PART B: Improvement Targets and Initiatives 2013-14

Four Counties Health Services

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	0 cases- rate 0.00	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 stewardhip 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
	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.
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**	0.06	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. The assumptions we make are at risk without timely input from the Ministry of Health and Long Term Care.
Access	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.	100.0%	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 achievement.		Quarterly report to QUM, Corporate Dashboard

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	Diabetes Education Centre (DEC)	**Average Wait Time Days for DEC patients for initial appointment.**	8.87	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: ED** "Overall, how would you rate the care and services you received at the hospital?"	89.32	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: ED "Would you recommend this hospital to your friends and family?"	68.34	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.	93.00%	85 % Initial response to complaints within 2 business days.	85%	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. Q3 2011-12-Q2 2012-13;, DAD, CIHI	32.43	39.5	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 greater regular accessibility to collaborate 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.	