PART B: Improvement Targets and Initiatives

St. Joseph's Healthcare Hamilton

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

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	0.69	0.39	1	1) Achieve Goal for Reducing CDI Rate per 100 Patient Days.	CDI Rate by March 2012	39%	The target aligns with the indicator goal.	
						2) Implement Infection Control Resource Team (ICRT) Report findings.	% Completed	100%	The ICRT is an independent external review team, invited conducted an in-depth review of infection control	
						3) Antibiotic Stewardship Process.	% Compliance by March 2012	>70%	Based on best practices from organizations and jurisdictions with successful programs and the ICRT Review (above).	
						4) Unit Decontamination Protocols.	% Implementation	100%		
						5) Trigger Tool to launch pre-outbreak interventions.	% Implementation	100%		
	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	1.95	≤ 2.5	3					
	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	63%	90%	1	1) Hand hygiene compliance before patient contact.	% Compliance	85%	Significant progress toward indicator goal.	
						2) Implement Standard Education for new employees, physicians and learners.	% Implemented	85%	Based on best practices from organizations and jurisdictions with successful programs.	
						3) Implement PDSA cycle planning for lowest performing unit each month.	% Implemented by March 2012	100%		
						4) Monthly reporting of audit -publicly displayed in clinical units.	% Implemented by March 2012	90%		
	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	1.15	≤ 2.8	3					
	Maintain rate of MRSA infections within target.	**Rate of MRSA bacteremia (BSI) infections per 1000 patient days:** total number of newly diagnosed cases divided by the number of patient days in that reporting period, multiplied by 1,000 - Average for Jan-Dec. 2010. The performance goal is internal - equivalent to approximately one case per quarter	0.02	≤ 0.05	3					
	Maintain rate of VRE infections within target	**Rate of VRE bacteremia (BSI) infections per 1000 patient days:** total number of newly diagnosed cases divided by the number of patient days in that reporting period, multiplied by 1,000 - Average for Jan-Dec. 2010. The performance goal is internal - equivalent to approximately one case per quarter	0.00	≤ 0.05	3					
	Reduce mental health Seclusions	**Seclusions:** Annual number of mental health inpatients who are placed in a secure secluded environment in response to a crisis during their care. Number for 2009/10	614	200	1	1) Reduce the annual number of seclusions.	Annual Number	200	The target is the same as the indicator goal.	
						2) Mandatory education for staff and physicians.	% implemented	95%	Based on literature review of best practice and emotional trauma-informed care.	
						3) Introduce standardized assessment tool.	% Completed	100%		
						4) Implement comprehensive debrief after seclusion events.	% Implemented	95%		
	Increase Standardization in surgery	**Increase standardization in surgery:** Building on the success of the surgical checklist in the Perioperative Program, new surgical checklists will be introduced for the Minor Procedures Program and Endoscopy. Indicator represents % project completion	N/A	100%	1	1) Develop Checklist Tool(s).	% completed	100%	Based on review of best practices and incidents.	
						2) Implement Checklist(s).	% Implemented	100%		
						3) Introduce Compliance Monitoring and Set Targets.	% Completed	100%		
	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	Not Selected							
	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	Not Selected							
Effectiveness	Reduce unnecessary deaths in hospitals	**HSMR:** number of observed deaths/number of expected deaths x 100 - FY 2009/10, CIHI	80	≤80	3					

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	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	17.50%	15.00%	2					
	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	19.40%	11.00%	1	1) ALC Designation Review.	% Completed	100%	Based on Auditor General's Report for Hospitals	
	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	0.66%	0.00%	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	23.8 hrs	≤23.8 hrs						
		ER Wait times: 90th percentile ER Length of Stay for Complex conditions. Q3 2010/11, NACRS, CIHI	15.7 hrs	≤15.7 hrs	2					
Patient-centered	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)	Q3 Fy 09/10 76.5%	80.0%	2					
	Improve patient satisfaction in ambulatory care	**Ambulatory Care Patient Satisfaction:** Implement a patient satisfaction survey for designated ambulatory care clinics. Ambulatory care patients are the largest patient group not reached by existing surveys. The goal for positive overall satisfaction is 85%	N/A	85%	1	1) Develop new survey to reach ambulatory patients in designated clinics.	% Implemented	100%	Without a new survey this patient group are not represented. The survey design and process, will be based on research evidence.	
						2) Identify main drivers of satisfaction to support process improvement.	% Completed	100%		
						3) Achieve Patient Satisfaction Indicator Goal.	% Satisfaction	85%	The target is the same as the indicator goal.	
	Increase the "Patient Voice"	**Patient Voice:** The number of projects involving in patients that have an impact on decision making	N/A	20	1	1) The number of projects involving in patients that have an impact on decision making.	Number of Projects Achieved by March 2012	20	The target is the same as the indicator goal.	
						2) Appoint one patient to each Quality Council for major clinical programs.	% Completed	75%	The target represents a significant patient involvement in our quality improvement structures and processes.	
						3) Annual joint session of the Quality and Mission Committee, and the Patient Advisory Council.	% Completed	100%	This target brings together community, hospital and patient representatives.	