Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2016/17 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 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	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 2014 - September 2015; NRC Picker)	933	CB	CB	CB	Continue to collect baseline with 1 full year of data
2	"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 2014 – September 2015; NRC Picker)	933	CB	CB	CB	Continue to collect baseline with 1 full year of data
3	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; January 2015 – December 2015; Publicly Reported, MOH)	933	0.34	0.25	0.37	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

4	ED Wait times: 90th percentile ED length of stay for Admitted patients. (Hours; ED patients; January 2015 - December 2015; CCO iPort Access)	933	28.70	20.90	29.30	•Focus on maintaining ED admission rates at 10% at Met Campus and 13% at Ouellette Campus, or lower to increase ED capacity and performance and improved bed utilization across both sites. Hospital is 2 years post realignment of two major acute sites which has allowed for integration of medical and admin leadership to further reinforce standardization of practices. • Implement ' Zones' where patients move through for assessment, testing, treatment and monitoring to improve patient flow •Maintain a 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
5	Falls with injury for acute inpatients (Rate per 1000 patient days/month; Acute Inpatient; 2015; Hospital collected data)	933	0.06	0.05	0.05	•Continue Corporate Fall Prevention Program including Fall Prevention and Comfort Round Bundles through reinforcing best practice evidence on assessment of risk and implementation of strategies/ interventions • Roll out of Model of Care training to all inpatient medical surgical nursing units. • Standard unit working groups integrate standardized best practices through standard work to achieve quality care and outcomes.
6	Hospital Standardized Mortality Ratio (HSMR) (Number of observed deaths divided by the number of expected deaths multiplied by 100.; All patients; CY2015; CIHI)	933	104.00	96.00	105.00	•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. • Continued physician engagement with acuity summary compliance

7	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 (Rate per total number of admitted patients; Hospital admitted patients; most recent quarter available; Hospital collected data)	933	44.20	50.00	41.70	•Engage physicians, ED staff and pharmacy staff to review current state. Research best practices. Design future state process and revise med rec form with clearly identified roles and responsibilities of nursing, physicians (ED and MRP) and pharmacists/pharmacist techs.
8	Number of times all three phases of the surgical safety checklist were performed ('briefing', 'timeout' and 'debriefing') during the reporting period, divided by the total number of surgeries performed in the reporting period, multiplied by 100. (%; All surgical procedures; Jan 2015 - Dec - 2015; Publicly Reported, MOH)	933	99.96	100.00	99.90	•Ongoing auditing of compliance with use of surgical safety checklist during all three phases: briefing; timeout; and debriefing. Compliance with the surgical safety checklist reduces the number of communication failures, promotes proactive and collaborative team communication and identify patient safety problems and concerns
9	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 2015 - Dec 2015; Publicly Reported, MOH)	933	94.50	95.00	95.50	•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 Hand Hygiene Software
10	Overall, how would you rate the care and services you received at the ED? (%; ED patients; Oct 2014- Sep 2015; EDPEC)	933	CB	CB	CB	Continue to collect baseline with 1 full year of data
11	Overall, how would you rate the care and services you received at the Hospital? (%; All patients; Oct 2014 - Sep 2015; CIHI portal)	933	CB	CB	CB	Continue to collect baseline with 1 full year of data

12	Percentage of acute hospital inpatients discharged with selected HBAM Inpatient Grouper (HIG) that are readmitted to any acute inpatient hospital for non-elective patient care within 30 days of the discharge for index admission. (%; Discharged patients with selected HIG conditions; July 2014 – June 2015 ; CIHI DAD)	933	15.01	14.26	15.36	•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 selected HIG's • 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 continues with realignment of programs and services
13	Risk-adjusted 30-day all-cause readmission rate for patients with CHF (QBP cohort) (Rate; CHF QBP Cohort; January 2014 – December 2014; CIHI DAD)	933	22.96	21.81	22.74	Initiated QBP multidisciplinary team focusing on implementation of best practices for the CHF patient and development of CHF order set, clinical pathway and patient experience pathway. Oversight of project from QBP steering committee and SOP executive sponsors (senior level administrators).
14	Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort) (Rate; COPD QBP Cohort; January 2014 – December 2014; CIHI DAD)	933	22.94	21.24	21.60	•Multidisciplinary team meets weekly to review readmission rates and overall COPD QBP scorecard and indicators. QBP senior level oversight committee reviews monthly. Physician representation includes Family Medicine, Internal Medicine and Respirology and multidisciplinary team includes nursing, respiratory therapy, CCAC, and decision support.
15	Risk-adjusted 30-day all-cause readmission rate for patients with stroke (QBP cohort) (Rate; Stroke QBP Cohort; January 2014 – December 2014; CIHI DAD)	933	9.67	8.76	7.04	•Initiated QBP multidisciplinary team focusing on implementation of best practices for the Stroke patient and development of Stroke order set, clinical pathway and patient experience pathway. Oversight of project from QBP steering committee and SOP executive sponsors (senior level administrators). •Acute Stroke Unit will be officially launched to ensure that all patients with stroke receive the appropriate expert care in a cohosted setting. Partnered with CCAC to develop and implement an innovative rehab strategy to promote earlier discharge and provide more timely rehab services in the home.

16	Total number of alternate level of care (ALC) days contributed by ALC patients within the specific reporting month/quarter using near-real time acute and post-acute ALC information and monthly bed census data (Rate per 100 inpatient days; All inpatients; July 2015 – September 2015; WTIS, CCO, BCS, MOHLTC)	933	19.00	12.70	11.67	•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 through the continued utilization of WRH's Discharge Planning Policy that introduces a CCAC response time within 48 hours of admission and sees an overall ALC reduction strategy and a reduction of ALC to LTC across both sites • Provide 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 Team. Develop a LHIN wide Surge strategy during times of increased pressure regarding patient flow.