AIM		Measure						Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
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 2017(Q1 FY 2017/18)	75%	85.00%	Recent changes to the patient survey and the questions that pertain to this	1)Patient education is being targeted to the specific patient populations(surgery) that are identifying that they do	Standing agenda item on Patient and family Advisory Council (PFAC) will continue to ensure that education is pertinent and clearly outlined. Thorough review and understanding of questions in patient survey whereby patients are identifying that	All patient education through PFAC. Staff members from specific units developing educational material to be present when education is reviewed and discussed.	March 31, 2019	Patient Satisfaction Survey; Ontario average
	Coordinating care	Percentage of patients identified with multiple conditions and complex needs (Health Link criteria) who are offered access to Health Links approach	% / Patients meeting Health Link criteria	Hospital collected data / most recent 3 month period	15 care plans	30.00 care plans	Improve referral by 50% or more this upcoming year; will help reduce wait times and access to care	1)Early identification and improved integrated care for patients with multiple conditions and complex needs who will require	Identify health links patient with four or more active chronic conditions and complete Coordinated Care Plan for patients	1)Measure total number of Coordinated Care Plans completed 2)measure and monitor readmission rates with early identification of patient s whop would benefit from CCP's in turn reducing avoidable admission rates: staff demonstrate uptake of	Increase # of referrals to Health Links and Coordinated Care Plans by 50%	Patients will be identified in collaboration with the SW LHIN Home and
								2)Develop new philosophy and approach in the management of complex patients with frequent emergency room visits	Identification of patient with 4 or more hospital admissions in the last year or 5 or more ED visits in the past year	Implementation of CCP referral with those patient s identified with frequent avoidable ED visits	Increase referral to Health Links and Coordinated Care Plans by 50% resulting in 30	Patients are identified in collaboration with the SW LHIN Home and
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 2017	12.51 % per 100 inaptient days	12.00% per 100 inpatient days	This indicator has been on our QIP for the last three years. We have made	1)Early identification and intervention for complex patients who will require additional resources and supports	ALC tracked daily in acute and non acute care; patient flow to monitor all complex patients at risk for difficult discharge; early contact with patient family re discharge planning;referral to Health Links and CCP.	Number of EDD beyond target in acute and non acute care; case reviews and referrals done and plan implemented	Reduce ALC in acute and non acute care by March 31,2109	SW LHIN H Health Links
Patient-centred	Person experience	"Would you recommend this hospital to your friends and family?" (Inpatient care)	% / Survey respondents	CIHI CPES / April - June 2017 (Q1 FY 2017/18)	88.2	90.00	Goal is to trend above provincial average and above past performance	1)Follow up discharge calls to patients for targeted inpatient units; increase real time patient audits during senior team and leadership	Follow up calls to complex medical patients and surgical patients; in hospital survey pre-discharge; increased leadership walkabouts	Number of call made to targeted patients; number of leadership walkabouts; patient and Family Advisory reports twice yearly	Number of calls made; number of suggestion from patient feedback implemented;	SHoPPs survey; PFAC
		Percentage of complaints acknowledged to the individual who made a complaint within	% / All patients	Local data collection / Most recent 12 month period	86.36	100.00	All complaints are taken very seriously and all efforts are towards a	1)All complaints acknowledged within 3 to 5 business days with a description of follow up and when to expect next	Complaints are received through various avenues into the hospital. A clear plan with designated individuals and back ups has been developed so that each complaint is documented and acknowledged within three to five business days	Additional resources have been added to the quality portfolio. A plan to provide complete coverage of complaints during all business days with alternate coverage and follow up by departments is in place	Measure complaint follow up turnaround times	ECCFA
Safe	Safe care/Medication safety	Medication reconciliation at discharge: Total number of discharged patients for whom a	Rate per total number of discharged patients / Discharged	Hospital collected data / October – December (Q3) 2017	CB	CB	Preliminary data shows that medication reconciliation is being done for	1)Medication reconciliation is being performed in inpatient areas areas of the hospital. The last two years that focus has been on	Performance improvement specialist will focus education on med rec at discharge in key areas to improve compliance and improve patient safety	Chart audits routinely scheduled; results shared at medication safety committee and posted in each unit for staff to review; daily med rec (admission and discharge) posted on Huddle boards.	Increase number of medication reconciliation upon discharge in key areas with high	Patient Safety; Medication Safety
	Workplace Violence	**Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.**	**Count / Worker**	**Local data collection / January - December 2017**	**132 incidents**	**110.00 incidents**	**As a new indicator preliminary data has been collected and education rolled out to staff. Potential for increase in reported incidents of violence**	**1)Education to all staff, highlighting staff safety and training and reporting violent incidents through incident reporting software**	**Education at orientation and at yearly hospital education event; staff in high risk areas to receive additional non-violent crisis intervention and gentle persuasion techniques; assessment and identification of all patient for behavioral risks at point of entry**	**Number of incidents reported in reporting software; number of incidents reported to occupational health and safety office**	**Reduction in violent incidents; reduction in injuries to staff; increase in staff education and awareness**	**FTE=905**
Timely	Timely access to care/services	Total ED length of stay (defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ED) where 9 out of 10 complex patients completed their visits	Hours / Patients with complex conditions	CIHI NACRS / January - December 2017	5.63 hrs	5.50 hrs	Align with Pay for Results target	1)1)Schedule ED physician resources to meet peak patient volume demands	Additional physician RAZ (rapid assessment zone for complex patients)coverage 6hr/day. Expansion of physician RAZ hours to 2 additional 6 hr evening shifts/ week. Re education for physicians on lean strategies and ED process efficiencies.	i) 90th percentile LOS all complex patients (admitted and nonadmitted) ii) 90th percentile time to initial physician assessment for all complex patients iii) 90th percentile disposition decision time for all complex patients	i) Target 90th percentile LOS for all complex patients 5.5 hrs. ii) Target 90th	Pay for results. PIA and disposition decision times are closely
								2)2)Improve turn-around time (TAT) for Diagnostic Imaging tests	Expand i-Drive access to DI staff and Radiologists to heighten visibility of DI TAT; Trial allocate MRT resources to match ED, In-Patient and Out-Patient demands	i)90th percentile time from exam completion to radiologist interpretation reports in CERNER for CT scans and U/S for all complex patients.ii) 90th percentile time US order to US started.	i) Target 90th percentile for CT and US radiologist report for all complex patients	Length of stay is related to physicians having results of exams and tests in order