2015/16 Quality Improvement Plan for Ontario Hospitals
"Improvement Targets and Initiatives"

Leamington District Memorial Hospital 194 Talbot Street West

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	704*	12.1	10.9	Based on past performance and previous lean projects that identified that this is an achievable target.	1)Review and revise current protocols for ED patients waiting for CT scans, as well as laboratory results.	Working on CT Scan Protocols. Implement IStat training and use of IStat in the Emergency Department.	Daily review of DART and EDIS stats.	To complete Radiology/ED protocol for request for CT Scan. To decrease time from request to radiologist protocol.	
		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	CCO iPort Access / Jan 1, 2014 - Dec 31, 2014	704*	3.6	3.2	Based on past performance and previous lean projects that identified that this is an achievable target.	1)Review current admission processes and work with the Flow Coordinator to tighten up the process.	Enhance current infection control identification process between the Emergency Department and the Registration Department.	Daily review of DART and EDIS stats.	Monthly audit by Infection Control Practitioner for reviewing infection control practice processes.	
		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	CCO iPort Access / Jan 1, 2014 - Dec 31, 2014	704*	7	6.3	Based on past performance and trend of LOS for High Acuity LOS patients.	1) Review and revise current protocols for ED patients waiting for CT scans, as well as laboratory results.	Working on CT Protocols. Implement IStat training and use of IStat in the Emergency Department.	Daily review of DART and EDIS stats.	To complete radiology/ED protocol for request for CT. To decrease time from request to Radiologist protocol.	
		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, whichever comes first, to the time the patient leaves the ER)	Hours / ED patients	CCO iPort Access / Jan 1, 2014 - Dec 31, 2014	704*	4.8	4.3	Based on past performance and current LIHN target.	1) Review and revise current processes with NP's, PA's, nursing and MD's regarding a fast track process.	Review financial and human resources for physician coverage.	Daily review of DART and EDIS stats.	Evaluate the resources available for a 2nd physician to work the fast track process. Evaluation to be completed by September 2015.	

		ER Wait Times: 90th percentile wait time to physician initial assessment NACRS, CIHI (The time waiting in the emergency department until the physician initial assessment).	Hours / ED patients	CCO iPort Access / Jan 1, 2014 - Dec 31, 2014	704*	4.1	3.7	Based on past performance and LIHN target times.	1)Review and revise current processes with NP's, PA's, nursing and MD's regarding a fast track process.	Renovations to Triage area to include 2 fast track stretcher areas.	Daily review of DART and EDIS stats.	Evaluation to be completed by September 2015.	
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)	704*	-1.57	0	Fiscal 15-16 Operating Plan was based on the recommendations from 'Aligning Sustainable Hospital Services' report.	1) Ontario 3.6% for April 2013 to March 2014, Healthcare Indicator Tool, MOHLTC	Fiscal 15-16 Operating Plan was based on implementing the recommendations from "Aligning Sustainable Hospital Services" (HAY) report	Restructuring nursing area with implementation of new staffing model of care; all departments improving operating efficiency by achieving at a minimum, median performance as benchmarked in the Hay Report; implement order sets for all Quality Based Procedures based on QBP handbooks	Monitor monthly operating reports to the Board of Directors; benchmark departmental performance based on quarterly reporting to the MOH; monitor adherence to QBP Order Sets.	Balanced budget.
	Reduce unnecessary hospital readmission	Readmission within 30 days for Selected Case Mix Groups	% / All acute patients	DAD, CIHI / July 1, 2013 - Jun 30, 2014	704*	15.6	14.8	Decrease current performance by 5 %.	1) Continue to monitor and refine the daily reassessment of the inpatient indicators for readiness for discharge for patients with CHF, Stroke, COPD, Pneumonia.	Daily monitoring of discharge summary during bullet rounds. Development standardized care plans for complex patients with chronic diseases that are identified repeat readmission.	Every 6 months audits are completed on the Quality Based Procedure order sets, discharge summaries, nursing documents and individual patient COPD action plan.	Audit planned for September 2015. Communicate results to nursing, respiratory therapists, internists and physicians.	
Patient-centred	**Improve patient satisfaction**	From NRC Canada: "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 / October 2013 - September 2014	704*	67.2	71.4	Increase current performance by 5%.	1) Increase patient satisfaction by providing more education/info to patients while in hospital and upon discharge. (including plan of care, eDD, and disposition on discharge) Increase nursing time at the bedside.	Develop and implement education brochures for patients. Develop ALC brochure for families to outline differences from acute care. Change documentation to be less time consuming and to bring the nurse to the bedside.	Monitor and respond to patient complaints. Continue to communicate NRCC results to staff.	5% increase in 2015-2016	
		From NRC Canada: "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 / October 2013 - September 2014	704*	90.4	91	Maintain current performance.	1) Increase nursing time at the bedside with the patient.	Change the nursing documentation to be less time consuming and to bring the nurse to the bedside.	Monitor and respond to patient complaints. Continue to communicate NRC picker results to staff.	Maintain current performance in 2015-2016	

		From NRC Canada: 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 / October 2013 - September 2014	704*	58	61	Increase current performance by 5%.	1) Increase patient satisfaction by focusing on customer service and reducing emergency department wait times.	The addition of a 12 hour staff member during prime time with a focus on improving the patient experience and assisting the physician with a fast track process. Implementation of discharge instruction documentation to be given at discharge.	Monitor and respond to patient complaints. Continue to communicate NRC Picker results to staff.	Monitor the trend in the internal complaints received.	
		From NRC Canada: "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 / October 2013 - September 2014	704*	83.9	85	Increase current performance by 2%.	1) Increase patient satisfaction by focusing on provision of best practice care.	Implementation of quality initiatives are planned which include the following: identification of sepsis, improvement in care of the mental health patient. Implementation of discharge instruction documentation to be given at discharge.	Monitor and respond to patient complaints. Continue to communicate NRC Picker results to staff.	Audit sepsis tool planned for September 2015.	
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. 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	704*	0.46	0.46		1) Implement Plan of Care for Patient Isolation on Admission.	Documented acknowledgement that patients and families understand isolation protocols. Information sheets are given specific to diagnosis or suspected diagnosis, and teaching how to put PPE on. Staff held accountable for teaching.	Audits on forms, and monitor visitor compliance with PPE.	Educate patients and families; Reinforce proper PPE use with staff - 'lead by example'.	
									2) Continue with Antibiotic Stewardship initiative.	Audit antibiotic utilization.			
									3) Ensure best practices for environmental cleaning are utilized including implementing any new recommendations that might arise.	Review cleaning protocols per PIDAC standards. Initiate audit tool for room cleaning. Educate staff.	Monitoring and Auditing.		
									4) Increase availability of laundry hampers and garbage pails.	Provide laundry hamper/ garbage pail in each room to reduce risk when transporting contaminated items for discard.	Staff feedback.		
		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 / Jan 1, 2014 - Dec, 31, 2014	704*	93.92	95		1) Improve hand hygiene compliance rates.	Lunch and Learns with all staff on "Public Reporting' and their roles and responsibilities.	Increase hand hygiene audits.		
									2) Increase availability of gel dispensers.	Install additional gel dispensers in Emergency Department and elsewhere as identified.			
									3) Change culture to promote a team approach to hand hygiene.	Encourage staff to 'speak up' and remind each other if non-compliance is noted.			
									4) Improve Public awareness on hand hygiene.	Install door skins promoting hand hygiene on elevator doors.			