PART B: Improvement Targets and Initiatives

Strathroy Middlesex General Hospital, Middlesex Hospital Alliance

AIM		MEASURE				CHANGE				
Quality dimension	**Objective**	**Outcome Measure/Indicator**	**Current performance**	**Performance goal 2011/12**	**Priority**	**Improvement initiative**	**Methods and results tracking**	**Target for 2011/12**	**Target justification**	**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. 2010, consistent with publicly reportable patient safety data	5 cases- 0.31 rate	Continue to meet / exceed the Ontario rate of 0.29-0.34	2	Identify any common causitive antibiotic. Pharmacist review usage and indications for prescribing, make recommendations for use	Chart review and antibiotic usage review through electronic tracking	Review-educate and audit for reduction in inappropriate use	As antibiotic usage is implicated in CDI cases, review of cases for common causitive antibiotic will help to alert physicians to inappropriate use	Trends are investigated and any common antibiotics are reviewed.
						Ensure nursing staff alert to monitoring for CDI and intitiating precautions as per protocol	ICP daily rounds - monitoring of abnormal lab results	0.29-0.34 or less	2010 all the C.diff cases were single cases each month and in three cases symptoms developed after discharge.- There was no signs of transmission to other patients during the in-patient stay of any of the cases.	Present CDI protocols have lead to timely identification of CDI cases, early isolation and strict environmental cleaning procedures have controlled spread.
	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. 2010, consistent with publicly reportable patient safety data	0 cases and 0 rate	N/A	N/A	Presently not demonstrating any Ventilator Associated Pneumonias.				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 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 - 2009/10, consistent with publicly reportable patient safety data	Before Pt contact 63% : After Pt Contact 66%	Before Patient contact 85 % compliance; After Patient Contact 85% compliance	1	Continue to ensure product availability at point of care- update as new brackets etc. become available	Monitor maintenance request forms for installation of new brackets, product availability in dispensers, and associated increase in product supply and utilization.	Provide install any new product where required as requested.	Improved product accessibility at point of care , will improve hand hygiene compliance.	Jan 2011 hand hygiene product representative along with infection control audited the hospital to review product placement - approximately 130 new brackets installed
						Ongoing hand hygiene awareness for physicians and staff	Hand hygiene audits. All staff completion of hand hygiene education and quiz.	85% compliance before and after patient contact.	Decreased nosocomial infections- increased patient safety.	In 2010 audit numbers for physicians compliance was shared at MAC and the medical staff meeting. Presentation by RICN medical coordinator at Grand Rounds . Continued staff education on hand hygiene through RICN Inservices-on-Demand- hand hygiene contests
	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. 2010, consistent with publicly reportable patient safety data	0 Cases and 0 rate	N/A	N/A	Presently not demonstrating any Central Line Blood Stream Infections.				Enrolled in the Safer Health Care Now CLI initiatives and monitoring compliance

