Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for the 2015/16 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 2015/16	Org Id	Current Performance as stated on QIP2015/16	Target as stated on QIP 2015/16	Current Performance 2016	Comments
1	"Overall, how would you rate the care and services you received at the ED?", add the number of respondents who responded "Excellent", "Very good" and "Good" and divide by number of respondents who registered any response to this question (do not include non-respondents). (%; ED patients; October 2013 - September 2014; NRC Picker)	4773	81.56	91.80	79.50	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;
2	"Overall, how would you rate the care and services you received at the ED?", add the number of respondents who responded "Excellent", "Very good" and "Good" and divide by number of respondents who registered any response to this question (do not include non-respondents). (%; ED patients; October 2013 - September 2014; NRC Picker)	1079	79.40	91.80	80.80	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;
3	"Overall, how would you rate the care and services you received at the hospital?" (inpatient), add the number of respondents who responded "Excellent", "Very good" and "Good" and divide by number of respondents who registered any response to this question (do not include non-respondents). (%; All patients; October 2013 - September 2014; NRC Picker)	4773	91.63	96.40	92.40	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
4	"Overall, how would you rate the care and services you received at the hospital?" (inpatient), add the number of respondents who responded "Excellent", "Very good" and "Good" and divide by number of respondents who registered any response to this question (do not include non-respondents). (%; All patients; October 2013 - September 2014; NRC Picker)	1079	94.13	96.40	93.60	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
5	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 FY 2014/15 (cumulative from April 1, 2014 to December 31, 2014); OHRS, MOH)	933	0.56	2.00	-3.06	Requires a balanced budget before net building amortization and is consistent with H-SAA reporting.
6	Readmission within 30 days for Selected Case Mix Groups (%; All acute patients; July 1, 2013 - Jun 30, 2014; DAD, CIHI)	4773		16.00	15.01	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

7	Readmission within 30 days for Selected Case Mix Groups (%; All acute patients; July 1, 2013 - Jun 30, 2014; DAD, CIHI)	1079		16.00	15.01	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 • 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
8	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI during the reporting period, divided by the number of patient days in the reporting period, multiplied by 1,000. (Rate per 1,000 patient days; All patients; Jan 1, 2014 - Dec 31, 2014; Publicly Reported, MOH)	4773	0.56	0.25	0.29	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
9	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI during the reporting period, divided by the number of patient days in the reporting period, multiplied by 1,000. (Rate per 1,000 patient days; All patients; Jan 1, 2014 - Dec 31, 2014; Publicly Reported, MOH)	1079	0.44	0.25	0.42	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
10	ED Wait times: 90th percentile ED length of stay for Admitted patients. (Hours; ED patients; Jan 1, 2014 - Dec 31, 2014; CCO iPort Access)	4773	28.63	20.90	29.80	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.
11	ED Wait times: 90th percentile ED length of stay for Admitted patients. (Hours; ED patients; Jan 1, 2014 - Dec 31, 2014; CCO iPort Access)	1079	25.17	20.90	27.30	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
12	HSMR: Number of observed deaths/number of expected deaths x 100. (Ratio (No unit); All patients; April 1, 2013 to March 31, 2014; DAD, CIHI)	4773	95.00	95.00	115.00	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.
13	HSMR: Number of observed deaths/number of expected deaths x 100. (Ratio (No unit); All patients; April 1, 2013 to March 31, 2014; DAD, CIHI)	1079	84.00	95.00	92.00	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.

