

PARI B: Improvement Targets and Initiatives

Red Lake Margaret Cochenour Memorial Hospital

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

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	0	1 patient or less quarterly	3					
	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	87.40%	Maintain or exceed current performance	3					
	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	0	1 or less per quarter as per definition	3					
	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	Data currently collected does not separate falls for Complex Continuing Care residents from general patient population	Less than one patient fall monthly	2	Falls risk assessment to be done on all patients on admission	Audit of all patient charts to ensure completed risk assessment	100% of all falls assessments to be completed within 12 hours of admission		
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	26.80%	Reduce readmissions within 30 days for select CMGs by 25%	1	Commence discharge planning at time of admission	Review patient record to ensure needs assessments completed for discharge	75% of all patient charts reviewed for patients with select CMG's will have discharge planning commenced during admission.		
						Early consultation with CCAC to establish better coordination of day after home care visit.	Assess number of patients discharged with selected CMG's with those who have follow up visit within one day of discharge	75% of patients with select CMG's will have a follow up visit by home care within one day of discharge		This indicator will be impacted on the availability of home care services within the community
						Ensure comprehensive written discharge instructions including review of discharge medications are given to all patients with select CMG's. Train staff to use "teach back" method to ensure patients understand these instructions.	Audit discharge instruction sheets on all patients discharged with select CMG's	100% of all patients discharged with select CMG's will have comprehensive written discharge instructions provided to them.		
						Work with FHT to establish family doctor follow up appointments within one week of discharge	Assess number of patients discharged with selected CMG's with those who have follow up appointments within one week of discharge	75% of patients with select CMG's will have a follow up appointment with family doctor within one week of discharge		This indicator will be impacted on the availability of family doctor appointments which is directly dependant on the number of practicing physicians in the community
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	Q1-Q3 14.98% Q3 21%	To be determined. NW LHIN Target 15.4%	2					ALC days is proportional to the amount of home support and services available in the community
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, QHRS	0.00%	0.00%	2					
Access	Reduce wait times in the ED	ER Wait times: 90th Percentile ER length of stay for Admitted patients. Q3 2010/11, NACRS, CIHI	Data currently not available	Meet or exceed NW LHIN target of 25 hours	2					
		ER Wait times: 90th percentile ER Length of Stay for Complex conditions. Q3 2010/11, NACRS, CIHI	Data currently not available	To be determined	2					
Patient-centred	Improve patient satisfaction	Please choose the question that is relevant to your hospital:	Data not available based on format of current in-house questionnaire	80%	2	Revise patient satisfaction survey to reflect indicator				
		NRC Picker / HCAPHS: "Would you recommend this hospital to your friends and family?" (add together percent of those who responded "Definitely Yes")				Health records department to mail surveys on scheduled basis to discharged patients.				
		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)				Determine feasibility of NRC Picker survey for our organization.				