

# PART B: Improvement Targets and Initiatives

[Insert Hospital Logo]

St. Joseph's General Hospital Elliot Lake

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
Patient Safety	Maintain 0% Ventilator Associated Pneumonia (VAP) rate	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	0%	0%	3	As a Level 2 facility we have no long term Vented patients and this will continue	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	maintain 0%	best practice initiative that has a patient safety implication	current rate =0% and the objective is to maintain 0%
	Improve employee hand hygiene compliance above the 57% rate	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	57%	65%	1	staff education related to the importance of hand hygiene and patient contact  installation of 300 Purel hand hygiene applicators and education of staff, visitors, physicians  advertise success to all staff	audit of compliance	our objective is to increase the compliance to 65% in the first year	This is a best practice initiative that has implications for patient safety	It is our objective to increase the compliance each year
	Maintain 0% central line blood stream infections (CLU) rate	Rate of central line blood stream infections per 1,000 central line days: total number of newly diagnosed CLU 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	0%	0%	3	employees follow established policies and procedures on dressing changes  low volume	same as outcome measurement indicator	maintain 0%	best practice initiative that has a patient safety implication	current rate =0% and the objective is to maintain 0%
	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%	0%	3	maintain 0% rate	same as outcome measurement indicator	maintain 0%	best practice initiative that has a patient safety implication	
	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	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	Reduce falls in Hospital per 1000 patient days to 3.9	Reduction in the number of patient falls reported by incident based on number of falls per 1,000 patient days using data from 2009-10 as the base	4.5	3.9	1	1) a timed up and go program is in place  2) establish a walking program 3) Staff education on falls prevention  4) patient education brochure on falls prevention	an analysis of patient incident falls	our objective is to reduce the number of patient falls to 3.9 based on the number of falls per 1,000 patient days	by reducing the number of falls from 4.5 to 3.9 per 1,000 patient days, this will dramatically improve patient safety	our objective is to improve compliance each year

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
Effectiveness	Maintain low Hospital Standard Mortality Ratio (HSMR), subject to limitations of statistical anomalies caused by small sample size	HSMR: number of observed deaths/number of expected deaths x 100 - FY 2009/10, CIHI	87	100	3	SIGH EL case are below the 2,500 threshold; therefore, HSRM results are statistically unreliable and are not publically reported because of the distortions caused by a few deaths one way or the other.	CIHI quarterly data.	We strive to achieve normal results over time over a number of years for reasons already stated.	Our 2010/11 Q2 results of 87 are lower than previous period results and below the expected norm. However, due to the our small sample size fluctuation above and below expected are common and inconclusive.	<2500 cases - too small to provide statistical value.
	Reduce unnecessary hospital readmission, awaiting information from CIHI	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	12.60%	14.4	2	Collaborative with local Family Health Team to articulate Congestive Heart Failure and COPD Roadmaps, patient education, best practices and referral processes for patients being discharged from hospital. The Oaks Withdrawl Management will facilitate personal	CIHI report	14.40%	This is the NELHIN target	Readmission for repeat unscheduled and unplanned emergency visits within 30 days for mental health conditions should realistically be an
	Reduce non Long Term Care Home Alternate Level of Care type ALC days in acute care beds	Percentage ALC days: Total number of inpatient days designated as ALC, divided by the total number of inpatient days. Q2 2010/11, DAD, CIHI	34.60%	34.60%	3	continue to work with the NELHIN to improve the CCAC home care service	through CIHI data	reduce the non-LTCH ALC patient days to less than 17% of acute patient days	17% is unrealistic due to the lack of long term care beds and community based home care services in our area. ALC's have no impact on patient admissions or Emergency Department Length of Stay	no control over LTC beds or homecare capacity
	Achieve 2011/12 budgeted Total Margin ratio	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%	-2.41%	3	secure equitable funding from the NELHIN	by financial statements	equal or better budgeted	very low per weighted case funding	funding inequity not being addressed by HBAM/PbP formula
	Reduce number of errors in Patient Identification	Patient Identification process: percent by which patient identification is completed using 2 unique identifiers to ensure proper identification occurs	70%	75%	1	At any time a patient is to undergo a treatment - surgical, laboratory, radiology, physiotherapy - 2 identifiers are to be used - patient name and patient birthrate - to ensure the procedure is going to be done on the right patient	through an audit process of all patients receiving a procedure, we can determine our success rate	as stated, our objective is to achieve 75% compliance in the first year	patient identification is a patient safety issue that the Hospital will work diligently on to improve	our objective is to improve compliance each year
	Reduce the error factor in the Surgical Checklist process(SCL)	All patients having surgical procedures are identified as to right patient, right procedure, right site and pre-operative antibiotics administered to the appropriate patient	91%	95%	1	In order to ensure the right patient is getting the surgical procedure they require, it is important to identify the patient, identify the procedure with the patient, ensure the surgical procedure is being done on the right site and ensure re-operative antibiotics are administered to the appropriate patient. Education of all staff associated with the surgical process will be done	through an audit process of all surgical patients, we can determine our success rate	as stated, our objective is to achieve 95% compliance	the surgical checklist process is a patient safety initiative to improve patient safety	we just started this process in July 2010
	Improve Incontinent Control of Long Term Care Home residents	reduce the percentage of residents with worsening bladder control based on last 7 days	25.80%	23.0%	1	1) Ensure all residents have up to date assessments and screening done 2) Provide appropriate continence products 3) assess environmental barriers such as distance to the bathroom and lighting 4) review risk scale of past falls, restraints and proper footwear 5) develop a plan to motivate the resident and engage the family's involvement in the program 6) review policies and procedures to ensure they reflect evidence based best practice	RAI-MDS Reporting reports from CIHI	to reduce the worsening of incontinence to 23% of our 64 residents	SJM has identified special challenges that we will address, which is that home has a higher than average percentage of residents with advanced cognitive impairment. These residents are less compliant with the caregiver and more frequently incontinent.	

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
	Reduce repeat Emergency Department addictions visits within 30 days to 19% or less	Target is to reduce the number of repeat emergency department visits for addiction patients within 30 days	19.10%	19.00%		1 formalized education program is being conducted to increase knowledge and reduce readmissions by meeting with Emergency department staff, hospital nursing staff, clerical staff, Family Health Team members local addiction/mental health service providers to increase the probability of referrals to the Oaks Treatment Centre  2) patients visiting the Emergency Department with substance abuse concerns will receive an offer to meet with a clinician from the Oaks in order to meet their needs	NACRS data	reduce repeat Emergency addictions visits within 30 days to 19% or less	NELHIN target and proactive initiative to get addictions patients into treatment	encourage healthy lifestyle to reduce demand on our healthcare system
Access	Admit inpatients admitted through the Emergency Department at or better than the rate of the top 10% of Ontario hospitals	ER Wait times: 90th Percentile ER length of stay for <u>Admitted</u> patients. Q3 2010/11, NACRS, CIHI  ER Wait times: 90th percentile ER Length of Stay for Complex conditions. Q3 2010/11, NACRS, CIHI	TBD - information is not currently available	TBD	TBD	match Provincial average improvement	CIHI data	TBD	address patient needs in proper setting	current results are good
			n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Patient-centred	Complete patient satisfaction survey by September 30, 2011	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): the percentage of patients that responded to the following statement that agree or strongly agree with "I would speak positively of SJGHEL to my family and friends"	Survey is a work in progress	75%		2 patient survey to be conducted in 2011-2012	tabulate results of survey	75%	Reasonable target for first survey	first patient satisfaction survey not yet complete