Strathroy Middlesex General Hospital

AIM		MEASURE					CHANGE			
Quality dimension	Objective	Measure/Indicator	Current performance	Target for 2012/13	Target justification	Priority level	Planned improvement initiatives (Change Ideas)	Methods and process measures	Goal for change ideas (2012/13)	Comments
Safety	Reduce clostridium difficile associated diseases (CDI)	**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. 2011, consistent with publicly reportable patient safety data	6 case-0.35 rate	0.28-0.40 (Ontario averages) with marginal variation related to low incidence and low patient days.	Improve or maintain current rate	2	1) Complete review of IHI Improvement Map-Antibiotic Stewardship and continue review of cases by ICP and Pharmacy and Therapeutics committee for causitive antibiotics and review of judicial use of antibiotics.	Resource review, chart review , lab results , early identification of patients with previous C. Diff , electronic tracking, P&T meetings	100% review of each case by pharmacist and Infection control	Review of all CDI cases as standing agenda item on P&T committee.
							2)Review literature and PIDAC best practices for Prevention and Control in Health Care Settings and recommendations for cleaning procedures or new products.	Review of standards and guidelines	Improve in all areas identified to optimize prevention.	Presently follow cleaning protocols as outlined in PIDAC guidelines - never more than one case at a time on any unit at SMGH - no evidence of transmission from an active case- CDI cleaning checklists filled out each day by housekeeping staff
	Reduce incidence of Ventilator Associated Pnemonia (VAP)	**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 in that reporting period, multiplied by 1,000 - Average for Jan-Dec. 2011, consistent with publicly reportable patient safety data	0 cases and 0 rate	Maintain current performance.	No incidence year over year, small number of ventilated patients .	3	1) Presently not demonstrating any Ventilator Associated Pneumonias.	Daily reporting in CCIS and quarterly reporting internally to Quality Utilization Management, Infection Control meetings and critical care units through public reports.	Maintain 0 Cases on monthly basis.	Enrolled in the Safer Health Care now VAP initiatives and monitoring compliance with clinical practice recommendations.
	Improve provider hand hygiene compliance	**Hand hygiene compliance before and after 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 and after initial patient contact multiplied by 100 - Jan-Dec. 2011, consistent with publicly reportable patient safety data	84%	90%	Hand hygiene continues to a be a priority indicator for all patient care areas .	1	1) Reassess -point -of care placement and accessibility to hand hygiene product .	Product recently supplied on all overbed tables in all in-patient rooms.	100% placement of hand hygiene product in all patient rooms.	Product will be available for patients to use prior to eating or during the day and be more readily for staff.
							2) Improve the auditing and reporting process for compliance	New on-line program purchased (mAiRiner)to make auditing and reporting easier for auditors.	Quarterly reporting to all areas and disciplines	MHA purchased a web based hand auditing program that has greatly improved the numbers of audits being completed and has allowed many more reports to be circulated to the individual units and disciplines.
							3) Hand hygiene has been incorporated into many department indicators to be monitored and reported	Compliance numbers will be supplied by the auditors and infection control to all the requesting departments and disciplines.	Quarterly reporting to all areas and disciplines	Improved visibility of provider compliance.
	Reduce rate of central line blood stream infections	**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 - Average for Jan-Dec. 2011, consistent with publicly reportable patient safety data	0 cases and 0 rate.	Maintain current performance.	No incidence year over year, small number of CL insertions.	3	1) Presently not demonstrating any Central Line Infections.	Daily reporting in CCIS and quarterly reporting internally to Quality Utilization Management, Infection Control meetings and critical care units through public reports.	Maintain 0 Cases on monthly basis.	Enrolled in the Safer Health Care now VAP initiatives and monitoring compliance with clinical practice recommendations.
