Whole System Measures Monitoring Report: Data Available as of Jan 2010

Legend: Green=positive–tracking on target Yellow=monitor–tracking around target Red=needs attention–below target Orange=no data available

Trend: favourable improving trend unfavourable diminishing trend relatively stable trend

Quality Domain:

Work Life

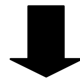
supporting wellness in the work environment

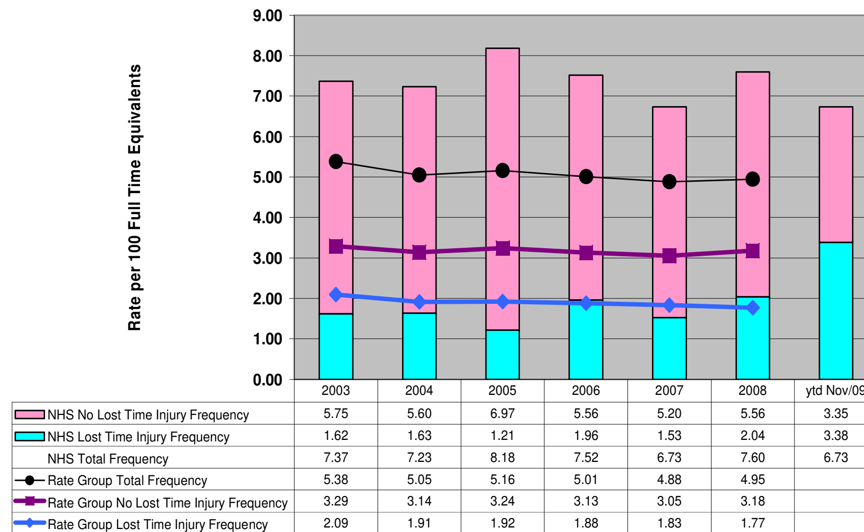
Occupational Incidents –

WSIB Injury Frequency

Last reporting period

This reporting period





	2003	2004	2005	2006	2007	2008	ytd Nov/09
NHS No Lost Time Injury Frequency	5.75	5.60	6.97	5.56	5.20	5.56	3.35
NHS Lost Time Injury Frequency	1.62	1.63	1.21	1.96	1.53	2.04	3.38
NHS Total Frequency	7.37	7.23	8.18	7.52	6.73	7.60	6.73
Rate Group Total Frequency	5.38	5.05	5.16	5.01	4.88	4.95	
Rate Group No Lost Time Injury Frequency	3.29	3.14	3.24	3.13	3.05	3.18	
Rate Group Lost Time Injury Frequency	2.09	1.91	1.92	1.88	1.83	1.77	

Data Source: WSIB Account Rate Profile

Source of Data:
WSIB Account Rate Profile

Reporting Cycle:
Quarterly with annual benchmarks

Definitions:
Injury Frequency is the number of allowed WSIB (Workplace Safety & Insurance Board) claims per 100 full-time equivalent workers.

Rate Group consists of Hospitals submitting WSIB premiums.

Comments:
The NHS was slightly higher than the hospital rate group in 2008 for Lost Time Injury Frequency at 2.04 compared to 1.77, and significantly higher than the hospital rate group for No Lost Time Injury Frequency at 5.56 compared to 3.18.

The majority of injury claims are related to slips and falls that occur when arriving or leaving work that may or may not be on hospital premises and claims as a result of infectious outbreaks. The infection control practices, such as Just Clean your Hands program is expected to reduce the frequency of the injury claims related to infectious outbreaks.

NHS has experienced an increase at year-to-date November 2009 for Lost Time Injury frequency to 3.38 per 100 full time equivalents from 2.04 in 2008. No Lost Time frequency has decreased comparing the same time periods to 3.35 from 5.56.

Occupation Health has engaged a third party for more rigour in appeal/query of WSIB/NEER claims.

Legend: Green=positive–tracking on target Yellow=monitor–tracking around target Red=needs attention–below target Orange=no data available

Trend: favourable improving trend unfavourable diminishing trend relatively stable trend

Quality Domain:

Work Life

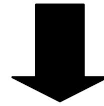
supporting wellness in the work environment

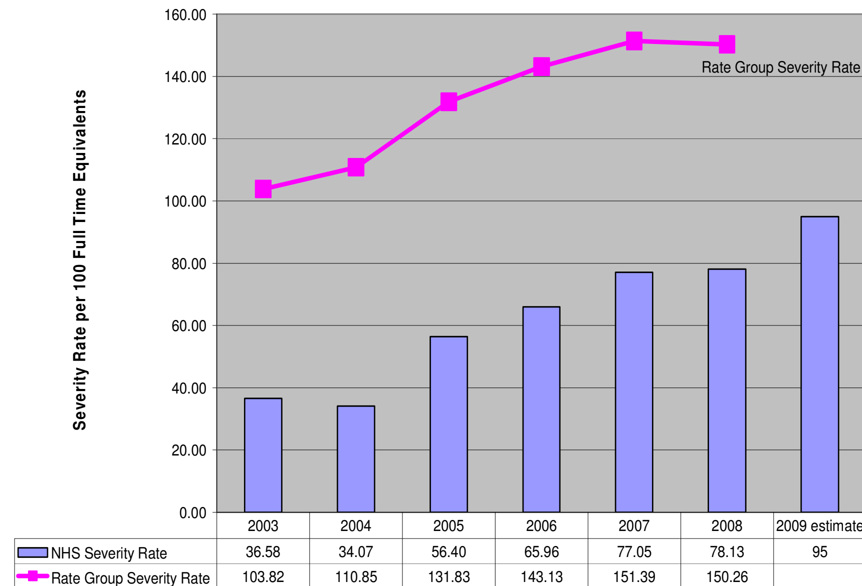
Occupational Incidents –

WSIB Injury Severity Rate

Last reporting period

This reporting period





	2003	2004	2005	2006	2007	2008	2009 estimate
NHS Severity Rate	36.58	34.07	56.40	65.96	77.05	78.13	95
Rate Group Severity Rate	103.82	110.85	131.83	143.13	151.39	150.26	

Data Source: WSIB Account Rate Profile for 2003 to 2008, 2009 estimate provided by AON

Source of Data:
WSIB Account Rate Profile

Reporting Cycle:
Annual, with estimates

Definitions:
Severity Rate is the number WSIB lost day claims per 100 full-time equivalent workers.

Lost days equal actual lost days plus a projection for future lost days based on type of claim.

Rate Group consists of Hospitals submitting WSIB premiums.

Comments:
The NHS has consistently been below the hospital peer group average in WSIB severity rate per 100 full time equivalents.

NHS has experienced an increase at year-to-date July 2009 for estimated Severity rate to 95 per 100 full time equivalents from 78.13 in 2008.

Occupation Health has engaged a third party for review of WSIB/NEER claims and processes.

Legend: Green=positive–tracking on target Yellow=monitor–tracking around target Red=needs attention–below target Orange=no data available

Trend: favourable improving trend unfavourable diminishing trend relatively stable trend

Quality Domain:

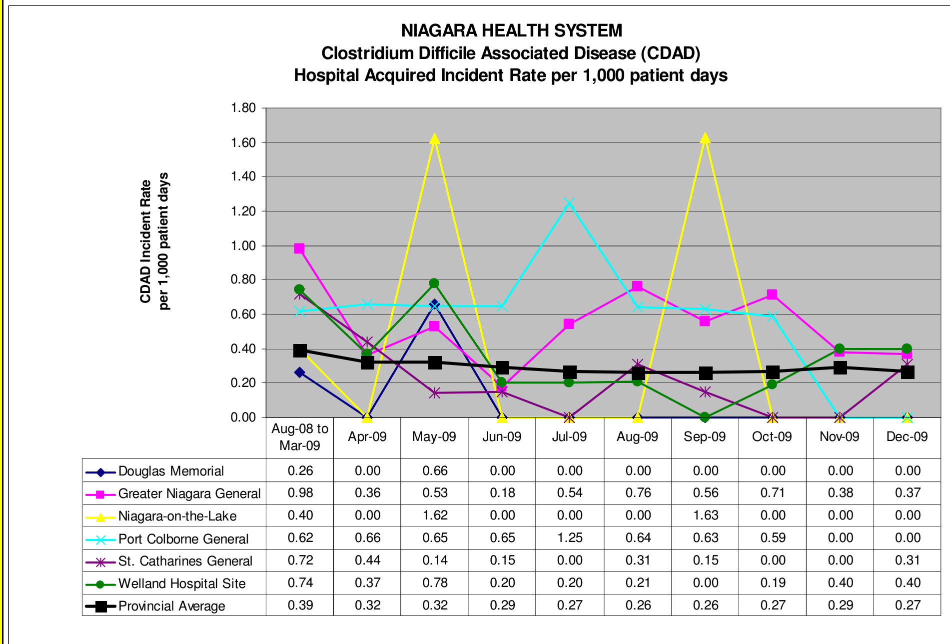
Safe

people should not be harmed by an accident or mistakes when they receive care

Hospital Acquired C. Difficile Rates

Last reporting period

This reporting period



	Aug-08 to Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09
Douglas Memorial	0.26	0.00	0.66	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Greater Niagara General	0.98	0.36	0.53	0.18	0.54	0.76	0.56	0.71	0.38	0.37
Niagara-on-the-Lake	0.40	0.00	1.62	0.00	0.00	0.00	1.63	0.00	0.00	0.00
Port Colborne General	0.62	0.66	0.65	0.65	1.25	0.64	0.63	0.59	0.00	0.00
St. Catharines General	0.72	0.44	0.14	0.15	0.00	0.31	0.15	0.00	0.00	0.31
Welland Hospital Site	0.74	0.37	0.78	0.20	0.20	0.21	0.00	0.19	0.40	0.40
Provincial Average	0.39	0.32	0.32	0.29	0.27	0.26	0.26	0.27	0.29	0.27

NIAGARA HEALTH SYSTEM
Clostridium Difficile Associated Disease (CDAD)
Period: August 2008 - December 2009

Number of New Hospital Acquired Cases of CDAD:

Site	Aug-08 to Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09
Douglas Memorial	<5	0	<5	0	0	0	0	0	0	0
Greater Niagara General	43	<5	<5	<5	<5	<5	<5	<5	<5	<5
Niagara-on-the-Lake	<5	0	<5	0	0	0	<5	0	0	0
Port Colborne General	8	<5	<5	<5	<5	<5	<5	<5	0	0
St. Catharines General	40	<5	<5	<5	0	<5	<5	0	0	<5
Welland Hospital Site	32	<5	<5	<5	<5	<5	0	<5	<5	<5

Source of Data:
Infection Control department

Reporting Cycle:
Publicly reported monthly

Definitions:
C. difficile or Cdiff, also known as Clostridium difficile, is a bacteria that can be found in stool (a bowel movement). Cdiff disease occurs when antibiotics kill your good bowel bacteria and allow the Cdiff to grow. When Cdiff grows, it produces toxins that can damage the bowel and may cause diarrhea.

Incident rate of CDAD =
# of new hospital acquired cases of CDAD in our facility x 1000
Total number of patient days (for one month)

Number of new hospital acquired cases of CDAD - patient has not had CDAD in the past 8 weeks, CDAD was not present on admission (i.e. the onset of symptoms is >72 hours after admission) OR the infection was present on admission but related to a previous admission to the same facility within the last 4 weeks.

Comments:
The number of new cases of CDAD was 6 in December 2009 down from 8 in August 2009 and a decrease from an average of 11 between August 2008–November 2009.

Precautions used to prevent spread in hospital:

- Patient placed in private room until free from diarrhea for at least 2 days after treatment is finished. Signs are placed on the outside the door called Contact Isolation.
- Patient's activities outside the room may be limited.
- Hand hygiene
- Staff and visitors must wear gowns and gloves if they expect to come in contact with patient and upon entering the room.
- Dedicated equipment may be left in the room solely for patient's use.
- Thorough cleaning of the patient's room and equipment will be regularly done.

Legend: Green=positive–tracking on target Yellow=monitor–tracking around target Red=needs attention–below target Orange=no data available

Trend: favourable improving trend unfavourable diminishing trend relatively stable trend

Quality Domain:

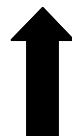
Safe

people should not be harmed by an accident or mistakes when they receive care

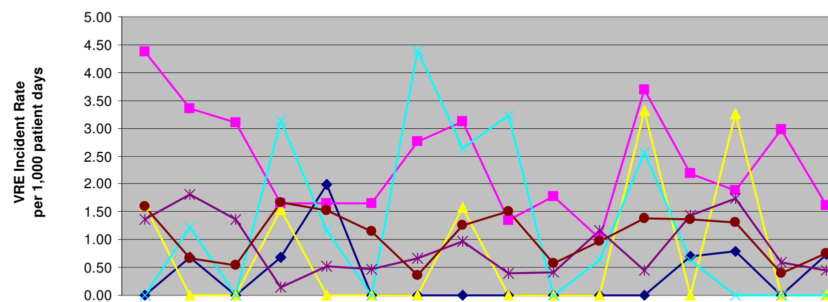
Hospital Acquired MRSA Colonized Rates

Last reporting period

This reporting period



NIAGARA HEALTH SYSTEM
Methicillin Resistant *Staphylococcus Aureus* (MRSA)
Hospital Acquired Colonized Cases - Incident Rate



	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09
Douglas Memorial	0.00	0.68	0.00	0.68	1.99	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.70	0.78	0.00	0.73
Greater Niagara General	4.37	3.36	3.10	1.64	1.64	1.65	2.76	3.11	1.34	1.77	1.03	3.70	2.18	1.88	2.98	1.61
Niagara-on-the-Lake	1.61	0.00	0.00	1.54	0.00	0.00	0.00	1.58	0.00	0.00	0.00	3.32	0.00	3.26	0.00	0.00
Port Colborne General	0.00	1.22	0.00	3.14	1.16	0.00	4.39	2.63	3.23	0.00	0.63	2.57	0.63	0.00	0.00	0.00
St. Catharines General	1.37	1.81	1.37	0.14	0.52	0.46	0.66	0.96	0.40	0.41	1.16	0.44	1.43	1.73	0.60	0.44
Welland Hospital Site	1.60	0.67	0.53	1.66	1.52	1.14	0.35	1.25	1.50	0.57	0.97	1.38	1.37	1.30	0.39	0.75

Source of Data:
Infection Control department

Reporting Cycle:
Monthly

Definitions:
MRSA happens when S. aureus develops resistance to certain antibiotics. Staphylococcus aureus is a germ that lives on the skin and mucous membranes of healthy people. Occasionally S. aureus can cause an infection.

Colonization is the presence and growth of a micro-organism in or on a body with growth and multiplication but without tissue invasion or cellular injury. The patient will be asymptomatic.

