2018/19 Quality Improvement Plan
"Improvement Targets and Initiatives"

Erie Shores HealthCare, 194 Talbot Street West, Leamington ON

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	Goals for change ideas	Comments
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	Coordinating Care	% of patients identified as meeting Health Links criteria who are offered access to Health Links approach	Total # of patients offered HL access / Total # of patients identified through clinical level assessments	Hospital collected data / most recent 3 month period	36%	Increase the total percentage of patients who were offered access to the Health Link approach to 100% of program eligible participants.	All ESHC patients meeting Health Links criteria should be referred to the program.	Develop coordinated care plans across ESHC, LAFHT and other primary care providers.	Social worker to refer Health Links eligible patient population from ESHC to Health Links coordinator at LAFHT.	# of patient referrals to Health Links / # of patients who meet the Health Links criteria	Goal is to refer 100% of ESHC Health Links eligible patients to the Health Links coordinator at LAFHT.	Data to be included in Utilization Committee Scorecard
								Track readmit rates for Health Link participants and HL eligible participants.	Develop referral process to Social Worker who will ensure referral is made to Health Links at LAFHT.			
Effective	Effective Transitions	Reduce unscheduled Emergency visits within 30 days for Mental Health conditions	Total repeat visits within 30 days following a mental health visit at ESHC divided by the total unscheduled ED Mental Health Visits at ESHC	IDS BI Portal Health Information Insights / October - December 2017	18.10%	16%	ESHC LHIN target in FY 2017-18 is 16% . This is a priorty health care iniative within the ESC LHIN and Province	Improve coordination and safety of care transitions from Emergency Department to Community through links to Community resources and effective referrals.	Implement Psychiatric Assessement Nurse Monday-Friday from 12-8 pm.	# of patients assessed by PAN nurse . Track the number of repeat ED visits within 30 days.	Decrease the number of return ED visits for Mental Health diagnosis. < 16%	Data to be included in Utilization Committee Scorecard
									Continune to partner with CMHA, CHC, MHRU, and other community based programs that provide patients with Mental Health Crisis quick access, quality care and support in the community setting.	# of referrals made to Community Mental Health and Addictions programs/support.	Increaes referrals to community resources.	Data to be included in Utilization Committee Scorecard
Patient-Centered	Person Experience	Percentage of respondents who responded positively to the following question from the Ontario Emergency Department Patient Experiences of Care Survey (EDPEC): **"Would you recommend this emergency department to your friends and family?"** **Add the number of respondents who answered "Definitely yes" to the question.**	% of responses that were "Definitely yes" / Total # of ED Survey respondents	ESHC EDPEC / April - June 2017 (Q1 FY 2017/18)	39.30%	43.30%	Improve current performance by 10%	Develop an educational module to improve communication techniques with patients. Improve Patient flow through the emergency department.	Implement ED rounding program. Implement Oculys prEDict by July 1. 2018 to visualize wait time in ED.	# of patient concerns regarding interpersonal communications.	100% of ED staff and physicians will have completed customer service/ED rounding program by October 1, 2018.	Implement AIDET® Cutomer Service program for Staff and Physicians
		Percentage of respondents who responded positively to the following question from the Canadian Patient Experiences Survey - Inpatient Care (CPES-IC): **"Would you recommend this hospital to your friends and family?"** **Add the number of respondents who answered "Definitely yes" to the question.**	% of responses that were "Definitely yes" / Total # of Inpatient Survey respondents	ESHC CIHI CPES / April - June 2017 (Q1 FY 2017/18)	58.70%	64.60%	Improve current performance by 10%	A) Develop an educational module to improve communication techniques with patients. B) Use white boards in patient rooms to increase communcation of the plan of care /goals for discharge - to be started on admission and updated daily. C) Comfort rounding on all inpatient units. D) Implement Oculys StayTrack program by July 1, 2018.	A) Implement Customer Service education program for all employees. B) Implement Oculys StayTrack by July 1, 2018. (Decrease LOS and increase patient satisfaction).	# of patient concerns regarding interpersonal communications. Audit white board completion and comfort rounds on inpatient units.	A) 100% of employees, 80% physicians will have completed customer service program by October 1, 2018. B) Comfort round audits - 95% completion. C) StayTrack updated daily on 100% of inpatients.	Implement AIDET® Cutomer Service program for Staff and Physicians
Safety	Workplace Violence	Number of workplace violence incidents (overall) reported by hospital workers (as by defined by OHSA) within a 12 month period. ESHC FTE's for 2018-19 = 255.98	Count (# of Reports)	Local data collection / January - December 2017	13	Increase reporting by 100% = 26 reports for 2018-19	ESHC is focused on building our reporting culture for this indicator as it is new.	Increase the awareness of the importance to report workplace violence incidents.	100% of Staff will be educated on the RL6 eLearning module to create informed input for all workplace violence incidents. Manager/Directors will review incidents with staff.	Increase the number of workplace violence incident reports. Identify trends/root causes for incidents and adjust care plan as needed. Report trends/causes and countermeasures at Care Team meetings. Managers/Directors will close incidents after review.	RL6 module -100% staff education completion by March 31, 2018. Implement a standardized Violence Assessment Tool by May 1, 2018.	
