Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for the 2015/16 QIP MHA- FCHS and SMGH

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 2015/16	Org Id	Current Performance as stated on QIP2015/16	Target as stated on QIP 2015/16	Current Performance 2016	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 2013 - September 2014; NRC Picker)	FCHS	87.00	93.00	84.00	Performance of Overall Care remains under target, but relatively stable. NRC Picker survey utilized to the end of Q 4 2014-15. NRC contract not renewed. All staff of FCHS attended C.A.R.E (Connect,Appreciate,Respond,Empower) training to enhance consistency of staff customer service approach and respect of patients. Survey, investigation and development of new patient satisfaction survey tools occurred throughout the fiscal year, including review of new NRCC survey tool this winter. A final decision regarding the survey tool of choice and implementation is expected by Q2 2016. Numerous education opportunities for staff and senior leadership regarding experience based design and patient engagement. All patient compliments and concerns are addressed within 2 business days of receipt. The majority of concerns are resolved within 2 weeks. The Board Quality Committee reports a variety of patient stories and reports on compliments and complaints.

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 FY 2014/15 (cumulative from April 1, 2014 to December 31, 2014); OHRS, MOH)	FCHS	5.58	0.00	4.19	Currently achieving this performance goal and will continue to monitor through Board Finance Committee. Ongoing analysis and education surrounding Health System Funding Reform / Quality Based Procedures and Health Based Allocation Model as they do or will pertain to small hospitals. The hospital is engaged in many regional initiatives to enhance patient care which are tied to performance. They include the SW LHIN Regional Integration Decision Support team; the SW LHIN Local Partnership Initiative to identify funding issues and challenges while providing education; the SW LHIN Integrated Health Plan looking at clinical services planning; and regional surgical services. The hospital continues to monitor changes to the Not-For-Profit Corporations Act and the potential impact on governance and changes to Cost Per Weighted Case.
3	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 FY 2014/15 (cumulative from April 1, 2014 to December 31, 2014); OHRS, MOH)	SMGH	3.19	0.00	3.31	Currently achieving performance goal and will continue to monitor through Board Finance Committee. Challenges include adapting to changes to HBAM and Quality Activity Funding Formula and provincial funding overall. The MHA continues to develop its growth and knowledge in the Health System Funding Reform. All levels of organization have been included including Physician and staff health care providers, professional practice committee incorporating care pathway development and best practices, finance, health records and decision support. The hospital benefited from the removal of the upper mitigation corridors on QBP and HBAM funding, along with the new year four QBP procedures.

4	Readmission within 30 days for Selected Case Mix Groups (%; All acute patients; July 1, 2013 - Jun 30, 2014; DAD, CIHI)	SMGH	16.08	16.56	15.00	Current Performance of the required report period is 15.00, so the target was achieved. Focus this year has been on completing reviews of patient readmission for reasons associated with the readmission. Stroke patient pathway working well to avoid readmission. COPD pathway implementation ready. New CNS/NP position enhancing discharge teaching, accessible telephone follow-up and early FP follow-up.
5	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; Jan 1, 2014 - Dec 31, 2014; Publicly Reported, MOH)	SMGH	0.00	0.29	0.32	We did not meet the provincial target of 0.29 because of the low patient days that will inflate the average. There was only one case this year on a patient who had many predisposing factors at increased the risk for CDI. There was no transmission from the patient to others on the unit. Housekeeping practices continue as per protocol with checklists and ATP testing to verify cleaning practices. Have researched the Nocospray, portable disinfection system (using a hydrogen peroxide and silver compound) to augment the terminal cleaning of CDI rooms. Will include the purchase of this equipment in the capital budget process. Hand hygiene numbers continue to meet the 90% compliance goals Antibiotic stewardship continues to be monitored by the pharmacist. Collecting defined daily doses continues to be a challenge as we can only run reports on the number of doses dispensed. However, just because a dose was dispensed does not necessarily mean it was actually administered. Often extra doses are dispensed. With the use of eMAR, the regional pharmacy leaders group had put in a request to generate some new reporting within Discern Analytics that would actually return results for doses administered. However the microbiology department is populating data from the isolates cultured from the MHA to produce an antibiogram for the MHA to guide physicians in antibiotic selection .

6	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; Jan 1, 2014 - Dec 31, 2014; Publicly Reported, MOH)	SMGH	0.38	0.29	0.19	We exceeded our target this year by reducing the number of CDI cases by half. There was no transmission to other patients during times when the infections were present in the units. Housekeeping practices continue as per protocol with checklists and ATP testing to verify cleaning practices. Have researched the Nocospray, portable disinfection system (using a hydrogen peroxide and silver compound) to augment the terminal cleaning of CDI rooms. Will include the purchase of this equipment in the capital budget process. Hand hygiene numbers continue to meet the 90% compliance goals Antibiotic stewardship continues to be monitored by the pharmacist. Collecting defined daily doses continues to be a challenge as we can only run reports on the number of doses dispensed. However, just because a dose was dispensed does not necessarily mean it was actually administered. Often extra doses are dispensed. With the use of eMAR, the regional pharmacy leaders group had put in a request to generate some new reporting within Discern Analytics that would actually return results for doses administered. However the microbiology department is populating data from the isolates cultured from the MHA to produce an antibiogram for the MHA to guide physicians in antibiotic selection.

