2018/19 Quality Improvement Plan
"Improvement Targets and Initiatives"

South Huron Hospital 24 Huron Street West

AIM		Measure								Change				
Quality dimension	Issue	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) A= Additional (do not select from drop down menu if you are not working on this indicator) C = custom (add any other indicators you are working on)														
Effective	Effective transitions	Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?	P	% / Survey respondents	CIHI CPES / April - June 2017(Q1 FY 2017/18)	655*	95	85.00	Keeping target the same as 2017/18 as only two quarters of data on this indicator been collected.	1)Evaluate current patient discharge tool/checklist being provided to discharged inpatients.	Tool review with Chief Nursing Executive and staff. Re-education of use of discharge tool and protocol. Chart audit.	# of discharge tool/checklists being completed and provided to inpatients being discharged home.	85%	
										2)Implementation of new inpatient face sheet.	New tool being developed by Lead Hospitalist. Educate all Physicians. Chart Audit.	# of face sheets being completed on all inpatients.	85%	
		Risk-adjusted 30-day all-cause readmission rate for patients with CHF (QBP cohort)	P	Rate / CHF QBP Cohort	CIHI DAD / January - December 2016	655*	X	22.30	Target represents a 4 quarter average of SHHA's calculated expected readmission rate (i.e. risk adjusted) and is slightly below the provincial reference rate and target of 22.5.	1)Monitor and ensure completion of CHF patient's discharge tool/checklist.	Coder will continue to monitor for completion and verification by clinical staff with patient upon discharge of CHF patients.	# of completed CHF discharge tool/checklists	100%	
		Rate of repeat unscheduled emergency visits within 30 days for mental health conditions.	C	Rate / ED patients	CIHI NACRS / Fiscal quarter	655*	39	16.30	Same as SWLHIN and provincial target.	1)Referrals to community agencies/specialists for patients readmitted with mental health/addiction	Health Records Coder will run report and provide to MAC and CNE. Education to staff and physician about mental health resources available.	# of referrals to community agencies/specialists for patients readmitted for mental health/addiction # of patients readmitted for mental health/addiction	80%	

Efficient	**Access to right level of care**	Total number of alternate level of care (ALC) days contributed by ALC patients within the specific reporting month/quarter using near-real time acute and post-acute ALC information and monthly bed census data	P	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July - September 2017	655*	5.37	9.15	Alignment with 2018/19 H-SAA target which acknowledges recent improvements and aims to sustain below 9.15% while keeping below the provincial target of 12.7%	1)Utilization of ALC Flowsheet and Physician order for ALC.	Audit use of ALC Flowsheet/Physician order for ALC. Provide to MAC and CNE.	# of ALC Flowsheet/Physician order for ALC being completed # of ALC patients	100%	
Patient-centred	**Person experience**	Would you recommend this Hospital to your friends and family? (oupatient/ED/Inpatient care)	C	% / All patients	In-house survey / Fiscal quarter	655*	CB	95.00	Same. Continue to strive for exceptionally high performance.	1)Enhance our culture of compassion and service.	Provide staff, Board, MD's and volunteers with education opportunities (e.g. short videos) throughout the year to explain the principles of patient-centred care.	# of education opportunities provided to staff, Board, MD's and volunteers.	6 education opportunities per year.	
										2)Implement the next step for Senior Friendly Hospitals.	More initiatives/education opportunities.	# of new initiatives.	3	
Safe	**Safe care/Medication safety**	Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged.	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / October – December (Q3) 2017	655*	98	93.00	Keeping target the same even though consistently reached due to new med dispense system being rolled out in upcoming year.	1)Implementation of Medical Device Integration at Bedside (interface and recording of electronic medical records and monitors. This will eliminate the need to manually enter patient data, reducing medication errors.	Implement system and train all inpatient department staff.	System implemented.	System implementation and staff training completed.	
	Workplace Violence	**Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.**	**MANDATORY**	**Count / Worker**	**Local data collection / January - December 2017**	**655***	**CB**	**0.00**	**To enhance education, support and volume and process of reporting of Workplace violence injury and report quarterly.**	**1)Review and educate about current form for reporting and documenting any incident of injury/workplace violence incident by any employee, physician, volunteer or student of the SHHA.**	**HR lead discussion to review current reporting in an effort to streamline reporting to a single source to which to report so that process is simple and easy for staff. - Review current workplace violence policy and procedure to reflect changes and clarity of definitions - Education and training for all staff**	**Total workplace violence incidents in the SHHA**	**Collecting baseline**	**Currently staff is unsure of process for reporting workplace violence incidents. 70 FTE**

										2)Review and educate on flagging process activated by front line direct and indirect patient care staff that alerts staff to the potential aggressive/violent patients	Working through the JHSC, HR and Cerner Coordinator to support evolving adjustments to current violent patient flagging process - Monitor and report on frequency of patient flagging events in a month/in every quarter. - Finalize a policy and procedure which provides explicit instructions to front line clinical and support staff about how to report incidents of aggression/violence and to ensure that flagging is applied and removed appropriately. - Train Staff on the policy and procedure of how to recognize the flag so as to take appropriate precautions when dealing with a previously flagged individual"	Total flags applied in a month or in a quarter	Collecting Baseline	