Jersey City Medical Center Patient Safety Clinical Quality Council Scorecard 2012

	Strategy: Ongoing evaluation of our patient population and areas of risk to identify innovative approaches for achieving and maintaining top-decile performance in safety	Baseline	Target	Chair	Responsible Party	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	YTD
	Patient safety - Strategic Plan Measures																		
Patient Safety	Decrease rate of patients being admitted to Critical Care within 24 hours of admission.	14%	10%	Hall	Garzon-Rivera	14%	9%	18%	18%	15%	8%	7%	5%	10%	7%	8%	0%	9.9%
	Reduce catheter-associated infections (central venous catheters, PICCs, arterial lines, urinary catheters) CLABSI (Hospitalwide)	0.25	0	Hall	DeChirico	0.94	0	0	0	0.96	1.18	0.90	1.78	0	0	0	0	0.42
	Reduce catheter-associated infections (central venous catheters, PICCs, arterial lines, urinary catheters) CAUTI (Hospitalwide)	0.95	0.75	Hall	DeChirico	0	0	0	0	0	0	0	0.92	0	0	0	0	0.07
	Reduce incidence of postoperative physiologic and metabolic derangement	1.00	0.72	Hall	Curci	0	22.2	0	0	0	0	0	0	0	0	0	0	1.85
	Reduce the incidence of postoperative abdominal wound dehiscence in abdominopelvic surgical patients	3.13	0.18	Petrocelli	Simeone	0	0	0	0	0	0	0	0	0	0	0	0	0
	2011 - Strategic/ Regulatory					Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	YTD
	1. Rate of healthcare-associated infections with clostridium	0.30	0.25	Hall	Dr. Grigoriu	0.26	0.57	0.28	0	0.42	0	0.25	0.13	0.13	0.54	0	0.27	0.24
	2a. Falls Rate (Falls/1000patient days): Med-Surg/CC	4.15	2.4 or <	Hall	P. Petrucelli	5.26	4.02	2.08	3.89	2.58	4.81	2.48	2.63	2.94	3.51	3.28	2.93	3.41
	2b. Falls Rate (Falls/1000patient days): Behavioral Health	4.49	4.05	Hall	P. Petrucelli	3.3	5.88	4.18	7.62	5.45	4.53	7.03	2.65	2.61	4.48	0.00	2.22	4.24
	3. The percent of patient encounters in which care-givers perform with all three key hand hygiene procedures correctly.	86%	88%	Hall	V. DeChirico	85%	88%	87%	85%	86%	87%	88%	87%	87%	89%	93%	93%	88%
	4. MRSA Infection Rate (hospital acquired)	0.10	0.05	Hall	V. DeChirico	0.00	0.14	0.14	0.14	0.00	0.14	0.13	0.13	0.00	0.13	0.00	0.00	0.08
	5. Elective induction bundle compliance:	100%	100%	Hall	L. Reyes/ Dr. Bimonte	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	6.Elective Induction	16%	15%<	Hall	R. Dalalian/ Dr. Bimonte	10.3%	14%	14%	18%	15.3%	12.7%	12.2%	16%	16.5%	18%	7.4%	13%	13.9%
	7. Rate of Adverse Drug Events using IHI trigger tool. (HR e-i)	0	0	Hall	M. Curci	0	0	0	0	0	0	0	0	0	0	0	0	0
	8. PCI in 90 minute compliance.	100%	100%	Hall	L. Semenoff	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	9. Total number of codes outside critical care/ED.	3.75	0	Hall	C. Garzon-Rivera	3	4	8	3	1	2	2	8	5	2	6	1	3.75
	10.. RRT calls per 1000 discharges	18	25	Hall	C. Garzon-Rivera	38.6	23.4	29.5	43.3	43.9	43.2	39.8	44	29.9	42.2	46.5	50.7	40.8
Quality	**QUALITY - Strategic Plan Measures**																	
	Decrease severe sepsis & septic shock mortality rate	36%	30%	Flores	LaForgia	27%	36%	21%	25%	30%	14%	24%	18%	26%	20%	25%	22%	24%
	Decrease cardiac cath w/o AMI ALOS DRG 287	3.13	1.70	Abed	Lester	2.55	3.79	3.17	2.65	3.31	3.10	3.50	4.25	3.67	3.50	3.00	2.11	3.21
	Decrease Primary C-section rate	32%	27.5%<	Bimonte	Reyes	22%	30%	16.4%	25.5%	29.7%	32.5%	23.4%	32.1%	24.7%	24.2%	33.0%	19.8%	26%
	Decrease CHF 30-day readmission rate (Medicare only)	21%	17%	Abed	Baillie	13%	26%	23%	21%	6%	13%	13%	29%	13%	18%	4%	20%	17%
	Decrease AMI 30-day readmission rate (Medicare only)	16%	13%	Abed	Baillie	15%	8%	15%	18%	17%	8%	8%	20%	0%	15%	26%	10%	14%
	Decrease Pneumonia 30-day readmission rate (Medicare only)	12%	10%	Abed	Baillie	20%	0%	10%	17%	25%	8%	14%	0%	0%	0%	25%	17%	11%
	Decrease Behavioral health 30-day readmission rate	7.9%	7% or <	Chandak	Sacco	8.5%	5.7%	2.4%	7.6%	6.8%	8.1%	7.4%	3.5%	8.5%	5%	5%	5%	6.2%
	Increase HCAHPS pain management score	65.0%	78.0%	Ratner	Y. Selleroll	62%	70%	64%	55%	56%	56%	72%	65%	70%	58%	72%	70%	64
	2011 Strategic / Regulatory					Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	YTD
	1. Pressure Ulcer: Pressure Ulcer Prevelence Study	0	2.8		P. Petrucelli		0.24%			0%			0%			0%		0.06%
	3. AMI appropriate care score.	100%	100%		Dr. Abed	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	4. CHF appropriate care Score.	100%	100%		Dr. Abed	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	5.. SCIP appropriate care score.	100%	100%		Dr. Krause	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	6. PNEUMONIA appropriate care scorecard	100%	100%		Dr. Bessette	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	7. STROKE Defect Free Score	100%	100%		K. Sietsma	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	8. Immunizations appropriate care score	na	100%		Nurse Mgr	71.3%	82.8%	78.7%	91.8%	94.4%	98.1%	100%	97.6%	100%	97.7%	97.5%	100%	92.4%
	10. OET appropriate care score	na	100%		Dr. Bessette	37.8%	100%	99.2%	95.1%	96.8%	96.7%	100%	100%	100%	100%	100%	100%	93.7%
	11. VAP rate	0.62	0.31		V. DeChirico	0.00	0.00	3.56	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.29

