

PART B: Improvement Targets and Initiatives

Please do not edit or modify provided text in Columns A, B & C

28-Mar-11

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	0	3	maintain current performance by ensuring following best practices as per PIDAC recommendations, tracking compliance with hand hygiene through audits and providing ongoing education to staff related to prevention	HAI control chart in place for 4 years. Continue with current process	Maintain current baseline of "0"	have had only 1 case of Cdiff diagnosed since 2009. There was no cross infection associated with this case	because of our small reporting size, one case would put us over the threshold. (Executive compensation)	
						2)					
						... N)					
		Reduce incidence of Ventilator Associated Pneumonia (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			1)				
							2)				
							... N)				
	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	66.36	76%	1	We will continue with our efforts to educate, evaluate, monitor and report compliance with hand hygiene. We publish our audits publicly, in our internal newsletter, and on our quality improvement boards on each care unit.	monthly audits and reporting of data to staff on a quarterly basis	To improve our rate of compliance in performing hand hygiene before initial contact by 15% to a compliance of 76%	Staff rate of compliance improved by 52% from 2008/09 to 2009/10 through education and investment in point of care hand hygiene products. We will build on that success to continually improve our rate of compliance	Executive compensation	
						... N)					
	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			1)					
						2)					
						... N)					
	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	0	see below	3	1)				there are only 10 complex continuing care beds in our organization. Our beds are part of one unit that has 10 complex continuing care beds, 10 eldcap beds, and 22 nursing home beds. We monitor pressure sores for the entire 42 beds as a program and do not break our data down between these small sections. We use the information in the LTC OHQC reporting to set our benchmarks.	
						2)					
						... 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	0	see below		1)				there are only 10 complex continuing care beds in our organization. Our beds are part of one unit that has 10complex continuing care beds, 10 eldcap beds, and 22 nursing home beds. We monitor our falls for the entire 42 beds as a program and do not break our data down between small sections. We use the information in the LTC OHQC reporting to set our benchmarks.	
						2)					
						... N)					

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	Space for additional indicators	Falls: Percent of complex continuing care, eldcap, and LTC residents who have had a fall in the last 30 days	13.40%	11.40%	2	Continue to use our tools to identify residents who are at risk for falling. We want to use our tools effectively to try to reduce the number of falls that a high risk resident has recognizing that in order to balance quality of life with risk, that the goal of the program for a high risk resident might be to prevent serious injury as a result of a fall.	falls prevention and management is in place for all residents. Falls risk assessment using the MORSE scale is done on admission and when a resident's condition changes or the resident has a fall. Residents who frequently fall have an interdisciplinary in-depth assessment to see if there are any factors that could be causing frequent falling e.g. medications, delirium. Audit tools in place for completion of falls assessment as part of the admission audits, Care plan audits include updated information related to falls	GOAL: The percent of residents who sustain a fall will be reduced by 15% from 13.4% to 11.4% by March 2012.	RNAO best practice guideline has been implemented. OHQC provincial reporting has been used to set our performance goals.	executive compensation
		Pressure Ulcers: Percent of complex continuing care, eldcap, and LTC residents with a new pressure ulcer (stage 2 or higher) in last month.(09/10)	1.60%	1.60%	3	Maintain our current performance through continuing with our use of best practice guidelines, yearly educational updates for staff, develop restorative care goals for all non-ambulatory residents	audit care plans to ensure that 100% of all non-ambulatory residents have a restorative care goal related to immobility	To maintain our current mean of 1.6% +1SD or less of residents developing a stage 2 or greater pressure sore.	There is an active wound and skin committee in place. There has been a financial investment in developing nursing champions to drive best practice which has resulted in improved outcomes.	executive compensation
Effectiveness	Reduce unnecessary deaths in hospitals	HSMR: number of observed deaths/number of expected deaths x 100 - FY 2009/10, CIHI	N/A			1) 2) ... N)				
	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	15.19%	13.83%	1	through an interdisciplinary approach to care, an enhanced discharge management team and process, through improved patient education on self care of chronic disease, and post discharge follow-up, the patient care experience will be improved. Patients will be better prepared for discharge. The outcome will be a reduction in the readmission rate.	% of discharged patients who state that they understood their discharge instructions. % of patients who stated they understood their medication administrations instructions. Create patient education materials for atrial fibrillation, COPD, asthma. Include case managers from community agencies in discharge planning. Redesign the discharge form to include a medication list that is also the discharge medication prescription with a copy to the patient, the family physician, the community pharmacist, the patient's chart for future reference, and to the Nurse Manager who does the discharge telephone call follow-up	GOAL: reduce the rate of readmission for specific CMGs by 15% to a readmission rate of 12.78% by end of March 2013.	The acute care interdisciplinary team has included the community health care partners in the weekly patient care rounds for the 12 months. The team has received education on best practices such as home first philosophy, restorative care, and importance of medication reconciliation not only at the time of admission but also at the time of discharge. The LHIN-13 goal for hub hospitals is 14.4%.	

