2014/15 Quality Improvement Plan for Ontario Hospitals
"Improvement Targets and Initiatives"

Lake- Of- The- Woods District Hospital 21 Sylvan Street

AIM		Measure								Change				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current p	Target	Target justificatio	Priority level	Planned improvement initia	Methods	Process measures	Goal for change ide	Comments
Access	Reduce wait times in the ED	ED Wait times: 90th percentile ED length of stay for Admitted patients.	Hours / ED patients	CCO iPort Access / Q4 2012/13 – Q3 2013/14	826*	10.43	11	This target is based on the effects of the unavailability of Long Term Care interim beds which may increase our wait times.	Maintain	1)Adoption of patient order sets.	Patient order set working group to prioritize the development and implementation of Physician order sets.	5 Order sets to be completed for 2014/15.	Improve flow and prevent delays in transfer of patients from ER to inpatient units	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. Ongoing collaboration with discharge coordinator.	Monthly monitoring ER Wait times.	Strategies to improve the flow process and a decrease in admitted wait times in the ER.	Process improvement intervention.
										3)Review and analyze CTAS (Canadian Triage Acuity Scale)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.	Target ER wait times will be maintained. Patients will be triaged according to CTAS guidelines.	Process improvement/ fostering engagement intervention.
										4)Share ER wait time data with ER staff on an ongoing basis.	Involve staff in flow process review and development of strategies to reduce ER wait times for admitted patients.	The ER staff will have knowledge of ER admitted wait times.	Wait times will remain stable within identified target.	Communication/building awareness intervention.
										5)Decrease admissions to ER.	Monitor ER admissions.	Admitting patients to inpatient wards by collaborating with the utilization coordinator and/or nursing supervisor; assess if an alternate care ward can accommodate the ER patient waiting on an admission bed.	Achieve target wait time.	Process improvement Intervention.
										6)Continue to provide Home First Program Services and access the rapid response nurse services when/if applicable/available.	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.
										7)Continue to seek funding for a Nurse Practitioner in the ER.	Continue to advocate for a Nurse Practitioner in the ER.	Funding will be approved and a Nurse Practitioner will be recruited to the department.	Decrease ER wait times.	Patient flow improvement strategy.
Effectiveness	Improve organizational financial health	Total Margin (consolidated): % 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.	% / N/a	OHRS, MOH / Q3 2013/14	826*	0	0	Strive to maintain a balance budget.	Maintain	1)Ongoing reviews of LWDH utilization data by Management 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 the Utilization Committee. Utilization Committee to meet and address at least one Quality Based Procedure 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.	Balanced for Q3 data Compliance under the MOHLTC definition of margin.	Incentive/ motivation intervention/ process improvement.

										2)Quality Based Procedure Committees to review current practices for relevant CMG (case mixed groups) and incorporate best practice guidelines.	The review of current services by the QBP committees and the the consideration and implementation of best practices.	Consideration and implementation of Quality Based Procedure recommendations will promote funding	Q3 balanced budget.	Process improvement intervention
										3)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 areas for review in 2014/15. Perform review, measure and document resource savings achieved through changes in process.	Identification of and addressing inefficient processes assists in balancing the budget.	Q3 balanced budget.	Incentive/ motivation/ intervention/ process improvement.
										4)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. (Fiscal Advisory Committee and capital)	Ongoing agenda item at the Midmanagement and Medical Advisory Committee meetings, suggestions communicated to VP of finance.	Proactive identification of less efficient areas provides an opportunity to improve processes to achieve a balanced budget.	Q3 Balanced budget	Incentive/ motivation/ process improvement intervention.
										5)Participate in group purchasing to take advantage of volume buying and streamline costs.	Reports to managers of quarterly group purchasing savings.	Purchases are done through group purchasing and result in savings.	Q3 balanced budget	Reminder/ Incentive/ motivation intervention
										6)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 its regular use. Comparative data shared with all managers for review.	Provide education to managers regarding the Ministry of Health Information Tool (HIT).	Reviewed by all managers.	Q3 balanced budget.	Process improvement intervention.
										7)Ongoing agenda item at all departmental staff meetings: saving strategies/ideas discussed at all staff meetings and communicated by manager to Senior management	Saving strategies/ideas discussed at all staff meetings.	Suggestions communicated to Managers/Senior Managers for consideration.	Q3 balanced budget.	Process improvement intervention.

