Quality Improvement Plans (QIP): Progress Report for 2015/16 QIP Leamington District Memorial Hospital

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.

	INDICATOR (UNIT; POPULATION; PERIOD; DATASOURCE)	Performance Stated in previous QIP	Performance Target as Stated in Previous QIP	Current Performance	Comments	Change Ideas from Last Year 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?	Insert 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 KG	"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)	83.89	85	84.50	Staying consistent with satisfaction rating.	Increase patient satisfaction by focusing on provision of best practice care.	Yes, implemented ED Stroke order set with focus on care of the ED CVA patient.	The main factors that influence patient satisfaction are: wait times and communication of information.	Implemented discharge instruction form.	Yes	Implementing the discharge instruction form improved the communication of patient specific discharge instructions.
2 LG	"Overall, how would you rate the care and services you received at the hospital?" (inpatient), 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). (%; All patients; October 2013 - September 2014; NRC Picker)	90.40	91.00	93.10		Increase nursing time at the bedside with the patient.	Yes	Change to the call bell system forces nurses to bedside. Continue to work on documentation changes.			
3 KG	"Would you recommend this ED to your friends and family?" add the number of respondents who responded "Yes, definitely" (for NRC Canada) or "Definitely yes" (for HCAHPS) 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)	57.99	61.00	55.60	Opportunity for improvement.	Increase patient satisfaction by focusing on customer service and reducing emergency department wait times.	Yes, implemented a 1200-2400 ED RN shift to assist with running a fast track area.	The main factor that influences whether patients would recommend our ED is their experience with wait time for care. Emergency Department MD resources significantly impact the wait times for low acuity ED patients.			
4 LG	"Would you recommend this hospital (inpatient care) to your friends and family?" add the number of respondents who responded "Yes, definitely" (for NRC Canada) or "Definitely yes" (for HCAHPS) and divide by number of respondents who registered any response to this question (do not include non-respondents). (%; All patients; October 2013 - September 2014; NRC Picker)	67.20	71.40	65.10		Increase patient satisfaction by providing more education and information to patients while in hospital and upon discharge, (including the Plan of Care, Estimated Date of Discharge (EDD), and disposition on discharge). Increase nursing time at the bedside.	Yes	Patient satisfaction was influenced by the lack of information on discharge. Patient education brochures were created and implemented.			

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5 SG	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)	-1.57	0.00	-4.00 (YTD) (Feb 2016 - .65%)		Balance the budget. Based on implementation of recommendations from "Aligning Sustainable Hospital Services "(HAY) report. Specifics included restructuring the nursing area with implementation of new staffing model of care; all departments improving operating efficiency by achieving at a minimum the median performance as benchmarked in the Hay Report; implement order sets for all Quality Based Procedures.	Yes	Not all recommendations from the HAY report were supported by the LHIN and only partial recommended funding was received. Hospital was able to improve operational efficiency most specifically by implementing new staffing model of care. As well, increase in number of QBP cases and related funding has resulted in improved operating margin.			
6 LG	Readmission within 30 days for Selected Case Mix Groups (%; All acute patients; July 1, 2013 - Jun 30, 2014; DAD, CIHI)	15.60	14.80	14.80		Continue to monitor and refine the daily reassessment of the inpatient indicators for readiness for discharge for patients with CHF, Stroke, COPD, and Pneumonia.	Yes	QBP specific discharge summary needs to be initiated along with the QBP specific order sets. Discharge summaries have made a difference in discharge rates as well as staff hand-off reports.	Ordered the materials and staff are providing Heart and Stroke CHF reference guides to patients.	Yes	More patient education is needed upon discharge.
7 PD	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)	0.46	0.46	0.48	Continue to monitor and educate.	Implement Plan of Care for Patient Isolation on Admission. Continue with Antibiotic Stewardship initiative. Ensure best practices for environmental cleaning are utilized including implementing any new recommendations that might arise. Increase availability of laundry hampers and garbage pails.	Yes	Continue to audit charts for compliance and identify teaching opportunities. Ongoing Antimicrobial Stewardship Program. Follow best practices-clean both beds with bleach if patient is isolated in a semi-private room used as a private while other bed is on reserve. Quick access to linen hampers for prevention of spread and tossing linen on floor.	All patients with loose stools are isolated and the room is cleaned with bleach until determination of C-Diff or other cause.	Yes	Proactive prevention of spreading infection is key - along with staff compliance and prompt isolation.

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8 KG	ED Wait times: 90th percentile ED length of stay for Admitted patients. (Hours; ED patients; Jan 1, 2014 - Dec 31, 2014; CCO iPort Access)	12.10	10.90	11.50	Continue to focus on improving areas of the admission process.	Review and revise current protocols for ED patients waiting for CT scans, as well as laboratory results.	Yes, implemented early morning CT scan ordering criteria.	This indicator is dependent on inpatient census and bed availability as well as waiting for DI test results.			
9 KG	ER wait times 90th percentile time to 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). (Hours; ED patients; Jan 1, 2014 - Dec 31, 2014; CCO iPort Access)	3.6	3.2	3.02	There has been continuous improvement in reduction of Time to Inpatient Bed.	Review current admission processes and work with the Flow Coordinator to tighten up the process.	No	All staff have been educated on the expected target time and have increasingly assumed responsibility for this indicator.			
10 KG	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, to the time the patient leaves the ER) (Hours; ED patients; Jan 1, 2014 - Dec 31, 2014; CCO iPort Access)	7.00	6.30	6.88	Staying consistent with this indicator.	Review and revise current protocols for ED patients waiting for CT scans, as well as laboratory results.	Yes, implemented the early morning CT scan ordering criteria.	This indicator is dependent on the ability to arrive at a diagnosis and plan of care for the high acuity patient.			
11 KG	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 leaves the ER) (Hours; ED patients; Jan 1, 2014 - Dec 31, 2014; CCO iPort Access)	4.80	4.30	4.55	This indicator is impacted by ED MD resources.	Review and revise current processes with NP's, PA's, nursing and MD's regarding a fast track process.	Yes, implemented a 12-24 ED RN shift with the intent to run a fast track area.	Having one physician scheduled per shift limits the ability to run a fast track area therefore impacts this indicator.			
12 KG	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). (Hours; ED patients; Jan 1, 2014 - Dec 31, 2014; CCO iPort Access)	4.10	3.70	4.08	This indicator is impacted by ED MD resources.	Review and revise current processes with NP's, PA's, nursing and MD's regarding a fast track process.	Yes	NP turnover has had some impact on this metric and LDMH will likely reduce the wait time to PIA going forward.			
13 PD/ RC	Number of times that hand hygiene was performed before initial patient contact during the reporting period, divided by the number of observed hand hygiene opportunities before initial patient contact per reporting period, multiplied by 100. (%; Health providers in the entire facility; Jan 1, 2014 - Dec, 31, 2014; Publicly Reported, MOH)	93.92	95.00	94.00	Opportunity for improvement.	Improve hand hygiene compliance rates. Increase availability of gel dispensers Change culture to promote a team approach to hand hygiene Improve Public awareness on hand hygiene	Yes	Increase Hand Hygiene results communicated to staff via administrative support from CEO's office. New Signage in patient rooms.	Peer Hand Hygiene audits are done with staff champions in infection control. Chart audits done on inpatients on admission being advised to ask their health care provider "If they have washed their hands prior to care given."	Yes	Rotating staff responsible for performing audits increases our chances of education opportunities for staff in their practices. Results are shared with staff as feedback from the Director.