PART B: Improvement Targets and Initiatives

Perth and Smiths Falls District Hospital — 60 Cornelia St. W. Smiths Falls District Hospital, Ontario, K7A 2H9

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	.08 per patient day	Continue to meet or exceed present performance	low	1) No new initiatives set. 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. 2010, consistent with publicly reportable patient safety data	**Not Applicable**			1) 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 - 2009/10, consistent with publicly reportable patient safety data	N/A See below Hand Hygiene target			1) 2) … N)				
	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	**Not Applicable**			1) 2) … N)				
	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	**Not Applicable**			1) 2) … N)				
	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	See Reduce Fall Target			1) 2) … N)				
	Educating about Medication Reconciliation	To implement the PSFDH standardized medication reconciliation process on the 3rd Floor (23 bed medicine, rehabilitation and complex continuing care unit) at the GWM site, thereby preventing adverse drug events, at all interfaces of care.	Implementation on 3rd Floor, Perth to begin April 2011.	Completion of Medication Reconciliation Program on 3rd floor.	1	Implement the PSFDH Medication Reconciliation Education Training Program for our Interprofessional Teams including the Registered Nurses working on 3rd Floor that includes orientation.	o Percentage of charts that demonstrate evidence of medication reconciliation on admission at initial assessment.	Target is 70% by March 31st, 2012 completion in the chart at Admission	Research has shown that inadequate communication of medical information each time a patient moves from one setting to another is a contributing factor to adverse medication events. The Hospital will begin the next stage of the medication reconciliation process on 3rd floor (23 bed medical, rehabilitation and complex continuing care unit) to provide a safer environment for patients. This was a focus of Accreditation Canada's recommendations from the Final Report in October 2010 that Medication Reconciliation be an important focus over the next two years.	
	Reducing Falls	To engage all hospital staff, physicians and volunteers in the process of fall and injury prevention. Continuing education related to fall risk reduction and harm will be offered during the annual 2011 "Better Safe Than Sorry" Education Training.	Completion of Annual Educational Initiative	Engagement of staff in the hospital	1	• Regular communication about the Fall Risk Assessment and Enhancement of the tool to hospital staff, physicians and volunteers. • Posting of Fall Data on inpatient units. • Patient Safety Committee to enhance assessment through systematic root cause analysis. • Engagement of all care givers and hospital staff in the Fall Prevention education and programs.	o Percentage of staff who attended Fall Risk Reduction and Prevention Session on the mandatory 2011 Better Safe Than Sorry Sessions Establish a baseline fall rate	Target is 75% attendance at the Better Safe Than Sorry Education Training, specifically the Falls Education Session	To reduce the fall rate, the Hospital will focus on education, training , auditing and root cause analysis along with following Best Practice Guidelines from the Registered Nurses Association of Ontario (RNAO).	
	Improving Hand Hygiene	*To improve hand hygiene compliance before patient contact.*	April 09-March2010 Smiths Falls 59.26% GWM 48.87%	Improve before patient contact compliance rates	1	o Perform hospital wide audits - showing compliance before patient contact. o To strengthen and complement the work already be done to improve hand hygiene the following will be required: • Evaluation of the present hand hygiene strategies will be completed; • Implement new evidenced based strategies that improve compliance; • Evaluate success of meeting hand hygiene aims; • Engage physicians in hand hygiene education and protocols	o Direct observation hand hygiene audits reporting : • First Moment – Before initial patient /patient environment contact	Target will be to meet or exceed the provincial average rate of 65.75 % before patient contact.	To improve hand hygiene compliance the measurement of the results and assessment of strategies will demonstrate that changes are leading to an improved, safer patient and staff environment.	
Effectiveness	Reduce unnecessary deaths in hospitals	**HSMR:** number of observed deaths/number of expected deaths x 100 - FY 2009/10, CIHI	Not Applicable			1) 2) … N)				
	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				1) 2) … N)				
	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	Q/ 2 /2010 17.7% of inpatient days were designated as ALC	Pending ALC SE LHIN initiatives		1) 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 2010/11, OHRS								
	Space for additional indicators									
Access	Reduce wait times in the ED	**ER Wait times:** 90th Percentile ER length of stay for Admitted patients. Q3 2010/11, NACRS, CIHI				1) 2) … N)				
		ER Wait times: 90th percentile ER Length of Stay for Complex conditions. Q3 2010/11, NACRS, CIHI	Q/3/100-11 Smith Falls Site = 4.4 hours GWM Site =5.5 hours	PSFDH ER Wait time is better than the provincial target.	low	1) No new initiatives set. 2) … N)				
	Space for additional indicators									
Patient-centred	Improve patient satisfaction	*Please choose the question that is relevant to your hospital:* 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 (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)	PSFDH NRC Picker Reports includes 4/Q/ from Oct 2009 to Sept 2011 that responded yes to recommending hospital to friends and family ED Score = 66.4% Acute Care Score = 80%	Seeking to be among the top quartile of the highest rated community hospitals for patient satisfaction within the next three fiscal years	med	1) Strategic Planning 2011 priority 2) … N)				
	Space for additional indicators									