2022/23 Quality Improvement Plan
"Improvement Targets and Initiatives"

West Haldimand General Hospital, 75 Parkview Rd, Hagersville, ON, N0A 1H0

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: Timely and Efficient Transitions	**Timely**	Timely transfer of Stroke Patients	C	Hours / ED Patient	Hospital Data collection April 2021-March 2022	734*	CB	CB	High Reliability Organization		Educate Staff on Stroke Criteria	Educate staff on Stroke Algorithm and transfer process	% of staff completed education through EI Sevier	80%	EI Sevier
											Development of Stroke Checklist	Create and develop checklist for stroke intervention	Checklist completed and accepted into practice	completed	Manual
Theme : Service Excellence	**Patient-centred**	Patients received adequate information about their health and care at discharge	C	% / ED patients	NRC Picker / April 2021 to Sept 2022	734*	81%	83%	Top box at 75th percentile	NRC	Patients have new medications explained to them prior to discharge	Education will be provided to patients with new medicaiton, and documented on checklist, provided verbally and through written instruction (EI Sevier)	Communication with patients about their medicines	65%	NRC 75 percentile top box 72%
											Educate patients with diabetes prior to discharge	Diabetes education clinic referral for education indicated on discharge checklist	Number of diabetic patients with referrals on discharge	50%	Manual
											Refresh of Discharge Checklist	Redevelop and roll out of patient Discharge Checklist	% of D/C checklists completed on audit	50%	Manual
		Number of deaths reported to TGLN	C	%/ Deaths	TGLN/Hospital data April 2021-March 2022	734*	0	CB	High Reliability Organization	Trillium Gift of Life	Development of TGLN Process	Policy and Procedure, service agreement developed	Processes completed and approved	Process developed	Manual
											Educate staff on Process and TGLN requirements	Education developed and rolled out to ED/IPU nursing staff	% of education completed	80%	EI Sevier
Theme: Safe and Effective Care	**Effective**	Proportion of hospitalizations where patients with a progressive, life-limiting illness, are identified to benefit from palliative care, and subsequently (within the episode of care) have their palliative care needs assessed using a comprehensive and holistic assessment.	C	Proportion / All patients	Hospital data collection / April 2021-Dec 2022	734*	29%	40%	High Reliability Organization	Palliative Care Network	Redevelop PPS/ESAS tool	Tool being reviewed and redeveloped	Tool developed and accepted into practice	Tool developed	Manual
											Code Status Policy developed	Code status policy and process for discussion to occur within 48hr of admission	% of audits where code status discussed within 48hr	60%	Manual
											Improve management of Palliaitive patients	Develop standardized Palliative Order set	% of audits where orderset completed	40%	Manual
Theme: Safe and Effective Care	**Safe**	Reduction in reportable workplace violence	C	Count / Worker	Hospital data collection / April 2021-Dec 2021	734*	4	15	Maintain Reporting		Development of deescalation program	Program developed and reviewed	Program developed and approved	Program developed	Manual
											Increase emergency code awareness	Perform Mock Code Silver (person with a weapon) with debrief	Completed 1 mock code silver with debrief within the year	1	Manual
		Hand Hygiene before patient contact	C	%/healthcare providers	Hospital data collection / April 2021-Dec 2021	734*	94%	95% maintain	High Reliability Organization		Maintain accountability across the organization	Leaders will audit, post and include monthly rates in safety huddles	Increased compliance at the department level, monthly reports at the leadership	Monthly reports at management forum	Minutes
											Increase volume of audits	Leaders to complete 10 audits per month	Over 60 Audits submitted/month by leadership team	60/mnth	HH Platform
		Reduce total number of falls causing harm	C	Number / All patients	Hospital data collection / April 2021-Dec 2021	734*	54	49 (reduction by 10%)	High Reliability Organization		Redevelop Move on Program	Identify gaps in progressive utilization of program and develop education to bridge knowledge	Education of staff on redeveloped move on program	80%	EI Sevier
											Initiate safety huddle	Completed safety huddle template daily by charge nurse	Audit template used at each safety huddle	70%	Manual