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
Guidance for completing the Progress Report	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)		0	0	0	Maintain infection prevention and control best practices. Continuous staff/visitor/patient education through awareness campaigns.

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Investigate sentinel events and establish plan of action to eliminate reoccurrence	2010 = 18 Incidents 2011 = 17 Incidents	Decrease number of occurrences and ensure a plan of action is completed	2012 – 18 incidents	Reporting medium, high and severe impact incidents. Culture change regarding safety allows for decrease in actual incidents. No blame approach with error reporting allows for increase reporting of near misses which prompts changes to process prior to events occurring. Observed an increase in reporting breach of confidentiality - Staff awareness training on confidentiality done in 2012. All privacy breaches are reported to Privacy Officer as per legislation.
Improve provider hand hygiene compliance	81% (April/11) 83% (April/12)	Increase of 2% for April 2013	84 % (Feb/13) Representing a 1% increase in compliance	More frequent audits. Visibility of auditing team serves as a reminder to staff and visitors.

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Improve organizational safety record	Incidents: 2009 - 63 2010 - 48 2011 - 50	Decrease number of incidents	2012 – 44 incidents	▪ Compliance with all aspects of the WSIB Workwell audit – final mark of 94.65%. ▪ Revising the Health & Safety program to align with the elements of the Workwell audit. ▪ Culture change regarding safety. Staff awareness on workplace hazards. ▪ Participation in 2013 OHA Sponsored Safety Group ▪ E-learning programs in place for employee teaching and training
Reduce incidence of new pressure ulcers – CCC	2011 = 0 incidents	Maintain or decrease	2012 = 2 incidents	Increase in incident due to changes in patient's mobility ▪ became bedridden ▪ comorbidity contributing to deteriorating condition ie: diabetes
Reduce incidence of new pressure ulcers - LTC	2011 = 3 incidents	Maintain or decrease	2012 = 4 incidents	
Avoid patient falls - CCC	2011 = 46 incidents	Maintain or decrease	2012 = 35 incidents	Initiatives to decrease fall occurrences: ▪ Fall prevention and management program o Patient assessment

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				○ Medication review ○ Nutritional review ○ Assistive devices ▪ Hip protectors ▪ High/Low beds ○ Environmental review ○ Continence management ○ Exercise program ▪ Staff Safe Client Handling training Initiative to further improve: ▪ Earlier patient assessment regarding fall potential ▪ Bed/mattress alarms
Avoid patient falls - LTC	2011 = 73 incidents	Maintain or decrease	2012 = 78 incidents	Initiatives to decrease occurrences: ▪ Fall prevention and management program ○ Patient assessment ○ Medication review ○ Nutritional review ○ Assistive devices ▪ Hip protectors ▪ High/Low beds ○ Environmental review ○ Continence

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				management ○ Exercise program Increase number of occurrences explained by an increase in patient turnover in 2012-2013 Initiative to further improve: ▪ Earlier patient assessment regarding fall potential ▪ Bed/mattress alarms
Reduce use of physical restraints – LTC – % of resident who were physically restrained at lease once in the 3 days prior to initial assessment	2011 = 3 residents out of 52 admissions 5.8 %		2012 = 1 resident out of 32 admissions = 1 %	▪ Minimal use of restraint policy and practice ▪ Gentle Persuasion Approach classes given to staff
Medication Reconciliation	91 % of patients discharged with medication reconciliation	Maintain or better	2012 = 95 % of patients discharged with medication reconciliation	Chart audit and staff training – admission and discharge audit
Improve organizational financial health	Balanced Budget		Total margin (consolidated) = 10.32	▪ Review and reinforce signing authority ▪ Tighter controls with financial policies ▪ Tighter controls with vendor selection and

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				purchasing processes ▪ Working with hospital Foundation ▪ Balanced budget anticipated ▪ Improved cash flow ▪ Medical Clinic mortgage paid ▪ Two loans paid
Reduce wait times in the ED	Complex = 6.2 Minor = 3.5	Maintain or decrease	April 2012 to present Complex conditions = (CTAS 1-2) - 7 hrs Minor conditions = (CTAS 3-5) - 3.9 hrs	▪ Patient flow assessment ▪ Physician involvement and by-in ▪ On-going monitoring and implantation of best practices to improve ER flow and patient satisfaction ▪
Improve patient satisfaction	92% of respondents with a reply to the question, answered yes	Maintain or better	98% of respondents with a reply to the question, answered yes	Continue to ensure patient and family satisfaction. Looking at customer service components.
Reduce unnecessary time spent in acute care	2010 = 42 % 2011 = 28 %	Maintain or better Ongoing / continued improvement initiative	2012 = 31 %	▪ Implement patient flow initiatives on inpatient unit within 24 hours of admission. Establish process involving Discharge Planner, Clinical

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				Coordinators, Nursing staff and physicians. Ensure patients are placed in appropriate level of care. ▪ Bullet rounds with multidisciplinary team including CCAC and other partners twice a week. Establish processes with the Discharge Planner, Clinical Coordinator and nursing for improved patient discharge. Process change to increase frequency of 'bullet' rounds and discharge process. Culture change regarding focus of 1100 hrs discharge time. Advocate for continuity of care in rural community. ▪ Partnership with CCAC for earlier discharge process - Adopt/establish changes in process where required.

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Reduce unnecessary hospital readmission	2010 = 8.48 % 2011 = 8.28 %	Maintain or decrease	2012 = 11 %	ALC pressures, access to acute care beds and repatriation at our district and regional hospitals plays a significant role in our readmission rates. Until regional ALC percentage decreases, we do not anticipate our readmission rate to decrease. Our repatriation ensures availability of acute and tertiary beds for partners.

Mr. Collin Bourgeois
Board Chair

Mrs. Sylvie Belanger
Quality Committee Chair

Mrs. Cynthia Desormiers
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