2014/15 Quality Improvement Plan for Ontario Hospitals
"Improvement Targets and Initiatives"

Leamington District Memorial Hospital 194 Talbot Street West

AIM		Measure								Change				
Quality dimen	Objective	Measure/Indicator	Unit / Popul	Source / Period	Organi	Current p	Target	Target justification	Priority	Planned improvement initiative	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 / Q4 2012/13 – Q3 2013/14	704*	15.15	14.1	Current performance is the average of Q4 2012/13 - Q3 2013/14.Continue with current performance. ESCLHIN 13-14 YTD Performance 22.5 hours. Target is 20.	Improve	1)Coordinate the Registration, Housekeeping and Bed assignment processes. Expedite the admission process.	VSM on the admission process from decision to admit to the time to inpatient bed. Implement change ideas identified during VSM.	Daily huddle board to review performance indicators at 10am. Monthly overview by Senior Management, quarterly review during Stocktake. Physician individual reports and engagement.	Implement daily huddle by March 31, 2014. Complete VSM exercise by April 30, 2014. Implement change ideas by June 30, 2014. Continued monitoring of improvement. Plan to see 50% improvement by September 30, 2014.	
		ER wait times 90th percentile time to inpatient Bed, NACRS, CIHI (after the decision to admit has been made, the length of time it takes for a patient to be transferred to an inpatient bed).	Hours / ED patients	CIHI eReporting Tool / 2012-2013	704*	6.5	3	We have set a target of 3 hours time to inpatient bed based on the performance of STEGH and expect that 80% of the time we will meet this. *When this target is missed we have an escalation process to address this. ESC LHIN 13-14 YTD Performance 16.5 hours. Target is 13.1.	Improve	1)Expedite discharge on inpatient units and admission process for patients admitted from ED.	VSM on the admission and discharge processes. Implement change ideas identified during VSM.	Daily huddle on inpatient units at 0800 and review at bullet rounds 1030 to identify missed targets, follow escalation process and review performance, make changes in real time from feedback received. Physician individual reports and engagement. Monitor EDIS reports daily.	Implement daily huddle by March 31, 2014. Complete VSM exercise by April 30, 2014. Implement change ideas by June 30, 2014. Continued monitoring of improvement. Plan to see 50% improvement by September 30, 2014.	
		ER Wait Times: 90th percentile ER length of stay for High Acuity (CTAS 1,2 and 3) Non-admitted Patients, NACRS, CIHI (ER length of stay is defined as the time from triage to registration, whichever comes first, to the time the patient leaves the ER)	Hours / ED patients	CCRS, CIHI (eReports) / 2012-2013	704*	7	6.5	*Q3 performance is 7.6 but variable. ESC LHIN 13-14 YTD Peformance 6.9 hours. *Target is 6.5.	Improve	1)Continue to use nursing medical directives to initiate and expedite care.	Monitor the use of nursing medical directives.	ED chart audits for use of nursing medical directives.	Expectation of 80% initiation of medical directives where indicated.	
		ER Wait Times: 90th percentile ER length of stay for low acuity (CTAS 4 and 5) Non-admitted Patients, NACRS, CIHI (ER length of stay is defined as the time from triage to registration, whicheve comes first, to the time the patient leaves the ER)	Hours / ED patients	CCRS, CIHI (eReports) / 2012-2013	704*	4.3	3.9	Based on current performance and continuous quality improvement. ESC LHIN 13-14 YTD Performance 3.8 hours. Target is 3.9	Improve	1)NP standard work for episodic care	Provide standard work for NP episodic care appropriate for ED. Implement standardized ED charting model. Provide individual NP report cards and performance improvement as required.	Audit NP charts to ensure episodic standard work is being followed. Audit triage charts to ensure they are appropriately triage CTAS 4 and 5.	Implement standardized ED charting model by June 30, 2014.	

