PART B: Improvement Targets and Initiatives

Lake of the Woods District Hospital 21 Sylvan St. Kenora, ON P9N 3W7

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	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.	42%	85%	1	1) Ensure all new hire staff, students, volunteers complete online Hand Hygiene education module.	Audit completion rates.	90% completion.	All new staff require training in hand hygiene.	Most recent audit 2010 shows significant increase in performance/compliance. Maintain improvement.
						2)Participate in national 'STOP! Clean Your Hands Day", May05/11- education and staff promotion day.	Document participation by medical & general staff.	n/a	Participation will promote compliance and achievement.	
						3) Encourage patients to ask providers if they've washed hands before pt. contact.	Patient safety survey includes this question.	50% positive response rate.	Pts. are reluctant to ask health care providers.	
		The number of times that hand hygiene was performed after patient contact divided by the number of observed hand hygiene indications for after patient contact multiplied by 100-2009/10, consistent with publicly reportable patient safety data.	65%	90%						
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 number of expected non-elective readmissions - Q1 2010/11, DAD, CIHI	11.80%	11.00%	1	1) CHF- BNP testing available in ER for timely differential diagnosis.	Track implementaion progress and # tests done.	BNP testing available.	Continue to exceed provincial average (12%). CHF is LWDH highest readmission rate.	
						2)Focus on discharge strategies for CHF inpatients: Discharge medication reconciliation completed; follow up appts. made for high risk readmission patients;	% D/C med.rec. completed on pts. with diagnosis of CHF.	80%		
						3) Promote consistent medical management of CHF through adoption of CHF Patient Order Sets.	Audit use of CHF order sets.	Adoption & implementation of CHF order sets	Use of order sets will standardize in-hospital orders with best practice standards.	
	Reduce unecessary time spent in acute care	**Percentage ALC days:** Total number of inpatient days designated as ALC, divided by the total number of inpatient days. Q2 2010/11, DAD, CIHI	35%	26.9% (LHIN target)	1	1)Promote & educate medical staff, interprofessional team members, patients and families about CCAC "Home First" program.	Document information & education strategies and attendance.	Co-Host 2 information sessions with CCAC.		
						2) CCAC "Wait at Home Strategy"- partner with CCAC to identify ALC clients that could be discharged with WAHS in place.	Identify LWDH ALC patients who would benefit form WAHS.	WAHS in place.		
						3)Continue to lobby LHIN to open additional long term care beds.	Percentage ALC days.	Additional LTC beds opened.	Target has been set by LHIN in 2011/12 H-SAA to align with NW LHIN target	10 additional ALC beds announced 2010- have not been opened to date.
	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**	1.60%	0%	1	1) Incorporate realistic assumptions regarding revenues & expenses into budgeting procedures.	Monthly financial statement and quarterly LHIN reporting	0%	Target is set by MOHLTC/LHIN in H-SAA. Several strategies were implemented in 2010/11 to balance the budget and these will continue into 2011-12. By law hospitals are not allowed to run a deficit, and although we may negotiate a balanced budget waiver with the LHIN, If necessary services will be re-aligned to ensure a balanced budget.	
						2) Work with managers, staff & partners through the HAPS & CAPS processes to prioritize services				
						3) Identify measures and efficiencies to most effectively deliver services within the allocated financial resources				

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Access	Reduce wait times in the ED	**ER Wait times:** 90th Percentile ER length of stay for Admitted patients. Q3 2010/11, NACRS, CIHI	12.2 hours	10.9 hours	2	1) Utilization of Surge policy/procedure.	Audit # times Surge Policy implemented.	Audit completed.	Improvement in this area is dependent upon resolution of ALC issues. Orgnanization has little control over these factors. Goal is to meet/exceed LHIN target of 10.9 hours.	
						2) Ensure Discharge times adhered to on inpatient units.	Audit of time from discharge order to bed vacated, room ready for next patient.	Audit completed.	Data collection & analysis will assist to identify areas for improvement.	
						3) Examine admission process from ER to inpatient units- acceptance	Audit of time from ward notification to patient arrival on unit.	To be determined.	Identify areas where timing/process can be improved.	
Patient-centred	Improve patient satisfaction	Building a Future- MOHLTC funding approved to proceed with Stage 1- Capital Planning for a new health care campus.	Application submitted.	Capital approval by MOHLTC.	1	1) Continue to lobby MOHLTC for approval to proceed.	Monitor project progress, response from MOHLTC	Consultant in place.	Board of Directors' priority project	
						2) Board of Directors to communicate project information to the public through Board Engagement meetings				
		In house survey: Response to question, "Would you recommend this hospital to your friends and family?". (Percent of those who responded "Definitely Yes".)	(54.73% NRC SURVEY)	80%	2	1) Develop & implement an in house patient satisfaction survey tool.	Audit survey results.	70%	Meets Provincial average.	
						2) Administer survey tool at time of discharge.				