2015/16 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 performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	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 / Jan 1, 2014 - Dec 31, 2014	826*	12.63	15	This target is based on the effects of the closure of beds on 2E bed and 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 to prioritize the development and implementation of Physician Order Sets.	Patient Order Sets to be completed for 2015/16.	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 improve flow and to	Develop strategies from identified delays from "decision to admit" to "admission". Monitor ER wait times, NACRS, and CIHI. Monitor most recent Patient Satisfaction Survey results. Ongoing collaboration with the Discharge Coordinator.	Monthly monitoring of ER wait times.	Strategies to improve the flow process and a decrease in admitted wait	Process improvement intervention.
									3)Review and analyze Canadian Triage Acuity Scale (CTAS)audits to determine if admitted patients are initially	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	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)Avoid 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	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.
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 FY 2014/15 (cumulative from April 1, 2014 to December 31, 2014)	826*	-2.68	0	Strive to maintain a balanced budget.	1)Quality Based Procedure (QBP) Committees to review current practices for relevant Case Mixed Groups (CMG) and incorporate best	Quality Based Procedures (QBPs) will be reviewed and best practices as recommended by the QBP Case Mixed Group's Handbooks will be implemented.	Identification of services and the incorporation of quality best practice improvements.	Q3 balanced budget.	Incentive/motivation/intervention /process improvement.
									2)Ongoing reviews of LWDH utilization data by management to target areas where resources being expended appear to	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 Corporate Services.	Identification of and addressing inefficient processes to assist in balancing the budget.	Balanced for Q3 data compliance under the MOHLTC definition of margin.	Incentive/ motivation intervention/ process improvement.
									3)Investigate feasibility of both internal and external reviews using tools such as LEAN to determine where processes can be adjusted	Target areas for review in 2015/16. Perform review, measure and document resource savings achieved through changes in process.	Identification of and addressing inefficient processes to assist in balancing the budget.	Q3 balanced budget.	Incentive/ motivation/ intervention/ process improvement.
									4)Provide education to Managers and physicians regarding Health System Funding Reform (HSFR) and implications of the Health	Ongoing agenda item at the Mid-Management and Medical Advisory Committee meetings, suggestions communicated to VP Corporate Services.	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 updates to	Provide education to managers regarding the Ministry of Health's 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	Saving strategies/ideas discussed at all staff meetings.	Suggestions communicated to Managers/Senior Managers for consideration.	Q3 balanced budget.	Process improvement intervention.
									8)The closure of beds on 2E.	Closure of beds is a cost saving initiative based on bed census statistics and trends – Currently staff for 25 beds (89% Occupancy) ◦Occupancy averages 61% (including Pediatrics) ◦Pediatric occupancy averages less than 20% With the opening of Long Term Care	Monitor the financial effects of the closure of beds and total margin on a quarterly basis.	Balanced budget for Q3	Organizational efficiency initiative
									9)The consideration of relocating/almagamating the Maternity unit.	A measure which will be considered to further mitigate the funding shortfall include: Relocate and/or Amalgamate Obstetrics with another Patient Care Unit Currently a stand alone unit with 5 Obstetrical and 3 Medical Beds staffed with 2 RNs 24/7 Average	Ongoing discussion and planning is necessary to achieve this measure.	To achieve a balanced budget.	Organizational efficiency initiative.
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. *100	% / All acute patients	Ministry of Health Portal / Oct 1, 2013 - Sept 30, 2014	826*	17.51	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.	1)Continue partnership with Northwest Community Care Access Centre (CCAC) to support the Home First Philosophy, and maintain	Regular meetings with the Community Care Access Centre (CCAC).	There will be a reduction in the number of ALC to LTC.	Reduction of ALC days.	Process improvement intervention.
									2)Endeavour to provide education for ER physicians/locums and nurses to increase knowledge of Community	Ongoing education of staff by ER Manager and Discharge Coordinator regarding Community Care Access Centre's services.	ER physicians and nursing staff will be aware of community services available.	Decrease in 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	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 member's educational needs related to discharge resources.	Decrease in ALC days.	Measurement and process improvement intervention.
