Excellent Care For All.

Quality Improvement Plan (QIP)

2015-2016

Cornwall Community Hospital
Hôpital communautaire de Cornwall

2015-03-05

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a quality improvement plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to HQO (if required) in the format described herein.

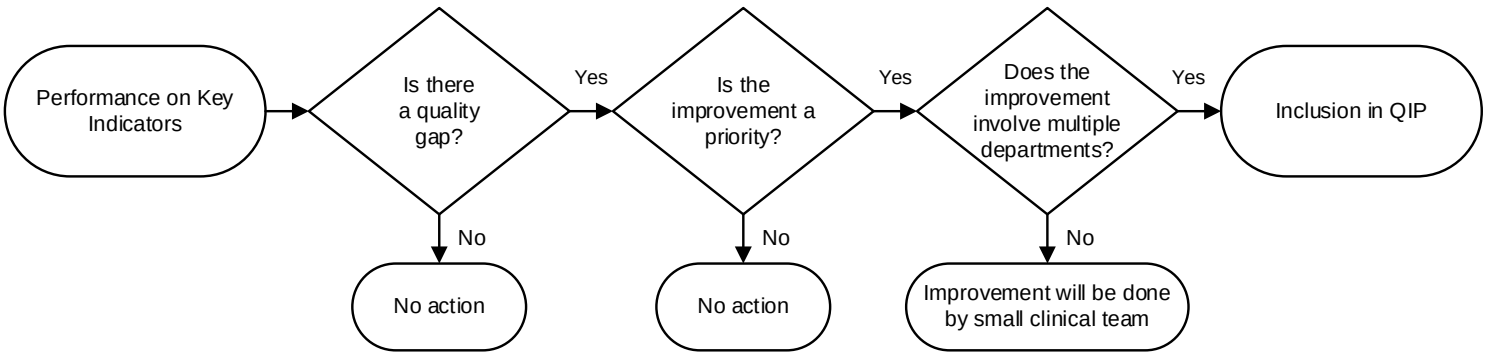
Overview

The Cornwall Community Hospital (CCH) quality indicators selected to be a priority focus for the 2015/16 QIP represent key indicators associated with patient safety, quality[1] and flow. Particular emphasis has been placed on violence prevention and management within the workplace and care environment. The rationale underlying this emphasis is our recognition that ensuring and sustaining a safe and respectful workplace is essential to fulfilling our strategic direction: people development/workplace of choice. Also, ensuring and sustaining a safe and respectful care environment is essential to fulfilling our strategic direction: excellence in quality, patient safety and service delivery as well as fulfilling our commitment to continuously improve the patient experience. Our selection process[2] of priority indicators to be incorporated within our QIP also considered provincial priorities, i.e., patient engagement; integration and coordination; and, quality and funding.

	QIP5 Hospital Priority Indicators for 2015/16
1.0	90th percentile ED Length of Stay (LOS) for admitted patients[3]
2.0	30 day readmission rate to any facility[4]
3.0	% Alternate Levels of Care (ALC) days
	Quality-Based Procedures (QBPs)
4.0	Stroke[5]
5.0	Hip Fracture[6]

[1] In addition to the Excellent Care for All Act, 2010 definition of a high quality health care system, CCH has adopted the NHS definition of quality: care that is effective, safe and provides as positive an experience as possible" (Quality in the New Health System, 2013, p. 4).

[2]



[3] QIP4 priority indicator, results have been substantially higher than target values established.

