2016/17 Quality Improvement Plan
"Improvement Targets and Initiatives"

LAKE OF THE WOODS DISTRICT HOSPITAL

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
Effective	**Reduce readmission rates for patients with CHF**	Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with CHF (QBP cohort)	% / CHF QBP Cohort	DAD, CIHI / January 2014 – December 2014	826*	25.45	25.00	The target will be the evaluation of our care services and the incorporation of Quality Based Procedures best practices specific to the CHF patients. This evaluation will be performed during Quarter 3. The purpose of the service evaluation performed in Q3 will be to assess if the target has been met re: the incorporation of the applicable QBP practices based from the QBP CHF Handbook. (The accuracy of our annual CIHI data for CHF readmission is under review therefore the number will not be our focus for measurement. The Target is the QI initiatives considered and implemented per Quality Based Procedure recommendations for the CHF patients)	1)Medication Reconciliation performed within 24-48 hours	Ongoing assessment, process improvement strategies related to improving the Medication Reconciliation performance.	Quarterly Medication Reconciliation on Audits to measure compliance. Assess Med Rec compliance during the scheduled audits.	Consideration and implementation of QBP recommendations.	Process improvement intervention.

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									2)CHF 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 CHF Handbook.	Ongoing meetings with the CHF Quality Based Procedure Committee which includes the CHF Physician lead to review services, plan and establish timelines for QI initiative changes. -Establish timelines and accountabilities for the CHF Quality Based Procedure Committee	Review and present ongoing progress of the CHF steering committee at Senior Management and Medical Staff meetings.	Quality improvements to be considered and adopted if/when appropriate	Process improvement intervention.
									3)Regular presentation to the Quality of the Board Committee by the CHF QBP Lead re: program status and quality improvements implemented into our services.	CHF 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)Develop and implement the CHF Discharge checklist to be used on the Med/Surg and Adult Medicine units. This checklist will be in conjunction with the "Baton Project" Readiness for discharge checklist. The goal of these checklists is to ensure the patients are discharged with the best practice recommendations in place.	The CHF discharge checklist will be used for every CHF patient upon discharge. 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 CHF.	Quality Improvement intervention.

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Efficient	**Reduce unnecessary time spent in acute care**	Total number of ALC inpatient days contributed by ALC patients within the specific reporting period (open, discharged and discontinued cases), divided by the total number of patient days for open, discharged and discontinued cases (Bed Census Summary) in the same period.	% / All acute patients	WTIS, CCO, BCS, MOHLTC / July 2015 – September 2015	826*	19.1	25.00	With the absence of interim LTC beds and the limited community resources, it is likely that the number of ALC days at LWDH could increase.	1)Continue partnership with Northwest Community Care Access Centre (CCAC)and the Rapid Response nurse to support the Home First Philosophy, and maintain regular Joint Discharge Operational Team (JDOT) meetings to identify barriers in the discharge of ALC patients	Regular bullet rounds with the multidisciplinary team which includes Community Care Access Centre (CCAC)staff to identify and access appropriate services to facilitate discharge.	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/ family physicians and nurses to increase knowledge of community services, and the role of Community Care Access Centre Care Coordinators within the hospital.	Ongoing education of staff by ER Manager and Discharge Coordinator regarding Community Services.	ER physicians and nursing staff will be aware of community services available.	Decrease in ALC days.	Education/skill development intervention
									3)The Community Care Access Centre Case Coordinators located in LWDH work closely with the Utilization Coordinator and ER staff to divert admissions whenever possible. The Rapid Response nurse endeavors to visit the ER daily to assess the need for home support when issues with patient discharge arise.	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.

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									4)Continue to communicate to the patient and/or family with regard to the care plan and discharge date. We have family meetings when necessary to address patient and family concerns related to discharge.	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 time is posted; however, nursing staff, at times, encounter barriers to same and will be encouraged to seek the assistance of the Utilization Coordinator to address and problem solve these barriers.	Discharge times 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)The LWDH utilization Committee will meet regularly to perform reviews related to the ALC rate, to look at target areas for service improvement and where resources can be used to mitigate ALC occurrences.	Regular reviews by the Utilization committee and the consideration of process change improvements.	Proactive identification of areas of improvement.	Decrease ALC rate.	Process improvement intervention.

