PART B: Improvement Targets and Initiatives 2012/13

Norfolk General Hospital, 365 West Street, Simcoe Ontario

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 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					1)			N/A
							2)			
							… N)			
	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					1)			N/A
							2)			
							… N)			
	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	82.30%	90%	Internal targeting exercise. Best Practice	1	Annual education for all health providers about when to clean their hands (visual reminders)	Quarterly education attendance records	90% staff trained	Ongoing education is provided to staff by ICP. Also included in orientation
							Education for healthcare providers about patient participation in hand hygiene	Quarterly education attendance records	90% staff trained	Patient participation, in which the patient understands and accepts the opportunity to become involved in the care process and contribute to safer delivery of healthcare. *American Journal of Medical Quality, 26 (1), 10-17.*
							Patient engagement: patient encouraged to ask care provider if they washed their hands	NRC Picker patient experience survey (customized question)	40%	Patients will be introduced to a partnership in hand hygiene on admission. Information will be provided both verbally and in writing. *Patient centered care, therapeutic nurse-client relationship*
							Ongoing monitoring and observation of hand hygiene practices, with feedback to healthcare providers. Champions for each unit. Senior team involvement in compliance audits.	Quarterly hand hygiene audits	Quartetly reports posted for care areas 100% of time	
	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. 2011, consistent with publicly reportable patient safety data					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) - FY Q3 2011/12, CCRS					1)			
							2)			
							… N)			

AIM		MEASURE					CHANGE			
	Avoid patient falls	**Falls**: Reduce patient falls related to restratints by 50%	7.9% of falls	4%	Practice of least restraint and reduce use of restraints is considered to be best practice and college standard. *Registered Nurses Association of Ontario, College of Nurses of Ontario*	3	Education to all nurses about least restraint use	Education inservice attendance	90% staff trained	Registered Nurses Association of Ontario Best Practice Guideline College of Nurses of Ontario Standard. Patient Centered Care
							Root cause analysis of all falls over bedrails	RL Solutions incident reporting system	100% of incidents analyzed	Root causes identified and opportunity for improvement addressed at Patient Safety Committee/ Nursing Practice Committee
							Introduce PEEK-in and Safety Huddle risk assessment in all units	Unit Director quarterly report to VP Patient Care	100% of inpatient units using strategies	Spread of initiative from current unit to all units *(Senior Friendly Care, RGP)*
							Information to all patients and their families about restraint policies and practices	Patient handbook, Meditech admission screen	100% of patients provided information on admission	Admission screens in meditech to include restraint information.
	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					1)			N/A
							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 initial assessment divided by all cases with a full admission assessment - Q4 FY 2009/10 - Q3 FY 2010/11, OMHRS					1)			N/A
							2)			
							... N)			
	Space for additional indicators									
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					1)			N/A
							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 2011/12, OHRS	-1.20%	0%	To ensure sustainability	1	Increase revenues	Financial information	$70,000.00	Increase pricing for various products and services. Install drug dispensing unit. Investigate providing services to other Community Healthcare providers. Will compare year over year revenues
							Increase staffing efficiencies	Financial report	$625,000.00	Benchmark against the best performing hospitals. Will compare year over year efficiency indicators

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							Reduce supply costs	Financial information	$155,000.00	Use product substitutions. Improve utilization. Investigate alternative contracting opportunities. Will compare year over year product costs.
							Reduce sick time	Financial report	$25,000.00	Continue and enhance healthy worklace initiatives. Will compare year over year absenteeism
							Reduce overtime	Financial report	$25,000.00	Improve staff utilization. Will compare year over year overtime rates
	Space for additional indicators									
Access	Reduce wait times in the ED	**ER Wait times:** 90th Percentile ER length of stay for Admitted patients. Q3 2011/12, NACRS, CIHI	22.6 hrs	20.4 hrs	10% improvement	1	Implement a Rapid Assessment Zone	Percentage of patients assessed in RAZ	20% of CTAS 4 & 5	
							Reduce time to initial physician assessment by drafting a physicain scorecard to share with physicians	90th percentile time to initial physician assessment (LHIN 4 Non-par site)	3.6 hrs	The performance goal is 10% improvement. Current performance (Q3 2011-12) is 4.0 hrs
							Review of frequent visitors to ED	Number of improvement initiatives for this patient population	2	Quarterly review fo patient charts identified as frequent visitor and analysis of themes and LEAN methodology applied
							Train front line staff in LEAN methodology	Number of staff training with basis level certification	10% staff	Education for staff to engage front line workers in improvement initiatives and spread LEAN philosophy
							ED retreat for process review	Number of process improvements initiated	2	Staff engagement in process improvement
	Improve access to Schedule 1 facility	Reduce Form 1 patient days at NGH	5.5 pt days	< 2 pt days	50% reduction in wait for Schedule 1 Facility bed	3	Quarterly meeting with Schedule 1 Factility	Number of meetings	4	
							Quarterly meetings with CMHS	Number of meetings	4	
Patient-centred	Improve patient satisfaction	*Please choose the question that is relevant to your hospital:*					… N)			
		From NRC Picker / HCAPHS: "Would you recommend the Emergency Department Services?" Yes, definetely.	47.2% (Q2 2011/2012)	60%	We are within the reach of the Ontario Community Hospital average therefore we will stretch to the Ontario average.	2	Nurses include patient centered discussion in the admission process	NRC Picker: Nurses discuss anxiety and fears	70% positive score	Current performance is 38.3% and we re within reach of the Ontario average therefore we will strive for the High Performer target.