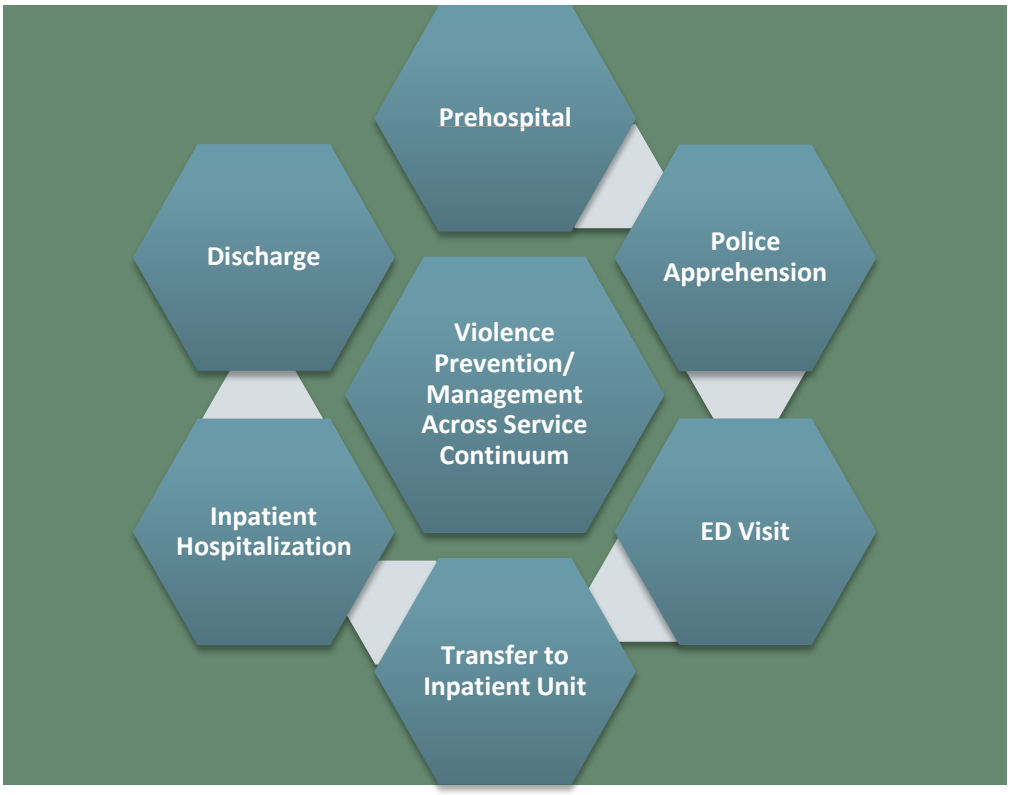
[4] QIP4 priority indicator, remains an area for significant improvement, subpopulation generating a significant number of potentially avoidable hospital days, CIHI-HSP reported results significantly higher than peers, particularly within the medicine subpopulation.

[5] Stroke subpopulation generating a significant number of potentially avoidable readmissions/hospital days, suggested indicator: Percentage of Stroke/TIA discharged on antithrombotics (QBPs: Clinical Handbook for Stroke, Sept-2013).

[6] Hip fracture subpopulation generates a significant number of potentially avoidable readmissions/hospital days, suggested indicator: Acute care FH LOS 5 day post-operative (QBPs: Clinical Handbook for Hip Fractures, May-2013).

	Accreditation Canada ROPs
6.0	Workplace violence prevention and management[7]
7.0	Medication reconciliation at care transitions[8]

- Violent episodes within the workplace and care environment within CCH has become the highest ranked risk within our Integrated Risk Management (IRM) risk registry. In undertaking to reduce the frequency and magnitude of violent episodes within the workplace and care environment, we determined that early identification and intervention was a critical overarching principle. This principle has required engagement of internal and external providers and other stakeholders to ensure that risk mitigation strategies are implemented consistently and effectively across the service continuum. The initial scope of this priority initiative will encompass persons with psychiatric and/or substance use disorders entering CCH via the emergency department and transferred to our inpatient psychiatric unit.



Integration & Continuity of Care

- CCH is undertaking a cross-sectoral, multiagency "prehospital to discharge" approach to preventing and managing violence within the workplace and care environment, e.g., LEAD protocol development and training, multiagency service planning for at-risk, complex patients.

[7] Prevention and management of violence is a major corporate focus, suggested indicators include: Physician/employee injuries resulting from a workplace violence incident per 1000 Psychiatric Care Unit (PCU) patient days and Physician/employee injuries resulting from a workplace violence incident per 1000 Emergency Department (ED) patient visits.

