2013/14 Quality Improvement Plans for Ontario Hospitals

Improvement Targets and Initiatives

Joseph Brant Hospital 1230 North Shore Blvd. Burlington, ON L7S 1W7

lower is better

higher is better

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

AIM		MEASURE							CHANGE			
Quality dimension	**Objective**	**Measure/Indicator**	**Current performance**	**Prov Performance**	**Target for 2012/13**	**Target for 2013/14**	**Target justification**	**Priority level**	**Planned improvement initiatives (Change Ideas)**	**Methods and process measures**	**Goal for change ideas (2013/14)**	**Comments**
Safety	Reduce hospital acquired infection rates	**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. 2012, consistent with publicly reportable patient safety data	0.24	0.32	<=0.15	<=0.15	as target set for 2012/13 and lower than provincial target	3	1) Maintain current practices in relation to surveillance, monitoring, environmental cleaning, hand hygiene and antimicrobial stewardship			Long term goal is 0 per 1,000 patient days
									Continue to report hand hygiene rates weekly at the Quality Wall (leadership rounds) and in patient care areas			
		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. 2012, consistent with publicly reportable patient safety data	77.3% based on internal audits from Jan to Dec 2012. 75.06% for FY 2011/12 consistent with public reporting	80.52% (April 2011 to March 2012; consistent with public reporting)	>=85%	>=85%	as target set for 2012/13 and higher than provincial performance	1	Simplify hand hygiene audit processes using specially designed software allowing for faster turnaround times of results and enhanced accuracy	minimum number of audits for data reliability; defined # of audits performed on each unit on a weekly basis	100% of required audits are performed each week	Measurement and feedback intervention to support change
									Hand Hygiene Steering Committee developing strategies for staff, physician and patient engagement in hand hygiene. Use of visual aids as reminders at patient interaction points	Strategies include but are not limited to: i) computer pop-up's as reminders to care providers, ii) weekly reporting and posting of results in a public area, iii) daily huddles with staff on the units where weekly results are posted, and iv) visual reminders through posters and letters to patients to engage patients/families and staff in hand hygiene practices	90% of patient care spaces have visual reminders to engage patients and staff in hand hygiene practices, including ED, inpatient and outpatient areas	Awareness and participation in process improvement initiatives is critical to success
									Continue to report hand hygiene rates weekly at the Quality Wall (leadership rounds) and in patient care areas	Weekly reporting increases departmental accountability for improvement strategies, enhances visibility of metrics and encourages sharing of challenges and successes among leaders	100% leader attendance at weekly reporting at the Quality Wall	Awareness and participation in process improvement results in ownership for outcomes
		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. 2012, consistent with publicly reportable patient safety data	0	0.96	<=1.22	0	consistent with theoretical best performance	3	1)Maintain use of recognized best practices and VAP bundles in management of ventilated patients			Long term goal is 0 per 1,000 patient days
									2)			
		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. 2012, consistent with publicly reportable patient safety data	0.37	0.58	0	0	as target set for 2012/13 and lower than provincial performance	3	1) Review each incidence of CLI for root cause and implement improvement measures			Reach 0% and sustain rate
									2) Maintain use of best practices in management of central lines			
	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) - Q2, FY 2012/13, CCRS	7.2%	2.2%	<=5.5%	<=5.5%	as target set for 2012/13; although current performance is higher than target, it is lower than 2012 actual performance	2	Maintain improvement efforts to decrease incidence of pressure ulcers in this population			Long term goal is 0%
									2)			
	Avoid patient falls	**Falls**: Percent of complex continuing care residents who fell in the last 30 days - Q2, FY 2012/13, CCRS	8.4%	9.7%	<=7.5%	<=7.5%	as target set for 2012/13 and lower than current actual and provincial performance	3	1) Noted improvement from previous year's actual performance (12.6%) to current performance therefore maintain current falls reduction programming			Long term goal is 0 %
									2)			
	Reduce use of physical restraints	**Physical Restraints:** The number of patients who are physically restrained at least once in the 3 days prior to a full admission divided by all cases with a full admission assessment - Q4 FY 2010/11 - Q3 FY 2011/12, OMHRS	6.2%	4.5%	<=5.6%	<=5.6%	as target set for 2012/13	3	1) Recent updates to least restraint policy and practices to support performance improvement			Goal is to meet and exceed provincial performance
									2)			