7	ED Wait times: 90th percentile ED length of stay for Admitted patients. (Hours; ED patients; Jan 1, 2014 - Dec 31, 2014; CCO iPort Access)	SMGH	11.45	10.53	10.4	Current performance for the required reporting period is 10.4. So this HSAA target has been achieved. SMGH continues to participate with the SWLHIN ED knowledge transfer group to reduce time to transfer to inpatient bed. A revamp and implementation of new admission and bed flow standard operating procedures has occurred, reinforcing the collaboration of all departments in timely patient flow. Daily huddles in all patient care areas and hospital wide enhance the regular flow of key metrics and performance day to day of discharge from ED within 1 hour of 'ready for transfer' call. Communication white boards with communications related to patient goals and need, discharge planning and family communications assist in all participants having the same information to work towards.
8	“Overall, how would you rate the care and services you received at the hospital?”, 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). (%; Inpatient, ED and Same Day Care; Jul 2014 - Jun 2015; NRC Picker)	SMGH	92.00	93.00	95.00	Performance of Overall Care exceeded the target for the first time this year. NRC Picker survey utilized to the end of Q 4 2014-15. NRC contract not renewed. All staff of SMGH are currently attending C.A.R.E (Connect,Appreciate,Respond,Empower) training to enhance consistency of staff customer service approach and respect of patients. Survey, investigation and development of new patient satisfaction survey tools occurred throughout the fiscal year, including review of new NRCC survey tool this winter. A final decision regarding the survey tool of choice and implementation is expected by Q2 2016. Numerous education opportunities for staff and senior leadership regarding experience based design and patient engagement. All patient compliments and concerns are addressed within 2 business days of receipt. The majority of concerns are resolved within 2 weeks. The Board Quality Committee reports a variety of patient stories and reports on compliments and complaints.

9	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; Hospital collected data)	FCHS	82.00	90.00	82.00	The performance target was not achieved during this fiscal year, however performance has improved. Process issues around obtaining the Best Possible Medication History (BPMH) and reviews were identified and additional training was provided to the nursing staff in the Emergency Department by a Pharmacist student. Additional Physician support has been provided by the addition of 2 new Nurse Practitioners. Ongoing monitoring and review of statistical data is expected to continue. This improvement process will be under continuous review as it gains some stability with all staff in the ED. As the BPMH become more accurate this improves patient safety and will assist Clinicians in finalizing the Admission Med Rec process. The challenges for this program during this year remain with funding and providing trained staff.
10	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; Hospital collected data)	SMGH	87.00	90.00	86.00	The performance target was not achieved during this fiscal year. However, process issues around obtaining the Best Possible Medication History (BPMH) and reviews were identified. Additional training was provided to the nursing staff in the Emergency Department by a Pharmacist student. Pharmacy Technicians performed BPMH interviews in the ED and throughout the hospital periodically throughout the year with great success. A project review was conducted and additional funds where provided to continue the BPMH process however, challenges still exist with providing licensed staff. To assist with the process, University of Waterloo Pharmacist students were brought in to continue this service. Ongoing monitoring and review of statistical data is expected to continue. This improvement process will be under continuous review as it gains some stability with all staff in the ED and pharmacy. As the BPMH become more accurate this improves patient safety and will assist Clinicians in finalizing

						the Admission Med Rec process. The challenges for this program during this year remain in funding and providing trained licensed staff.
11	Percentage ALC days: Total number of acute inpatient days designated as ALC, divided by the total number of acute inpatient days. *100 (%; All acute patients; Oct 1, 2013 - Sept 30, 2014; Ministry of Health Portal)	FCHS	35.64	32.10	38.88	The Percent ALC days for FCHS is 38.88. ALC is managed very closely through daily inpatient huddles where discussions regarding patient acute vs non acute status is discussed, as well as discharge planning. This small community hospital ALC percentage days and rate is always high due the relatively low patient days overall and a rural catchment with a primarily senior population.Transition options are significantly limited by number and type of options, bed type available and facility outbreaks in this catchment area.
12	Percentage ALC days: Total number of acute inpatient days designated as ALC, divided by the total number of acute inpatient days. *100 (%; All acute patients; Oct 1, 2013 - Sept 30, 2014; Ministry of Health Portal)	SMGH	16.92	15.23	15.07	The Percent ALC days for SMGH 18.10 which exceeds the HSAA target. ALC is managed very closely through daily inpatient and hospital wide huddles where discussions regarding patient acute vs non acute status is discussed, as well as discharge planning. This community hospital works closely with CCAC, with support of clinical managers, social worker and PT/OT to address ALC patients. Very few patients have benefited from the Intensive Home- Home First program, however many patients are receiving enhanced services on discharge. Significant efforts to avoid repatriation patients without discharge planning initiated. Transition options limited by number and type of options, bed type available and facility outbreaks.