[8] Significant additional requirements within 2015 Accreditation Canada accreditation surveys, suggested indicator would be related to demonstrated achievement of both major and minor tests for compliance, i.e., percentage of patients with medications reconciled when transferred to and from Critical Care Unit.

Challenges, Risks & Mitigation Strategies

- Several higher risk patient subpopulations have unique assessment and interventional needs:
  - Individuals with concurrent disorders: psychiatric illness and substance abuse disorder.
  - Individuals with traumatic and nontraumatic brain injury exhibiting challenging behaviours and severe behaviour management problems.
  - Individuals with dual diagnosis have a primary diagnosis of a developmental disability and a secondary diagnosis of a psychiatric disorder.
  - Individuals with dementia exhibiting challenging behaviours.
- CCH has undertaken to consult with specialized healthcare providers, e.g., ROHCG, to develop early intervention and management guidelines which will be incorporated within the advanced training for designated primary responders to behavioural emergencies.

Information Management

- CCH continues to invest in information systems/infrastructure to support, promote and sustain quality and continuous improvement initiatives, e.g., ED and inpatient flows, patient profiles, incident reporting, management and trending, etc.
- CCH is making a significant investment in a new hospital-wide integrated electronic health record that will transform the way clinicians work throughout the hospital. This 20 month project will engage physicians, clinicians and administrative staff in defining new process flows based on best practices. Operational efficiencies will be gained, and patient safety will be improved by automating processes, reducing duplicate documentation, and improving access to information services.
- The implementation of new hospital inventory management systems helps ensure that supplies are available when required while ensuring appropriate turnover.
- Ongoing improvements to the hospital bed management system and the emergency patient tracking system to improve access to information.
- Health Links project has been initiated including engaging a broad range of regional health care providers.

Engagement of Clinicians & Leadership

- CCH continues to invest in executive, mid-level managers and front-line practitioners in professional development/training with a focus on continuous improvement and lean methodologies and techniques.

Continuous Improvement and Lean Methodologies Training		
No.	**%**	**Front-Line Staff**
400	**47%**	Full and part-time staff having received formal training
334	**39%**	White belt
46	**6%**	Yellow belt
20	**2%**	Green belt
1	**0%**	Black belt
		Management Staff
64	**90%**	Yellow or green belt

- Staff that have participated on project teams are very passionate about improving their work environment and the patient experience. We have taken some staff that were reluctant participants during previous projects, put them on the project team and they have become re-engaged employees.
- Even after the project phase is over, project team members continue to want to improve their work and the patient experience. The challenge is, in most departments, we do not have the capability to continue to improve outside of a project. To fill this gap, we are implementing department idea boards, performance boards and daily huddles to provide a framework for daily continuous improvement.
- In addition, we are planning to provide coaching training to our management team to support them in daily improvement.

Patient/Resident/Client Engagement

- Our Health Links planning group has included clients and their families in the business planning process. Patients/families were also included in a value stream analysis (VSA) that developed a client value declaration statement for our Health Link. We also have had clients tell their stories at various working groups and steering committees during the planning phase. This work is ongoing and a patient advisory committee will be formed to inform the implementation of the project.
- Although the patient remains at the centre of what we do, most of our continuous improvement projects to date have focused on removing the waste from our internal processes, which in turn allows our staff to provide better customer service/patient care. There are two specific projects that had patients participate on the project team:
  a. Emergency Department triage project included a mother who had brought her child to our ED who had submitted a complaint regarding her visit experience.
  b. Single Point Access and Referral project completed by the community mental health programs, incorporated voice of the customer surveys to ensure the new process would meet the needs of both the clients and the referral sources.
- As our continuous improvement capabilities mature we will be including more patients and families on our project teams.
- Due to ongoing concern with National Research Corporation Canada survey products, i.e., utility, timeliness of reports provided and cost, CCH has embarked on an in-house process for distribution and analysis of the Canadian Patient Experiences Survey-Inpatient Care Survey (CIHI product).
- Although still in the early implementation phase of this initiative, e.g., insufficient survey returns received to confidently undertake a statistical analysis of the responders' experience, we anticipate that this instrument and in-house process will provide a superior solution.

