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

Alexandra Marine and General Hospital 120 Napier Street

AIM		Measure							Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Effective	**Effective transitions**	Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital.	% / Discharged patients	Hospital collected data / Most recent 3 month period	663*	66	70.00	Internal target	1)Continue to audit monthly and determine compliance	Report metric monthly to MAC, QA committee	Metrics reported monthly and posted on dashboards. Develop action tools as needed to address deficiencies	Monthly	Transcriptionists not available weekends, after hours or STAT holidays. Looking to add some weekend shifts.
									2)Education/support as needed for physicians to encourage dictation of discharge summary at time of discharge	Review metric and trends at MAC meetings. Determine reasons for not completing dictation at time of discharge	.	.	.
		Rate of psychiatric (mental health and addiction) discharges that are followed within 30 days by another mental health and addiction admission	Rate per 100 readmissions / Discharged patients with mental health & addiction	CIHI DAD,CIHI OHMRS,MOHTLC RPDB / January 2015 - December 2015	663*	18.1	14.50	From H-SAA agreement	1)AMGH is a member of Huron Perth Addiction and Mental Health Alliance (HPAMHA)	HPAMHA has included 30 days readmission rate analysis on their work plan to identify opportunities as a system.	Further interventions/actions will be directed by this group.	.	.
		Percentage of patients who gave a positive response to the following query on DaySurgery Patient Satisfaction Surveys "I know who to call if I have any questions or concerns" after discharge.	% / Day Surgery Patients	In-house survey / 2016/17 Q1-3	663*	97.5	100.00	Maintain current performance	1)Peri-operative committee and Clinical Manager to identify specific initiatives	Review of metric to be standing item on quarterly Peri-operative committee meetings. Action plans to be created as needed to address low performance	Continue to track and report quarterly. Post results on dashboards and communication boards as appropriate	Metric posted quarterly. Action plans as needed.	.
Patient-centred	**Palliative care**	Percent of palliative care patients discharged from hospital with the discharge status "Home with Support".	% / Palliative patients	CIHI DAD / April 2015 – March 2016	663*	83.33	85.00	Internal Target - Maintain current performance while reviewing data	1)Monitor and analyze quarterly to identify current trends	Review of metric on quarterly basis- disuss with staff and MAC	Metrics reviewed /reported quarterly	Quarterly	Our numbers are small. Any deviation has the ability to greatly impact performance rate
	Person experience	Percentage of ER patients who had their wait time explained	% / ED patients	In-house survey / 2016/17 Q1-3	663*	80	92.00	Same as current year-not quite achieved	1)Chief of ER, Clinical Manager and ER committee to identify specific initiatives	Review of this metric to be standing item on agenda for ER Committee meetings. Action plans created as needed to address low performance.	Continue to track monthly and post on dashboards and communication boards	Metrics posted each month. Action plans created as needed.	.

								2)Promote/reinforce use of regular rounding on patients by front line staff. Instruct new staff on tactic during unit orientation.	Discussion during daily huddles, monthly rounding sessions with staff. Education during unit orientation.	Leaders to promote / reinforce regular rounding on patients with staff during monthly rounding sessions.	All leaders meeting monthly targets for rounding.	.
	Percentage of ER pts who indicate their pain/discomfort was addressed	% / ED patients	In-house survey / 2016/17 Q1-3	663*	93	95.00	Target same as this year- not quite achieved	1)Chief of ER, Clinical Manager and ER Committee to identify specific initiatives.	Review of this metric to be standing item on agenda for ER Committee meetings. Action plans created as needed to address low performance.	Continue to track monthly and post on dashboards and communication boards.	Metrics posted every month. Action plans created as needed.	.
								2)Promote / reinforce regular rounding on patients with front line staff. Instruct new staff on tactic during unit orientation.	Discussion during daily huddles, monthly rounding sessions with staff. Provide education during unit orientation.	Leaders to promote/reinforce regular rounding on patientsduring monthly rounding sessions.	All leaders meeting monthly targets for rounding.	
	Would you recommend this emergency department to your family and friends?	% / Survey respondents	In-house survey / 2016/17 Q1-3	663*	99	100.00	Maintain overall positive response	1)Promote/reinforce regular rounding on patients by front line staff. Instruct new staff on tactic during unit orientation	Clinical Managers to promote /reinforce use of regular rounding on patients by staff during monthly rounding sessions. Discussion during daily huddles, monthly rounding sessions with staff.	All leaders promote/reinforce regular rounding on patients with staff during monthly rounding sessions	All leaders meeting monthly targets for rounding.	.
								2)Promote/reinforce use of "AIDET" communication tool by staff, physicians and volunteers. Instruct new staff re tool during unit orientation.	Promote/reinforce/instruct/model use of "AIDET" communication tool.	All leaders promote/reinforce use of tool with front line staff/ provide education for new staff during unit orientation	All staff, physicians and volunteers use communication tool consistently	
								3)Continue to survey patients and post metrics on Quality Boards and within Document Management system	Patients surveyed and responses entered into electronic system. Action plans developed as needed to improve performance in areas of concern.	Internal data collection and results posted monthly. Metrics reviewed monthly by Quality Committee.	Metrics posted monthly. Action plans developed as needed.	.
	Would you recommend this hospital to your family and friends" (InPatient Care)	% / Survey respondents	In-house survey / 2016/17 Q1-3	663*	99	100.00	Maintain overall positive response	1)Promote/reinforce regular rounding on patients by front line staff. Instruct new staff on tactic during unit orientation.	Discussion during daily huddles, monthly rounding sessions with staff. Education during unit orientation for new staff	All leaders to promote/reinforce regular rounding on patients with their staff during monthly rounding sessions	All leaders meeting monthly rounding targets.	.
								2)Promote/reinforce use of "AIDET' communication tool by staff, physicans and volunteers. Instruct new staff re tool during unit orientation.	Promote/reinforce/instruct/model use of "AIDET" communication tool	All leaders promote/reinforce use of tool with front line staff during monthly rouning sessions.	All staff, physicians and volunteers use communication tool consistently	.
								3)Continue with daily interdisciplinary huddles on inpatient units to ensure all staff within circle of care are aware of patients needs and goals	Huddles to continue on weekdays	.	.	.

