2017-2018

Quality Improvement Plan

Listowel Wingham HOSPITALS ALLIANCE

Enriching Life's Journey Together

Contents per Page

Acronyms

Healthcare and hospital terminology can be difficult to understand. A list of acronyms utilized in this document is shown below. Listowel Wingham Hospitals Alliance has provided this table in hope to clarify any acronym concerns and associated language.

Acronym	Description		Acronym	Description
ALC	Alternate Level of Care		LTC	Long Term Care
BPMH	Best Possible Medication History		LWHA	Listowel Wingham Hospitals Alliance
CAM Tool	Confusion Assessment Method Tool		MSA	Medical Staff Association
CCP	Coordinated Care Plan		MAC	Medical Advisory Committee
CCAC	Community Care Access Centre		NRC Picker	National Research Corporation
CNL	Clinical Nurse Lead		OB	Obstetrics
COPD	Chronic Obstructive Pulmonary Disease		OR	Operating Room
CPOE	Computerized Provider Order Entry		OT	Overtime
CT	Computed Tomography		OTN	Ontario Telemedicine Network
CTAS	Canadian Triage and Acuity Scale		PDSA	Plan, Do, Study, Act
DI	Diagnostic Imaging		QBP	Quality Based Procedures
ED	Emergency Department		QIP	Quality Improvement Plan
ED-LOS	Emergency Department Length of Stay		SFH	Senior Friendly Hospital
eMAR	Electronic Medication Administration Record		SWLHIN	South West Local Health Integration Network
FHT	Family Health Team		VSM	Value Stream Mapping
HSFR	Health System Funding Reform		WDH	Wingham and District Hospital
LHIN	Local Health Integration Network		WTIS	Wait Time Information System
LMH	Listowel Memorial Hospital			

Organizational Overview

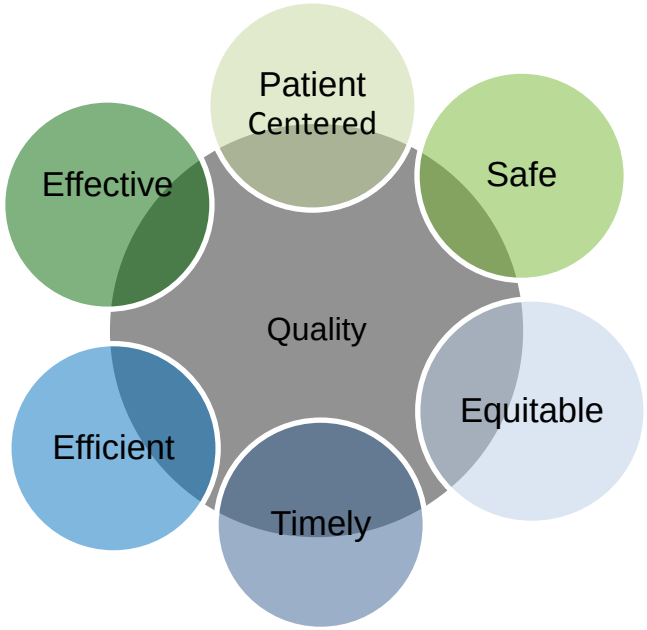
The Listowel Wingham Hospitals Alliance (LWHA) was formed on July 1, 2003 as a partnership between Listowel Memorial Hospital and Wingham and District Hospital. As an Alliance, we share a common management structure with a single management team and one Vision, Mission, and Values. Although we remain as separate corporations, there is a single Alliance Board. We look for opportunities to share services and programs across our two communities and find creative ways to work with our community partners in order to serve patients and their families.

In the spring of 2016, LWHA released an updated strategic plan that articulates an organizational mission including: *cultivating a sustainable and resilient environment* that is here for future generations, *cultivating quality care* that is patient centered, timely, efficient, effective, equitable and safe, *cultivating a workplace that nurtures* individual and collective potential, as well as *cultivating partnerships* to offer a seamless patient experience. These mission statements will be shadowed through our organizational values of respect, teamwork, communication, professionalism and compassion/caring.

The 2017-2018 Quality Improvement Plan (QIP) is a documented plan to facilitate achievement of the vision of LWHA and our strategic priorities. The goals, action plan, and stretch targets were selected by our clinical and corporate leaders, with feedback from providers, staff, patients and families.

The 2017-2018 QIP reflects the organization's definition of quality. In the framework, Health Quality Ontario's quality dimensions provide focus to the work of LWHA, with a significant emphasis on patient and family centered care.

An organization with a culture of quality is:



Mission, Vision and Values

Engagement and the QIP

Patient and Family Engagement

LWHA values the input provided from our patients and families utilizing hospital services. Some methods of patient and family engagement include but are not limited to in-house patient experience surveys using survey monkey, patient rounding, focus groups, committee participation and engaging patients through face-to-face interactions, phone or email on change processes within the organization.

LWHA recently held focus groups for a review of the Obstetrical Program at Listowel Memorial Hospital. Patients that had delivered at LMH within the last year were encouraged to attend. The Maternal Child Steering Committee was able to use this patient feedback to draft recommendations of change for the program.