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							ED nurses will assess client pain and with the team and implement strategies	NRC Picker: "ED did everything it could to control pain"	75% positive score	Current performance is 42.9% and we will strive for the High Performer score
							Patient-partnered care	NRC Picker: Have enough say about care	65%	Current performance is 51.7% and we will strive for the Ontario average
		From NRC Picker: In-patient "Would you recommend for stay"	51.9% (Q1 2011/2012)	75%	We will stretch to the Ontario average	2	We will improve patient centered care	NRC Picker: Responsiveness to call bells	85%	Current performance is 56.6% and we are within reach of the Ontario average therefore we will strive for the High Performer target.
							Provide information about medication side effects. Include information related to discharge on a communication board at patient bedside as a strategy to inform and include patients and their families in the discharge process	NRD Picker: Medication side effects	80%	Current performance is 63.6% and we will strive for the High Performer target
							Patients will be provided with information about self care on discharge. Investigate a self refer process for patients as a strategy to improve knowledge base for self care	NRC Picker: danger signals to watch for	70%	Current performance is 53.9% and we will strive for the high performer target
							Patient centered approach to care: Therapeutic Nurse-client relationship	Education sessions for all nurses	90% of staff receive education	RNAO Best Practice. CNO Standard
		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)					... N)			N/A
	Space for additional indicators									
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, DAD, CIHI	21.40%	20.30%	This indicator relies on effective partnership with CCAC and other community agencies, high volumes of frail elderly with multiple conditions impact length of stay. We will strive for a 5% improvement	2	Maintain regular meetings with CCAC to determine barriers for discharge of ALC patients	Number of meetings	8	Partnership with other community agencies is needed to support appropriate patient placement
							Provide education for ED physicians and nurses to increase knowledge of CCAC services and role within the hospital in providing increased care to patients and prevent admission	Number of patients discharged from ED who have received increased CCAC services and prevented admission	5% of patients eligible for CCAC services	
	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	17.65	15.14	To achieve the average readmission rate for large community hospital in LHIN 4	1	Improve discharge process for patients with Congestive Heart Failure to include identification of patient needs, written instructions about self care and medication administration review	Therapeutic Self Care measures completed on discharge	90% of charts will identify the completion of the Therapeutic Self Care measures	Discharge instructions must be patient specific to this patient population and reflect the self care needs of the patient.

AIM		MEASURE					CHANGE			
							Chart review for patient population with Dx of Congestive Heart Failure to identify themes for improvement	Number of initiatives implemented	2	
							Review care path for Congestive Heart Failure	Update care path	90%	CHF admission with care path
							Train front line staff in LEAN methodology	Number of staff training with basis level certification	10% of staff	Education for staff to engage front line workers in improvement initiatives and spread LEAN philosophy
							Partner with CCAC to provide a plan for self management support for Congestive Heart Failure clients	Patients discharged with self management plan	50%	RNAO best practice guideline: *Strategies to support self management in chronic condition: collaboration with clients*
							Internal referral process to discharge planning for patients at high risk for readmission	Referral to discharge planning	100% of patients at risk	Investigate utility of readmission risk assessment (LACE) index to predict unplanned readmission after disacharge *CMAJ 182 (6)*
	Space for additional indicators									