									4)Continue to survey patients and post metrics on Quality Boards / Document Management System	Patients surveyed and responses entered into electronic system. Action plans developed as needed to improve performance in areas of concern.	Internal data collection and results posted monthly. Metrics reviewed monthly by Quality committee.	Metrics posted monthly. Action plans developed as needed.	.
		Would you recommend this hospital to your family and friends? (Mental Health)	% / Survey respondents	In-house survey / 2016/17 Q1-3	663*	98	100.00	Maintain overall positive response	1)Promote/reinforce regular rounding on patients by front line staff. Instruct new staff on tactic during unit orientation.	Clinical Managers to promote/reinforce regular rounding on patients by staff during monthly rounding sessions. Discussion during daily huddles, monthly rounding sessions with staff.	All leaders promote/reinforce regular rounding on patients with staff during monthly rounding sessions.	All leaders meeting monthly targets for rounding.	.
									2)Promote/reinforce use of "AIDET" communication tool by staff, physicians and volunteers. Instruct new staff re tool during unit orientation.	Promote/reinforce/instruct/model use of communication tool.	Leaders to promote/reinforce use of tool during monthly rounding sessions with staff	All staff, physicians and volunteers use communication tool consistently.	.
									3)Continue with daily interdisciplinary huddles on inpatient unit to ensure all staff within circle of care aware of patient's needs and goals.	Huddles to continue on weekdays.	.	.	.
									4)Continue to survey patients and post metrics on Quality Boards / Document Management System	Patients surveyed and responses entered into electronic system. Action plans developed as needed to improve performance in areas of concern.	Internal data collection and results posted monthly. Metrics reviewed monthly by Quality Committee.	Metrics posted monthly. Action plans developed as needed.	.
Safe	**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	Rate per total number of admitted patients / Hospital admitted patients	Hospital collected data / Most recent 3 month period	663*	98	98.00	Maintain current performance	1)Continue to audit monthly and determine compliance	Report metric monthly to units, QA committee, MAC	Metrics are reported monthly to MAC and posted on dashboards and communication boards. Develop action plans as needed to address decreases in completion rates.	.	.
									2)Education / support as needed to staff and physicians	Review indicator and trends at MAC, unit meetings. Identify any knowledge and practice gaps and develop work plans as needed to address.	.	.	.
									3)Utilize Pharmacy Technician to obtain medication histories	Pharmacy Technician will obtain medication histories one day per week on a trial basis beginning April 1, 2017	Percentage of medication histories with NO errors on days that medication histories are taken by Pharmacy Technician	95% of medication histories taken by Pharmacy Technician will contain NO errors	.
		Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible	Rate per total number of discharged patients / Discharged patients	Hospital collected data / Most recent quarter available	663*	95	95.00	Maintain current performance	1)Continue to audit monthly and determine compliance	Report metric monthly to MAC, QA committee	Metrics reported monthly to QA committee and MAC. Report posted monthly on dashboards and communication boards. Develop action plans as needed to address decreases in completion rates	.	.

		Medication Discharge Plan was created as a proportion the total number of patients discharged.							2)Education / support as needed for physicians	Review indicator and trends at MAC. Identify any knowledge and practice gaps	.	.	.
	Safe care	The number of hospital patients who were physically restrained at least once in the 3 days prior to a full admission assessment, divided by all patients with a full admission assessment in the reporting period.	% / Mental health patients	CIHI OMHRS / October 2015 - September 2016	663*	5.81	5.81	Maintain current performance while analyzing data	1)Monitor and analyze over coming year to identify trends / determine valid target	.	.	.	There have been changes to regional access to MH services, resulting in increased volumes and an increase in the volume of acutely ill MH patients at AMGH. These factors all influence performance rate
									2)Review / update policies and processes	.	.	.	.
									3)Plan for education rounds	.	.	.	.