									4)Continue to participate in the FLO Project in all acute inpatient units. Continue to communicate to the patient and/or family with regard	Active engagement with patients and their 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 process, focusing on the discharge time of 10:00 a.m.	Discharge times are posted in patient rooms, written in the LWDH Patient Services Directory, and written on the whiteboard under the "Discharge Planning" section.	Patient and families will be aware that the discharge time is at 10:00 a.m.	Efforts to adhere to discharge times will demonstrate a decrease in ALC days.	Process improvement intervention.
									6)Maintain the Assess and Restore Program (restorative care) to improve the patient's functional abilities to	Access the Assess and Restore Program.	Improve a patient's functional abilities, which will facilitate early discharge.	Reduction of ALC days.	Process improvement intervention.
	Reduce unnecessary hospital readmission	Readmission within 30 days for Selected Case Mix Groups	% / All acute patients	DAD, CIHI / July 1, 2013 - Jun 30, 2014	826*	19.9	50	Target justification is to improve the quality of patient care and decrease readmissions by enhancing interdepartmental coordination and collaboration. The LWDH's readmission provincially mandated priority indicator target is: All patients being sent from Morningstar will have the "Transfer to ER" form completed and faxed to the	1)Regular meetings with ER and Morningstar will be scheduled to review and evaluate this QI initiative.	Review and evaluate this indicator.	Increase staff awareness and understanding of the communication tool's usage as evidenced by staff following the process.	The communication tool will be used consistently between the ER	Process improvement intervention.
									2)A PDSA will be conducted and the results communicated to all partners.	The PDSA method will be used to review and evaluate process.	Results from PDSA will be used to improve the process and therefore, usage will be achieved.	Improve discharge planning process and quality of care.	Process improvement intervention.
									3)Quarterly audit reports conducted and shared with ER staff, Morningstar staff, and the Quality Committee of the Board. Reports will	Quarterly audit reports will determine compliance with the process so that the QI Team can determine any gaps.	Auditing the process will improve data analysis and the evaluation process.	To demonstrate consistent usage of the discharge tool and therefore, target will be met.	Incentive/motivation/process improvement intervention.
									4)The comparison of ER readmission rate of Morningstar patients before and after the implementation of this	Ongoing reviews of readmission data by the QI Team will assist in evaluating the process and identifying opportunities for improvement.	Ongoing agenda item of the QI Team. QI Team to meet and address gaps in the process. Data will be shared with Senior Management and the Quality Committee of the Board.	Evaluating data and identifying areas of improvement will assist us in	Patient flow improvement strategy.
									5)Patient Engagement Initiative: Implement five (5) case studies (random sample of Morningstar patients who have had the	A qualitative study will be performed by interviewing five (5) patients associated with this process. Common themes will be identified and shared with the QI Team, Quality Committee of the Board, Quality/Patient Safety/Risk Management Committee, and Senior	Increase the QI Team's awareness and understanding of the process as evidenced by the patient's shared experience.	Consideration of patient feedback to implement QI process change(s).	Process improvement/fostering patient engagement intervention.
Patient-centred	**Improve patient satisfaction**	From NRC Canada: "Would you recommend this hospital (inpatient care) to your friends	% / All patients	NRC Picker / October 2013 - September 2014	826*	95	90	Maintenance: 90% or > We will continue to survey and maintain status	1)In house Patient Satisfaction Survey once a year: Spring 2015.	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 (with the exception of N/A responses).	Maintain 90% or > result	Measurement and feedback intervention.

		and family?" (add together % of those who responded "Definitely Yes" or "Yes, definitely").						quo.	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 > 90% 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 the hospital's services.	Collate data from 500 survey submissions in order to analyze and compare data to assess gaps/areas to improve in our services.	Maintain > 90% result.	Measurement and feedback intervention.
									4)Completion of the online and educational Cultural Competency and Safe Care Module by all LWDH new hires and students.	Staff and student completion of module. Monitored by Human Resources and the Education Department.	Compliance reports from Human Resources/Education Department. 100% of newly hired staff and student compliance.	Survey result > 90%	Skill development intervention.
		Patient satisfaction: for the in-house Patient Satisfaction Survey question "I am aware of the Aboriginal services within the hospital".	% / of inpatients that self declare their aboriginal ancestry in the survey document	In-house survey / Annual survey	826*	29	50	% of Aboriginal inpatients (self declared as aboriginal in the survey) who respond "yes" to the survey question.	1)In-house Patient Satisfaction Survey once per year: Spring 2015.	Survey patients once per year. Communicate results to patients and staff.	Improve from 29% to 50%.	Achieving a 50% result/target.	Measurement and feedback intervention.