Accountability Management

- 2015/16 QIP scorecard will be developed to capture progress of change ideas and process measures as well as trending towards target performance.
- Performance to-date will be reviewed monthly by the Director, Quality & Risk and quarterly by the Senior Leadership Team and Quality, Monitoring & Performance Committee of the Board.
- If progression towards target performance is not evident at review milestones, the VP overseeing this area, in consultation with the Director, Quality & Risk, is accountable for liaising the designated most responsible persons MRPs, monitoring the development/implementation of an appropriate turnaround strategy.
- Strategies In Action (SIA) Metrics are a means to measure our progress towards fulfilling our commitments set out in our strategic directions. The SIA metrics will align goals, behaviours and processes within the

organization. Measuring and monitoring performance through SIA huddles with the management team will align resources and focus where needed.

- Leader Standard Work will ensure corporate strategies and accountabilities are cascaded throughout the organization and performance is reported back to the Senior Leadership Team. Leader Standard Work sets out clear expectations and accountabilities appropriate at each level of the organization. Cascaded, overlapping regular exchanges provides the structure to continuously and consistently monitor performance and respond quickly when required. Leader Standard Work also provides the opportunity to develop employees through mentoring and coaching.
- Restructuring of budgetary process has ensured fair and equitable allocation of resources.

Performance Based Compensation [As part of Accountability Management]

- Cornwall Community Hospital did not have any performance pay during the last performance cycle ending before the "effective date" of March 31, 2012 (2010/2011 performance pay cycle). As stipulated by the BPSAA, executives within our organization do not have any pay-for-performance tied to the achievement of targets in our 2015/2016 QIP.

Health System Funding Reform (HSFR)

- Four Quality-Based Procedures (QBPs) have either been directly or indirectly, i.e., within planned improvement initiatives (change ideas), incorporated into our 2015/2016 QIP:

No.	Quality-Based Procedures (Direct)
1.0	Stroke
2.0	Hip Fracture
	30 Day Readmission Rate to Any Facility (Indirect)
3.0	Chronic Obstructive Pulmonary Disease
4.0	Congestive Heart Failure

Sign-off

I have reviewed and approved our organization's Quality Improvement Plan

Michael E. Turcotte
Board Chair

Christopher M. Giggey
Quality and Performance Monitoring Committee Chair

Jeanette Despatie
Chief Executive Officer

1 2015/16 CCH Quality Improvement Plan: "Improvement Targets and Initiatives"