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Patient-centred	**Improve patient satisfaction**	"Would you recommend this hospital (inpatient care) to your friends and family?" add the number of respondents who responded "Yes, definitely" (for NRC Canada) or "Definitely yes" (for HCAHPS) and divide by number of respondents who registered any response to this question (do not include non-respondents).	% / All patients	NRC Picker / October 2014 – September 2015	826*	X	90.00	Maintenance:90% or > We will continue to survey once a year: Summer 2016.	1)In house Patient Satisfaction Survey once a year: Summer 2016.	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.
									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)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.

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		The patient Post Discharge Follow-up Phone Call process will be implemented as evidence by 25 post-discharge phone calls will be performed in Quarter 3 (from the Med-Surg and Acute Medicine Units).	From the Med Surg and Acute Medicine Unit: 25 post discharge phone calls will be performed during Quarter 3 / All acute patients	Hospital collected data / Fully implemented by the end of the fiscal year.	826*	X	100.00	This is a new initiative to enhance the patient experience and therefore there is no baseline. A post discharge follow-up phone call is a venue to obtain valuable information about the quality of the services rendered during hospitalization by engaging the patient. The goal is to have this process fully implement as evidence by 25 discharge phone calls will be performed in Quarter 3.	1)Patient consent to have a follow-up phone call following discharge will be obtained upon admission.	This information will be entered into the Meditech electronic documentation system.	Patients contacted have given consent prior to the phone call.	Need to adhere to HIROC's recommendations and to the LWDH consent policy.	Process improvement intervention
									2)A PDSA will be used as necessary to evaluate the process and make improvements.	A structured process PDSA is an effective evaluation tool to make QI improvements.	The PDSA will be used and reviewed by the Post Follow-up Discharge Committee.	the successfully implemented follow-up discharge phone call will enhance the patient experience and promote patient engagement.	Process improvement/ Fostering engagement
									3)The regular review of the patient feedback for the consideration for service improvement.	The information obtained from the patient will be shared with the Manager of the department and the Quality & Risk Manager.	The patient feedback resulting from the discharge phone call will be reviewed by each department (Manager and staff, by the Quality Committee of the Board and by the Quality/Patient Safety/Risk Management Committee.	Enhance the patient experience and engagement by using the information from the patients for quality improvement.	Quality improvement intervention & fostering engagement

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Safe	**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*	86	77.00	The average in % from all inpatient units with medications reconciled from an audit performed in Quarter 3	1)Quarterly and ad hoc meetings of 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.	77% Q3 result achieved.	Process/ incentive motivation intervention.
									2)Standardized audit tool to be followed for Q1 and Q3 audits identifying compliance rates with all 3 steps of the med rec process.	The utilization of a standardized audit tool with compliance requirements set by the Med Rec committee focusing on quality improvement. (Follow Safer Health Care Now audit tool and Accreditation Canada's recommendations)	Standardized audit tool will improve data analysis and evaluation processes.	Achieve 77% target	Evaluation process improvement.
									3)Ongoing Education to the multidisciplinary team.	Continue to consult physician liaison on an ad hoc basis to maintain communication of process status and 100% sharing of meeting minutes to champion physician, standing agenda on Med Rec committee the need to consult physicians, Staff Educational opportunities will be a standing item on the Med Rec working group agenda and staff attendance to in-services will be submitted to Human Resources. Highlighted and educational blitz for staff and patients during Patient Safety Week	Staff awareness will demonstrate improved compliance.	77% target achieved.	Process improvement intervention.
	Increase proportion of patients receiving medication reconciliation upon discharge	Medication reconciliation at discharge: The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital	% / All acute patients	Manual collection / Audit results for Quarter 2	826*	68	65.00	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,	To review and evaluate 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 65% compliance.	Process improvement intervention.

