	AIM	MEASURE										CHANGE				
THEME	Quality dimension	Measure/ Indicator	Type	Unit / Population	Source / Period	Org ID	Current performance	Target	Target justification	External Collaboration	Executive compensation	Planned change initiatives	Methods	Process measures	Target for process measure	Comments
MANDATORY	**Safe**	Number of workplace violence incidents (overall) (defined as any incident, occurrence, report or investigation involving verbal or physical abuse/assault) Number of FTE 2018 = 316 FCHS 57.43, SMGH 265.06	Mandatory	Number of workplace violence incidents reported by hospital workers	In house data collection from Employee incident reports, Code White, V as RL Solutions, Parklane Systems, etc. from January -December 2018	4472	32 (FCHS 2, SMGH 30)	Increase 25% to target of 40 occurrences, including near misses.	The MHA goal is to enhance education, support, volume and process of reporting of Workplace violence injury and report quarterly. An initial increase in reporting is anticipated.		Yes	1. Workplace Violence (WPV) Risk Assessments	1. To be completed on yearly basis per department 2. Departmental and Organization action plans to be summarized 3. Prioritize items to be completed, set timelines and goals for completion 4. Complete proposals to determine most suitable training for MHA and implement a sustainability plan for ongoing required training including de-escalation for clinical vs non-clinical staff, Gentle Persuasion Approach, Pinel restraints, etc.	Annual completion of WPV risk assessments by each department, develop and complete goals identified. Quarterly Report to SLC and Board Quality	December 2019 to complete MHA action items	MHA overarching goal related to WPV staff injury resulting in lost time remains at Zero.
												2. Establish regular review of violence statistic reports for correction and prevention initiatives	1. Create quarterly reports combining injury and RL reports 2. Share with Joint Health & Safety to provide insight on recommendations	Quarterly Report to Joint Health and Safety, SLC and Board Quality	Fall 2019	
												3. Code White	1. Emergency Preparedness Committee to update policy and training 2. Educate and train all staff 3. Complete regular mock drills 4. Create sustainability and improvement plan	Emergency Preparedness Committee to provide Quarterly Report to SLC and Board Quality. Track number of drills and progression of improvements made by MHA	Fall 2019	
												4. Clinical Implementation of risk assessment pre-screening and Behaviour Alert Flagging process activated by front line direct and indirect patient care staff that alerts staff to the potentially aggressive/violent patients	1. Finalize a policy and procedure which provides explicit instructions to front line clinical and support staff about how to report risk of aggression/violence 2. Train Staff on the policy and procedure of how to recognize the risk so as to take appropriate precautions when a patient has an existing behavior risk dealing with a previously flagged individual 3. Monitor and report on frequency and severity of patient Behaviour Alert events monthly and quarterly.	Total flags applied monthly and quarterly.	Collecting baseline	Currently pre screening is not done consistently and a single person in the organization holds ability to flag patients.
	Timely	NEW 90P Time to inpatient bed described as the time interval btw Disposition Date/Time and Date/Time patient left ED for admission to an inpatient bed or operating room.	Mandatory	ED Admitted patients	CIHI NACRS/ October-December 2018	1515	14.68	9.50	Stretch goal of 35% improvement during this fiscal year represents a significant improvement over current performance.		No	Establish current performance and QIP/ HSAA target.	· Review of segments and actionable tasks of ED admission visit - disposition to admission to inpatient bed, disposition decision and completion of admission order to admission to bed, Best Possible Medication History (BPMH), medication reconciliation and test results review. · Review longest waits for visit type, diagnosis, intervals of care to identify areas of improvement. · Establish metric for DART for daily ED and MHA huddle boards, Service of ED meetings, Charge Nurse Meeting, and Clinical Leadership meeting for early and regular review of circumstances impacting lengthening wait times for admitted patients · Educate expected performance hospital wide, monitor and address bed flow issues for improvements .	90th percentile ED length of stay from disposition data/time to admission date and time.	SMGH targeting to improve by 35% gradually over this fiscal year to a target of 9.5 hours with transfer from ED .	Stretch target for Year 1 of the ED disposition to admit time metric with plans to continue to improve upon this metric in subsequent years.
												Review of current admission ordering practices in ED.	• Education of new metric and definition for physicians and staff • Improve the timeliness of order completion, patient ready • Timely communication of admit plan with inpatient units • Daily huddle discussion of bed availability and timing • Define an actionable trigger for 'approaching max target to admit time' and escalation process	90th percentile ED length of stay from disposition data/time to admission date and time.	We are targeting to improve by 35% gradually over this fiscal year to a target of 9.5 hours with transfer from ED .	
