2013-14 QIP Plan for: Lake Of The Woods District Hospital

AIM		MEASURE					CHANGE				
Quality Dimension	**Objective**	**Measure/Indicator**	**Current Performance**	**Target for 2013/14**	**Target Justification**	**Priority level**	**Initiative Number**	**Planned Improvement Initiative (change ideas)**	**Methods and Process Measures**	**Goal for change ideas (2013/14)**	**Comments**
Access	Reduce wait times in the ED	ER Wait times: 90th Percentile ER length of stay for Admitted patients. Q4 2011/12 – Q3 2012/13, iPort	10.2 hours average	11 hours	Improve wait times for admitted patients.This target is higher than current performance as the potential closure of LTC beds may increase our wait times.	1	**1**	Adoption of Patient order sets for physicians in the ER	Patient Order Set Working Group to prioritize the development and	5 Order sets to be completed for 2013/2014	Process improvement intervention.
							2	Review and analyze the most recent ER flow study for admitted patients audit and develop an action plan to decrease any unavoidable delays in ER admissions.	Develop strategies from identified delays from 'decision to admit' to 'admission'. Monitor ER wait times; NACRS, CIHI. Monitor most recent patient satisfaction survey. Work with Discharge / Utilization Coordinator to	Strategies identified to improve the flow process and a decrease in admitted wait times in the ER.	Process improvements intervention. Measurement and feedback intervention.
							3	Review and analyze data of patient flow to allow for movement of patients from ER to the patient wards.	Meet with Utilization committee and identify strategies from flow process data to improve movement to the patient wards in a timely manner.	Increase percentage of patients that are discharged from the wards to reflect a higher percentage of	Process improvemtn Intervention
							4	Review and analyze CTAS audits to determine if admitted patients are initially assessed as urgent care; this will decrease wait time prior to physician assessment.	Quarterly CTAS audits. ER staff to assist with audits to increase their knowledge.	Quarterly stats will be completed; June, September, December, March. 100% of ER RNs will have a chan	Process improvement/fostering engagement intervention
							5	Share data with ER staff on an ongoing basis to assist.	Involve staff in flow process review and development of strategies to reduce	100% of ER staff will have knowledge of ER admitted wait times	Communication/building awareness intervention
							6	Decrease admissions in the ER.	Monitor monthly ER admissions.	Admitting patients to inpatient wards; assess if an alternate care ward can accommodate the ER patie	Process improvement Intervention
							7	Continue to provide Home First Program Services and access the rapid response nurse services when applicable.	Meet on a regular basis with Home First Committee and review admitted patients in the ER.	Full implementation of Home First. Decrease in admitted wait times.	Process improvement intervention
							8	Seek funding for a Nurse Practitioner in the ER.	Submit a proposal for a Nurse Practitioner in the ER to the LHIN.	Funding approved and a Nurse Practitioner recruited to the department.	Patient flow improvement strategy
Effectiveness	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 2013/14, OHRS	0.76	0	Strive to maintain a balance budget	1	**1**	Ongoing reviews of LWDH utilization data by Management and by Utilization Committee to target areas where resources being expended appear to be out of line with provincial benchmarks and identify opportunities for improvement	Ongoing agenda item of Utilization Committee. Utilization Committee to meet monthly and address at least one Quality Based Procedure per month where costs are higher than provincial benchmarks. Report back to Senior Management through VP Finance.	Identification of and addressing inefficient processes assists in balancing the budget and ensures	Incentive/motivation intervention/process improvement
							2	Investigate feasibility of both internal and external reviews using tools such as LEAN to determine where processes can be adjusted to ensure the most efficient use of resources	Target two areas for review in 2013-14. Perform review and measure and document resource savings to achieved through changes in process.	Proactive identification of less efficient areas provides an opportunity to improve processes	Incentive/motivation intervention/process improvement
							3	Provide education to Managers and physicians regarding Health System Funding Reform and implications of the Health Based Allocation Model (HBAM) with respect to future funding and increase Physician involvement in the budgeting process (FAC and capital)	Ongoing agenda item at the MAC meetings, suggestions communicated to VP finance.	Cost saving suggestions assist in balancing the budget and ensure that resources are being expended	Incentive/motivation intervention/process improvement
							4	Participate in group purchasing to take advantage of volume buying and streamline costs.	reports to managers of quarterly group purchasing savings	At least 50% of purchases are done through group purchasing and result in savings over purchasing a	Reminder/Incentive/motivation intervention

							5	Look at comparative data with peer facilities to identify opportunities for efficiencies	: Provide education update to managers regarding Ministry of Health Health Information Tool (HIT) and encourage	100% review by all managers	Process improvement intervention
							6	ongoing agenda item at all departmental staff meetings	saving strategies/ideas discussed at all staff meetings and communicated by	100% hospital wide	Process improvement intervention
Integrated	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. Q3 2011/12 – Q2 2012/13, DAD, CIHI	21.58	25	This target is slightly above the LHIN target however with the impending closure of Interim LTC beds it is likely that the number of ALC days at LWDH could increase.	1	1	Continue partnership with NWCCAC to support Home First philosophy and maintain regular JDOT meetings to identify barriers to discharge of ALC patients.	Regular meetings with CCAC	There will be a reduction in the number of ALC to LTC. Any applicant for LTC from hospital must be a	
							2	Develop education for ER physicians and nurses to increase knowledge of CCAC services and role within the hospital.	CCAC Rapid Response Nurse will work closely with the ER team and provide ongoing informal education while collaborating with team.	ER physicians and nursing staff will be aware of community services available. Patients to CCAC whos	Skill development intervention
							3	Continue to participate in FLO project in all acute in-patient units.	Whiteboards have been placed at all patient bedsides. Ongoing education in the use of whiteboards will ensure the	Communication to the patient and/or family with regard to the care plan and discharge date will impr	Education/motivation intervention.