									2)100% staff commitment from all patient unit areas and from the Cross Cultural Care Coordinator to distribute and collect	Providing staffing resources to ensure accurate and timely survey results. Survey results will determine the success of the QI initiative.	100% staff commitment from all patient unit areas to distribute and collect surveys.	Improve and achieve the 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 has been strategically displayed with cultural art in high patient traffic areas and public areas to promote awareness to patients and families of the hospital's Aboriginal Services available. Consider displaying the Aboriginal sign in every patient room.	Increase inpatient and staff member's awareness of in-house services.	Improvement in survey results.	Process intervention.
									4)Staff education regarding the in-house Aboriginal Services is included in the mandatory Cultural Competency and Safe Care	Education of staff regarding the in-house Aboriginal Services will promote the offering of cultural services; therefore, promoting quality services to all patients.	100% compliance for training completion.	Target achievement.	Process intervention.
									5)Statistics showing # of patients seen by the Cross Cultural Care Coordinator will reflect that services were accessed by inpatients	Number of referrals to the Cross Cultural Care Coordinator and/or Native Healer Program will remain stable.	Patients and families will share positive comments regarding their care to staff/Cross Cultural Coordinator.	Achieve target result.	Evaluation intervention.
									6)Continue to increase the availability of the Aboriginal Cultural Services within the hospital.	Ongoing evaluation of the program and resources required.	Cross Cultural Care Coordinator's availability will meet patient needs.	Achieve target result.	Process improvement 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	826*	79	75	Increase proportion of patients receiving medication reconciliation upon admission. The average in % from all inpatient units with medications reconciled within 48 hours from an audit	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	The utilization of a standardized audit tool with compliance requirements set by the Med Rec Committee focusing on quality improvement (Follow Safer Health Care Now audit tool and Accreditation Canada's recommendations).	Standardized audit tool will improve data analysis and evaluation processes.	Achieve Q3 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 item on Med Rec Committee's Agenda: "the need to consult physicians." Staff	Staff awareness will demonstrate improved compliance	Q3 75% target achieved.	Process improvement intervention.
	Increase proportion of patients receiving medication reconciliation upon discharge	Medication reconciliation at discharge/transfer: The total number of inpatients with medications reconciled at discharge	% / Inpatients Only	Hospital collected data / Quarter 2	826*	83	55	55% audit result from Q2 data (target lower than previous results due to the implementation of a more stringent standardized auditing tool).	1)Quarterly and ad hoc meetings of Working Group to review audit results and develop improvement strategies, alternating	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 58% 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. Standing agenda item on the Med Rec Committee's Agenda: "the need to consult physicians."	Increase staff awareness and understanding of the Med Rec process as evidence by an increase in compliance demonstrated by the audit results.	Achievement of the 58% 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.	A standardized audit tool will improve data analysis and evaluation processes (adhering to the recommendations by Safer Health Care Now and Accreditation Canada's Audit Tool).	58% target achieved.	Process improvement intervention.

									4)Implement a Discharge Checklist Tool on 2E and a trial on 3E and Maternity.	The staff will be educated and will utilize a Discharge Checklist Tool with a focus on med rec review.	Discharge Checklist Tool will be utilized for inpatient discharges on 2E and trailed on 3E and Maternity.	Patient chart audits will demonstrate consistent usage of the Discharge	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. 2014, consistent with HQO's Patient Safety public reporting website.	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / Jan 1, 2014 - Dec 31, 2014	826*	X	0	CDI (nosocomial) rates will remain at or below monthly provincial average as per reporting data for MOHLTC(Q3).	1)All patients identified as meeting the case definition of CDI will have contact precautions initiated by any regulated heath care	Contact precautions will be implemented when indicated.	Case reviews by the Infection Control Practitioner.	Maintain 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	Strict adherence to cleaning policies and procedures.	Case reviews by Infection Control Practitioner and the Manager of Enviro Services.	Maintain current status.	Process maintenance.
