2017/18 Quality Improvement Plan
"Improvement Targets and Initiatives"

Lake of the Woods District Hospital: District Hospital 21 Sylvan Street

AIM		Measure							Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Effective	Coordinating care	The Lace Tool that identifies high risk for readmission patients will be used for all patients 65 years of age and older.	% / Admitted patient 65 year and >	EMR/Chart Review / Quarter 3	826*	CB	50.00	50% of patients 65 years and > will have the lace tool completed as evidence by an audit performed in quarter 3. The lace score will be communicated to the multidisciplinary team so intense discharge planning can be provided.	1)The discharge coordinator and or delegate will complete the lace tool for the admitted patients on the med surg and acute medicine units. The discharge coordinator will communicate those patients that score high risk for readmission to the health care team at bullet rounds/ multidisciplinary rounds.	Quarterly audits will be performed to asses compliance	The audit results will be reviewed by the LWDH Utilization committee	50% of the admitted patients 65 years and > (on med surg and acute medicine)will have the lace tool completed.	Coordination of care improvement
									2)The lace tool will be sustained so we can determine its effectiveness in decreasing the risk of readmission.	The status of this initiative will be communicated to the Utilization Committee, to the Quality/Patient/Safety/Risk Management Committee and the Quality Committee of the Board on a quarterly basis.	Quarterly meeting minutes will reflect this initiative's status	The lace tool indicator status will be presented at the applicable meetings at every quarter 100% of the time	A coordination of care improvement
									3)The lace tool score will be communicated to the multidisciplinary team so that the patient's plan of care can be developed accordingly	The lace tool score will be added to the electronic documentation status board (meditech) and to the kardex.	The meditech program will automatically display the lace score on the patient's status board for the team to reference.	The lace tool score will be displayed on the meditech status board for 50% of patients 65 years and > admitted to 3E and 2E	
									4)Educate the multidisciplinary team on the lace tool. Arranging Lace tool education will be directed by the utilization committee.	A nursing grand round and or Grand Round session will present on the lace tool, its purpose and process. The lace tool will be highlighted during patient safety week.	Formal and informal education will occur throughout the year.	One formal and one informal education session will occur during the year	Communication strategy initiative.

	Effective transitions	Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort)	Rate / COPD QBP Cohort	CIHI DAD / January 2015 – December 2015	826*	23.66	0.00	The target is the review and the implementation of the applicable QI initiatives/interventions as per the province's Quality Based Procedure Handbook recommendations for the COPD patient. This activity will be completed in Quarter three.	1)Medication Reconciliation performed within 24-48 hours	Ongoing assessment, process improvement strategies related to improving the Medication Reconciliation performance.	Quarterly Medication Reconciliation Audits to measure compliance.	Medication Reconciliation is a QBP recommendation.	Process improvement intervention.
									2)COPD Quality Based Procedure Committee will review current practices and will consider implementing if/when applicable the best clinical evidence-informed practices recommended in the QBP COPD Handbook.	Review and present ongoing progress of the COPD steering committee at Senior Management.Ongoing meetings with the COPD Quality Based Procedure Committee which includes the COPD Physician lead to review services, plan and establish timelines for the order set roll out.	The established timelines and accountabilities will guide the COPD Quality Based Procedure Committee to achieve the target	Quality improvements to be adopted if/when appropriate	Process improvement intervention.
									3)Regular presentation to the Quality of the Board Committee by the COPD QBP Lead re: program status and quality improvements implemented into our services.	COPD lead to present program status and Q3 audit results.	Q3 audit result and service evaluation will determine QBP service quality status.	QI improvements considered and implemented if/when appropriate.	Process improvement intervention
									4)Complete the Readiness for Discharge checklist for all the COPD Discharged patients on the Med/Surg and Adult Medicine units. The goal in its use is to ensure that patients are discharged with all relevant discharge information.	Audits to assess usage and on the spot staff education about the checklist will be performed.	Ongoing reviews done when warranted to assess its consistent use.	Consistent use of the tool is believed to potentially reduce the risk of readmission for patients with COPD.	Quality Improvement intervention.

