes across both acute care sites due to Oct 1st, 2013 realignment of programs and services

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•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-	Yes	

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	
Focusing on and creating unique process to address populations that return to hospital frequently by implementing a standardized care pathway to guide care from admission in the Emergency Department to discharge and beyond for both CHF and COPD patients . • Utilize appropriate risk assessment to prospectively identify patients who might benefit from more intense post discharge care • Conduct coordinated individualized discharge planning • Ensure collaboration with the CCAC to ensure community nursing support for patient once discharged from acute care. • Standardization of processes across both acute care sites due to Oct 1st, 2013 realignment of programs and services	Yes

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9	Percentage of acute hospital inpatients discharged with selected Case Mix Groups (CMGs) that are readmitted to any acute inpatient hospital for non-elective patient care within 30 days of the discharge for index admission. % All acute patients Q2 2012/13-Q1 2013/14 DAD, CIHI	15.32	13.00	26.10	Continue on improvement strategies for the Ouellette Campus. Focusing on and creating unique process to address populations that return to hospital frequently by implementing a standardized care pathway to guide care from admission in the Emergency Department to discharge and beyond for both CHF and COPD patients . • Utilize appropriate risk assessment to prospectively identify patients who might benefit from more intense post discharge care • Conduct coordinated individualized discharge planning • Ensure collaboration with the CCAC to ensure community nursing support for patient once discharged from acute care. • Standardization of processes across both acute care sites due to Oct 1st realignment of programs and services

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•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	Yes	

processes across both acute care sites	
•Focusing on and creating unique process to address populations that return to hospital frequently by implementing a standardized care pathway to guide care from admission in the Emergency Department to discharge and beyond for both CHF and COPD patients . • Utilize appropriate risk assessment to prospectively identify patients who might benefit from more intense post discharge care • Conduct coordinated individualized discharge planning • Ensure collaboration with the CCAC to ensure community nursing support for patient once discharged from acute care. • Standardization of processes across both acute care sites due to Oct 1st realignment of programs and services	Yes

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10	From NRC Canada: "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 Oct 2012- Sept 2013 NRC Picker	94.35	96.40	94.13	Continue improvement strategies at the Metropolitan Campus. Improve on existing overall patient satisfaction scores by engaging and working with patients to help deliver health care that is linked to their needs and create a culture where 'compassion is our passion'. •As a result of realignment on October 1, 2013, continue to standardize practices across both campuses to increase the patients overall experience . •Continue roll-out of the 'Well-come program to all medical units • Ongoing communication with patients and visitors using elevator signage, hospital television monitors and patietn televisions, Brahms' Lullaby and Lean on Me Songs, volunteers posted at key entrance areas to help with way finding and the President's Welcome Letter to every admitted patient.• Seek immediate feedback from patients through patient advocate office and the above and beyond program• Continue the service recovery program where we make things right after something has gone wrong with the patient's experience. • Continue AIDET Training for all staff . •Invite patients to bring their story to the monthly Quality of Care Meeting of the Board and Leadership

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	intended? (Y/N button)	this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
●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	Yes	
Improve on existing overall patient satisfaction scores by engaging and working with patients to help deliver health care that is linked to their needs and create a culture where 'compassion is our passion'. •As a result of realignment on October 1, 2013, continue to standardize practices across both campuses to increase the patients overall experience . •Continue roll-out of the 'Well-come program to all medical units • Ongoing communication with patients and visitors using elevator signage, hospital television monitors and patietn televisions, Brahms' Lullaby and Lean on Me Songs, volunteers posted at key entrance areas to help with way finding and the President's Welcome Letter to every admitted patient.• Seek immediate feedback from patients through patient advocate office and the above and beyond program• Continue the service recovery program where we make things right after something has gone wrong with the patient's experience. • Continue AIDET Training for all staff . •Invite patients to bring their story to the monthly Quality of Care Meeting of the Board and Leadership	Yes	

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11	From NRC Canada: "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 Oct 2012- Sept 2013 NRC Picker	91.38	96.40	91.63	Continue improvement strategies at the Ouellette Campus. Improve on existing overall patient satisfaction scores by engaging and working with patients to help deliver health care that is linked to their needs and create a culture where 'compassion is our passion'. •As a result of realignment on October 1, 2013, continue to standardize practices across both campuses to increase the patients overall experience . •Continue roll-out of the 'Well-come program to all medical units • Ongoing communication with patients and visitors using elevator signage, hospital television monitors and patietn televisions, Brahms' Lullaby and Lean on Me Songs, volunteers posted at key entrance areas to help with way finding and the President's Welcome Letter to every admitted patient.• Seek immediate feedback from patients through patient advocate office and the above and beyond program• Continue the service recovery program where we make things right after something has gone wrong with the patient's experience. • Continue AIDET Training for all staff . •Invite patients to bring their story to the monthly Quality of Care Meeting of the Board and Leadership

