Quality Improvement Plans (QIP) 2012/13: Progress on QIP Year One (2011/12) SMGH

Priority Indicator (year 1)	Performance as stated in the year 1 QIP	Performance Goal as stated in the year 1 QIP	Progress to date	Comments
Safety: Hand Hygiene Compliance: Before Initial Patient/Patient environment contact and After Patient/Patient Environment contact	63% before patient/patient environment 66% after patient/patient environment	85% before and after patient/patient environment	89% before patient/patient environment 95 % after patient/patient environment	Excellent improvement. Inconsistent manual auditing processes addressed during fiscal 2011-12. Implementation of several change processes has resulted in achieving this 2011-12 stretch target. The implementation of electronic hand hygiene audit has significantly improved ease of documentation, frequency, volume, types of care providers and support staff completion of audits. In addition, this reporting allows for improved timeliness and quality of reports to individual departments at least quarterly. Challenges remain in frequency of missed hand hygiene opportunities before patient contact, in combination with use of gloves and contact with unclean objects (eg charts, equipment) moving from one patient to the next and particularly with physicians, but also with other disciplines and support staff. Opportunities for hand hygiene following patient contact is consistently high so we will move to only using before patient / patient environment contact as an indicator. Excellent compliance with yearly electronic education and quiz in hand hygiene instituted through infection control education packages.

Quality Improvement Plans (QIP) 2012/13: Progress on QIP Year One (2011/12) SMGH

Priority Indicator (year 1)	Performance as stated in the year 1 QIP	Performance Goal as stated in the year 1 QIP	Progress to date	Comments
Safety: Clostridium Difficile	SMGH- 5 cases -0.31	Continue to meet or exceed the Ontario rate of 0.29-0.34	SMGH: 6 cases-rate 0.35	SMGH is presently maintaining incidence of C diff numbers at 5-6 per year. Nursing staff are diligent in sending samples for testing and isolating patients quickly as per infection control guidelines. Housekeeping cleaning routines have been established, refresher education provided and audited. There have never been two cases on the same unit at the same time and usually just one case in the month. There has not been any indication of transmission from an active case within a unit. Although our monthly rates are at the 80th percentile, due to low patient days our yearly average meets the Ontario average.
Safety: Surgical Safety Checklist	97% completion of surgical safety checklist	90%	100% (Q3 2011-12)	Surgical Safety Checklist implemented, sustained and exceeded performance at onset of QIP 2011-12. Surgical services committed to consistent completion of surgical checklist through shared team accountability, regular reporting and recognition at Perioperative Governance and Quality Utilization management. Demonstrated near miss review and reinforcement of benefits through occurrence reporting systems. Monthly results posted within surgical department and quarterly results posted to SMGH Performance Dashboard and reviewed by Quality Committee of the Board.

Quality Improvement Plans (QIP) 2012/13: Progress on QIP Year One (2011/12) SMGH

Priority Indicator (year 1)	Performance as stated in the year 1 QIP	Performance Goal as stated in the year 1 QIP	Progress to date	Comments
Effectiveness- Reduced unnecessary time spent in acute care	10.2 days	10.2 days	10.2 Days, (Q2 2011-12)	Performance maintained in this initial year. Improvements in ALC days may be realized with increasing practice trend to identify patients at risk of not being likely to return home following acute care episode. Improved documentation of ALC patients seen with WTIS ALC go live reporting from May 2011.Patient flow process LEAN initiative to track patient treatment orders for early identification and follow through towards discharge. Home first program initiated in SWLHIN, but not available to SMGH catchment until 2014. Challenges to reduce ALC wait days include low to moderate availability of nursing home, CCC, rehabilitation, palliative care beds, and lack of social work support in discharge planning. In addition, the ability to transfer patients is regularly limited by outbreak designation in LTC homes and at times limited by the timeliness of CCAC ALC designation. This may continue to be challenged due to limited CCAC human resources. Earlier identification may also increase overall ALC days. SMGH and CCAC completed a review of the process together to clarify roles and responsibilities, streamline communications and patient planning.
Effectiveness: Improve organization financial health	Performance Q3 2010-11 4.25%	≥ 0	Performance Q3 2011-12 1.09	Currently achieving performance goal and will continue to monitor through Board Finance Committee. Challenges include changes to HBAM and Quality Activity Funding Formula and provincial funding overall.

Quality Improvement Plans (QIP) 2012/13: Progress on QIP Year One (2011/12) SMGH

Priority Indicator (year 1)	Performance as stated in the year 1 QIP	Performance Goal as stated in the year 1 QIP	Progress to date	Comments
Access: Reduce Wait Times in ED – 90th%ile for Admitted Patients	Performance Q3 2010-11 12.2 hours	10.1 hours	Performance Q3 2011-12 17.10 hours	ED admitted length of stay continues to be challenged by ALC patient volumes, internal admitting practices, and extended time intervals between decision to admit and transfer to inpatient unit. Significant improvements seen in Q4 2011-12 approaching target hours following LEAN patient flow process review, tracking of inpatient discharge times, notification of housekeeping and bed availability turnaround time. All time segments of patient ED and admitting process under review and monitoring. Improved visibility of real time wait times through current daily dashboard reports. In addition, electronic tracking board to be implemented with expansion of ED EPR summer 2012.
Access: Reduce Wait Times in ED – 90th %ile ED Length of Stay for Complex Conditions	5.9 hours	≤ 5.9 hours	7.9 hours Q3 (2011-12)	Quarterly performance through 2011-12 variable from 6.0 to 7.9 hours. Improved visibility of real time wait times through current daily dashboard reports. In addition, electronic tracking board to be implemented with expansion of ED EPR summer 2012.
Patient- Centered: Improve Patient Satisfaction- "Would you recommend to family and friends?"	75.2 % Patients completing NRC Picker survey positively to whether they would recommend SMGH to family and friends.	Performance goal set to meet or exceed provincial average of 74%	Current performance from Oct 2010- Sept 2011 demonstrates 76.86% positive respondents to "would you recommend to family and friends?"	Performance goal for this indicator was reached. Individual patient care areas are reviewing compliments and complaints. ED concerns associated most frequently with ED wait times and customer service of care delivery. Overall satisfaction remains significantly higher in all patient care areas. Customer complaint initial response completed within 24 hours. Quality patient care and nursing Quality Worklife Fund addressing respect and professionalism in the workplace for both