AIM		Measure							Change				
Quality Dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Org-ID	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
Access	Reduce wait times in the ED	ED Wait times: 90th percentile ED length of stay for Admitted patients.	Hours / ED patients	CCO iPort Access Jan 1, 2014 - Dec 31, 2014	967*	38.9	30	Target based on 13/14 HSAA obligation	1) Optimize patient throughput and bed turnaround times on the inpatient units: a) Implement measures focused on time-to-inpatient bed, i.e., Continuous Improvement Project on Predictive Discharges Discharge Preparedness Documentation Tool, MD rounds on Medicine, Bullet Rounds 7 days/week. b) Increase compliance with 10:00 discharge time. c) Increase compliance with Pathways and GAP (Guidelines Applied to Practice) tools specific to QBPs: Chronic Obstructive Lung Disease (COPD), Congestive Heart Failure (CHF), Pneumonia. d) Increase use of discharge chairs within 1 hour after discharge order is written to support bed turnaround time, i.e., housekeeping, bed management, porters.	• QIP5 scorecard will be developed to capture progress of change ideas & process measures as well as trending towards target performance. • Performance to-date will be reviewed monthly by the Director, Q/R & quarterly by the Senior Leadership Team & Quality, Monitoring & Performance Committee of the Board.	a) Unit-specific Time to Inpatient Bed b) Compliance with 1100 discharge times	a) Time to inpatient bed for Critical Care Unit (CCU) and Psychiatric Care Unit (PCU) is 90 min and 18 hrs for all other inpatient care areas (SIA). b) > 35% compliance with 1100 discharge time.	Nil
									2) Optimize patient flow throughout the organization to mitigate overcrowding in the Emergency Department (Accreditation Canada Required Organizational Practice: Client Flow ROP (15)): a) Refine process for Geriatric Emergency Management Nurses and CCAC interventions to prevent admissions for patients not requiring acute hospital care. b) Support real-time admissions and decrease batching to support patient flow out of ED 24/7. c) Increase adherence and accountability for Bed Management and Bed Assignment policies and guidelines. d) Increase adherence with Overcapacity and Escalation Policy to support flow of admitted patients out of ED, including moving patients to hallways on inpatient units while beds are being cleaned or patients are waiting to leave.	• QIP5 scorecard will be developed to capture progress of change ideas & process measures as well as trending towards target performance. • Performance to-date will be reviewed monthly by the Director, Q/R & quarterly by the Senior Leadership Team & Quality, Monitoring & Performance Committee of the Board.	a) Number of patients with Alternate Level of Care (ALC) designation within 48 hours of admission. b) 90th percentile Length of Stay (LOS) for admitted patients.	a) Less than 10% of all ALC have an ALC designation within 48 hours of admission to hospital. b) Achieve CCH-specific performance target as outlined in 2014/2015 HSAA.	Nil
	Reduce potentially avoidable readmissions	Percentage of Stroke/TIA (QBP parameters) patients discharged on antithrombotics	% / QBP Stroke Patients	DAD, CIHI / Q1 & Q2 FY 2014/15	967*	84.8	100	Target based on theoretical best	1)Evaluate and implement, as appropriate, recommended practices related to: Module 5: Admission to Inpatient Rehabilitation; Module 6: Early Supported Discharge for Rehabilitation; and, Module 7: Outpatient/Community Rehabilitation Module 1: Early Assessment (QBPs: Clinical Handbook for Stroke, September, 2013).	QIP5 scorecard will be developed to capture progress of change ideas & process measures as well as trending towards target performance. • Performance to-date will be reviewed monthly by the Director, Q/R & quarterly by the Senior Leadership Team & Quality, Monitoring & Performance Committee of the Board.	a) Percentage of applicable recommended practices implemented.	a) 100% of applicable recommended practices implemented within Q3, 2015/16.	Nil

Priority Indicators =

2 2015/16 CCH Quality Improvement Plan: "Improvement Targets and Initiatives"