LWHA also has patients sitting at the table on various committees. Although the overall number is small, a goal of 2017-18 is to engage and interact with more patients at several committees, patient partners were able to participate in recent staff interviews conducted to obtain new employees in Wingham and District Hospitals Rehabilitation Program. Patients are also engaged when implementing new or changing current processes within the hospital, such as sitting on the Infection Prevention and Control working group for process design, as well as implementation of a new organization wide Falls Prevention Program.

This year, patient partners were utilized as the key engagement group for the 2017-18 QIP development. Patient partners had an opportunity to voice his/her opinion on important quality initiatives and focus for quality improvement this fiscal year.

Patient and family feedback is also be obtained through shared complaints and compliments with the organization. Using complaint feedback allows LWHA to identify issues and understand opportunities for future improvement. Upgraded software, RL Feedback, will allow LWHA to track and trend complaint details in order to monitor for improvement.

LWHA is actively recruiting patient and family partners to join in our Quality Council. The Quality Council purpose is to oversee quality through development, implementation and monitoring quality within the organization. Quality is monitored at the committee level, and then brought forth to the Quality Council. The Council terms of reference are to be finalized and the Council established in the upcoming fiscal year. The *Patient and Family Centered Care and Engagement Framework* will be integrated within the organization's *Quality Framework*, as a dimension of quality care. Advising on the annual QIP will be an important mandate of the council.

Patient and family centered care is a key organizational focus upon orientation and is upheld within the culture at LWHA. Partnerships between patients, families and health care providers are mutually beneficial and rewarding.

Engagement and the QIP

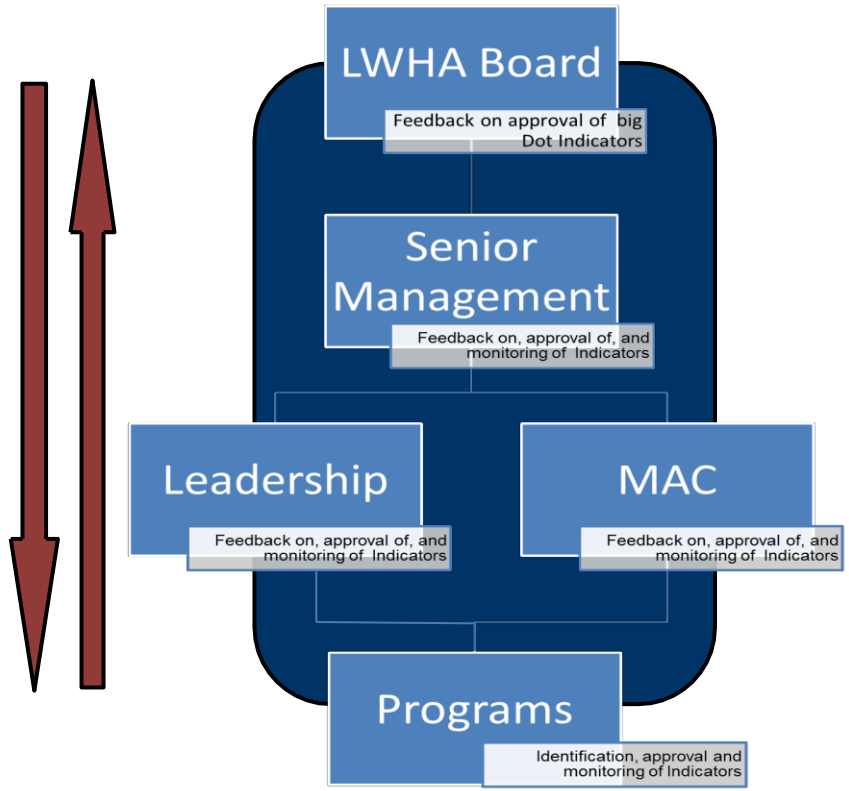
Clinician and Leadership Engagement

LWHA's senior leadership team is responsible for ensuring that all leaders are actively pursuing activities to improve the quality of services we provide. Engagement of clinicians and leaders occurs at numerous points in the development of the QIP and subsequent operational plans.

The development of QIP priorities is the responsibility of all levels of the organization, each relying on the other for feedback on appropriateness and implementation strategies. Patient engagement will inform all levels of development to ensure the priorities of the organization are aligned with the priorities of our patients and their families.

Monitoring of quality indicators occurs at the program level by way of process indicator or "*Little Dots".* This information flows to the leadership team, MAC and the Quality Council (note: not yet established), which in turn will flow to the board of directors. There is an emphasis on how the "Little Dots" impact the "Big Dots" monitored on the QIP.

Feedback Mechanism for QIP Priorities



Patient Centred Care, and the Quality Council, will inform QIP at all levels on a go forward basis

Integration and Continuity of Care

LWHA is committed to the safety, security and satisfaction of our health care providers and patients alike. We remain in continuous contact with our local Community Care Access Centre (CCAC) and continue to work together to improve care provided at LWHA, with special attention on our partnership to improve discharge planning for our patients. LWHA continues to reach out to our community healthcare providers and regional groups, such as the North Huron Family Health Team and North Perth Family Health Team (FHT), to facilitate patient flow and local coordination of patient care. Recent integrated project work includes a care pathway for patients admitted with COPD (Chronic Obstructive Pulmonary Disease). Upon discharge, these patients receive follow-up appointments with a primary health care provider within 7 days. Partnering with the FHT provides all involved parties with an understanding that an integrated healthcare system creates efficiency and allows for continuous improvement in quality. A key component to the success of all quality dimensions includes well informed staff and ongoing communication with our health care partners.