Incident rate of colonized MRSA case=
# of new hospital acquired cases of colonized MRSA in our facility x 1000
Total number of patient days (for one month)

Number of new hospital acquired cases of colonized MRSA - MRSA was not present on admission (i.e. the onset >72 hours after admission) OR was present on admission but related to a previous admission to the same facility within the last 72 hours.

Provincial benchmarks are not available.

Comments:
The number of new cases of colonized MRSA was 17 in December 2009. This represents a decrease from 36 in August 2009 and a decrease from an average of 29 between September 2008–November 2009.

Precautions used to prevent spread in hospital:

- Single room accommodation
- Isolation precautions
- A long-sleeved gown and gloves
- Sign placed on the door to remind about the special precautions
- The room and the equipment used in the room will be cleaned and disinfected regularly
- Hand hygiene
- Ongoing education of staff & visitors

Legend: Green=positive–tracking on target Yellow=monitor–tracking around target Red=needs attention–below target Orange=no data available

Trend: favourable improving trend unfavourable diminishing trend relatively stable trend

Quality Domain:

Safe

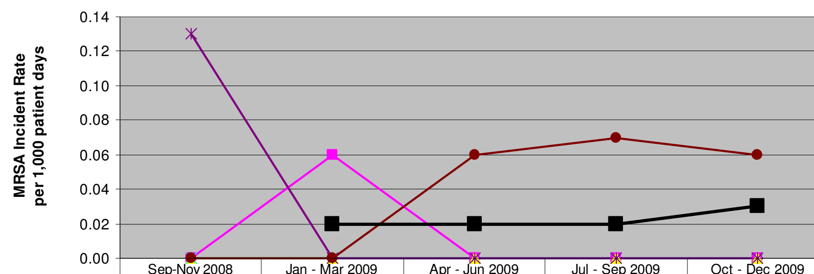
people should not be harmed by an accident or mistakes when they receive care

Hospital Acquired MRSA Bacteraemia Rates

Last reporting period

This reporting period

NIAGARA HEALTH SYSTEM
Methicillin Resistant *Staphylococcus Aureus* (MRSA)
Bacteraemia Infection - Hospital Acquired Incident Rate



	Sep-Nov 2008	Jan - Mar 2009	Apr - Jun 2009	Jul - Sep 2009	Oct - Dec 2009
Douglas Memorial	0.00	0.00	0.00	0.00	0.00
Greater Niagara General	0.00	0.06	0.00	0.00	0.00
Niagara-on-the-Lake	0.00	0.00	0.00	0.00	0.00
Port Colborne General	0.00	0.00	0.00	0.00	0.00
St. Catharines General	0.13	0.00	0.00	0.00	0.00
Welland Hospital Site	0.00	0.00	0.06	0.07	0.06
Provincial Average		0.02	0.02	0.02	0.03

NIAGARA HEALTH SYSTEM
Methicillin Resistant *Staphylococcus Aureus* (MRSA) Bacteraemia Infection
Period: September 2008 - December 2009

Number of New Hospital Acquired MRSA Bacteraemia Infection cases:

Site	Sep-Nov 2008	Jan - Mar 2009	Apr - Jun 2009	Jul - Sep 2009	Oct - Dec 2009
Douglas Memorial	0	0	0	0	0
Greater Niagara General	0	<5	0	0	0
Niagara-on-the-Lake	0	0	0	0	0
Port Colborne General	0	0	0	0	0
St. Catharines General	<5	0	0	0	0
Welland Hospital Site	0	0	<5	<5	<5

Source of Data:
Infection Control department

Reporting Cycle:
Monthly
Publicly reported quarterly

Definitions:
MRSA happens when S. aureus develops resistance to certain antibiotics. Staphylococcus aureus is a germ that lives on the skin and mucous membranes of healthy people. Occasionally S. aureus can cause an infection.

Bacteraemia is the presence of bacteria in the bloodstream and is referred to as a bloodstream infection.

Incident rate of bacteraemia MRSA case= # of new hospital acquired cases of bacteraemia MRSA in our facility x 1000 / Total number of patient days (for one month)

Number of new hospital acquired cases of bacteraemia MRSA - MRSA was not present on admission (i.e. the onset of symptoms >72 hours after admission) OR infection was present on admission but related to a previous admission to the same facility within the last 72 hours

Comments:
The number of new cases of bacteraemia MRSA was one from October-December 2009. This is the same as the July-September 2009 period.

Precautions used to prevent spread in hospital:

- Single room accommodation
- A long-sleeved gown and gloves must be worn
- A sign may be placed on the door to remind others who enter the room about the special precautions
- The room and the equipment used in the room will be cleaned and disinfected regularly
- Hand hygiene

Legend: Green=positive–tracking on target Yellow=monitor–tracking around target Red=needs attention–below target Orange=no data available

Trend: favourable improving trend unfavourable diminishing trend relatively stable trend

Quality Domain:

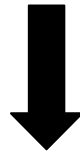
Safe

people should not be harmed by an accident or mistakes when they receive care

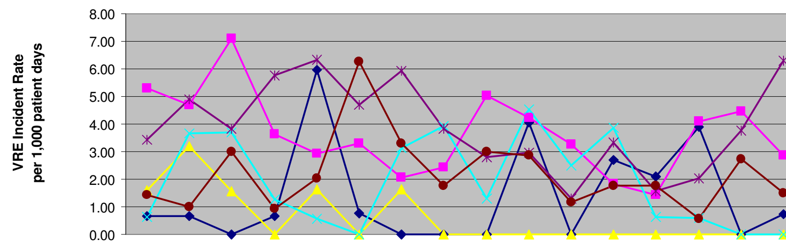
Hospital Acquired VRE Colonized Rates

Last reporting period

This reporting period



NIAGARA HEALTH SYSTEM
Vancomycin Resistant Enterococcus (VRE)
Hospital Acquired Colonized Cases - Incident Rate



	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09
Douglas Memorial	0.66	0.68	0.00	0.68	5.96	0.78	0.00	0.00	0.00	4.07	0.00	2.70	2.11	3.89	0.00	0.73
Greater Niagara General	5.29	4.70	7.11	3.64	2.95	3.29	2.07	2.42	5.03	4.25	3.26	1.85	1.45	4.11	4.46	2.86
Niagara-on-the-Lake	1.61	3.20	1.57	0.00	1.63	0.00	1.64	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Port Colborne General	0.63	3.67	3.70	1.26	0.58	0.00	3.13	3.94	1.29	4.52	2.50	3.86	0.63	0.59	0.00	0.00
St. Catharines General	3.43	4.90	3.83	5.76	6.35	4.71	5.95	3.84	2.80	2.98	1.30	3.34	1.57	2.02	3.78	6.30
Welland Hospital Site	1.42	1.00	3.00	0.92	2.03	6.27	3.31	1.78	3.01	2.86	1.16	1.77	1.76	0.56	2.74	1.51

Source of Data:
Infection Control department
Reporting Cycle:
Monthly

Definitions:
Vancomycin-resistant enterococci (VRE) are strains of enterococci that are resistant to the antibiotic vancomycin. Enterococci are germs that live in the gastrointestinal tract (bowels) of most people and generally do not cause harm (this is termed 'colonization'). If a person has an infection caused by VRE, such as a urinary tract infection or blood infection, it may be more difficult to treat.
Colonization is the presence and growth of a micro-organism in or on a body with growth and multiplication but without tissue invasion or cellular injury. The patient will be asymptomatic.

Incident rate of case colonized VRE cases=

$$\frac{\text{\# of new hospital acquired cases of colonized VRE in our facility} \times 1000}{\text{Total number of patient days (for one month)}}$$

The number of new cases of colonized VRE - VRE was not present on admission (i.e. the onset is >72 hours after admission) OR was present on admission but related to a previous admission to the same facility within the last 72 hours.
Provincial benchmarks are not available.

Comments:
The number of new cases of colonized VRE was 68 in December 2009. This represents an increase from 52 in August 2009 and an increase from an average of 66 between September 2008–November 2009.
Precautions used to prevent spread in hospital:

- Single room accommodation
- A long-sleeved gown and gloves must be worn by everyone who cares for the patient – isolation precautions
- A sign may be placed on the door to remind others who enter the room about the special precautions
- The room and the equipment used in the room will be cleaned and disinfected regularly
- Hand hygiene & on going education

Legend: Green=positive–tracking on target Yellow=monitor–tracking around target Red=needs attention–below target Orange=no data available

Trend: favourable improving trend unfavourable diminishing trend relatively stable trend

Quality Domain:

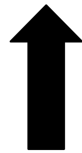
Safe

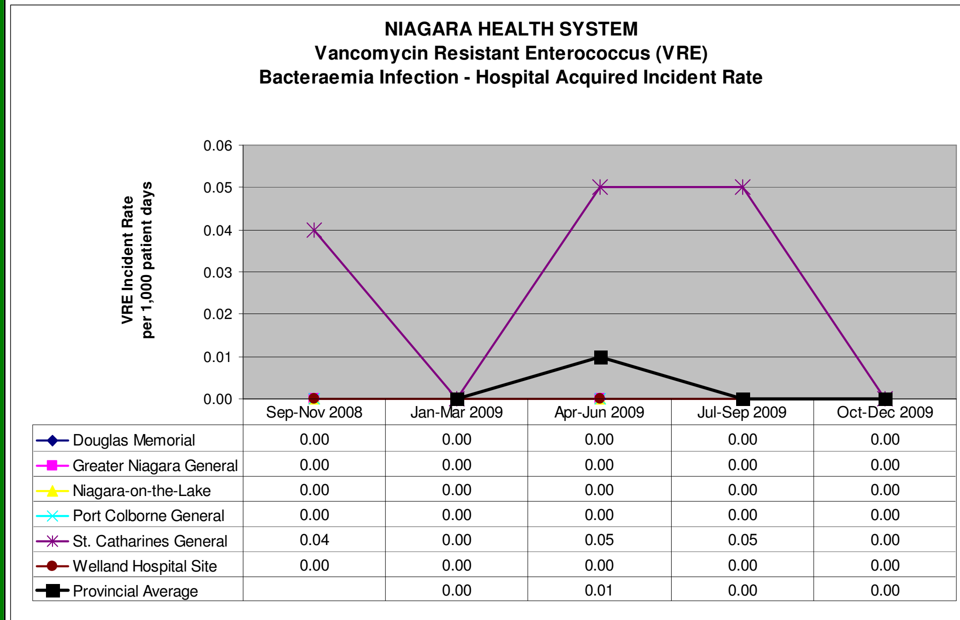
people should not be harmed by an accident or mistakes when they receive care

Hospital Acquired VRE Bacteraemia Rates

Last reporting period

This reporting period





NIAGARA HEALTH SYSTEM
Vancomycin Resistant Enterococcus (VRE) Bacteraemia Infection
Period: September 2008 - Decemeber 2009

Number of New Hospital Acquired VRE Bacteraemia Infection cases:

Site	Sep-Nov 2008	Jan-Mar 2009	Apr-Jun 2009	Jul-Sep 2009	Oct-Dec 2009
Douglas Memorial	0	0	0	0	0
Greater Niagara General	0	0	0	0	0
Niagara-on-the-Lake	0	0	0	0	0
Port Colborne General	0	0	0	0	0
St. Catharines General	<5	0	<5	<5	0
Welland Hospital Site	0	0	0	0	0

Source of Data:
Infection Control department

Reporting Cycle:
Monthly
Publicly reported quarterly

Definitions:
Vancomycin-resistant enterococci (VRE) are strains of enterococci that are resistant to the antibiotic vancomycin. Enterococci are germs that live in the gastrointestinal tract (bowels) of most people and generally do not cause harm (this is termed ‘colonization’). If a person has an infection caused by VRE, such as a urinary tract infection or blood infection, it may be more difficult to treat.
Bacteraemia is the presence of bacteria in the bloodstream and is referred to as a bloodstream infection.
Incident rate of bacteraemia VRE cases= # of new hospital acquired cases of bacteraemia VRE in our facility x 1000
Total number of patient days (for one month)

Number of new cases of bacteraemia VRE - VRE was not present on admission (i.e. the onset of symptoms is >72 hours after admission) OR the infection was present on admission but related to a previous admission to the same facility within the last 72 hours.

Comments:
The number of new cases of bacteraemia VRE was zero between October-December 2009. This is a decrease from July-September 2009. NHS had one case in each of Sept 2008, Apr 2009, and July 2009.

Precautions used to prevent spread in hospital:

- Single room accommodation
- A long-sleeved gown and gloves must be worn by everyone who cares for the patient
- A sign may be placed on the door to remind others who enter the room about the special precautions
- The room and the equipment used in the room will be cleaned and disinfected regularly
- Hand hygiene

Legend: Green=positive–tracking on target Yellow=monitor–tracking around target Red=needs attention–below target Orange=no data available

Trend: favourable improving trend unfavourable diminishing trend relatively stable trend

Quality Domain:

Safe

people should not be harmed by an accident or mistakes when they receive care

Central-Line Primary Blood Stream Infection (CLI)

Last reporting period

This reporting period

NIAGARA HEALTH SYSTEM
Central Line Infection Bloodstream Infection (CLI-BSI)
Intensive Care Units
Period: January - December, 2009

CLI incidents diagnosed after day 2 of admission for adult patients greater than 18 years of age:

Site	Jan-Mar 2009		Apr-Jun 2009		Jul-Sep 2009		Oct-Dec 2009	
	Number of CLI-BSI Incidents	CLI-BSI Rate per 1,000 Central Line days	Number of CLI-BSI Incidents	CLI-BSI Rate per 1,000 Central Line days	Number of CLI-BSI Incidents	CLI-BSI Rate per 1,000 Central Line days	Number of CLI-BSI Incidents	CLI-BSI Rate per 1,000 Central Line days
Douglas Memorial	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Niagara-on-the-Lake	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Port Colborne General	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Greater Niagara General	0	0.00	0	0.00	0	0.00	0	0.00
St. Catharines General	0	0.00	0	0.00	0	0.00	0	0.00
Welland Hospital Site	0	0.00	0	0.00	0	0.00	0	0.00
Provincial Numbers	106	1.60	95	1.40	79	1.20		

Notes:

* *N/A* - do not have designated intensive care units

Source of Data:
Critical Care Information System (CCIS)

Reporting Cycle:
Quarterly

Definitions:
CLI occurs when a central venous catheter/line placed into a patient's vein gets infected. It occurs when bacteria grows in the line and spreads to the patient's blood stream. Patients are placed on a central line when blood, fluid replacement and/or nutrition need to be given to them intravenously. Central lines also allow health care providers to monitor and test the heart and blood.

CLI rates are determined by:

Number of newly diagnosed ICU CLI cases after at least 48 hours of central line insertion
Number of central line days in that reporting period, multiplied by 1,000.