Legend

Meets or Exceeds Target

Within 5% of Target Varience

Outside Acceptable Target Varience

No Target or Actual Results

No.	Goal/Overarching Strategy/Objective/Strategy/Tactic	Assigned	Due	Baseline	Target
2	STRATEGY: Ongoing evaluation of our patient population and areas of risk to identify innovative approaches for achieving and maintaining top-decile performance in safety				
3	**Decrease rate of patients being admitted to Critical Care within 24 hours of admission(failure to rescue).**		**12/31/2012**	**14%**	**10%**
4	Implement failure to rescue plan	Garzon-Rivera	2/1/2012		
5	Review cases of all patient transfers to any higher acuity level of care within 24 hours of admission	Garzon-Rivera	2/1/2012		
6	Roll out EWSS hospital wide	Garzon-Rivera	2/1/2012		
7	Conduct sepsis screening	Garzon-Rivera	2/1/2012		
8	Review rapid response cases transferred to a higher level of care	Garzon-Rivera	2/1/2012		
9	Review all code blues outside of critical care	Garzon-Rivera	2/1/2012		
10	**Reduce catheter-associated infections (central venous catheters, PICCs, arterial lines, urinary catheters) CLABSI**	**Hall**	**12/31/2012**	**0.25**	**0.00**
11	**Reduce catheter-associated infections (central venous catheters, PICCs, arterial lines, urinary catheters) CAUTI**	**Hall**	**12/31/2012**	**0.95**	**0.75**
12	Implement catheter-associated infections plan	Garzon-Rivera	4/1/2012		
13	Revise policies for venous and arterial line management that are evidence based	Garzon-Rivera	2/1/2012		
14	Establish Hudson County interfacility collaborative to prevent selected infections due to medical care	DeChirico	2/1/2012		
15	Implement NHSN-CDC bundles hospital wide	DeChirico	4/1/2012		
16	Conduct mandatory annual clinical practitioner competency	Sardinas	4/1/2012		
17	Create clinical MEM and non-clinical MEM	Sardinas	4/1/2012		
18	**Reduce incidence of postoperative physiologic and metabolic derangement**	**Hall**	**12/31/2012**	**1.00**	**0.72**
19	Implement postoperative physiologic and metabolic derangement plan	Curci	3/1/2012		
20	Conduct literature search to develop standardized preventative protocol	Sardinas	1/15/2012		
21	Develop a pre-surgery/cardiac cath risk assessment	Curci	3/1/2012		
22	Add to pre-op checklist to flag at-risk patients	Curci	3/1/2012		
23	Trend and analyze patterns in cases with post-operative acute renal failure	Curci	3/1/2012		
24	**Reduce the incidence of postoperative abdominal wound dehiscence in abdominopelvic surgical patients**	**Hall**	**12/31/2012**	**3.13**	**0.81**
25	Implement postoperative abdominal wound dehiscence plan	Simeone	6/30/2012		
26	Partner with medical records to identify wounds intentionally left open vs. dehiscence secondary to complications	Simeone	1/30/2012		
27	Review all cases coded as wound dehiscence 2009-2010	Simeone	2/28/2012		
28	Identify patients at risk for wound dehiscence and post-op sepsis (**HOLD**)	Simeone	3/31/2012		
29	Develop multidisciplinary assessment tool (**HOLD**)	Simeone	3/31/2012		
30	Standardize the language for documenting changes in wound quality and wound progression (**HOLD**)	Petrucelli	5/31/2012		
31	Provide education for physicians, PAs, RNs, and medical records coders (**HOLD**)	Petrucelli	6/30/2012		
32	Increase percent of Summit Avenue diabetic patients who have annual eye and dental exam **(Delete)**	Kharode	12/31/2012	90%	95%
33	Assess patients with diabetes to see if they have had annual exams		3/31/2012		
34	Identify diabetic patients and schedule annual exams	Kharode	3/31/2012		
35	Add metric to performance improvement scorecard and monitor monthly	Kharode	3/31/2012		