								All patients - admitted patients and those triaged in ED will have a Violence Assessment Tool completed as part of their documentation.	Director Inpatient will identify # of missed WPV risk assesements and follow up with Director of ED.	# of WPV risk assessement tool completed / # admisssions /ED patients triaged	Violence Asessment Tool will be complete on all ED and admitted patients	
Timely	Timely Access to Care/Services	90th Percentile LOS for Admitted Patients Defined as the time from registration date/time or triage date/time (whichever is earlier and valid) to the date/time the patient left ED (Admitted patients only)	90th Percentile Hours	October - December (Q3) 2017 (CCO ATC, iPort)	16.35 Hours	14.70 Hours	Decrease by 10%	A) Review present transporter role. B) Develop standard work to include transport of patient in ED to DI and inpatient units.	Develop standard work processes for admitted patients to be transferred to inpatient bed.	Number of admissions following the standard work process/number of admissions.	90% of all admissions utilizing the standard work process by September 30, 2018.	Data to be included in Utilization Committee Scorecard
								Follow-up with inpatient programs. Charge nurse to be hired with main duties to include patient flow.	Continue follow-up with inpatient program members to review options to expedite admissions to the unit.	Follow-up with inpatient program members to review options to expedite admissions to the unit.	Evaluate progress each month. Develop action plan(s) to address deficits in admission process.	
		90th Percentile ED LOS for Complex Patients (Admitted and Non-Admitted) (CTAS 1-3) Defined as the time from registration date/time or triage date/time (whichever is earlier and valid) to the date/time the patient left ED	90th Percentile Hours	October - December (Q3) 2017 (CCO ATC, iPort)	7.13 Hours	6.42 Hours	Decrease by 10% Provincial target is 8 hours.	Identify opportunities for safe reduction of diagnostic testing when unnecessary testing contributes to longer ED LOS.	Refer to Choosing Wisely Canada -ED Medicine Guidelines for Diagnostic testing recommendations.		Reduce unnecessary diagnotic testing for patients in ED to decrease LOS in ED.	Data to be included in Utilization Committee Scorecard
		90 Percentile ED LOS for Non-Admitted Minor Patients (CTAS 4-5) Defined as the time from registration date/ time or triage date/time (whichever is earlier and valid) to the date/time the patient left ED	90th Percentile Hours	October - December (Q3) 2017 (CCO ATC, iPort)	4.78	4.0 Hours	Decrease by 10% Provincial target is 4 hours.	Increase # of patient assessments /treatment by ED NP to 15/shift.	Conduct process mapping exercise to identify gaps in the ED journey for this patient group.	Number of patients assessed by NP/number of CTAS 4-5 patients registered during NP shift.	Increase number of patients assessed by NP to increase patient flow through ED.	Data to be included in Utilization Committee Scorecard
		90th Percentile Time to Physician Initial Assessment (Hours) Defined as the time from registration date/time or triage date/time (whichever is earlier and valid) to the physician initial assessment date/time	90th Percentile Hours	October - December (Q3) 2017 (CCO, ATC, iPort)	4.00 Hours	3.60 Hours	Decrease PIA by 10%	Implement Clinical Resource Nurse in ED daily 9-5pm role to increase patient flow through ED.	Discuss P4R measures in monthly departmental meetings. Develop action plan to improve or sustain measure. Implement P4R indicator tracking.	Provide report to ED Physician Lead outlining PIA time by Physician/Practioner and CTAS level.	Reduce PIA time to 3.60 hours.	Data to be included in Utilization Committee Scorecard
								Implement Oculys prEDict tool by July 1, 2018				
Safety	Medication Safety	Medication Reconciliation at Discharge	Current monthly audit is based on a sample of 50 discharged patient charts from various units/ services at ESHC excluding Obstetrics, newborns and deaths. / Discharged patients	Hospital collected data / October - December 2017 (Q3)	90.00	90%	Compliance with Accreditation Canada ROP	1) Review discharge medication reconciliation process and redesign standard tool used. Develop standard work regarding medication reconciliation on discharge. Going forward, we will be reporting on the total number of discharged patients for whom a Best Possible Medication Discharge Plan (BPMDP) was created as a proportion of the total number of patients discharged, excluding discharge that is death, OB patients, newborn or stillborn.	A) Medication Management Committee will review discharge medication process/present tool used. B) Develop new tool for after hours and pharmacy unavailability C) Provide education to all users regarding standard work/process medication reconciliation on discharge. Current Data Collection Methodology-retrospective chart review monthly on a subset random sample of 50 charts from various units/services at ESHC. The audit consists of reviewing the chart to ensure the discharge prescription reflecting home medications and in hospital medications is being printed out, medications are addressed in terms of "continue, hold, stop", additional prescriptions for new medications and/or narcotics/controlled substances are written for, and each page of the discharge prescription is signed by the physician.	Medication reconciliation rate upon discharge.	90% completion upon discharge.	Compliance with Accreditation Canada Required Organizational Practices