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						2)		PROCESS MEASURES:90% of patients surveyed through discharge telephone feedback will indicate they understood their discharge instructions. 90% of patients surveyed through discharge telephone feedback will indicate they understood their medication instructions		executive compensation
						... N)				
	Reduce unnecessary 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				1) improve the tracking of ALC days on acute care to establish an accurate baseline. Ensure that the ALC form is completed and updated prior to sending the patient chart for coding.	Health Information will include the ALC form as part of their "deficient information" review. Incomplete forms will be sent back to Acute Care for completion prior to coding. The weekly LHIN ALC weekly tracking will be used to compare to the data captured by quarter in the DAD, CIHI	Establish an accurate baseline of ALC days by March 2012	We have not been tracking ALC days accurately.	ALC days have been under reported for several years. A preliminary review of the major cause of ALC days on our acute care unit is for patients who are awaiting placement in a LTC bed. Over the past 8 months we have been using a "Home First" philosophy. We have been able to get some patients home to wait for a LTC bed. However, there are cases where the community supports are not enough and the person does not do well at home and needs institutional support. All failed discharges are reviewed by the interdisciplinary team rounds weekly.
						2)				
						... N)				
	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	3.39%	0%		3) provide managers with further education on how to read and analyze the functional centre reports that have changed since Meditech financial systems were implemented. Provide the departmental managers with on line reporting. Require departmental managers to provide monthly variance reports to their Senior Managers on cost overruns or 10% or more. Variance reports to include recovery plan where feasible. Implement an attendance management program that will allow the managers to have tools to assist them in managing attendance issues to reduce the amount of paid sick time to full time employees.	monthly financial reports to the departmental Managers	Total margin will be 0%	The LHIN target is 0%. We anticipate that our total margin from Q3 will drop to 1% due to wage pressures and amortization of the new information system that has not been realized but will be by the end of this fiscal year.	executive compensation (Note: For the purposes of BRDHC, total corporate (consolidated) revenues and expenses applies strictly to Fund Type 1 only.)
	<i>Space for additional indicators</i>	Percent of paid hours for sick time for full time employees of the corporation (acute, LTC, other votes)	4.10%	3.90%		2) Develop an attendance management program that recognizes good attendance and addresses issues of employees with excessive lost time for short term absences (i.e. exclude long term absences related to surgical leaves etc.)	monthly tracking report of sick time, quarterly reviews of lost time by senior managers and discussion at the management meeting quarterly about performance with action plans developed	Reduce the % of paid sick hours from current baseline of 4.10% by 5% to 3.90% by March 2012	The paid sick time includes sick time for short term type illnesses (e.g. colds) as well as long term absences (e.g. surgical leaves). Because of our aging workforce we have had several leaves per year for age related causes. Many of these employees have had exemplary attendance records in the past. We do offer return to work programs for employees who are able to do modified work.	executive compensation

