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Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2012/13 QIP

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
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 - Jan-Dec. 2011, consistent with publicly reportable patient safety data	81.3% Cumulative as at Q3 2011/12	84.3%	82.1% for Jan – Dec 2012	Challenges with hand hygiene compliance were identified with the data collection from the various hand hygiene observers and their level of training. Need to focus on a standard level of training for the hand hygiene observers and the method by which they are collecting data. Data for the Before Patient/Patient Environment is lower than After Patient/Patient Environment, hand hygiene observers not actually seeing if the health care providers were performing hand hygiene or not. Hand hygiene observers need to follow health care providers to ensure all moments of hand hygiene are being met, not viewing from a distance. A formal training program for hand hygiene observers has been established for 2013/14 and the remainder Q4 of 12/13. Another challenge is with employees who exhibit an allergic reaction causing dermatitis, employees were less likely to use the alcohol base hand rub (ABHR). Infection Control Nurse trialed other products that were less invasive and still meet the guidelines. These products are only used on an individual basis with employees who exhibit dermatitis to the ABHR, continuing to

				research better products. Moving forward we have kept hand hygiene on the QIP as priority 1 indicator with a goal to improve our current level of compliance.
Falls Reduction: Reduce the number of level 3 & 4 falls for the organization. Acute & LTC combined. Q4 FY 2010/11 - Q3 FY 2011/12	19	18	30	Falls reduction was not a level one priority for us, but we felt we needed to comment on our progress. Our current performance for falls was disappointing to us. We have dealt with the challenge of being a multi-site, multi-service organization by trying to incorporate all services into program goals. This led to setting our own indicator for falls reduction rather than using the core indicator definition. By including LTC data, where the majority of falls occur, into our falls reduction program and promoting our policy of Least Restraint, we accepted the reality that falls would occur, but focused on reducing harm from falls. Our one-size fits all plans have not been effective. We are looking at two different Falls Assessment Tools, one for LTC and one for Acute. Some interventions cannot be consistent, for example Rainycrest is able to utilize Hi/Low beds; however the other sites utilize beds made by Stryker, who do not produce Hi/Low beds. Reporting of severity of falls is also not as consistent as we would like, so staff re-education also needs to be considered. We are keeping Falls Reduction on the QIP for 2013/14, and have developed a new set of change ideas to work toward our goal of reducing the number and severity of falls by 10%.

Total Margin (consolidated): Percent 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. Q3 2011/12, OHRS	0.78%	0	0.79%	Current performance exceeded target due to positive variance between budgeted funding based on recommended assumptions and the actual funding received. In addition, conservative budgeting utilized to recognize benefit expense reduction from pooled regional initiative; however, actual savings materially exceeded budget levels due in part from involvement in planned initiatives. Total Margin will remain on the QIP for 2013/14 along with ongoing participation in Northwest Supply Chain in order to achieve expanded savings. Renewed focus on sick time and overtime reduction.
Percent of approved capital equipment: Purchases made in quarter planned	N/A	100%	85%	Current performance below theoretical best. The root causes are identified as follows: (1) challenges with Management completing project charters in a timely manner; (2) impact of Northwest Supply Chain and St. Joseph's Buying group purchasing schedule; and (3) Supply Chain department workload challenges. We implemented quarterly reports, however, the quarterly reporting was not always provided in a timely manner in order to be responsive to performance challenges. While we did not meet theoretical best, the changes have confirmed the root causes that will continue to be addressed in order to improve overall performance. Planned quarter will be more appropriately defined to adjust for buying group schedules and completion of project charters where appropriate. In addition, timeliness of quarterly reporting and monitoring will be enhanced.
Strategic Plan Implementation: Achievement of all process measures required for initiation of formal strategic planning.	N/A	100%	100%	Overall very pleased with having this indicator on the QIP. The change plan outlined a structured process and timelines for achieving the goal of having a functional Strategic Plan to guide business and program decisions. The revised Mission & Vision statements as well as the three organizational pillars of Quality, Organizational Health and Partnerships have been shared widely. An implementation workbook has also been developed for managers to use to assist them in aligning their departments to the strategic pillars. The organization is looking forward to engaging our staff and partners in working towards our goals.

Number of Level 4 & 5 patient visits: Number of triage level 4 (less urgent) and level 5 (Non urgent) patients seen in our Emergency/Urgent Care Departments as a percentage of the total number of patients seen	53%	43%	52%	An Ad-hoc group was formed to review Level 4 & 5 ED visits and develop a monitoring process. Reports have been created and are used by the group with a reporting schedule. An audit was performed at all three sites in the fall to identify if we are triaging our patients accurately. This audit did identify that we are at times under triaging our patients. For example, a patient that was triaged as a level 4 was identified that they should have been triaged as a level 3. As a result we are having a triage course on April 23rd, 2013 led by an experienced emergency room nurse with the thoughts that it will improve patient's being accurately triaged. After the education we will perform another audit this summer/fall. Our physician shortage remains a factor on this indicator. Patients are waiting too long of a period to get an appointment at the clinic. Therefore, they come to the emergency department. We began a trial at the end of January of an Ambulatory Day Clinic to attend to patients for scheduled visits such as dressing changes, IV therapy, etc. with the hopes this would decrease our wait times in the emergency room overall, not just level 4 & 5. We are keeping the indicator on the 2013/14 QIP and will evaluate the effectiveness of the Day Clinic.
Effective Service Recovery: Development of a review process for patient oriented service recovery	N/A	100%	100%	Our current program did not have a clearly defined process to address concerns and complaints. We needed to ensure consistency in managing patient relations for effective service recovery, and establish clear points of accountability for reporting and feedback. As well, concerns and complaints need to be addressed at a level commensurate with severity. Nor did we have a system in place for tracking, trending and analysis of concerns/complaints. A review process has been developed and includes a new brochure, policy, procedures, tracking form and reporting template (captures level of severity, location, category and days to resolution). The revised Concerns Complaints and Compliments "Program" has been vetted through Senior Leadership Team, QSR and Quality Committee. At the last Quality Committee meeting a few minor suggestions were brought forward and changes have been made. These will go to the next Quality Committee meeting for approval of the changes, and subsequently to the Board for final approval. We have trialled the process with one of our nurse managers and this went

				smoothly. Next steps will include educating and training managers and staff in the service recovery process, implementing across all sites to ensure consistent documentation and tracking of concerns/complaints and establishing a baseline over the next year for trending, analyzing and reporting concerns/complaints data as this relates to severity, location, category and days to resolution.
Percentage ALC days: Total number of inpatient days designated as ALC, divided by the total number of inpatient days. Q2 2011/12, DAD, CIHI	15%	13.6%	13%	WTIS expansion has been completed as of March 4th, 2013. There has been a change in Bed Utilization/Discharge Planner over the past year. ALC patients are being managed effectively, however reducing the number of days is in ALC (to meet our target) is often difficult to manage due to many factors, some of these would include any type of outbreak at Rainycrest where the facility is closed to admissions and/or repatriation; community demand; CCAC process, etc. A report has been created for tracking ALC activity and will be sent to each site. The indicator will remain on the QIP for 2013/14