LWHA also partners with Huron Perth Health Link to review transitions and break down barriers along the patient journey, with an initial focus on seniors and patients with complex needs. Common goals are an integral focus on patient centered care, ensuring the patient receives high-quality, accessible and coordinated care, as well as a reduction in unnecessary ED visits and improved patient experience. Complex patients are identified by staff at various facilities (hospital, CCAC, FHT, etc) and a coordinated care plan may be conducted to include the patient/family in his/her plan of care.

Lastly, LWHA partners with Long Term Care (LTC) facilities within Huron and Perth Counties. A discussion is held at LWHA with partnering LTC homes attending. Matters such as transitions of care, advanced care planning and transportation issues are generally topics of discussion during the semi-annual meeting.

Enriching life's journey, together.

Every partner in our health care system has an opportunity to enrich the patient's journey. This is only accomplished by working together to break down barriers that impact the patient's ability to move through the system in a way that reduces stress and enhances their experience

Overview of QIP 2017-18

When considering priorities for the 2017-2018 QIP, special attention was given to provincial and SWLHIN priorities, unique patient populations within our community, patient and family feedback and previous year's successes and challenges.

Six goals have been established for this year that address priority indicators from each of the quality dimensions. Ambitious stretch targets have been established with appropriate actions plans to facilitate success. The principle of patient and family centered care highly influenced all goals. Special emphasis was placed on seniors, a significant patient population for LWHA. For the 2017-2018 year, the organization has selected one historical indicator to monitor in a maintenance capacity.

Our Six Goals for the 2017-2018 QIP are to:

Timely

1. Improve access to the Emergency Department by reducing the Emergency Department length of stay for admitted patients.

Efficient

2. Operation of the CT Scanner with an expected 10% growth according to the implementation plan and utilization.

Effective

3. Improve the integrated care provided to patients that is evidenced by the reduction of unplanned readmission rates for patients with Chronic Obstructive Pulmonary Disease (COPD). (Priority)

Safe

4. Improving patient safety by increasing the number of patients that receive medication reconciliation on discharge. (Priority)

Patient Centered

5. Improve patient and family centered care by implementation of 2 key actions within the domains of a Senior Friendly Hospital

6. Improving patient centered care by focusing on increasing overall patient satisfaction with the care provided by the organization (Priority)

Our Goals and Performance Targets - Timely

Goal 1: Improve access to the Emergency Department by reducing the Emergency Department length of stay for admitted patients.

LWHA continues to provide extremely timely access to Emergency Department Services. While wait times are significantly better than the 90th percentile of admitted patients, we are committed to improvements in the flow of patients through the department and the quality care they receive while they are with us.

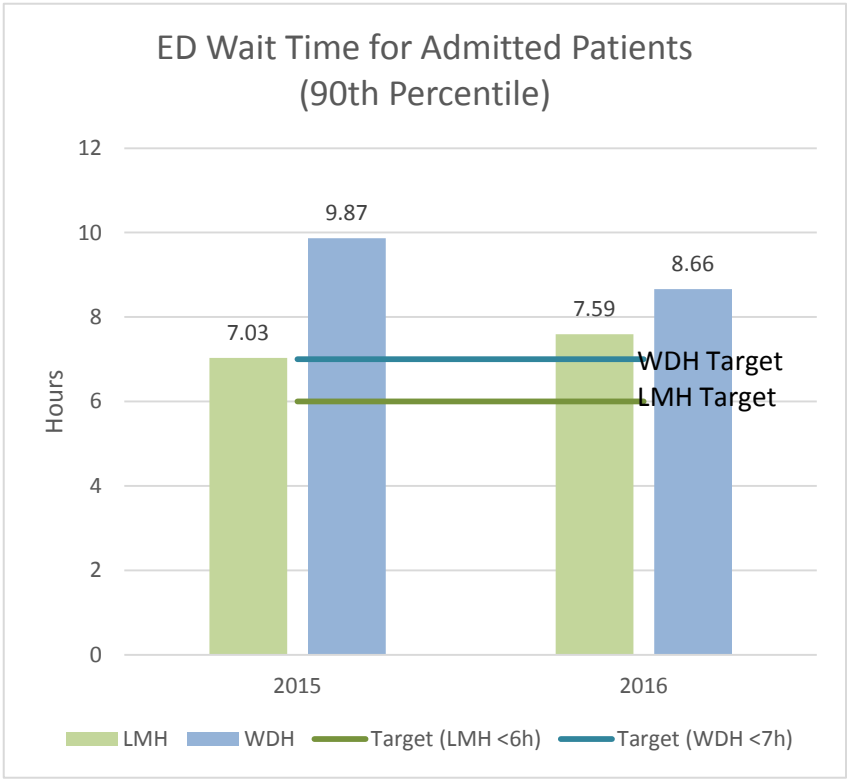
Indicator
90th percentile ED length of Stay for Admitted patients (ED-LOS): the time from triage or registration, whichever comes first, to the time the patients leaves the ED

Target 2017-2018
LMH target less than 6 hours
WDH target less than 7 hours (due to potential transportation delays eg. imaging)

Target Rationale
Review of current process and length of time required for imaging, lab tests, medication reconciliation, etc., targets for admission within 6 hours for LMH and 7 hours for WDH are highly appropriate.

