HEALTH INSURANCE ORGANIZATION

HOSPITALS PERFORMANCE INDICATORS

''GUIDE''

SEPTEMBER 2013

Acknowledgment

Health Insurance Organization (HIO) covers about 57% of Egypt population and is committed to provide health care services to all beneficiaries. Those services meet the quality standards and dimensions, through forty HIO owned hospitals and about 600 contracted hospitals, were there performance measurements of those facilities are considered as priority.

We appreciate the effort done by Dr Mohsen George the Chief Medical Officer and Dr Manal Abdel-Mongy the Head of Quality Department for the production of this manual, which is an important guide to measure the performance of the hospitals.

Wishing best health to our population, and all the success to everyone who works with conscience and sincereness in providing the best care available to our patients.

Dr Abdel-Rahman El-Sakka
C.E.O
Health Insurance Organization

SEPTEMBER 2013

Introduction

Measurement is central to the concept of quality improvement; it provides a mean to define what hospitals actually do, and to compare that with the original targets in order to identify opportunities for improvement.

The principal methods of measuring hospital performance are; regulatory inspection, public satisfactory survey, third party assessment, and statistical indicators.

Statistical indicators can suggest issues for performance management and quality improvement. The publication of hospital performance indicators will encourage improvement, demonstrate commitment to transparency, empower patient choice, and contribute to public accountability.

Hospital performance indicators are expressed in numerical values that allow analysis and comparison of the results within the hospital, between hospitals and between different organizations.

Hospital performance indicators are tools for assessing hospital performance and should be designed to measure the achievement of predetermined objectives. They represent an accessible, fairly economical, potentially standard, and non-invasive means of performance measurement.

This GUIDE is the second edition of Hospital Performance Indicators that is published by Health Insurance Organization after the first edition which was published in September 2008 that was based on the Performance Indicators Profile of the Ministry of Health & Population.

In this edition; two new performance indicators namely: “Cancellation Rate” and “Patient Fall Rate” were added to the list of indicators, in addition to re-editing and re-formatting the whole text.

Dr Mohsen George
Chief Medical Officer
Health Insurance Organization

SEPTEMBER 2013

Preface

The Health Insurance Organization leaders believe that quality improvement represents a promising strategy for improving hospital quality of care.

Collection of the hospital quality indicators offers an opportunity for the health insurance organization to identify higher and lower performing hospitals.The information serves as a benchmark, or point of reference, to judge the hospitals performance in future periods and to compare between them in order to find and implement ways to improve performance.

The present work, aims to have a standardized tool to be used by the central quality department in the HIO and their hospitals to collect hospital performance data ,in order to have information about the quality of care and patient safety, easy to interpret.

Dr MANAL ABD EL MONGY
M.D., Community Medicine & Public Health
Head of the quality department
Health Insurance Organization

SEPTEMBER 2013

Definitions and Abbreviations

AMBULATORY CARE: IS A HEALTH CARE CONSULTATION, TREATMENT OR INTERVENTION DELIVERED ON AN OUTPATIENT BASIS (I.E. WHERE THE PATIENT'S STAY AT THE HOSPITAL DOES NOT REQUIRE AN OVERNIGHT STAY).

BED DAYS AVAILABLE: BEDS AVAILABLE FOR USE EACH DAY / THE MAXIMUM NUMBER OF INPATIENT DAYS OF CARE THAT WOULD HAVE BEEN PROVIDED (AVAILABLE FOR USE) IF ALL BEDS WERE FILLED FOR A CERTAIN PERIOD OF TIME.

CCU : CARDIAC CARE UNIT.

DAY CASE SURGERY: is a planned program where patients are admitted, operated upon and discharged during the normal working hours of the day.

EPISODE OF INFECTION: ONE SINGLE SITE OF INFECTION.

INDICATOR: MEASURE OF THE PERFORMANCE OF FUNCTIONS, SYSTEMS, OR PROCESSOR ACHIEVEMENT OF AN OUTCOME OVER TIME

ICU : INTENSIVE CARE UNIT.

