## Theme I: Timely and Efficient Transitions

## Measure

**Dimension:** Timely

| Indicator #1 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital. | P | % / Discharged patients | Hospital collected data / Most recent 3 month period | 8.16 | 35.00 | The goal for this target is to reach the 2019/20 target of 35% | |

## Change Ideas

Change Idea #1 Educate physicians on the chart completion policy and process for forwarding discharge summaries to the Primary Care Provider.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| The Health Records Manager and the Quality Manager will develop physician education. The Manager of Health Records will monitor compliance to this indicator. Data will be presented to the Medical staff and MAC as well as reported on a quarterly basis to the Quality Committee of the Board. | Education to be complete and delivered by the end of Q1. | 75% of all physicians will have completed the education by the end of Q1. 90% of attending physicians will have completed the education by the end of Q3 | |

Change Idea #2 Update chart completion policy.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| The Medical Records department and Manager will update the chart completion policy and send out the revised policy to privileged physicians. | Number of email reminders sent our to physicians regarding updated policy. | Chart completion policy to be revised and disseminated by the end of Q1. | |

Change Idea #3 Determine which Physicians are not completing discharge summaries in a timely manner and provide education.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Medical records will log the number of complete and incomplete discharge summaries per Physician. This information will be shared with each Physician and the MAC. | Percentage of discharge summaries completed within 48 hours/Physician. | By the end of Q3 all physicians will have at least 35% of their discharge summaries delivered to the primary care provider within 48 hours of patient's discharge from hospital. | |

## Measure

**Dimension:** Timely

| Indicator #2 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| The time interval between the Disposition Date/Time (as determined by the main service provider) and the Date/Time Patient Left Emergency Department (ED) for admission to an inpatient bed or operating room. | M | Hours / All patients | CIHI NACRS, CCO / Oct 2019– Dec 2019 | 4.53 | 4.50 | Maintain or exceed current performance. | |

## Change Ideas

Change Idea #1 Continue to move patients out of the ER once the decision to admit has been made. Utilize off service beds as a temporary strategy, as necessary. Continue to implement strategies to improve communication between physicians and the utilization coordinator/supervisor to expedite discharges.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Continue to monitor patients who have not been moved to an inpatient bed, to determine any mitigating factors. | Number of patients who are in an inpatient bed within 4.5hrs of the decision to admit. This data is reported at the Utilization Committee and sent monthly to the ER manager. | By the end of Q3 time to an inpatient bed will be less than or equal to 4.5 hours. | Time to inpatient bed is under the provincial average, we aim to maintain our current performance of 4.5. |

Change Idea #2 Multidisciplinary rounds daily M-F to identify discharges on the inpatient wards to make room for admitted patients in the ER.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Utilization to meet with inpatient units daily to identify potential discharges and identify the number of beds that can be made available for admissions. | Number of patients who are in an inpatient bed within 4.5 hours of the decision to admit over the total number of admitted patients. | Patients admitted from the ER will be in an inpatient bed within 4.5 hours or less after the decision to admit has been made by the ER physician. | |

Change Idea #3 Discharge time will be posted in patient rooms and in the patient handbook. An agreement is in place with the onsite Hostel to allow patients to wait at the Hostel for transportation once discharged.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Utilization will track the number of on time and delayed discharges. | Number of discharged patients that are able to leave their inpatient bed by 10am over the number of discharged patients. | 50% of beds will be available to accept new admissions by 10am. | |

# Theme II: Service Excellence

## Measure

**Dimension:** Patient-centred

| Indicator #3 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Percentage of respondents who responded “completely” to the following question: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital? | P | % / Survey respondents | CIHI CPES / Most recent 12 months | 89.90 | 90.00 | As the organization adopts PODS (Patient Oriented Discharge Summaries) and the discharge follow up phone call process is enhansed, we anticipate an improvement in this indicator. | |

## Change Ideas

Change Idea #1 Use of PODS (Patient Orientated Discharge Summaries) for all medical inpatients.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Staff will replace the current patient discharge instruction form with PODS. The PODS will be reviewed with patients prior to discharge, and the patient will have an opportunity to ask questions/make notes on the PODS. Patients and the discharging nurse will sign the PODS, which indicates that the instructions have been given and understood. The PODS contains a list of community providers that can be contacted if the patient has concerns once they are home. | Percentage of patients indicating a positive response in the Patient Experience Survey over the total number of surveys completed. | 90% of patients completing and returning a Patient Experience Survey will answer yes to the question "Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital" by the end of Q3. | Total Surveys Initiated: 426 |

