Quality Improvement Plans (QIP): Progress Report for 2014/15 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 (2014/15 QIP)	Performance (2013/14 QIP)	Performance Goal (2014/15 QIP)	Progress to Date	Progress Period	Comments
Hand Hygiene Compliance Before Patient Contact	89.5%	89.5%	91.5%	Jan – Dec 2014	The engagement of frontline staff and leadership to drive hand hygiene compliance allowed TEGH to surpass its performance target. This sense of engagement and accountability was driven by support for leadership audits of hand hygiene.
Falls with Harm	0.64	.58	0.42	Jan – Dec 2014	Identifying and managing high risk fallers have been key root causes to the falls with harm rate challenging the organization. The successful reduction of the falls with harm rate at TEGH by 25% was accomplished through the engagement of a cross disciplinary team in the development of falls prevention standard work. This process allowed for the hardwiring of post fall huddles and individualized care plans for these patients. TEGH will aim to maintain its performance in falls with harm while safely encouraging patients to be mobilized to prevent deterioration.

ER Wait Times: 90th Percentile ER Length of Stay for Admitted Patients	8.5 hours	7.5 hours	8.2 hours	April 2014 – Feb 2015	TEGH was able to reduce ER wait times by 5% but was unsuccessful in reaching its targeted wait time. The ED QIP for the 2014-2015 fiscal year included a blend of tactics involving physicians, the ED, and inter-departmental areas. Tactics focused on reducing process times in ED support areas have been a great success for providing better timely care to patients. Going forward, there is a need to focus more on tactics within the ED to further reduce wait times.
CDI Rate per 1,000 Patient Days	0.21	0.21	0.28	Jan – Dec 2014	TEGH was unable to maintain its CDI performance rate. The high volume of patients with influenza and lower respiratory tract infections led to an increase in the use of high risk antimicrobials which increased organizational risk for C. difficile. This increased risk coupled with resource strain associated with Ebola preparedness and delays in isolating at-risk C.diff patients resulted in an increased rate of CDI. TEGH will continue efforts to reduce CDI going forward.
Patient Satisfaction	In-patients 88.1% ED 78.2%	In-patients 90% ED 80%	In-patients 92% ED 82.6%	October 2013 – September 2014	By adopting best practices to establish a foundation of patient centred care, Toronto East General Hospital has been able to achieve and exceed its target while sustaining results. The development and implementation of unit based team agreements, patient videos and unit specific patient satisfaction scores have helped to drive performance.
Alternative Level of Care	12.1%	11.5%	15.5%	Q3 2013/14 –	TEGH was unable to effectively influence a

				Q2 2014/15	reduction in its ALC indicator, observing a growth of more than 3% in overall ALC % Days. The implemented change ideas saw only a marginal influence on the ALC lag indicator. However, they did help uncover critical root causes of the organization's current performance, highlighting the importance of proactive planning for ALC patients, standardized discharge practices and the increasing need to build effective partnerships with community agencies. The proposed ALC tactics for 15/16 are focused on driving performance in these core root causes.
Length of Stay: Quality Based Procedures	0 days saved	9.9 days saved	2.8 Days Saved	Apr 2014 – Jan 2015	Utilizing the length of stay for quality based procedures as a proxy measure for organizational effectiveness and financials stewardships served to be an effective model. In 2014/15, TEGH switched from management of Acute Length of Stay (LOS) to management of Total LOS (including ALC). It is a more accurate and realistic approach, yet at the same time there are more factors outside of the hospital's control (in particular, ALC-related factors).This year's target was set by adding 10 Total Days Saved on top of the 11 Acute Days already saved in FY 2013/14, so the current result of 2.8 Days Saved, in fact, represents an impressive savings – or reduction of 13+ days.

30 day Readmission Rates	17.19.2%	17.19%	17.89%	Q2 2013/14-Q1 2014/15	TEGH QIP monitors Readmission Rates data that is provided by CIHI (Canadian Institute of Health Information) via MOHLTC (Ministry of Health and Long-term Care). The data is available with a substantial time lag. To monitor and manage Readmission Rates, in 2014/15 TEGH designed and implemented the following key activities: development and implementation of an innovative in-house TEGH Readmission rate monitoring system; active sharing of readmission data throughout the key levels of the organization; and implementation of patient-centred care and discharge planning with a focus on sustainable or durable discharges, started in the summer of 2014.
Rounding for Quality	80%	90%	94%	Q1 14/15 – Q4 14/15	The development of an electronic system to record rounding compliance and the subsequent establishment of a daily rounding report that is sent out across the organization highlighting compliance rates for each inpatient unit helped influence front line staff behaviour and drive the compliance of rounding for quality. However, increasing compliance of rounding for quality highlighted the parallel need to drive the quality of rounding. This challenge of ensuring quality rounding is being met by the new proposed change ideas for 15/16 which are focused on staff development and the patient experience of rounding.
Pressure Ulcers	n/a	0.82%	0.7%	April 2014 – Feb 2015	Several root causes were addressed to achieve and then surpass our target. Perhaps the most impactful change was customizing the approach

					to implementation to fit the specific patient care areas, while using data to demonstrate performance towards unit specific goals. The ability to report the number of patients with pressure ulcers – on a monthly basis – led to important discussions among care providers on every ward using existing communication platforms, most importantly the daily team huddles. This was a key enabler of improvement ideas and on-going tests of change. While satisfied with our improvement efforts this past year, we acknowledge the significant effort required to sustain the gains. Staff training and awareness programs will continue to be updated and rolled out across all the patient service areas.
Medication Reconciliation at Admission	72.3%	80%	78%	Most recent quarter Dec 2014 – Feb 2015	A large proportion of low acuity patient discharged within 24 hours challenged the achievement of the organizational target. However, leveraging student pharmacists and a robust reporting structure facilitated a 10% improvement in performance against the baseline. Continued efforts will be made to refine and improve the associated process to enable effective medication reconciliation at discharge downstream.