INFECTION: THE TRANSMISSION OF A PATHOGENIC MICROORGANISM.

INPATIENT: A PATIENT WHO IS ADMITTED TO A HOSPITAL FOR TREATMENT THAT REQUIRES AT LEAST ONE OVERNIGHT STAY.

INPATIENT DAYS OF CARE: SUM OF EACH DAILY INPATIENT CENSUS FOR A CERTAIN PERIOD OF TIME / DAILY NUMBER OF PATIENTS STAYING OVERNIGHT AT THE FACILITY.

NICU: NEONATAL INTENSIVE CARE UNIT.

OUTPATIENT: PATIENT VISITED THE OUTPATIENT CLINICS.

SSI: SURGICAL SITE INFECTION.

LIST OF INDICATORS

ID	INDICATOR	PURPOSE	TARGET
01	INPATIENT VOLUME	CONFIRMS PATIENT DEMAND	MORE THAN PREVIOUS YEAR
02	OUTPATIENT VOLUME	CONFIRMS PATIENT DEMAND	MORE THAN PREVIOUS YEAR
03	OUTPATIENT/INPATIENT RATIO	OPERATIONAL EFFICIENCY	MORE THAN 3:1 & ANNUAL IMPROVEMENT
04A	GROSS UNADJUSTED INPATIENT MORTALITY RATE	QUALITY OF CARE	LESS THAN 2%
04B	ICUS MORTALITY RATE	QUALITY OF CARE	
04C	GROSS UNADJUSTED MORTALITY RATE WITHIN 24 HOURS OF ADMISSION	QUALITY OF CARE	ZERO %
04D	NICU MORTALITY RATE	QUALITY OF CARE	
04E	MORTALITY RATE BY CLINICAL DEPARTMENTS	QUALITY OF CARE	VARY BY SPECIALTY
05A	HOSPITAL ACQUIRED INFECTION RATE	QUALITY OF CARE	LESS THAN 5%
05B	SURGICAL SITE INFECTION RATE	QUALITY OF CARE	LESS THAN 5%
06	READMISSION RATE FOR INPATIENTS WITHIN 30 DAYS	QUALITY OF CARE	LESS THAN 2%
07	READMISSION RATE FOR EMERGENCY PATIENTS WITHIN 72 HOURS	QUALITY OF CARE	LESS THAN 2%
08	AVERAGE LENGTH OF STAY (ALOS)	OPERATIONAL EFFICIENCY	ANNUAL IMPROVEMENT
09A	BED OCCUPANCY RATE (INPATIENT)	OPERATIONAL EFFICIENCY	> 75% (BEDS DOWNSIZING IS CONSIDERED IF LESS THAN TARGET)
09B	BED OCCUPANCY RATE (ICUS)	Confirms patient demand & operational efficiency	ANNUAL IMPROVEMENT
010	BUDGET EXECUTION	FINANCIAL MANAGEMENT	ACTUAL EXPENDITURES WITHIN APPROVED BUDGET
011	CANCELLATION RATE	OPERATIONAL EFFICIENCY	< 5%
012	PATIENT FALLS RATE	QUALITY OF CARE	< 5 PER THOUSAND

1 - INPATIENT VOLUME

MEASURE ID: (01)

QUALITY MEASURE NAME: INPATIENT VOLUME

DEPARTMENT(S) INCLUDED: ALL INPATIENT WARDS

PURPOSE: CONFIRMS PATIENT DEMAND

TYPE OF MEASURE: PROCESS

NUMERATOR: ALL PATIENTS ADMITTED TO THE HOSPITAL And REQUIRE AT LEAST ONE OVERNIGHT STAY

DATA SOURCE: DAILY INPATIENT CENSUS

TARGET: MORE THAN PREVIOUS YEAR

DATA REPORTED AS: NUMERICAL VALUE

FREQUENCY OF MEASUREMENT: MONTHLY

2 - OUTPATIENT VOLUME

MEASURE ID: (02)