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									2)Ongoing education of the multidisciplinary team.	Continue to consult physician liaison on an ad hoc basis to maintain communication of process status and 100% sharing of meeting minutes to champion physician, standing agenda on Med Rec committee the need to consult physicians Staff Educational opportunities will be a standing item on the Med Rec working group agenda and staff attendance to in-services will be submitted to Human Resources. Highlighted and educational blitz for staff and patients during Patient Safety Week.	Increase staff awareness and understanding of the Med Rec the process as evidence by an increase in compliance demonstrated by the audit results.	Achievement of the 65% 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)	65% target achieved.	Process improvement intervention.
									4)Continued usage of the Readiness for discharge checklist tool.	The Readiness for discharge check list tool provides a reminder to staff to complete the Medication Reconciliation process at discharge.	The Readiness for Discharge checklist tool will be utilized during all patient discharges (audits performed).	Patient chart audits will demonstrate consistent usage of discharge tool and therefore med rec compliance target will be achieved.	Process improvement intervention.
	Ensure the thorough completion of the preoperative checklists	All items on the Preoperative Checklist will be accurate. An audit of 25 charts in Q3 will show that 80% of all elements of the preop checklists will be completed correctly.	Manual chart audits / Preoperative patients	Chart reviews / Quarter 3	826*	X	80.00	There is no baseline data. An audit of 25 charts in Q3 will show that 80% of all items of the preop checklists will be completed correctly. The FMEA (Failure Methods Effects Analysis) process is an Accreditation ROP. This FMEA process will be used as a strategy to improve the compliance to fully and effectively complete the preoperative checklist. The target is a realistic goal to demonstrate improvement.	1)The FMEA Committee members, consisting of mostly front line staff from the OR, Med Surg, Acute Medicine/Pediatrics, ER and Maternity and will meet monthly to follow the standardized FMEA steps.	The FMEA process is a systematic method of evaluating the current preop checklist process.	Failure modes, failure causes and failure effects will be identified and addressed.	Empowering staff through open dialogue enhances solution driven discussions. Thoroughly completed preoperative checklist.	Intervention system improvement

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									2)Implement the identified mitigating strategies (interventions)stemming from the FMEA.	All stakeholders will be involved in supporting the interventions stemming from the FMEA. This will involve engaging the Quality/Patient Safety/Risk Management Committee, the Patient Care Committee, the Professional Advisory Committee and the Surgical Services Committee.	On going evaluation of the interventions will be monitored by the FMEA Committee	The preoperative checklists will be thoroughly and accurately completed.	Process improvement intervention.
									3)Regular reports of the FMEA status to the Quality Committee of the Board and Senior management.	The FMEA lead will be invited to the Quality Committee of the Board and Senior management present on the FMEA's activities.	Regular updates to the Quality Committee of the Board	Motivation strategy to meet the target goal.	Process improvement
									4)Ongoing monitoring of the issues with the accuracy of the preoperative checklist by the review of the risk monitor entries by the Quality & Risk Management and the Unit Managers.	The daily review of the risk monitor incidents.	The Quality & Risk Manager will give access to the appropriate unit Manager to review investigate and implement corrective actions.	To ensure the accuracy of the preoperative checklist.	Process improvement
	Suicide Risk Prevention	Perform a Q3 audit of 20 patient charts to assess that the patient was assessed for risk of suicide at regular intervals or as needs change.	% / Mental Health / Addiction patients	Hospital collected data / Patient's Meditech chart	826*	X	90.00	To ensure we continue to meet Accreditation Canada's Required Organizational Practice "Suicide Risk Prevention", The team assesses each client on Schedule 1 of risk of suicide at regular intervals, or as needs change.	1)Formal training/education on the assessment for risk of suicide to all schedule 1 staff and new hires.	The Manager will provide formal training to the Schedule 1 staff re: Suicide Risk assessment.	Human Resources will track staff training completion.	The assessment of clients for suicide risk will be performed regularly and when client condition changes.	Process improvement intervention/Patient safety intervention
									2)The progress/activities for this initiative will be communicated to those who oversee the QIP.	The Manager of Schedule 1 and a front line staff representative if available will present on the status of the ROP test of compliance # 7.5.1 initiative at the Quality Committee of the Board, Senior Management and the Quality/Patient/Safety Risk Management Committee.	Regular Presentations	The Schedule 1 patients are assessed for risk of suicide at regular intervals or as needs change.	Process improvement/ awareness intervention
									3)Enhance the Meditech documentation tools to better capture patient risk.	Work collaboratively with front line staff with the revisions that need to be made, working with the Meditech lead, and our LWDH it department.	The standards of care will be more inclusive to include formalized risk assessment tools which will result in clearer direction for staff. .	To ensure maximum client safety.	Intervention improvement

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Timely	**Reduce wait times in the ED**	ED Wait times: 90th percentile ED length of stay for Admitted patients.	Hours / ED patients	CCO iPort Access / January 2015 - December 2015	826*	12.2	15.00	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 2016/17.	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	The ER staff will have knowledge of ER admitted wait times.	Wait times will remain stable within identified target.	Communication/building awareness intervention.
									3)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.
									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.