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12	From NRC Canada: "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 2013 NRC Picker	87.79	91.80	81.56	Continue improvement strategies at the Ouellette Campus. Sustain and improve on existing overall patient satisfaction scores •As a result of realignment on October 1, 2013, continue to standardize practices across both campuses to increase the patients overall experience, such as the Well-come Mat program; the AIDET Training ; the service recovery program;

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13	From NRC Canada: "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 2013 NRC Picker	85.86	91.80	79.40	Continue improvement strategies at the Metropolitan Campus. Sustain and improve on existing overall patient satisfaction scores •As a result of realignment on October 1, 2013, continue to standardize practices across both campuses to increase the patients overall experience, such as the Well-come Mat program; the AIDET Training ; the service recovery program;

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14	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 Most recent quarter available (e.g. Q2 2013/14, Q3 2013/14 etc) Hospital collected data	44.50	50.00	44.20	Continue improvement strategies at the Ouellette Campus. Introduce aligned process/documentation across both campuses to increase compliance by ensuring the standardization of practice to obtain the Best Possible Medication History (BPMH), a precursor to effective medication reconciliation compliance •Increase compliance with medication reconciliation education using annual e-learn and new physician orientation •Expand unit-based re-design across both campuses (RPH + tech pair) assigned to Med/Surg units to support timely Med Rec completion •Increase documentation of Med Rec incidents in RL6 (incident reporting program) by pharmacists and nurses •Implement (electronic) transfer orders to improve medication information sent to receiving institution

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• 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	Yes	

Ouellette in 3 areas and spreading to Met this year – pilot on 6N currently)	
Introduce aligned process/documentation across both campuses to increase compliance by ensuring the standardization of practice to obtain the Best Possible Medication History (BPMH), a precursor to effective medication reconciliation compliance •Increase compliance with medication reconciliation education using annual e-learn and new physician orientation •Expand unit-based re-design across both campuses (RPH + tech pair) assigned to Med/Surg units to support timely Med Rec completion •Increase documentation of Med Rec incidents in RL6 (incident reporting program) by pharmacists and nurses •Implement (electronic) transfer orders to improve medication information sent to receiving institution	Yes

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15	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 Most recent quarter available (e.g. Q2 2013/14, Q3 2013/14 etc) Hospital collected data	52.40	55.00	24.10	Continue improvement strategies at the Metropolitan Campus. Introduce aligned process/documentation across both campuses to increase compliance by ensuring the standardization of practice to obtain the Best Possible Medication History (BPMH), a precursor to effective medication reconciliation compliance •Increase compliance with medication reconciliation education using annual e-learn and new physician orientation •Expand unit-based re-design across both campuses (RPH + tech pair) assigned to Med/Surg units to support timely Med Rec completion •Increase documentation of Med Rec incidents in RL6 (incident reporting program) by pharmacists and nurses •Implement (electronic) transfer orders to improve medication information sent to receiving institution

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Change Ideas from Last Years QIP (QIP 2014/15)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
• 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	Yes	

Med/Surg units to support timely Med Rec completion (current pilot on one unit to spread to other medical	
Introduce aligned process/documentation across both campuses to increase compliance by ensuring the standardization of practice to obtain the Best Possible Medication History (BPMH), a precursor to effective medication reconciliation compliance •Increase compliance with medication reconciliation education using annual e-learn and new physician orientation •Expand unit-based re-design across both campuses (RPH + tech pair) assigned to Med/Surg units to support timely Med Rec completion •Increase documentation of Med Rec incidents in RL6 (incident reporting program) by pharmacists and nurses •Implement (electronic) transfer orders to improve medication information sent to receiving institution	Yes

ID	Measure/Indicator from 2014/2015	Current Performance as stated on QIP14/15	Target as stated on QIP 14/15	Current Performance 2015	Comments
16	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 2013 Publicly Reported, MOH	0.46	0.25	0.56	Continue improvement at the Ouellette Campus. Monitor use of Clorox products for cleaning CDI patient rooms and equipment corporate wide •Continue investigations of every incident of hospital acquired infection • Standardize human waste management procedures, i.e. bedpan, commode usage and reprocessing. Daily leadership rounding by ops/CPM/c's for appropriate supplies/cleaning of equipment •Housekeeping audits conducted by supervisors- (tracer audits) •Conduct HAI investigation meetings weekly •Roll out aligned Corporate Human Waste Management Policy and Procedure

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Change Ideas from Last Years QIP (QIP 2014/15)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
●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.	Yes	

"	
Monitor use of Clorox products for cleaning CDI patient rooms and equipment corporate wide •Continue investigations of every incident of hospital acquired infection • Standardize human waste management procedures, i.e. bedpan, commode usage and reprocessing. Daily leadership rounding by ops/CPM/c's for appropriate supplies/cleaning of equipment •Housekeeping audits conducted by supervisors- (tracer audits) •Conduct HAI investigation meetings weekly •Roll out aligned Corporate Human Waste Management Policy and Procedure	Yes

