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

West Parry Sound Health Centre 6 Albert Street

	Measure						
Issue	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification
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)	931*	CB	75.00	We are collecting baseline in Q1 and Q2. This may be a stretch goal as we don't have a current baseline
	Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort)	Rate / COPD QBP Cohort	CIHI DAD / January 2015 – December 2015	931*	16.98	15.00	Moderate improvement expected with change plans for this indicator

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)	931*	39.57	30.00	This may be a stretch target due to the factors impacting this that are beyond our control
Patient-centred	**Palliative care**	Percent of palliative care patients discharged from hospital with the discharge status	% / Palliative patients	CIHI DAD / April 2015 – March 2016	931*	80.77	90.00	We are collaborating with Hospice WPS and CCAC to ensure
	Person experience	"Would you recommend this emergency department to your friends and family?"	% / Survey respondents	EDPEC / April - June 2016 (Q1 FY 2016/17)	931*	54.8	75.00	We expect our change of staffing model to impact the patient
		"Would you recommend this hospital to your friends and family?" (Inpatient care)	% / Survey respondents	CIHI CPES / April - June 2016 (Q1 FY 2016/17)	931*	CB	80.00	Collecting baseline data in Q1 and Q2, will then implement change ideas
Safe	**Medication safety**	Medication reconciliation at admission: The total number of patients with medications	Rate per total number of admitted patients / Hospital admitted patients	Hospital collected data / Most recent 3 month period	931*	94.2	80.00	We are changing our method for collecting this data, to include tracking of the
		Medication reconciliation at discharge: Total number of discharged patients for whom a	Rate per total number of discharged patients / Discharged	Hospital collected data / Most recent quarter available	931*	CB	80.00	Collecting baseline data in Q1 and Q2. This may be a stretch goal that will

	Safe care	Number of times that hand hygiene was performed before initial patient contact.	Rate per total number of admitted patients / All inpatients	CCO iPort Access / 2017	931*	93.8	90.00	We are implementing a new method for collecting information on
Timely	**Timely access to care/services**	Total ED length of stay (defined as the time from triage or registration, whichever comes	Hours / Patients with complex conditions	CIHI NACRS / January 2016 – December 2016	931*	7.83	15.00	Current performance based on low volume time for our hospital.

Change				
Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
1)This is a new indicator for us. We will add the question to our patient surveys and measure it in Q1 and Q2. We will then develop	Patient satisfaction survey responses monitored for both inpatients and emergency patients.	Percent of patients responding positively to the question on the survey	75%	This may be a multiyear target for us as we don't know what our baseline is.
2)Revise discharge instruction sheet with a senior friendly focus	Involve patient input in revision of discharge instruction sheet	Gather feedback after implementation of draft new discharge instruction sheet	90% satisfaction with the readability and usefulness of the new discharge instruction sheet	
1)Admission order set for COPD implemented	Roll out education to physicians. Audit use of ordersets in Q2 to assess uptake.	Number of ordersets used divided by the number of COPD patients admitted	50% in Q2 70% in Q4	
2)Roll out of Discharge orderset for COPD	Education of staff and physicians on new orderset	Measure number of ordersets used divided by number of COPD patients discharged	50% in Q2, 70% in Q4	
3)Educate staff on services available for COPD patients in the community	Education sessions and online information available	Percent of inpatient clinical staff who receive education	90%	

1)Implement HELP program on Acute care to assist in prevention of delirium and functional decline	Initial data collection on number of referrals received.	Number of referrals to HELP per month	Initial tracking	
2)Promote early involvement of Behaviour Supports Ontario (BSO) for those patients with reactive behaviours.	Discharge planner will track the number of referrals to BSO	Number of referrals to BSO per month	Initial tracking of referrals	
3)Pareto tracking of issues/barriers to discharge to better understand the local cause of ALC days	Identify all barriers to discharge for each ALC placement. Track on Pareto chart and review quarterly	Percent of ALC patients with listed barriers to discharge	100% of barriers to discharge will be tracked	
1)Weekly palliative multidisciplinary rounds in collaboration with CCAC and Hospice to support patient centered discharges	track completion of weekly rounds	number of palliative rounds completed per year attendance by the multidisciplinary team	48 per year	
1)Introduce a communication framework for communicating with patients in the Emergency department	ED Core team to review relevant literature and create education tools and resources to implement framework	% of ED staff educated in communication framework	80% ED staff completed education	
1)Improve patient satisfaction in preparation for surgeries	Value stream mapping of current process. Development of new process for OR booking/preparation through engagement of patients and staff.	Patient satisfaction with the process prior to change in process vs satisfaction post change in process	20 % improvement in satisfaction	
1)Track number of sources used for medication reconciliation on admission	Audit medication reconciliation on admission	number of medication reconciliations on admission utilizing at least two sources of information divided by total number of medication reconciliations on admission.	Tracking this for this year	
1)Currently collecting baseline data	Regular audit of discharged patient charts.	number of best possible medication discharge plans divided by number of charts audited	80	This may be a stretch target as we have no baseline data yet.

1)Develop champions for specific units	Train the trainers for each area in Q1 and 2 Develop unit specific hand hygiene compliance monitoring and reporting	Number of champions trained	100% of specific units will have a trained champion for hand hygiene compliance	
1)Change in staffing model and hours to address peak time and season flow issues.	Review of current model and analyze data for peak use times.	Track time from triage to time seen by physician to assess	5% improvement in 90 percentile time from triage to time seen by physician	