									3)Effective Antimicrobial Stewardship Program will review and encourage appropriate antibiotic use and the discontinuation of	Ongoing reviews, recommendations to physicians, and audits by the Antimicrobial Stewardship Program Committee.	Antimicrobial Stewardship audit reviews will demonstrate effective use of patient antibiotic therapy.	Maintain 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	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 on the Complex Care Unit and the Med Surg Unit.	% / All patients	Hospital collected data / Q3	826*	0	50	50% Discharge Checklist Tool usage determined by a one month audit of 25 patient charts to assess tool usage at discharge (audit: scheduled during Q3).	1)Implement a Discharge Checklist Tool with a teach back component for priority discharge information to be used in all 2E discharges.	Usage of a Discharge Checklist Tool for all discharges on 2E. Staff education for tool usage by the Education Department.	25 patient chart audits performed in Q3 to measure compliance of Discharge Checklist Tool usage.	Improve discharge planning process.	Process improvement intervention.
									2)The Discharge Coordinator and Quality/Risk Manager will collaborate with 3E and Maternity staff to develop a	The Discharge Coordinator and the Quality/Risk Manager will meet with the Discharge Improvement Committee, 3E and maternity staff to create an appropriate Discharge Checklist Tool that fits their needs.	A Discharge Checklist Tool will be developed with everyone's input.	Staff buy-in will promote the utilization of the tool.	Participation and motivation intervention.
									3)A trial using the Discharge Checklist Tool on 3E and Maternity will be performed.	A trial done on both units.	PDSA done to evaluate process. Checklist modified as per trail outcome.	Staff buy-in when staff participate in the process development and implementation.	Motivation and evaluation intervention.
	Improve the quality of patient care by implementing a successful Antimicrobial Stewardship Program	Meet compliance for the Accreditation Canada's Required Organizational Practices (ROPs) Antimicrobial Stewardship Program	Meet Accreditation Canada's test for compliance October 2015 / Meet Accreditation Canada's test for compliance October 2015	October 2015 / October 2015	826*	0	100	100% of Accreditation Canada's major and minor ROP compliance items are met.	1)Establish and develop an Antimicrobial Stewardship Program.	Form a multidisciplinary committee and meet on a regular basis to review, assess, and address major and minor ROPs, as per Accreditation Canada's tests for compliance.	The Antimicrobial Stewardship Program Committee will meet all major and minor ROP requirements following the accreditation surveyor's visit.	Improve the quality of patient care by meeting the Accreditation Canada's ROP	Process improvement intervention.
									2)Share the progress of the Antimicrobial Stewardship Program.	Share the committee's progress with the Quality Committee of the Board, Quality/Patient Safety/Risk Management Committee, the Infection Prevention and Control Committee, and with our stakeholders.	The Antimicrobial Stewardship Committee will be invited to present their program and findings.	Strategy to educate and engage.	Communication and motivation intervention.
									3)Optimize antimicrobial use.	Examine interventions that will optimize antimicrobial use.	The examination of interventions that will optimize antimicrobial use will be a standing agenda item at every Antimicrobial Stewardship Committee Meeting.	Provide a focus to the multidisciplinary committee members.	Process improvement intervention.
									4)Develop a resource for practitioners.	Create a hospital drug formulary to be available to practitioners as a resource.	Pharmacy will follow best practices and develop a hospital drug formulary to be posted on the hospital's internal website.	Practitioners will use best practice recommendations when ordering antimicrobial	Process improvement intervention.
									5)Complete an annual audit.	Audit once a year to determine that antimicrobial use has been appropriate.	Laboratory and Pharmacy staff will audit and report their findings to the committee once a year.	Evaluate practices to identify gaps within the process.	Evaluation and process improvement intervention.
									6)Implement a Patient Order Set.	The review and implementation of one (1) Patient Order Set.	Collaborate with physicians and refer to the Patient Order Set Network.	Patient Order Sets are a patient safety initiative and follows best practices.	Process improvement intervention.
									7)Educate staff and patients about the Antimicrobial Stewardship Program	Highlighted during Patient Safety Week and in the LWDH Newsletter.	The Antimicrobial Stewardship Program will be highlighted as an accredited patient safety initiative for a full day during Patient Safety Week, and twice a year in the hospital newsletter.	Staff and patients are aware of the Antimicrobial Stewardship Program.	Process awareness and improvement intervention.

									8)Utilize Grand Rounds to educate staff and physicians.	The Antimicrobial Stewardship Committee will present at Grand Rounds to a multidisciplinary audience.	Educational session by the Antimicrobial Stewardship Program by the Committee in April 2015.	The multidisciplinary team is aware of the Antimicrobial Stewardship	Awareness and improvement intervention.