ID	Measure/Indicator from 2014/2015	Current Performance as stated on QIP14/15	Target as stated on QIP 14/15	Current Performance 2015	Comments
17	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 2013 Publicly Reported, MOH	0.24	0.21	0.44	Continue improvement at the Metropolitan Campus. Monitor use of Clorox products for cleaning CDI patient rooms and equipment corporate wide •Continue investigations of every incident of hospital acquired infection • Standardize human waste management procedures, i.e. bedpan, commode usage and reprocessing. Daily leadership rounding by ops/CPM/c's for appropriate supplies/cleaning of equipment • Housekeeping audits conducted by supervisors- (tracer audits) •Conduct HAI investigation meetings weekly •Roll out aligned Corporate Human Waste Management Policy and Procedure

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Change Ideas from Last Years QIP (QIP 2014/15)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
●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	Yes	

investigate every incident of hospital acquired infection	
Monitor use of Clorox products for cleaning CDI patient rooms and equipment corporate wide •Continue investigations of every incident of hospital acquired infection • Standardize human waste management procedures, i.e. bedpan, commode usage and reprocessing. Daily leadership rounding by ops/CPM/c's for appropriate supplies/cleaning of equipment • Housekeeping audits conducted by supervisors- (tracer audits) •Conduct HAI investigation meetings weekly •Roll out aligned Corporate Human Waste Management Policy and Procedure	Yes

ID	Measure/Indicator from 2014/2015	Current Performance as stated on QIP14/15	Target as stated on QIP 14/15	Current Performance 2015	Comments
18	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 2013 Publicly Reported, MOH	97.78	95.00	97.00	

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Change Ideas from Last Years QIP (QIP 2014/15)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
•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		

ID	Measure/Indicator from 2014/2015	Current Performance as stated on QIP14/15	Target as stated on QIP 14/15	Current Performance 2015	Comments
19	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 2013 Publicly Reported, MOH	70.31	95.00	90.00	

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Change Ideas from Last Years QIP (QIP 2014/15)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
"•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. "		

ID	Measure/Indicator from 2014/2015	Current Performance as stated on QIP14/15	Target as stated on QIP 14/15	Current Performance 2015	Comments
20	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 2013 Publicly Reported, MOH		0.00	X	

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Change Ideas from Last Years QIP (QIP 2014/15)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
• 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		

ID	Measure/Indicator from 2014/2015	Current Performance as stated on QIP14/15	Target as stated on QIP 14/15	Current Performance 2015	Comments
21	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 2013 Publicly Reported, MOH	0.00	0.00	0.00	

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Change Ideas from Last Years QIP (QIP 2014/15)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
• 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		

ID	Measure/Indicator from 2014/2015	Current Performance as stated on QIP14/15	Target as stated on QIP 14/15	Current Performance 2015	Comments
22	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 2013 Publicly Reported, MOH		0.00	X	

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Change Ideas from Last Years QIP (QIP 2014/15)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
•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.		

ID	Measure/Indicator from 2014/2015	Current Performance as stated on QIP14/15	Target as stated on QIP 14/15	Current Performance 2015	Comments
23	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 2013 Publicly Reported, MOH	0.00	0.00	X	

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Change Ideas from Last Years QIP (QIP 2014/15)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
"• 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."		

ID	Measure/Indicator from 2014/2015	Current Performance as stated on QIP14/15	Target as stated on QIP 14/15	Current Performance 2015	Comments
24	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 Q2 FY 2013/2014 Hospital collected data	0.79	0.70	0.17	

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Change Ideas from Last Years QIP (QIP 2014/15)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
•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.		

ID	Measure/Indicator from 2014/2015	Current Performance as stated on QIP14/15	Target as stated on QIP 14/15	Current Performance 2015	Comments
25	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 Q2 FY 2013/2014 Hospital collected data	0.07	0.06	0.08	

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Change Ideas from Last Years QIP (QIP 2014/15)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
•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		

ID	Measure/Indicator from 2014/2015	Current Performance as stated on QIP14/15	Target as stated on QIP 14/15	Current Performance 2015	Comments
26	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 2012/13 CIHI eReporting Tool	4.85	4.06	X	

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Change Ideas from Last Years QIP (QIP 2014/15)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
•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		

ID	Measure/Indicator from 2014/2015	Current Performance as stated on QIP14/15	Target as stated on QIP 14/15	Current Performance 2015	Comments
27	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 2012/13 CIHI eReporting Tool	11.88	8.58	X	

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Change Ideas from Last Years QIP (QIP 2014/15)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
•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		

ID	Measure/Indicator from 2014/2015	Current Performance as stated on QIP14/15	Target as stated on QIP 14/15	Current Performance 2015	Comments
28	Physical Restraints: Number of admission assessments where restraint use occurred in last 3 days divided by the number of full admission assessments in time period % All patients Q4 2010/12 - Q3 2012/13 OMHRS, CIHI	2.70	2.50	3.98	

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Change Ideas from Last Years QIP (QIP 2014/15)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
•Enforce current least restraint policy		