

PART B: Improvement Targets and Initiatives



Women's College Hospital | 76 Grenville Street, Toronto, Ontario M5S 1B2

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	Improve safety checklist compliance	Compliance with the use of the surgical safety checklist: The number of times the surgical safety checklist was performed over the total number of appropriate surgeries.	99.60%	>91.8%	2	1) Monitor surgical checklist compliance and provide timely feedback.	Audit and report surgical checklist compliance on a monthly basis.	Maintain current status.	Sustain current performance to meet/exceed 91.8% the Ontario Academic Mean.	
	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	72% annual corporate average	80% annual corporate average	1	1) Implemented a interprofessional, multifaceted hand hygiene program and hand care program to facilitate adherence to best practices which included: - Environmental changes and system supports, - Education for health care providers - Ongoing monitoring with feedback to health care providers; and - Client/patient/resident engagement		Corporate compliance of 80% for moment 1 of hand hygiene.	Internal targeting exercise to increase corporate hand hygiene compliance to 80% in moment 1.	
						2) Prepare a workflow pattern and risk assessment to facilitate placement of products and stations.	Utilize Discovery and Action Dialogue, PDSA and other quality improvement tools to initiate change.	100% of clinic/department assessments completed		
						3) Educate health care providers and patients annually on hand hygiene indications, products, techniques and hand care focusing on: how, when and why to clean hands (four moments of hand hygiene)	Audit attendance at live education sessions or employee e-learning modules for annual review of hand hygiene education.	100% of full time/part time staff completion of education session/e-learning module		
						4) Monitor health care provider hand hygiene compliance with the provision of timely feedback.	Provide pamphlets and educational materials to patients/families.	80% corporate hand hygiene compliance		
						Report compliance rates quarterly. Unit managers to provide action plans to address compliance that does not meet performance goal.				
Effectiveness	Improve Operating Room first case start time accuracy	% First Case On-time (ORBC); Percent of first OR case that starts on time or early.	65%	67%	2	1) To set up a taskforce to assess barriers to compliance for OR cases starting on time e.g. the administration of blocks and to review and update guidelines, P&P and expectations.	Prospective analysis to determine barriers to success with recommendations and action plans developed	Completion of Prospective Analysis process by June 2011	Internal targeting exercise to increase compliance by 2% this year to 67% as we move towards the Ontario academic mean of 73.2% in Year 2.	
						2) Monitoring of all first OR cases for appropriate start time on a daily basis.	Observation of actual start times on first OR cases	100% observations of OR start time daily		
	3) Posting of graphed reports representing start time compliance on a daily/weekly basis by service.	Audit and post compliance of first OR case start time by service daily/weekly	100% compliance							
	Improve employee/physician survey results	Accreditation Canada Worklife Pulse Survey results: "How satisfied are you with your job?" Percentage of staff/physicians who respond positively to this question.	Baseline from 2010	Trend over time	3 In development	1) The Worklife Pulse survey from Accreditation Canada will be administered every 1-2 years	Analysis and trending over time		Internal targeting exercise to improve how satisfied individuals are with their job at Women's College Hospital	
						2) Analysis of survey results and action plans developed for those indicators that don't meet national average	Audit and track completion of action plans/interventions and track change over time			
Access	Reduce wait times for Medical Imaging procedures	US wait times: To increase access to musculoskeletal ultrasounds by establishing a program at WCH.	0	150 patients/year	2	1) To add an additional 1/2 day per week for MSK ultrasounds.	Session available for booking patients	May, 2011	Internal targeting exercise to increase access to MSK ultrasounds to 150 patients per year.	
						3) Establish process and communicate to the respective Family Health Teams.	Initial communications complete	June, 2011		
						4) Evaluate	Audit and post results and referral results for each FH team	Referral received at expected rate		

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	Improve same day access to primary care	Same day access in primary care (Family Practice Teams): Primary healthcare office access and efficiency will be improved during a nine month period allowing patients to see their provider on the day of their choice and to reduce the Third Next Available appointment time (as per Ministry's Quality Improvement and Innovation Partnership (QIIP)).	Baseline in development	3rd next available appointment	3 In development	1) Family Practice Teams enrolled in the Quality Improvement and Innovation Partnership through the Ministry, interprofessional working group formed and 4 pilot physicians chosen.	Charter document developed to guide this work and a quality coach assigned to WCH FP		In first 6 months after enrollment in QIIP to demonstrate measureable changes in standard outcome measures such as: TNA, patient will see their own provider, reduction in no show rate, decreased cycle time and increased face to face contact with care team. Next three months will demonstrate sustainability. In Year 2 roll out will occur to other physicians/areas.	
						2) Supporting measures collected for information gathering /PDSA development.	Metrics such as demand, supply, activity, panel size and visit rate will be collected utilizing standardized tools developed by Ontario Health Quality Council			
						3) Advanced Access philosophies will be applied to the four physician's practices that were selected.	Increments of change will be made and evaluated as per the Access Change Concepts			
						4) Outcome measures will be developed and monitored.	Outcome measures will be collected and reported monthly. These metrics will be reviewed through the working group			
Patient-centred	Improve patient satisfaction in UCC	NRC Picker: Percentage of those individuals who responded 'positively' to the questions in the physical comfort dimension.	60%	62.70%	1	1) To understand what drives physical comfort in our environment and to assess pain assessment evidence that improves physical comfort and adopt relative strategies or develop appropriate interventions.	Review of literature, internal environment.	Review completed by June 2011	To improve patient satisfaction scores in physical comfort dimension to meet Ontario average of 62.7%.	
						2) Modify our internal satisfaction survey to reflect NRC Picker questions in the physical comfort dimension and to survey our UCC patient population on day of visit.	Audit UCC patients on same day of visit and monitor results.	100% of patients offered a survey on day of visit.		
						3) Provide customer service training to staff to promote comfort and enhance the patient's perception of their experience.	Customer service training provided to staff	100% staff attend education sessions.		
						4) Monitor internal satisfaction survey results and NRC Picker results.	Audit and monitor internal satisfaction results and post. Compare to NRC Picker results.	Will trend internal results over time and post results		
	Improve patient satisfaction	NRC Picker: To improve ambulatory care patient experience scores by improving survey methodology by enhancing sampling plan.	Baseline from 2010	Trend over time	3 In development	1) To gain an understanding of the surveys and sampling plans already in use.	Review NRC Picker surveys for questions and sampling plans.	Review completed by June 2011	Internal targeting exercise to improve patient satisfaction data available.	
						2) To work with NRC Picker to develop new sampling plans based on our volumes and their recommendations.	NRC Picker confirm receipt of new sampling plans	September, 2011		
						3) Implement new survey plan and evaluate effectiveness.	Review patient response rates to ambulatory care survey.	Results posted in clinical areas		