							4	Develop and implement a formal discharge planning framework and processes, in particular focusing on the discharge time of 10 am.	Discharge time is posted in all patient rooms and written in the patient information booklet. Discussion with Unit Managers requesting staff make	Discharges will be facilitated by 10 am in order to reduce ALC days.	Reminder Intervention
							5	Maintain the Assess and Restore Program (Restorative care) to improve patient's functional abilities.	Process measure as per Assess and Restore program.	Improving patient's functional abilities will facilitate early discharges and reduce ALC days. The p	Motivational intervention
Patient-centred	Patient Satisfaction	In-house survey (if available): provide the percent response to a summary question "Would you be willing to recommend the hospital to friends or family"	96%	>95%	Improve how our institution is perceived by the general public.	3	1	Survey patients once a year, Communicate results to patients and staff	In-house survey spring 2013	improve from 96.16 % to 97.02 %	Measurement and feedback intervention
							2	Provide staffing resources to ensure accurate and timely survey results	100% staff committement from all patient unit areas to distribute and collect surveys	Recieve 500 returned surveys	Feedback intervention
							3	Review survey results and assess for gaps/areas to improve in our service	Analyse and compare data from last year	Information will be shared with all hospital staff to provide feedback of hospitasl services	Measurement and feedback intervention
Safety	Avoid Patient falls (Inpatients)	# of falls for Inpatients per year.	120	114	Accreditation Standard ROP and standard of Care	2	1	Monthly Falls ctte meetings to review the trend stats and recommend mitigating strategies	-Posting quarterly number of patient falls on all inpatient units for staff review. -Member of falls ctte keeps the	-Falls data communicated to Units -100% quarterly posting in departments	Measurement and feedback intervention
							2	Continue to utilize falls risk assessment tool on all patients on admission and implement the falls prevention strategies that apply.	Annual audit to monitor screening tool usage	100% risk for falls screening tool used	Process improvement intervention
	Outpatient Falls	# of falls for Outpatients per year.	6 falls per year	5 falls per year	Accreditation recommendation ROP and standard of care	2	1	Monthly Falls ctte meetings to review the trend stats and recommend mitigating strategies	- Monthly Falls ctte meetings to review the trend stats and recommend mitigating strategies Methods and	-Falls data communicated to Units - 100% quarterly posting in departments - Qu	Measurement and feedback intervention
							2	Continue to utilize falls risk assessment tool on all patients on registration	Annual audit to monitor screening tool usage	100% risk for falls screening tool used	Process improvement intervention
	Enhance cultural Sensitive Care	In house survey "I felt that the doctors, nurses and other hospital staff were respectful of my cultural needs".	92%	94%	Survey result would represent all cultures	3	1	On line module Cultural sensitivity education mandatory to all staff/students	Mandatory modules to all staff/students upon hire and then yearly , performance compliance monitored in	100% staff/student compliance	Skill development intervention
							2	Showcase Aboriginal art to increase awareness, Consider Boardroom table art	Display Cultural art in front lobby/entrance in hospital	Visibility Of Cultural Diversity	
							3	Cultural menu days in the cafeteria	Cultural menu days in the cafeteria	100% cultural Thursdays implemented	Reminder intervention

							4	The Aboriginal Health Advisory Committee will continue to meet quarterly to review and evaluate the implemented culturalsensitivity strategies and communicate suggestions to Senior Management.	Committed to Quarterly meetings	Communication and considerations of proactive ideas	Review/Evaluation intervention
							5	Develop alternate methods of reporting Cultural Sensitivity complaint/compliment process that is would be submitted to the Risk Manager and discussed with the Aboriginal Health Advisory sub-committee	Preported data can be investigated in a concrete manner.	All Cultural Sensitivity complaints will be investigated in a timely a manner	Measurement and feedback intervention
	Increase proportion of patients receiving medication reconciliation upon admission	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 - Hospital-collected data, most recent quarter available (e.g., Q2 2012/13, Q3 2012/13)	73.00%	75%	Achievable with action plan (moving toward 2014 ROP medication Reconciliation at Care Transitions) Reconciliation at Care Transitions)Average of compliance of all applicable units of most recent audit)	1	1	Quarterly and ad hoc meetings of Working Group to review audit results and develop improvement strategies	Alternating Quarterly Audits ie. Admission med rec Q1, Q3, Transfer/discharge Q2,Q4	Provides compliance data to determine on process evaluation.	Measurement and feedback measurement