QUALITY MEASURE NAME: OUTPATIENT VOLUME

DEPARTMENT(S) INCLUDED: ALL OUTPATIENT CLINICS

PURPOSE: CONFIRMS PATIENT DEMAND

TYPE OF MEASURE: PROCESS

Numerator Statement: number of patient visited the outpatient clinics through a certain period of time whether discharged or referred to other places

DATA SOURCE: OUTPATIENT CENSUS

TARGET: MORE THAN PREVIOUS YEAR

DATA REPORTED AS: NUMERICAL VALUE

FREQUENCY OF MEASUREMENT: MONTHLY

3 - OUTPATIENT / INPATIENT RATIO

MEASURE ID: (03)

QUALITY MEASURE NAME: OUTPATIENTS / INPATIENTS RATIO

DEPARTMENT(S) INCLUDED: ALL INPATIENTS WARDS/MEDICAL RECORDS DEPARTMENT

PURPOSE: OPERATIONAL EFFICIENCY

TYPE OF MEASURE: PROCESS

NUMERATOR STATEMENT: NUMBER OF PATIENTS RECEIVED OUTPATIENTS (AMBULATORY) SERVICES INSIDE THE HOSPITAL (E.G. DAY CASE SURGERY, CHEMOTHERAPY, RENAL DIALYSIS, ENDOSCOPIES, INTERVENTIONAL RADIOLOGY, EMERGENCY CASES ……ETC)

Data Source: Daily ambulatory services census in the hospital

DENOMINATOR STATEMENT: NUMBER OF INPATIENT CENSUS

DATA SOURCE: ADMISSION REGISTERY (ADMISSION OFFICE)

Number of patients received outpatient services: Inpatient census

TARGET: MORE THAN 3: 1 & ANNUAL IMPROVEMENT

DATA REPORTED AS: RATIO

FREQUENCY OF MEASUREMENT: MONTHLY

4A - GROSS UNADJUSTED INPATIENT MORTALITY RATE

MEASURE ID: (04A)

QUALITY MEASURE NAME: GROSS UNADJUSTED INPATIENT MORTALITY RATE

DEPARTMENT(S) INCLUDED: ALL INPATIENT DEPARTMENTS

PURPOSE: QUALITY OF CARE

TYPE OF MEASURE: OUTCOME

NUMERATOR STATEMENT: NUMBER OF DEATHS WITHIN HOSPITAL INPATIENT CENSUS

EXCLUDED POPULATION:

- -MORTALITY OF PATIENTS WHO WERE DIRECTLY ADMITTED TO ICUs
- -INPATIENTS DEATHS THAT stay IN ICU < 48 HOURS
- -DEATHS IN EMERGENCY DEPARTMENT
- -INPATIENT DEATHS IN LESS THAN 24 HOURS

DATA SOURCE: MORTALITY LOG BOOK

DENOMINATOR STATEMENT: TOTAL NUMBER OF DISCHARGED PATIENTS (INCLUDING THE DEATHS)

DATA SOURCE: DISCHARGE REGISTER (DISCHARGE OFFICE) -MORTALITY LOG BOOK

$$\frac{\textbf{NUMBER OF DEATHS WITHIN HOSPITAL INPATIENT CENSUS}}{\textbf{TOTAL NUMBER OF DISCHARGED PATIENTS (INCLUDING DEATHS)}} \textbf{ X 100}$$

TARGET: LESS THAN 2%

DATA REPORTED AS: PERCENTAGE

FREQUENCY OF MEASUREMENT: MONTHLY

4B - ICUs Mortality Rate

Measure ID: (04B)

Quality measure name: ICUs mortality rate

Department(s) included: ICU departments

Purpose: Quality of care

Type of measure: Outcome

Numerator Statement: Number of Deaths within ICUs patient census

Excluded population:

-Inpatients deaths that stays in ICU less than 48 hours

-patients admitted directly to ICU and died within 24 hours

Data Source: mortality log book

Denominator statement: Total Number of ICUs discharged patients (including the deaths)

Data source: Discharge registry (discharge office)

$$\frac{\text{Number of deaths within ICUs patient census}}{\text{Total number of ICUs discharged patients (including deaths)}} \times 100$$