												Aligning DART targets with QIP/HSAA targets	• Explore opportunity to have this metric added to the regional wide, hospitals Daily Activities Reporting Tool(DART) to facilitate daily tracking of the metric at huddle boards and early review of circumstances impacting lengthening wait times for admitted patients • Align DART target with QIP/HSAA target	Daily Activity Report value and target available for daily huddles.	Current DART report available and communicated daily at bed huddle.	
Service Experience	**Patient Centred**	Percentage of respondents who responded " Definitely yes!" (TOPBOX) to the survey question: "Would you recommend this Emergency Department to your family and friends?"	Custom	All ED Patients	CPES and In House Paper Survey / January to December 2019	4472	60.18	80.00	Stretch target to improve patient experience at the MHA hospitals.		No	Improve patient satisfaction of experience within their emergency department visit.	1. Develop, implement and maintain strategies to obtain patient and family feedback: • Continue to encourage patient awareness and participation in the Picker email satisfaction survey. • Develop, implement and sustain real time paper based patient satisfaction survey. 2. Develop, implement and sustain strategies to provide the ED Team with patient feedback results: • Compliments and complaints shared with staff for improvement opportunities: 1 on 1 discussion, huddles, Service of Emergency Meeting 3. Develop and implement action plan for ED team appreciation, personal and team accountability for patient satisfaction: · Continue to shadow staff at triage and provide real time feedback · Continue to provide standardized scripting for staff to use at triage · One on one review of comments or concerns , feedback provided and accountability action plan to be implemented. 4. Increase nursing interaction and visibility with waiting patient within the department · Implement regular purposeful rounding within the ED (within the department and waiting room) · Implement bedside shift report 5. Explore opportunity for external consultant partnership in developing and implementing a targeted ED patient satisfaction improvement initiative. 6. Develop and implement ED "process" information for patient rooms and waiting room.	CPES and paper based survey response rate. Percentage of positive responses to "Would you recommend this emergency department to friends and family?"	80% positive responses	

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THEME	**Quality dimension**	**Measure/ Indicator**	**Type**	**Unit / Population**	**Source / Period**	**Org ID**	**Current performance**	**Target**	**Target justification**	**External Collaboration**	**Executive compensation**	**Planned change initiatives**	**Methods**	**Process measures**	**Target for process measure**	**Comments**
Safe and Effective	**Effective**	Medication reconciliation at discharge described as the total number of discharged patients for whom medication reconciliation is completed as a proportion to the total number of patients discharged. Hospitals are being asked to provide the numerator and denominator in the workplan submission and	Priority	Inpatients with Best Possible Medication History Plan and Medication Reconcilation completed at Discharge.	Rate of completion per total number of discharged patients / Discharged patients	4472	92.90	Increase, Stabilize and Sustain	This is the first quarter that MHA has exceeded our established target of greater than or equal to 90%. The MHA focus will be to sustain this performance over the nexts quarters.		No	1. Ensure completion of medication reconciliation at discharge.	• Builds upon accurate completion of BPMH and med rec on admission. • Accurate completion of discharge medication reconciliation by physicians. • Training of all new and existing nursing staff on the medication reconciliation process at discharge. • Reinforce expectations and suggestions for timely completion of medication reconciliation at discharge by physicians and nurse practitioners • Continue to provide physician with med reconciliation at discharge performance reports	Percent of medication reconciliation completed at discharge.	90% completion of med reconciliation at discharge.	Challenges: timely notification of pharmacist when a patient is being discharged and requires med rec/education
												2) Sustain recent improvements beyond target , stabilize.	· Monitor report through EMR of medication reconciliation completion by physician provider, nurse practitioner at discharge physician · Review of medication incidents related to incomplete medication reconciliation with HCP · Engage discussion with Chief of Staff with intent to provide results to individual physicians. · Identify outlier providers, giving performance feedback, expectations and education review and resource · Nursing staff refresher of Best Possible Medication History - annual education review · Continue to provide HCP admission and discharge medication reconciliation completion performance reports	Quarterly report to physicians of med reconciliation performance. Real time follow-up to medication reconciliation medication errors.	90% completion of med reconciliation at discharge by all HCP. Reduction in medication reconciliation medication errors.	
