2018/19 Quality Improvement Plan
"Improvement Targets and Initiatives"

Lake Of The Woods District Hospital 21 Sylvan Street

AIM		Measure								Change				
Quality dimension	**Issue**	**Measure/Indicator**	**Type**	**Unit / Population**	**Source / Period**	**Organization Id**	**Current performance**	**Target**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**	**Comments**
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) A= Additional (do not select from drop down menu if you are not working on this indicator) C = custom (add any other indicators you are working on)														
Effective	**Effective transitions**	Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort)	P	Rate / COPD QBP Cohort	CIHI DAD / January - December 2016	826*	14.86	14.86	This is a maintenance target. A rate of 14.86 is lower than the provincial rate of 19.9%.	1)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.	The Readiness for Discharge Checklist will be used 90% of the time in Q3.	Quality improvement intervention.
										2)COPD Quality Based Procedure Committee will review current practices and will consider implementing clinical, evidence-informed practices as recommended in the QBP COPD Handbook.	Present ongoing progress of the COPD Quality Based Procedure Committee at the Quality Committee of the Board and Quality and Risk Committee.	Accountability will guide the COPD Quality Based Procedure Committee to achieve the target.	Quality improvements to be adopted if/when appropriate.	Process improvement initiative.
										3)Medication Reconciliation performed within 24-48 hours.	Ongoing assessment, process improvement strategies related to improving the Medication Reconciliation performance. Adoption of an Electronic Medication Reconciliation program through Think Research.	Quarterly Medication Reconciliation Audits to measure compliance.	78% (QIP goal) of admission medication reconciliations will be completed in 24-48 hours in Q3.	Process improvement intervention.

	Wound Care	Percentage of chronic medical/ALC patients that develop a newly occurring Stage 2 or higher pressure ulcer in the last three months.	C	% / Hospital admitted patients	Hospital collected data / Q3	826*	CB	5.40	This is a new indicator for LWDH and therefore will aim to achieve less than, or equal to the provincial average of 5.4%.	1)Development of a standardized reporting system for chronic medical/ALC patients with a newly occurring stage 2 or higher pressure ulcer in the last three months.	The incident reporting software, Risk Monitor, will be utilized by staff to report pressure ulcers. Reports of the number of new stage 2 or higher, pressure ulcers will be run on a quarterly basis by the Infection Control Practitioner. The results of the reports will be reviewed and analyzed by the Infection Control Practitioner. Results of the quarterly audits will be presented at the Quality/Risk meeting as well as at the Quality Committee of the Board of Directors.	-Number of risk monitor reports reporting new stage 2 or higher pressure ulcers per month. -Percentage of Braden scores competed for all chronic medical/ALC patients. -Number of high risk patients that have preventative care measures implemented in their care plan.	70% of stage 2 or higher newly acquired pressure ulcers will be documented in the Risk Monitor System by December 2018 (end of Quarter 3).	The organization is implementing a new Risk Monitor version in June 2018. There will be a learning curve for staff to adjust to the new system. Our long term goal is that reporting numbers will improve, as the system is much more user friendly, however short term reporting may decrease as staff make the adjustment.
										2)Staff education regarding how to use the Braden scale.	The Infection Control Practitioner will do targeted education to staff working with chronic medical/ALC patients. Records of education attendance will be kept. Staff will be surveyed (written and face to face) to determine the education effectiveness and comfort level with using the Braden scale. The Infection Control Practitioner will analyze and review this data and make changes as necessary. This information will be reported at the Quality and Risk Committee, the pressure injury committee, as well as the Quality Committee of the Board.	-Number of staff that demonstrate uptake of education documented at the end of Quarter 3.	-By Quarter 3, 95% of patients will have Braden scales completed on admission, and 75% will have an additional Braden scale completed every 48hrs, or after a significant change in condition.	The Infection Prevention Practitioner is currently enrolled in International Inter-professional Wound Care Course. She is completing her selective on pressure injury prevention and obtaining further knowledge and best practice information on this topic.
										3)Auditing implementation of methods to reduce pressure ulcers in high risk patients.	The Infection Prevention Practitioner will audit the number of patients with moderate to high risk Braden scale scores and ensure recommendations, to reduce likelihood of developing a pressure ulcer, have been implemented.	-Number of recommendations implemented in patients that have moderate to high risk Braden scale scores.	95% moderate to high risk patients will have pressure ulcer reducing recommendations implemented in Quarter 3.	