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Quality dimension	Objective	Outcome Measure/Indicator	Current performance	Performance goal 2011/12	Priority	Improvement initiative	Methods and results tracking	Target for 2011/12	Target justification	Comments
	Avoid new pressure ulcers	**Pressure Ulcers**: Percent of complex continuing care residents with new pressure ulcer in the last three months (stage 2 or higher) - FY 2009/10, CCRS	N/A	N/A	N/A	No Complex Continuing Care Residents.				New risk occurrence reporting system customized to enhance tracking of incidence in acute care.
						… N)				
	Avoid falls	**Falls**: Percent of complex continuing care residents who do not have a recent prior history of falling, but fell in the last 90 days - FY 2009/10, CCRS	N/A	N/A	N/A	No Complex Continuing Care Residents.				Implementation of enhanced Falls Risk Assessment, Education, Audit Process Q3-4 2010-11
						… N)				
	Surgical Safety Checklist	**SSCL:** Percentage of surgeries in which a surgical safety checklist is performed inclusive of each of three required . phases, 'briefing', 'time out' and 'debriefing'.	97% (Q3 10/11)	90%	2	Maintain and consistency achieve 100% SSCL compliance	Daily monitoring of SSCL compliance. Monitor near miss event rates related to SSCL completion.	Consistent > than 90% Compliance	Achieving 100% SSCL compliance during last months 2010/11. Report compliance and near miss event rates monthly at Surgical Services, Quarterly at Quality Utlization Management. Teamwork effort to ensure completion and documentation.	All team members responsible for completion. Results routinely posted within the department and distributed by surgeon and anesthesiologist.
Effectiveness	Reduce unnecessary deaths in hospitals	**HSMR:** number of observed deaths/number of expected deaths x 100 - FY 2009/10, CIHI	Number of observed deaths- 129	N/A	N/A	Number of observed deaths below required reporting volume.				Volume of deaths below reportable volumes. Continue to monitor volumes.
	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 2010/11, DAD, CIHI	10.2	Maintain 10.2 %	2	Appropriate timing, designation of ALC patients. ALC WTIS data expansion May 2011. Regular reporting through QUM ,MAC, community interests groups, hospital, board. Collaboration with CCAC , patient and families re Home First.	Care Team/Physician decision re ALC designation and planning. Monitor and circulate reports, QUM.	Maintain 10% ALC bed utilization.		
	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 2010/11, OHRS	Q3 = 4.25%, forecast Q4 = 2.51%	≥ 0	3	Currently achieving performance goal and will continue to monitor through Board Finance Committee.				This is a high priority item because is tied to HSAA and WTIS funding agreement. Currently we are meeting the minimum target therefore a priority 3.
Access	Reduce wait times in the ED	**ER Wait times:** 90th Percentile ER length of stay for Admitted patients. Q3 2010/11, NACRS, CIHI	12.2	Provincial target < 8Hr, LHIN target 12 hrs, SMGH target 10.1 hours	1	LEAN process to address delays.Includes CCAC, Home First initiatives, Early Discharge Planning , Daily Bed Huddles, ALC pressures, Regional Access and Flow	Daily Monitoring of admitted patient volumes, monthly tracking of wait times for admitted and Los for discharge patients.	Improve from current 90%ile of 12.2 , by half the variance between provincial target and current actual Ie 10.1 hours.	Lean process for GREEN Zone patients improved LOS and satisfaction. LOS for admitted patients may be impacted by lower LOS green zone patients, internal processes of inpt adm and transfer, time, bed huddle and external factors of CCAC , Home First program, Tertiary Care Emergency Access LImitations.	High priority item also reflected in patient centred indicator of satisfaction.
		ER Wait times: 90th percentile ER Length of Stay for Complex conditions. Q3 2010/11, NACRS, CIHI	CTAS 1-3 5.9 CTAS 4-5 4.2	Maintain CTAS 1-3 ≤ 5.9 Improve CTAS 4-5 ≤ 4 hrs.	2					

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Quality dimension	**Objective**	**Outcome Measure/Indicator**	**Current performance**	**Performance goal 2011/12**	**Priority**	**Improvement initiative**	**Methods and results tracking**	**Target for 2011/12**	**Target justification**	**Comments**
Patient-centred	Improve patient satisfaction	NRC Picker / HCAPHS: "Would you recommend this hospital to your friends and family?" (add together percent of those who responded "Definitely Yes")	NRC Picker Oct 2009 to Sept 2010, Day Surgery- 83.13% , Emergency 56.21 %, Inpatient 86.22 %	Day Surgery and Inpatients- Aim to match or improve current results. ED aim to meet or exceed provincial average 74% satisfaction.	1	NRC picker survey.Review of Compliments and complaints. Assess for Customer Service focus.	NRC Picker results review and sharing of results. Complaints assessment for resolution and learning needs.	Meet provincial average of 74% satisfaction 2011-12 survey, a 4% improvement.	Improvement of flow issues, length of stay, customer service, will improve satisfaction.	