	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 - Jan-Dec. 2011, consistent with publicly reportable patient safety data	Monthly Reports Quarterly Average 97.65	98%	Target to maintain current 100% compliance.	2	1) Monthly reporting at Perioperative Governance and Quarterly at Quality Utilization Management and visibility of excellent results to all surgical participants to complete process.	Daily tracking of incomplete completion of data entry . Monthly tracking and review of results.	Monthly monitoring by OR unit clerk staff and reporting to Safer Health Care now , QUM and POGT by patient safety representatives and clinical leader OR.	Monthly reports are monitoring and reported quarterly at Quality Utilization Management and monthly Perioperative Governance Committee. Compliance outcomes posted monthly within Surgical Services area. Concurrent monitoring of monthly cancellation cases and surgical death rate and reasons. Process review and refresh underway to ensure continued compliance with all required steps in the process.
							2) Monthly review of surgical services occurrence reports at Perioperative governance including near miss, surgical safety checklist associated occurrences	Process reviews to ensure near miss is not a system issue that needs to be addressed.	Monthly reporting of occurrences highlighting SSCL near miss.	Frequent success of implementation cited at Perioperative Governance to be team accountability to integrating routine practice of SSCL.
Effectiveness	Improve organizational financial health	**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	1.09	Greater than or equal to 0.	Zero or greater indicates good total margin.	1	1) Currently achieving performance goal and will continue to monitor through Board Finance Committee. Sustaining Total Margin at zero or better balance of institutional financial health requiring rapid internal learning curve relative to new Quality Based Funding model and Hospital Service Accountability Agreement(HSAA)	Monthly financial tracking and reporting. Enrollment in HBAM and QBP HSFR education sessions and review of resources provided. Develop template for monitoring and costing of QBP procedures, following review of monthly and forecasted volumes.	Monthly completion of finance account by manager of finance, reported to CFO within 2 weeks of month end. Quarterly report ot Finance Committee of the Board and publicly quarterly through corporate dashboard.	This is a priority item because it is tied to HSAA funding and unknown impact related to new HBAM and Quality Activity Funding 2012-13. LEAN initiatives related to improved patient care , education, access, but also costing underway.

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Access	Reduce wait times in the ED	**ER Wait times:** 90th Percentile ER length of stay in hours for Admitted patients. FY YTD Q3 2012-13	17.1	12.2	Significant stretch target to reach 2010-11 HSAA target	1	1) Patient Flow Improvements	1) Daily Dashboard display and communications 2) Patient tracking board 3) LEAN project outcomes for inpt discharges, root cause of patient delays, bed accessibilty, early discharge planning. 4) Identify and address impacts of ALC patient days as possible.	Analysis of all factors impacting admission delays to be addressed and improved. Daily monitoring of admitted patient wait times, patient discharge times and turnover times by ED,Inpatient and housekeeping clinical leaders.	Improved visibility of real time wait times through current daily dashboard reports. In addition, electronic tracking board to be implemented with expansion of ED EPR summer 2012. LEAN process initiation of daily patient progress bullet rounds and critical review of all stages of patient ED visit, timely admission , discharge and bed turnover.
		ER Wait Times: 90th Percentile ER length of stay in hours for High Acuity Non- Admitted patients. FY YTD Q3 2012-13 NACRS, CIHI	7.9	6.2	Stretch target to reach 2011-12 HSAA target	2	1) Departmental redesign and expansion of electronic patient tracking information	1) Daily Dashboard display and communications 2) Patient tracking board 3) Green zone redesign to facilitate fast tracking of low acuity patients and enhance triage and treatment of high acuity patients.	Daily monitoring by ED clinical leader and manager. Quarterly reporting at Service of ED , QUM and corporate dashboard. Improve wait times for all patients seen in ED.	Improved visibility of real time wait times through current daily dashboard reports. In addition, electronic tracking board to be implemented with expansion of ED EPR summer 2012.