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		Percent of accreditation standards met	80%	85.00%	2	Focus work on compliance with Required Operational Practice and high priority standards. Engage front-line staff to sit on teams and become champions of the implementation of new processes and procedures to support improved quality of care	self assessment completion, evidence of required implementation of standards is evident through new policy and procedure written material and through audits where applicable e.g. Hand hygiene, completion of medication reconciliations, infection control monitoring and reporting	the number of met standards will increase by 5% over past survey of 2008 to 85% compliance to met standards in June 2011 after on site survey completion	The care teams have been working on compliance with accreditation standards since the 2008 survey. More front-line staff have been engaged in the process and have a better understanding about the requirements, the changes that need to be made in practice, and what the surveyors are looking for.	executive compensation
Access	Reduce wait times in the ED	ER Wait times: 90th Percentile ER length of stay for <u>Admitted</u> patients. Q3 2010/11, NACRS, CIHI	2.83 see below	2.55	3			see below	Because we have a very short length of stay for all of our emergency room patients, our admitted patients are included with our complex patients in our current method of data collection and analysis of wait times.	
		ER Wait times: 90th percentile ER Length of Stay for Complex conditions. Q3 2010/11, NACRS, CIHI	2.83	2.55	3	maintain our baseline mean of 2.55		maintain our baseline of 2.55 hours + 1 SD which is below the target of 8 hours. This includes our admitted patients as well as we track this in one report		executive compensation
	Space for additional indicators									
Patient-centred	Improve patient satisfaction	Please choose the question that is relevant to your hospital: NRC Picker / HCAPHS: "Would you recommend this hospital to your friends and family?" (add together percent of those who responded "Definitely Yes") In-house survey (if available): provide the percent response to a summary question such as the "Willingness of patients to recommend the hospital to friends or family" (Please list the question and the range of possible responses when you return the QIP)	do not track data for this indicator	no baseline	1		will add this question to the next annual survey.			
										we are a small hospital with approximately 450 separations/year from our acute care unit which is only 16 beds. We have not been able to get a return rate of 100 surveys over the past two mailings (2008 & 2010). Our return rate is approximately 28%. We have had to send out surveys to patients who were discharged 7 months previously. Patient recall is compromised when the survey is sent to someone who had an admission 7 months ago. Our discharge follow up telephone calls provide us with much more valuable information. We use that format to follow-up on the overall themes for improvement that can be determined from the annual survey results (even though not statistically significant)
	Space for additional indicators	On a scale of 1-10 how would you rate your overall satisfaction with your care. Percent of acute care patients who rated their overall satisfaction on a scale of 1-10 as an 8 or more (2008 survey results)	85%	n/a will not be asking this question as our overall satisfaction with service as not a standard question	1				Because of our low volume of patients we must go back 6 months in order to get a significant sample size. It is difficult to obtain a statistically significant sample size. We would prefer to survey our patients bi-annually and use our feedback from our discharge telephone calls to monitor satisfaction on an ongoing basis.	

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		Did an employee give you a list of the medications you would be taking at home?	82.50%	100%		1 Each patient who is on medications will receive a discharge medication list.	discharge medication list is forwarded to the person doing the discharge telephone follow-up. A copy is in the patient's chart.	100% of patients discharged home will be given a list of their medications.	process changes already in place. Links with readmission indicator	executive compensation
		Did an employee give you written instructions about your follow-up care?	to be established	100%		1 Each patient who is on medications will receive a discharge follow-up form that will advise of follow-up appointments, teaching materials provided, and other individualized instructions e.g. Home care services.	discharge follow-up form is forwarded to the person doing the discharge telephone follow-up. A copy is in the patient's chart.	100% of the patients discharged will receive a discharge follow-up form	process changes already in place. Links with readmission indicator	executive compensation