Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2013/14 QIP

The following template has been provided to assist with completion of reporting on the progress of your organization's QIP. Please review the information provided in the first row of the template which outlines the requirements for each reporting parameter.

Priority Indicator	Performance	Performance Goal	Progress to date	Comments
ED Wait times: 90th percentile ED length of stay for Admitted patients. Hours ED patients Q4 2011/12 – Q3 2012/13 CCO iPort Access Improve	22.30	8.00	18.84	This indicator is not meeting target but we have again been successful in demonstarting improvement and are moving closer to the provincial average of 11.5 for 10/11.
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 2012/13 OHRS, MOH Maintain	0.53	1.00	-1.16	This target was not met but we are performing better than expected at this point in the budget year. We had forecasted -2.58 as the total margin for the end of Q3. We are performing $790,000 better then forecasted.
Percentage ALC days: Total number of acute inpatient days designated as ALC, divided by the total number of acute inpatient days.	26.79	25.45	25.29	This multi year initiative has met target and will continue to be an organizational priority for improvement each year until provincial average is acheived or the best acheived

% All acute patients Q3 2011/12 – Q2 2012/13 Ministry of Health Portal Improve				to date(provincially) is reached.
Reduce unnecessary readmission rate for the COPD CMG- one of the top user's of MAHC resources and a QBP for 13/14 (core-population change) Cases Population Period Source Improve	12.37	10.00	17.95	Target was not met but we have initiated a number of our change ideas and done extensive work through working groups on the COPD Quality Based Procedure(QBP) Clinical Handbook and recently implemented patient order sets, clinical pathways, as well as LACE Scores, and safe discharge checklists/practices organizationally. Roll out of Lace Score and Safe Discharge checklists was not optimal related to organizational changes that occurred mid QIP cycle and inconsistent Patient flow navigators.
From NRC Picker: "Would you recommend this hospital (inpatient care) to your friends and family?" (add together % of those who responded "Definitely Yes" or "Yes, definitely"). % All patients Oct 2011- Sept 2012 NRC Picker Maintain	71.42	82.00	97.65	This target has been met and has been historically reported as "Yes Definitely and Yes probably" and MAHC going forward will strengthen this indicator in the "Yes Definitely" category as we strengthen our focus on providing patient and family centered care.
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.	74.50	90.00	92.00	This target was met and will be a maintain target for 14/15. The organization will focus on improving the quality of our admission med/rec processes and focus on transitions and discharge med/rec in

% All patients Most recent quarter available (e.g. Q2 2012/13, Q3 2012/13 etc) Hospital collected data Improve				preparation for our next Accreditation cycle, Nov 2014
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 2012 Publicly Reported, MOH Improve	0.23	0.17	0.39	This target was not met and this QIP year has strengthened our committment to safe, appropriate antibiotic usage. One of our sites had a rate of 0.20/1000 pt days and the other site was 0.53/1000 pt days. The majority of cases had antibiotic exposure during their hospitalization.
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 2012 Publicly Reported, MOH Improve	83.14	87.30	91.40	This target was met and as an organization we have had tremendous success with this indicator. The practices have been embedded and we will approach next QIP year with a maintain approach to ensure sustainability.
Readmission rate for	12.19	10.00	7.19	This target was met this QIP

pneumonia CMG (core-population change) Cases Population Period Source Improve				year.
The number of measureable quality/safety improvements implemented across the organization to elimate waste and improve efficiencies number of improvements Population Period Source Maintain	22.00	200.00	172.00	This indicator is being met and has been utilized to embed a culture of continuous quality improvement and drive our usage of Lean quality improvement methodologies across the organization.