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	ED Wait times: 90th percentile ED length of stay for Admitted patients. Hours ED patients Q4 2012/13 – Q3 2013/14 CCO iPort Access	11.52	11.52	15.67	Data quality concerns – improper coding - corrected

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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	0.00	0.00	0.00	Balanced Budget.

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3	Percentage ALC (Alternate Level of Care) days: Total number of acute inpatient days designated as ALC, divided by the total number of acute inpatient days. % All acute patients Q3 2012/13 – Q2 2013/14 Ministry of Health Portal	45.39	38.58	47.51	Data quality concerns

Change Ideas from Last Years QIP (QIP 2014/15)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) 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?
Thorough study of ALC in acute and complex care.	Yes	Patient classified ALC on floor but not changed in system until the discharge date. This creates skewed results and a variance in reporting. It is a physician led issue. Our aging population with multiple comorbidity and inadequate community support increases the demands for ALC classification. It is recommended that the 'Patient Care Committee' look at patient flow processes.
Liaise with same size and proximity hospital to identify other initiatives.	Yes	Developing interim strategies regarding common pressures and patient movement affecting ALC designation.
Review our discharge process and liaise with Community partners for early return home	Yes	Discharge Planner liaises with partners for 100% of patients: CCAC (Community Care Access Centre), Community Living, Meals on Wheels, Home for the Aged Program Coordinator, Nipissing First Nation Health Services, Alliance Centre – Mental Health/Crisis Placement/Homelessness Initiative, West Nipissing Non-Profit Housing, Lifeline, Near North Palliative Care, PHARA (Physically Handicapped Adults Rehab Association), near North Palliative Care, Capacity Assessors, PATH (Priority Assistance for Transition Homes), ODSP (Ontario Disability Support Program), Community Paramedicine Program, BOS (Behavioral Support Ontario)
Trial discharge planning process in Emergency Department for at risk patients	No	This initiative was not implemented.

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4	Percentage of acute hospital inpatients discharged with selected Case Mix Groups (CMGs) that are readmitted to any acute inpatient hospital for non-elective patient care within 30 days of the discharge for index admission. % All acute patients Q2 2012/13-Q1 2013/14 DAD, CIHI	16.36	16.30	13.78	As a small hospital we are compliant with repatriation of patients from district and referral hospitals.

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5	In-house survey (if available): provide the % response to a summary question such as the "Willingness of patients to recommend the hospital to friends or family" (Please list the question and the range of possible responses when you return the QIP). % Other Other In-house survey	97.10	97.10	97.00	"Would you recommend the West Nipissing General Hospital to your family and friend?" (Answers - Definitely Yes and Probably Yes). Goal is to maintain target value.

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6	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 (e.g. Q2 2013/14, Q3 2013/14 etc) Hospital collected data	94.70	100.00	96.00	Did not reach projected target but improved from previous year level. 100% compliance with Medication Reconciliation at Discharge.

Change Ideas from Last Years QIP (QIP 2014/15)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) 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?
Re/instruction of HFO physicians regarding medication reconciliation at admission.	Yes	96% compliance - 4% due to patients with no medication, therefore Medication Reconciliation not necessary and not documented. Medication Reconciliation is now documented on those patients with no medication.
Re-instruction to staff regarding medication reconciliation process. If patient has no prescribed medications, the chart needs to reflect the medication reconciliation as having been done.	Yes	96% compliance - 4% due to patients with no medication, therefore Medication Reconciliation not necessary and not documented. Medication Reconciliation is now documented on those patients with no medication.

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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	0.42	

Change Ideas from Last Years QIP (QIP 2014/15)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) 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?
Video to be played on TVs in waiting area to increase awareness to visitors, patients, staff of the importance of hand hygiene	Yes	Videos played on Global Hand Hygiene Day - May 5, 2014 - "Stop, Clean Your Hands Day". Along with various puzzles distributed to employees.
Ministry of health - Core Competency Training on Hand Hygiene	Yes	Core competency training assigned to all existing employees and new employees at orientation. 100 % compliance in completing and passing the course.
Portable automatic dispensers for hand sanitizers strategically placed during outbreak season and/or outbreaks	Yes	No outbreaks declared in 2014-2015 reporting period. Portable dispensers placed at front entrances of hospital to encourage hand hygiene of staff/visitors/vendors entering facility.
Poster campaign in all staff washrooms on Routine Practices including Hand Hygiene	No	Poster campaign implemented. Survey on effectiveness of poster not done - difficult to assess effectiveness.
Implementation of bedpan/commode hygienic covers with absorbent pad instead of bedpan cleaning wands to rinse bedpans	Yes	Eliminated use of toilet wands to clean bedpans, therefore reducing splash incidents.
Review of infection prevention and control and environmental services policies related to hospital acquired infections	Yes	Done - C-difficile policy revised in April 2014.
Antibiotic Stewardship Program	Yes	Studying antibiotic use of patients with C-difficile positive conditions.
Hand Hygiene Compliance	Yes	84 % compliance

