2016/17 Quality Improvement Plan for Ontario Hospitals
WORKPLAN

Leamington District Memorial Hospital 194 Talbot Street West, Leamington Ontario

AIM		Measure							Change				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Org Id	Current performance	Target performance	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
EFFECTIVE													
#1	**Reduce 30 day readmission rates for select HIGs**	**Percentage of acute hospital inpatients discharged with selected HBAM Inpatient Grouper (HIG) that are readmitted to any acute inpatient hospital for non-elective patient care within 30 days of the discharge for index admission.**	% / All acute patients	DAD, CIHI/ July 2014-June 2015	704	14.58	14.5	Achieve 5% less than ESC LHIN target.	1) Updating patient information on discharge as it relates to QBP's being monitored.	1) Review current discharge information available. 2) Educate staff on QBP results.	1) Disperse information to providers at care team meetings. 2) Evaluate discharge materials by April 30, 2016.	To improve patient understanding of their disease, the processes and ensure staff understand the importance of providing discharge instructions.	Will continue to monitor.
#2	**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	704	15.47	14.7	Decrease by 5%	1) Enhance education provided to patients starting on admission through discharge (both written and visual education materials).	1) Develop education packages to be provided to patients.	1) Monitor readmissions rates after initiation of enhanced patient education materials.	To improve patient understanding of their disease, the processes and ensure staff understand the importance of providing discharge instructions.	Will continue to monitor.

#3	**Reduce readmission rates for patients with COPD**	**Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with COPD (QBP cohort)**	% / COPD QBP Cohort	DAD, CIHI January 2014 – December 2014	704	19.89	19.2	Reduce COPD readmission rates by 3.5%	1) Enhance education provided to patients starting on admission through discharge (both written and visual education materials).	1) Develop education package to be provided to patients.	1) Monitor readmissions rates after initiation of enhanced education materials.	To improve patient understanding of their disease, the processes and ensure staff understand the importance of providing discharge instructions.	Will continue to monitor.
#4	**Reduce readmission rates for Stroke patients**	**Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with Stroke (QBP cohort)**	% / Stroke QBP Cohort	DAD, CIHI January 2014 – December 2014	704	10	9.5	Decrease by 5%	1) Enhance education provided to patients starting on admission through discharge (both written and visual education materials).	1) Develop education package to be provided to patients.	1) Monitor readmissions rates after initiation of enhanced education materials.	To improve patient understanding of their disease, the processes and ensure staff understand the importance of providing discharge instructions.	Will continue to monitor.
EFFICIENT													
#5	**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	704	26.5	20	Dcrease of 25 %. Provicncial average ranges between 10-25%. ESCLHIN target 9.46%, Q3 15/16 ESCLHIN performance 17.7%	1) Have 1 dedicated director lead utilization to monitor and guide flow. 2) Recreate hospital discharge policy.	1) Recreate LDMH discharge policy. 2) Work closely with CCAC to implement the Home First philosophy and put support services in home.	1) Monitor ALC rates and flow after lead of utilization implemented.	See improvement in ALC numbers.	Will continue to monitor.

PATIENT-CENTERED													
#6	**Improve patient satisfaction**	**"Overall, how would you rate the care and services you received at the ED?", 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 (do not include non-respondents).**	% / ED Patients	NRC Picker/ October 2014 - September 2015	704	84.5	85	Improve current performance by 0.5 points	1) Increase satisfaction by implementing "Hourly Comfort Rounds" concept.	1) Use of white board in room. 2) Use of scripting when speaking to patients and families. 3) Use of the 4 P's (pain, potty, positioning & possessions).	1) Educate staff on hourly rounding concepts by May 31, 2016	Improve performance by .5%	Communication of reason for wait time for care impacts this indicator. This information will be communicated to physicians and staff at QC, MAC, and the Board on a quarterly basis.
#7	**Improve patient satisfaction**	**"Overall, how would you rate the care and services you received at the hospital?" (inpatient), 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 (do not include non-respondents).**	% / All patients	NRC Picker/ October 2014 - September 2015	704	93.1	91	Maintain target at 91% from previous QIP.	1) Increase satisfaction by implementing "Hourly Comfort Rounds" concept.	1) Use of white board in room. 2) Use of scripting when speaking to patients and families. 3) Use of the 4 P's (pain, potty, positioning & possessions).	1) Educate staff on hourly rounding concepts by May 31, 2016.	Maintain target at 91%.	This information will be communicated to physicians and staff at QC, MAC, and the Board on a quarterly basis.

#8	**Improve patient satisfaction**	**"Would you recommend this ED 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).**	% / ED Patients	NRC Picker/ October 2014 - September 2015	704	55.6	58	Achieve target performance of 58% which was obtained in previous QIP (Oct 13 - Sept 14 data).	1) Increase satisfaction by implementing ""Hourly Comfort Rounds" " concept.	1) Use of white board in room. 2) Use of scripting when speaking to patients and families. 3) Use of the 4 P's (pain, potty, positioning & possessions).	1) Educate staff on hourly rounding concepts by May 31, 2016.	improve communication to patient.	This information will be communicated to physicians and staff at QC, MAC, and the Board on a quarterly basis.
#9	**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	704	65.1	66.5	Increase current performance by 1.4 points.	1) Increase satisfaction by implementing ""Hourly Comfort Rounds" " concept.	1) Use of white board in room. 2) Use of scripting when speaking to patients and families. 3) Use of the 4 P's (pain, potty, positioning & possessions).	1) Educate staff on hourly rounding concepts by May 31, 2016.	Increase current performance by 2 %.	This information will be communicated to physicians and staff at QC, MAC, and the Board on a quarterly basis.

SAFE													
#10	**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	704	94%	95%	Improve current performance by 1.0 point.	1) Education of staff.	1) Include standardized process for completion of medication reconciliation in new hire nursing orientation. 2) Utilize medication reconciliation coordinator to provide education.	1) Continue to audit medication reconciliation at all transitions of care and educate staff on a 1:1 basis when gaps identified.	Increase medication reconciliation completion on admission for maternal/ newborn patients.	Will continue to monitor.
#11	**Reduce hospital acquired infection rates**	**CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI during the reporting period, divided by the number of patient days in the reporting period, multiplied by 1,000.**	Rate per 1,000 patient days / All patients	Publicly Reported MOH / January 2015 - December 2015	704	0.48	0.46	Improve current performance by 4%.	1) Using Plan of Care for Patient Isolation on Admission. 2) Continue with Antibiotic Stewardship initiative. 3) Staff training to ensure best practices for environmental cleaning and increase in private rooms.	1) CDI e-learnings, routine practices and Personal Protective Equipment e-learning. 2) Chart audits for compliance. 3) Any patient with loose stools isolated until determined C-Diff or other cause.	1) Complete audits on documentation. 2) Monitor staff and visitor compliance with use of Personal Protective Equipment. 3) Staff teaching patient and families on prevention of spread.	Educate patients and families on proper Personal Protective Equipment use with staff on a "lead by example" basis.	Will continue to monitor and educate.
TIMELY													
#12	**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	704	11.5	10.9	Improve current performance by 5%.	1) Utilize staff, patient and community input to investigate opportunities for improvement in wait times.	1) Real-time survey for Emergency Department patients to provide opportunities for improvement. 2) Trial of increasing Emergency Department MD resources (overlap shift).	1) Work with MD's to trial an overlap of 2 MD's during peak volume times in ED.	See target.	Department acuity and staffing resources impact this indicator.