Safe and Effective	**Effective**	Risk Adjusted 30-day all-cause readmission rate to Ontario acute care facilities for patients with congestive heart failure (CHF) (Quality Based Cohort)	Custom	% inpatient readmission/CHF cohort	CIHI DAD/ October 2018 to Sept 2019	1515	20.12	14.00	Consistent with current HSAA Target	H&CC, West Elgin CHC, FCHS Family Health Team	No	1. Develop Congestive Heart Failure pathway and implement.	· Explore existing pathways , QBP recommendations, Best Practice Guidelines , Current order and care sets. · Develop draft pathway in collaboration with Service of Medicine , patient input, H&CC, external providers including FCHS Family Health Team, West Elgin Community Health Centre · Pilot process to evaluate quality and clarity of the pathway ; adjust, implement, evaluate.		90% of CHF primary diagnosis have CHF pathway	
												2. Patient CHF management education guide	· Develop CHF patient management guide following review of available resources , provider and patient feedback. · Reinforce education and CHF management from admission to discharge, early discharge follow-up with HCP, including consultation with FCHS Family Health Team, West Elgin Community Health Centre, through clinical best practices, visual and written education materials.	Monitor patient satisfaction preparation for discharge home.	90% of patients with CHF received CHF education	
												3. Telemedicine referrals to H&CC for Home management of CHF	· Daily huddle and weekly complex rounds with discussion and decision of referral . · Education of HCP of program availability.		90% of CHF are screened for telemedicine CHF Management	
Safe and Effective	**Effective**	Risk Adjusted 30-day all-cause readmission rate to Ontario acute care facilities for patients with chronic obstructive lung disease(COPD), (Quality Based Cohort)	Custom	% inpatient readmission/COPD cohort	CIHI DAD/ October 2018 to Sept 2019	1515	14.29	14	Consistent with current HSAA Target	H&CC, West Elgin CHC, FCHS Family Health Team	No	1. Revised COPD pathway in circulation for several months enhancing consistency of care through best practices, QBP recommendations, complex patient identification tool early in admission, qualification for Health Links program, high risk of readmission tool and follow-up appointment information at time of discharge.	• Assess use of pathway, reinforce education to nursing and clinical support staff, highlight patient preparation for discharge plan • Monitor number of COPD admissions and readmissions, including reason for readmission- COPD or other, timing of readmission to assess for additional education and discharge planning for smooth transition to community including Family physicians and health teams , FCHS Family Health Team, and West Elgin Community Care Centre. • Adherence to Best Practice Guidelines - COPD, Dyspnea, Chronic Conditions • Early referral to H&CC re complex discharge, readmission risk, assessment for Health Links COPD program • Collaborative work with the SWLHIN H&CC to ensure the development and implementation of Coordinated Care Plans for appropriate patients • Include assessment of tobacco use within previous 6 months • Weekly multidisciplinary complex discharge rounds with H&CC review patient readmission and develop coordinated care plans. At FCHS site, a single H&CC coordinator covers community, hospital and Family Health Team support , providing a very coordinated approach to the various episodes of care for patients.	Readmission Rate of COPD patients. Number of COPD pathways completed for COPD patients.	Rate 12.87 , Performance target <14.0 HSAA target SWLHIN	
												2. Improved utilization of physician care sets for COPD	• Informatics report of utilization • Education of care sets physician through Department and Service meetings of Medicine and ED, meetings of Health Hub Committee (FCHS hospital, FCHS FHT and WE Community Health Centre)	Number of patients with care sets selected, over number of patient admitted with COPD	90% of COPD primary diagnosis have COPD pathway	
												3. Improve the patient ability to demonstrate their understanding of the benefits and inhalation device(s).	• Improved referral to respiratory therapy through COPD pathway trigger • Inhaler use education of nursing, physio staff by respiratory therapist. • Enhance existing education material with input from patients. • Seek feedback regarding educational material from patients and staff for effectiveness. • Ensure patient are able to Teach Back and demonstrate proper use and understanding of the inhalation device. • Evaluate through patient feedback following Teach Back and patient assessment of knowledge and performance.	Patient will demonstrate appropriate use of the inhalation device.	90% of COPD patients receive education re inhalation use and technique.	
												4. Participation in Ottawa Model of Smoking Cessation(OMSC) initiative to promote smoking cessation of patients with COPD .	• Identification and documentation of smoking status of all patients at admission or intake. • Ask every patient of any tobacco use in last six months • Provide strong personalized advice to quit smoking and offer support. • Consultation to and follow-up by Smoking Cessation Champion • Incorporate into COPD Pathway • Education for frontline staff (nursing, rehab, RT) , pharmacists, champions, physicians	Number of patient assessed for smoking status. Number of patients requesting participation in smoking cessation support and Nicotine Replacement Therapy (NRT).	80% of patients who smoke will request NRT.	
												5. Monitor immunization status on admission consistent with admission history and COPD pathway.	• Offer vaccines and prophylactic influenza antiviral medication where needed.	Number of patients on COPD Pathway that receive or are offerec vaccines and antivirals.	Collecting baseline.	