Excellent Care For All.

BEFORE YOU BEGIN...

As part of the **ECFAA Legislation**, the annual quality improvement plan must be developed having regard to:

- The results of the surveys (patient and staff - if available)
- Data relating to the patient relations process
- Aggregated critical incident data

Please ensure this information is reviewed and considered in the process of developing your plan.

Helpful hints for how to review this information are provided in the guidance document.

Link to Online Updates

Key messages	Technical Information
PART B: Improvement Targets and Initiatives	
Measures (columns B-F) –There is a core set of measures identified within this spreadsheet. This is to ensure alignment, consistency and standardization of reporting. There is however, an expectation that measures will be added that align with your own hospital and regional priorities	Current performance: What is your organization's current performance data/rate? A timeframe is specified within the table for core indicators.
	Performance goal 2011/12: At the end of the improvement initiative, what is the outcome your organization expects to achieve?
	Priority: Only indicators assigned as Priority 1 require a change plan (columns G-K). Please see the **guidance document** for more information.
Change plan (columns G-K) – These columns should be completed where you have flagged a measure as Priority 1 (column F). Understanding that hospitals do not all have the same priorities, we expect these plans to be developed with your own hospital's priorities in mind. Change priorities should be focused on areas where improvement is necessary.	High-level improvement plan: This section defines the details of the quality improvement initiative. Hospitals are required to complete the change section for all high priority (1) initiatives.
	Methods and results tracking: Include your measures/current data (i.e. process measures) as appropriate
	Target for 2011/12: All Priority 1 indicators must have a target defined for 2011/2012. Organizations should aim to review their existing data over time to set "stretch targets" on a select number of objectives. Please see the Guidance document for more information on target setting.
	Target justification: Why was the specific target selected? i.e. is the target based on research literature; best practice; provincial or other defined benchmarks; scientific evidence; organizational targeting exercise?
	Comments: If there are any additional comments that you would like to make about the initiative, please indicate these here.

PART B: Improvement Targets and Initiatives

South Huron Hospital Association - 24 Huron Street West, Exeter, ON, N0M 1S2

AIM		MEASURE				CHANGE				
Quality dimension	Objective	Outcome Measure/Indicator	Current performance	Performance goal 2011/12	Priority	Improvement initiative	Methods and results tracking	Target for 2011/12	Target justification	Comments
Safety	Reduce clostridium difficile associated diseases (CDI)	**CDI rate per 1,000 patient days:** Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1,000 - Average for Jan-Dec. 2010, consistent with publicly reportable patient safety data	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Improve provider hand hygiene compliance	**Hand hygiene compliance before patient contact**: The number of times that hand hygiene was performed before initial patient contact divided by the number of observed hand hygiene indications for before initial patient contact multiplied by 100 - 2009/10, consistent with publicly reportable patient safety data	95%	95%	1	1) Mandatory education and training sessions annually and as needed	Audit to show 80% of staff trained			N/A
						2) Annual audit of performance completed	Audit complete	75%	Better than provincial average	
	Avoid new pressure ulcers	**Pressure Ulcers**: Percent of complex continuing care residents with new pressure ulcer in the last three months (stage 2 or higher) - FY 2009/10, CCRS	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Avoid falls	**Falls**: Percent of complex continuing care residents who do not have a recent prior history of falling, but fell in the last 90 days - FY 2009/10, CCRS	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Improve Medication Reconciliation compliance upon discharge	**Medication Reconciliation Compliance Rate upon Discharge:** total number of patients discharged divided by the total number of patients for whom a Best Possible Medication Plan was created	80%	95%	1	1) Perform monthly chart audits	Audit to show 95% compliance	95%	Internal Benchmark	N/A
						2) Report findings to physicians, nursing, and pharmacy on a monthly basis	Communication in Minutes			
Effectiveness	Reduce unnecessary hospital readmission	**Readmission within 30 days for selected CMGs to any facility:** The number of patients with specified CMGs readmitted to any facility for non-elective inpatient care within 30 days of discharge, compared to the	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Reduce unnecessary time spent in acute care	**Percentage ALC days:** Total number of inpatient days designated as ALC, divided by the total number of inpatient days. FY 09/10, DAD, CIHI	13%	15%	2	1) Work with our LHIN and CCAC to ensure patients are accessing home care and rehab resources to facilitate transition to home.	Audit of monthly statistics	15%	Internal Benchmark	N/A
	Improve organizational financial health	**Total Margin (consolidated):** Percent by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expense, excluding the impact of facility amortization, in a given year. Q3 2010/11, OHRS	0%	0%	2	1) Continue to secure our financial future through the maintenance of budgetsand contracts while maximizing revenues obtained from external sources	Audit of monthly statistics	0%	H-SAA Target	N/A
Access	Reduce wait times in the ED	**ER Wait times:** 90th Percentile ER length of stay for Admitted patients. Q3 2010/11, NACRS, CIHI	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		ER Wait times: 90th percentile ER Length of Stay for Complex conditions. Q3 2010/11, NACRS, CIHI	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Improve access to Ambulatory Care	**Scheduled Outpatient Clinics:** Number of scheduled General Surgery, Pre-Admit, Gynecology, Endocrinology, Pediatric Respiratory, General Medicine, Dermatology visits, Q3 2010/11	1076	950-1200	3	1) Investigate and implement outpatient ambulatory clinics that meet the needs of our population	Audit of monthly statistics	950-1200	Internal Benchmark	N/A
Patient-centred	Improve ED patient satisfaction	NRC Picker / HCAPHS: "Would you recommend this hospital to your friends and family?" (add together percent of those who responded "Definitely Yes")	76.60%	75%	2	1) Enhance communication with focus on explaining reason for wait, danger signs to look for upon discharge and discuss patient's fears and anxieties	Survey patients using NRC Picker	75%	Better than provincial average	N/A