Central line days include all patients in the ICU 18 years and older.

Comments:
The number of new Central Line Primary Bloodstream Infections was zero in October-December 2009.

Steps used to prevent infection include implementation of the Safer Healthcare Now "bundles". A "bundle" is a collection of processes needed to effectively and safely care for patients undergoing particular treatments with inherent risks.

The Central Line Insertion Bundle elements are:

- Hand hygiene
- Maximal barrier precaution (Sterile Gloves and Gown, Mask and Hat)
- 30 second scrub with Chlorhexidine 2% with 70% alcohol plus 2 minute dry time
- Optimal catheter site selection, with subclavian vein as the preferred site for non-tunneled catheters in adult patients

The Central Line Maintenance Bundle elements:

- Daily review of line necessity, with prompt removal of unnecessary lines
- Dedicated lumen for Total Parenteral Nutrition (TPN)
- Accessing the lumens aseptically
- Checking entry site for inflammation with every change of dressing

Legend: Green=positive–tracking on target Yellow=monitor–tracking around target Red=needs attention–below target Orange=no data available

Trend: favourable improving trend unfavourable diminishing trend relatively stable trend

Quality Domain:

Safe

people should not be harmed by an accident or mistakes when they receive care

Ventilator Associated Pneumonia (VAP)

Last reporting period

This reporting period

NIAGARA HEALTH SYSTEM
Ventilator Associated Pneumonia (VAP)
Intensive Care Units
Period: January - December, 2009

VAP incidents diagnosed after day 2 of admission for adult patients greater than 18 years of age:

Site	Jan-Mar 2009 Number of VAP Incidents	Jan-Mar 2009 VAP Rate per 1,000 Mechanically Ventilated days	Apr-Jun 2009 Number of VAP Incidents	Apr-Jun 2009 VAP Rate per 1,000 Mechanically Ventilated days	Jul-Sep 2009 Number of VAP Incidents	Jul-Sep 2009 VAP Rate per 1,000 Mechanically Ventilated days	Oct-Dec 2009 Number of VAP Incidents	Oct-Dec 2009 VAP Rate per 1,000 Mechanically Ventilated days
Douglas Memorial	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Niagara-on-the-Lake	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Port Colborne General	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Greater Niagara General	0	0.00	0	0.00	0	0.00	0	0.00
St. Catharines General	0	0.00	0	0.00	0	0.00	0	0.00
Welland Hospital Site	0	0.00	0	0.00	0	0.00	0	0.00
Provincial Numbers	176	3.50	145	2.95	146	3.01		

Notes:

' *N/A* - do not have designated intensive care units

Source of Data:
Critical Care Information System (CCIS)

Reporting Cycle:
Quarterly

Definitions:
VAP is defined as pneumonia (a serious lung infection) that can occur in patients (specifically ICU patients) who need to be on a ventilator for at least 48 hours. VAP occurs when the ventilator tube that pumps air into vulnerable lungs becomes contaminated.

VAP rates are determined by 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.

Ventilator days are the number of days spent on a ventilator for all patients in the ICU 18 years and older.

Comments:
The number of new Ventilator Associated Pneumonia incidents was zero in October-December 2009.

Steps used to prevent infection:
Implementation of the Safer Healthcare Now “bundles”. A “bundle” is a collection of processes needed to effectively and safely care for patients undergoing particular treatments with inherent risks.

The VAP Bundle elements are:
- Elevate the head of the patient's bed 30 degrees
- Daily sedation vacation and daily assessment of readiness to extubate
- Use of Oral versus Nasal Tubes
- Use of EVAC Tubes

Legend: Green=positive–tracking on target Yellow=monitor–tracking around target Red=needs attention–below target Orange=no data available

Trend: favourable improving trend unfavourable diminishing trend relatively stable trend

Quality Domain:

Safe

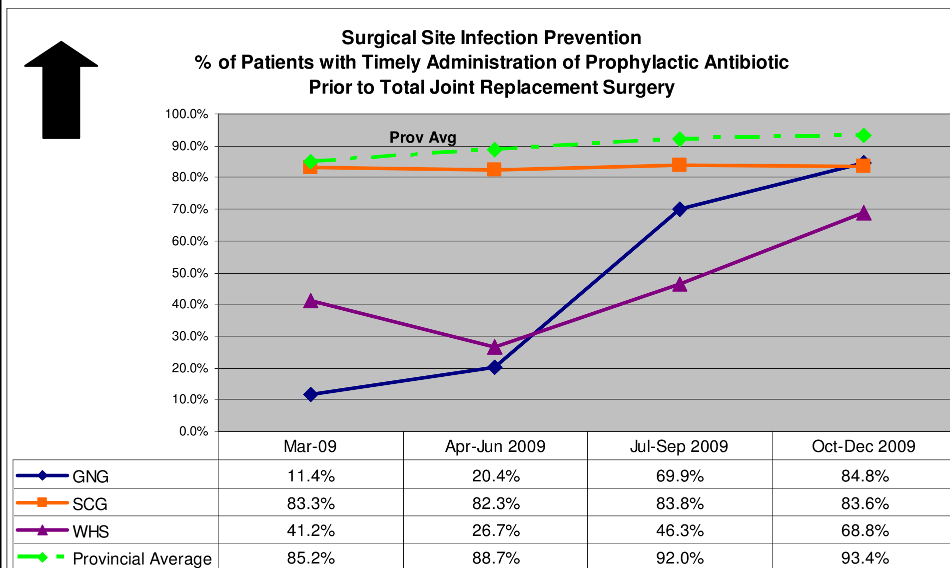
people should not be harmed by an accident or mistakes when they receive care

Surgical Site Infection Prevention

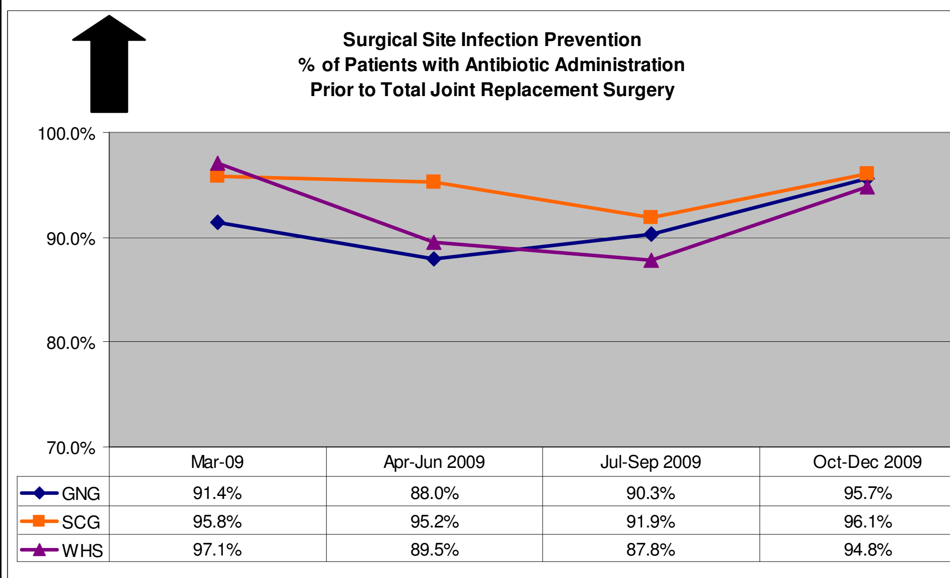
Timely Prophylactic Antibiotic Adminis- tration for Total Joint Replacement Surgery

Last reporting period

This reporting period



	Mar-09	Apr-Jun 2009	Jul-Sep 2009	Oct-Dec 2009
GNG	11.4%	20.4%	69.9%	84.8%
SCG	83.3%	82.3%	83.8%	83.6%
WHS	41.2%	26.7%	46.3%	68.8%
Provincial Average	85.2%	88.7%	92.0%	93.4%



	Mar-09	Apr-Jun 2009	Jul-Sep 2009	Oct-Dec 2009
GNG	91.4%	88.0%	90.3%	95.7%
SCG	95.8%	95.2%	91.9%	96.1%
WHS	97.1%	89.5%	87.8%	94.8%

Source of Data:
PICIS and Infection Control Software

Reporting Cycle:
Quarterly

Definitions:
Surgical site infections occur when harmful germs that occur regularly in the environment, and on your skin, enter your body through the surgical site. Most infections are caused by germs found on and in your body.

One way to prevent surgical site infection is to give patients antibiotics 0 to 60 minutes (for usual antibiotics) or 0 to 120 minutes (for an antibiotic known as vancomycin) before surgery.

The percentage of patients with antibiotic administration within the appropriate time is calculated by :

total patients who received antibiotics within the appropriate time period prior to surgery

Total number of surgical patients during the reporting period, multiplied by 100. Included are patients 18 years or older who undergo primary hip or knee joint replacement surgery, including total, partial or hemi arthroplasty.

Comments:
All the NHS sites that perform joint surgery are below the provincial average of 93.4% for Oct-Dec 2009. GNG is now the closest to the provincial average at 84.8%. SCG is very close at 83.6%. It is important to note that antibiotics are administered to approximately 95% of the patients.
There were three surgical site infections related to total joint replacement surgery that presented to hospital during Oct-Dec 2009. There were 2 surgical site infections related to total joint replacement surgery during Jul-Sept 2009.

Steps being implemented to increase rates::
The peri-operative program is currently working on standardizing and changing processes to ensure that the antibiotics are given in a timely manner at all three sites.

Legend: Green=positive–tracking on target Yellow=monitor–tracking around target Red=needs attention–below target Orange=no data available

Trend: favourable improving trend unfavourable diminishing trend relatively stable trend

Quality Domain:

Safe

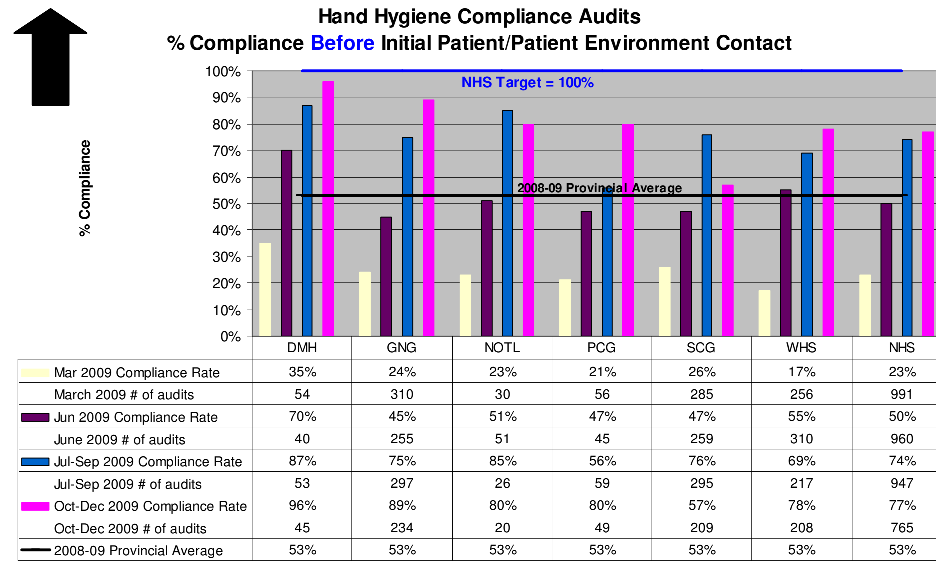
people should not be harmed by an accident or mistakes when they receive care

Hand Hygiene Compliance

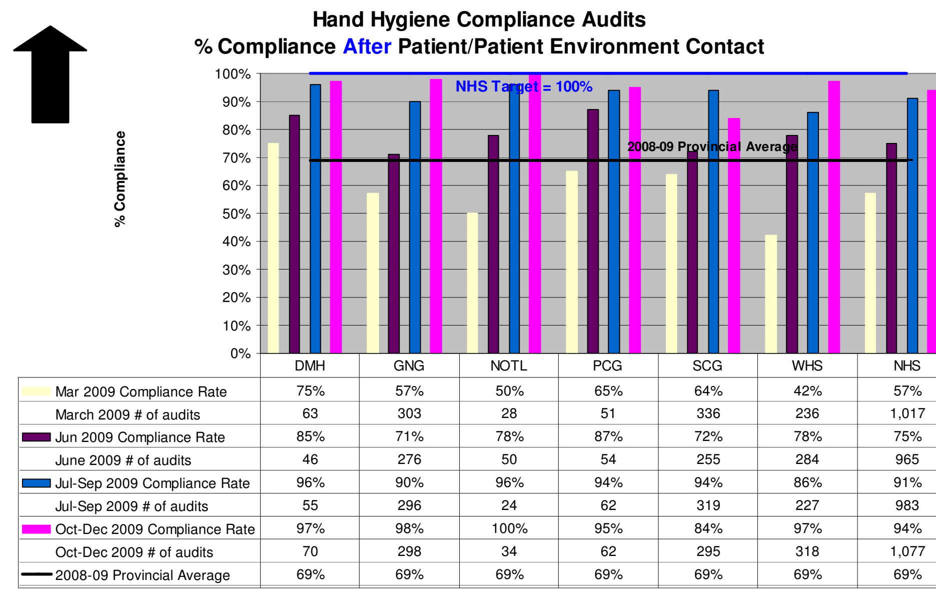
Percentage Compliance for Before and After Patient/ Patient Environment Contact

Last reporting period compared to Provincial Average

This reporting period compared to Provincial Average



	DMH	GNG	NOTL	PCG	SCG	WHS	NHS
Mar 2009 Compliance Rate	35%	24%	23%	21%	26%	17%	23%
March 2009 # of audits	54	310	30	56	285	256	991
Jun 2009 Compliance Rate	70%	45%	51%	47%	47%	55%	50%
June 2009 # of audits	40	255	51	45	259	310	960
Jul-Sep 2009 Compliance Rate	87%	75%	85%	56%	76%	69%	74%
Jul-Sep 2009 # of audits	53	297	26	59	295	217	947
Oct-Dec 2009 Compliance Rate	96%	89%	80%	80%	57%	78%	77%
Oct-Dec 2009 # of audits	45	234	20	49	209	208	765
2008-09 Provincial Average	53%	53%	53%	53%	53%	53%	53%



	DMH	GNG	NOTL	PCG	SCG	WHS	NHS
Mar 2009 Compliance Rate	75%	57%	50%	65%	64%	42%	57%
March 2009 # of audits	63	303	28	51	336	236	1,017
Jun 2009 Compliance Rate	85%	71%	78%	87%	72%	78%	75%
June 2009 # of audits	46	276	50	54	255	284	965
Jul-Sep 2009 Compliance Rate	96%	90%	96%	94%	94%	86%	91%
Jul-Sep 2009 # of audits	55	296	24	62	319	227	983
Oct-Dec 2009 Compliance Rate	97%	98%	100%	95%	84%	97%	94%
Oct-Dec 2009 # of audits	70	298	34	62	295	318	1,077
2008-09 Provincial Average	69%	69%	69%	69%	69%	69%	69%

Source of Data:
MoHLTC Hand Hygiene Observation Tool and internal audit information.