							2	Post audit results on all inpatient Units	100% posting on all inpatient units.	Incentives/motivation intervention	
							3	Continue to consult physician liaison on an ad hoc basis to maintain communication of process status.	100% sharing of meeting minutes to champion physician, standing agenda on Med Rec committee “the need to consult physicians”	Process improvement intervention	
							4	Staff Educational opportunities will be a standing item on the Med Rec working group’s agenda und staff attendance to in-services will be submitted to Human Resources.	Discussed at every Med Rec meeting. At least one educational session on Med Rec offered to all staff yearly	Education	
	Medication Reconciliation on Discharge (new indicator)	Medication Reconciliation at Discharge/transfer: The total of patients with medications reconciled as a proportion of the total number of discharged/transferred in the hospital- Hospital collected data.	30	40	Accreditation standard	1	1	Quarterly and ad hoc meetings of Working Group to review audit results and develop improvement strategies	Alternating Quarterly Audits ie. Admission med rec Q1, Q3, Transfer/discharge Q2,Q4	Improve from 30% to 40% in discharge /transfer since new indicator	Measurement and feedback measurement
							2	Post audit results on all outpatient Units	100% posting on all outpatient units	Incentives/motivation intervention	
	Reduce hospital acquired infection rates	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 - Jan-Dec. 2012, consistent with publicly reportable patient safety data	89% before	90% before	Current performance exceeds the provincial average. Hospitals that demonstrate success in hand hygiene have been shown to have a strong organizational commitment to improvement. We will continue to strive for the highest compliance (100%)	3	1	Hand Hygiene poster on every patient bathroom door reminding patients to “do not hesitate to ask your health care provider if they washed their hand”	100% of patient bathrooms will have poster display on bathroom door	Visible educational poster for result.	Process measurement and improvement intervention.
							2	Post Unit specific audit compliance results on each unit.	100% of patient unit with visible poster posting audit results.	Results will cascade down through all levels of the hospital	Measurement and feedback intervention
							3	Utilize known observational auditors to perform hand hygiene compliance assessments as this promotes result accuracy and enhances staff learning.	auditors will be known to staff	Maximize accuracy of audit results.	Process improvement intervention
							4	Hand Hygiene Awareness Raising Campaign Spring 2013	Education Blitz to all hospital staff by email, poster displays and hospital	80% staff participating in the education blitz.	Reminder intervention
							5	Post Unit specific completion of online module results on each unit.	Visible poster posting audit results on all patient units.	100% of all 8 patient units.	Measurement and feedback intervention
							6	Award for unit that have met or exceeded the hand hygiene target as per audit result.	Award to be presented by the CEO at the Staff forum.	Award given annually	Incentives/motivation intervention.
							7	Increase physician awareness strategies with result of increased physician compliance	observational audit and “on the spot” education/feedback. Audit will be posted on physician communication board and	Audit physician group and study results	process measurement and improvement intervention.

	Surgical Site Infections/Preoperative Anti -Microbial Coverage	Percentage of administered antibiotics within on hour incision time for TKA,,Csections and lap choles (annual report- due January 2014)	84%	87%	Safer healthcare now standard and publically reported data.	2	**1**	80% Antibiotic administration within one hour cut time for scheduled Total Knee Arthroplasties, C-sections and lap cholecystectomy	Develop a pathway that the surgical team will follow that dictates when the antibiotic should be administered.	100% antibiotic pathway will be used	Process improvement intervention
							2	Request that the Anesthesia group add this item as a standing agenda item at all their meetings, discuss quarterly report target data and develop and share strategies to the surgical services committee to ensure target for the timely administration of antibiotic is met.	100% Quarterly audit reports will be provided to Chief of Anesthesia to present at their meetings and the incorporation of Anesthesia recommendations into existing surgical checklist.	agenda item for discussion at all Anesthesia meetings	