Current Performance Reporting Period
January 1, 2016 – December 31, 2016

Risks and Mitigation
The risk of not meeting the target is minimal. LWHA has consistently performed well. However, it is essential that resources are secured to ensure the process measures are completed according to time lines.



Goal 1: Improve access to the Emergency Department by reducing the Emergency Department length of stay for admitted patients.

Change Ideas	Process Measures and Goals	Planned Actions
Ensure compliance with the CTAS (Canadian Triage and Acuity Scale) reassessment requirements	% of patients are reassessed according to triage requirements (audit) **Target: 80%**	1. Triage Reassessment audits completed by ED Clinical Nurse Lead (CNL) 2. Reassessment audit results posted on ED quality boards and in dashboard file 3. Audit results to be shared with staff and ED Care Committee 4. Education to staff on issues identified
Monitor processes and turnaround times for diagnostic imaging and laboratory tests that impact patient movement in the ED	Time from ordering of diagnostic exam to the time exam is complete (ED to DI) **Target: 60 minutes** Time from diagnostic exam complete to the time the radiologist final report is available to the ED physician **Target: 24 hours** # Plan-Do-Study-Act (PDSA) cycles completed on process that will impact patient movement from ED to DI **Target: 1** Time from ordering of internally performed laboratory test to the time results are available to the ED physician **Target: 90 minutes** (call back time included in this) Time from laboratory sample received in the lab to the time results are available to the ED physician **Target: 60 minutes**	1.Develop and implement PDSA to test improvements to cycle time: thoughts are improving communication between ED and DI by having DI staff contact ED to note if patient is ready for exam 2. DI manager and Lab manager to educate staff to document delays in exams to ensure accurate and realistic targets (ie. CXR ordered now to be done in a few hours, or troponin ordered now to be completed in 8 hours) 3. Turnaround times to be shared on diagnostic imaging and laboratory quality boards (extracted from CERNER data) 4. Turnaround times to be monitored at Clinical Leadership. 5. Exam if turnaround times impact length of stay for admitted patients.
Track and audit the barriers for admitted patients in the Emergency Department.	# charts review of patients with delays in admission > 6-7 hours **Target: monitor raw data** (monthly by registration date)	1. Medical records to send ED manager admissions > 7 hours for the previous week each Monday 2.ED Manager to review patient charts, looking for trends 3. Collect data related to barriers 4. Discuss data findings at ED Care Committee
Improve access to community supports (LTC, Coordinated Care Plans, Geriatric Co-op, Mental Health, CCAC) in effort to decrease ED length of stay	# Patients with more than 3 ED visits within a two week span (LMH) expand to WDH **Target: monitor raw data** # cases reviewed with physician **Target: monitor raw data**	1. Medical records and/or decision support to send ED manager data on those patients with frequent ED visits 2. ED manager to review with ED Care Committee physicians 3. Physicians to refer/alert patients' family physician of community resources, rather than utilizing ED
To monitor ED wait times overall	Average wait times in ED per CTAS rating scale **Target: Monitor raw data**	1. Decision Support Analyst to pull wait time data 2. ED Manager to review, looking for trends and correlation to ED LOS

Our Goals and Performance Targets - Efficient

Goal 2: Operation of the CT Scanner with an expected 10% growth according to the implementation plan and utilization.

The Listowel Wingham Hospitals Alliance (LWHA) will be implementing a CT scanner that will serve the residents of North Perth, North Huron and area. This new CT service will result in a measurable improvement in access to a major diagnostic imaging modality.

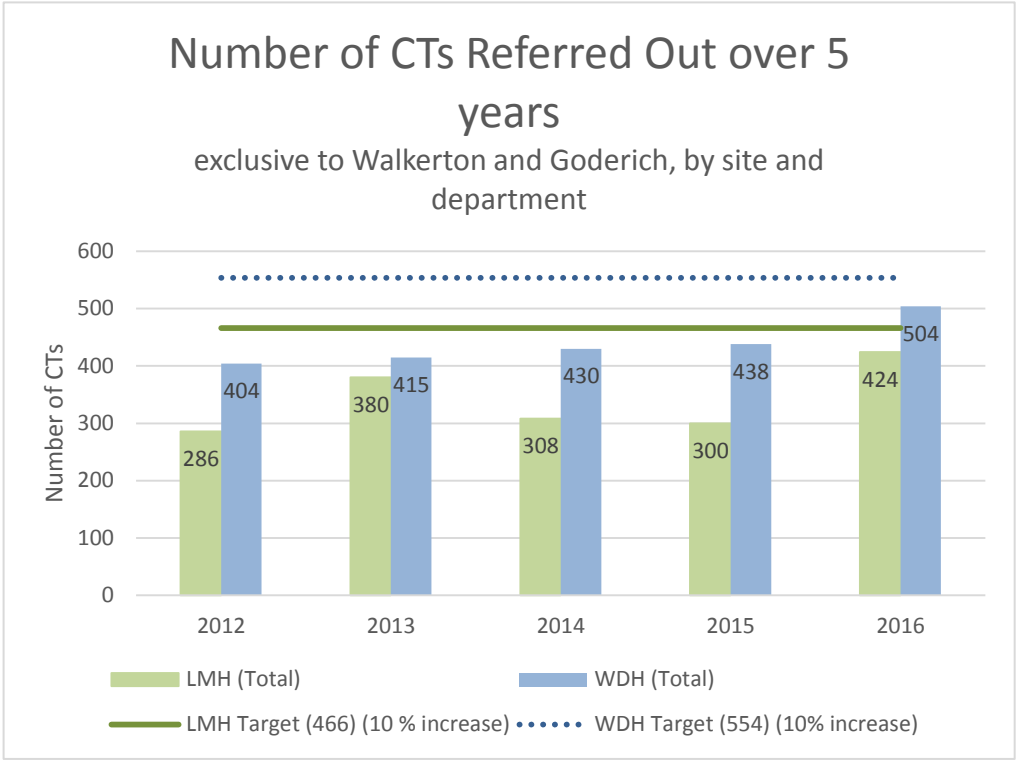
Indicator
To expect a 10% growth in the number of total CT's ordered on LWHA patients in comparison to 2016 volumes