PART B: Improvement Targets and Initiatives

Four Counties Health Services, Middlesex Hospital Alliance

AIM		MEASURE				CHANGE				
Quality dimension	Objective	Outcome Measure/Indicator	Current performance	Performance goal 2011/12	Priority	Improvement initiative	Methods and results tracking	Target for 2011/12	Target justification	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. 2010, consistent with publicly reportable patient safety data	0 cases- 0 rate	continue as present	2	Identify any common causitive antibiotic. Pharmacist review usage and indications for prescribing, make recommendations for use	Chart review and antibiotic usage review through electronic tracking	Review-educate and audit for reduction in inappropriate use	As antibiotic usage is implicated in CDI cases, review of cases for common causitive antibiotic will help to alert physicians to inappropriate use	Trends are investigated and any common antibiotics are reviewed.
						Ensure nursing staff alert to monitoring for CDI and intitiating precautions as per protocol	ICP daily review - monitoring of abnormal lab results	Maintain below provincial target 0.29-0.34 or less	No cases.	Protocols for timely identification of CDI cases, early isolation and strict environmental cleaning procedures in place.
	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. 2010, consistent with publicly reportable patient safety data	N/A	N/A	N/A	No ventilators or ICU in FCHS				
	Improve provider hand hygiene compliance	**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 - 2009/10, consistent with publicly reportable patient safety data	Before patient contact 68% ; After patient contact 69%	Before Patient contact 85 % compliance; After Patient Contact 85% compliance	1	Continue to ensure product availability at point of care- update as new brackets etc. become available	Monitor maintenance request forms for installation of new brackets, product availability in dispensers, and associated increase in product supply and utilization.	Provide, install any new product where required as requested.	Improved product accessibility at point of care , will improve hand hygiene compliance.	Jan 2011 hand hygiene product representative along with infection control audited the hospital to review product placement - approximately 130 new brackets installed
						Ongoing hand hygiene awareness for physicians and staff	Hand hygiene audits. All staff completion of hand hygiene education and quiz.	85% compliance before and after patient contact.	Decreased nosocomial infections- increased patient safety.	In 2010 audit numbers for physicians compliance was shared at MAC and the medical staff meeting. Presentation by RICN medical coordinator at Grand Rounds . Continued staff education on hand hygiene through RICN Inservices-on-Demand- hand hygiene contests
	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. 2010, consistent with publicly reportable patient safety data	N/A	N/A		No ICU in FCHS				
	Avoid new pressure ulcers	**Pressure Ulcers**: Percent of complex continuing care residents with new pressure ulcer in the last three months (stage 2 or higher) - FY 2009/10, CCRS	N/A	N/A	N/A	No Complex Continuing Care Residents.				New risk occurrence reporting system customized to enhance tracking of incidence in acute care.
	Avoid falls	**Falls**: Percent of complex continuing care residents who do not have a recent prior history of falling, but fell in the last 90 days - FY 2009/10, CCRS	N/A	N/A	N/A	No Complex Continuing Care Residents.				Implementation of enhanced Falls Risk Assessment, Education, Audit Process Q3-4 2010-11

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Quality dimension	Objective	Outcome Measure/Indicator	Current performance	Performance goal 2011/12	Priority	Improvement initiative	Methods and results tracking	Target for 2011/12	Target justification	Comments
Effectiveness	Reduce unnecessary deaths in hospitals	**HSMR:** number of observed deaths/number of expected deaths x 100 - FY 2009/10, CIHI	Number of observed deaths 125	N/A	N/A	Number of observed deaths below required reporting volume.				Volume of deaths below reportable volumes. Continue to monitor volumes.
	Reduce unnecessary hospital readmission	**Readmission within 30 days for selected CMGs to any facility:** The number of patients with specified CMGs readmitted to any facility for non-elective inpatient care within 30 days of discharge, compared to the number of expected non-elective readmissions - Q1 2010/11, DAD, CIHI	Number of readmission within 30 days Q1 2010/11, less than 5. FY2009/10 15.4% with expected ratio 14.6%	N/A	N/A	Number of readmission within 30 Non reportable due to low volumes.				Continue to monitor readmission rates.
	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 2010/11, DAD, CIHI	15.7	≤15.7	1	Appropriate timing, designation of ALC patients. ALC WTIS data expansion May 2011. Regular reporting through QUM ,MAC, community interests groups, hospital, board. Collaboration with CCAC , patient and families re Home First.	Care Team/Physician decision re ALC designation and planning. Monitor and circulate reports, quality committee.	Maintain 10% ALC bed utilization.		
	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 2010/11, OHRS	Q3 = 1.78%, Q4 forecast = 1.12%	≥ 0	3	Currently achieving performance goal and will continue to monitor through Board Finance Committee.				This is a high priority item because is tied to HSAA funding agreement. Currently we are meeting the minimum target therefore a priority 3.
Access	Reduce wait times in the ED	ER Wait times: 90th Percentile ER length of stay for Admitted patients. Q3 2010/11, NACRS, CIHI	NR	NR	NR					
		ER Wait times: 90th percentile ER Length of Stay for Complex conditions. Q3 2010/11, NACRS, CIHI	NR	NR	NR					
Patient-centred	Improve Patient Satisfaction	NRC Picker / HCAPHS: "Would you recommend this hospital to your friends and family?" (add together percent of those who responded "Definitely Yes")	70.1	ED Aim is to meet or exceed provincial average of 74%.	1	NRC picker survey.Review of Compliments and complaints. Assess for Customer Service focus.	NRC Picker results review and sharing of results. Complaints assessment for resolution and learning needs.	Meet provincial average of 74% satisfaction 2011-12 survey, a 4% improvement.	Improvement of flow issues, length of stay, customer service, will improve satisfaction.	