2018/19 Quality Improvement Plan - Lady Minto Hospital
"Improvement Targets and Initiatives"

AIM		Measure						Change				
Quality dimension	**Issue**	**Measure/Indicator**	**Unit / Population**	**Source / Period**	**Current performance**	**Target**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**	**Comments**
Efficient	**Access to right level of care**	Total number of alternate level of care (ALC) days contributed by ALC patients within the specific reporting month/quarter using near-real time acute and post-acute ALC information and monthly bed census data	Rate per 100 inpatient days / All inpatients	Local data collection/ Jan-December 2017	23%	equal or less than 25.3%	NELHIN current performance is 25.3%	Review discharge planning model to identify special patient needs and address issues associated with timely discharge	Hold regular interdisciplinary care conferences with our complex continuing care patients (awaiting placement) with a focus on discharge planning with adequate supports. Involve patients families/loved ones and make them aware of various options and supports available	# care conferences held	Our goal is to ensure patients are discharged home if desired and appropriate with adequate supports	
								Continue to strenghthen the relationships with our community partners (Home and Community Care and Red Cross)	Regular conversations/consultations between Care Transition Coordinator. Sharing of information regarding discharge planning	# consultations with Care Transitions Coordinator		
Patient-Centered	**Person experience**	How would you rate the quality of care or services provided by the staff?	% / ED survey respondents	Local data collection / Jan-Dec 2017	72.8%	15% improvement (83.7%)	We strive to achieve equal or higher than 90%	Review ED survey questions and administrative process for Emergency Department Experience Survey	Set up meeting(s) to review questions and discuss methods for administering survey. Involve staff and members of the PFAC	% completion of review	Our goal is to review and make changes to the current ED experience survey then drill down to the cause of dissatisfaction with the quality of services by collecting meaningful data	*Priority Indicator **Executive Compensation
								Select one quality improvement initiative based on survey findings (by December 2018)	Select QI team, develop project charter, establish measures and utilize PDSA cycles to make improvements and monitor progress. Involve staff, physicians and members of the Patient and Family Advisory Council	% achievement of project		
Safe	**Workplace Violence**	Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.	Count / Worker	Local data collection / January - December 2017	BMH CB AGH CB LMH CB	BMH CB AGH CB LMH CB	We will be collecting our baseline data for this upcoming year	Develop clear process for capturing incidents of workplace violence as per Occupational Health and Safety definition	Reivew RL6 data to identify which files relate to workplace violence. 1b) Develop report and/or spreadsheet and determine who will collect data, what information will be collected and how report will be disseminated	# reports generated quarterly	Although we are collecting some data via RL6, we want to ensure we are meeting the requirements of this indicator for next year. Our goal is to stengthen our reporting culture and improve the quality of our reporting	

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								Increase knowledge of workplace violence for all staff	Provide education to managers and frontline staff re: workplace violence definitions, when to report, importance of conducting debriefs and follow-up	% staff who have received education		
	Medication Safety	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.	Rate per total number of discharged patients / Discharged patients	Hospital collected data / October – December (Q3) 2017	50%	95%	We strive to maintain our current performance to be equal or greater than 95%	To strengthen the compliance with medication reconciliation at discharge	Review audit MRP practices and provide snapshot of current compliance rates	Review compliance bi-monthly at staff meetings, including MAC and P&T.	Long term goal is 100%	**Executive Compensation
								Review auditing tool/process for capturing med rec on discharge	Use the Plan, Do, Study, Act (PDSA) cycle of improvement to implement and refine the formal process of medication reconciliation at discharge	100% completion by Dec 2018		
Timely	**Timely access to care/services**	Total ED length of stay (defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ED) where 9 out of 10 non-complex patients completed their visits	Hours / Patients with non-complex (CTAS IV-V) conditions	CIHI NACRS (Your Health System Insight) / October 2016 - September 2017	4.9hrs	equal or less than 4.2hrs	We strive to achieve equal or lower than the NELHIN's current performance of 4.2hrs	Engage staff and physicians regarding lenghts of stay (LOS) in the ED	Collect data on various LOS indicators and share with staff who work in the department. 1b) Share LOS data at clinical utilization meetings, Medical Advisory Committee and departmental meetings. 1c) Post LOS data in the emergency department for staff to see	# of meeting held	Our goal is to increase awareness of wait times within the organization and to develop strategies to decrease the length of stay for non-complex patients	*Chief of Staff compensation
								2) Conduct real time audits to drill down to root cause of wait times	2) Process to be developed with consultation from Patient Care Managers, staff, PFAC. Frequency of audits to be determined as well	2) # audits completed		