2019/20 Lakeridge Health Quality Improvement Plan

AIM	Measure				Change				
Quality dimension	Measure/Indicator	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Safe and Effective Care	Rate of psychiatric (mental health and addiction) discharges that are followed within 30 days by another mental health and addiction admission (%)	15.3%	14.3%	Comparing to our peer hospitals, the benchmark is 12%-12.5%. Meeting the benchmark will mean a 3 percentage point improvement. This plan will take three years, thus a 1 percentage point per year improvement.	1) Spread the Rapid Access Addiction Medicine (RAAM) Clinic Model	1) Determine the appropriate funding model to maximize value 2) Explore a spread model to other hospitals within Lakeridge Health	Volumes of new patients to clinic	More than 475 patients	
					2) Complete the Mental Health Model of Care roll out	Complete all project deliverables including: 1) Deploy therapeutic groups 2) Standardized patient plan of cares 3) Carry out an anti-stigma campaign	Complete all project deliverables	100% implementation of new model of care at LHO (Oshawa Hospital) and LHAP (Ajax Pickering Hospital) in-patient mental health units	
					3) ED/MH model of care / collaboration	Develop and execute MH model of care in the ED that will improve access and quality of care for MH patients	% of patients where a controlled document was used	Increase from current	
Service Excellence	Would you recommend this emergency department to your friends and family? (% positive)	70.4%	76.7%	2019/20 will be year two of a three year goal of achieving 80% positive responses. 76.7% indicates the year two target to meet the overall aim of 80%	1) ED/MH model of care / collaboration	Develop and execute MH model of care in the ED that will improve access and quality of care for MH patients	1) Patient satisfaction scores and comments 2) ED Length of Stay (LOS) 3) Frequency of Code White 4) Staff engagement scores	1) 76.7% or greater 2) Meet or exceed pay for results (P4R) targets at 90th percentile, all sites 3) Establish baseline 4) Improve by at least 10%	Note: confirming changes ideas for improving ED experience will occur after April 1st. Any modifications will be documented in the 2019/20 progress report.
					2) Pre-triage and kiosk strategy	1) Implementation of new patient kiosk system to facilitate and expedite pre-triage process 2) Process work related to pre-triage improvements that will support the kiosk as a tool 3) Implementation of medical directives	1) Door to triage time 2) patient satisfaction scores and comments 3) ED LOS	1) establish baseline 2) 70.5% or greater 3) meet or exceed P4R targets at 90th percentile, all sites	Note: confirming changes ideas for improving ED experience will occur after April 1st. Any modifications will be documented in the 2019/20 progress report.
					3) Renovation project to EMS space **LHO ED only	Renovations to the current EMS offloading area to improve EMS offload wait times	Ambulance Offload Times (AOT)	Meet or exceed P4R target at 90th percentile, all sites **while renovations are at LHO ED only, AOT will be a continued area of focus for FY 19/20	Note: confirming changes ideas for improving ED experience will occur after April 1st. Any modifications will be documented in the 2019/20 progress report.
					4) Service delivery model and ER MD-HR plan	Service delivery model includes: 1) Integration of physicians assistants to address PIA 2) Hours of coverage and overlap 3) Utilization of internal surge plan	1) Physician Initial Assessment (PIA) time 2) ED LOS	1 and 2: meet or exceed P4R target at 90th percentile, all 4 sites	Note: confirming changes ideas for improving ED experience will occur after April 1st. Any modifications will be documented in the 2019/20 progress report.
Safe and Effective Care	Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.	695	695	There is a continued inclusion of incidents for other contracted staff, volunteers, students & trainees. The target is based on maintaining the volume as year one was focused on increasing reporting.	1) Encourage reporting of incidents	1) Refresh poster campaign, communications Strategy 2) Provide education re: Workplace Violence (WPV)/Workplace Harassment (WH) to encourage more accurate reporting 3) Clarification of reporting Code Whites (ensure they are visible to Occupational Health and Safety (OHS) for f/u)	1) Number of reported workplace violence incidents 2) Reported incidents incorrectly classified or not reported	1) Maintain the # of reported workplace violence incidents (physical and verbal) 2) Decrease in workplace violence incidents classified incorrectly	Central East Local Health Integration Network (CELHIN) as a collaborator for the LHIN Workplace Violence Sub-committee.
