HUMBER RIVER HOSPITAL

2018/19 Quality Improvement Plan

Improvement Targets and Initiatives

Issue		Measure								Change			
		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
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)	941*	49.3	57.50	57.5% is the NRC Health Benchmark	1) Conduct a heuristic analysis on the design of patient whiteboards for inpatient areas to understand the utility to	Review the heuristics and usability of whiteboards by patients and frontline users.	Complete an analysis for each of the designed whiteboards and measure utility.	100% of the identified areas have a heuristic assessment on their whiteboards
										2) Implement a SMART discharge package.	Implement the Institute for Healthcare Improvement's Signs, Medications, Appointments, Results, and Talk (SMART) discharge package.	Percentage of inpatient units that are using SMART discharge.	100% of the identified inpatient units to use SMART discharge.
		Risk-adjusted 30-day all-cause readmission rate for patients with stroke (QBP cohort)	P	Rate / Stroke QBP Cohort	CIHI DAD / January - December 2016	941*	13.53	8.07	8.07% readmission is based on a 5% improvement of internal performance data of 8.5%	1) Expand the dysphagia screening tool training in priority areas.	Education delivery by clinical practice leaders.	Percentage of staff that completed the continuing education in the identified priority areas.	85% of staff within the identified priority areas completed the dysphagia
										2) Pilot the discharge planning pathway and iPlan as a tool to identify complex stroke patients for early escalation/discussion.	Use the Central LHINs discharge planning pathway and iPlan as a technical tool for ALC escalation for complex stroke patients.	Number of complex stroke patients that required escalation identified through the discharge pathway and escalated via iPlan.	100% of identified complex stroke patients to leverage the discharge planning
Efficient	Access to right level of care	Total number of alternate level of care (ALC) days contributed by ALC patients within the	P	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July - September 2017	941*	15.3	14.60	Target determined by the Central LHIN	1) Continue to build capacity by using iPlan and the CLHIN's discharge planning pathway as tools for ALC management.	Leverage iPlan and the CLHIN's discharge planning pathway.	Tracking of patients through iPlan.	100% of ALC patients to be tracked through iPlan.
Patient-centred	Palliative care	Percent of palliative care patients discharged from hospital with the discharge status "Home with Support".	P	% / Discharged patients	CIHI DAD / April 2016 - March 2017	941*	63.64	71.00	71% of palliative care patients discharged home with support is a 5% improvement from the FY17/18 target (67.7%)	1) Expand palliative care education for staff in the identified priority areas.	Education delivery by the clinical practice leaders.	Percentage of identified priority area staff that completed the palliative care education.	85% of available staff educated in the identified priority areas.
										2) Implement the standardized palliative care order set.	Implementation by the clinical practice leaders.	Compliance with order set utilization.	100% order set compliance for palliative care patients.
	Person experience	"Would you recommend this emergency department to your friends and family?"	P	% / Survey respondents	EDPEC / April - June 2017 (Q1 FY 2017/18)	941*	60.6	70.60	As determined by Health Quality Ontario	1) Rounding on staff.	Unit leadership to round on staff and physicians to build trust, enhance communication and support a just patient safety culture.	Unit leadership to round on staff and physicians.	Monthly rounding.
										2) Reinventing Care Council (frontline ownership).	Unit quality council with patient representation to implement quality improvement initiatives.	Identify and implement quality improvement initiatives.	One co-designed quality improvement project completed.
		"Would you recommend this hospital to your friends and family?" (Inpatient care)	P	% / Survey respondents	CIHI CPES / April - June 2017 (Q1 FY 2017/18)	941*	70.4	81.80	81.80% is the NRC Health Benchmark	1) Pilot rounding on patients.	Pilot rounding on patients for real-time feedback on three units/areas.	Pilot units/areas to round on patients.	100% of pilot units/areas to conduct rounding on patients.
										2) Corporate Patient and Family Advisor Council.	Patient and family representation to guide quality improvement/service design initiatives.	Identify and implement quality improvement initiatives.	One co-designed quality improvement project completed.
Safe	Safe care/Medication safety	Medication reconciliation at admission: The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital	A	Rate per total number of admitted patients / Hospital admitted patients	Hospital collected data / October – December (Q3) 2017	941*	96.7	100.00	Based on organizational improvement strategy	1) Reflect on expanding pharmacy technician hours to facilitate medication reconciliation on admission in priority areas.	Reflect on enhancing staffing resources for pharmacy technicians for BPMH in priority areas.	Percentage of eligible patients who had a medication reconciliation performed at the time of admission.	100% of eligible patients have a medication reconciliation performed at the
										2) Incorporate the Digital Health Drug Repository (DHDR) as a tool to facilitate BPMH on admission.	Facilitate BPMH on admission by incorporating review of the DHDR.	Percentage of admitted patients where the DHDR was used leveraging queries to Ministry reports.	100% of eligible patients have a medication reconciliation performed at the
										3) Improve the quality of BPMH to facilitate medication reconciliation on admission in priority areas.	Establish an evaluation method and measure adherence to complete and accurate information within the BPMH.	Total number of non-documented and unintentional discrepancies identified in the sample after the medication reconciliation process has been completed.	Decrease the number of non-documented and unintentional discrepancies by
		Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / October – December (Q3) 2017	941*	77	81.00	81% is a 5% improvement from the current audit (1 Mar 2018)	1) Enhance physician adoption of the medication reconciliation process.	Improve the physician medication reconciliation interface.	Implement Meditech 6.16 Web Acute.	Implementation of Meditech 6.16 Web Acute.
										2) Enhance physician adoption of the medication reconciliation process.	Inpatient physician training on the medication reconciliation process.	Percentage of inpatient physicians that have completed and passed a competency evaluation.	85% of inpatient physicians complete and pass a competency evaluation.
	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**	**941***	**126**	**120.00**	**Decrease the number of discreet events by 5%**	1) Conduct event reviews to share learnings.	Event reviews to be conducted by Occupational Health and Safety.	Incidences of workplace violence to be stratified by whether: (a) a flagged patient was involved; (b) a code white was called; (c) a root cause analysis was undertaken; and (d) an action plan was developed and implemented within 30 days of the incident.	An event review will be completed on 100% of incidents.
										2) Reduction of incidents of violence (Joint Centres objective).	Occupational Health and Safety to measure and monitor workplace violence statistics.	Report to unit driven quality councils (Reinventing Care Councils).	Number of incidents of workplace violence that result in lost days.
										3) Reduction of incidents of violence (Joint Centres objective).	Occupational Health and Safety to measure and monitor workplace violence statistics.	Report to unit driven quality councils (Reinventing Care Councils).	Number of incidents of workplace violence that result in the provision of health care (for staff employed by the hospital).