Efficient	**Access to right level of care**	Total number of alternate level of care (ALC) days contributed by ALC patients within the specific reporting month/quarter using near-real time acute and post-acute ALC information and monthly bed census data	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July – September 2016 (Q2 FY 2016/17 report)	826*	31.35	25.00	This is a monitoring indicator only. Although LWDH endeavors to avoid ALC occurrences by arranging the provision of the appropriate discharge services for the ALC patient, this is often dependent on the availability of long term care beds and services within the community.	1)Operationally, we continue to self manage by these actions: • Continued partnership with NW CCAC to support Home First Philosophy. • The active partnership with CCAC Case Coordinators located at LWDH and the Rapid Response nurse that supports a close working relationship with the Utilization Coordinator and ER staff to divert admissions whenever possible • Maintained the Assess and Restore Program (restorative care) to improve patient's functional abilities.• Continue to effectively communicate with the patient and/or family with regard to the care plan and discharge date and the use of a standardized discharge checklist.	Continue ongoing efforts organizational wide.	ALC status reported quarterly to the Quality Committee of the Board.	For monitoring only	Efficiency Process Intervention.
Patient-centred	**Person experience**	"Would you recommend this hospital to your friends and family?" (Inpatient care)	% / Survey respondents	CIHI CPES / April - June 2016 (Q1 FY 2016/17)	826*	86	90.00	90% or > We will continue to survey once a year: Summer 2017.	1)In house Patient Satisfaction Survey once a year: Summer 2017.	Survey patients once a year. Communicate results to the applicable Quality Teams	Add the number of respondents who responded definitely yes and probably yes and divide by the number of respondents who registered any response to this question (with the exception of N/A responses).	Achieve 90% or > result	Measurement and feedback intervention
									2)Staff commitment from all patient unit areas to distribute and collect surveys.	Provide staffing resources to ensure comparability and timely survey results in order to receive acceptable numbers of returned surveys.	The appropriate number of surveys have been collected for the data to be significantly reliable.	Achieve > 90% result	Feedback intervention.
									3)Communicate results and analyze the survey results to address gaps/areas to improve in our service.	Information will be shared with all hospital staff to seek QI feedback	Collate data from the survey submissions in order to analyze and compare data to assess gaps/areas to improve in our services.	Achieve > 90% result.	Measurement and feedback intervention.
									4)A working group will meet to assess the efficacy of the patient experience survey and to make improvements.	The working group will present any proposed QI changes to the survey to senior management and to the Patient and Family Advisory Committee for consideration.	Any QI proposed changes to the survey will be added to the senior management meeting agenda for discussion	The consideration of all QI changes regarding the survey.	Process improvement intervention

	A patient experience survey will be given to the patient and or family hospitalized for > one month. This is a recommendation submitted by the Patient and Family Advisory committee.	80% / Admitted patients hospitalized for greater than one month	Hospital collected data / Over the fiscal year	826*	CB	80.00	80% of patients hospitalized for greater than one month will receive a Patient Experience.	1)The Quality and Risk Manager will provide the patient and or family that is hospitalized for > one month with the Patient Experience Survey Questionnaire.	A meditech report will be developed to identify those patients who need a survey.	Monthly assessment of the meditech patient census report will identify the target group	80% of patients hospitalized for > than one month will receive a patient experience survey.	Evaluation and feedback intervention
								2)Completed surveys will be given to the executive secretary for analysis and forwarded to the appropriate individual for follow-up.	Any trends in information from the results will be discussed at the appropriate quality meetings.	Data from all surveys will be analyzed and addressed.	Data from 100% of the surveys received will be analyzed and addressed.	Evaluation and feedback intervention for QI purposes.
	The White Boards at the patient bedside will be used on the Med Surg and Acute Care units to communicate the patient's care plan by the end of Quarter 3 (this is a recommendation from the Patient and Family Advisory Committee and from the results of the Post discharge follow-up phone call experience survey.	% / Patients from 3E and 2E	Hospital collected data / Quarter 3	826*	CB	50.00	This is a new indicator and involves multidisciplinary action and therefore a 50% target is both challenging and achievable.	1)A working group will be developed to create a standardized format and process for the white board intervention.	A multidisciplinary group will meet to formulate the process.	The finalized process will be communicated to the unit staff.	The process will be finalized and the initiative implemented by the end of Q3.	Process improvement intervention.
								2)Staff education will take place on how to use the whiteboards. The working group will identify the most appropriate teaching methods to be used.	A variety of education methods will be used to teach staff on its use.	A variety of teaching strategies will be used in an effort to teach/reach all staff.	Staff will sign off that they have received the education	The dissemination of process information
								3)An audit during quarter three will be done to assess the consistent use of the white board initiative. The working group will determine the audit details.	The Quality and Risk and the patient unit Managers will conduct the audit during Q3	The results of the audit will show that the white board is being used correctly and accurately 50% of the time.	The white board will be used correctly and accurately 50% of the time.	Process evaluation and feedback.

