PART B: Improvement Targets and Initiatives

Weeneebayko Area Health Authority QIP 2012/13

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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	0 cases- Fort Albany and Attawapiskat			not a priority	1) 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	N/A			not a priority	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 - Jan-Dec. 2011, consistent with publicly reportable patient safety data	* Moose Factory site before patient-environment contact: 87% * Fort Albany-Attawapiskat site before patient-environment contact: 56%	* to increase compliance in Moose Factory by at least 5% * to increase compliance in Fort Albany-Attawapiskat by at least 14%		1	identification of staff auditors	training intervention for auditors	5 auditors trained targets set for each auditor	stretch target: 100% compliance in all sites
							communication intervention	staff communiques inform of progress	feedback loop	1/4 ly to staff via the quality department
								senior / middle mgt mtgs to discuss performance objectives	leadership engagement	incorporated into performance management cycle
							training intervention	just clean your hands training curriculum to front line staff	increasing our staff's hand hygiene compliance rates before patient contact	all front line staff are trained in each of WAHA sites on the just clean your hands curriculum
							... 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. 2011, consistent with publicly reportable patient safety data	N/A			not a priority	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		to collect baseline data	to set future performance objectives	1	gap analysis	needs assessment with staff to determine training needs	training needs identified for staff - gap areas identified and assessed	Stretch target: zero incidences of stage I, II, III, IV, DTI, unstageable ulcers as measured monthly
							team engagement	engage the assistance of a team to lead implementation	monthly meetings to monitor progress	refine model if necessary
							training intervention	curriculum - RNAO Best Practices Guidelines	best practices are implemented consistently	standardized curriculum
							communication intervention	1/4 ly communiques to staff via the quality department	feedback loop	progress evaluated 1/4ly
							process intervention	standardized policies among all sites	knowledge transfer among the sites	policy/procedures reviewed annually to ensure accuracy based on up to date evidence
								use of Braden scale to assess risk	patients identified as high risk are monitored more actively	reduce the # of stage 1 pressure ulcers
								pressure ulcers identified and staged	prevent the worsening of existing ulcers	consistent practice standards are implemented to treat ulcers
							... N)			
	Avoid patient falls	**Falls**: Percent of complex continuing care residents who fell in the last 30 days - FY Q3 2011/12, CCRS		to collect baseline data	to set future performance objectives	1	gap analysis	needs assessment with staff to determine training needs	training needs identified for staff - gap areas identified and assessed	training standardized and delivered to staff
							training intervention	deliver falls prevention curriculum to staff (RNAO Best Practice Guidelines and Canadian Falls Prevention Curriculum)	promoting safe mobility; risk assessments; multi-disciplinary strategies; alternatives to restraints and/or other restricted devices	stretch target: 100% of high risk patients are identified
							measurement	standardized the data collection process among all sites	base line data available for fiscal year 2012-2013	stretch targets: -zero cases reported of patients who fell - zero cases who sustained significant harm - zero who sustained injury - zero who died as a result of a fall
							communication intervention	1/4 ly communiques to staff via the quality department	feedback loop	engagement of staff
							process intervention	use Fall Scale Assessment Record to assess risk with all patients	completing a fall risk assessment on at least 70% of all patients within 8 hours of being admitted to WAHA	stretch target: completing a fall risk assessment on 100% of all patients within 8 hours of being admitted to WAHA
							... N)			
	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				not a priority	1) 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				not a priority	1) 2) ... N)			
	improve medication safety	Rate of completed medication reconciliation. Numerator - # of patients admitted during the measurement period receiving formal medication reconciliation. Denominator - total # of patients admitted during the reporting period. Multiply results by 100 to determine the percentage.	to establish a baseline	to collect baseline data	to set future performance targets	1	gap analysis	create a standardized data collection process among all sites	To gather data in order to establish a baseline for 2012-2013	stretch target: eliminate undocumented intentional discrepancies and unintentional discrepancies by reconciling medication, at all interfaces of care
							policy standardization	review policies and procedures from all sites	standardize policies and processes across all WAHA sites pertaining to medication reconciliation	stretch target: eliminate undocumented intentional discrepancies and unintentional discrepancies by reconciling medication, at all interfaces of care
							process intervention	use a standardized reconciliation form to implement in admission	70% of patients in admissions going through the medication reconciliation process	* number of admission medications reconciliations completed. * stretch target: 100% of patients in admissions going through the medication reconciliation process
								create a medication transfer letter that could to be sent to receiving institutions if external transfer is required	decrease number of adverse events due to medication errors	stretch target: 0 adverse events due to medication errors
								use the best possible medication history and the last 24 hour adminstration record as referenced and create a best possible medication (BPM) discharge plan for the patient	keep track of the number of BPM discharge plans developed for patients	reconcile medications the patient should be taking post discharge to ensure all changes are intentional and discrepancies are resolved
Effectiveness	Reduce unnecessary deaths in hospitals	**number of patients admitted during the reporting period. Multiply the results by 100 to determine the percentage.**					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) 2) ... N)			
	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					1) 2) ... N)			
	Space for additional indicators									
Patient-centred	Improve patient satisfaction	*Please choose the question that is relevant to your hospital:*					... N)			
		In-house survey (if available): provide the percent response to a summary question such as the "Number of patients responding excellent or good to the question "Overall, how would you rate the services provided to you?"		to collect baseline data for the ER department	to set future performance targets for the ER department	1	Survey implentation - Implement a patient satisfaction survey in the emergency department	create an instrument to be implemented in the emergency departments of WAHA	70% reported satisfaction in the quality of care received by patients as identified in the annual patient satisfaction survey for the emergency department	stretch target: 100% reported satisfaction in the quality of care received by patients as identified in the annual patient satisfaction survey
	Space for additional indicators									
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. Q2 2011/12, DAD, CIHI					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 2011/12, DAD, CIHI					1) 2) ... N)			
	Space for additional indicators									