2019/20 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				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	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) C = custom (add any other indicators you are working on)															
Theme I: Timely and Efficient Transitions	**Efficient**	Average number of inpatients receiving care in unconventional spaces or ER stretchers per day within a given time period.	P	Count / All patients	Daily BCS / October - December 2018	826*	0.35	0.30	Current performance is very close to 0.		1)Utilize supervisor to clear barriers to access inpatient beds such as utilizing off service beds as an interim measure; utilize Code Surge as a last resort; Track number of ER admits that are discharged within 24 hr to determine if admission could have been prevented with use of community resources	ER Manager and Medical Adviser will monitor Daily Bed Census summary quarterly. ER Manager to monitor # of discharges of admitted patients in ER within 24 hr of admission	% of patients who are admitted who are in unconventional spaces (per definition) over number of patients admitted. Daily Bed Census Summary to be reported to Quality Committee of the Board quarterly	0.3% or less of admitted patients who occupy unconventional spaces or ER stretchers as of midnight on any day	this is a rare occurrence in our hospital as indicated by our benchmark. However we will monitor it for a year to determine if we can get to zero.
		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 2018	826*	33.48	30.00	Since we have limited ability to affect this target as we are dependent on number of beds available in LTC and specialized rehab and palliative care which offers service to multiple communities in NWO, we can only monitor our performance and apply for A1 status when our ALC's climb too high.		1)Continue to participate in the following strategies: - participation with the LHIN; Home First philosophy; Assess and Restore, continue with quarterly meetings with community and LTC partners; Rapid Response Nurse; ER diversion strategies; working with families; Assisted living; Aboriginal navigator in collaboration with the Kenora Chiefs advisory, Discharge planning communication process (red light, yellow light, green light), use of Patient Care Plan Boards to communicate planned discharge.	Data is collected through BCS and WTIS and Utilization Coordinator reports ALC data monthly to Patient Care committee. Quality Risk Manager reports ALC data to Quality Committee of the Board and the Professional Advisory/ Quality Committee quarterly	Number of patients in acute care beds who are designated ALC over total number of acute care occupied beds.	30% or less of acute care beds will be occupied by ALC patients	Timely and efficient Transitions

											2)Continue to work with the LHIN to improve access to a LTC facility with open beds; Advocating with the LHIN for Pinecrest to open permanent beds which are funded by the MOH	This has been an ongoing issue in our community for years and a strategy if needed to address this gap in access. Ongoing negotiations with the LHIN, the MOH and our LTC and community partners is essential	Number of acute care beds occupied by ALC patients over the number of acute care beds	30% or less acute care beds will be occupied by patients who have been designated ALC.	This in a chronic ongoing challenge in the Northwest and nothing substantial has been done to address it. Our aging population suggests that this problem will only get worse if reliable access to LTC is not addressed.
Timely	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	826*	26.36	35.00	Because this is a new indicator we feel that this benchmark is reasonable while we refine our processes		1)Look at current process for forwarding discharge summaries to Primary Care Provider to include Discharge summaries being prepared and signed in a timely manner; signed discharge summaries distributed in a timely manner; update chart completion policy; determine which Physicians are not completing Discharge summaries in a timely manner and provide education.	Completed Discharge Summaries will be sent to the Primary Care Practitioner within 48 hours of Discharge. This practice will be monitored by the Manager of Health Records Present data to Medical staff and MAC through the GP Extender group quarterly	We will measure the number of Discharge summaries that are sent to the Primary Care practitioners over the number of discharges. Results to be reported to the Quality Committee of the Board Quarterly	35% of Discharge summaries will be sent to the Primary Care Practitioner within 48 hr.	This is a new indicator
	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 A N D A T O R Y**	**Hours / All patients**	**CIHI NACRS / October 2018 – December 2018**	**826***	**4.6**	**4.60**	**We are well below the provincial average (26.2 hours Dec 2018 - cumulative over 9 months)**		**1)Continue to endeavor to move patient's out of the ER within 4 hours once the decision to admit has been made, including use of off service beds as a temporary strategy, improved communication between physicians and utilization to expedite discharges**	**Continue to monitor patient's who have not been moved to an inpatient bed within 4.6 hours to determine any mitigating factors**	**Number of Patients who are in an inpatient bed within 4.6 hours of the decision to admit. This data is reported at Utilization Committee and sent monthly to ER manager**	**Percentage of ER patients who have and order to admit will be in an inpatient bed within 4.6 hr over total number of patients who have an order to admit from ER**	**Our time to inpatient bed is very low and we will endeavor to maintain this benchmark. The provincial benchmark for the first 3 quarters of 2018 was 26.2 hours**
										2)Multidisciplinary Rounds daily, Monday to Friday to identify discharges	Utilization to meet with inpatient units daily to identify potential discharges	Continue to monitor patients who exceed the benchmark of 4.6 hr to inpatient bed	4.6%	

											3)Discharge time is posted in patient rooms and in patient handbook and an agreement is in place with Hostel on site to allow patients to wait for transportation once discharged	Patient's who are discharged will leave their beds by 1000 hours	Number of patients discharge beds that are available for admissions by 1000 over the number of discharges	50% of beds will be available to accept new admissions by 1000	As we have a large patient population who live in remote rural areas it is sometimes difficult to move the patient from the bed at 1000.