									4)The White Board initiative status will be communicated to the applicable Quality Committees.	Quarterly reports will be presented on the white board status at the Quality Committee of the Board, the Quality/Patient Safety & Risk Management and the Patient and Family Advisory Committee.	The white board initiative's progress will be monitored closely so support can be provided if and when warranted.	Quarterly reports will be presented to all applicable Quality Committees	Process evaluation intervention
Safe	**Medication safety**	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	Rate per total number of admitted patients / Hospital admitted patients	Hospital collected data / Most recent 3 month period	826*	78	78.00	The average in % from all inpatient units with medications reconciled from an audit performed in Quarter 3	1)Quarterly and ad hoc meetings of the Med Rec Working Group to review audit results and develop improvement strategies	Ongoing Med Rec committee meetings to review progress and consider QI strategies	Scheduled quarterly audits and Med Rec meetings scheduled every 6-8 weeks to review and discuss results.	78% Q3 result achieved	Process/ incentive motivation intervention.
									2)A standardized audit tool to be used for Q1 and Q3 audits to identify 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. (Following Safer Health Care Now audit tool and Accreditation Canada's recommendations)	The standardized audit tool will improve data analysis and evaluation processes.	Achieve 78% 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. Staff Educational opportunities will be a standing item on the agenda for the Med Rec working group to address. Staff attendance to in-services will be submitted to Human Resources. An educational blitz on medication reconciliation will be presented and displayed for staff and patients during Patient Safety Week.	Staff awareness will demonstrate improved compliance.	78% target achieved.	Process improvement intervention.

	Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged.	Rate per total number of discharged patients / Discharged patients	Hospital collected data / Most recent quarter available	826*	72	68.00	The average in % from all inpatient units with medications reconciled from an audit performed in Quarter 2. The target is slightly less than the previous year however due to an influx of new staff hires, the Medication Reconciliation Committee felt that this year's target would provide a satisfactory stretch for improvement.	1)Quarterly and ad hoc meetings of Working Group to review audit results and develop improvement strategies	Alternating Quarterly Audits i.e. Discharge med rec Q2, Q4, and the review and evaluation of audit results for QI purposes	The utilization of a standardized audit tool with compliance requirements set by the Safer Health Care Now audit and Accreditation Canada's recommendations)	Achieve 68% compliance	Process improvement intervention
								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. Staff Educational opportunities will be a standing item on the agenda for the Med Rec working group to address. Staff attendance to in-services will be submitted to Human Resources. An educational blitz on medication reconciliation will be presented and displayed 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 audit results.	Achievement of the 68% 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 improvement.	The utilization of a standardized audit tool will improve data analysis and evaluation processes. (Following Safer Health Care Now audit tool and Accreditation Canada's recommendations)	68% target achieved.	Process improvement intervention
								4)Continued usage of the Readiness for discharge checklist.	The Readiness for discharge check list provides a reminder to staff to complete the Medication Reconciliation process at discharge.	The Readiness for Discharge checklist will be utilized during all patient discharges (audits performed).	Patient chart audits will demonstrate consistent usage of discharge checklist and therefore med rec compliance target will be achieved.	Process improvement intervention

	Safe care	The Pass the Baton Tool will be used consistently in the ER department for admitted patients. This initiative is to meet the Accreditation Required Organizational Practice mandate.	% / All inpatients	Hospital collected data / Quarter 3	826*	CB	60.00	The Pass the Baton Tool is a change in practice and with all changes in practice, there can be barriers. The 60% value is an achievable and yet challenging target.	1)The Pass the Baton Tool will be assessed and modified to best meet the needs of the patient as well as the ER nurses.	The tool will be reviewed and revised by the ER staff nurses.	Auditing will be used to monitor successful compliance	60% tool use for quarter 3	Process measurement for QI purposes
									2)The quarterly performance audits will be presented at the applicable Quality Committees to assess compliance	Quarterly presentations will be performed to the Quality Committee of the Board and other applicable committees	Communicate results at Quality Committee of the Board meetings.	Presented at 100% of quarterly Quality Committee	
Timely	**Timely access to care/services**	ED Wait times: 90th percentile ED length of stay for Admitted patients.	% / Hours / ED patients	CCO iPort Access / January 2015 - December 2015 / 3	826*	13.3	15.00	Target is based on a review of past trends in ER inpatient wait times associated with bed unavailability. We anticipate that this will increase our wait times. Are target is based on a comparison of historical trending data of the ER in patient wait times.	1)Adoption of Patient Order Sets	Patient Order Set Working Group will prioritize the development and implementation of Physician Order Sets.	ER specific Patient Order Sets will be completed in 2017/18.	Improve flow and prevent delays in transfer of patients from ER to inpatient units	Process improvement intervention.
									2)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	Standing agenda item for all ER staff meetings (nursing and physician)so that ER staff will have knowledge of ER admitted wait times.	Wait times will remain stable within identified target.	Communication/building awareness intervention
									3)The collaboration with the Utilization Coordinator and/or Nursing Supervisor before admitting patients to inpatient wards when possible.	ER to consult the Utilization Coordinator and/or Nursing Supervisor before decision to admit.	Avoid admissions to ER	Achieve target goal	Process improvement Intervention
									4)Continue to provide Home First Program Services and access the Rapid Response Nurse services when applicable.	Meet on a regular basis with the Home First Committee and review admitted patients in the ER.	Full implementation of Home First.	Decrease in admitted wait times	Process improvement Intervention