Target 2017-2018
Growth of 10% of total scans per site
2016 Total Scans LMH 424 scans, **Target 466 scans**
2016 Total Scans WDH 504 scans, **Target 554 scans**
Total scans are reflective of inpatient and emergency patients scans only.

Target Rationale
This target is important to provide efficiencies for patients to provide care closer to home, while at the same time containing costs to the new CT program. It is important to improve efficiency for patients so they are receiving the care they need and deserve.

Current Performance Reporting Period
Jan 1, 2016 – Dec 31, 2016

Risks and Mitigation
There is moderate risk to achieving this target. Success is highly dependent on the number of requested orders. The risk is that if the service is more accessible, the number of orders will increase. First year will be a financial burden due to staff training and education. CT is becoming a primary diagnostic tool and use is on the increase province wide.



Goal 2: Operation of the CT Scanner according to the implementation plan and utilization.

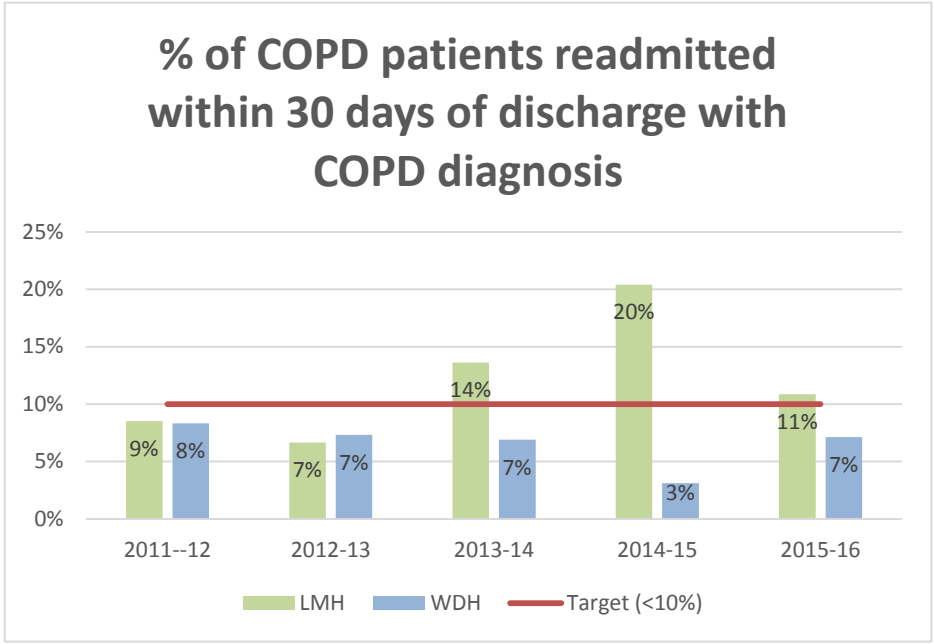
Change Ideas	Process Measures and Goals	Planned Actions
Ensure the CT Scanner is financially successful in terms of transportation and staffing costs.	Tracking costs of all Voyageur Transportation services in comparison 2016 year. **Target: Monitor** Tracking costs of diagnostic imaging CT call back hours for Listowel Memorial Hospital **Target: Monitor**	1. Manager to review Call Back and OT monthly for DI 2. Finance to provide quarterly reports on transportation costs and CT call back hours 3. Data is disseminated through the CT steering committee
Track and audit the ordering practices of our roster of physicians.	Average # of CT performed per business day **Target: 10**. # of CT scans rejected that were better managed using other imaging sources (ie. ultrasound) **Target: Monitor**	1. Number of CT exams will be monitored on a monthly basis by the DI Manager 2. Data shared with staff through means of the DI quality board, as well as the hospital board 3. Trending and review of ordering practices will be discussed at MAC level 4. CT scan rejections will be monitored through cerner data, if able. If unable, manual tracking is required.
To track and publically report exam wait times for scans.	Wait times priorities (P1, P2, P3, P4) to follow standards for reporting **Target: monitor in accordance to standards** Risk- may not have this data at onset of program **Priority 1 - Immediate (24 hours)** diagnose and/or treat disease or injury that is immediately threatening to life or limb **Priority 2- Urgent (48 hours)** diagnose and/or treat disease or injury and/or alter treatment plan that is not immediately threatening to life or limb. **Priority 3- Semi-urgent (2-10 days)** diagnose and/or treat disease or injury and/or alter treatment plan **Priority 4- Non-urgent (4 weeks/28 days)** diagnose and/or treat disease or injury, where, based on provided clinical information, no negative long-term medical outcome related to delay in treatment is expected for the patient if the examination is completed within the benchmark period.	1. Decision Support Analyst to collect data for DI manager 2. DI manager to compare to provincial standards 3. DI manager to update staff with results, may utilize DI quality board. Will also share data with leadership. *Goal of 2018 for public access as per WTIS.