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	Reduce rates of deaths and complications associated with surgical care	**Rate of in-hospital mortality following major surgery:** The rate of in-hospital deaths due to all causes occurring within five days of major surgery - FY 2011/12, CIHI CHRP eReporting tool NEW	7.12% (adjusted rate)	9.18% (Prov adjusted rate); 8.58% (peer adjusted rate)	N/A	7.00%	consistent with current performance and below provincial performance	3	Recent changes to hospitalist model supportive of performance; continue to optimize models of care in this population			Goal is to exceed provincial performance
									2)			
		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. 2012, consistent with publicly reportable patient safety data	99.9%	99.3%	100%	100%	consistent with theoretical best performance	3	1) Maintain high levels of performance			Achieve and remain at 100%
									2)			
	Increase proportion of patients receiving medication reconciliation upon admission	**Medication reconciliation at admission:** The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital - Hospital-collected data, most recent quarter available (e.g., Q2 2012/13, Q3 2012/13) NEW PC	50% (Q3 2012/13)	N/A	N/A	70%	incremental increase to current performance	3	1) Focus on surgical patient population; specifically, Pre-Op Assessment Clinic			Long term goal is 100%
									2)			
	JBH - specific indicator	**Falls** - with injury as determined by risk assessment categories contained in internal occurrence reporting system (rating of 4 and above)	14 falls (rating 4 and above) from Q3 11/12 to Q2 12/13 (12 mths)	N/A	4	4 falls rating 4 and higher	as target set for 2012/13 as current performance exceeds target	2	1) Maintain falls reduction programming including risk assessments and reporting of risk at Transfer of Accountability (TOA); weekly reporting of falls with injury at the Quality Wall			Long term goal is 0 falls
Effectiveness	Reduce unnecessary deaths in hospitals	**HSMR:** number of observed deaths/number of expected deaths x 100 - FY 2011/12, as of December 2012, CIHI	85	100 (Standardized Provincial Rate)	<=85	<=80 Previous best internal score using old methodology was 67 which translates to 80 under new methodology	target set to match previous best internal score reached in 08/09 (re-calculated using new CIHI methodology)	2	Continue to examine coding opportunities, and standardize practices through the use of patient order sets			Long term goal is < 65
									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 2012/13, OHRS	0.24%	(0.4%) - HSAA Performance Standard	-0.39%	0.00%	consistent with provincial performance standard	3	1)			Achieve and maintain 0% total margin
									2)			
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	51.6	8 hours or less	<=39.0	39 hours	as target set for 2012/13 as current performance is higher than target	1	1) Maintain Daily Performance Action Team (DPAT) meetings and focus on patient flow at Quality and Performance Management Council (QPMC) to continuously engage all leaders to optimize access and flow	Continue to include CCAC leadership at QPMC to examine care across the continuum; monitor attendance via meeting records and minutes; follow-up as required to ensure participation	average of 80% attendance at DPAT for all participants over a one-year period	Awareness and participation in patient flow discussions is critical to success
									2) Continue to roll-out Patient Order Sets to standardize care including identification of expected date of discharge, ensure early discharge planning and engagement of community providers as needed	% of patients admitted under a patient order set to direct care expectations and timelines	80% of patients admitted under an order set over a one-year period	Engages patient, family and team members in setting discharge goals
									3) Review and revise bed map and bed management policy to optimize patient flow and ensure the right care in the right bed	Broad internal and external consultation in development of bed map and policy	Revised bed map and bed management policy in place	Process improvement initiative
Patient-centred	Improve patient satisfaction	*Please choose the question that is relevant to your hospital:*										
		From NRC Picker / HCAPHS: "Would you recommend this hospital to your friends and family?" (add together percent of those who responded "Definitely Yes" or "Yes, definitely")	IP = 61.7% ED = 46.5% (Q3 11/12 to Q2 12/13)	OCHA (Q2 11/12 to Q1 12/13) IP 68.9% ED 55.7%	IP = 70% ED = 65%	IP 70% ED 65%	as target set for 2012/13 to exceed Ontario Community Hospital Average (OCHA)	2	1) Emergency Services processes continue to be a corporate priority; Service Excellence Steering Committee and sub-committees in place to support improvement strategies across the organization			
		From NRC Picker: "Overall, how would you rate the care and services you received at the hospital?" (add together percent of those who responded "Excellent, Very Good and Good")	IP = 83.0% ED = 71.8% (Q3 11/12 to Q2 12/13)	OCHA (Q2 11/12 to Q1 12/13) IP 92% ED 84.25%	IP = 93% ED = 90%	IP 93% ED 90%	as target set for 2012/13 to exceed Ontario Community Hospital Average (OCHA)	2	1) Emergency Services processes continue to be a corporate priority; Service Excellence Steering Committee and sub-committees in place to support improvement strategies across the organization			
		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/A	N/A	N/A							