Integrated	**Reduce unnecessary time spent in acute care**	Percentage ALC days: Total number of acute inpatient days designated as ALC, divided by the total number of acute inpatient days.	% / All acute patients	Ministry of Health Portal / Q3 2012/13 – Q2 2013/14	826*	17.01	25	This target is slightly above the LHIN target however with the unavailability/closure of Interim LTC beds it is likely that the number of ALC days at LWDH could increase.	Maintain	1)Continue partnership with Northwest Community Care Access Centre to support Home First philosophy and maintain regular Joint Discharge Operatinal Team (JDOT) meetings to identify barriers in the discharge of ALC patients.	Regular meetings with Community Care Access Centre.	There will be a reduction in the number of ALC to LTC.	Reduction of ALC days.	Process improvement intervention.
										2)Endeavor to provide education for ER physicians/Locums and nurses to increase knowledge of **Community Care Access Centre** services and role within the hospital.	Ongoing education of staff by ER manager and discharge coordinator regarding Community Care Access Centre services.	ER physicians and nursing staff will be aware of community services available.	Decreasein ALC days.	Education/ Skill development intervention.
										3)Community Care Access Centre has been unable to secure the Rapid Response Nurse however the CCAC Case Coordinators located in LWDH work closely with the Utilization Coordinator and ER staff to divert admissions whenever possible.	Community Care Access Centre staff will continue to work closely with the ER team. ER team will be aware of community services available.	ER manager will monitor ER flow processes and staff educational needs related to discharge resources.	Decrease in ALC days.	Measurement & Process improvement intervention.
										4)Continue to participate in the FLO Project in all acute in-patient units. Continue to communication to the patient and/or family with regard to the care plan and discharge date.	Active engagment with patients and families when planning discharge.	Discharge information communicated to patients and families using the whiteboard. Discharge planning added to patient care plan	Decrease ALC days.	Communication and motivation intervention.
										5)Develop and implement a formal discharge planning checklist and processes, focusing on the discharge time of 10 am. Discharge time is posted however nursing staff at times encounter barriers to same and will be encouraged to seek the assistance of the Utilization Coordinator to address and problem solve these barriers.	Discharge times posted in patient rooms. Patient discharge times written in the LWDH patient information booklet. Written on whiteboard under discharge planning section.	Patient and families will be aware of discharge time at 1000.	Efforts to adhere to discharge time will demonstrate a decrease in ALC days.	Process improvement intervention.

										6)Maintain the Assess and Restore Program (Restorative care) to improve patient's functional abilities to promote early discharges.	Access the "Assess and Restore Program"	Improve patient's functional abilities will facilitate early discharges.	Reduction of ALC days.	Process improvement intervention.
	Reduce unnecessary hospital readmission	30-Day Readmission Rate to Any Facility for Stroke or TIA (Transient Ischemic Attack) patients(A Specific Case Mix Group) The evaluation of our services and the incorporation of QBP best practices.	Service Evaluation / Stroke/TIA (Transient Ischemic Attack) patients	Audit perfomed Quarter 3 to assess the incorporation of QBP best practices.	826*	1	1	Our annual CIHI data for Stroke/ TIA (Transient Ischemic Attack) readmission is very low therefore the number will not be our focus for measurement.The Target is the QI initiatives considered and implemented per QBP recommendations for Stroke and TIA (Transient Ischemic Attack) patients.	Maintain	1)Medication Reconciliation performed within 24-48 hours	Ongoing assessment, process improvement strategies related to improving the Medication Reconcilation performance.	Quarterly Medication Reconcilation Audits to measure compliance. Assess Med Rec on admission compliance during the Q3 scheduled audits.	Consideration and implemntation of QBP recommendations.	Process improvement intervention.
										2)Stroke/TIA Quality Based Procedure Committee to review current practices and to consider implementing the clinical practices recommended in the QBP Stroke/TIA Hand book.	Ongoing meetings with the Stroke/TIA Quality Based Procedure Committee to review services, plan and establish timelines for QI initiative changes.	Review and present ongoing progress of the Stroke/TIA steering committee at Senior Management and Medical Staff meetings.	Quality improvements to be considered.	Process improvement intervention.
										3)Regular presentations to the Quality of the Board Committee by the Stroke/TIA QBP Lead re: program status and quality improvements implemented into our services.	Stroke/TIA lead to present program status and Q3chart audit results	Q3 audit result and service evaluation will determine service quality status.	QI improvements considered and implemented when apropriate.	Process improvement intervention.
Patient-centred	**Improve patient satisfaction**	Patient Satisfaction: For the In house Patient satisfaction survey question "I am aware of the Aboriginal services within the hospital".	% / All patients	In-house survey / Annual survey (3 month period)	826*	16	50	% result of patient's who responded "Yes" New Indicator: Dependent on the # of survey submissions.	Improve	1)In house Patient Survey once a year: Spring 2014.	Survey patients once a year, Communicate results to patients and staff	improve from 16 % to 50 %	Achieving a 50% result/ target	Measurement and feedback intervention.
										2)100% staff commitment from all patient unit areas to distribute and Collect surveys. Provide staffing resources to ensure accurate and timely survey results in order to receive 500 returned surveys.	Provide staffing resources to ensure accurate and timely survey results. Survey results will determine the success of the QI initiatives.	100% staff committement from all patient unit areas to distribute and collect surveys	Improve and achieve target of 50%	Measurement and feedback intervention.
										3)Signage in English and Ojicree advertising the Aboriginal services available for patients are posted throughout the hospital.	Signage strategically displayed with cultural art in high patient traffic areas and public areas to promote awareness to patients and families of the hospital Aboriginal Services available. Consider displaying the Aboriginal sign in every patient room.	Increase in patient and staff awareness of in-house services.	Improvement in survey results.	Process intervention.
										4)Staff education regarding the In-house Aboriginal services are included in the mandatory Cultural Awareness training module and a training session to be completed by all new hires, current staff and students	Education of staff regarding in-house available Aboriginal services will promote the offering of cultural services therefore promoting quality service to all patients.	100% staff compliance for training completion.	Target achievement.	Process intervention.