AIM		Measure						Change					
Quality Dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Org-ID	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
Effectiveness	Improve organizational financial health	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	OHRS, MOH / Q3 FY 2014/15 (cumulative from April 1, 2014 to December 31, 2014)	967*	-1.19	0.45	Target set according to HSAA obligations	1)				Performance monitored within Corporate Scorecard. Please note: performance based on April- Oct.
	Reduce unnecessary deaths in hospitals	HSMR: Number of observed deaths/number of expected deaths x 100.	Ratio (No unit) / All patients	DAD, CIHI / April 1, 2013 to March 31, 2014	967*	76	74	Based on HSMR Peer Group H2 best quartile performance for 2013-14					
	Effectively manage post-operative length of stay	Acute care Fractured Hip (QBP specifications) length of stay 5 days post-operative	% / QBP Hip Fracture patients	DAD, CIHI / Q1 & Q2 FY 2014/15	967*	48.1	75	Progression toward optimal flow	1)Evaluate and implement, as appropriate, recommended practices related to: Module 1: Care in the ED; Module 2:Pre-operative Management; Module 3: Surgery; Module 4: Post-operative Management; and, Module 5: Post-acute Care (QBPs: Clinical Handbook for Hip Fracture, May, 2013), including but not limited to: Optimize use of Fractured Hip Pathway Interdisciplinary bullet rounds, i.e., progress reviews and potential barrier to discharge and most appropriate setting.	• QIP5 scorecard will be developed to capture progress of change ideas & process measures as well as trending towards target performance. • Performance to-date will be reviewed monthly by the Director, Q/R & quarterly by the Senior Leadership Team & Quality, Monitoring & Performance Committee of the Board.	a) Percentage of applicable recommended practices implemented, i.e., % fractured hip patients completing the pathway / total fractured hip patients; and, % fractured hip short stay rehab patients admitted to CCH rehab within 5 days post-op.	a) 85+% of applicable recommended practices implemented within Q3, 2015/16, i.e., 85% of all fractured hip patients requiring CCH rehab will be admitted within 5 days.	Nil.
Integrated	Reduce unnecessary time spent in acute care	Percentage ALC days: Total number of acute inpatient days designated as ALC, divided by the total number of acute inpatient days. *100	% / All acute patients	Ministry of Health Portal / Oct 1, 2013 - Sept 30, 2014	967*	14.26	13.5	Target based on HSAA obligations	1)Implementation of Accreditation Canada Required Organizational Practice: Client Flow Major and Minor Tests for Compliance, including but not limited to: Refine process for Geriatric Emergency Management Nurses and CCAC interventions to prevent admissions for patients not requiring acute hospital care; Optimize compliance with patient care conferences as per policy for long-stay patients; Maximize use of community support services to support transition home (Going Home Program / Assisted Living for High Risk Seniors / Community Paramedicine); and, Interagency Weekly Joint Discharge Review (JDR) meetings for all Alternate Level of Care (ALC) and ALC Bound patients, patients with complex discharges needs and those at high risk for readmission	• QIP5 scorecard will be developed to capture progress of change ideas & process measures as well as trending towards target performance. • Performance to-date will be reviewed monthly by the Director, Q/R & quarterly by the Senior Leadership Team & Quality, Monitoring & Performance Committee of the Board.	a) Percentage of Major and Minor Tests of Compliance implemented, i.e., % ALC patients with ALC designation within 48 hours of hospitalization; Number of patient care conferences/unit/year; and, Number of Weekly Joint Discharge Review meetings per year.	a) 100% of Major and Minor Tests of Compliance implemented within Q2, 2015/16. b) Less than 10% of all ALC have an ALC designation within 48 hours of admission to hospital. c) 60% of all patients with LOS > 13 days in acute care units or 21 days in mental health unit will have a interdisciplinary care conference. d) Minimum 48 Joint Discharge Review meetings / year.	Please note: current performance gathered internally, not from MOH portal

Priority Indicators =

3 2015/16 CCH Quality Improvement Plan: "Improvement Targets and Initiatives"

