2019/20 Quality Improvement Plan
"Improvement Targets and Initiatives"

West Haldimand General Hospital 75 Parkview Road

AIM		Measure									Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	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) C = custom (add any other indicators you are working on)															
Theme I: Timely and Efficient Transitions	**Timely**	**The time interval between the Disposition Date/Time and the Date/Time patient left the emergency department for admission to an inpatient bed or operating room**	**MANDATORY**	Hours / All patients	CIHI NACRS, CCO / April-September	734*	8.7	4.00	Provincial Target		1)Timely completion of orders for medical inpatient admissions	Uptake of medical inpatient admission order sets	Utilization of order sets	All inpatients admitted	
											2)Transfer of Accountability (TOA)	Documentation of Transfer of Accountability	Timely hand over	All TOA completed prior to admission from ED to inpatient unit	
											3)Medical Directives	Development of Medical Directives to improve flow of patients in the ED	Number of Medical Directives developed	Uptake in using medical directives	
											4)Bed-ahead strategy	Incorporate a bed ahead discussion into daily huddles	Daily identification of the next bed space for an admitted patient	Time from disposition in ED to inpatient bed is less than 4 hours	
Theme II: Service Excellence	**Patient-centred**	**Percentage of respondents who responded positively to the following 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?**	PRIORITY	% / Survey respondents	CIHI CPES / Most recent consecutive 12-month period	734*	44.19	65.00	75th percentile for top box (in house survey)		1)Individual Patient Discharge Plan	Develop and implement a patient specific discharge plan	Plan developed and included in patient discharge information	All discharge patients will have an individualized patient discharge plam	
											2)Discharge Package: Going Home from Hospital	Develop and provided a discharge information package to all patients at admission that includes community resources available to patients and their families	Plan provided to all discharged patients	100% of discharged patients will receive a Discharge Information Package	
											3)Standardized discharge checklist	Develop with input from the Patient and Family Advisory Council, a discharge checklist that is standardized and patient centered	All discharges will include review of a standardized checklist for discharge	All patient assessed against the discharge checklist	
		Communication prior to release from the ED	CUSTOM	% / ED patients	NRC Picker / 2018 19 Q2	734*	84	90.00	NRC 75th percentile top box		1)Patient specific information about new medications	Develop written information regarding patient medications side effects	Number of patient information forms developed	Top 10 most common medications prescribed	
											2)Standardized discharge process for all ED patients	Discharge checklist for all ED patients	Develop discharge checklist with input from patients and families	Implemented standardized communication at discharge	
Theme III: Safe and Effective Care	**Effective**	Patients readmitted to same hospital within 30 days of discharge with primary diagnosis of CHF	CUSTOM	% / Discharged patients with selected HIG conditions	CIHI DAD / Q2 2018 19	734*	13	0.00	High Reliability Healthcare: elimination of preventable harm		1)Individualized Discharge Care Plan for CHF patients	Develop and implement a care plan specific for this patient population	Patients receive an individualized discharge care plan	All CHF patients receive a care plan at discharge that is customized to their specific needs	
											2)Patients with diagnosis of Congestive Heart Failure will recieved patient focused information to support healthy living	Development and implementation of CHF focused information package	Patients with diagnosis of CHF will receive information to support a safe transition out of hospital	All patients with discharge diagnosis of CHF receive information package	
		Patients readmitted to same hospital within 30 days if discharge with primary diagnosis of COPD	CUSTOM	% / Discharged patients with selected HIG conditions	CIHI DAD / Q2 2018 19	734*	6	0.00	eliminate preventable harm	Grand River CHC	1)COPD education provided to all COPD admitted patients	COPD Discharge Package provided to all COPD clients at discharge	COPD patients will have a better understanding of their condition	Patient experience measure	
											2)Community based education for COPD clients/families	Referral to the Grand River COPD Clinic	Number of referrals to the COPD Clinic	Collecting baseline	

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Theme III: Safe and Effective Care	**Safe**	**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 2018**	**734***	**5**	**CB**	**Increase reporting of incidents**		**1)Enhanced Incident Reporting of workplace violence**	**Develop with input from staff an incident reporting template for workplace violence incidents**	**Ease of entry of workplace violence incidents**	**All workplace violence incidents will be reporting electronically**	**FTE=99 98.56 FTE**
											2)Debriefing Team	**Communication with the debriefing team who will respond to all workplace violence incidents**	**Standardized process for workplace violence debriefing**	**All workplace violence incident will be reviewed by the Debriefing Team**	
											3)Gentle Persuasive Approach education	**Maintain certification and provide ongoing education for GPA.**	**Number of staff on Inpatient Unit trained**	**90% of inpatient unit staff**	
	Safe	Catheter Associated UTI	CUSTOM	Number / All patients	CIHI DAD / 2018 19	734*	15	8.00	eliminate preventable harm	Incontinence Clinic	1)Enhanced knowledge for staff: Continence Training	Provide on-site education for staff	Number of staff participating in educational opportunity	80% inpatient staff attend Continence Training	
											2)Best practice for urinary incontinence	Standardize care plan for urinary incontinence	Number of catheters reinserted post removal	No catheters reinserted once removed	
											3)Order set for catheterization	Develop and implement an orderset for catheterization that included Choosing Wisely guidelines	Use of order set	Order set avaialable electronically	
		Falls causing harm	CUSTOM	% / All patients	Hospital collected data / 2018 19	734*	35	29.00	eliminate preventable harm	Alzheimers Society, Regional Geriatric Program	1)Senior Sensitivity Training	Education for staff related to senior friendly care	Number of staff completing the education	75% of inpatient staff	
											2)Move On program	Educate staff and implement move-on program on inpatient unit	Reduce falls on the inpatient unit	Decrease falls injuries	
											3)Standardized interprofessional care planning to maintain fuctional status for admitted patients	Assessment using a valid tool: Barthel Index	Measure functional status at admission, two weeks and discharge	All admitted patients have a completed functional status measurement	
											4)Visual awareness for falls	Implementation of Safety Cross on inpatient unit	Safety Cross posted on Quality Boards	Enhanced awareness by staff of falls incidents each day	
											5)Standardized approach to addressing falls incidents	Development and impelementation of post fall order set	Post fall order set completion	Utilization of post fall order set for all falls	