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	P	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July - September 2017	826*	27.99	25.00	This is a monitoring indicator only. LWDH endeavors to avoid ALC occurrences by arranging the provision of the appropriate discharge services for ALC patients, this is dependent on the availability of long term care beds and community services.	1)Operationally, we continue to self manage by these actions: • Continued partnership with LHIN Home and Community Care program and the Home First Philosophy. • The active partnership with LHIN Home and Community Care 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 • Assess and Restore Program (rehabilitation 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 to reduce ALC rates organizational wide. This involves regular meeting of the utilization committee and coordination between the discharge planner, nursing supervisor, and ER physician to implement the ALC diversion strategy.	ALC status reported quarterly to the Quality Committee of the Board.	25% or less of admitted patients will be designated ALC by Q3.	Efficiency process intervention.
Patient-centred	**Person experience**	"Would you recommend this hospital to your friends and family?" (Inpatient care)	P	% / Survey respondents	CIHI CPES / April - June 2017 (Q1 FY 2017/18)	826*	92	90.00	Maintaining a target of 90% or higher is attainable, and higher than the provincial average of 81.8%	1)In house Patient Satisfaction Survey once a year: Summer 2018.	Paper surveys will be distributed by all hospital departments. Results will be forwarded to administration for analysis and compilation of the results. Results of the survey will be communicated by senior management to the applicable Quality teams and staff members.	Number of respondents who responded definitely yes and probably yes and divide and divide the number of respondents to registered any response to this question (excluding N/A responses).	90% or greater responses will indicate that the patient would definitely or probably recommend the hospital to family and friends by the end of the survey period.	Measurement and feedback intervention.
										2)Staff commitment from all departments to distribute and collect surveys.	Provide education to staff, as well as adequate staffing resources to ensure comparability and timely survey results in order to receive a statistically significant survey sample size. Attach surveys to discharge chart package in a prepaid envelope.	Number of completed surveys collected by the end of the survey period.	340 completed surveys will be collected and returned to administration for data analysis by the end of the survey period.	Feedback intervention
										3)Communicate survey results and analyze the survey results to address gaps/areas requiring improvement.	Administration will collect and analyze the survey results and communicate results with staff and applicable Quality Committees.	Communication with staff in the form of memos, placement of results on the hospital intranet, and dissemination of information to applicable committees.	Regular communication about survey results will be provided to staff and committees at the end of the survey period.	Feedback intervention.

		Utilization of Patient Care Plan boards at the patient bedside on the medical/surgical and acute care units to communicate the patient's care plan by the end of Q3.	C	% / medical/surgical patients and complex continuing care admitted patients.	In-house survey / Q3	826*	47	75.00	75% is a stretch goal by the end of Q3.	1)The working group will meet to design a new, permanent 'Patient Care Plan' board, incorporating feedback from the multi disciplinary team, patients, and Patient and Family Advisory Committee,	The Quality and Risk Manager will lead this initiative and complete quarterly audits of usage of the Patient Care Plan boards. QIP data will be collected in Q3.	Percentage of completed Patient Care Plan boards in Q3.	75% of Care Plan boards will be completed on the medical/surgical unit and medicine/pediatric /obstetric care units in Q3.	Process improvement intervention.
										2)Staff education will take place regarding usage of the Patient Care Plan boards. The working group will determine the most appropriate teaching methods to be used.	A variety of education methods will be used to educate staff. The Quality and Risk Manager will report quarterly compliance to the Quality Committee of the Board and Quality/Risk/Patient Safety Committee.	Percentage of staff demonstrating consistent usage of the Patient Care Plan boards.	70% of staff will sign off that they have received education on usage of the Patient Care Plan boards by the end of Q3.	Process improvement intervention
										3)Q3 audit to assess the consistent use of the Patient Care Plan board initiative. The working group will determine the audit details.	The Quality and Risk Manager will compete the audit during Q3	Number of Patient Care Plan boards completed in Q3	75% of Patient Care Plan boards will be completed by the end of Q3.	Process evaluation and feedback. The long term goal for this indicator is to have >90% of Patient Care Plan boards completed.
Safe	**Safe care/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	A	Rate per total number of admitted patients / Hospital admitted patients	Hospital collected data / October – December (Q3) 2017	826*	66	78.00	78% is a stretch target for this indicator. This target was carried forward from the 2017/2018 QIP.	1)Quarterly and ad hoc meetings of the working group to review audit results and develop improvement strategies.	Unit managers will complete alternating quarterly audits i.e. admission med rec in Q1 and Q3. Unit managers will share audit results with the Quality and Risk Manager and present audit results at working group meetings.	Quarterly audits utilizing a standardized audit tool with compliance requirements set by the Safer Health Care Now audit and Accreditation Canada recommendations.	Achieve 78% compliance in Q3.	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. 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 78% compliance target in Q3.	Process improvement intervention.
										3)Utilization of a standardized audit tool to be followed for Q1 and Q3 audits.	The utilization of a standardized audit tool with compliance requirements set by the Med Rec committee focusing on quality improvement.	Consistent usage of the standardized audit tool during Q1 and Q3 audits. Usage of the standardized tool will improve data analysis and evaluation processes. (Following Safer Health Care Now audit tool and Accreditation Canada's recommendations)	Achievement of the 78% compliance target in Q3.	Process improvement intervention.
		Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / October – December (Q3) 2017	826*	76	80.00	80% is a realistic improvement target for this indicator.	1)Quarterly and ad hoc meeting of the working group to review audit results and develop improvement strategies.	Unit managers will complete alternating quarterly audits i.e. discharge med rec Q2 and Q4. Unit managers will share audit results with the Quality and Risk Manager and present audit results at working group meetings.	Quarterly audits utilizing a standardized audit tool with compliance requirements set by the Safer Health Care Now audit and Accreditation Canada recommendations.	Achieve 80% compliance in Q4.	Process improvement intervention.