Our Goals and Performance Targets - Effective

Goal 3: Improve the integrated care provided to patients that is evidenced by the reduction of unplanned readmission rates for patients with COPD (Chronic Obstructive Pulmonary Disease)

Priority

Patients leave hospitals after an illness with the expectation that they will not be experiencing an unplanned return to the hospital for care related to their initial admission. Unplanned readmissions are difficult for patients and costly to the health care system. Patients with COPD, within our LHIN, have a higher rate of readmissions. It is for these reasons that we will be implementing change ideas to reduce unplanned readmissions



Indicator
Proportion of patients discharged with chronic obstructive pulmonary disease (COPD) with a readmission to any facility with COPD within 30 days.

Target 2017-2018
Less than 10%

Target Rationale
The identified target is a reasonable target for the organization. There is little variability in our readmission rates per site from quarter to quarter

Current Performance Reporting Period
April 1, 2015 – March 31, 2016

Risks and Mitigation
Reaching this target is a moderate risk for the organization. The significant area of risk is the ability of the organization to resource the work based on competing priorities. This indicator is a priority indicator. N value is extremely low, thus quarterly reporting is not a true representation of current data. This indicator should be looked at semi-annually instead of quarterly due to low N value.

Goal 3: Improve the integrated care provided to patients that is evidenced by the reduction of unplanned readmission rates for patients with COPD (Chronic Obstructive Pulmonary Disease)

Priority

Change Ideas	Process Measures and Goals	Planned Actions
Implement Evidence Informed Care Pathways for patients with COPD	% of patient that are started on COPD care pathway **Target: 75%** % of patient that have COPD power plan initiated on admission **Target: 75%**	1. COPD quality group and steering committees have been secured. Continue to utilize and engage these staff members and FHT involvement. 2. COPD care pathway and power plans have been reviewed and passed for use. Continue to roll out PDSA: monitor patient diagnoses for use within both organizations. 3. Medical Records / Decision Support Analyst to gather data related to use of care pathways and COPD power plans on admission using Med2020. Data provided to clinical team for review. 4. Upcoming education by the FHT for all hospital nursing staff
Improve primary care follow up for patients with COPD	% patients discharged from hospital in our roaster or attached to physician of North Huron/North Perth Family Health Team that have contact with a primary care provider within 7 days of discharge **Target: 75%** # hours from when discharge summary is dictated from the physician to the date of patient discharge **Target: within 48hrs 90% of the time** # hours from when discharge summary is dictated from the date of patient discharge to the date of signed report by physician (then released to family physician) **Target: within 48hrs 80% of the time**	1. In collaboration with FHT, a follow up process has been established for LMH. 2. Transfer follow up booking process to WDH after FHT are settled into new location at Royal Oaks Health and Wellness Centre 3. Discharge summary information to be provided to the clinical team by the Decision Support Analyst for analysis (able to pull from cerner data) 4. Discharge results data to be taken to MAC/MSA 5. Organization wide implementation of auto-authentication for physician dictated reports.
Monitor conservable days for COPD patients	Conservable days: expected LOS vs actual LOS for COPD patients **Target: zero (monitor)**	1. Decision support to provide to Christine Reyes 2. Chris to monitor 3. Data to be reviewed at COPD working group and steering committees

Our Goals and Performance Targets - Safe

Goal 4: Improving patient safety by increasing the number of patients that receive medication reconciliation on discharge

Priority

It is essential that patients have accurate medication lists as they transition throughout the health care system. Errors related to medication reconciliation can cause unnecessary pain and suffering to the patient and increase cost to the health care system. While LWHA has made significant strides to the improvement of medication reconciliation through implementation of our electronic health record, we still have improvements to make. It is for these reasons we are committed to continuing our improvement.

Indicator

The total number of patients with medication reconciled as a proportion of the total number of patients discharged from the hospital

