PART B: Improvement Targets and Initiatives 2013-14

Strathroy Middlesex General Hospital

AIM		MEASURE					CHANGE			
Quality dimension	Objective	Measure/Indicator	Current performance	Target for 2013/14	Target justification	Priority level	Planned improvement initiatives (Change Ideas)	Methods and process measures	Goal for change ideas (2013/14)	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. 2012, consistent with publicly reportable patient safety data	3 cases- rate 0.20	0.36	Improve or maintain current rate	2	1) Review of cases by ICP and Pharmacy and Therapeutics committee for causitive antibiotics and review of judicial use of antibiotics was successful in reducing numbers of cases in 2012. In 2013 antibiotic stewardship will be expanded to meet accreditation standards by establishing an antibiotic stewardship team to promote intitiatives	Resource review, chart review , lab results , early identification of patients with previous C. Diff , electronic tracking, P&T meetings	Continue with 100% review of each case by pharmacist and Infection control	Continue to include review of all CDI cases as standing agenda item on P&T committee.
							2)Continue to follow PIDAC best practices for Prevention and Control in Health Care Settings and recommendations for cleaning procedures or new products.	Continue with paper checklist of cleaning of C.diff rooms but will add the ATP testing after discharge clean. Quarterly report to the Infection Control committee of results	100% use of ATP testing after every discharge	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. Have recently switched to Bleach wipes so will monitor for effectiveness
	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. 2012 consistent with publicly reportable patient safety data	0 cases and 0 rate	1.26	Although small number of ventilated patients will occassionly have a long term patient so need to meet provincial standards	3	Review the new Safer Health Care Now bundle for preventing VAP and include new key components in the checklists	Daily reporting in CCIS and quarterly reporting internally to Quality Utilization Management, Infection Control meetings and critical care units through public reports.	Strive to Maintain 0 Cases on monthly basis or meet the provincial average	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. 2012, consistent with publicly reportable patient safety data	92%	90%	Hand hygiene continues to a be a priority indicator for all patient care areas .	1	1. Hand hygiene learning modules now incorporated into an e-learning program that will allow for better tracking for compliance	use reports issued from e-learning to monitor compliance with education and allow for follow-up from managers	95-100% compliance with taking e-learning hand hygiene course	MHA purchased an e-learning program from Medworxx Learning Management that will provide better tracking of learning modules
							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 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.
	Medication Reconciliation at admission	**Medication reconciliation at admission.** The total number of patients with medication reconciled as a proporation of the total number of patients admitted to the hospital. 	100%	90%	New indicator warrants some review and assessment to ensure all requirements met.	2	Med Rec required by pharmacy for processing any patient orders. Integrated into standard admission assessment and completion. User input into documentation record. Patient safety initiative and accrediation ROPS.	Continue to measure med rec completion.	Monthly reporting MOHLTC	Births and Amb care not included. Inpatient admissions only. Med reconciliation completed on all patients, part of Accreditation Oct 2013 ROPS review . Med Rec orders to be incorporated into electronic physician order entry. Potential challenges related to PT pharmacy business and call hours.
	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 2012, consistent with publicly reportable patient safety data	0 cases and 0 rate.	0.48	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	**Rate of in-hospital mortality following major surgery:** The rate of in-hospital deaths due to all causes occurring within five days of major surgery - FY 2011/12, CIHI CHRP eReporting tool 	7.4	Less than 10 death per 1000 within 5 days of major surgery	10.08 Provincial average	2	Monitor and report 5 day in hospital mortality rate at Quarterly QUM .	Chart reviews and risk stratification. Report to COO , Quality Board, Chief of staff.	Quarterly	New indicator for SMGH. Increasing scope and volume of major surgery. Continue with preadmission screening for high risk patients, SSCL maintain and sustain providing refresh early 2013.
		Surgical Saftery Checklist (January - December 2012) The number of times all three phases of the surgical safety checklist was performed ('briefing','timeout', and "debriefing') divided by the total number of surgeries peformed, multiplied by 100, consistent with public reporting data.	100%	90%	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. Review of safety checklist requirements, assessment of compliance with processes ,and education refresh beginning early 2013-14.	Monthly monitoring by OR unit clerk staff and reporting to Safet 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.
							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 2012/13, OHRS**	0.01	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) . A Financial Planning Analyst role was created to become more involved in Ministry funding analysis as well as planning and benchmarking analysis. The hospital is engaged in many regional initiatives to enhance patient care which are tied to performance. They include the SW LHIN Regional Integration Decision Support team; the SW LHIN Local Partnership Initiative to identify funding issues and challenges while providing education; the SW LHIN Integrated Health Plan looking at clinical services planning; and Regional Orthopaedic Services. The hospital is investigating recent changes to the Not-For-Profit Corporations Act and the potential impact on governance and changes to Cost Per Weighted Case.	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. The priority is in managing limited funding with cost pressures while at the same time sustaining and improving the orthopaedic program. The assumptions we make are at risk without timely input from the Ministry of Health and Long Term Care.