	Discharge Plan was created as a proportion the total number of patients discharged.								2)Ongoing education of the multidisciplinary team.	Continue to consult physician liaison on an ad hoc basis to maintain communication of process status and 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. 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 80% target in Q4.	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.	Consistent usage of the standardized audit tool during Q2 and Q4 audits. Usage of the standardized tool will improve data analysis and evaluation processes. (Following Safer Health Care Now audit tool and Accreditation Canada's recommendations)	80% target achieved in Q4.	Process improvement intervention.
	The Pass the Baton Toll will be used consistently in the ER department for admitted patients. This initiative is to meet the Accreditation Required Organizational Practice Mandate.	C	% / All inpatients	Hospital collected data / Q3	826*	67	75.00	75% is a realistic and achievable stretch goal.	1)A Working group will be formed to modify the Pass the Baton Tool to best meet the needs of the patient as well as the ER nurses.	The Quality and Risk Manager will lead this initiative, and together with the working group solicit input from staff.	Number of times the Pass the Baton Tool is used during a transfer of care from the ER to the medical/surgical/ICU or chronic medical unit.	The Pass the Baton Tool will be used 75% of the time during a patient transfer from the ER to the medical/surgical/ICU or Complex Continuing Care unit in Q3.	Process measurement for QI purposes.
									2)Quarterly performance audits will be presented to the applicable Quality Committees to assess compliance. The working group will determine details of the audit.	The Quality and Risk Manager will present audit data the Quality Committee of the Board and other applicable committees.	Number of times staff report the Pass the Baton was completed during a patient transfer of care from the ER to the medical/surgical/ICU or Complex Continuing Care unit on an audit form.	The Pass the Baton Tool will be used 75% of the time for of all transfers of care from the ER to the medical/surgical/ICU or Complex Continuing Care unit.	
									3)Create a tear off pass the baton check list note pad and place in nursing stations/by the phone. This idea will be trialed and replaces the prior laminated versions of the tool.	The Quality and Risk manager will find a company to make these customized pass the baton checklist 'post-it' notes.	Number of Pass the Baton post it notes used.	75% of patient transfers between the ER to the medical/surgical/ICU or complex continuing care unit will use the Pass the Baton checklist in Q3.	Process measurement for QI purposes.

	Workplace Violence	**Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.**	**MANDATORY**	**Count / Worker**	**Local data collection / January - December 2017**	**826***	**69**	**75.00**	**LWDH is focused on building a culture of incident reporting, therefore the goal is to increase the number of reported workplace violence incidents.**	**1)Continue to provide Crisis Prevention and Intervention education (the Non-Violent Crisis Intervention program). This training focuses on recognizing violence/potential violence and teaches corresponding appropriate responses. Augment CPI full certification courses with advanced physical skill training. Monitor staff attendance though Human Resources.**	**The education department will continue to plan certification/recertification courses on a monthly basis and distribute training opportunities to all staff. Managers will be provided with updated lists on a regular basis demonstrating which staff are required to certify/recertify in CPI training.**	**Number of CPI full certifications and recertification courses planned/month, and the number that had to be cancelled due to low (<3) sign ups.**	**90% of staff, working in high risk areas, will be up to date on their CPI training by Q3. 75% of regular staff will be up to date in their CPI training by Q3.**	**FTE=319 Safety improvement intervention.**
										2)Implement a new standardized debrief processes for all high risk incidents. Process will include: •Criteria for a debrief •What the debrief process is •Who is involved •What is the follow up.	Senior management, in conjunction with the Occupational Health Nurse and Risk Manager will review incidents requiring debriefing. Recommendations from using the debriefing tool will be shared with this group and changes will be made as required.	Debrief process and tools developed and education rolled out. Monitor % High risk incidents in Q3 with a debrief.	Education regarding debrief process and tools developed. Implementation and education begins by April 2018 . 70% of high risk incidents will have a debrief in Q3.	Safety improvement intervention.
										3)Implement a new Risk Monitor reporting software (RL 6). Train employees on the usage of the program.	The Quality and Risk Manager will work with administration, unit manager and the Occupational Health and Safety nurse to customize incident reporting software for the needs of the organization. The Quality and Risk manager will be responsible for implementing an education program for staff.	Monitoring of the project timeline/goals and commitment to stay on timeline to have new software implemented by June 2018.	80% of staff will have completed training for the RL6 program by Q3.	