Reporting Cycle:
Publicly reported annually.

Definitions:
Hand hygiene relates to the removal of visible soil and the removal or killing of microorganisms from the hands and may be accomplished using soap and running water or an alcohol-based hand rub. Four indications define proper hand hygiene compliance:
(i) Before initial patient/patient environment contact;
(ii) Before aseptic procedure;
(iii) After body fluid exposure risk;
(iv) After patient/patient environment contact.
Hand hygiene compliance rates are a percentage for time periods identified by the Ministry of Health and Long-Term Care, using the following formula:

$$\frac{\text{\# of times hand hygiene performed X 100}}{\text{\# of observed hand hygiene indications}}$$

Comments:
The % of compliance BEFORE initial patient/patient environment contact ranges from 57% to 96% across the NHS for Q3 2009-10. The NHS is now above the 2008-09 provincial average of 53% at all sites.
The % of compliance AFTER initial patient/patient environment contact ranges from 84% to 100% across the NHS for Q3 2009-10. The NHS is above the 2008-09 provincial average of 69% at all sites.

Steps being implemented to increase compliance::
- Infection Control Practitioners will be providing education on the correct methods of hand hygiene and the importance.
- Compliance auditing will continue throughout the year after targeted education and re-education will be provided as deemed necessary by audit results.
- Staff will be asked to complete the MOHLTC training modules and this may be mandatory.
- Lunch n Learns will be held on a rotating basis which will include physicians.

Legend: Green=positive–tracking on target Yellow=monitor–tracking around target Red=needs attention–below target Orange=no data available

Trend: favourable improving trend unfavourable diminishing trend relatively stable trend

Quality Domain:

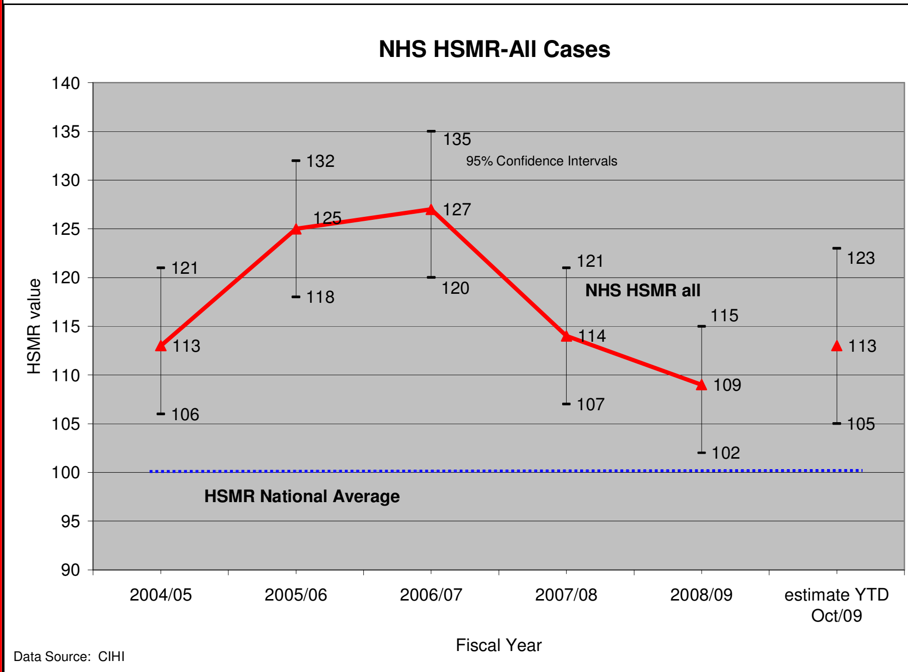
Effective

doing the right thing to achieve the best possible result

Hospital Standardized Mortality Ratio (HSMR)

Last reporting period

This reporting period



Source of Data:
CIHI – Canadian Institute of Health Information

Reporting Cycle:
Quarterly

Definitions:
Hospital Standardized Mortality Ratio compares the expected vs. actual inpatient deaths within a hospital. The expected deaths are based on the comparison of hospital cases against a national regression analysis, which assigns a probability of death. A ratio greater than 100 indicates that there are more deaths then expected compared to the 2004/05 national average. A ratio of 100 means the hospital mortality is in line with the national experience.

Comments:
- 2008/09 results have decreased to 109, with a 95% confidence interval of 102 to 115, which is still statically higher than the nation average
- The final HSMR results have decreased by 14% in the last two years from 127 to 109.
- YTD Oct/09 have shown an increase from 08/09 by 4%, a chart review position has been approved to assist in chart reviews.

Factors Affecting HSMR include:
- Opportunities for quality improvement
- Infrastructure in the community
- Population Characteristics
- Population Served

Action Plan – 5 key items:
1. Patient Safety plan
2. Review of Safer Healthcare Now (SHN) and Institute of Health Improvement (IHI) initiatives – new item is approval of early warning system in Apr/10
3. Ongoing analysis and monitoring
4. Chart review process
5. Education and follow up

Legend: Green=positive–tracking on target Yellow=monitor–tracking around target Red=needs attention–below target Orange=no data available

Trend: favourable improving trend unfavourable diminishing trend relatively stable trend

Quality Domain:

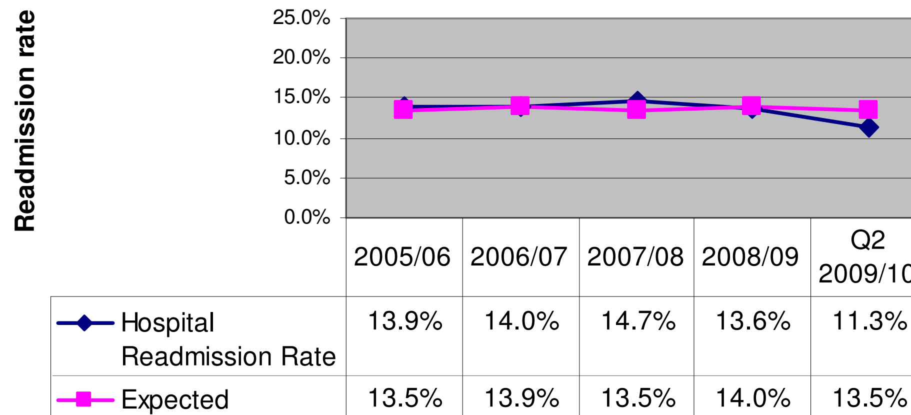
Effective

doing the right thing to achieve the best possible result

Hospital Readmission Rate

Last reporting period

This reporting period



Hospital Medical Readmission Rate

	2005/06	2006/07	2007/08	2008/09	Q2 2009/10
Hospital Readmission Rate	13.9%	14.0%	14.7%	13.6%	11.3%
Expected	13.5%	13.9%	13.5%	14.0%	13.5%

Source of Data:
DAD – CIHI database

Reporting Cycle:
Quarterly

Definitions:
The number of patients readmitted to same hospital site within the NHS for an unplanned inpatient acute readmission to original NHS site, within 30 days from the index admission (note: the second admission may or may not be related to the initial admission)

Expected is calculated based on Hospital Accountability Agreement (HSAA) Indicator tool provided by JPPC.

Comments:
NHS overall 30 *day readmission rates* (to any facility within the NHS) are fairly consistent between fiscal years.

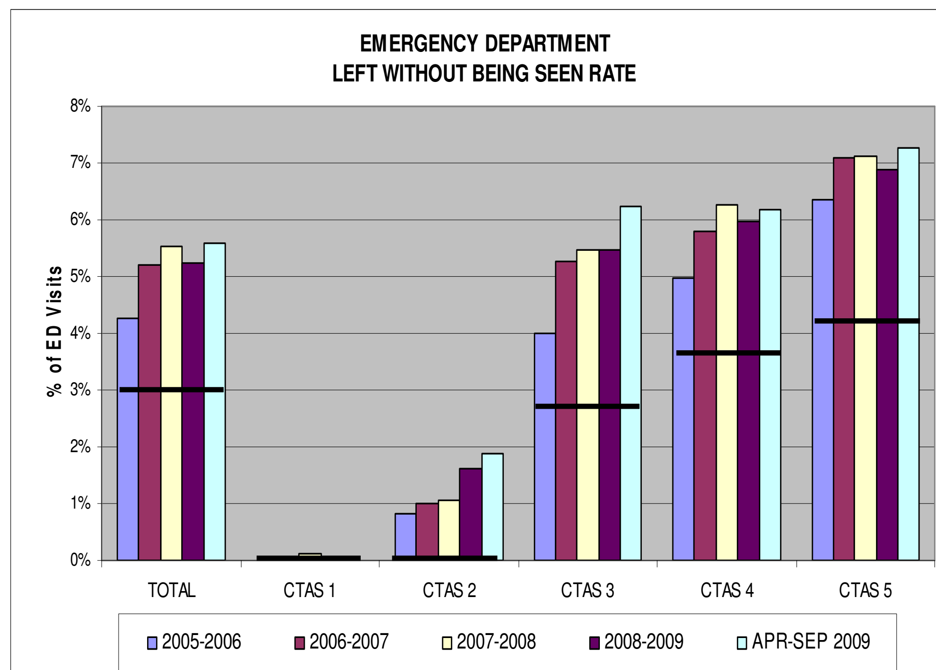
First quarter has seen a decrease, but the quarterly rate can fluctuate and is not as stable as annual values.

The rate has decreased slightly by the second quarter of 2009-10. This decrease is partly due to three initiatives:

- Heart Function Clinic
- Diabetic Clinic
- Earlier identification of chest pain in ED patients and transfer to HHSC for cardiac catheterization (part of the RAN study)

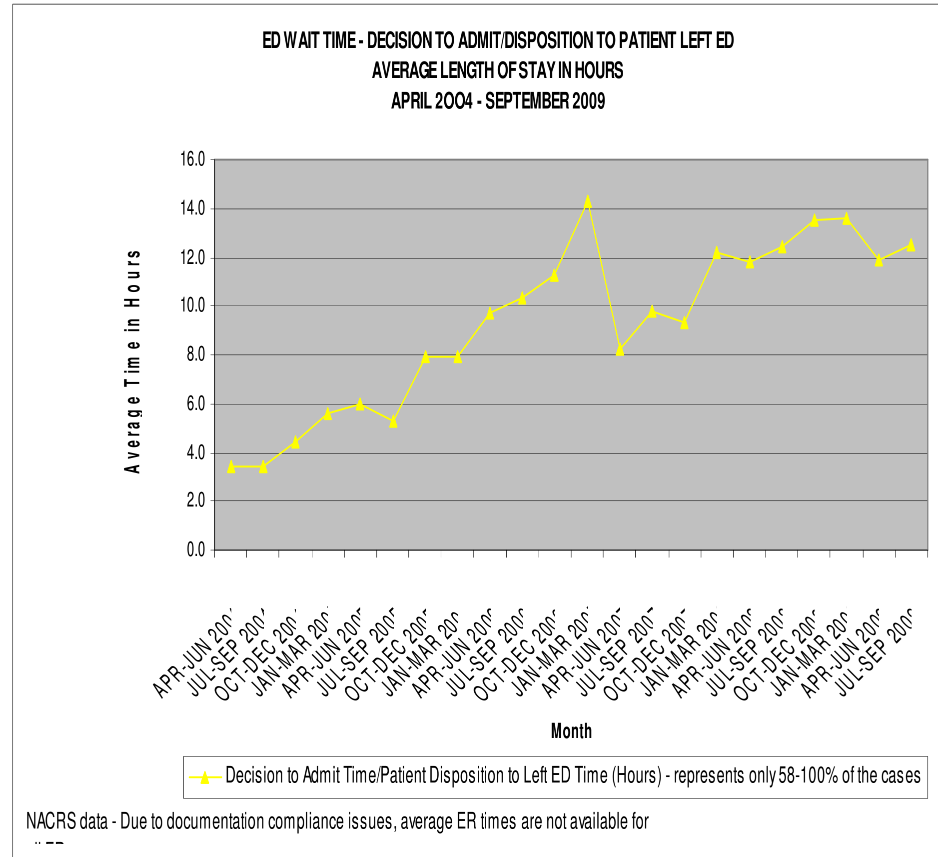
Legend: Green=positive–tracking on target Yellow=monitor–tracking around target Red=needs attention–below target Orange=no data available

Trend: favourable improving trend unfavourable diminishing trend relatively stable trend

Quality Domain: **Timely** *providing care at the right time*	**Left Without Being Seen (LWBS) from Emergency Department**	Last reporting period	This reporting period		*Source of Data*: NACRS CIHI database Benchmark data from CIHI's "Understanding Emergency Department Wait Times" report. *Reporting Cycle*: Annual *Definitions*: Percentage of patients that left the emergency department without being seen. *Comments:* Patients who are triaged and assessed as non-urgent CTAS Level 4 & 5 (less urgent) usually wait longer to be seen, and have a greater tendency to leave without being seen. The sickest patients requiring urgent care are less likely to leave without being seen. 5.6% of NHS ED patients left the ED without being seen by a physician in Q2 2009. The majority of these patients are CTAS levels 5 at 7.3% and CTAS 3 & 4 at 6.2%. The largest percentages are at WHS 11.2% and SCG 8.4%. Other sites GNG 5.4%, PCG 1.6%, OSS 2.3%, and DMH 1.5%. *The 3% benchmark is compared to the total LWBS* and not to the CTAS breakdown. The Canadian benchmark by CTAS level is as follows: ➢ CTAS 1 – 0.1% ➢ CTAS 2 – 0.8% ➢ CTAS 3 – 2.8% ➢ CTAS 4 – 3.6% ➢ CTAS 5 – 4.1% Patients leaving without being seen are an in-direct measure of patient satisfaction (or dissatisfaction).