Target: variable

Data reported as: Percentage

Frequency of measurement: monthly

4C - GROSS UNADJUSTED MORTALITY RATE WITHIN 24 HOURS OF ADMISSION

MEASURE ID: (04C)

QUALITY MEASURE NAME: GROSS UNADJUSTED MORTALITY RATE WITHIN 24 HOURS OF ADMISSION

DEPARTMENT(S) INCLUDED: ALL DEPARTMENTS

PURPOSE: QUALITY OF CARE

TYPE OF MEASURE: OUTCOME

NUMERATOR STATEMENT: NUMBER OF DEATHS WITHIN 24HOURS OF ADMISSION INCLUDING DAY CASES PATIENT CENSUS

EXCLUDE: ICUS & EMERGENCY DEPARTMENT DEATHS

DATA SOURCE: MORTALITY LOG BOOK

DENOMINATOR STATEMENT: TOTAL NUMBER OF DISCHARGED PATIENTS WITHIN 24 HOURS

DATA SOURCE: DISCHARGE REGISTRY (DISCHARGE OFFICE)

$$\frac{\text{NUMBER OF DEATHS WITHIN 24 HOURS INCLUDING DAY CASES PATIENT CENSUS}}{\text{TOTAL NUMBER OF DISCHARGED PATIENTS WITHIN 24HOURS}} \times 100$$

TARGET: ZERO % (CONSIDERED AS ADVERSE EVENT)

DATA REPORTED AS: PERCENTAGE

FREQUENCY OF MEASUREMENT: MONTHLY

4D - NICU MORTALITY RATE

MEASURE ID: (04D)

QUALITY MEASURE NAME: NICU MORTALITY RATE

DEPARTMENT(S) INCLUDED: NICU

PURPOSE: QUALITY OF CARE

TYPE OF MEASURE: OUTCOME

NUMERATOR STATEMENT: NUMBER OF DEATHS WITHIN NICU PATIENT CENSUS

EXCLUDED POPULATION:

- -INPATIENTS DEATHS THAT STAYS IN NICU LESS THAN 48 HOURS
- -PATIENTS ADMITTED DIRECTLY TO NICU AND DIED WITHIN 24 HOURS

DATA SOURCE: MORTALITY LOG BOOK

DENOMINATOR STATEMENT: TOTAL NUMBER OF NICU DISCHARGED PATIENTS (INCLUDING THE DEATHS)

DATA SOURCE: DISCHARGE REGISTRY (DISCHARGE OFFICE)

$$\frac{\text{NUMBER OF DEATHS WITHIN NICU PATIENT CENSUS}}{\text{TOTAL NUMBER OF NICU DISCHARGED PATIENTS (INCLUDING DEATHS)}} \times 100$$

TARGET: VARIABLE

DATA REPORTED AS: PERCENTAGE

FREQUENCY OF MEASUREMENT: MONTHLY

4E - MORTALITY RATE BY CLINICAL DEPARTMENTS

MEASURE ID: (04E)

QUALITY MEASURE NAME: MORTALITY RATE BY CLINICAL DEPARTMENTS

DEPARTMENT(S) INCLUDED: CLINICAL INPATIENT DEPARTMENTS

PURPOSE: QUALITY OF CARE

TYPE OF MEASURE: OUTCOME

NUMERATOR STATEMENT: NUMBER OF PATIENTS WHO DIED IN EACH CLINICAL DEPARTMENT SEPARATELY AND THOSE WHO DIED WITHIN 48 HOURS AFTER REFERREL TO ICUS

EXCLUDED POPULATION: INPATIENT DEATHS LESS THAN 24HOURS & ICUS DEATHS 48 HOURS AFTER REFERRAL

DATA SOURCE: INPATIENTS RECORDS (ADMISSION OFFICE)

DENOMINATOR STATEMENT: TOTAL NUMBER OF PATIENTS DISCHARGED FROM EACH CLINICAL DEPARTMENT SEPARATELY (INCLUDING THE DEATHS)

