Improvement Targets and Initiatives

St. Joseph's Healthcare Hamilton

St. Joseph's Healthcare Hamilton | 50 Charlton Ave. E., Hamilton, Ontario L8N 4A6

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

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 hospital acquired infection rates	**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	0.44	0.39	SJHH Internal Target	2	1)			
							2)			
							… N)			
		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 - Jan-Dec. 2012, consistent with publicly reportable patient safety data	89%	92%	HQO Benchmark for Best Performers	1	1) Use 10 'beacon' units to achieve very high performance. Beacon units will then partner with low performing units.	The process measure will be Hand Hygiene Compliance in 10 designated beacon units using current auditing processes.	95% hand hygiene compliance in beacon units	As per IHI model for high performance.
		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	1.50	0	HQO Benchmark for Best Performers	2	1)			
							2)			
							… N)			
		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	1.44	0	HQO Benchmark for Best Performers	2	1)			
							2)			
							… N)			
	Reduce incidence of new pressure ulcers	**Pressure Ulcers**: Percent of complex continuing care residents with new pressure ulcer in the last three months (stage 2 or higher) - Q2, FY 2012/13, CCRS	1.80%	TBD*	Target Under Review*	2	1)			
							2)			
							… N)			
	Avoid patient falls	**Falls**: Percent of complex continuing care residents who fell in the last 30 days - Q2, FY 2012/13, CCRS	0.80%	TBD*	Target Under Review*	2	1)			
							2)			
							… N)			
	Reduce use of physical restraints	**Physical Restraints:** The number of patients who are physically restrained at least once in the 3 days prior to a full admission divided by all cases with a full admission assessment - Q4 FY 2010/11 - Q3 FY 2011/12, OMHRS	Acute = 0.014 Tert'y=0.042 (Q3 Data is not available)	Acute=0.013 Tert'y=0.038	SJHH Internal Target	3	1)			
							2)			
							… N)			
	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 NEW	5.34 CHRP	4.8	SJHH Internal Target of 10% Improvement	2	1)			
							2)			
							… N)			
		Surgical Safety Checklist: number of times all three phases of the surgical safety checklist was performed ('briefing', 'time out' and 'debriefing') divided by the total number of surgeries performed, multiplied by 100 - Jan-Dec. 2012, consistent with publicly reportable patient safety data	99%	100%	HQO Theoretical Best	2	1)			
							2)			
							… N)			
	Increase proportion of patients receiving medication reconciliation upon admission	**Medication reconciliation at admission:** The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital - Hospital-collected data, most recent quarter available (e.g., Q2 2012/13, Q3 2012/13) NEW PC	n/a				1)			
							2)			
							… N)			
	Improve the recognition and treatment of Sepsis	**Treatment of Sepsis:** The percentage of 2L/IV Fluids administered within an hour of the recognition of SIRS. As determined by Chart Review.The percentage of IV Antiobiotics commenced within an hour of the recognition of SIRS. In the Emergency Department. As determined by Chart Review.	n/a	100%	SJHH Target - Theoretical Maximum Compliance	1	1) Implement SJHH Sepsis Protocol in the Emergency Department	We will implement a Sepsis Protocol developed using research evdence of best practice and measure a range of processes to ensure compliance with the protocol.	75% IV Fluid administered & 75% IV Antibiotic started < 1hr	

AIM		MEASURE					CHANGE			
	Reduce seclusions in mental health	**Seclusions:** Annual number of mental health inpatients who are placed in a secure secluded environment in response to a crisis during their care. Average numbr of reported incidents per quarter 2012	149	134	SJHH Internal Target of 10% Improvement	1	1) We will increase staff accountability for each seclusion.	We will implement pilots that use debriefing sessions following individual seclusions. We will measure number of seclusions and the time spent in seclusion.	A 10% reduction in seclusions (see target) and a 10% reduction in time spent in seclusion from 3971 to 3574 hrs.	This builds on the 25% reduction since 2011
Effectiveness	Reduce unnecessary deaths in hospitals	**HSMR:** number of observed deaths/number of expected deaths x 100 - FY 2011/12, as of December 2012, CIHI	93	84	SJHH Internal Target of 10% Improvement	3	1)			
							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 2012/13, OHRS	0.12%	0	HQO Theoretical Best	2	1)			
							2)			
							… N)			
	Space for additional indicators									
Access	Reduce wait times in the ED	**ER Wait times:** 90th Percentile ER length of stay for Admitted patients. Q4 2011/12 – Q3 2012/13, iPort	28.0	25.0	LHIN Target	2	1)			
							2)			
							… N)			
	Space for additional indicators									
Patient-centred	Improve patient satisfaction	*Please choose the question that is relevant to your hospital:*								
		From NRC Picker / HCAPHS: "Would you recommend this hospital to your friends and family?" (add together percent of those who responded "Definitely Yes" or "Yes, definitely")					1)			
		From NRC Picker: "Overall, how would you rate the care and services you received at the hospital?" (add together percent of those who responded "Excellent, Very Good and Good")					2)			
		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). Question: "I would recommend this clinic to my family and friends" with a 5 point scale of *Strongly Agree* to *Strongly Disagree* .	93%	95%	SJHH Internal Target	2	… N)			
	4. Develop Team-based action plans to improve quality and patient care by boosting staff/physician engagement	**Percentage Staff/Physician Engagement Plans:** The Percentage Staff/Physician Engagement Plans Prepared and Submitted by Major Programs and Services	0	95%	SJHH Internal Target of Full Compliance Adjusted for Turnover	1	1) Engagement plans to boost engagement in quality and patient safety.	We will put in place engagement plans to boost engagement in quality and patient safety. Leaders of major clinical programs and services will submit plans by the end of Q2 2012-13.	Plan submitted 95%	This builds on our Staff /Physician Engagement Survey Dec 2012
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	16.35%	11%	LHIN Target	2	1)			
							2)			
							… N)			
	Reduce unnecessary hospital readmission	**Readmission within 30 days for selected CMGs to any facility:** The number of patients with select CMGs readmitted to any facility for non-elective inpatient care within 30 days of discharge, compared to the number of expected non-elective readmissions - Q2 2011/12 – Q1 2012/13, DAD, CIHI	18.60% Awaiting Q1 Data	16.74%	SJHH Internal Target of 10% Improvement	2	1)			
							2)			
							… N)			
	Space for additional indicators									

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