Legend: Green=positive–tracking on target Yellow=monitor–tracking around target Red=needs attention–below target Orange=no data available

Trend: favourable improving trend unfavourable diminishing trend relatively stable trend

Quality Domain:	Time from Decision to Admit to Inpatient Bed	Last reporting period	This reporting period		
Timely *providing care at the right time*					*Source of Data*: NACRS CIHI database *Reporting Cycle*: Quarterly *Definitions*: The length of time for an ED patient to leave the emergency department to an inpatient ward once a decision to admit has occurred. Provincial benchmarks are currently not available for this segment of ED care, but overall provincial target for total ED length of stay is 8 hours for admitted patients. *Comments:* Q1 2007/08 (8.2 hours) represents a decrease, which was due to the opening of additional beds at HD, compared to the maxim um time observed in Q4 2006/07 of 14.3 hours, however the average time starts to increase again in Q2 07/08 to an average of 9.8 hours and ending the final quarter of 07/08 with an average of 12.2 hours, the highest average of the year. This average continues to climb in 2008/09 to 12.9 hours. The first two quarters of 09/10 has seen a decrease to 12.2 hours. ED wait time from decision to admit to an inpatient ward bed, is greatly impacted by patient flow in the hospital that has been impacted by growing number of ALCs. The MOHLTC Pay for Results initiative recognizes this as a major driver of ED wait time and the funded initiatives focus on improving patient flow through the hospital. SCG ED was provided $1.2M under the Pay for Results initiatives to decrease ED wait time from Oct/08-Mar/09 and renewed again in 2009/10. Total wait time target from triage to admission for admitted patients is 8 hours.

Legend: Green=positive–tracking on target Yellow=monitor–tracking around target Red=needs attention–below target Orange=no data available

Trend: favourable improving trend unfavourable diminishing trend relatively stable trend

Quality Domain:

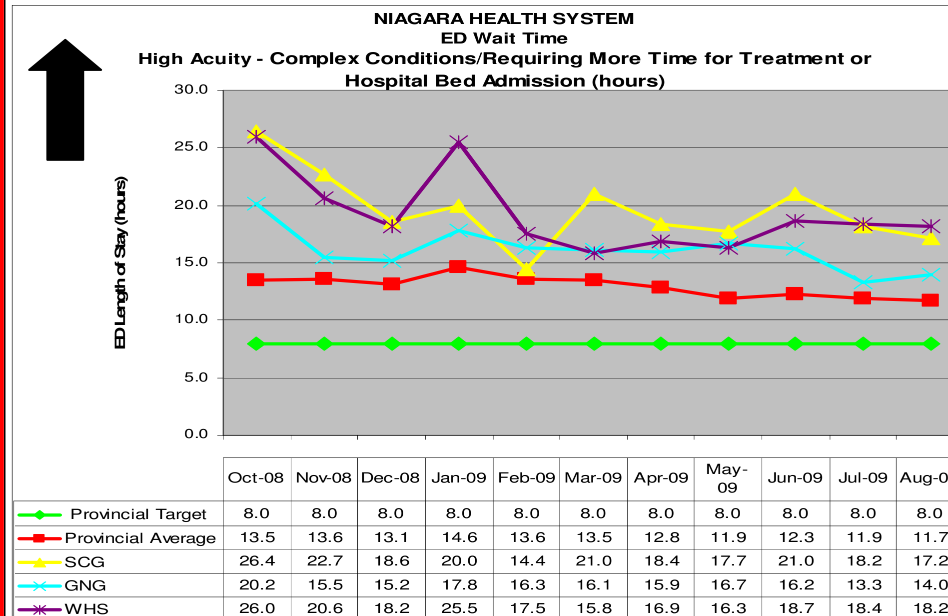
Timely

providing care at the right time

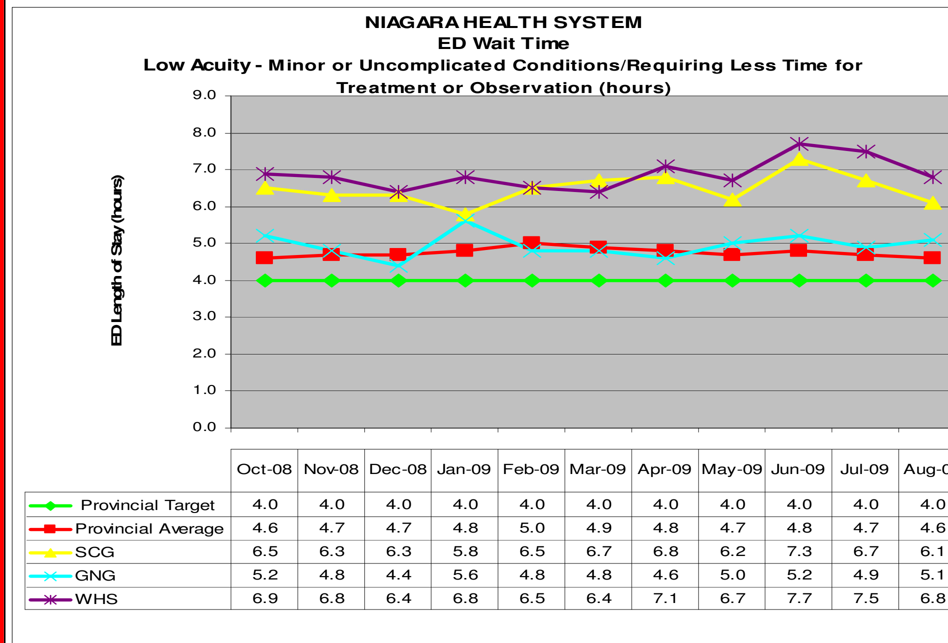
Wait Time – Total Time Spent in Emergency Department

Last reporting period

This reporting period



	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09
Provincial Target	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0
Provincial Average	13.5	13.6	13.1	14.6	13.6	13.5	12.8	11.9	12.3	11.9	11.7
SCG	26.4	22.7	18.6	20.0	14.4	21.0	18.4	17.7	21.0	18.2	17.2
GNG	20.2	15.5	15.2	17.8	16.3	16.1	15.9	16.7	16.2	13.3	14.0
WHS	26.0	20.6	18.2	25.5	17.5	15.8	16.9	16.3	18.7	18.4	18.2



	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09
Provincial Target	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0
Provincial Average	4.6	4.7	4.7	4.8	5.0	4.9	4.8	4.7	4.8	4.7	4.6
SCG	6.5	6.3	6.3	5.8	6.5	6.7	6.8	6.2	7.3	6.7	6.1
GNG	5.2	4.8	4.4	5.6	4.8	4.8	4.6	5.0	5.2	4.9	5.1
WHS	6.9	6.8	6.4	6.8	6.5	6.4	7.1	6.7	7.7	7.5	6.8

Source of Data:
EDRS – Emergency Department Reporting System

Reporting Cycle:
Publicly reported monthly

Definitions:
Total Time Spent in ER: The maximum amount of time 9 out of 10 patients spend in an ER being diagnosed, receiving treatment or waiting for admission to a hospital bed. Most patients spend less time, while one out of ten patients will spend more time.

Comments:
Based on Apr-Aug 09 data,90% of patients experienced the following wait times:

- The target wait time for minor/ uncomplicated patients is 4 hours; Ontario average was 4.7 hours. The NHS ED average was slightly higher at 6.2 hrs.
- For complex/complicated patients, the target wait time is 8 hours, the Ontario average was 12.1 hours and the NHS ED average was 17.1 hours.

These numbers are not surprising, considering the very high numbers of Alternate Level of Care (ALC) patients across NHS sites. ALC patients no longer require acute care but remain in hospital beds while awaiting appropriate placement in long-term care, a rehab bed or home-care services.

On a daily basis average, the NHS admits 20 to 40 patients directly to our EDs because there are no beds. When this happens, they experience a much longer wait in the ED than is ideal. This is particularly pronounced at NHS's large sites where the sickest, most complex patients present.

As NHS ALC bed pressures remain high at 25-30% of acute bed capacity, compared to the provincial average of 19%. As a result, there were as many as 15-45 admit-no-bed patients in our EDs waiting for an acute care bed daily impacting ED wait times.

Strategies to improve:

- SCG ED pay for results funding of $1.2M to reduce wait times
- Dedicated off load delay nurses at SCG, WHS and GNG starting in Feb 2009

Legend: Green=positive–tracking on target Yellow=monitor–tracking around target Red=needs attention–below target Orange=no data available

Trend: favourable improving trend unfavourable diminishing trend relatively stable trend

Quality Domain:

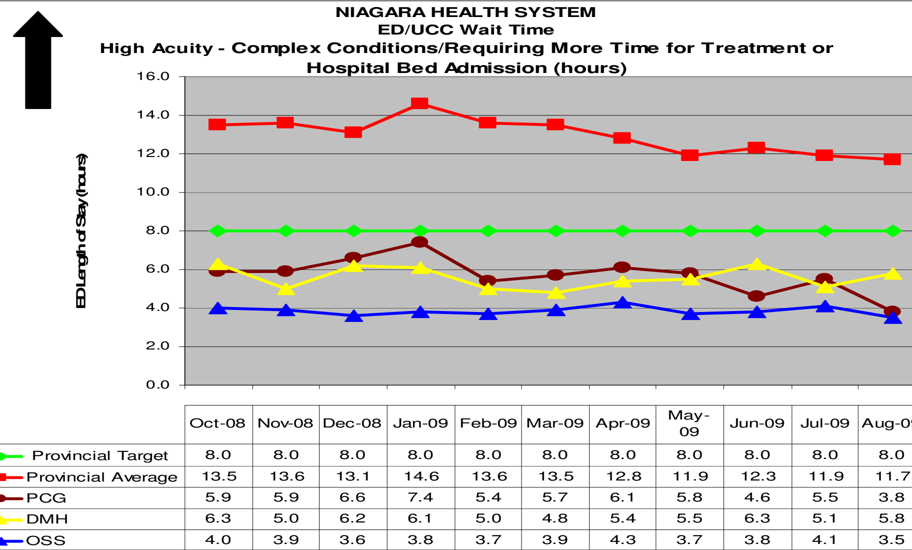
Timely

providing care at the right time

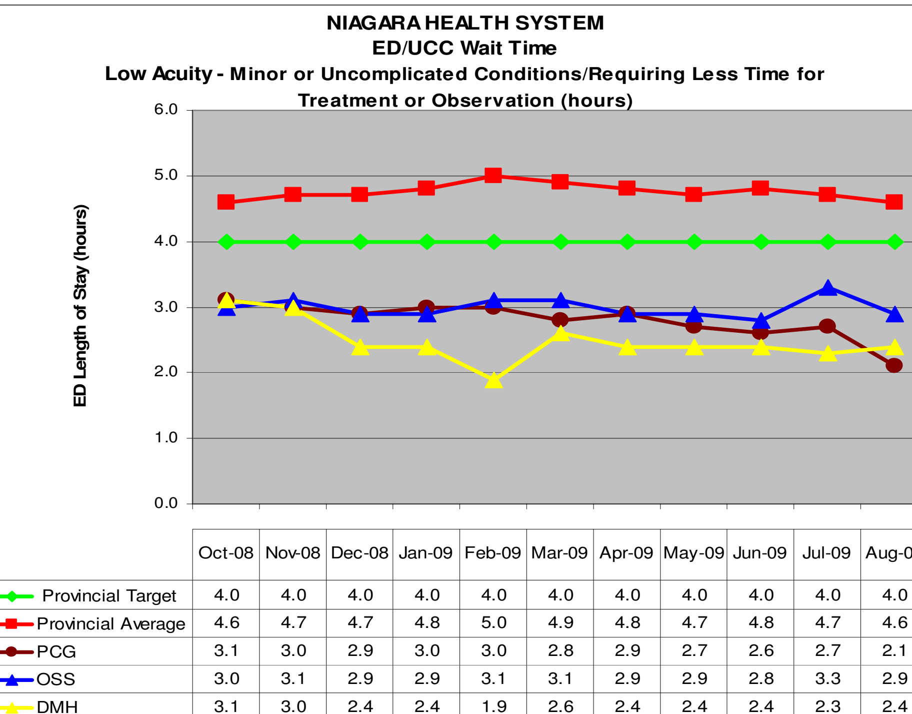
Wait Time – Total Time Spent in Emergency Department

Last reporting period

This reporting period



	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09
Provincial Target	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0
Provincial Average	13.5	13.6	13.1	14.6	13.6	13.5	12.8	11.9	12.3	11.9	11.7
PCG	5.9	5.9	6.6	7.4	5.4	5.7	6.1	5.8	4.6	5.5	3.8
DMH	6.3	5.0	6.2	6.1	5.0	4.8	5.4	5.5	6.3	5.1	5.8
OSS	4.0	3.9	3.6	3.8	3.7	3.9	4.3	3.7	3.8	4.1	3.5



	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09
Provincial Target	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0
Provincial Average	4.6	4.7	4.7	4.8	5.0	4.9	4.8	4.7	4.8	4.7	4.6
PCG	3.1	3.0	2.9	3.0	3.0	2.8	2.9	2.7	2.6	2.7	2.1
OSS	3.0	3.1	2.9	2.9	3.1	3.1	2.9	2.9	2.8	3.3	2.9
DMH	3.1	3.0	2.4	2.4	1.9	2.6	2.4	2.4	2.4	2.3	2.4

Source of Data:
EDRS – Emergency Department Reporting System

Reporting Cycle:
Publicly reported monthly

Definitions:
Total Time Spent in ER: The maximum amount of time 9 out of 10 patients spend in an ER being diagnosed, receiving treatment or waiting for admission to a hospital bed. Most patients spend less time, while one out of ten patients will spend more time.

Comments:
Based on Apr-Aug 09 data,90% of patients experienced the following wait times:

- The target wait time for minor/ uncomplicated patients is 4 hours; Ontario average was 4.7 hours. The NHS UCC average is lower at 2.6
- For complex/complicated patients, the target wait time is 8 hours, the Ontario average was 12.1 hours and the NHS UCC average was 4.9 hours.

These numbers are not surprising, considering the very high numbers of Alternate Level of Care (ALC) patients across NHS sites. ALC patients no longer require acute care but remain in hospital beds while awaiting appropriate placement in long-term care, a rehab bed or home-care services.

On a daily basis average, the NHS admits 20 to 40 patients directly to our EDs because there are no beds. When this happens, they experience a much longer wait in the ED than is ideal. This is particularly pronounced at NHS's large sites where the sickest, most complex patients present..

As NHS ALC bed pressures remain high at 25-30% of acute bed capacity, compared to the provincial average of 19%. As a result, there were as many as 15-45 admit-no-bed patients in our EDs waiting for an acute care bed daily impacting ED wait times.

