Theme I: Timely and Efficient Transitions

Measure

Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Median ED length of stay (LOS) for admitted patients (hours)	C	Hours / ED patients	Hospital collected data / 2023 YTD	24.50	22.10	The target represents a 10% improvement goal over the previous year's baseline. It was purposely chosen to help identify an incremental goal in order to reach the overall OE target for the region in subsequent years. It was endorsed by members of the ED leadership team as well as SLT.	Durham OHT

Change Ideas

Change Idea #1 Unit Rearrangement Project

Methods	Process measures	Target for process measure	Comments
Increase Medicine bed capacity	# additional Medicine beds	44 additional medicine beds	

Change Idea #2 Medicine unit coordinator role embedded in LHAP/LHO EDs

Methods	Process measures	Target for process measure	Comments
Develop standardized approach to early discharge planning and rounds	Time to inpatient bed (reduce by 10% from YTD Oct 2022 = 21.34 h)	The target for this process measure is 19.3 hours	

Change Idea #3 CHF (Congestive Heart Failure) Clinic

Methods	Process measures	Target for process measure	Comments
Pilot a rapid referral CHF clinic connected to virtual HF services in the community (OH pilot and OHT related).	# of CHF Patient Admissions	Reduce by 25% Q4 2024.	CHF Clinic is part of the Durham OHT.

Change Idea #4 Sustain Standardized EDD Rounds Across all Inpatient Areas

Methods	Process measures	Target for process measure	Comments
Ensure standardization while expanding to ALC management practices (e.g. ALC Designation)	EDD Rounds Quality Check compliance	All targeted units compliance 80% of the time	

Change Idea #5 Update of the 90 Minute Challenge

Methods	Process measures	Target for process measure	Comments
Update 90 Minute Challenge process to include EPIC triggers and reporting.	Time that bed is empty from discharge to admission – Toes out to Toes In	Collecting Baseline	

Change Idea #6 Surge Working Group

Methods	Process measures	Target for process measure	Comments
Development of guiding documents to support identification of budgeted beds and surge capacity in both conventional and unconventional spaces, along with base equipment needs for support	Completion of documentation	Complete by April 2023	

Measure **Dimension:** Efficient

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of potentially avoidable ED visits for Lakeridge Gardens Long-Term Care residents (Lakeridge Gardens)	C	Rate per 100 / Patients deemed palliative or end of life	CIHI CCRS, CIHI NACRS / Q1 2022/2023	6.50	5.70	Target performance to be consistent with provincial average	LHAP ED and Medicine Leadership

Change Ideas

Change Idea #1 Collaborate with LHAP ED to streamline care pathways to avoid emergency room usage

Methods	Process measures	Target for process measure	Comments
Quarterly review with LHAP ED and Medicine Senior Leadership	Completion of quarterly reviews	100% compliance by June 1, 2023	

Change Idea #2 Standardized approach collaborative process to track and analyze ED transfers.

Methods	Process measures	Target for process measure	Comments
Enact QRM module within PCC to enable daily review of data and discussed daily at nursing leadership huddles (compliance with documentation of transfer forms) Monthly review with Quality Committee forum with senior leadership	Work with PCC partners on quarterly basis to maximize database utilization - results will be reported out to Quality Committee on a monthly basis Achieve quorum for Quality Committee and QIP reviewed monthly at this forum	In place by June 1, 2023, 100% quorum achieved on a monthly basis	

Change Idea #3 Consultation before ED transfer

Methods	Process measures	Target for process measure	Comments
Registered nurse consult with manager, physician or NP prior to transfer utilizing SBAR	% of transfers to ED with consultation	100% compliance by June 1, 2023	

Theme III: Safe and Effective Care

Measure

Dimension: Effective

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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.	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / Oct–Dec 2022 (Q3 2022/23)	63.90	70.00	Target Performance based on internally estimates from the Pharmacy department.	

Change Ideas

Change Idea #1 Med Rec PowerBI Reporting Systems

Methods	Process measures	Target for process measure	Comments
Develop centralized reporting systems at Med Safety Committee and share results to physicians/ programs for localized improvement. Focus Pharmacy leadership supports on lowest performing programs.	% of Programs Using Med Rec reports at Program Council or Prorgam Placemat.	Target to be determined	

Change Idea #2 Pharmacist Driven Admission Med Rec

Methods	Process measures	Target for process measure	Comments
Pharmacists within the hospital to perform Admission Med Rec once “Pharmacists’ Clinical Scope of Practice – Policy and Procedures” goes live.	% Admission Med Rec	Target to be determined	

Change Idea #3 Med List Clean-up

Methods	Process measures	Target for process measure	Comments
Pharmacists to “clean up” med list through Admission Navigator to facilitate retrospective Admission Med Rec by providers.	Confirmed pharmacy support by year end.	All clinical programs except Women's and Children's Healthcare	

Measure

Dimension: Effective

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Documented assessment of palliative care needs among residents identified to benefit from palliative care (Lakeridge Gardens)	C	% / Patients deemed palliative or end of life	In house data collection / 2023/2024	CB	100.00	In accordance with the quality standards for palliative care, all residents identified to benefit from palliative care will have a documented assessment	

