2017/18 Quality Improvement Plan
"Improvement Targets and Initiatives"

South Huron Hospital Association 24 Huron Street West, Exeter, ON, N0M 1S2
Organization Id 655*

AIM		Measure						Change			
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure
Effective	Coordinating care	Emergency Department readmission rates for mental illness.	Rate / ED patients	CIHI NACRS / Fiscal Quarter	21	16.30	SWLHIN target	1) SHHA Social Worker part of South Huron Drug Awareness Steering Committee, which focuses on substance abuse and mental illness as Concurrent Disorders. 2) Social Worker will educate staff at all levels to understand the basic needs of an individual in a mental health crisis and provide resources. 3) Courses such as Mental Health First Aid and additional educational opportunities will be offered to all staff and physicians. 4) Physicians will be provided with sensitivity training.	Monitor the reoccurrence of Mental Health Patients seen in South Huron Hospital Association Emergency Department that are seen at another facility within 30 days.	Number of SHHA ED visits with mental health diagnosis within 30 days to any facility divided by the total number of SHHA ED visits with mental health diagnosis.	No more than 16.3% ED readmit rate of patients with mental illness. This target aligns with the SWLHIN.

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	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?	% / Survey respondents	CIHI CPES / April - June 2016 (Q1 FY 2016/17)	81	85.00	Our current performance is already at 81%. We therefore feel that adding change activities we can at least stretch by 5%. We aim to increase this satisfaction result by 5%. Challenge: New tool and new method of collection to include electronic.	1) Updating patient experience survey to include question: 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? 2) Continue to bring patient stories to the hospital Board. 3) Educate healthcare professionals on "Teach Back". 4) Standing agenda item for Medical Advisory Committee. 5) Focus on communication between healthcare team and patients/families.	Survey Monkey	Number of patients answering yes to that question/month	85% answer yes to the question
								6) Implement call backs by nursing staff to both discharged emergency and inpatient patients.	Script will be provided to nurse. Call backs will be made from Inpatient Unit and Emergency Department to random discharged patients.	CNE will monitor number of call backs.	ED = 10/day (weekdays) Inpatient Unit = Will be dependent on # of discharges
		Risk-adjusted 30-day all-cause readmission rate for patients with CHF (QBP cohort)	Rate / CHF QBP Cohort	CIHI DAD / January 2015 - December 2015	16.93	10.00	Same target as previous year.	1) Develop new tool to ensure follow up appointment is made to Primary Care within 7 days post discharge.	Audit from inpatient chart	Monthly # of CHF discharges that have primary care appointment obtained within 7 days of discharge with primary care provider.	100%
								2) Development of Order sets for complex conditions.	Inpatient chart audit Utilization reports from web application (Think Research)	Number of CHF order sets utilized over the number of CHF cases	100%

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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	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July – September 2016 (Q2 FY 2016/17 report)	29.12	10.08	Target set based on H-SAA	1)Interdisciplinary team work closely with CCAC, Social Work, Hospitalist to ensure discharge plan in place. Development of ALC patient information physician order and ALC flow sheet. Continue ALC Meetings with Regional CCAC, Social work & CNE to collaborate ideas and review appropriateness and discharge destination.	Data will be collected in WTIS ALC. Report to Board Quality, Utilization & Risk Committee, CCAC, CNE, Social Work	Increase/decrease in ALC rate	10.08% as per H-SAA
Patient-centred	**Person experience**	Would you recommend this hospital to your friends and family?	% / All patients	In-house survey / 2017/18	93	95.00	Increased target because we consistently met or exceeded the previous target.	1)Launching new survey tool Patient compliments, complaints and feedback will be tracked and alerts sent directly to the patient relations coordinator and the manager of the department. Various reports will be generated for MAC, Board, Quality, etc.	Patients will be offered a variety of different options to complete patient experience survey (paper, website, tablet)	Number of surveys completed with positive experience over the number of completed surveys.	95%

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Safe	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.	Rate per total number of discharged patients / Discharged patients	Hospital collected data / Most recent quarter available	90	93	Target based on previous year. We consistently achieve this target quarterly.	1) Involve SHHA Pharmacy team with Medication Reconciliation education to staff utilizing resources such as the Institute for Safe Medication Practices Canada ISMP) and Safer Health Care Now. 2) Revise the Inpatient Discharge form to include Discharge Med Rec. 3) CNE will review those discharges missing discharge Med Recs to identify consistencies i.e. Patient discharge destination. 4) CNE will present stats to staff and Physicians (MAC). 5) Collaboration with community LTC facilities to discuss processes regarding discharge Med Recs.	Internal inpatient chart audit.	# of discharge Med Recs present on inpatient chart over the number of inpatient discharge charts, excluding deaths.	93%