Target 2017-2018

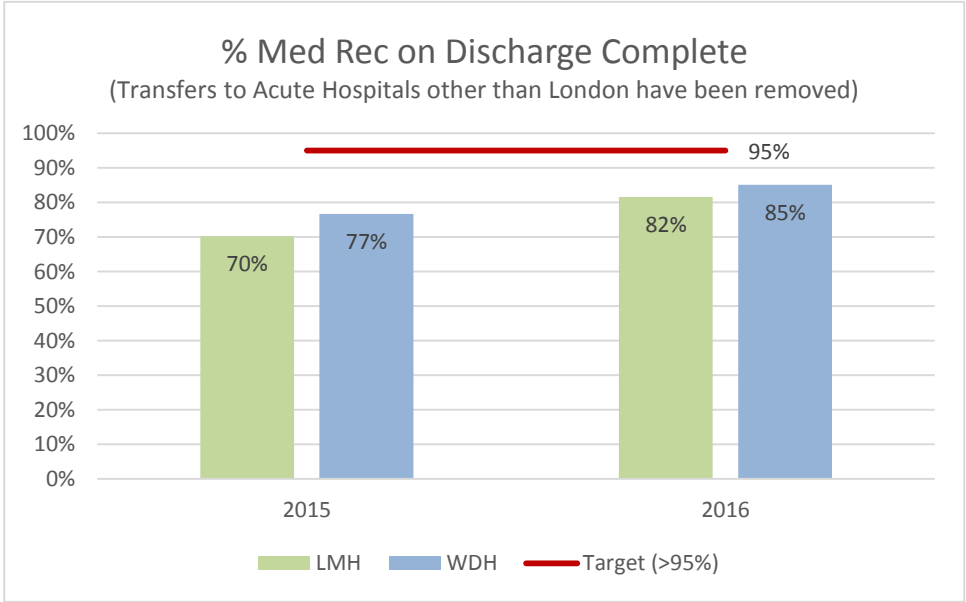
Greater than 95%

Target Rationale

The organization feels that this is an appropriate target based on current performance. Medication reconciliation is an essential patient safety initiative to ensure patient's safe transition of care upon discharge from the hospital.

Current Performance Reporting Period

Jan 2016 - Dec 2016



Risks and Mitigation

Reaching this target is a moderate risk. LWHA can meet this target; however, the quality of the discharge medication reconciliation should be considered in meeting this target. Mitigation strategies are identified in the "planned actions" and the organization had invested significantly in Clinical Informatics and Pharmacy Coordination resources in an effort assist with adoption and sustainability of electronic medication reconciliation.

Goal 4: Improving patient safety by increasing the number of patients that receive medication reconciliation on discharge

Priority

Change Ideas	Process Measures and Goals	Planned Actions
Implement delegated role of BPMH collection to pharmacy technicians and expand role of pharmacists to review BPMH	% of patient that had a BPMH conducted by a pharmacist or pharmacy technician within 72 hours of admission **Target: 80%**	1. PDSA trial completed in Listowel. Need to move and complete PDSA trial in Wingham. 2. Report for new admissions reviewed by pharmacist and pharmacy technicians to notify of BPMH's required 3. BPMH completed by pharmacist or pharmacy technicians for within 72 hours of admission 4. Track this using cerner, if able. If unable, track internally
Implementation of quality monitoring of BPMH and medication reconciliation completion	% of patients that have BPMH's completed within 24hours of admission **Target: 90%**	1. Tracking BPMH completion through Cerner Reports 2. Data is shared with ePractice Committee. (Report shows completed, not completed, not started) 3. Monitor provider compliance with medication reconciliation on admission and discharge, disseminate information to providers through MAC/MSA
Expand the role of the Pharmacist to conduct discharge med reconciliation in planned state prior to the patient being discharged.	% of completed discharge medication reconciliations facilitated by a pharmacist on patients with more than 10 medications or requested by a physician **Target: 25% of completed total discharge medication reconciliation**	1. Pharmacist conducts discharge med rec in planned state 2. Physician reviews pharmacist facilitated med rec from planned state 3. Physician makes changes and/or signs the discharge medication reconciliation. 4. Discharge Medication Plan is reviewed with the patient to inform patients of medication changes/updates (by nurse or by pharmacist).
With significant improvements on the number of medication incidents occurring within the organization, monitor the total number of incidents that occur, especially those causing harm to patients.	# of medication incidents per quarter **Target: Monitor** % of total medication incidents that cause harm to the patient (severity 3,4,5,6) **Target: <5% total incidents** *2015-16 data saw 7.2% harmful incidents (8/111)* *2016-17 data (Q1-3) saw 1.6% harmful incidents (1/62)*	1. When a medication incident occurs, staff report the incident using a submission through RL6 incident reporting system 2. All medication incidents are reviewed in high detail at committee levels, through the Safe Medication Committee and Pharmacy and Therapeutics Committee. 3. Quality improvements are identified and conducted through these medication reviews. 4. Medication incident data are posted on ED, Inpatient, Oncology and OB quality boards.

Our Goals and Performance Targets – Patient Centered

Goal 5: Improve patient and family centered care by implementation of 2 key actions within the domain of a Senior Friendly Hospital

Seniors are an important patient population that LWHA provides services for. It is vital that care is delivered in a manner that meets their unique needs. We are committed to ensuring the Seniors Friendly Framework is implemented to improve the quality of care provided.