AIM		Measure							Change				
Quality Dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Org-ID	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
	Reduce unnecessary hospital readmission	Readmission within 30 days for Selected Case Mix Groups	% / All acute patients	DAD, CIHI / July 1, 2013 - Jun 30, 2014	967*	10	7	Based on internal Strategy In Action target	1)Evaluate and implement, as appropriate, recommended practices related to Chronic Obstructive Lung Disease (COPD) Acute Exacerbation Episode of Care (QBPs: Clinical Handbook for COPD, January, 2013) and Congestive Heart Failure (CHF) Episode of Care Pathway (QBPs: Clinical Handbook for CHF, January 2013), including but not limited to: Maximizing use of protocols, pathways and GAP (Guidelines applied to practice) tool for all COPD, CHF and Pneumonia patients; Referral to CCAC Rapid Response Nurse for all COPD and CHF patients; Maximizing Discharge Follow-up phone calls for all patients discharged from acute care programs, currently being conducted by late career nurses; Monthly reviews of all readmissions with same or related diagnosis within 7 days and 8-28 days for all diagnoses; Evaluate results of discharge calls and implement measures to improve compliance with: filling prescriptions on discharge / having primary care follow-up within 7 days of discharge / knowing how to manage disease at home / referral to CCAC as appropriate.	• QIP5 scorecard will be developed to capture progress of change ideas & process measures as well as trending towards target performance. • Performance to-date will be reviewed monthly by the Director, Q/R & quarterly by the Senior Leadership Team & Quality, Monitoring & Performance Committee of the Board.	a) Percentage of applicable recommended practices implemented, i.e., % compliance with pathway implementation for COPD, CHF, Pneumonia; % compliance with GAP tool for COPD, CHF, Pneumonia; Number of discharge follow-up phone calls / total number of discharges; % compliance with filling prescription; % compliance with Primary Care Follow-up for COPD discharges.	a) 100% of applicable recommended practices implemented within Q3, 2015/16. b) Scorecard target for compliance with GAP tools = 70% of COPD patients receiving Primary Care Provider follow-up within 7 days of discharge (IDEAS Target).	Current performance based on 2012-13 data. Pulled from CIHI's HSP site
													Nil
Patient-centred	Improve patient satisfaction	From NRC Canada: Would you recommend this ED to your friends and family?" (add together % of those who responded "Definitely Yes" or "Yes, definitely")	% / ED patients	NRC Picker / October 2013 - September 2014	967*	59.85	89.5	Target based on Ontario Community Hospital average performance at Q4 FY 13/14			Due to ongoing concern with National Research Corporation Canada survey products, i.e., utility, timeliness of reports provided and cost, CCH has embarked on an in-house process for distribution and analysis of the Canadian Patient Experiences Survey-Inpatient Care Survey (CIHI instrument). Although still in the early implementation phase of this initiative, e.g., insufficient survey returns received to confidently undertake a statistical analysis of the responders' experience, we anticipate that this instrument and in-house process will provide a superior solution.		
		From NRC Canada: "Overall, how would you rate the care and services you received at the ED?" (add together % of those who responded "Excellent, Very Good and Good").	% / ED patients	NRC Picker / October 2013 - September 2014	967*	83.98	85.5	Ontario Community Hospital average for Q4 FY 13/14					
Safety	Increase proportion of patients receiving medication reconciliation upon admission	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.	% / All patients	Hospital collected data / most recent quarter available	967*	90	100	Theoretical best.	1)				

Priority Indicators =

4 2015/16 CCH Quality Improvement Plan: "Improvement Targets and Initiatives"

AIM		Measure				Change							
Quality Dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Org-ID	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
	Increase proportion of patients receiving medication reconciliation upon discharge	Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged.	% / All patients	Hospital collected data / Most recent quarter available	967*	0	100		1)				
	Reduce hospital acquired infection rates	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. 2014, consistent with HQO's Patient Safety public reporting website.	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / Jan 1, 2014 - Dec 31, 2014	967*	0.17	0	Target based on HSAA obligations	1)				Please note: current performance based on Q3 (2014/15)
		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	Publicly Reported, MOH / Jan 1, 2014 - Dec, 31, 2014	967*	80	80						
		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	Publicly Reported, MOH / Jan 1, 2014 - Dec, 31, 2014	4470*	76	80						
		VAP rate per 1,000 ventilator days: the total number of newly diagnosed VAP cases in the ICU after at least 48 hours of mechanical ventilation, divided by the number of ventilator days	Rate per 1,000 ventilator days / ICU patients	Publicly Reported, MOH / Jan 1, 2014 - Dec 31, 2014	967*	0	0	Target based on HSAA obligations					

Priority Indicators =

5 2015/16 CCH Quality Improvement Plan: "Improvement Targets and Initiatives"