Change Idea #2 Enhancement of the discharge follow up phone call program

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| All completed PODS will be collected by the Health Records department. The follow up phone call nurse will use the PODS form as a template to guide the follow up phone call and address patient concerns and discharge challenges. | Number of patients who receive a follow up phone call over the number of patients who consent to receiving a follow up phone call. | By the end of Q3, 75% of patients who consent to receiving a follow up phone call will receive a follow up phone call. | |

Change Idea #3 Continue to utilize the Electronic Patient Experience Survey, in addition to the traditional paper survey.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Paper copies of the Patient Experience Survey are available in inpatient and outpatient units. Patients who consent to receive an electronic survey, are sent an email with a link to the Electronic Patient Experience Survey, through Surge Learning. Results of the paper and electronic surveys are collated. | The Executive team reviews results of the electronic and paper survey on a quarterly basis. Annual reviews of this data are presented to the Patient and Family Advisory Committee, the Quality Committee of the Board, Leadership and the Board of Directors. | All patients who consent will be sent an electronic survey. All patients in inpatient and out patient departments will have access to a paper copy of the survey. | Since implementing an electronic version of the Patient Experience Survey, the number of completed surveys has substantially increased. |

## Measure

**Dimension:** Patient-centred

| Indicator #4 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Number of patients who receive a follow up phone call over the number of patients who consent to receive a follow up phone call. | C | % / All inpatients | In house data collection / Q3 | CB | 0.75 | 75% is a reasonable target for this new indicator. | |

## Change Ideas

Change Idea #1 Enhancement of the follow up phone call program. A dedicated staff member will be tasked with completing follow up phone calls for all admitted medical patients. The Patient Oriented Discharge Summaries (PODS) will be utilized as a guide for the follow up phone call nurse.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| The Quality Manager will track the number of follow up phone calls completed as well as review data collected from the follow up phone call. The data collected will be utilized to identify gaps in the discharge process and identify future quality improvements. | Number of patients who receive a follow up phone call over the number of patients who consent to receive a follow up phone call. | 75% of patients who consent to a follow up phone call will be called by the follow up phone call nurse by the end of Q3. | This indicator was selected to meet the Accreditation Canada Required Organizational Practice regarding transfers of care. |

Change Idea #2 Consent for a follow up phone call will be collected on discharge. (Currently, patients are being asked on admission if they consent to receiving a follow up phone call.)

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| The Quality Manager will remove the consent question from the admission history package, and add it to the discharge package. | Number of follow up phone call consents received at discharge, over the total number of discharges. | By the end of Q1 the consent question will be added to the nursing discharge intervention. | |

# Theme III: Safe and Effective Care

## Measure

**Dimension:** Effective

| Indicator #5 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| 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. | P | Rate per total number of discharged patients / Discharged patients | Hospital collected data / Oct 2019–Dec 2019 (Q3 2019/20) | 84.68 | 90.00 | Exceed current performance by 5% | Community Pharmacies |

## Change Ideas

Change Idea #1 Continue to utilize Pharmacy Medication Reconciliation Technicians. This was a pilot position in 2019, hiring of these Technicians dramatically improved compliance with Medication Reconciliation.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Medication Reconciliation on Discharge data will be monitored quarterly by the Pharmacy Medication Reconciliation Technicians. Results will be analyzed and reported to the Medication Reconciliation Committee. | The percentage of patients discharged who had medication reconciliation completed on discharge over the total number of discharged patients. | 85% or more of discharged patients will have a completed medication reconciliation. | Patients transferred urgently to another facility will be excluded. |

Change Idea #2 Continue to educate nursing staff on patient safety related to medication reconciliation.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| The Medication Reconciliation Committee will analyze data from quarterly audits. Trends identified will be addressed, and education will be generated to be shared with nursing, physicians and pharmacy. The clinical educator will assist disseminating education regarding medication reconciliation. | Number of education sessions delivered and newsletter articles written regarding medication reconciliation. | By the end of Q3, 90% of patients will have a Best Possible Medication Discharge Plan created. | The Best Possible Medication Discharge Plan will be shared with patients on their PODS(Patient Oriented Discharge Summary). |

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| Change Idea #3 | Medication reconciliation technicians will call patients community pharmacies to 1) ensure the medication reconciliation was received 2) ensure there are no medication issues or questions 3) assist addressing insurance coverage questions. The medication reconciliation technicians will act as a liaison between the community pharmacy and the discharge physician if questions arise. |

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| The Pharmacy manager will develop a tracking form to record the number of discharge medication reconciliations that are sent to the pharmacy department and the number of follow up calls made to community pharmacies. | Number of phone calls conducted/total number of medication reconciliation discharge forms sent to pharmacy. | 100% of discharge medication reconciliations that come to pharmacy will have a follow phone call to the community pharmacy. | |