					2) Ensure reported incidents are followed up on	1) Updating the proper classification 2) Investigation conducted to identify root causes 3) Preventive actions identified 4)Follow up completed	1) Reported incidents are investigated and controls are implemented 2) Number of incident reports for which a prevention plan has been completed as follow-up	1) All incidents are investigated. Controls are implemented for all incidents where appropriate. 2) The investigation and follow-up for all incidents is documented	
					3) Reduce WPV incidents by providing appropriate violence prevention and response training for LH Colleagues	Identify appropriate training and plan to roll out training	% of LH Colleagues trained in violence prevention and response training	Increase in the number of LH Colleagues trained in violence prevention and response training	
					4) Maintain workplace violence risk assessments	1) Review and updating of existing workplace violence risk assessments (WVRAs) 2) Completion of new workplace violence risk assessments	Number of workplace violence risk assessments outstanding	All existing WVRAs completed/ reviewed as per plan; new WVRAs completed as per plan; identified preventive controls in progress/implemented	
					5) Process implemented to communicate the risk of workplace violence from patients with history or potential for violence	Implement Patient Flagging (note: refers to LH Worker Advisory Guidelines)	Number of worker advisories implemented (Worker Advisory Guidelines implemented in pilot areas)	Increased number of worker advisories implemented	
					6) Unit/area specific safety prevention initiatives as identified	Engage workplace stakeholders in initiatives to prevent workplace violence	Collected root causes and trends on WV	Data on root causes and trends will be available	

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Timely and Efficient Transitions	Emergency department 90th percentile wait time for inpatient bed (hours)	40.25 hours	34 hours	Benchmarking to peer hospitals indicate 20-22 hours is our benchmark. Accomplishing this over a three year period means that an improvement of around 6 hours per year is necessary. 6 hour improvement in 2019/20 is the target.	1) Standardized Discharge Rounds	1) Standardized approach to Rounds including timing, attendance and accountability 2) Estimated Date of Discharge (EDD) process defined and implemented across medicine program 3) Early identification of complex and at risk of ALC patients 4) IP collaboration process to provide early and robust interventions to facilitate timely discharge	% of inpatients units that are meeting the required discharge round standards. Note: this is for targeted units only. Standard rounds in Paediatrics, NICU, Labour & Delivery, Post-partum, Emergency Department and are excluded.	100% by year end	
					2) Bed management policy refresh	Review and approval an updated bed management policy focusing on roles and responsibilities of all stakeholders	Compliance of standardized practices and communications regarding bed management policy	Audited compliance of all stakeholders as per policy	
					3) Refresh the "90 Minute Patient Transfer Challenge" (time from bed dirty to next patient in the same bed)	1) Reintroduce a focus on transfer of accountability communication between ED and inpatient units 2) Investigate using technology to fast-track communication of "bed clean" status into the Bed Management Tool 3) Carry-out a series of enhancement to the Bed Management Tool to improvement communication of EDD and barriers to discharge	Percentage achievement of the 90 minute patient challenge	Developing a baseline. Target to be determine.	
					4) Implement the use of conservable days for quality improvement	Standardize the use of conservable days methodology. Develop communication and education on how to assess long conservable days and develop unit-base improvements. Monitor improvements.	Percentage of inpatient units that access monthly conservable day data	Developing a baseline. Target to be determine.	
Timely and Efficient Transitions	Total rate of inpatient days designated as Alternate Level of Care ALC (%)	23.7%	18.0%	This target is set to be aligned to our peer hospital benchmark by year end.	1) Transition to home (TTH) in the ED/ Bridge to Home	1) Patient & family advisors on our clinical working group, co-designing processes 2) Develop a process to assess gaps and opportunities in patient experience (phone survey, interviews, reviewing concerns from Patient Experience Office) 3) Identifying & implementing possible strategies for post-discharge follow-up care 4) Implement a patient-oriented discharge summary (PODS) 5) Improve the capability of ED staff and TTH for teaching patients self-management and self-care strategies 6) Develop a discharge educational package for patients (e.g. for managing common issues at home)	Currently in discussion with the working group. Not a specific measure yet, however will be available in the next several weeks. Examples include total volumes of patients diverted from ED, ED LOS or patient satisfaction of the program.	Target for this process measure will be available at a later date.	Note: CELHIN and Carriage House will be named as QIP Collaborators for the ALC Indicator.
					2) Transitional Care Models	1) Continue Carriage House transitional care model 2) Explore additional offsite transitional model with potential community partners (retirement homes, hotels etc.).	% of patients discharged from the program without readmission to hospital.	100%	
					3) Standardized Discharge Rounds	1) Standardized approach to Rounds including timing, attendance and accountability 2) EDD process defined and implemented across medicine program 3) Early identification of complex and at risk of ALC patients 4) Interprofessional collaboration process to provide early and robust interventions to facilitate timely discharge	% of inpatients units that are meeting the required discharge round standards. Note: this is for targeted units only. Standard rounds in Paediatrics, Neonatal Intensive Care Unit, Labour & Delivery, Post-partum, Emergency Department and are excluded.	100% by year end	
					4) Behavioral Supports Ontario (BSO) - acute care expansion	1) Co-design BSO acute care model 2) Build capacity of teams to support patients with responsive behaviors 3) Effective transitions across continuum of care 4) Timely consultations and effective care planning with inpatient teams 5) Develop and monitor referral processes, documentation requirements and metrics reporting	Collecting baseline information	Collecting baseline information	