PART B: Improvement Targets and Initiatives

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	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	65%	92%	Current performance is at the provincial average. Set an internal stretch target to get to top performance this year, and reach 100% in the following year.	1	1) Post unit specific compliance results on each unit	% of in-patient units with a visible poster per month tracked via unit quality councils	100% of the 14 inpatient units	Measurement & Feedback intervention
							2) Installation of "empty flags" on all hand sanitizer dispensers	% Installation; Weekly audits by housekeeping that the flags are being used appropriately.	100% installation by April 30; 90% compliance with weekly audits	Process Improvement intervention
							3) Educate new hires via e-learning module	% of new hires with verified handwashing skills. IPAC staff to test via use of UV light monthly.	80% on first attempt	Skills development intervention
							4) Implement hand hygiene screen-saver prompts	% of nursing station computers with screen saver prompts loaded. IT staff to load new image quarterly.	100% of the 14 inpatient units	Reminder intervention
							5) Awards for units that have met or exceeded the hand hygiene target of 92%	Number of quarters where awards are given out; awards to be presented by the CEO at the monthly staff forum.	Award given to 3 units quarterly	Incentives/ motivation intervention
Effectiveness	Reduce unnecessary deaths in hospitals	**HSMR:** number of observed deaths/number of expected deaths x 100 - FY 2010/11, CIHI	7.30%	4.60%	Reduce AMI readmissions to the provincial average of 4.6% with the longer term goal of reaching top provincial performance of 3.4%	1	1) Provide quarterly data to physicians regarding AMI readmissions	Number of days data is provided to physicians within the time it is available. Inclusion in MAC meeting and minutes	Within 30 days of availability	Measurement & Feedback intervention
							2) Use standard order sets, based on classification, for admitted AMI patients	% of patients admitted with AMI with a complete pre-printed standard order sets on chart	100%	Process Improvement intervention
							3) Cross-train staff and CCAC discharge planners on the LACE index to identify risk of AMI readmissions	Hospital and CCAC staff LACE scores determine level of home support. Anyone with a score of 10 or higher, received NP and med rec services, and a visit within 5 days.	RAI score reduced by 10 within 30 days of discharge	Skills development intervention
							4) Follow-up calls from Nurse Practitioner to re-review discharge instructions within 4 business days	% discharged patients with AMI with follow-up checklist on chart. Reviewed monthly at unit quality council.	100%	Reminder intervention
							5) Physician gift certificate draw for 100% completion of AMI medication reconciliation at discharge	% physicians, who care for individuals with AMI, entered into the draw/month. Tracked by health information management staff.	100%	Incentives/ motivation intervention
Access	Reduce wait times in the ED	**ER Wait times:** 90th Percentile ER length of stay for Admitted patients. Q3 2011/12, NACRS, CIHI								
	Space for additional indicators									
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")	77%	79%	Move the 'large dot' measure by 2% from the 75th percentile performance into the 90th percentile	1	1) Each patient on discharge asked the NRC question on pain	% of patients who responded "definitely yes." Results reviewed at unit/board quality councils monthly.	Improve from 55% to 90%	Measurement & Feedback intervention

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					by focusing on hospital-wide pain control NRC Picker: “Do you think the hospital did everything they could to help control your pain?”		2) Implement a pain self-medication policy	% of patients self medicating for pain control. Pharmacist consult on admission for appropriateness, and daily review via eMAR.	90% hospital-wide	Improve from 55% to 90%
							3) All staff educated in the CPR method (communication pain control, responsiveness)	% of shift report forms with completed CPR documentation. Random weekly 10% chart audit by palliative care team.	100% completion	Skills development intervention
							4) Hourly rounds including a check on pain; enabling pts to anticipate what interactions will occur	% of patients that had the pain scale completed on hourly rounds. Resource nurse to audit documentation at end of shift.	98%	Reminder intervention
							5) Provide a massage therapy service by engaging local massage therapy students as volunteers	Pilot with trained volunteers on the oncology unit for one month. % of patients that responded definitely yes to the question “Did the massage help to reduce your pain, or anxiety?”	100% on target unit then spread to next unit	Incentives/ motivation intervention