										5)Stats for the Native Healer program will reflect that services were accessed by inpatients and outpatients. (Staff refer patients to Native Healer programs by phone, email; page or by completing a referral form and submitting it by fax)	Number of referrals to the Native Healer Program will remain stable.	Patients and Families will share positive comments regarding their care to staff/Aboriginal advisor.	Achieve target result	Evaluation intervention.
										6) Increase the availability of the Aboriginal Service Advisor.	Proposal to Senior Management to consider.	Aboriginal service advisor availability has increased.	Achieve target result	Process improvement intervention
		Patient Satisfaction: For the In house Patient satisfaction survey question "I would recommend this hospital to a friend or family member"	% / All patients	In-house survey / Over a 3 month period	826*	97.1	90	Maintenance: We will continue to survey and maintain status quo.	Maintain	1)In house Patient Survey once a year: Spring 2014.	Survey patients once a year. Communicate results to patients and staff	Add the number of respondents who responded "Excellent", "Very good", and "Good" and divide by number of respondents who registered any response to this question	Maintain > 95% result	Measurement and feedback intervention.
										2)100% staff commitment from all patient unit areas to distribute and Collect surveys.	Provide staffing resources to ensure accurate and timely survey results in order to receive 500 returned surveys.	500 surveys collected.	Maintain > 95% result	Feedback intervention
										3)Communicate results to patients and staff and review survey results to assess for gaps/areas to improve in our service	Information will be shared with all hospital staff to provide feedback of hospitasl services	Collated data from 500 survey submissions in order to analyse and compare data to assess gaps/areas to improve in our services.	Maintian > 95% result.	Measurement and feedback intervention.
										4)Completion of the On-line Cultural Training educational module by all LWDH staff.	Staff completion monitored by Human Resource. Staff Compliance reports sent to Managers to remind staff the need to complete.	Compliance reports from Human Resources. 100% staff compliance.	Survey result > 90%	Skill developmnet intervention
Safety	**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.	% / All patients	Hospital collected data / Most recent quarter available (e.g. Q2 2013/14, Q3 2013/14 etc)	826*	58	75	The average in % from all inpatient units with medications reconciled from an audit performed in Quarter 3	Improve	1)Quarterly and ad hoc meetings of Working Group to review audit results and develop improvement strategies	Ongoing Med Rec committee meetings to review progress and consider QI strategies.	Med Rec meetings scheduled for every 6-8 weeks.	75% Q3 result achieved.	Process/ incentive motivation intervention.
										2)Standardized audit tool to be followed for Q1 and Q3 audits identifying compliance rates with all 3 steps of the med rec process.	The utilization of a standardized audit tool with compliance requirements set by the Med Rec committee focusing on quality improvement. (Considering Safer Health Care Now audit tool and Accreditation Canada's recommendations	Standardized audit tool will improve data analysis and evaluation processes.	Achieve 75% target.	Evaluation process improvement.
										3)Ongoing Education to the multidisciplinary team.	Continue to consult physician liaison on an ad hoc basis to maintain communication of process status and 100% sharing of meeting minutes to champion physician, standing agenda on Med Rec committee "the need to consult physicians" Staff Educational opportunities will be a standing item on the Med Rec working group's agenda and staff attendance to in-services will be submitted to Human Resources. Highlighted and "educational blitz" for staff and patients during "Patient Safety Week".	Staff awareness will demonstrate improved compliance	75% target achieved.	Process improvement intervention.