DATA SOURCE: DISCHARGE REGISTRY (DISCHARGE OFFICE)

$$\frac{\text{NUMBER OF PATIENTS WHO DIED IN EACH CLINICAL DEPARTMENT SEPARATELY DURING THEIR STAY FOR MORE THAN 24 HOURS}}{\text{TOTAL NUMBER OF PATIENTS DISCHARGED FROM EACH CLINICAL DEPARTMENT SEPARATELY (INCLUDING THE DEATHS)}} \times 100$$

TARGET: VARY BY SPECIALTY

DATA REPORTED AS: PERCENTAGE

FREQUENCY OF MEASUREMENT: MONTHLY

5A - HOSPITAL ACQUIRED INFECTION RATE

MEASURE ID: (05A)

QUALITY MEASURE NAME: HOSPITAL ACQUIRED INFECTION RATE

DEPARTMENT(S) INCLUDED: ALL HOSPITAL CLINICAL DEPARTMENTS

PURPOSE: QUALITY OF CARE

TYPE OF MEASURE: OUTCOME

Numerator Statement: TOTAL NUMBER OF INFECTION EPISODES/PATIENT IN ALL CLINICAL DEPARTMENTS INCLUDING ICUS AFTER 48 HOURS OF ADMISSION IN A CERTAIN PERIOD OF TIME

DATA SOURCE:

-INFECTION CONTROL DATA SHEETS
-INFECTION CONTROL COMMITTEE

Denominator statement: TOTAL NUMBER OF PATIENTS DISCHARGED FROM INPATIENT AND ICUS WITHIN THE SAME PERIOD OF TIME

DATA SOURCE: DISCHARGE REGISTRY (DISCHARGE OFFICE)

$$\frac{\text{TOTAL NUMBER OF INFECTION EPISODES IN ALL CLINICAL DEPARTMENTS INCLUDING ICUS}}{\text{TOTAL NUMBER OF PATIENT DISCHARGED FROM INPATIENT AND ICUS}} \times 100$$

TARGET: LESS THAN 5%

DATA REPORTED AS: PERCENTAGE

FREQUENCY OF MEASUREMENT: MONTHLY

5B - SURGICAL SITE INFECTION RATE

MEASURE ID: (05B)

Quality measure name : Surgical Site Infection rate (SSI)

DEPARTMENT(S) INCLUDED: SURGICAL WARDS

PURPOSE: QUALITY OF CARE

TYPE OF MEASURE: OUTCOME

Numerator Statement: Number of infected patient wounds during hospitalization or readmitted with SSI within 30 days of discharge or up to one year in the presence of implants

DATA SOURCE:

-INFECTION CONTROL DATA SHEETS
-SSI DATA SHEET
-INFECTION CONTROL COMMITTEE

DENOMINATOR STATEMENT: TOTAL NUMBER OF SURGICAL OPERATIONS.

DATA SOURCE: OPERATING ROOM LOG BOOK

$$\frac{\text{NUMBER OF INFECTED PATIENT WOUNDS AFTER SURGICAL OPERATION DONE IN THE SAME HOSPITAL}}{\text{TOTAL NUMBER OF SURGICAL OPERATIONS.}} \times 100$$

TARGET: LESS THAN 5%

DATA REPORTED AS: PERCENTAGE

FREQUENCY OF MEASUREMENT: MONTHLY

6 - READMISSION RATE FOR INPATIENTS WITHIN 30 DAYS

MEASURE ID: (06)

QUALITY MEASURE NAME: READMISSION RATE FOR INPATIENTS WITHIN 30 DAYS

DEPARTMENT(S) INCLUDED: ALL MEDICAL DEPARTMENTS

PURPOSE: QUALITY OF CARE

TYPE OF MEASURE: PROCESS

NUMERATOR STATEMENT: NUMBER OF PATIENTS WHO WERE READMITTED TO THE SAME HOSPITAL WITHIN 30 DAYS OF DISCHARGE FOR THE SAME MEDICAL REASON IN A CERTAIN PERIOD OF TIME.

DATA SOURCE: Admission office

DENOMINATOR STATEMENT: TOTAL NUMBER OF PATIENTS DISCHARGED OF THE HOSPITAL DURING THE MONTH (INCLUDING DEATHS).