Strategies to improve:

- SCG ED pay for results funding of $1.2M to reduce wait times
- Dedicated off load delay nurses at SCG, WHS and GNG starting in Feb 2009

Legend: Green=positive–tracking on target Yellow=monitor–tracking around target Red=needs attention–below target Orange=no data available

Trend: favourable improving trend unfavourable diminishing trend relatively stable trend

Quality Domain:

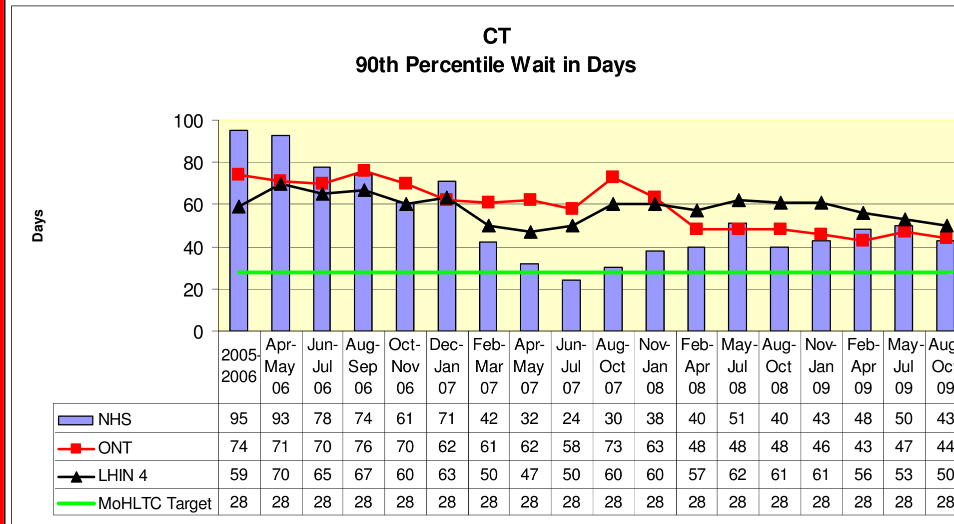
Timely and Equitable

providing care at the right time & same quality of care regardless who the client is

Wait Time – Diagnostic Imaging - CT

Last reporting period

This reporting period



	2005-2006	Apr-May 06	Jun-Jul 06	Aug-Sep 06	Oct-Nov 06	Dec-Jan 07	Feb-Mar 07	Apr-May 07	Jun-Jul 07	Aug-Oct 07	Nov-Jan 08	Feb-Apr 08	May-Jul 08	Aug-Oct 08	Nov-Jan 09	Feb-Apr 09	May-Jul 09	Aug-Oct 09
NHS	95	93	78	74	61	71	42	32	24	30	38	40	51	40	43	48	50	43
ONT	74	71	70	76	70	62	61	62	58	73	63	48	48	48	46	43	47	44
LHIN 4	59	70	65	67	60	63	50	47	50	60	60	57	62	61	61	56	53	50
MoHLTC Target	28	28	28	28	28	28	28	28	28	28	28	28	28	28	28	28	28	28

Source of Data:
MOHLTC Ontario Wait Times Public Information Web Site.

Reporting Cycle:
Publicly reported monthly with a 3 month rolling calculation

Definitions:
Wait time is defined as the difference between the decision to treat and date of exam

Comments:
CT wait times at the NHS begin to decrease slightly and trend shorter than the LHIN 90th percentile. Recent results show CT waits are slightly below the provincial 90th percentile. The NHS 90th percentile is at 43 days which is above the MoHLTC target of 28 days. The NHS has received an additional 402 CT hours for the 2009-10 fiscal year through the Wait Time Strategy. This is a 63% reduction in funded hours from 2007-08 (1071 hrs)

Average number of CT exams per month at the NHS is at 2,293.

To further reduce the Wait Time, additional funding would be required. Funding has been and continues to be made available from the MOHLTC/LHIN but the amount has been insufficient to significantly reduce the Wait Time. It is important to note that there is a process in place to deal with 'urgent or stat' requests.

Legend: Green=positive–tracking on target Yellow=monitor–tracking around target Red=needs attention–below target Orange=no data available

Trend: favourable improving trend unfavourable diminishing trend relatively stable trend

Quality Domain:

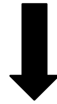
Timely and Equitable

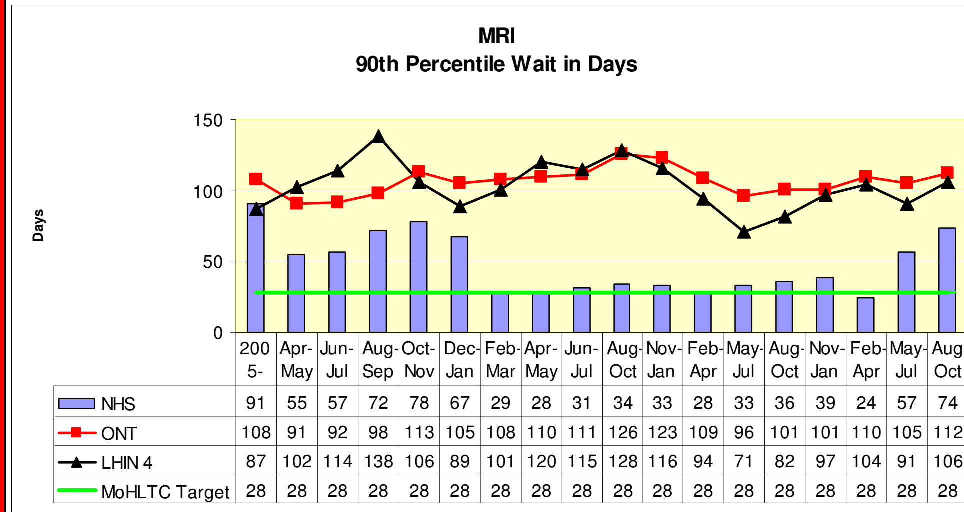
providing care at the right time & same quality of care regardless who the client is

Wait Time – Diagnostic Imaging - MRI

Last reporting period

This reporting period





	2005-	Apr-May	Jun-Jul	Aug-Sep	Oct-Nov	Dec-Jan	Feb-Mar	Apr-May	Jun-Jul	Aug-Oct	Nov-Jan	Feb-Apr	May-Jul	Aug-Oct	Nov-Jan	Feb-Apr	May-Jul	Aug-Oct
NHS	91	55	57	72	78	67	29	28	31	34	33	28	33	36	39	24	57	74
ONT	108	91	92	98	113	105	108	110	111	126	123	109	96	101	101	110	105	112
LHIN 4	87	102	114	138	106	89	101	120	115	128	116	94	71	82	97	104	91	106
MoHLTC Target	28	28	28	28	28	28	28	28	28	28	28	28	28	28	28	28	28	28

Source of Data:
MOHLTC Ontario Wait Times Public Information Web Site.

Reporting Cycle:
Publicly reported monthly with a 3 month rolling calculation

Definitions:
Wait time is defined as the difference between the decision to treat and date of exam

Comments:
MRI wait times continue to rise. The NHS wait time is now trending about five weeks shorter than the provincial 90th percentile and the LHIN 90th percentile. The NHS 90th percentile is at 74 days which is above the MoHLTC target of 28 days. The NHS received an additional 1,680 MRI hours funded in Dec/07 through the Wait Time Strategy. Original wait time funding allocation for 2009/10 was a decrease of 578 hrs or 11%. The NHS received an additional 578 hours from the LHIN from the Q2 reallocation of hours.

Average number of MRI exams per month at the NHS is 1,259.

To further reduce the Wait Time, additional funding would be required. Funding has been and continues to be made available from the MOHLTC/LHIN but the amount has been insufficient to significantly reduce the Wait Time. It is important to note that there is a process in place to deal with 'urgent or stat' requests.

Legend: Green=positive–tracking on target Yellow=monitor–tracking around target Red=needs attention–below target Orange=no data available

Trend: favourable improving trend unfavourable diminishing trend relatively stable trend

Quality Domain:

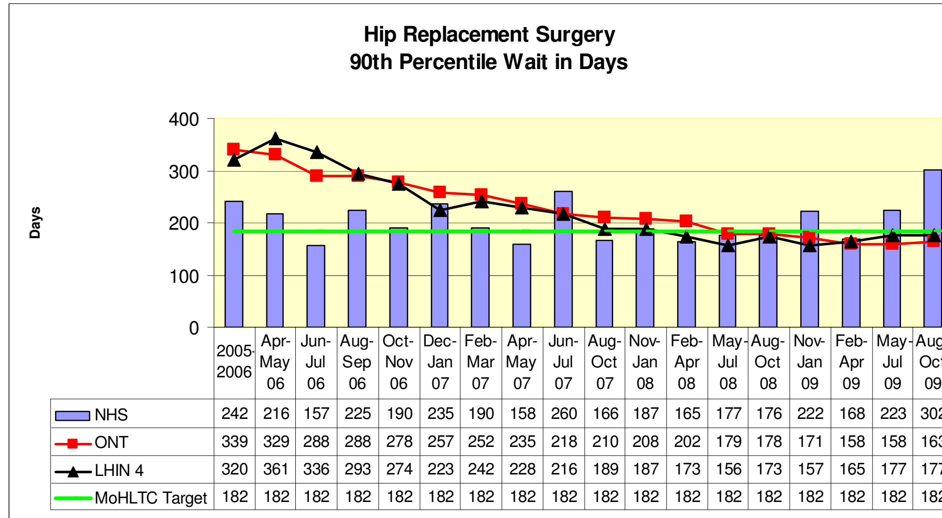
Timely and Equitable

providing care at the right time & same quality of care regardless who the client is

Wait Time – Hip Replacement

Last reporting period

This reporting period



	2005-2006	Apr-May 06	Jun-Jul 06	Aug-Sep 06	Oct-Nov 06	Dec-Jan 07	Feb-Mar 07	Apr-May 07	Jun-Jul 07	Aug-Oct 07	Nov-Jan 08	Feb-Apr 08	May-Jul 08	Aug-Oct 08	Nov-Jan 09	Feb-Apr 09	May-Jul 09	Aug-Oct 09
NHS	242	216	157	225	190	235	190	158	260	166	187	165	177	176	222	168	223	302
ONT	339	329	288	288	278	257	252	235	218	210	208	202	179	178	171	158	158	163
LHIN 4	320	361	336	293	274	223	242	228	216	189	187	173	156	173	157	165	177	177
MoHLTC Target	182	182	182	182	182	182	182	182	182	182	182	182	182	182	182	182	182	182

Source of Data:
MOHLTC Ontario Wait Times Public Information Web Site.

Reporting Cycle:
Publicly reported monthly with a 3 month rolling calculation

Definitions:
Wait time is defined as the difference between the decision to operate and date of operation.

This data excludes procedures at OSS for the months of Aug-Sep/05.

Comments:
NHS Hip replacement wait times continue to increase. Waits now trend about twenty weeks longer than provincial 90th percentile and about eighteen weeks longer than the LHIN 90th percentile. The NHS 90th percentile is at 302 days which is higher than the MoHLTC target of 182 days.

The NHS had received funding from the LHIN on a Data Integrity Project which was recently completed in Mar/09 to review the quality and integrity of wait time data being reported for hips and knees. The education and learning from the review will ensure accurate wait times continue to be reported.

Average number of hip replacement cases per month at the NHS is 29.

Legend: Green=positive–tracking on target Yellow=monitor–tracking around target Red=needs attention–below target Orange=no data available

Trend: favourable improving trend unfavourable diminishing trend relatively stable trend

Quality Domain:

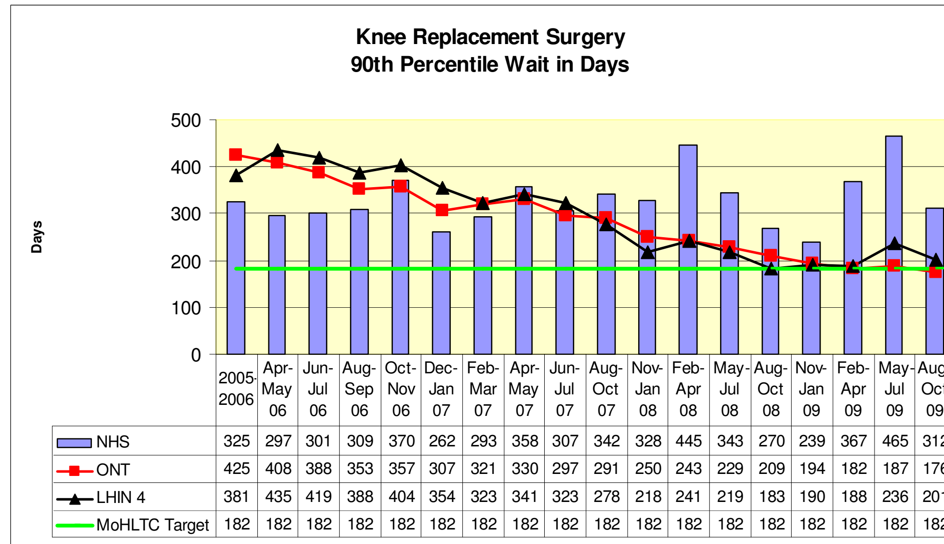
Timely and Equitable

providing care at the right time & same quality of care regardless who the client is

Wait Time – Knee Replacement

Last reporting period

This reporting period



	2005-2006	Apr-May 06	Jun-Jul 06	Aug-Sep 06	Oct-Nov 06	Dec-Jan 07	Feb-Mar 07	Apr-May 07	Jun-Jul 07	Aug-Oct 07	Nov-Jan 08	Feb-Apr 08	May-Jul 08	Aug-Oct 08	Nov-Jan 09	Feb-Apr 09	May-Jul 09	Aug-Oct 09
NHS	325	297	301	309	370	262	293	358	307	342	328	445	343	270	239	367	465	312
ONT	425	408	388	353	357	307	321	330	297	291	250	243	229	209	194	182	187	176
LHIN 4	381	435	419	388	404	354	323	341	323	278	218	241	219	183	190	188	236	201
MoHLTC Target	182	182	182	182	182	182	182	182	182	182	182	182	182	182	182	182	182	182

<u>Source of Data</u>:
MOHLTC Ontario Wait Times Public Information Web Site.

<u>Reporting Cycle</u>:
Publicly reported monthly with a 3 month rolling calculation

<u>Definitions</u>:
Wait time is defined as the difference between the decision to operate and date of operation.

This data excludes procedures at OSS for the months of Aug-Sept/05.

<u>Comments:</u>
The NHS knee replacement wait time decreased this reporting period and is now nineteen weeks longer than the provincial 90th percentile and sixteen weeks longer than the LHIN 90th percentile. The NHS 90th percentile is at 312 days which remains well above the MoHLTC target of 182 days.

The increasing wait times are being reviewed and there are a number of strategies that the NHS is working on in conjunction with the physicians, LHIN, Bone and Joint Network and MOHLTC wait time branch to address.

- Joint assessment centre
- Review of block utilization
- Review of data reporting and practices

Average number of knee replacement cases per month at the NHS is 60.