AIM		MEASURE					CHANGE			
Access	Reduce wait times in the ED	**ER Wait times: 90th Percentile ER length of stay for Admitted patients. Q3 2012/13, NACRS, CIHI**	10.40 hours	12	Significant stretch target to reach 2010-11 HSAA target	2	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, Firstnet electronic tracking board to be implemented March 2013 and Hugo implementation January 2014. 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. SW LIN project planned for may 2013- Knowledge Transfer of Lean Best Practices in SW LHIN EDand Organizations
		ER Wait Times: 90th Percentile ER length of stay for High Acuity Non- Admitted patients. Q3 2012/13, NACRS, CIHI	5.6	6.2	Stretch target to reach 2012-13 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 charge nurse 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, Firstnet electronic tracking board to be implemented in March 2013 and Hugo implementation January 2014.SW LIN project planned for May 2013- Knowledge Transfer of Lean Best Practices in SW LHIN EDand Organizations
	Urgent Hip Fracture Surgery	**Hip Fracture Repair** :Time to Hip Fracture repair surgery within 48 of diagnostic X-ray to time of surgery for inpatients.	90.4%	90 % completion of hip fracture repair surgery within 48 hours of diagnostic X-ray	Consistent with provincial BJHN recommended clinical guidelines.	1	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 had orthopedic call coverage 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. Expansion of the orthopedic program beginning May 2013 will increase ortho on call coverage to >95% and therefore earlier access to surgery internally.
	CT Wait Times	**90th Percentile CT Wait Time in Days.**	10	11	Within provincial and SWLHIN target	2	Monitor wait time targets and wait days monthly as scope and service volumes increase..	Quarterly results reviewded by department managers, shared with staff and posted within department. Establish departmental targets for		Quarterly report to QUM, Corporate Dashboard
	Diabetes Education Centre (DEC)	**Average Wait Time Days for DEC patients for initial appointment.**	13.46	30	Unknown at this time as current state of long wait percieved.	2	Assess current performance and establish target to improve.			
Patient- Centered	Patient Satisfaction	**From NRC Picker:** "Overall, how would you rate the care and services you received at the hospital?"	88.75	93%	Sustain and improve upon current excellent performance	2	1) Tracking and Communication of Quarterly Departmental Results	Quarterly results reported to QUM, Quality committee of the Board, Patient Care areas..	Establish departmental targets for achievement.	Continued improving trend with professional development, unit specific goals and performance targets.
		From NRC Picker / HCAPHS: "Would you recommend this hospital to your friends and family?"	75.91	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 2011-12. Continued trend with professional development, unit specific goals and performance targets.
	Patient Experience	**Patient Complaints**: Percentage of patient complaints initial respond within 2 business days of reciept of complaint.	87.70%	85 % Initial response to complaints within 2 business days.		1	Reporting and Tracking of Complaints response times.	Documentation of current expectations to respond to patient complaints within 2 business days.	85%	Early response to patient concerns and complaints can greater restore patient and family confidence in the care and attention they receive. Electronic complaints system has enhanced complaints reporting, still requires manual manipulation to collect appropriate followup field.
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 2012/13, DAD, CIHI	15.61	19	Performance over quarters annually quite variable. Broader reporting period results in need to establish higher targer, yet to be negotiated through HSAA agreement.	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.	