AIM		Measure							Change				
Quality Dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Org-ID	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
		in that reporting period, multiplied by 1,000 - consistent with publicly reportable patient safety data.											
		Rate of central line blood stream infections per 1,000 central line days: total number of newly diagnosed CLI cases in the ICU after at least 48 hours of being placed on a central line, divided by the number of central line days in that reporting period, multiplied by 1,000 - consistent with publicly reportable patient safety data.	Rate per 1,000 central line days / ICU patients	Publicly Reported, MOH / Jan 1, 2014 - Dec 31, 2014	967*	0	0	Target based on HSAA obligations					
	Reduce rates of deaths and complications associated with surgical care	Surgical Safety Checklist: number of times all three phases of the surgical safety checklist was performed (briefing; time out; and debriefing) divided by the total number of surgeries performed, multiplied by 100 - consistent with publicly reportable patient safety data.	% / All surgical procedures	Publicly Reported, MOH / Jan 1, 2014 - Dec 31, 2014	967*	98.5	100		1)				Performance based on January - November 2014
	Reduce use of physical restraints in Mental Health	Physical Restraints: Number of admission assessments where restraint use occurred in last 3 days divided by the number of full admission assessments in time period	% / All patients	OMHRS, CIHI / Oct 1, 2013 - Sep 30, 2014	967*	8.3	3.4	Target based on 5% reduction of FY 13/14 peer average	1)				Please note that performance is based on FY 14/15 Q2 performance
	Enhance Workplace Violence Prevention and Management	Physician/employee injuries resulting from a workplace violence incident per 1000 PCU patient days.	Rate per 1,000 patient days / PCU	Hospital collected data / Q1 - Q3 FY 2014/15	967*	TBD	TBD	20% reduction of current performance	1)Define Psychiatric Care Unit (PCU) staff positions required to act as primary responders with advanced training; primary responders; and, staff who are not primary responders in a crisis situation; Develop and test primary responders advanced training program and 'refresher' modules; Develop and test basic standardized training for staff who are not primary responders in a crisis situation and 'refresher' modules.	• QIP5 scorecard will be developed to capture progress of change ideas & process measures as well as trending towards target performance. • Performance to-date will be reviewed monthly by the Director, Q/R & quarterly by the Senior Leadership Team & Quality, Monitoring & Performance Committee of the Board.	Percentage of designated staff having successfully completed the level of training assigned to each staff category.	60% of designated staff have successfully completed the level of training assigned to each staff category within Q3, 2015/16. 90% of designated staff have successfully completed the level of training assigned to each staff category within Q4, 2015/16.	Nil

Priority Indicators =

6 2015/16 CCH Quality Improvement Plan: "Improvement Targets and Initiatives"

AIM		Measure							Change				
Quality Dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Org-ID	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
		Physician/employee injuries resulting from a workplace violence incident per 1000 ED patient visits	Rate per 1,000 patient visits / ED	Hospital collected data / Q1 - Q2 FY 2014/15	967*	TBD	TBD	20% reduction of current performance	1)Define ED staff category required to act as primary responders with advanced training; primary responders; and, staff who are not primary responders in a crisis situation; Develop and test primary responders advanced training program and 'refresher' modules; Develop and test basic standardized training for staff who are not primary responders in a crisis situation and 'refresher' modules.	• QIP5 scorecard will be developed to capture progress of change ideas & process measures as well as trending towards target performance. • Performance to-date will be reviewed monthly by the Director, Q/R & quarterly by the Senior Leadership Team & Quality, Monitoring & Performance Committee of the Board.	a) Percentage of designated staff having successfully completed the level of training assigned to each staff category.	a) 60% of designated staff have successfully completed the level of training assigned to each staff category within Q3, 2015/16. b) 90% of designated staff have successfully completed the level of training assigned to each staff category within Q4, 2015/16.	Nil
	Increase proportion of patients receiving medication reconciliation at care transitions	Medication reconciliation at care transitions: The total number of patients with medications reconciled as a proportion of the total number of patients with care transitions.	Not yet specified / All patients	Hospital collected data / Not yet specified	967*	0	100	Theoretical best.	1) Implementation of Accreditation Canada Required Organizational Practice: Medication Reconciliation at Care Transitions Major Tests for Compliance within Critical Care Unit (CCU).	• QIP5 scorecard will be developed to capture progress of change ideas & process measures as well as trending towards target performance. • Performance to-date will be reviewed monthly by the Director, Q/R & quarterly by the Senior Leadership Team & Quality, Monitoring & Performance Committee of the Board.	a) Percentage of Major Tests of Compliance implemented (CCU).	a) 100% of Major Tests of Compliance implemented within Q2, 2015/16 (CCU).	Nil

Priority Indicators =