Legend: Green=positive–tracking on target Yellow=monitor–tracking around target Red=needs attention–below target Orange=no data available

Trend: favourable improving trend unfavourable diminishing trend relatively stable trend

Quality Domain:

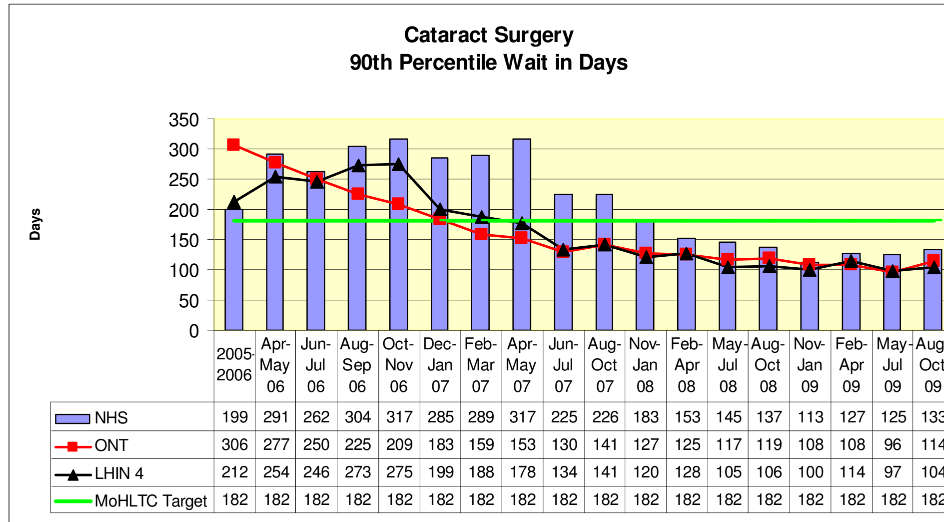
Timely and Equitable

providing care at the right time & same quality of care regardless who the client is

Wait Time – Cataract Surgery

Last reporting period

This reporting period



	2005-2006	Apr-May 06	Jun-Jul 06	Aug-Sep 06	Oct-Nov 06	Dec-Jan 07	Feb-Mar 07	Apr-May 07	Jun-Jul 07	Aug-Oct 07	Nov-Jan 08	Feb-Apr 08	May-Jul 08	Aug-Oct 08	Nov-Jan 09	Feb-Apr 09	May-Jul 09	Aug-Oct 09
NHS	199	291	262	304	317	285	289	317	225	226	183	153	145	137	113	127	125	133
ONT	306	277	250	225	209	183	159	153	130	141	127	125	117	119	108	108	96	114
LHIN 4	212	254	246	273	275	199	188	178	134	141	120	128	105	106	100	114	97	104
MoHLTC Target	182	182	182	182	182	182	182	182	182	182	182	182	182	182	182	182	182	182

Source of Data:
MOHLTC Ontario Wait Times Public Information Web Site.

Reporting Cycle:
Publicly reported monthly with a 3 month rolling calculation

Definitions:
Wait time is defined as the difference between the decision to operate and date of operation

This data exclude procedures at OSS for the months of August/05 and September/05.

Comments:
The cataract wait times remain relatively stable. The NHS wait time is trending three weeks longer than the provincial and four weeks longer than the LHIN 90th percentile. The NHS 90th percentile is at 133 days which is below the MoHLTC target of 182 days. Both the province and the LHIN remain below the MoHLTC target.

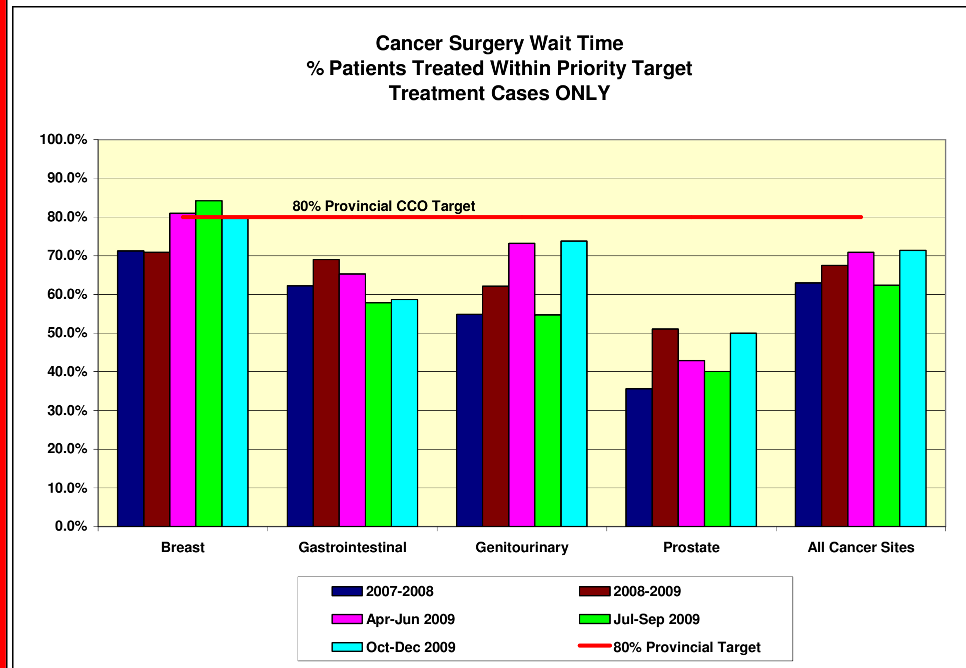
Through the Wait Time Strategy, the NHS received 1,511 cataract funded cases for 2009/10, an 11% increase from the previous year.

The NHS had received funding from the LHIN on a Data Integrity Project which was recently completed to review the quality and integrity of wait time data being reported for cataracts. The education and learning from the review will ensure accurate wait times continue to be reported.

Average number of cataract cases per month at the NHS is 441.

Legend: Green=positive–tracking on target Yellow=monitor–tracking around target Red=needs attention–below target Orange=no data available

Trend: favourable improving trend unfavourable diminishing trend relatively stable trend

Quality Domain:	Wait Time – % Cancer Patients Treated Within the Priority Target - Treatment Cases ONLY	Last reporting period	This reporting period		
Timely and Equitable *providing care at the right time & same quality of care regardless who the client is*		Last reporting period	This reporting period	 	*Source of Data*: MOHLTC Wait Time Strategy *Reporting Cycle*: Quarterly *Definitions*: Wait time is defined as the difference between the decision to operate and date of operation. Data includes ONLY treatment cancer surgery cases. It does NOT include diagnosis, staging, surveillance, reconstruction, and palliative cases. *Comments:* CCO has recently raised the target to 80% for the percentage of cancer patients who are treated within the priority target. This target is for TREATMENT cases only. At the end of December 2009, the NHS was below the target with a rate of 71.4%. This is slightly higher than Q1 2009-10. The graph shows the rates for our 4 highest volume specialties. The three areas that are driving down our percentage are Gastrointestinal, Genitourinary, and Prostate cancer. The NHS continues an internal review of the quality and integrity of wait time data being reported for cancer surgery. Education continues to be provided to ensure accurate wait times are reported.

Legend: Green=positive–tracking on target Yellow=monitor–tracking around target Red=needs attention–below target Orange=no data available

Trend: favourable improving trend unfavourable diminishing trend relatively stable trend

Quality Domain:

Efficient

Making the best use of resources

Conservable Beds

Last reporting period

This reporting period

Conservable Beds for Medicine & Surgery (ONLY)

Based on Provincial Percentile for CMG+ Methedology

Site	Service	All Cases at 50th Percentile			"Opportunity" Only Cases Over 50th Percentile			All Cases at 25th Percentile		
		07/08	08/09	Q2 09/10	07/08	08/09	Q2 09/10	07/08	08/09	Q2 09/10
NHS	Med	(13.9)	(19.5)	(23.2)	27.4	15.9	25.4	20.7	16.4	16.5
	Surg	(3.4)	(7.1)	(4.8)	15.3	7.9	14.4	12.6	8.5	11.6
	Total	(17.3)	(26.7)	(28.0)	42.7	23.8	39.8	33.3	24.9	28.1

Note: Beds calculated at 90% occupancy, grouped to 2009 Source: DAD

Key	
(green)	under target
(red)	over target

Source of Data:
DAD – CIHI database and Ontario Percentiles

Reporting Cycle:
Quarterly

Definitions:
The lengths of stay for typical cases (excludes, ALC, outliers, deaths) within the Medical/Surgical programs of the NHS are compared to the Ontario hospital Percentiles. Both years are grouped to CMG+ and beds are calculated at a 90% occupancy rate.

All Cases at 50% - NHS typical cases compared to 50% percentile Ont hospitals.

"Opportunity" - only cases over 50% percentile – total opportunity for savings if *all* cases at provincial average.

All Cases at 25% - NHS typical cases compared to 25% percentile Ont hospitals

NHS utilization target/goal is to minimally achieve the 50% for all cases and strive towards the 25%.

Comments:

Three benchmarks are presented in the table above:

- ***All Cases at 50%.*** All programs are currently performing at or below benchmark in Q2 09/10. Total NHS performance is 28.0 beds more efficient than the provincial average.
- ***"Opportunity" - Only Cases Over 50%.*** All sites and programs have an opportunity to improve, with the largest opportunity in Q2 09/10 being the med/surgical program at the SCG.
- ***All Cases at 25%***. GNG and WHS are close to the 25th percentile, majority of the opportunity is at SCG.

Based on recent utilization benchmarking comparisons with peer hospitals, the NHS is one of the most efficient facilities.

Legend: Green=positive–tracking on target Yellow=monitor–tracking around target Red=needs attention–below target Orange=no data available

Trend: favourable improving trend unfavourable diminishing trend relatively stable trend

Quality Domain:

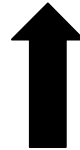
Efficient

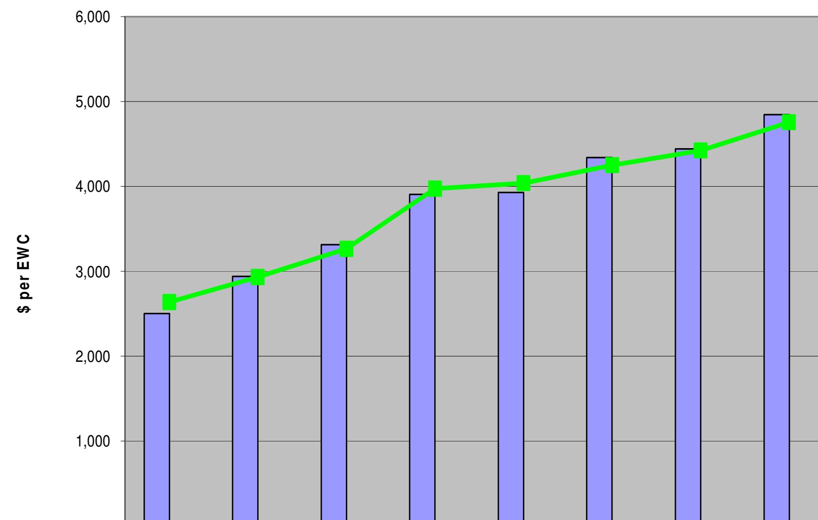
Making the best use of resources

Cost per Weighted Case

Last reporting period

This reporting period





	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08
ACPWC	2,504	2,938	3,315	3,904	3,929	4,339	4,441	4,846
Variance %	-5.01%	0.28%	1.61%	-1.72%	-2.75%	2.09%	0.43%	1.93%
ECPWC	2,636	2,930	3,262	3,973	4,040	4,250	4,422	4,754
Variance Over/(Under)	(132)	8	52	(68)	(111)	89	19	92

Source of Data:
MOHLTC and JPPC

Reporting Cycle:
Annually

Definitions:
Cost per Equivalent Weighted Case – cost per acute, day surgery and chronic equivalent cases.

Actual cost per equivalent weighted case (ACPEWC) results are compared to an expected (ECPEWC) target. The expected is derived from a provincial base rate and adjusted for a number of factors show to affect cost (eg. teaching, tertiary care, distance).

Hospitals at or below the expected costs are considered efficient.

Comments:

The NHS has traditionally been under or very close to its expected cost per equivalent weighted case. For 2007-08 the NHS actual cost per case was $4,846 versus an expected cost of $4,754, a negative variance of 1.9% per case, decreasing favorably from 06/07 variance of .43%.

The NHS is performing better than its peer hospitals with respect to actual versus expected cost per weighted case yet it still faces a significant deficit. Although further detail is required, this suggests that MoHLTC funding is lower than peer hospitals for the level of patient activity provided.

Legend: Green=positive–tracking on target Yellow=monitor–tracking around target Red=needs attention–below target Orange=no data available

Trend: favourable improving trend unfavourable diminishing trend relatively stable trend

Quality Domain:

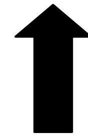
Continuity of Services

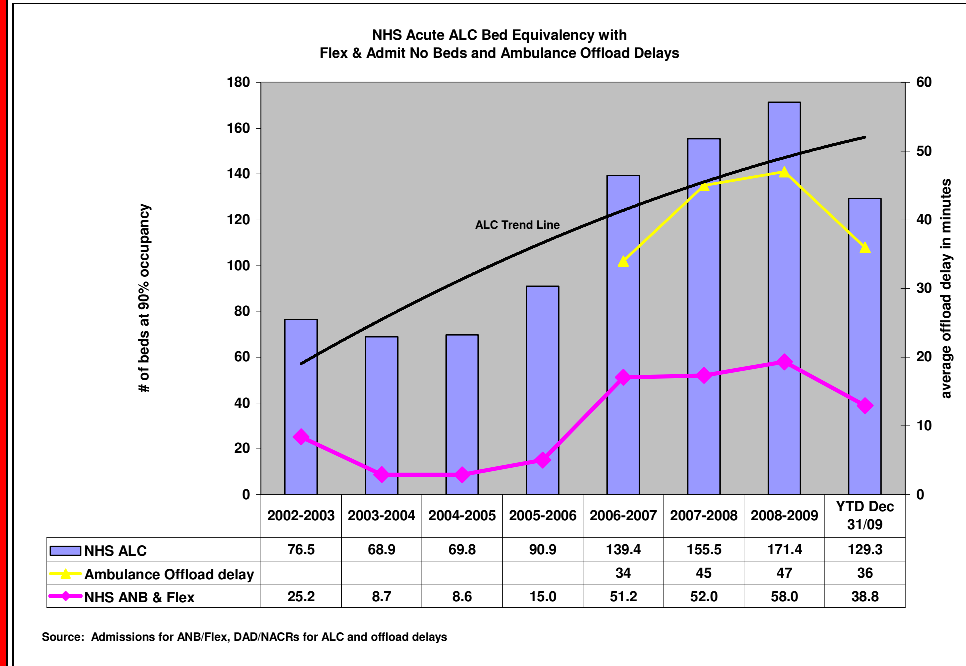
Experiencing coordinated and seamless services

Admit No Bed

Last reporting period

This reporting period





	2002-2003	2003-2004	2004-2005	2005-2006	2006-2007	2007-2008	2008-2009	YTD Dec 31/09
NHS ALC	76.5	68.9	69.8	90.9	139.4	155.5	171.4	129.3
Ambulance Offload delay					34	45	47	36
NHS ANB & Flex	25.2	8.7	8.6	15.0	51.2	52.0	58.0	38.8

Source: Admissions for ANB/Flex, DAD/NACRs for ALC and offload delays

Source of Data:
ALC DAD – CIHI Database

Reporting Cycle:
Quarterly

Definitions:
Comparison of acute ALC bed equivalency, ED 'admit no bed' and flex beds and EMS reported offload delay minutes.