Reduce hospital acquired infection rates	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. 2013, consistent with publicly reportable patient safety data.	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / 2013	826*	0	0	CDI (nosocomial) rates will remain at or below monthly provincial average as per reporting data for MOHLTC(Q3)	Maintain	1)All patients identified as meeting the case definition of CDI will have contact precautions initiated by any regulated heath care provider at the onset of diarrhea and prior to receipt of a C. Difficile test result.	Contact precautions will be implemented when indicated	Case reviews by the Infection Control Practitioner	Maintian low result.	Maintenance of current practices/processes.
									2)All patients identified as actual or potential C Diff will have proper environmental cleaning done following the Provincial Infectious Diseases Advisory Committee's recommendations which include room cleaning twice a day a hospital grade disinfectant and a sporicide.	Strict adherence to cleaning policies and procedures.	Case reviews by Infection Control Practitioner and the Houekeeping Manager	Maintain current status.	Process maintenance.
									3)Effective Antibiotic stewardship program will review and encourage appropriate antibiotic use and the discontinuation of antibiotic therapy as soon as the patient's condition permits.	Ongoing reviews, recommendations to physicians and audits by the Antibiotic Stewardship Program Committee.	Antibiotic stewardship audit reviews will demonstrate effective use of patient antibiotic therapy.	Maintin current status.	process reviews and improvement intervention.
									4)Continue effective Hand Hygiene Program, annual compliance audit and the presentation of audit results to Hospital Board and all staff.	Continued staff education as evidenced by the completion of infection control education modules. Annual educational "blitz" re: hand hygiene.	Satisfactory result of annual hand hygiene audit.	Maintain current status.	Process maintenance and improvement.
Improve discharge process(Regional Rural small hospital shared indicator)	Implement a standardized discharge checklist tool with teach back component in all Inpatient units and assess its usage.	Months / All patients	chart audit / Month of January 2015	826*	50%	50%	50% discharge tool usage determined by a one month audit of 25 patient charts to assess tool usage at discharge. (audit: scheduled for January 2015)	Improve	1)Implement a discharge checklist with a Teach back component for priority discharge information to be used in all discharges.	Development of a discharge tool by discharge coordinator and Quality/Risk Manager. Staff education for tool usage by the education department.	25 patient chart audits performed in January 2015 to measure compliance of discharge tool usage.	Improve discharge planning process.	Process improvement intervention.
									2)Adopt discharge tool from the Meditech electronic documentation system.	The education of staff on the Meditech system will include all relevant discharge forms/tools.	Staff will utilize the appropriate Meditech system discharge forms.	Patient chart audit results will demonstrate appropriate usage of discharge tool.	Skill and process improvement intervention.
Increase proportion of patients recieving Medication Reconcilation on discharge	The average in % from all in-patient units with medications reconciled at discharge. (non-urgent)	% / Inpatients	Chart audit / Q2	826*	75	58	58% audit result from Q2 data (target lower than previous results due to the implementation of a more stringent standardized	Maintain	1)Quarterly and ad hoc meetings of Working Group to review audit results and develop improvement strategies Alternating Quarterly Audits ie. Admission med rec Q2, Q4,	Review and evaluate audit results for QI purposes.	The utilization of a standardized audit tool with compliance requirements set by the (Considering Safer Health Care Now audit tool and Accreditation Canada's recommendations)	Achieve 50% compliance.	Process improvement intervention.

								auditing tool		2)Ongoing education of the multidisciplinary team	Continue to consult physician liaison on an ad hoc basis to maintain communication of process status and 100% sharing of meeting minutes to champion physician, standing agenda on Med Rec committee “the need to consult physicians” Staff Educational opportunities will be a standing item on the Med Rec working group’s agenda and staff attendance to in-services will be submitted to Human Resources. Highlighted and “educational blitz” for staff and patients during “Patient Safety Week”.	Increase staff awareness and understanding of the Med Rec the process as evidence by an increase in compliance demonstrated by the auditr results.	Achievement of the 50% target.	Process improvement intervention.
										3)The utilization of a standardized audit tool to be followed for Q2 and Q4 audits.	The utilization of a standardized audit tool with compliance requirements set by the Med Rec committee focusing on quality improvment.	Standardized audit tool will improve data analysis and evaluation processes. (Considering Safer Health Care Now audit tool and Accreditation Canada's recommendations)	50% target achieved.	Process improvement intervention.
										4)Implement a discharge checklist tool.	The development of a discharge check list tool followed by the staff education re:usage.	Discharge checklist tool will be utilized during all patient discharges.	Patient chart audits will demonstrate consistent usage of discharge tool and therefore med rec on discharge target will be achieved.	Process improvement intervention.