DATA SOURCE: DISCHARGE OFFICE

$$\frac{\textbf{Number of readmitted patients within 30 days}}{\textbf{Total number of patients discharged of the hospital}} \times 100$$

TARGET: LESS THAN 2%

DATA REPORTED AS: PERCENTAGE

FREQUENCY OF MEASUREMENT: MONTHLY

7 - READMISSION RATE FOR EMERGENCY PATIENTS WITHIN 72 HOURS

MEASURE ID: (07)

QUALITY MEASURE NAME: READMISSION RATE FOR EMERGENCY PATIENTS WITHIN 72 HOURS

DEPARTMENT(S) INCLUDED: ACCIDENT & EMERGENCY DEPARTMENT (ER)

PURPOSE: QUALITY OF CARE

TYPE OF MEASURE: PROCESS

Numerator Statement: NUMBER OF PATIENTS RETURNED BACK TO ER WITHIN 72 HOURS OF LEAVING THE ER.

DATA SOURCE: ER RECORDS

DENOMINATOR STATEMENT: NUMBER OF PATIENTS DISCHARGED FROM ER

DATA SOURCE: ER RECORDS

$$\frac{\textbf{NUMBER OF PATIENTS RETURNED BACK TO ER WITHIN 72 HOURS}}{\textbf{NUMBER OF PATIENTS DISCHARGED FROM ER}} \times 100$$

TARGET: LESS THAN 2%

DATA REPORTED AS: PERCENTAGE

FREQUENCY OF MEASUREMENT: MONTHLY

8 - Average Length of Stay (ALOS)

Measure ID: (08)

Quality measure name: Average length of stay (ALOS)

Department(s) included: All inpatient wards

Purpose: Operational efficiency

Type of measure: Process

Numerator Statement: Inpatient days of care (sum of daily inpatient census) for a certain period of time.

Data Source: Daily inpatient census (inpatient registers at admission office)

Denominator statement: Total number of discharged patients (including deaths)

Data source: Discharge Office

$$\frac{\textbf{Inpatient days of care (sum of daily inpatient census)}}{\textbf{Total number of discharged patients (including deaths)}}$$

Target: Annual improvement

Data reported as: Average

Frequency of measurement: Monthly

9A - INPATIENT BED OCCUPANCY RATE

MEASURE ID: (09A)

QUALITY MEASURE NAME: BED OCCUPANCY RATE (INPATIENT)

DEPARTMENT(S) INCLUDED: ALL INPATIENT WARDS

PURPOSE: OPERATIONAL EFFICIENCY

TYPE OF MEASURE: OUTCOME

NUMERATOR STATEMENT: INPATIENT DAYS OF CARE FOR A CERTAIN PERIOD OF TIME (SUM OF EACH DAILY INPATIENT CENSUS)

DATA SOURCE: DAILY INPATIENT CENSUS

DENOMINATOR STATEMENT: BED DAYS AVAILABLE FOR THE SAME PERIOD OF TIME.

DATA SOURCE: HOSPITAL RECORD

$$\frac{\textbf{INPATIENT DAYS OF CARE (SUM OF DAILY INPATIENT CENSUS)}}{\textbf{BED DAYS AVAILABLE FOR THE SAME PERIOD OF TIME}} \times 100$$

TARGET: not less than 75%

DATA REPORTED AS: PERCENTAGE

FREQUENCY OF MEASUREMENT: MONTHLY

9B - ICUs Bed Occupancy Rate

Measure ID: (09B)

Quality measure name: Bed Occupancy rate (ICUs)

Department(s) included: All (ICUs)

Purpose: Operational efficiency

Type of measure: Outcome

Numerator Statement: Inpatient days of care in ICU, CCU&NICU (sum of daily ICUs patients census) for a certain period of time

Data Source: Daily ICUs patients census

Denominator statement: Bed days available in ICUs for the same period of time

Data source: Hospital record

$$\frac{\textbf{Inpatient days of care in ICU,CCU \& NICU}}{\textbf{Bed days available in ICU, CCU \& NICU}} \textbf{ X 100}$$