	Urgent Hip Fracture Surgery	**Hip Fracture Repair** :Time to Hip Fracture repair surgery within 48 of diagnostic X-ray for medically stable patients.	Historically less than 90% completion of surgery within 48 hours of diagnostic xray	90%	Consistent with provincial BJHN recommended clinical guidelines.	2	1) Hip Fracture Pathway Implementation 2) Urgent Hip Fracture Regional Orthopedic On Call Project	Early patient identification, early assessment of medical complications and treatment to be able to proceed with surgery within appropriate timelines, documentation of patient on tracking form. Consult and transfer to alternate orthopedic surgical centre when required. Direct and indirect transfers from other centres are tracked to monitor compliance with provincial BJHN recommendations.	Reach 90% patient time to surgery 48 hours from time of diagnostic x-ray.	SMGH has orthopedic 80% of the time, and participates with several other ortho centres both tertiary and hospitals in SW LHIN Urgent Hip Fracture initiative to optimize orthopedic hip fracture coverage. Patients who exceed the 48 target hours will be reviewed to determine nature of the delay and may be excluded relative to availability of required internal medical consult, medical condition preventing proceeding with surgery until stable, or external factors beyond our control.
	CT Wait Times	**90th Percentile CT Wait Time in Days.**	12	11	Within provincial and SWLHIN target	2	Monitor wait time targets and wait days monthly.	Wait times tracked and reported quarterly.		
	Diabetes Education Centre (DEC)	**Average Wait Time Days for DEC patients for initial appointment.**	Unknown	30 days	New target, unknown current wait time, highly variable.	2	Assess current performance and establish target to improve.	Tracking of number of wait days to initial appointment for diabetes management.	Track departmentally on quarterly basis and post on departmental indicators.	Wide age, population and culture variance. Aiming to enhance consistency of time to initial appointment following physician or patient self referral.
Patient- Centered	Patient Satisfaction	**From NRC Picker:** "Overall, how would you rate the care and services you received at the hospital?"	91.5	93%	Sustain and improve upon current excellent performance	2	1) Tracking and Communication of Quarterly Departmental Results	Quarterly results retrieved by department managers, shared with staff and posted within department. Establish departmental targets for achievement.	Establish departmental targets for achievement.	Improved performance this year over 2010-11. Continued trend with professional development, unit specific goals and performance targets.
		From NRC Picker / HCAPHS: "Would you recommend this hospital to your friends and family?"	68.57	Greater than or equal to 74%	Improvement upon current performance below provincial average performance.	2	1) Tracking and Communication of Quarterly Departmental Results	Quarterly results retrieved by department managers, shared with staff and posted within department. Establish departmental targets for achievement.	Establish departmental targets for achievement. Quarterly monitoring of satisfaction results.	
							2) Quarterly Analysis of documented complaints and NRC Picker detail question.	Analyze specific questions to identify specific areas of strength and improvement . Eg Courtesy of ED nurse, call bell response time, care coordination, education etc.	Establish departmental targets for achievement. Quarterly monitoring of satisfaction results.	Improved performance this year over 2010-11. Continued trend with professional development, unit specific goals and performance targets.
	Patient Experience	**Patient Complaints**: Percentage of patient complaints initial respond within 2 business day of receipt of complaint.	Unknown	85% Initial response to complaints within 2 business days.	Actual performance is unknown, however variable.	1	Reporting and Tracking of Complaints response times.	Documentation of current expectations to respond to patient complaints within 2 business days.	85%	Patient complaints and compliments tracked within electronic occurrence reporting system. Policy and procedure established to support and decscribe documentation of first followup .
Integrated	Reduce unecessary time spent in acute care	**Percentage ALC days:** Total number of inpatient days designated as ALC, divided by the total number of inpatient days. Q2 2011-12 DAD, CIHI	11.4%	Less than or equal to 14.5 %	Annual performance Q3 2010- Q2 2011 11.41 %. Target established to reflect target for alliance hospitals and based on quarters identified.	1	1) Early identification of discharge plan	Nursing admission history inclusion of discharge destination assessment. Inclusion of CCAC and Support services referral orders in Patient Order Sets . Review roles and responsiblities of CCAC case manager of patient case reviews.	Earlier and Improved discharge planning of all patients, reducing number of ALC patients and length of ALC stay for ALC appropriate patients.	Factors for success include collaboraton with CCAC external provider, consistent use of ALC definition, timely transfers to ALC facilities.
							2) Monitoring of ALC days and patient types	WTIS ALC report through EPR documentation.	Quarterly distribution of ALC patient days and volumes.	