Change Ideas

Change Idea #1 Standardized approach to support early identification among staff and care providers to make a palliative care referral

Methods	Process measures	Target for process measure	Comments
Develop a Palliative Care Policy and Procedure	Completed Palliative Care Policy and Procedure One Resident and Family Advisor will be recruited to support the palliative care program	Approved Palliative Care Policy and Procedure May 2023	

Change Idea #2 Ensure providers have skills and confidence to provide Palliative Care

Methods	Process measures	Target for process measure	Comments
Palliative lead will provide education to all existing health care providers in alignment with the processes described in the Palliative Care Policy and Procedures. For all new staff, students and volunteers, this will be implemented during orientation	% of new and existing staff , students, and volunteers who attended orientation of palliative care	100% of all new and existing staff, students, and volunteers have completed palliative care education	

Measure **Dimension:** Safe

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Lakeridge Gardens)	P	% / LTC home residents	CIHI CCRS / Jul - Sept 2022	36.36	23.00	Progress towards the Provincial Benchmark. Consistent with achieving a least restraint environment (including chemical restraints).	Ontario Shores Centre For Mental Health Sciences, CareRx, Ontario Health, Provincial BSO

Change Ideas

Change Idea #1 Standardized review of resident diagnosis and medication among interdisciplinary team for residents receiving anti-psychotic medication in the absence of a diagnosis

Methods	Process measures	Target for process measure	Comments
-Monthly review at Quality Committee -Collaboration between physician/NP with RN/RPN quarterly review of medications with residents, partners in care, and pharmacist	-Achieve quorum for Quality Committee and QIP reviewed monthly at this forum -Work with CareRX on quarterly basis to maximize database utilization - results will be reported out to Quality Committee on a monthly basis	In place by April 2023 100% quorum achieved on a monthly basis	

Measure

Dimension: Safe

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.	P	Count / Worker	Local data collection / Jan 2022–Dec 2022	371.00	600.00	Workplace violence incidents appear to be under-reported at Lakeridge Health. Therefore, the goal will be to increase reporting. There is data to suggest the currently-reported number is lower than the true number of incidents. For example, data regarding Code Whites called indicates more Code White events than the number of reported workplace violence incidents. Additionally, Lakeridge Health plans to improve reporting processes for security staff as well as volunteers, which are expected to increase the number. Lakeridge Health will continue to prevent workplace violence incidents. The target value accounts for a large expected increase in reporting, as well as an expected decrease due to prevention initiatives.	

Change Ideas

Change Idea #1 a. Continued awareness campaign to change culture and encourage reporting b. Provide education regarding workplace violence reporting to encourage more accurate reporting c. Improve reporting processes for contract staff and volunteers

Methods	Process measures	Target for process measure	Comments
- Ensure awareness of how to report WV incidents by all LH team members - Training for leaders so that they encourage staff who verbally report to file a report - Communication regarding definitions of WPV, WPH - Clarification regarding reporting of Code Whites and WV - Introduce specific reporting processes for security personnel and volunteers that feed into existing processes	- # of reported workplace violence incidents - Reported incidents incorrectly classified or not reported	- Increased # of reported workplace violence incidents (physical and verbal); estimated increase of at least 50. This accounts for reporting by security personnel and volunteers as well as increased reporting by other staff - Decrease in workplace violence incidents reported incorrectly. Based on better review and validation by the OHS team and follow-up education with teams as necessary	FTE=4053

Change Idea #2 Reduce WPV incidents by providing violence prevention and response training for LH Colleagues

Methods	Process measures	Target for process measure	Comments
-Identify appropriate training and plan to roll out training	- Training plan developed - % of LH Colleagues trained in violence prevention and response training	- Training plan developed - Increase in the number of LH Colleagues trained in violence prevention and response training	

Change Idea #3 Engage workplace stakeholders in initiatives to prevent workplace violence

Methods	Process measures	Target for process measure	Comments
Workplace Violence Prevention Working Group, Joint Health and Safety Committees	- Root causes and trends on WPV - WPV Prevention initiatives include stakeholder input and informed by WPV statistics	- Data on root causes and trends available - WPV Prevention initiatives planned with stakeholder input	

Change Idea #4 Assessment of workplace violence risks completed

Methods	Process measures	Target for process measure	Comments
Review and updating of workplace violence risk assessments	# of workplace violence risk assessments completed	All WVRAs completed/ reviewed and identified preventive controls implemented	

Change Idea #5 Review reported incidents to establish appropriate preventative actions

Methods	Process measures	Target for process measure	Comments
Ensure all reported WPV incidents are reviewed to identify root causes and implement controls	- Reported incidents are investigated and controls are implemented - # of incident reports for which a prevention plan has been completed as follow-up"	All incidents are investigated. Controls are implemented for all incidents where appropriate.	

Change Idea #6 Process implemented assess and communicate the risk of workplace violence from patients with history or potential for violence

Methods	Process measures	Target for process measure	Comments
Continued encouragement and education on use of the Flagging system for violence risk	The percentage of required workplace violence individual client/patient assessments completed within 24 hours of admission	Initial target of 75% of required WPV client/patient violence risk assessments completed within 24 hours of admission	