1) Hand Hygiene survey of all staff. 2) Champion poster. 3) In-House Laboratory qualitative testing of C-difficile on liquid/loose stool samples for in-patients. 4) Cleaning all bathrooms with 'sporicidal agent' when increase incidents or prolonged cases of C-difficile. 5) Hand Hygiene awareness campaign in Diagnostics & Therapeutic Departments	Yes	1) Survey posted from January 5, 2015 to February 5, 2015. Self-assessment on knowledge and confidence on Hand Hygiene practices. 2) Poster includes Hand Hygiene committee members, CEO and Infection Prevention & Control physician. Posters posted across the organization. 3) Implemented January 2015 - aiming to provide earlier diagnostic/treatment, reduce unnecessary isolation and increased reaction time for preventive measures against nosocomial C-difficile infections. 4) Preventive measures against nosocomial C-difficile infections. 5) Increase compliance to four moments of hand hygiene and increase in utilization of hand sanitizer.

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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. % Health providers in the entire facility 2013 Publicly Reported, MOH	84.00	86.00	84.00	Did not reach projected target but maintain previous year level.

ID	Measure/Indicator from 2014/2015	Current Performance as stated on QIP14/15	Target as stated on QIP 14/15	Current Performance 2015	Comments
9	Percent of Complex Continuing Care (CCC) residents with a new pressure ulcer in the last three months (stage 2 or higher). % Complex continuing care residents Q2, 2013/14 CCRS, CIHI (eReports)		0.00	X	0% of CCC residents with a new pressure ulcer

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10	Percent of Long Term Care (LTC) residents with a new pressure ulcer in the last three months(stage 2 or higher). % LTC residents Q2 FY 2013/14 Hospital collected data	0.00	0.00	0.00	

ID	Measure/Indicator from 2014/2015	Current Performance as stated on QIP14/15	Target as stated on QIP 14/15	Current Performance 2015	Comments
11	Percent of Complex Continuing Care (CCC) residents who fell in the last 30 days. % Complex continuing care residents Q2 2013/14 CCRS, CIHI (eReports)		5.00	X	13.79% of CCC residents fell in the last 30 days (4 patients out of 29 – 4/29 admitted patients). No injuries sustained.

Change Ideas from Last Years QIP (QIP 2014/15)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) 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?
Ensure initial 'Falls Assessment' done at admission.	Yes	100% of new admissions have documented 'Falls Assessment' on chart.
Ensure on going 'Falls Assessment' for admitted patients	Yes	100% of patients having fallen have 'Falls Assessment' review documented on chart.
Identification of all patients at risk of falls using color coded bracelets.	Yes	88% of patients identified as 'high risk' for falls, are wearing their bracelets. Patients remove them for various reasons - staff applying another one when not being worn.

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12	Percent of Long Term Care (LTC) residents who fell in the last 30 days. % LTC residents Q2 FY 2013/14 Hospital collected data	0.00	0.00	1.82	Represents one patient out of 55 admitted (1/55) patients - non-compliant with instructions to request assistance when getting out of bed. No injury sustained.

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13	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 2013 Publicly Reported, MOH		100.00	100.00	Achieved and maintaining target - not included in 2015/16 QIP.

ID	Measure/Indicator from 2014/2015	Current Performance as stated on QIP14/15	Target as stated on QIP 14/15	Current Performance 2015	Comments
14	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 Q4 2010/12 - Q3 2012/13 OMHRS, CIHI		0.00	X	

ID	Measure/Indicator from 2014/2015	Current Performance as stated on QIP14/15	Target as stated on QIP 14/15	Current Performance 2015	Comments
15	Physical Restraints: The number of Long Term Care (LTC) residents who are physically restrained at least once in the 3 days prior to a full admission divided by all cases with a full admission assessment. % LTC residents Q2 FY 2013/14 Hospital collected data	0.00	0.00	0.00	

ID	Measure/Indicator from 2014/2015	Current Performance as stated on QIP14/15	Target as stated on QIP 14/15	Current Performance 2015	Comments
16	Percentage of Long Term Care (LTC) residents with worsening bladder control during a 90-day period. % LTC residents Q2 FY 2013/14 Hospital collected data	0.00	0.00	0.00	

ID	Measure/Indicator from 2014/2015	Current Performance as stated on QIP14/15	Target as stated on QIP 14/15	Current Performance 2015	Comments
17	Medication incidents: Total number of medication incidents divided by the total number of medication prescribed multiplied by 100. % All acute patients Q2 FY 2013/14 Hospital collected data	0.29	0.25	0.44	18 incidents from 4,052 (18/4,052) prescriptions ordered. No incidents with adverse effects. This indicator is included in our 2015/16 QIP.

Change Ideas from Last Years QIP (QIP 2014/15)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) 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?
Analysis of errors to determine which area requires re-education, re-enforcement and/or training	Yes	Omission is the most common cause of medication administration error. Root cause analysis determined these omissions caused by transcribing omissions.
Introduction of unit dose medication dispensing	Yes	Unit dose medication dispensing implemented. Medication errors still occurring. Further change ideas are required to decrease the incidents. Kept on 2015/16 QIP.
Implementation of primary care nursing in acute care	Yes	Primary care nursing in acute care implemented. Medication errors still occurring. Further change ideas are required to decrease the incidents. Kept on 2015/16 QIP.