Excellent Care for All

MUSKOKA ALGONQUIN HEALTHCARE

Quality Improvement Plans (QIP): Progress Report for 2012/13 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 (2012/13 QIP)	Performance as stated in the 2012/13 QIP	Performance Goal as stated in the 2012/13 QIP	Progress to date	Comments
State the name and definition of the **priority level 1** indicator listed in the 2012/13. Reporting on progress of other priority indicators (i.e. levels 2 and 3) is optional.	State the performance associated with the priority indicator that was included in the 2012/13 QIP.	State the performance goal that was included in the 2012/13 QIP. The stated performance goal indicates the outcomes that the organization expected it would be able to achieve for each priority level 1 indicator by the end of the current (e.g., 2012/13) fiscal year	For each of the indicators listed, state the organization's current level of performance associated with the priority indicator. Refer to the reporting periods included below for guidance on completing this section.	Describe how the QIP was implemented for the priority level 1 indicator. Please consider the following topics when completing this section: - What did you learn about the root causes of the current performance? - Were the proposed change ideas implemented? Why or why not? - If implemented, have the changes helped you to achieve or surpass the target? - What will you do to further improve on this indicator?
Reduce Clostridium Difficile-associated diseases (CDI) 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, and multiplied by 1,000. Average for Jan- Dec. 2011, consistent with publicly reportable patient safety data.	0.31	Below Provincial Average	0.23	We have been successful in developing and distributing an antibiogram to all prescribers at MAHC through the establishment of an Antibiotic Advisory Committee that was developed as a sub-committee of our Pharmacy and Therapeutics Committee. MAHC is in alignment with the regional Antibiotic Stewardship Committee and continues to be an active participant and advocate for

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				the regional proposal. Monthly audits continue to monitor and ensure that the Environmental Services performance of high touch surface cleaning is sustained at target and actions are implemented to address identified weakness or regressions. Safety checks are in place and provide a visual cue to frontline staff around healthcare acquired cases.
Improve provider 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 before initial patient contact multiplied by 100 - Jan-Dec. 2011, consistent with publicly reportable patient safety data.	64% overall compliance for 2011	5% above provincial average (April 2012) to a maximum of 100%	83.14%	MAHC has made significant improvement on this indicator but are presently tracking below the target of 85.52%. We have initiated a renewed 'push' for this final quarter to ensure the organization meets this priority target. All change ideas were implemented and in addition, a campaign in the month of August to ensure focus on this indicator. The August campaign was successful in achieving 200 staff pledging their commitment to

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				hand hygiene.
Avoid patient falls: Percentage of all patients who fell in the last 30 days - Q3 data 2011/12	29	10% reduction in injurious falls. This includes all falls minor, moderate and major with any degree of injury. Decrease by 12 falls/year.	19	Change ideas were successfully implemented and success was achieved with this indicator. We still have some Hi/Lo specialty beds to purchase but funding has been confirmed and we hope to complete the change idea in the coming months.
Reduce unnecessary time spent in Acute Care Percentage ALC days: Total number of inpatient days designated as ALC, divided by the total number of inpatient days	29.6 Acute and 15.4 CCC	5% reduction per year until alignment with provincial best performer's rate of 5.5%.	Acute 26.79 CCC- 14.28	MAHC has successfully met this target for both the acute and CCC classifications of ALC. Given our ongoing commitment to further improve this indicator we will continue with this as an organizational priority for 2013/14 and bring on staff Patient Flow Coordinators to ensure that discharge planning is initiated at admission. We will also be implementing a number of

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				initiatives, like the LACE tool, discharge checklist, etc., to ensure that we enhance the continuum of care and optimize our ability to prevent admissions/readmissions.
Reduce unnecessary hospital readmissions within 30 days for pneumonia to MAHC: The number of patients with pneumonia CMG readmitted to MAHC for non-elective inpatient care within 30 days of discharge, compared to the number of expected non-elective readmissions.	13.8% for 2010/11	10% reduction in readmission for the CMG to MAHC 12.42%.	12.19	MAHC has successfully met this indicator by a small margin but were unable, to date, to roll out our Standard Order Set. MAHC readmission data has experienced large fluctuations and the program committees have been tasked with reviewing each readmission. We will align this indicator with our antibiotic usage for 2013/14, as an appropriate measure of the clinical outcomes of antibiotic usage.

Indicator	Reporting period
Safety	
CDI rate per 1,000 patient days: consistent with publicly reportable patient safety data	Jan-Dec. 2012
VAP rate per 1,000 ventilator days: consistent with publicly reportable patient safety data	Jan-Dec. 2012
Hand hygiene compliance before patient contact: consistent with publicly reportable patient safety data	Jan-Dec. 2012
Rate of central line blood stream infections per 1,000 central line days: consistent with publicly reportable patient safety data	Jan-Dec. 2012

Pressure Ulcers: CCRS	Q2 2012/13
Falls: CCRS	Q2 2012/13
Surgical Safety Checklist: consistent with publicly reportable patient safety data	Jan-Dec 2012
Physical restraints: CIHI OHMRS	Q4 FY 2010/11 - Q3 FY 2011/12
Effectiveness	
HSMR: CIHI. Refer to the CIHI HSMR eReporting tool.	FY 2011/12 as of Dec. 2012
Total Margin (consolidated): OHRS. Refer to the MOHLTC Health Data Branch web portal.	Q3 2012/13
Access	
ER Wait times (Admitted): NACRS, CIHI	Q4 2011/12 – Q3 2012/13
Patient-centred	
NRC Picker / HCAPHS: "Would you recommend this hospital to your friends and family?"	Oct 2011 – Sept 2012
NRC Picker: "Overall, how would you rate the care and services you received at the hospital?"	
In-house survey (if available): "Willingness of patients to recommend the hospital to friends or family"	
Integrated	
Percentage ALC days: DAD, CIHI. Refer to the MOHLTC Health Data Branch web portal.	Q3 2011/12 – Q2 2012/13
Readmission within 30 days for selected CMGs to any facility: DAD, CIHI. Refer to the MOHLTC Health Data Branch web portal.	Q2 2011/12 – Q1 2012/13

Recommended reporting periods and methodologies for core recommended indicators used to populate "Progress to date"