PART B: Improvement Targets and Initiatives 2012/13

Markham Stouffville Hospital, 381 Church Street, Markham Ontario L3P 7P3

AIM		MEASURE					CHANGE			
Quality dimension	**Objective**	**Measure/Indicator**	**Current performance**	**Target for 2012/13**	**Target justification**	**Priority level**	**Planned improvement initiatives (Change Ideas)**	**Methods and process measures**	**Goal for change ideas (2012/13)**	**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. 2011, consistent with publicly reportable patient safety data	0.76 Markham site 0.00 Uxbridge site	< 0.60 Markham site	20% reduction which has been achieved in previous years.	1	Implementation of best practice CDI control measures including the development of standard work for cleaning, hand hygiene, isolation and waste management. Enhanced cleaning procedures to include an 'early warning system' when a unit has either 2 or more nosocomial CDI identified in 1 week, or if there are 3 active CDI cases.	Reconfigure control measures into standard work for environmental services and nursing. Develop an audit process to measure compliance with standard work.	80% compliance with standard work. Audits to be completed monthly from June 2012 - February 2013.	
							Continue to focus on antibiotic stewardship through the establishment of guidelines, education, monitoring and enforcement of apprporiate usage for surgical patients, ED patients sent home on antibiotics, patients with community acquired pneumonia and patients with a history of CDI.	Development and approval of guidelines and order sets. PDSA for non admitted ED patients sent home on antibiotics. Educational sessions for surgeons, hospitalists, emergency physicians and the inter-disciplinary team.	Reduce antibiotic usage by 5% in 2012/13 as measured by Defined Daily Dose (DDD). Total Antibiotic DDD baseline for 2011 per/100 pt days = 35.8 . Improve susceptability of Pseudomonas to antibiotics by 2% by March 2013.	
							Continued focus on hand hygiene (see below).			
	Reduce incidence of Ventilator Associated Pnemonia (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. 2011, consistent with publicly reportable patient safety data.	0.52	0	Best Practice which has been achieved in previous years.	2	Monitor compliance with Safer HealthCare Now VAP bundle.			
	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 - Jan-Dec. 2011, consistent with publicly reportable patient safety data. **NOTE that due to new approach (Unit based champions using handy audit software), current performance is based on January - March 2012 results (corporate, both sites.)**	82.7	85%	Recognized best practice.	1	Monthly auditing and feedback using Hand Hygiene Champions.	Monthly audits on all inpatient and ED units using the Handy Audit tool .	Increase results of all Individual unit and profession specific results to be 80% or above.	
							Identification of hospital specific barriers and solutions based upon the Joint Commission Centre for Transforming Healthcare 'Targeted Solutions Tool' .	Using a PDSA approach, will develop and administer a survey/audit tool on all inpatient units to identify specific barriers and solutions.		

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Safety, con't							Continued hospital-wide awareness and education regarding importance and best practice regarding hand hygiene.	Implement and monitor compliance with on line hand hygiene educational training and assessment module.	Establish baseline compliance level and determine action plan to achieve 80% compliance for 2013.	
	Reduce rate of central line blood stream infections (CLI).	**Rate of CLI 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. 2011, consistent with publicly reportable patient safety data.	0.74	0	Best Practice which has been achieved in previous years ,	2	Monitor compliance with Safer HealthCare Now CLI bundle.			
	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) - FY Q3 2011/12, CCRS								
	Avoid patient falls	**Falls**: Percent of complex continuing care residents who fell in the last 30 days - FY Q3 2011/12, CCRS								
	Reduce rates of deaths and complications associated with surgical care	**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. 2011, consistent with publicly reportable patient safety data.	99.45%	Maintain rate.	Current result is leading practice.	3	Monitor compliance with Surgical Checklist completion on a monthly basis.			
	Reduce use of physical restraints	**Physical Restraints:** The number of patients who are physically restrained at least once in the 3 days prior to initial assessment divided by all cases with a full admission assessment - Q4 FY 2009/10 - Q3 FY 2010/11, OMHRS								
	Reduce incidence of pressure ulcers for all inpatients	Percent of inpatients who acquire a new pressure ulcer during their hospital stay. Measured by yearly cross site prevalence & incidence study.	5% November 2011	Maintain at 5%	Current result is leading practice.	2	Monitor compliance with best practices related to wound care.			
	Reduce inpatient falls	Rate of inpatient falls per 1000 patient days	4.6 2011/12 Q3 YTD	4.3	6.5% reduction is a realistic target which will bring us to below community hospital comparators.	1	Monitor compliance with falls risk assessment policy on inpatient units.	% of falls risk assessments complete at 24 hours.	85% of falls risk assessments complete at 24 hours by March 2013.	Policies and processes updated last year to ensure compliance with best practice.
								% of falls risk assessments updated when patient change in status.	85% of falls risk assessments updated within 2 hours after a patient fall.	
Effectiveness	Reduce unnecessary deaths in hospitals	**HSMR:** number of observed deaths/number of expected deaths x 100 - FY 2010/11, as of December 2011, CIHI	71 (84 using new CIHI methodology effective April 1, 2012)	Maintain with a confidence interval of 63-80 (74-94 in new CIHI methodology)	Maintain current best practices.	1	Continue focus on sepsis best practices.	Compliance with sepsis order set for both emergency and inpatients.	Compliance with order sets 80% or above. Maintain sepsis mortality below 25%.	