		ER Wait Times: 90th percentile wait time to physician initial assessment NACRS, CIHI (The time waiting in the emergency department until the physican initial assessment).	Hours / ED patients	CCRS, CIHI (eReports) / 2012-2013	704*	3.7	3.2	Based on current LHIN performance. ESC LHIN 13-14 YTD Performance 3.5 hours. Target is 3.2.	Improve	1)Improve the patient experience by early physician assessment time.	Improve individual communication to ED physicians by Chief of ED. Provide monthly report cards to the Chief of ED for ED physicians and monitor performance. Daily huddle with ED staff including physicians and physician assistant.	Monitor performance by providing monthly reports to Chief of ED and escalation process.	Meet by December 21, 2014	
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 2013/14	704*	0	0	For Fiscal year 2014-2015 the target is a stretch as we submitted a budget with a negative variance of $292K	Maintain	1)Hay Group Study will recommend the services we should be providing in a rural community.	Financial statements.	Monitor monthly finance report to Board of Directors.	0 balance budget.	
Integrated	**Reduce unnecessary hospital readmission**	Readmission to any facility within 30 days for selected CMGs for any cause: The rate of non-elective readmissions to any facility within 30 days of discharge following an admission for select CMGs.	% / All acute patients	DAD, CIHI / Q2 2012/13-Q1 2013/14	704*	14.97	12.8	Meet LHIN target 12.8% Q1 2013/14 16.28% Source - Stocktake	Improve	1)Lead organization for ESS Health Links. Early identification of patients with complex discharge.	Educate staff and physicians on availability and best practice COPD, CHF and Stroke order sets; patient education and discharge planning requirements.	Quarterly audit for use of COPD, CHF, Stroke order sets and discharge plan/summary. Most significant CMG type is CHF, we have chosen this as the Health Links project to focus on QI in this CMG.	Meet LHIN target of 12.8% by Sept. 2014.	
Patient-centred	**Improve patient satisfaction**	From NRC Picker: "Would you recommend this hospital (inpatient care) to your friends and family?" (add together % of those who responded "Definitely Yes" or "Yes, definitely").	% / All patients	NRC Picker / Oct 2012- Sept 2013	704*	74.86	78.6	5% increase in current performance.	Improve	1)Increase patient satisfaction by increasing nursing time spent at the bedside and improving response time for patient assistance.	Hourly rounding by staff. Changing call bell system whereby staff need to enter the patient room to shut it off. Bring the nurses back to bedside: revamp documentation, decrease time chart = increased time at bed side.	Informal auditing by performing walkabouts. Management walkabouts will interview 10 patients per month, analyze and communicate the results to staff. Update has been made to NRC Picker reporting requirements and we expect to see more timely responses.	5% increase in 2014-2015.	
		From NRC Picker: "Overall, how would you rate the care and services you received at the hospital (inpatient care)?" (add together % of those who responded "Excellent, Very Good and Good").	% / All patients	NRC Picker / Oct 2012- Sept 2013	704*	91.68	96.26	5% increase in current performance.	Improve	1)Increase patient satisfaction by increaseing nursing time spent at the bedside and improving response time for patient assistance.	Hourly rounding by staff. Changing call bell system whereby staff need to enter the patient room to shut off. Bring the nurses back to the bedside: revamp documentation, decrease time chart = increased time at bed side.	Informal auditing by performing walkabouts. Management walkabouts will interview 10 patients per month, analyze and communicate the results to staff. Update has been made to the NRC Picker reporting requirements and we expect to see more timely responses.	5% increase in 2014-2015.	
		From NRC Picker: Would you recommend this ED to your friends and family?" (add together % of those who responded "Definitely Yes" or "Yes, definitely")	% / ED patients	NRC Picker / 2013	704*	57.22	60.08	5% increase in current performance.	Improve	1)Foster a culture of caring.	Use the CNO standards of practice to develop a customer service training program. Assess individual performance related to customer service. Identify and use role models to foster change. Recognize achievements.	NRC Picker quarterly monitoring. Analyze those results and communicate to staff and initiate change processes as needed.	100% of ED staff trained in customer service by Sept 30 2014.	
		From NRC Picker: "Overall, how would you rate the care and services you received at the ED?" (add together % of those who responded "Excellent, Very Good and Good").	% / ED patients	NRC Picker / 2013	704*	87.29	91.8	Established Benchmark for select QIP core indicators.	Improve	1)Foster a culture of caring.	Use the CNO standards of practice to develop a customer service training program. Assess individual performance related to customer service. Identify and use role models to foster change. Recognize achievements.	NRC picker quarterly monitoring. Analyze those results and communicate to staff and initiate change processes as needed.	100% of ED staff trained in customer service by Sept 30 2014.	

Safety	**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. 2013, consistent with publicly reportable patient safety data.	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / 2013	704*	0.58	0.44	Most recent Provincial Average for Large Hospitals.	Improve	1)Implementation of an order set for C Diff management.	Roll out and educate staff and physicians.	Chart audits to monitor use of order set.	100% use of order set.	
										2)Reduce bed moves.	Explore options to bring services to the patient. Track the number of patient moves.	Track number of bed moves for patients with C Diff.	<3 moves per patient.	
										3)Increase the number of private rooms.	Reallocate and redesign patient rooms.	Number of private rooms.	Increase to 18 private rooms from 12 (3 yr plan) (excluding OBS).	
										4)Increase involvement in regional Antibiotic Stewardship initiatives.	Include LDMH data in regional program.	Compare data results and use data to make improvements/share ideas and successes.	Meet Provincial averages.	
										5)Monitor antibiotic use in C Diff patients for any trends. Review latest literature and best practices and communicate to physicians.	Audit charts of C Diff cases and communicate information to physicians.	% of C Diff infections associated with antibiotic use.	100% consult by Pharmacy for C Diff.	Starting point. Need to ensure feedback to physician
		Hand hygiene compliance before patient contact: The number of times that hand hygiene was performed before initial patient contact divided by the number of observed hand hygiene indications for before initial patient contact multiplied by 100 - consistent with publicly reportable patient safety data.	% / Health providers in the entire facility	Publicly Reported, MOH / 2013	704*	91	91	High performance large hospital. We are currently above provincial average.	Maintain	1)Broaden communication of hand hygiene results back to staff volunteers and physicians	Unit specific results posted monthly on each individual unit	Monthly audits of compliance with hand washing policies.	100%	
										2)Encourage patients to ask care givers if they washed their hands.	Audit patient responses.	% of patients who asked the question.	Target 80% advised to ask staff.	

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