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; Hospital collected data)	4773	44.20	50.00	43.10	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
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; Hospital collected data)	1079	24.10	55.00	45.60	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
16	Number of times that hand hygiene was performed before initial patient contact during the reporting period, divided by the number of observed hand hygiene opportunities before initial patient contact per reporting period, multiplied by 100. (%; Health providers in the entire facility; Jan 1, 2014 - Dec, 31, 2014; Publicly Reported, MOH)	4773	90.00	95.00	92.60	• Continue best practice hand hygiene auditing with real-time feedback to staff/visitors/etc. • Educate patients and visitors regarding hand hygiene performance expectations on all unit- 2x4 campaign, brochures, teaching • Continue to implement Electronic HH Auditing Software, i.e. use of hand held devices, report distribution continue Just Clean Your Hands Hand Hygiene Audit training for all HH Auditors to ensure validity of HH results • Increase number of frontline staff trained in JCYH
17	Number of times that hand hygiene was performed before initial patient contact during the reporting period, divided by the number of observed hand hygiene opportunities before initial patient contact per reporting period, multiplied by 100. (%; Health providers in the entire facility; Jan 1, 2014 - Dec, 31, 2014; Publicly Reported, MOH)	1079	97.00	97.00	96.00	• Continue best practice hand hygiene auditing with real-time feedback to staff/visitors/etc. • Educate patients and visitors regarding hand hygiene performance expectations on all unit- 2x4 campaign, brochures, teaching • Continue to implement Electronic HH Auditing Software, i.e. use of hand held devices, report distribution • continue Just Clean Your Hands Hand Hygiene Audit training for all HH Auditors to ensure validity of HH results • Increase number of frontline staff trained in JCYHs, teaching • Continue to implement Electronic HH

18	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; Oct 1, 2013 - Sep 30, 2014; OMHRS, CIHI)	4773	3.98	2.30	3.46	• Enforce least restraint policy for psychiatric patients
19	Rate of central line blood stream infections per 1,000 central line days (Rate per 1,000 central line days; ICU patients; Jan 1, 2014 - Dec 31, 2014; Publicly Reported, MOH)	4773	X	0.00	0.19	• Ensure Safer Health Care Now (SHCN) best practices for central line insertion and maintenance are maintained.
20	Rate of central line blood stream infections per 1,000 central line days (Rate per 1,000 central line days; ICU patients; Jan 1, 2014 - Dec 31, 2014; Publicly Reported, MOH)	1079	X	0.00	0.00	• Ensure Safer Health Care Now (SHCN) best practices for central line insertion and maintenance are maintained.
21	This is not an indicator identified for acute care. WRH has identified this as a priority and has defined this indicator as the number of reported inpatient falls with injury expressed as a rate per 1000 patient days/month. (Rate per 1,000 patient days; All acute patients; F2014/15 Q2; Hospital collected data)	4773	0.17	0.12	0.07	• Continue with Fall Prevention Program including Fall Prevention And Comfort Round Bundles developed in 2012/2013; based on best practice evidence on assessment of risk and implementation of interventions. • 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
22	This is not an indicator identified for acute care. WRH has identified this as a priority and has defined this indicator as the number of reported inpatient falls with injury expressed as a rate per 1000 patient days/month. (Rate per 1,000 patient days; All acute patients; F2014/15 Q2; Hospital collected data)	1079	0.08	0.07	0.03	• 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 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
23	Total number of inpatient days where a physician (or designated other) has indicated that a patient occupying an acute care hospital bed has finished the acute care phase of his or her treatment, divided by the total number of inpatient days in a given period x 100. (%; All acute patients; October 2014 – September 2015; DAD, CIHI)	4773	22.07	12.00	23.23	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.

24	Total number of inpatient days where a physician (or designated other) has indicated that a patient occupying an acute care hospital bed has finished the acute care phase of his or her treatment, divided by the total number of inpatient days in a given period x 100. (%; All acute patients; October 2014 – September 2015; DAD, CIHI)	1079	14.71	12.00	15.65	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.
25	Ventilator-associated pneumonia (VAP) rate per 1,000 ventilator days: Total number of newly diagnosed VAP cases in intensive care units (ICU) after at least 48 hours of mechanical ventilation during the reporting period, divided by the number of ventilator days in that reporting period, multiplied by 1,000. (Rate per 1,000 ventilator days; ICU patients; Jan 1, 2014 - Dec 31, 2014; Publicly Reported, MOH)	4773	0.00	0.00	0.28	• Ensure Safer Health Care Now (SHCN) best practices for VAP maintained • Ongoing audits for compliance to best practice.
26	Ventilator-associated pneumonia (VAP) rate per 1,000 ventilator days: Total number of newly diagnosed VAP cases in intensive care units (ICU) after at least 48 hours of mechanical ventilation during the reporting period, divided by the number of ventilator days in that reporting period, multiplied by 1,000. (Rate per 1,000 ventilator days; ICU patients; Jan 1, 2014 - Dec 31, 2014; Publicly Reported, MOH)	1079	X	0.00	0.00	• Ensure Safer Health Care Now (SHCN) best practices for VAP maintained • Ongoing audits for compliance to best practice.