Theme II: Service Excellence	**Patient-centred**	Percentage of complaints acknowledged to the individual who made a complaint within five business days	P	% / All patients	Local data collection / Most recent 12 month period	826*	92	92.00	Timely response to complaints is essential to good patient care. We currently perform at a very high level. However, we implemented a new reporting system (RL6) in August of 2018 so our baseline data is based on only 6 months data. Our performance over the next year will be our true test of quality.		1)Review current policy and practice in formal acknowledgement of complainants within 5 business days. Educate appropriate staff on inclusion and exclusion criteria Create an alert in our RL6 reporting system to remind the appropriate staff person on the 4th day if an acknowledgement has not been documented. Update the patient handbook to include the patient's right to receive acknowledgement re their complaint within 5 business days	Complaints and acknowledgement of same will be monitored by the Quality/Risk Manager and/or the RL6 administrator(s)	Percentage of complaints that received acknowledgement within 5 business days over total number of complaints will be reported to the Quality committee of the board quarterly Same will be reported to the Patient/Family Advisory committee quarterly	92% of complaints received and documented in RL6 will be acknowledged within 5 business days	Our baseline is based on 6 months data since implementation of RL6. A large percentage of complaints are made in person or by telephone so are acknowledged at the time the complaint is received and the interview is done by the person receiving the complaint.
											2)Educate appropriate staff on inclusion and exclusion criteria	All managers will be educated in the process of acknowledgement of complaints and the inclusion and exclusion criteria and will be responsible to monitor complaints in their area through RL6 to ensure that the complainant receives acknowledgement within 5 business days.	Number of complaints received through RL6 that have been acknowledged within 5 business days over the total number of complaints.	92% of complaints received through RL6 will be acknowledged within 5 business days	
		Percentage of respondents who responded positively 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 consecutive 12-month period	826*	59.77	70.00	We have begun to now offer our Patient Experience survey on line so hope to get better response. This is a stretch goal		1)Have recently launched and electronic version of our Patient Experience Survey to enhance the existing paper survey format Supervisors continue to do follow up phone calls to patients who indicate consent to receive such calls Review and revise current discharge instruction document which is given to the patient	Monitor number of patients indicating on follow-up survey that they had enough information about what to do after discharge if you are concerned over all surveys returned.	Percentage of patients indicating a positive response in the Patient Experience Survey over the total number of surveys returned will be reported the the Quality Committee of the Board and the Patient /Family Advisory committee biannually.	70% 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 are worried about your condition or treatment after you left the hospital".	

Theme III: Safe and Effective Care	**Effective**	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 / October - December 2018	826*	70.59	75.00	Our previous goal was very ambitious and we were unable to meet it. We feel that 75% would be more achievable while we develop strategies to improve.		1)Work toward electronic med rec tool and explore expanded role for pharmacy in med rec. Continue to educate nursing on patient safety related to med rec.	Med Rec on Discharge data will be monitored on a quarterly basis by the Patient Care Managers and the Quality/Risk Manager using on site audit and reported to the Med Rec focus group	The percentage of patients in a discharge sample who had Medication Reconciliation completed upon Discharge over total number of charts audited will be Reported to the Quality Committee of the Board Biannually	75% or more of Patient charts audited will have a completed Medication Reconciliation on Discharge over the total number of discharge charts audited.	Medication Reconciliation focus group will focus on Med Rec on discharge over the next quarter. We exclude patients who are transferred urgently to another tertiary hospital.