AIM		MEASURE							CHANGE			
	JBH - specific indicator	Patient: "Yes, definitely" response to the question "In general, after you used the call button, was the time you waited for help reasonable?"	58.2% (Q3 11/12 to Q2 12/13)	N/A	IP = 70%	IP 70%	as target set for 2012/13	2	1) Continue with spread of process improvement initiatives established in 2012/13 across all units in 13/14			
Integrated	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. Q3 2011/12 – Q2 2012/13, DAD, CIHI	17.9%	11% (HSAA) 13.1% (Q1 12/13 Prov Avg)	<=17%	<=17%	Corporate and LHIN priority linked to patient flow initiatives	1	Performance improved over previous year by 2%; maintain leader engagement strategies to keep focus on metrics and discussions at DPAT and QPMC	Continue to include CCAC leadership at QPMC to examine care across the continuum; monitor attendance via meeting records and minutes; follow-up as required to ensure participation	average of 80% attendance for all participants over a one-year period	Awareness and participation in patient flow discussions is critical to success
									2) Continue focus on ALC avoidance and management strategies; continue with appropriate provider allocation in the ED to prevent delirium and deconditioning in admitted patients	# admitted patients referred and assessed in ED	100% of referred patients are assessed and have a treatment plan in place	Deconditioning is a major factor in determination of ALC status
									3) Maintain initiatives focused on early mobilization, delirium screening and continence management	% of admitted patients on appropriate protocols	100% of patients have appropriate protocol in place	Patient experiencing mobilization difficulties, delirium and continence issues can be delayed in safe and appropriate discharge
		Readmission within 30 days for selected CMGs to any facility: The number of patients with select CMGs readmitted to any facility for non-elective inpatient care within 30 days of discharge, compared to the number of expected non-elective readmissions - Q2 2011/12 – Q1 2012/13, DAD, CIHI PC	15.57%	16.5% (HNHB LHIN - Q4 11/12)	<=8%	8.00%	as target set for 2012/13 as current performance is higher than target	2	1) Continue to review readmissions weekly and report findings at Daily Performance Action Team (DPAT) meetings with leadership with focus on patterns and trends	# of readmits; # of readmits considered appropriate; # of readmits considered inappropriate	100% of reported readmits are reviewed by the care team for improvement opportunities	Automated data is not available; manual data is collected and reported
									2) Engage with CCAC to ensure early identification of required discharge supports so planning is complete by the time the patient leaves hospital	# of patients assessed by CCAC within 24 hours of admission	80% of identified patients seen within 24 hours of admission	Patients must be assessed quickly in order to have appropriate d/c supports in place and allow for shortened length of stay (LOS) in hospital
									3) Develop a process improvement strategy that focuses on frequent visitors to ED to avert unnecessary admissions to hospital	# of patient reviews conducted of those with frequent (once monthly or more) visits to ED	100% of patients meeting criteria are reviewed for admission avoidance strategies	Patients with frequent ED visits can benefit from appropriate community supports to avoid hospital admissions
	JBH - specific indicator	**Readmission within 30 days for selected CMGs to JBH:** The number of patients with select CMGs readmitted to JBH for non-elective inpatient care within 30 days of discharge, compared to the number of expected non-elective readmissions - Q2 2011/12 – Q1 2012/13, DAD, CIHI	12.65%	N/A	N/A	12%	can better address internal readmissions with appropriate improvement strategies and timelier data	1	1) Continue to review readmissions weekly and report findings at Daily Performance Action Team (DPAT) meetings with leadership with focus on patterns and trends	# of readmits; # of readmits considered appropriate; # of readmits considered inappropriate	100% of reported readmits are reviewed by the care team for improvement opportunities	Automated data is not available; manual data is collected and reported
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