STEVENSON MEMORIAL HOSPITAL

Lower is Better

Higher is Better

AIM		MEASURE						CHANGE		
Quality dimension	Objective	Quality Department Indicator Recommendations	Current performance	12/13 Target	Target for 2013/14	Target justification	Priority level	Planned improvement initiatives (Change Ideas)	Methods and process measures	Goal for change ideas (2013/2014)
Safety	Reduce hospital acquired infection rates	**Clostridium Difficile 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	0.0	0.0	0.0	Will continue to monitor to sustain this performance	3	1)Given our success in the last fiscal year, continue to monthly monitor compliance on Hand Hygiene	Comply with improvement initiatives for Hand Hygiene (See Hand Hygiene improvement initiatives). Follow process for hand hygiene compliance targets and measures.	Improve hand hygiene to 100%
								2) Continue to monitor utilization of antimicrobial therapy	Involve Pharmacy in analysis of antimicrobial usage. Antimicrobial audits completed on every patient and utilize best practice compliance.	100% antimicrobial use audited by Pharmacy
								3) Continue to monitor utilization and compliance with isolation precautions	Infection Prevention and Control will perform monthly audits for isolation precautions and compliance. Documentation of all audits will be recorded and Infection control will provide this information in her updates to Quality Patient Safety Committee (QPSC) as scheduled.	100% compliance for isolation precautions
	Improve provider hand hygiene compliance	The number of times that hand hygiene was performed before patient contact divided by the number of observed hand hygiene indications multiplied by 100. **Current Performance = Fiscal year 11/12 Stevenson Memorial.** **Moment 1 (before patient contact) = 90%** **Moment 4 (after patient contact) = 87%** **Blended percent compliance = 88%**	88.9%	100% Blended	100% on Moment 4	Theoretical best is 100% and represents our stretch goal hospital-wide	2	1) Conduct monthly audits on units involving all members of healthcare team.	Monthly audits measure "before" & "after" patient contact . These will be completed by IPAC and leaders Monthly reports are generated and posted for all staff, physicians and volunteers to elevate awareness on the hospital barometer	Monthly target 100% (annual target 100%)
								2) Focused and regular staff rounding, unit specific data reporting , internal coaching, education, and accountability systems to monitor improvement efforts.	Computer monitors are linked to display compliance monthly organizational and individual unit audit compliance rate. Unit specific results will be posted on all units performance boards.	Weekly safety walks and engagement with staff on inpatient units will address hand hygiene compliance.
	Reduce Inpatient Falls with Outcomes	Rate of Falls with Outcomes per 1000 inpatient days: Total number of falls with a severity rating of moderate, severe or critical divided by the number of inpatient days multiplied by 1000. Data Source: Internal Safepoint Incident Reporting System. Current Performance = FY12/13	1.50	0.66	1.35	This represents a 10% improvement	2	1) Inpatient Roundings	All inpatient units conduct regular hourly patient rounds. Conduct monthly audits and communicate results to the leadership team, staff and post on the quality boards	80% compliance
								2) Audit patient charts for fall risk assessments	Conduct audit patient charts for fall risk assessments	100% compliance
								3) Staff education on fall preventation initiatives (eg: sufficient light, possession, pain, potty, and position, etc)	Education and train staff on fall preventation strategies/initiatives. Track and report attendance and adoption of fall initiatives to department managers/administration	100% attendance
	Improve medication reconciliation compliance for Discharged Patients	**Percent of Adult Patients discharged on the Med-Surg receiving medication reconciliation** on discharge . **Current Performance = TBD**	TBD	New Improvement strategy	80%		2	1) Complete audit on current level of practice. 2) Pharmacy team to work with inpatient team to identify patients within 24 hours of discharge so that health teaching and medication reconciliation can be completed by pharmacy team measure	1) Complete Lean Improvement Workshop to identify current state of medication reconcilation. 2) Then develop future state of medication reconciliation practice 3) Will use multiple cycles of PDSA to develop best practice for medication reconciliation	80% of patients will have medication reconciliation on discharge by the pharmacy team
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.	0.07%	0	0	Given the uncertainty about our funding levels, this needs to continue to be a priority	1	1)Increase the # of DI bookings to increase SMH revenue 2) Implement best practices for all QBP patient populations 3)Participate in Health Links with Alliston Family Team, CCAC and Long term care to improve the coordination of care and reduce both ED visits and repeated admissions for the High User Group of patients	1)Complete patient calls to understand the barriers for High User Groups 2)Use the IHI PDSA Change Methodology and Lean Improvement Methodology to implement best practices	