## Measure **Dimension:** Effective

| Indicator #6 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Proportion of hospitalizations where patients with a progressive, life-limiting illness, are identified to benefit from palliative care, and subsequently (within the episode of care) have their palliative care needs assessed using a comprehensive and holistic assessment. | P | Proportion / All patients | Local data collection / Most recent 6 month period | 1.00 | 1.00 | Maintain current performance. | |

## Change Ideas

Change Idea #1 Enhance physician orientation regarding use of order sets. Explain purpose of the surprise question "would you be surprised if the patient was to die in the next year". Educate nursing staff and ward clerks that all 'No' responses generate an order for a palliative care referral and social work referral.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| The physician orientation package will be enhanced and complete by the end of Q1. | The number of general admission order sets used/the number of patients who end up receiving palliative care services. | By the end of Q3, 75% of palliative patients who end up using palliative care services, will have had an order set utilized on admission. | |

Change Idea #2 Add the question "would you be surprised if the patient was to die in the next year", to the nursing admission history. Educate nurses regarding early identification of palliative care needs (such as chronic conditions such as Chronic Heart Failure, Chronic Renal Failure).

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| The clinical educator will develop education regarding early identification of palliative care needs, and provide to nursing staff. | number of palliative care referrals generated from nursing staff/total number of palliative patients. | By the end of Q3, nursing staff will identify 50% of patients who require palliative referrals during admission. | |

Change Idea #3 Develop a referral form to refer out patients from dialysis and chemotherapy to the palliative care Nurse.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| The palliative care nurse will develop an outpatient referral form to palliative services. | The number of outpatient palliative referrals/total palliative referrals. | By the end of Q3, 50% of out patient chemotherapy and dialysis patients will be referred to palliative care. | |

## Measure

**Dimension:** Effective

| Indicator #7 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Percent of unscheduled repeat emergency visits following an emergency visit for a mental health condition. | P | % / ED patients | CIHI NACRS / April - June 2019 | 23.70 | 21.60 | Achieve or exceed provincial average. | OPP-Situational Table, Kenora Rainy River Mental Health and Addictions Network, MOU with the Kenora Jail, MOU with the ACT Team at CMHA Kenora, MOU CMHA Peer Support Fort Francis, MOU Childrens Mental Health Firefly , Kenora District Services Coordinating Committee, Crisis Response Planning Committee, Mental Health and Addictons Advisory Committee, MOU North Westwern Health Unit/Kenora Distict Services Board/CMHA Fort Francis/WHINAC for RAM, Waasegiizhig Nanaandaweiyewigamig (WNHAC) |

## Change Ideas

Change Idea #1 A Mental Health and Addictions Patient Oriented Discharge Summary will be utilized in the ER whenever social work is involved in the care of the patient. The PODS lists a number of community recourses to connect patients with relevant resources in the community for self-care, information, and support.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Social Workers will give out a PODS to all Mental Health patients they are referred to in the ER. | Chart audits will be conducted to evaluate out of the number of social work referrals in the ER how many PODS were given out. | By the end of Q3 80% of Mental Health patients referred to social work in the ER will be given a PODS. | |

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| Change Idea #2 | ASK Suicide tool will be utilized in the ER for all patients presenting with a mental health concern. The ASK suicide tool is a standardized tool to assess suicide risk. Any patients who answer 'yes' to any question on the tool, will be referred to a crisis worker. The ASK Suicide Tool will be added to the patients chart. |

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| The ASK suicide tool will be utilized by the Triage Nurse. High risk patients will utilize a safe room, which can be monitored by Nursing staff at the Nursing desk. | Number of ASK suicide tools utilized/number of patients presenting with a mental health concern. | By the end of Q3, the ASK Suicide Tool will be utilized on all patients who present to the ER with a mental health concern. | |

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| Change Idea #3 | The RAAM clinic will be introduced on April 1, 2020. It is a mobile service for people who have addictions issues. It meets a client where they are at and offers case management, medical treatment, harm reduction strategies. The program also has a cultural component. |

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| The RAAM clinic is a partnership with the Northwestern Health Unit, WNHAC, CMHA Fort Francis and the hospital. | -Number of clients who use the RAM clinic/quarter. -Of the number of unscheduled repeat ER visits for a mental health condition, the percentage of these visits that are also RAAM clients/quarter. | By the end of Q4, 200 clients will have utilized the RAAM clinic. | |

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| Change Idea #4 | Use the teach-back method to verify patients understand their discharge (PODS)instructions |

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Clinicians we be trained regarding 'teach back' techniques. | Number of PODS signed that indicate patients have understood their discharge instructions (this is a check box that patients check off themselves on the PODS) | 80% of PODS will indicate that patients have understood their discharge instructions by the end of Q3 | |

## Measure

**Dimension:** Safe

| Indicator #8 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period. | M | Count / Worker | Local data collection / Jan - Dec 2019 | 90.00 | 90.00 | Maintain current performance. | |

## Change Ideas

Change Idea #1 Enhancement of code silver. The code silver lockdown policy and procedure will be modified to be consistent with the local school and city emergency protocol (shelter in place, secure hospital and lockdown hospital).