Provincial benchmarks are not available.

Comments:
ANB have decreased slightly from Apr-July 2009 which is causing a decrease in EMS offload delays. In turn the ANB volumes are influenced by the volume of ALC patients occupying beds within the units.

Some relief was being experienced early in 2008/09 with a decrease in acute ALC's with the A-1 crisis designation initiative but it began to increase after the first quarter from an average of 156 in 07/08 to 171 in 2008/09, a 15 bed increase. But with targeted strategies, ALC has decreased by 42 beds ytd Dec/09 from 08/09, and the ANB has experienced a similar decrease.

ALC's continue to impact on admit-no-beds in the emergency department, ambulance offload delays and ALOS as patients wait for appropriate placement. A decrease has been experienced in flex/ANB from 58 to 39 beds, a 33% decrease in ALC's for YTD Dec 2009 compared to 2008/09.

At any given hour there was an average of between 11 to 41 ANB patients in the NHS ED's Apr-Dec/09. These pressures have impacted ambulance offload delays in the same period and ALOS as patients wait for appropriate placement. On any given day there are approximately 200 ALC patients in NHS acute and CCC beds across all sites.

Legend: Green=positive–tracking on target Yellow=monitor–tracking around target Red=needs attention–below target Orange=no data available

Trend: favourable improving trend unfavourable diminishing trend relatively stable trend

Quality Domain:

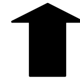
Continuity of Services

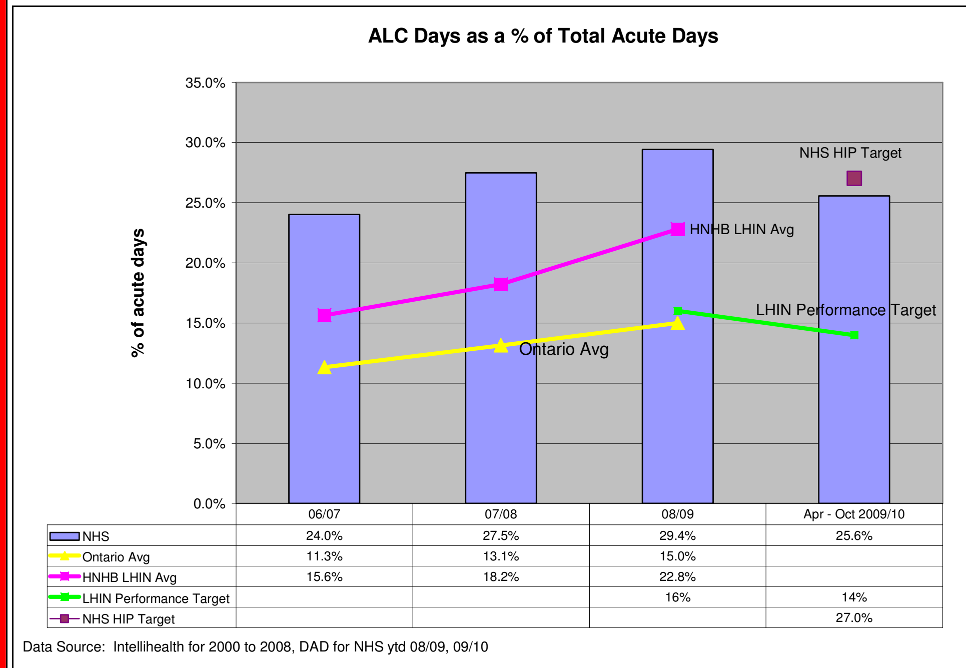
Experiencing coordinated and seamless services

ALC as a Percentage of Total Acute Patient Days

Last reporting period

This reporting period





	06/07	07/08	08/09	Apr - Oct 2009/10
NHS	24.0%	27.5%	29.4%	25.6%
Ontario Avg	11.3%	13.1%	15.0%	
HNHB LHIN Avg	15.6%	18.2%	22.8%	
LHIN Performance Target			16%	14%
NHS HIP Target				27.0%

Data Source: Intellihealth for 2000 to 2008, DAD for NHS ytd 08/09, 09/10

Source of Data:
CIHI Database
Reporting Cycle:
Quarterly
Definitions:
Alternate Level of Care (ALC) - When a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting (Acute, Complex Continuing Care, Mental Health or Rehabilitation), the patient must be designated Alternate Level of Care (ALC) at that time by the physician or her/his delegate. The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination (or when the patient's needs or condition changes and the designation of ALC no longer applies).
Indicator monitors ALCs in acute beds only.
Bed occupancy rate of 95%.

Comments:
NHS is consistently above the Ontario and LHIN average for ALCs and has one of the highest experiences in the province. LHIN MLA and HSAA target is 14% ALC rate.
The NHS would have to reduce approximately 100 beds currently filled with ALCs to meet the 14% ALC target.
The HIP includes significant savings from the closure of approximately 90 ALC beds over the next 3 years, related to ALCs being placed in more appropriate setting, based on community investment. For 2009/10, 30 acute care beds will be closed resulting in annual operating savings of $3 million. The NHS is committed to working with internal and external stakeholders to achieve these savings.
A number of ALC Strategies have been developed to improve patient flow and reduce the number of ALC patients. These include:

- Flo Collaborative
- Assess/Restore Beds

Additional funding through the HNHB LHIN Aging at Home program was announced in May 2009 of $26.6M to help seniors receive services in the comfort of their own homes.

Legend: Green=positive–tracking on target Yellow=monitor–tracking around target Red=needs attention–below target Orange=no data available

Trend: favourable improving trend unfavourable diminishing trend relatively stable trend

Quality Domain:

Population Focus

The health system should work to prevent sickness and improve the health of the community

Top ten Diagnosis Groups (CMG's)

Last reporting period

This reporting period

Top 10 Case Mix Groups (CMG) - CMG Plus Methodolgy

Case Mix Groups	2006-2007	2007-2008	2008-2009	Q2 Apr-Sept'09	Total
545 Vaginal Delivery, No Other Intervention	1,824	1,742	1,751	942	6259
576 Normal Newborn, Singleton Vaginal Delivery	1,734	1,646	1,598	784	5762
139 Chronic Obstructive Pulmonary Disease	1,127	952	1,024	427	3530
196 Heart Failure without Cardiac Catheter	776	696	670	303	2445
249 Enteritis	552	687	631	472	2342
321 Unilateral Knee Replacement	565	622	603	308	2098
577 Normal Newborn Multiple/Caesarean Delivery	563	566	489	277	1895
138 Viral/Unspecified Pneumonia	557	497	542	232	1828
502 Hysterectomy with Non Malignant Diagnosis	509	524	520	266	1819
202 Arrhythmia without Cardiac Catherter	501	511	470	255	1737
Total	**8,708**	**8,443**	**8,298**	**4,266**	**29,715**

Source of Data:
DAD – CIHI database

Reporting Cycle:
Quarterly

Definitions:
Case Mix Group (CMG) is assigned at the time of coding based on physician documentation in the patients chart. CIHI 2008 Grouper logic applied to all years for comparison purposes.

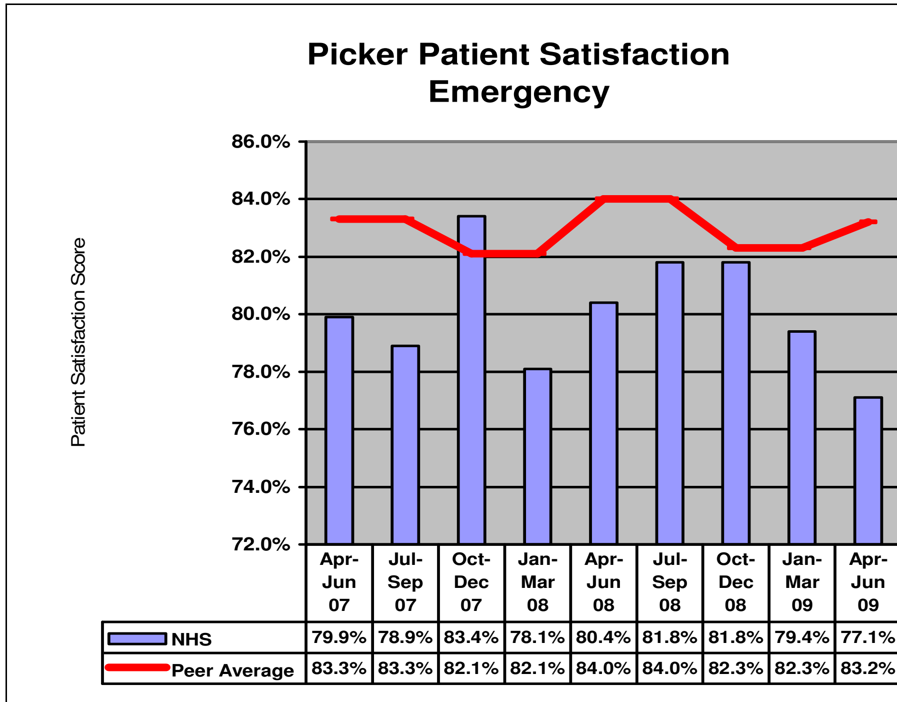
Comments:
Three of the top ten CMGs are consistently within the Maternal/Child Program; however the overall volume of these patients is decreasing.

Top 10 remain consistent between the years.

Legend: Green=positive–tracking on target Yellow=monitor–tracking around target Red=needs attention–below target Orange=no data available

Trend: favourable improving trend unfavourable diminishing trend relatively stable trend

Quality Domain:	Picker Patient Satisfaction – Emergency				
Patient - Centered *Putting clients and families first*		Last reporting period	This reporting period		*Source of Data*: NCR Picker *Reporting Cycle*: Quarterly *Definitions*: This indicator examines patients' perceptions of their emergency department experience, including their perceptions of overall quality of care, physician care, and waiting times. For each of the indicators in the Patient Satisfaction quadrant, a higher score is desirable. Similarly, a rating of above average performance is most desirable. *Comments:* Program Leaders continue to monitor quarterly findings against the Peer Average in order to continuously identify opportunities to improve annual Hospital Report Findings. Scores have decreased in the last quarter Apr-Jun 2009. NHS continues to trend below the PEER average.



	Apr-Jun 07	Jul-Sep 07	Oct-Dec 07	Jan-Mar 08	Apr-Jun 08	Jul-Sep 08	Oct-Dec 08	Jan-Mar 09	Apr-Jun 09
NHS	79.9%	78.9%	83.4%	78.1%	80.4%	81.8%	81.8%	79.4%	77.1%
Peer Average	83.3%	83.3%	82.1%	82.1%	84.0%	84.0%	82.3%	82.3%	83.2%

Legend: Green=positive–tracking on target Yellow=monitor–tracking around target Red=needs attention–below target Orange=no data available

Trend: favourable improving trend unfavourable diminishing trend relatively stable trend

Quality Domain:

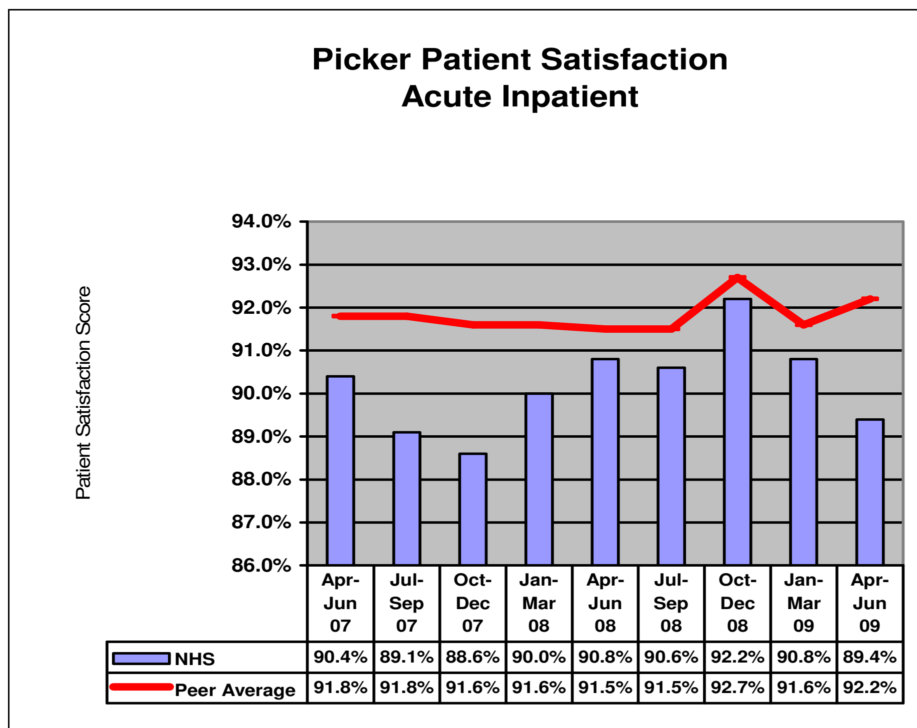
Patient - Centered

Putting clients and families first

Picker Patient Satisfaction - Acute Inpatient

Last Not reported

This reporting period



	Apr-Jun 07	Jul-Sep 07	Oct-Dec 07	Jan-Mar 08	Apr-Jun 08	Jul-Sep 08	Oct-Dec 08	Jan-Mar 09	Apr-Jun 09
NHS	90.4%	89.1%	88.6%	90.0%	90.8%	90.6%	92.2%	90.8%	89.4%
Peer Average	91.8%	91.8%	91.6%	91.6%	91.5%	91.5%	92.7%	91.6%	92.2%

Source of Data:
NCR Picker

Reporting Cycle:
Quarterly

Definitions:
This indicator examines patients' perceptions of their acute inpatient experience, including their perceptions of overall quality of care, physician care, and waiting times. For each of the indicators in the Patient Satisfaction quadrant, a higher score is desirable. Similarly, a rating of above average performance is most desirable.

Comments:
Program Leaders continue to monitor quarterly findings against the Peer Average in order to continuously identify opportunities to improve annual Hospital Report Findings.

Scores have decreased in the last quarter Apr-Jun 2009. NHS continues to trend below the PEER average.