Target: Annual Improvement

Data reported as: percentage

Frequency of measurement: monthly

10 - BUDGET EXECUTION

MEASURE ID: (10)

QUALITY MEASURE NAME: BUDGET EXECUTION

DEPARTMENT(S) INCLUDED: FINANCIAL DEPARTMENT

PURPOSE: FINANCIAL OPERATIONAL EFFICIENCY

TYPE OF MEASURE: OUTCOME

NUMERATOR STATEMENT: ACTUAL EXPENDED BUDGET

DATA SOURCE: THE ACTUAL EXPENDITURE BUDGET (FINANCIAL DEPARTMENT)

DENOMINATOR STATEMENT: APPROVED BUDGET

DATA SOURCE: THE APPROVED BUDGET (FINANCIAL DEPARTMENT)

$$\frac{\textbf{ACTUAL EXPENDED BUDGET}}{\textbf{APPROVED BUDGET}} \textbf{X 100}$$

TARGET: EXPENDITURE WITHIN APPROVED BUDGET

DATA REPORTED AS: PERCENTAGE

FREQUENCY OF MEASUREMENT: MONTHLY

11 – CANCELLATION RATE

MEASURE ID: (11)

QUALITY MEASURE NAME: CANCELLATION RATE

DEPARTMENT(S) INCLUDED: OPERATIONS ROOM

PURPOSE: OPERATIONAL EFFICIENCY

TYPE OF MEASURE: PROCESS

Numerator Statement: NUMBER OF THE CANCELLED OR POSTPONED ELECTIVE PROCEDURES

DATA SOURCE: THE OPERATIONS ROOM LOG BOOK

DENOMINATOR STATEMENT: TOTAL NUMBER OF THE SCHEDULED PROCEDURES

DATA SOURCE: THE OPERATIONS ROOM LOG BOOK

$$\frac{\text{NUMBER OF THE CANCELLED OR POSTPONED ELECTIVE PROCEDURES}}{\text{TOTAL NUMBER OF THE SCHEDULED PROCEDURES}} \times 100$$

TARGET: LESS THAN 5%

DATA REPORTED AS: PERCENTAGE

FREQUENCY OF MEASUREMENT: MONTHLY

12 – PATIENT FALL RATE

MEASURE ID: (12)

QUALITY MEASURE NAME: PATIENT FALL RATE

DEPARTMENT(S) INCLUDED: ALL INPATIENT WARDS

PURPOSE: QUALITY OF CARE

TYPE OF MEASURE: OUTCOME

NUMERATOR STATEMENT: NUMBER OF THE FALLS OF THE INPATIENTS

DATA SOURCE: THE ADVERSE EVENTS LOG BOOK, NURSING LOG BOOK

Denominator statement: TOTAL NUMBER OF PATIENT DAYS OF CARE

Data source: DAILY INPATIENT CENSUS

$$\frac{\textbf{NUMBER OF THE FALLS OF THE INPATIENTS}}{\textbf{NUMBER OF THE INPATIENTS DAYS OF CARE}} \textbf{X 1000}$$

TARGET: LESS THAN 5% $_{00}$

DATA REPORTED AS: PER THOUSAND

FREQUENCY OF MEASUREMENT: MONTHLY

"LIST OF INDICATORS"

Year: 20

	Indicator	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
01	Inpatient Volume												
02	Outpatient Volume												
03	Outpatient/Inpatient Ratio												
04A	Gross unadjusted mortality rate												
04B	ICUs mortality rate												
04C	Gross unadjusted mortality rate within 24 hours of admission												
04D	NICU mortality rate												
04E	Mortality rate by clinical departments												
05A	Hospital acquired infection rate												
05B	Surgical Site Infection rate												
06	Readmission rate for inpatients within 30 days												
07	Readmission rate for emergency patients within 72 hours												
08	Average length of stay (days)												
09A	Inpatient bed occupancy rate												
09B	ICUs Bed Occupancy Rate												
10	Budget execution												
11	cancellation rate												
12	patient fall rate												