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

The Sensenbrenner Hospital 101 Progress Crescent

AIM		Measure						
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification
Effective	Effective transitions	Did you receive enough information from hospital staff about what to do if you were worried	% / Survey respondents	CIHI CPES / April - June 2016 (Q1 FY 2016/17)	687*	90	92.00	36 sondages internes house surveys. 5 surveys blank. 28/31 positive.
		Risk-adjusted 30-day all-cause readmission rate for patients with CHF (QBP cohort)	Rate / CHF QBP Cohort	CIHI DAD / January 2015 - December 2015	687*	30.1	25.00	Introducing Standardized Order Set
		Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort)	Rate / COPD QBP Cohort	CIHI DAD / January 2015 – December 2015	687*	20.7	15.00	Introducing Standard Order Set
		Risk-adjusted 30-day all-cause readmission rate for patients with stroke (QBP cohort)	Rate / Stroke QBP Cohort	CIHI DAD / January 2015 - December 2015	687*	X	0.00	We currently don't have a CT Scanner and our Strokes are sent out
Efficient	Access to right level of care	Total number of alternate level of care (ALC) days contributed by ALC patients within the	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July – September 2016 (Q2 FY 2016/17 report)	687*		45.00	Currently 70% of all hospital beds for January 2017
Patient-centred	Palliative care	Percent of palliative care patients discharged from hospital with the discharge status	% / Palliative patients	CIHI DAD / April 2015 – March 2016	687*	100	100.00	Consults will be sent for all palliative clients

	Person experience	"Would you recommend this emergency department to your friends and family?"	% / Survey respondents	EDPEC / April - June 2016 (Q1 FY 2016/17)	687*	91	95.00	Out Patient Services Data
		"Would you recommend this hospital to your friends and family?" (Inpatient care)	% / Survey respondents	CIHI CPES / April - June 2016 (Q1 FY 2016/17)	687*	92	95.00	In house survey data
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	687*	100	100.00	Standard on admission
		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	687*	X	100.00	Not completed on a standard basis at this time
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	687*	5.23	8.10	Current data 8.1 hrs. as per Cancer Care Ontario iPort

Change				
Planned improvement initiatives (Change Ideas)	**Methods**	**Process measures**	**Target for process measure**	**Comments**
1)Only 3(10%)of the surveys filled out were negative.	Will continue to monitor satisfaction for trends.	Will use in house survey.	No quality improvement in this area at present.	
1)CHF order set developed to standardize care.	Will provide education in print format from the Heart and Stroke Foundation of Canada in French and English	Will have information available for clients in the ER and the SCU. We will monitor the use of the order sets	Will ask employees to consider material that they feel will assist their clients from	
1)COPD standard order set developed.	Provide standard education for COPD clients in the ER and SCU.	Education from the Canadian Thoracic Society	Have staff determine what education needs to be provided. Discuss with	
1)Will provide information for TIAs and Strokes	Will provide education in print format from the Heart and Stroke Foundation of Canada in French and English	Current staff will assess publication material that best meets the population needs	Timmins remains our Stroke Protocol hospital as we have no CT Scan	
1)Ongoing weekly interdisciplinary meetings to discuss discharge planning. Will continue to work with community agencies to find	Weekly meetings taking place and hospital will add palliative hospice facilitator to work with clients requiring end of life care and hospice services.	Meeting weekly/52 meetings per year	ALC rates can't be lowered in isolation as it is community issue.	
1)Palliative Hospice Facilitator will be added to team to meet with clients and families regarding end of life needs and assess	100% of clients admitted to hospital will receive consult	All clients will receive home support as needed	Facilitator will follow up at home as needed	Facilitator will work closely with client and supports, CCAC, discharge planner

1)Our measure was out-patient services	Implementing lean management with a focus on improving care and client experience	In house Survey data	Using measure of "Overall, how would you rate your care and Service?"	Will have survey blitzes, focusing on reducing wait times.
1)Our measure was in-patient services	Implementing lean management with a focus on improving care and client experience	In house Survey data	Using measure of "How would you describe your overall care by our hospital staff?"	Will have survey blitzes
1)Standard Practice	No planned change	One on each chart on admission	Practice to continue	Standard practice on admission
1)Rx given but Medication Reconciliation remains limited	Need to make standard practice	Chart review	On each chart	No formal process at present only informal
1)Current monthly data is not collected by CIHI.	Continue to monitor Cancer Care Ontario iPort for monthly data.	Hospitalist only admits from the ER department after tests and consults are completed and an admission is still required.	Our current average rate of 8.1 may remain unchanged	Test results and consults are completed in the ER department and the