Excellent Care for All

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 Maintain	24.50	22.00	22.20	Priority 2
Surgical Wait Time : 90th Percentile wait time for Hip Replacement Days Population Period Source Improve	201.00	182.00	167.00	Work continued throughout the year on surgical smoothing and a focus on reduction of surgical cancellations.There was focused work on monitoring wait time compliance in conjunction with physician offices to address all cases approaching wait time targets. In cooperation with WRH work began on integrating the surgical oversight committees of the two organizations in an effort to streamline inter-hospital transfers and explore joint call for ortho specialists. This particular initiative was suspended with alignment as all acute care came under the management and governance of WRH. This has improved the % meeting target and is demonstrated improvements in the 90th percentile for hip replacements during the first three quarters of 13-14.
% of TPA patients with door to needle time	4.25	20.00	14.30	The Continuous improvement team was

of <60 minutes % of Patients Population Period Source Improve				established. In Q1, 33% met target and 14.3% in Q2 against the target of 20%. The previous performance was 4.25%. RE-algignment of services occured in October which impacted our improvement team and data support resources. Targets have been set for 2014 / 2015 and Data collection is ongoing. The improvement team is reviewing processes, The Stroke scorecard is in re-development.
Percentage of Hip Fractures performed within 48 hours within HDGH Facility: Rate of hip fracture surgical procedures performed within 48 hours of admission per 100 hip fracture surgical procedures. April 2011 to March 2012 % Population Period Source Improve	58.41	75.00	64.50	This continues to be an area of challenge. There has been improved tracking and categorization of patients. HDGH initiated a new oversight committee structure to provide leadership to these change initatives however due to alignment all of these activities were suspended.
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 2012/13 OHRS, MOH Maintain	-0.30	0.00	N/A	Priority 2
HSMR: Number of observed deaths/number of expected deaths x 100. Ratio (No unit) All patients 2011/12 DAD, CIHI Maintain	103.00	99.00	91.00	Priority 2

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 2011/12 – Q2 2012/13 Ministry of Health Portal Maintain	17.50	12.00	33.70	Priority 2
Readmission within 30 days for CHF (internal readmission - inpatient's readmitted)- The number of patients with CHF readmitted to HDGH for non-elective inpatient care within 30 dyas of discharge, compared to the number of expected non-elective readmissions CORE - Population Change Percentage Population Period Source Maintain	12.95	10.50	10.30	Priority 2
% readmissions for schizophrenia Percentage Population Period Source 3	6.00	4.00	14.10	Priority 3
% of new dialysis patients on independent dialysis option within six months of initiating dialysis Percentage Population Period Source Improve	5.00	20.00	12.50	The Renal Dialysis Program supported independent dialysis by focusing efforts on the following key initiatives: 1. Developed a 'Transition Unit' with 6 stations for patients who are home therapy candidates. Transition Unit patients are educated on home dialysis options while receiving their treatment. 2. Developed and implemented standardized education for MDC patients promoting independent dialysis options. 3. Implemented local peer support initiative, yielding 10 local patient mentors to assist patients with modality decisions.

				4. Developed a partnership with CCAC to support PD patients through referral. 6. Developed a Quality Assurance Team with representation from across the Renal Program. The group focuses on promotion of home therapies and process improvement as patients move through the continuum of care. 7. Developed a standardized ID assessment tool for all patients seen within MDC clinic. The tool identifies if the patient is a candidate for home therapies and tracks the patient's modality decision. 8. QIP results were regularly shared with all staff and providers to continue to draw awareness to program priorities. 9. Home program hours of operation were standardized to better support home dialysis patients' needs.
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 Oct 2011- Sept 2012 NRC Picker Improve	89.76	93.00	93.10	Quarterly reporting continued to ER & IP Leadership/staff through the quarterly corporate reporting in 13-14. Due to realignment activities the Patient and Family Centred Care Committee was not fully established. The ER indicator progress to date is 86.67 (Q3) vs the target of 84.
% positive score - Continuity & Transition Dimension Percentage Population Period Source Improve	62.00	65.00	63.50	Due to realignment activities the Patient & Family Centred Care Committee was not fully established in 13-14.
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, and multiplied by 1,000 - Average for Jan-Dec. 2013, consistent with publicly reportable patient safety data.	0.32	0.30	0.69	Several improvement initiatives continued this year to keep the CDI rates close to target/benchmark. Ongoing dissemination and review of CDI rates, by unit assists in discussions for achievement of positive improvements and outcomes. Additionally the Senior Team commissioned a full review of the ICP needs for investment requirements. As a result,

Rate per 1,000 patient days All patients 2012 Publicly Reported, MOH Improve				a robust program of small equipment replacement was initiated, and a vision for the following was articulated: auditing enhancements, new reporting templates, enhanced staffing resources and hand sanitizing focus renewal. Alignment activities/planning moved this vision to the new organization leadership for consideration. There were challenges related to hand hygiene during the re-alignment when the department operated with only one manager overseeing the acute care site. Three new IPAC positions have been created and vacancies filled. There has been an increase in interventions campus wide including hand hygiene products, signage, auditing, leadership and front line staff infection control education and training, new visitation protocols and family and visitor education
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 2012 Publicly Reported, MOH 3	93.70	93.00	26.00	Priority 3
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 2012	0.49	0.00	0.00	Priority 2

Publicly Reported, MOH Maintain				
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 2012 Publicly Reported, MOH Maintain	0.43	0.00	0.00	Priority 2
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 2011/12 CIHI eReporting Tool Improve	11.88	9.18	12.94	Post op Mortality data was consistently provided to the M & M committee, as well, the OR Medical Director reviewed post op deaths. All post op deaths were reviewed by the Mortality and Morbidity committee through the review process and the breakdown of types of major surgery cases were reviewed. The team identified any process/clinical changes required through pre and post op processes. Due to the type of programs at HDGH, the complexity and severity of surgical cases related to major surgery are very high risk in nature. Q2 did see a drop to 8.6. Realignment suspended some of the regular reporting and processes in place.
Surgical Safety Checklist: number of times all three phases of the surgical safety checklist was performed (‘briefing’, ‘time out’ and ‘debriefing’) divided by the total number of surgeries performed, multiplied by 100 - consistent with publicly reportable patient safety data. % All surgical procedures 2012 Publicly Reported, MOH 3	100.00	100.00	100.00	Priority 3 Indicator

Rate of Post Admission Urinary Tract Infection (UTI) per 1000 patients falling in surgical and medical CMG's: number of post admission UTI's divided by the total number of surgical and medical discharges multipled by 1000 - April to December 2012 UTI's divided by CMG's multipled by 1000 Population Period Source Improve	23.16	20.00	20.42	There have been improvements in this indicator with continued challenges around sustainment. There are checks of patients with a foley catheter meeting criteria with audits on compliance. Rates continually improved over all three quarters in 13-14 towards the target of 20. Realingment took place in October 2013, however, the action plans were well in place and established through professional practice and clinical management team.
Rate of Post Admission Pressure Ulcers per 1,000 patients falling in Surgical and Medical CMG's: number of post admission Pressure Ulcers divided by the total number of surgical and medical discharges multipled by 1000 - April to December 2012. Rate of Ulers Population Period Source Improve	8.64	4.00	8.17	Priority 2
Surgical Site Infection - % hip/knee patients that received prophylactic antibiotic administration within appropriate time prior to surgery. Average of the quarterly rates for Jan to Dec 2012 Percentage - average of quarters Population Period Source 3	97.40	98.00	98.40	Priority 3