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	Average adjusted Length of Stay (LOS) for Moderate Stroke Patients (RPG - 1120 Days Rehab 12-13 YTD used for baseline IntelliHealth, MOH	33.90	28.00	26.40	The intake nurse role was reviewed this year and has assisted in improving patient flow from acute care to rehab services which assists in postive outcomes in functional efficiency and LOS . Standard order sets have been implemented and continue to be enhanced
2	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	CB	0.00	-2.50	We continue to finalize numbers for 14-15. Processes have been established for financial variance reporting process with all programs and 100% of variance reports are submitted by the due date for monthly on/off budget meetings as planned in the QIP. We continue to work towards Length of Stay (LOS) reporting and analysis in conjunction with various program and medical committees. Education continues to be provided to staff in various formats to assist in understanding and awareness of changes to funding structure . There are still impacts from realignment , including funding uncertainty, that continue to affect our financial performance.
3	% mental health patients readmitted to	31.00	20.00	6.30	There was significant focus on engagement

	same facility within 30 days (OMHRS)Q1 % Mental Health / Addiction patients Q1 - 13-14 used as baseline OMHRS, CIHI				of the entire care team within Mental health to review and perform root cause analysis on all readmissions to mental health from acute care. Improvements were made through enhancement of care plans and improvements to admission criteria to ensure that patients were appropriate for admission to specialized mental health, to reduce reoccuring returns to acute care. The majority of readmission's are related to medical and addictions comorbidities/factors.
4	From NRC Picker "Overall, how wouuld you rate the care and services you received at the hospital (add together percent of those who responded "excellent, very good and good " . (Rehab) % Rehab Q2 - 13/14 NRC Picker	81.90	95.00	89.30	We are still in process of setting up our Patient Advisory Council stucture and committee. The Rehab program receives quarterly patient satisfaction results and these are reviewed and discussed . There has been a focus this year on transition and the implementation of intake role within the acute care setting to improve patient transition and flow . As well , there have been changes to the charge nurse role which provides the patient with a single point of contact and coordination of their care. Weekly safety huddles have also been implemented on the units.
5	Internal Survey : "Overall, how would you rate the care and services you received at the hospital" (add together Excellent, Very good and Good) Complex Continuing Care % Complex continuing care residents bi-yearly survey In-house survey	96.00	95.00	97.10	We are still in the process of implementing our Patient Advisory structure and committee. The complex satisfaction (internal survey) was completed in December 2014 and we are in process of looking at a new survey tool and process to support complex care. Survey results are shared with the leadership and staff . There has been significant improvement work done around transition management from acute care and with patient /families .
6	Medication reconciliation at admission: The total number of patients with medications	44.00	100.00	23.00	Due to hospital realignment and delays in setting up a stand alone Pharmacy

	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				Department and staff compliment , this indicator is a key priority for 15-16 with plans to be fully implemented accross the organization by the Accreditation Canada timeline of 2018. The current performance data does not accurately reflect the current performance as this only represents reconciliation completed by Pharmacist. We are working on data collection and data quality issues around the collection of those completed by other professionals.
7	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	0.00	0.14	0.17	A process improvement team has been established and an infection control improvement work plan identified . A new audit software for hand hygiene audits was implemented this year and significant staff training and education related has been established and will continue to be developed and rolled out accross the organization. The co-horting of patients and identification of patient's transitioning from acute care with infections has been enhanced and more appropriately managed from a Patient Flow /Intake and Bed Allocation perspective. There is ongoing dissemination and review of CDI rates and discussion of infection control for achievement of positive results. IPAC positions were created with a focus on surveillance, auditng , education and training.
8	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. %	CB	95.00	55.00	A process improvement team has been established and an infection control improvement work plan identified . A new audit software for hand hygiene audits was implemented this year and significant staff training and education related has been established and will continue to be developed and rolled out accross the organization. IPAC positions were created with a focus on

	Health providers in the entire facility 2013 Publicly Reported, MOH				surveillance , auditng , education and training. We have completely changed our audit process and transitioned to an electronic auditing and reporting system recently and are establishing new baseline hand hygiene rates .
9	Total Falls rate with harm (Category E and above) per 1000 patient days (all in-patients) Rate per 1,000 patient days All patients Q3 - HDGH -baseline Hospital collected data	0.83	0.90	0.72	We have continued to improve our falls rate and have continued success below the benchmark of .9. Continued maintenance and improvement related to falls prevention . The focus is on falls prevention through various improvement initiatives . There are weekly reviews of all falls and monthly review of falls data , trending and contributing factors. There is weekly discussion with staff through staff meetings and safety huddles. A client safety brochure is given out on admission that discusses our falls prevention program and includes the patient/family role in promoting safety related to falls .