Priority Indicator (year 1)	Performance as stated in the year 1 QIP	Performance Goal as stated in the year 1 QIP	Progress to date	Comments
			Performance in individual areas of Inpatients, Surgical Day Care and ED remain variable.	collegues and patients. Challenges relatively brief focused relationship of care providers in ED vs. inpatient areas. Enhancements to EPR and tracking boards, use of daily dashboard results improving overall visibility of all patients and tracking of their pending and completed activities.

Quality Improvement Plans (QIP) 2012/13: Progress on QIP Year One (2011/12) FCHS

Priority Indicator (year 1)	Performance as stated in the year 1 QIP	Performance Goal as stated in the year 1 QIP	Progress to date	Comments
Safety: Hand Hygiene Compliance: Before Initial Patient/Patient environment contact and After Patient/Patient Environment contact	68% before patient/patient environment 69% after patient/patient environment	85% before patient/patient environment and after patient/patient environment	88% before patient/patient environment 90% after patient/patient environment	Excellent improvement. Inconsistent manual auditing processes addressed during fiscal 2011-12. Implementation of several change processes has resulted in achieving this 2011-12 stretch target. The implementation of electronic hand hygiene audit has significantly improved ease of documentation, frequency, volume, types of care providers and support staff ,completion of audits. In addition, this reporting allows for improved timeliness and quality of reports to individual departments at least quarterly. Challenges remain in frequency of missed hand hygiene opportunities before patient contact, in combination with use of gloves and contact with unclean objects (eg charts, equipment) moving from one patient to the next and particularly with physicians, but also with other disciplines and support staff. Opportunities for hand hygiene following patient contact is consistently high so we will move to only using before patient / patient environment contact as an indicator in 2012-13.Excellent compliance with yearly electronic education and quiz in hand hygiene instituted through infection control education packages.
Safety: Clostridium Difficile	0 cases – 0 rate	Continue as present	1 case, rate 0.28	FCHS maintains low excellent incidence of C diff numbers with only one case occurrence this year. Nursing staff are diligent in sending samples for testing and

Quality Improvement Plans (QIP) 2012/13: Progress on QIP Year One (2011/12) FCHS

Priority Indicator (year 1)	Performance as stated in the year 1 QIP	Performance Goal as stated in the year 1 QIP	Progress to date	Comments
				isolating patients quickly as per infection control guidelines. Housekeeping cleaning routines have been established following PIDAC best practice guidelines, refresher education provided and audited. There has not been any indication of transmission from an active case within the unit.
Effectiveness: Reduce unnecessary time spent in acute care.	15.7	15.7	9.29	Performance target for this quarter reached. Quarterly ALC patient days and total patient days remain highly variable. Improvements in ALC days may be realized with increasing practice trend to identify patients at risk of not being likely to return home following acute care episode. Improved documentation of ALC patients seen with electronic ALC reporting from Nov 2011. Home first program initiated in SWLHIN, but not available to FCHS catchment until 2014. Challenges to reduce ALC wait days include low availability of nursing home, CCC, rehabilitation, palliative care beds, lack of consistent unit charge nurse , lack of social work support, CCAC available only one day per week to address discharge planning. In addition, the ability to transfer patients is regularly limited by outbreak designation in LTC homes and by the timeliness of CCAC ALC designation. This may continue to be challenging due to limited CCAC human resources. Earlier identification may also increase overall ALC days.
Effectiveness: Improve organizational financial health.	Total Margin Q3 2010-11 1.78%	≥ 0	Total Margin Q3 2011-12 3.63	Currently achieving performance goal and will continue to monitor through Board Finance Committee. Challenges include unknown adjustment to budget related to Global , HBAM and Quality Activity funding changes.

Quality Improvement Plans (QIP) 2012/13: Progress on QIP Year One (2011/12) FCHS

Priority Indicator (year 1)	Performance as stated in the year 1 QIP	Performance Goal as stated in the year 1 QIP	Progress to date	Comments
Patient- Centered: Improve Patient Satisfaction.	70.1 % of patients respond positively to Would you recommend	74% to meet or exceed provincial average.	68.59 Q3 2010-Q2 2011	Performance goal for this indicator was not achieved. ED patient care area reviews and address compliments and complaints. ED concerns are associated most frequently with ED wait times and customer service of care delivery. Overall satisfaction with care remains significantly higher.. Customer complaint initial response completed within 24 hours. Quality patient care and nursing Quality Work life Fund addressing respect and professionalism in the workplace for both colleagues and patients. Challenge of relatively brief focused relationship of care providers in ED versus inpatient areas. Enhancements to EPR and tracking boards should improve overall visibility of all patients and tracking of their pending and completed activities.