		Proportion of hospitalizations where patients with a progressive, life-threatening illness have their palliative care needs identified early through a comprehensive and holistic assessment.	P	Proportion / at-risk cohort	Local data collection / Most recent 6 month period	826*	CB	80.00	this data has not been collected in the past so we have no benchmark. We feel that this target is reasonable as once we have added the "Surprise" question to the General Admission order set.	LHIN Home and Community Program, Family Health Team, Primary Care, Long Term Care	1)Add mandatory question to General Admission Order Set "Would you be surprised if the patient was to die in the next year?" ; All NO responses will trigger a referral for a Palliative Care Assessment; A Palliative Performance Scale (PPS)will be done on all new Palliative Care Referrals.	All Patients who are admitted using the General Admission Order set will be identified if a Palliative Care referral is recommended by answering "no" to the "Surprise" question. This data will be collected in MediTech and will be monitored by the Palliative Care Manager and the Quality/Risk Manager on a quarterly basis	The number of Palliative Care Referrals with a PPS done will be measured over the total number of Palliative Care referrals.	80% of Palliative Care referrals will have a PPS done.	We will begin by adding the "Surprise" question to the General Admission Order set. Other admission order sets will be added once our process is established and shown to be a useful measure.
		Rate of mental health or addiction episodes of care that are followed within 30 days by another mental health and addiction admission.	P	Rate per 100 discharges / Discharged patients with mental health & addiction	CIHI DAD,CIHI OHMRS,MOHTLC RPDB / January - December 2017	826*	11.31	11.00	We are currently below the provincial average so will look at a small improvement. Our Schedule 1 program will be experiencing a change in Medical support with the retirement of our in house psychiatrist. We will be covered by locums while we recruit and this could adversely affect our ability to meet our target.		1)Pilot revised consent for disclosure of information for all Mental Health patient discharged from hospital to ensure that appropriate support programs have the info they need in a timely manner to support the patient in the community Lobby to continue crisis support for patients in ER after hours (current Crisis support are withdrawing their services at the end of March). In the interim, for the next 6 months, LWDH will continue to provide Crisis Response using existing resources while alternatives are being investigated.	Information will be collected through DAD and OMHRS and ICD by health records and shared with the appropriate Patient Care managers and medical advisers on a biannual basis.	All patients with a Mental Health or Addictions Illness who are discharged from hospital and return in less than 30 days over all patients with Mental Health or Addictions Illness who are discharged from hospital.	11% or less patients will return within 30 days with a Mental Health and Addictions illness.	Our benchmark is currently below the provincial average of 12%.

	Safe	**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 2018**	**826***	**117**	**120.00**	**We are endeavoring to increase our reporting in the midst of implementing a number of initiatives which hopefully will decrease our incidents of violence. We have also implemented a new reporting program which should make it easier to report incidents**	**Kenora Land Ambulance, Pinecrest Home for the Aged, Birchwood Terrace**	**1)JOHSC will repeat a formal violence / risk assessment in 2019 Currently in the process of recruiting security personnel Continue to encourage and monitor reporting practices.**	**Continue to Monitor reporting practices of Violent incidents or threat of violence incidents with the goal of increasing reporting through RL6.**	**Number of Incident reports submitted through RL6 re incidents of violence or threat of violence over 12 months.**	**Greater than 120 incidents will be submitted in the fiscal year of 1019 - 20**	**FTE=325 We are currently in the process of implementing security changes in our hospital and will be able to evaluate this changes in the next fiscal year. Until then we have decided to continue to promote increased reporting.**
											2)Patient and Family Advisory committee will contribute to updating our Patient directory to educate the public on codes of conduct.	continue to monitor reporting practices of Violent Incidents with the goal of increasing the reporting of violence incidents	Number of Incident Reports submitted through RL6 re incidents of violence or threat of violence over 12 months	Greater than 120 incidents of violence or threat of violence will be submitted in RL6 in the fiscal year 2019-20.	
											3)Develop a Process by which partners (LTC, ambulance)can notify us if they are sending/bringing in a patient who is exhibiting violence tenancies.	Monitor number of patients arriving in ER by ambulance who were exhibiting violent / threat of violence behaviors where we were notified prior to arrival of this behavior.	Monitor the number of patients who were brought in to ER by Ambulance who where exhibiting violent / threat of violence behaviors where we were notified in advance of arrival over number of patients arriving in ER by ambulance who were exhibiting violent / threat of violence behaviors	60% of the time, ER will be notified in advance of patients arriving in ER by ambulance who were exhibiting violent / threat of violence behaviors	