

PART B: Improvement Targets and Initiatives



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

* Only those indicators given a priority level of 1 require a change improvement plan

AIM		MEASURE				CHANGE				
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
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. 2010, consistent with publicly reportable patient safety data	N/A							
	Reduce incidence of Ventilator Associated Pneumonia (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. 2010, consistent with publicly reportable patient safety data	N/A							
	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 - 2009/10, consistent with publicly reportable patient safety data	60.06%	65.73%	1	1) Staff participation in the "Just Clean Your Hands" Campaign 2) Distribute CPSI/Safer Healthcare Now!'s "Patient & Family Hand Hygiene Guide"	1) % of staff completing education component/test. 2010/2011 - 82% of staff completed education/test . 90% of staff to complete education/test in 2011/12. 2) Track number of guides distributed. All patients/families should be empowered and informed re:importance of hand hygiene. 100% of admitted patients will receive guide.	65.73%	As per Provincial Average for 2009/2010	1) Ongoing education for all staff via posters/newsletter reminders. 2) Currently not distributing guide.
	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. 2010, consistent with publicly reportable patient safety data	N/A							
	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	N/A							
	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							
	Venous Thromboembolism (VTE) Prevention	VTE prevention: Through participation in Safer Healthcare Now's "Stop the Clot" Venous Thromboembolism Collaborative, the team will monitor attendance at learning sessions.	100%	100%	3					
	Surgical safety checklist	Safe Surgery Checklist: The surgical team uses a safe surgery checklist to confirm safety steps are completed before beginning a surgical procedure. The number of surgical checklists completed over the total number of surgical procedures. Q3 10/11	99.80%	100%	3					

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Effectiveness	Reduce unnecessary deaths in hospitals	HSMR: number of observed deaths/number of expected deaths x 100 - FY 2009/10, CIHI	N/A							
	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 2010/11, DAD, CIHI	13.10%	<14.8%	3					
	Reduce unnecessary 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 2010/11, DAD, CIHI Source of current performance data and goal - H-SAA contract schedule.	15.40%	13.60%	2					
	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 2010/11, OHRS	0.27%	0% Total Margin Target is based on the assumption of 1.35% new funding	1	1) North West LHIN 2011/12 funding announcement 2) Operational review at Rainycrest Long Term Care facility to be completed by summer 2011	1) Measure impact of new funding on Total Margin 2) Evaluation of Rainycrest Long Term Care facility operational review planning document	0% Total Margin Target is based on the assumption of 1.35% new funding	As per Hospital Service Accountability Agreement	
	Current Ratio	Current Ratio: current assets divided by current liabilities:	1.36%	1.28%	3					
Access	Reduce wait times in the ED	ER Wait times: 90th Percentile ER length of stay for Admitted patients. Q3 2010/11, NACRS, CIHI	N/A							
		ER Wait times: 90th percentile ER Length of Stay for Complex conditions. Q3 2010/11, NACRS, CIHI	N/A							
	CT wait times	CT Wait Times: 9 out of ten patients have had procedure as per MOHLTC reporting	20 days	<28 days	3					
	Knee Replacement Surgery	Knee replacement surgery: 9 out of ten patients have had procedure as per MOHLTC reporting	47 days	<60 days	3					
Patient-centred	Improve patient satisfaction	<i>Please choose the question that is relevant to your hospital:</i>								
		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: The percent response to the question "How would you rate the overall care by our staff?" Response choices: Poor/Fair/Good/Excellent. Four point rating scale converted to a percentage	88%	90%	3						
Patient Relations	Response time: Number of complaints/concerns received through C.A.R.E. (Complaints, Concerns, Compliments Address, Respond, Evaluate) program responded to in <14 days total turnaround time Current performance is from calendar year 2010	90%	95%	3						