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.

	Priority Indicator	Current Performance stated on QIP 2014/15	Target on QIP 2014/15	Current Perform 2015	Change Ideas from Last Year QIP (2014/15)	Was change implemented Yes or No	Lessons Learned 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?	NEW Change Idea that were tested but not included in last year's QIP	Was change implemented Yes or No	Lessons Learned 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?
1	ER Wait times 90th percentile ER length to stay for Admitted (all CTAS Patients, NARS CIHI (ER length of stay is defined as the time from triage to registration whichever comes first, to the time the patient leaves the ER).	15.15	14.10	12.10	Coordinate the Registration, Housekeeping and Bed assignment processes. Expedite the admission process.	Yes	We were able to reduce the LOS by improving areas of the admission process			
2	ER Wait Times: 90th percentile ER length of stay for low acuity (CTAS 4 and 5) Non-admitted Patients, NACRS, CIHI (ER length of stay is defined as the time from triage to registration, whichever comes first, to the time the patient leave the ER)	4.30	3.90	4.97	NP, PA and nursing to work together to expedite episodic care for the lower acuity patient	Yes	We continue to monitor the LOS for the non-acute patients and utilize NP's and PA's to improve this metric			
3	ER Wait Times: 90th percentile ER length of stay for High Acuity (CTAS 1,2 and 3) Non-admitted Patients, NACRS, CIHI (ER length of stay is defined as the time from triage to registration, whichever comes first tot the time the patient leaves the ER)	7.0	6.5	7.8	Continue to use nursing medical directives to initiate and expedite care.	Yes	Reviewing and revising current CT scan protocols and monitoring wait time for lab and DI results			
4	ER Wait Times: 90th percentile wait time to physician initial assessment NACRS, CIHI (The time waiting in the emergency department until the physician initial assessment).	3.7	3.2	4.2	Improve the patient experience by early physician assessment time.	Yes	We continue to monitor the LOS for the non-acute patients and utilize NP's and PA's to improve this metric			
5	ER Wait times 90th percentile time in inpatient Bed, NACRS, CIHI (after the decision to admit has been made, the length of time it takes for a patient to be transferred to an inpatient bed).	6.5	3.0	4.5	Expedite discharge on inpatient units and admission process for patients admitted from ED.	Yes	Improved the admission process with nursing, registration and the inpatient unit			
6	Total margin consolidated: percent 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 Q3 2012é13, HHRS, Healthcare indicator Tool, MOHLTC Health Data Branch April 1 2012 to December 31, 2012 cumulative (core-period changed)	0.00	0.00	-1.60	Hay Group Study will recommend the services we should be providing in a rural community	Yes/Partial	The implementation of the recommendations is ongoing. The timing of the receipt of the report has meant that there have been delays in receiving public and other stakeholder input. There have also been additional review processes undertaken by the LHIN which have also required additional time. The successful implementation of the recommendations requires detailed planning and the			

							development of a contingency plan. Where possible, a phase in of the recommendations may be successful. Certain changes ideas that affect only internal hospital operations (i.e. Benchmarking results) have been implemented effectively.				
7	Readmission within 30 days for Selected Case Mix Groups (%; All acute patients; Q2 2012/13-Q1 2013/14; DAD, CIHI)	14.97	12.80	15.60	Lead organization for ESS Health Links. Early identification of patients with complex discharge.	No	Change idea was not implemented				
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8	From NRC Picket/HCAHS: Would you recommend this hospital to your friend and family. (the percentage of those who responded: "yes, Definitely"). Inpatient July 1, 20122 - June 30 2012(core-period changed)	74.86	78.60	68	Increase patient satisfaction by increasing nursing time spent at the bedside and improving response time for patient assistance.	New call bell system was implemented	No impact to satisfaction score. Key learning is that although time to bedside decreased, need to focus on the quality of nursing care/education at the bedside.				
9	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").	91.68	96.26	90.4	Increase patient satisfaction by increasing nursing time spent at the bedside and improving response time for patient assistance.	New call bell system was implemented	No impact to patient satisfaction score, remained relatively the same. Key learning is that although time to bedside decreased, need to focus on the quality of nursing care/education at the bedside				
10	From NRC Picker / HCAPHS: "Would you recommend this hospital to your friends and family?" (The percentage of those who responded "Yes, Definitely").Emergency Department	57.22	60.08	58	Foster a culture of caring.	Yes	Focus on caring for our community has improved the patient satisfaction				
11	From NRC Picker / HCAPHS: "Overall, how would you rate the care and services you received at the hospital?" (The percentage of those who responded "Excellent", "Very Good", and "Good").Emergency Department	87.29	91.80	83.9	Foster a culture of caring.	Yes	Focus on caring for our community has improved the patient satisfaction				
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12	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 -	0.58	0.46	0.46	Implementation of an order set for C Diff management.	YES	Mandatory pharmacy consult implemented with every C diff patient has provided a means to monitor and trend antibiotic				

	Average for Jan-Dec. 2013, consistent with publicly reportable patient safety data.						usage/history with each patient. Antibiotics are stopped and patient put on appropriate AB for Cdiff.			
					Reduce bed moves.	YES	We have improved the patient flow process to accommodate isolation – 'right bed first time'	Initiated comprehensive Infection Risk Assessment tool at Triage.	YES	Patient presenting with loose stools in ED are placed in immediate isolation whether admitted or not. CDiff protocol for cleaning rooms in effect in ED and on floors.
					Increase the number of private rooms.	YES as census permits	We strive to provide 'single occupancy' for as many patients as possible. This may vary as census varies.	We reduced the number of beds (72 excluding LDRP rooms) to 61 excluding LDRP). The remaining 11 beds are considered surge beds and utilized only if necessary.	YES	We have improved the patient flow process to accommodate isolation – right bed first time' (Reduce the moves) Patients who 'fail' Risk Assessment in ED with loose stools and are admitted are immediately put in single rooms until lab results are back which can impact patient flow.
					Increase involvement in regional Antibiotic Stewardship initiatives.	YES	We confirmed that our strategies for managing C diff are consistent with best practices and other hospital initiatives. The Regional Antimicrobial Stewardship team provides a link to resources such as Infectious Disease Specialists which we do not have on-site. Our pharmacists and ICP attend regional and provincial conferences and education days and in constant communication with other ICP's and pharmacists.	Daily infection control reports are circulated among the Windsor Regional Hospital (2 sites, Hotel Dieu Health Care and LDMH	YES	The past ARO/C diff history of patients who may have attended one of these other facilities previously is readily available. This has been beneficial in tracking infections.
					Monitor antibiotic use in C Diff patients for any trends. Review latest literature and best practices and communicate to physicians.	YES	Antibiotic usage on every C diff case is being recorded and monitored for any trends. Pharmacists discuss antibiotic use with physicians on a case by case basis. Antibiotics in use are discontinued and proper C diff treatment initiated (Flagyl or Vancomycin).			
13	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.	91.00	95.00	93.92	Broaden communication of hand hygiene results back to staff, volunteers and physicians	YES	Monthly Hand Hygiene reports circulated. Hand Hygiene results are topics at Town Hall Meetings.	Auditing processes reviewed and education to auditors provided by Public Health Ontario	YES	Lessons learned –difficult to keep auditors consistent in monitoring and recording practices with a large number of auditors. Continual education is required.
					Encourage patients to ask care givers if they washed their hands.	YES	Volunteers remind patients and staff advise patient on admission.	Admission forms documents that education was given.	YES	