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Effectiveness, con't							To reduce urosepsis by implementation of evidence based prevention guidelines for CAUTI including indications for catheritization, assessment, management and removal protocols. Establish baseline metrics for percent of unnecessary urinary catheters, unnecessary urinary catheter days and symptomatic UTI rate.	To create a urinary catheter bundle or order sets that address indications for urinary catheter insertion using set criteria.	To decrease urinary catheter inserted by 20%. 80% of urinary catheters will be removed within 48 hours of insertion.	Policies and processes will be updated to ensure compliance with best practice.
							Reduce preventable deaths from cardiac disease through implementation of an enhanced cardiac care unit (ECCU) as well as a Chest Pain Clinic.	Increase % of patients discharged with specified ACS diagnoses, compliant with best practice guidelines. Monitor number of patients newly diagnosed with CAD in the Chest Pain Clinic.	Establish baseline and target once enhanced cardic care unit is operational. Establish baseline and target once after 6 months experience operating the Chest Pain Clinic.	
	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 2011/12, OHRS	1.47%	Maintain better than H-SAA target of 0%	H-SAA target	2	Maximize revenue from patient focused revenue stream for Hip & Knee replacements (new Ministry of Health funding formula). Continue to focus on reducing costs and improving efficiency through benchmarking and product standardization.			Current performance of 1.47% was achieved with one time revenue adjustments and may not be sustainable.
	Staff Satisfaction	Percent of staff and physicians who state that they are satisfied or very satisfied with their job.	Baseline to be established May 2012	>70%	Target difficult to establish given this is a new tool	1	Undertake the NRC Picker Satisfaction and Engagement Survey in May/June 2012 and establish baseline metrics for staff and physicians. (First time with this tool).	Percentage of staff and physicians complete survey and who state they are overall, satisfied or very satisfied with their current job.	>50% of staff and physicians will complete survey.	

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							Implement a lean quality improvement system to engage front line staff in daily continuous improvement and sustainability. Roll out on 2 inpatient units by July 2012. Expand to remaining clinical and non clinical units by March 31, 2014.	Staff and physicians will agree or strongly agree that the organization Is committed to providing high-quality care, and that they understand the goals of the organization (Measured through NRC Staff Satisfaction tool to be completed in May/June 2012).	>50% of staff and physicians will agree or strongly agree.	
							Continue to invest in training and development for staff including Investing and leverage the Champions model in the areas of skin and wound, pain, falls, hand hygiene, breast feeding, informatics and delirium.	Staff will agree or strongly agree that the training, learning or development they received has helped them to do their job better and improved their chances of job advancement.	>50% of staff will agree or strongly agree.	
Access	Reduce wait times in the ED	**ED Wait times:** 90th Percentile ER length of stay for Admitted patients. Q3 2011/12, NACRS, CIHI	55.2 hours	40.3 hours	H-SAA target	1	Implementation of a mulitidisciplinary admission team in the ED to coordinate the care for patients awaiting transfer to an inpatient bed.	Reduction in ALOS for patients admitted through ED and cared for by the Admission Team.	Decrease the average acute length of stay for patients admitted through ED from 5.9 days (2011/12 YTD Q3) by 10% to 5.3 days	
							Reduce admissions for patients with lower risk cardiac disease by implementation of a post ED Chest Pain clinic with defined referral criteria. Objective is to achieve earlier diagnosis and intervene with medical management, lifestyle modification and self-management.	Patients will be provided with an appointment to Chest Pain Clinic within 72 hours of referral, as opposed to being admitted for investigation.	90% of patients referred from ED will have an appointment provided within 72 hours of referral. Admissions for patients with lower risk chest pain will be reduced by 10%. Baseline of 5% 2011/12 YTD Q3.	

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Patient-centred	Improve patient satisfaction.	**From NRC Picker / HCAPHS:** "Would you recommend this hospital to your friends and family?" (Oct 2010 - Sept 2011).	Yes definitely 72.6%	75%	At or above Community hospital average.	1	Implementation of Purposeful Rounding on inpatient units.	Reduction in call bells as well as improved response rate to NRC Picker satisfaction survey question 'Wait time after call bell reasonable'. Current performance 56.7% average Oct 1, 2010 - Sept 30, 2011.	Increase to 60% the number who feel time to call bell is reasonable. 20% reduction in call bells on inpatient units by February 28, 2013.	
		From NRC Picker: "Overall, how would you rate the care and services you received at the hospital?" (Oct 2010 - Sept 2011).	91.4% positive score for overall quality of care and services.	95%			Implement a real time patient satisfaction survey acute med/surg inpatients to identify in real time factors contributing to 'would you recommend'.	Survey 10 acute med/surg inpatients/week using real time patient satisfaction survey.	Starting April 1, 2012 complete 10 surveys/week and identify and address specific areas for improvement related to discharge and communications.	
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. Q2 2011/12, DAD, CIHI.	14.9 % -Markham Site 45.3% - Uxbridge Site	CLHIN 14% Markham site CELHIN 37.2% Uxbndge site	H-SAA target	2				
	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 2011/12, DAD, CIHI.	11.08%	At or below 11.08%	Maintain below hospital target .	1	Design and implementation of a standardized discharge planning and teaching protocol for inpatients. The approach will include a teach-back approach .	Implementation of standardized discharge teaching on 2 inpatient units.	90% of patients will be able to teach back their discharge instructions.	
							Increase the percentage of ACS patients in the ECCU who are compliant upon discharge with best practice guidelines.	Standardized ACS discharge summary set for all patients in the ECCU (Designated cardiac beds) .	90% of patients discharged from designated cardiac beds with evidence based treatment and follow-up plans.	