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| The Emergency Committee will identify a code silver working group to work on policy/procedure enhancements. | Number of shelter in place, secure hospital and lockdown hospital codes called by the end of Q3. | Complete policy and procedure by the end of Q2. | FTE=331<br><br>In collaboration with the OPP regarding code silver policy and procedure. |

Change Idea #2 Enhanced communication regarding no trespass orders with the OPP/Security services.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Inform the OPP/Security when a no trespass order is generated at Lake of the Woods District Hospital. | Number of No Trespass orders given | 100% of No Trespass Orders written will be shared with the OPP/Security services. | A No Trespass Order working group will clarify the policy/procedure regarding No Trespass orders by the end of Q1. |

Change Idea #3 Ongoing staff education regarding entering workplace safety concerns/incidents into the RL6 incident reporting software.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Re-education during staff safety week. Newsletter education articles regarding entering incidents into RL6. Staff meetings will be set up to discuss RL6 software and educate staff who may be unfamiliar with the process. | Number and type of education sessions provided in 2020. | By the end of Q3: Staff Safety week will have occurred and incident reporting will have been discussed; At least 1 newsletter article will be submitted regarding incident reporting; all managers will review RL6 incident submissions with their staff. | |

Change Idea #4 Completion of the Violence Risk Assessment, from the Public Services Health and Safety Association, in all high risk departments.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Each manger who works in a high violence risk department, will complete the online Violence Risk Assessment, from the Public Services Health and Safety Association. The Occupational Health Nurse will facilitate completion of each Risk Assessment. | Number of Violence Risk Assessments completed. | By the end of Q3, Violence Risk Assessments will be complete for all high departments. | Currently, the Morning Star Centre, an acute detox facility has completed the Violence Risk Assessment. |

## Measure

**Dimension:** Safe

| Indicator #9 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Percentage of admitted patients who experience a care transition for whom a standardized SBAR (Situation, Background, Assessment, Recommendation) transfer of care tool is completed, over the total number of care transitions. | C | % / All inpatients | In house data collection / Q3 | CB | 80.00 | The SBAR is an established tool at LWDH | |

## Change Ideas

Change Idea #1 The SBAR care transition paper tool will become a permanent part of the patient chart.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| All inpatient units will utilize the SBAR during care transitions, and add the SBAR tool to the patient chart. | Number of SBAR Tools completed/the total number of care transitions. Charts will be audited to monitor compliance. | By the end of Q3 80% of admitted patients who experience a care transition will have a standardized SBAR (Situation, Background, Assessment, Recommendation) transfer of care tool completed, and the SBAR will be on the patients chart. | The SBAR was introduced in 2019 as a transfer of care tool. It was not intended to be a permanent part of the chart initially. |

Change Idea #2 The SBAR tool will become a MEDITECH intervention.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Inpatient units (the OR, Maternity, IUC, Schedule 1, and medical units) will develop a MEDITECH SBAR intervention. | Number of SBARs completed | The SBAR will be implemented as a MEDITECH intervention by the end of Q1. By the end of Q3, 80% of inpatients who experience a care transition will have an SBAR completed. | It is an Accreditation Canada recommendation that the SBAR is part of the Electronic Medical Record. Creating a SBAR Meditec intervention satisfies this recommendation. |

Change Idea #3 The SBAR will be utilized as the end of shift report document, and replace taped report.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Once the SBAR is introduced as a MEDITECH intervention, it will be utilized as the end of shift report. The SBAR will be created to work as a flow sheet, and information can be added to it throughout a 12 hour shift. | Number of SBAR MEDITECH Interventions completed/12 hour shift. | By the end of Q1 taped report will be replaced by the SBAR MEDITECH intervention. By the end of Q2, compliance will be 100% using the MEDITECH SBAR intervention, as there will be no alternative method for delivering end of shift report. | Accreditation Canada recommended that the SBAR be part of the EMR. This improvement initiatives satisfies Accreditation recommendations. It is a major practice change to stop doing taped report, and replace end of shift report with the SBAR. However, this change standardizes the transfer of care, and has multiple benefits: 1) Staff no longer will have to sit in a report room to listen to report 2) Other disciplines can view the SBAR on the EMR and easily get up to date patient information, and add interventions they may done with the patient to the SBAR. The SBAR will be a multifunctional standardized tool which will benefit multiple disciplines, and ultimately the patient. |