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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 April - Nov. 2012	19.7	18.9	18.9	sustain	3	1) Hospital related ALC have remained high at SMH we will work with central LHIN and CCAC to develop a collaborative appoarch to decrease community related ALC in acute care.	1) Develop Integrated care Team with partner organizations 2)Continue to promote " Home First " approach with all complex patients	Stretch goal is to reduce ALC rate to LHIN target of 14%
								2) Ensure patient and family are included in the plan of care and with discharge planning from the day of admission	Staff will update whiteboards on a daily basis to reflect plan of care and discharge plan developed in collaboration with Physicians. Random audits will be performed Improve rates by 5% for discharges at 1100 and 1400. Current rates are 20% discharges at 1100 and 50% discharges at 1400	100% compliance with whiteboard utilization 80% of patients will be discharged by 1400 50% of patient will be discharged by 1100.
		ER Wait times: 90th percentile ER Length of stay for complex conditions April- Nov. 2012	6.1	6	6		3	Sustainability-	Daily monitoring of performance using the DART Daily review with the team during Quality Huddles to identify what worked well and what needs to change Monthly monitorin of the ERNI data	Achieve target
		ER Wait times: 90th percentile ER Length of Stay for non-complex conditions April - Nov. 2012	3.7	4	3.7		3	Sustainability-	Daily monitoring of performance using the DART Daily review with the team during Quality Huddles to identify what worked well and what needs to change Monthly monitorin of the ERNI data	Achieve target
		ER Wait times: 90th percentile Physician Initial Assement for all ED patients April- Nov. 2012	3.3	2.5	2.5		2	Increase of MD coverage in the ED	Lean Improvement project to eliminate any non-value added process steps that delay the Physician Initial Assessment time	Achieve target
Patient-centred	Improve patient satisfaction	**Percent positive score:** "Overall, how would you rate the care you received in the Hospital? (question from NRC Picker) **Current Performance = April 2012- Oct 2012.**	92%	95.5%	92%	Last years stretch target was unrealistic. We need to monitor and maintain current performance	3	1) While patient in our care, focus on Emotional Support dimension; Managing Patient anxieties, fears and concerns will have the greatest impact.	Utilize standardized questions in nursing, support staff & doctor interaction to reduce patient anxieties/ fears	Achieve target
								2) Post-discharge call for patients who have been sent home	Conduct post discharge calls to patients who were discharged home; regular trend reports sent to ED Manager	80% of patients called
Integration	Reduce the Readmissions of Specific Patient Populations	**Readmission rate within 30 days for Chronic Obstructive Pulmonary Disease (COPD) to Stevenson only:** The number of patients with COPD re-admitted to sMH for non-elective inpatient care within 30 days of discharge for a similar condition. **Current Performance = 11/12 Q3 - 12/13 Q2.**	14.1%	New Improvement strategy	12.7%	This represents a 10% improvement	1	1) Implement MOHLTC Best practices for CHF patients when available using Lean Quality Improvement approach	1) Complete Value Stream Map with Interprofessional team to understand current care practices 2) Complete Future state Value Stream Map once Best Practices are available to understand the gap between our current state and future state 3) Prioritize and Implement Opportunities identified by the Interprofessional Team	
		Readmission rate within 30 days for Congestive Heart Patients (CHF) Disease o Stevenson only: The number of patients with CHF re-admitted to sMH for non-elective inpatient care within 30 days of discharge for a similar condition. **Current Performance = 11/12 Q3 - 12/13 Q2.**	26.8%	New Improvement strategy	24.1%	This represents a 10% improvement	1	1) Implement MOHLTC Best practices for COPD patients when available using Lean Quality Improvement approach	1) Complete Value Stream Map with Interprofessional team to understand current care practices 2) Complete Future state Value Stream Map once Best Practices are available to understand the gap between our current state and future state 3) Prioritize and Implement Opportunities identified by the Interprofessional Team	