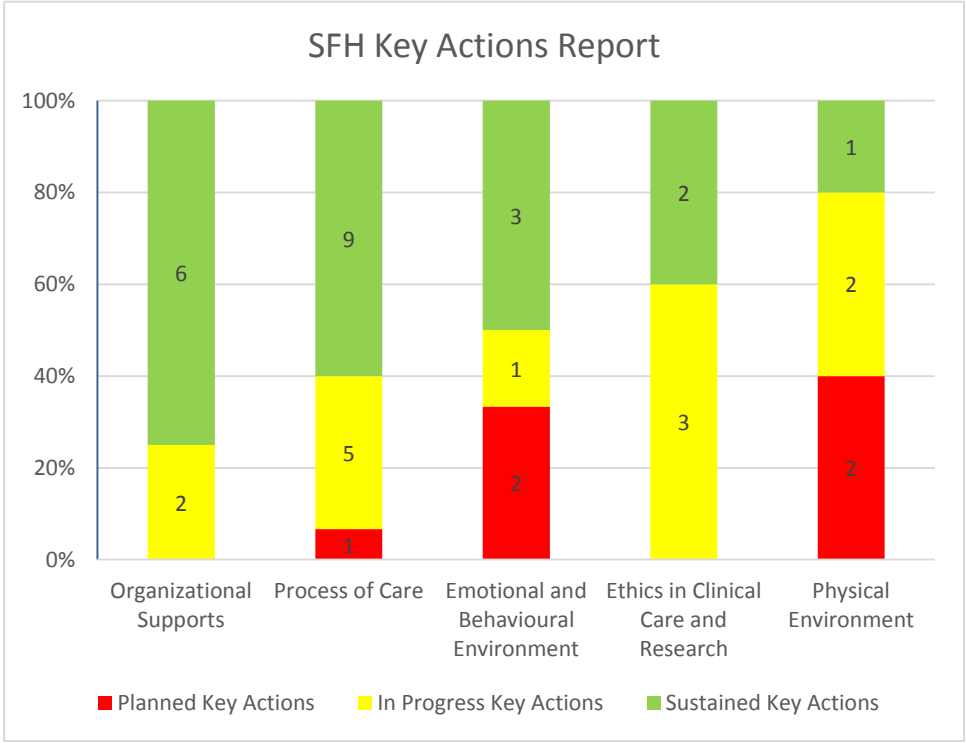
Indicator
Number of Senior Friendly Hospital (SFH) key actions in progress and sustained through the 5 SFH domains in this fiscal year.

Target 2017-2018
Minimum of 2 key actions moved to in progress or sustained within the 5 domains

Target Rationale
For 2016-17, LWHA began implementing 13 key actions and sustained 21 key actions from the senior friendly domains. Our goal regarding key actions in progress or sustained fits with an organizational senior friendly focus. The organization has a Senior Friendly Hospital specific quality improvement plan. The organization has invested resources to ensure that we make an improvement on our current state.

Current Performance Reporting Period
Internal 2016/2017 performance

Risks and Mitigation
The risks associated with this indicator are minor. The organization has secured resources and is well underway to achieving results. The SFH domains do not have equal workload, therefore one domain may surpass another.



Goal 5: Improve patient and family centered care by implementation of 2 key actions within the domain of a Senior Friendly Hospital

Change Ideas	Process Measures and Goals	Planned Actions
Sustaining the development of SFH key actions that were implemented in 2016-17	Annual environmental scans of hospital completed with a SFH lens **Target: 1 annually per site** Include senior friendly subcommittee members in project work for a SF focus **Target: Monitor**	1. Develop and implement environmental audit process that reviews the physical environment from a seniors perspective 2. Scan to be completed by senior friendly leads and maintenance 3. Develop plan to make improvements in the organization based on the environmental scan results, this may include a 5-10 year plan as developed by maintenance. 4. Share scan results with LWHA staff (ie. Newsletter) 5. Incorporate principles of Senior Friendly environment in areas of redevelopment in Wingham 6. Senior friendly subcommittee to be more involved in project work throughout the organization.
Sustainment of senior friendly sensitivity training within the organization (sustainment of 2016-17 key action)	% of staff that have participated in senior friendly (age) sensitivity training **Target: 75%**	1. Open training at orientation sessions to staff 2. Managers encourage staff to attend 3. Advertise session in newsletters 4. Staff attendance sheets
Continue to monitor, screen, diagnosis and treat delirium in the older adult (sustainment of 2016-17 key action)	% of delirium screens (CAM Tool) completed on adults aged 71 and over **Target: 80%**	1. Nursing screens all patients over the age of 71 for delirium. 2. Audits to be completed by inpatient managers and/or senior friendly PNLs or working group on patients over the age of 71 3. Education for staff was rolled out during CAM tool implementation, continue to educate based on audit results. 4. Develop lead champions in ED and Nursing units for screen that understand process and touch base with others
Implement and sustain an Incontinence Program, outlining the types of incontinence and management of incontinence, falls prevention with incontinence. (implement new 2017-18 key action)	% of patients with incontinence issues that have a fall **Target: < 5%** # of falls per severity level **Target: Monitor** % of falls that moderately to severely harm the patient (sev 4,5,6) **Target: Decrease by 25%**	1. Falls working group develop Incontinence Program 2. Education for Incontinence Program with Nursing 3. Continue to utilize post fall audits - Post fall audits have demonstrated that patients fall due to mobility issues, confusion and incontinence. 4. Review of new Falls Policy yearly via newsletter 5. Reporting of all falls monthly on Quality Boards

Our Goals and Performance Targets – Patient Centered

Goal 6 Improve patient centered care by focusing on increasing overall patient satisfaction with the care provided by the organization

Priority

Patients come to the hospital in a time when they are most vulnerable. It is essential that the care they receive while they are with us is of the utmost quality and the experience has a positive impact on their journey. LWHA is committed to continuing a high level of patient satisfaction.

Indicator

Overall satisfaction with the hospital (rating of excellent, excluding those surveys answered with good or poor) divided by the total number of survey responses

Target 2017-2018

Greater than 75% select excellent and good

Target Rationale

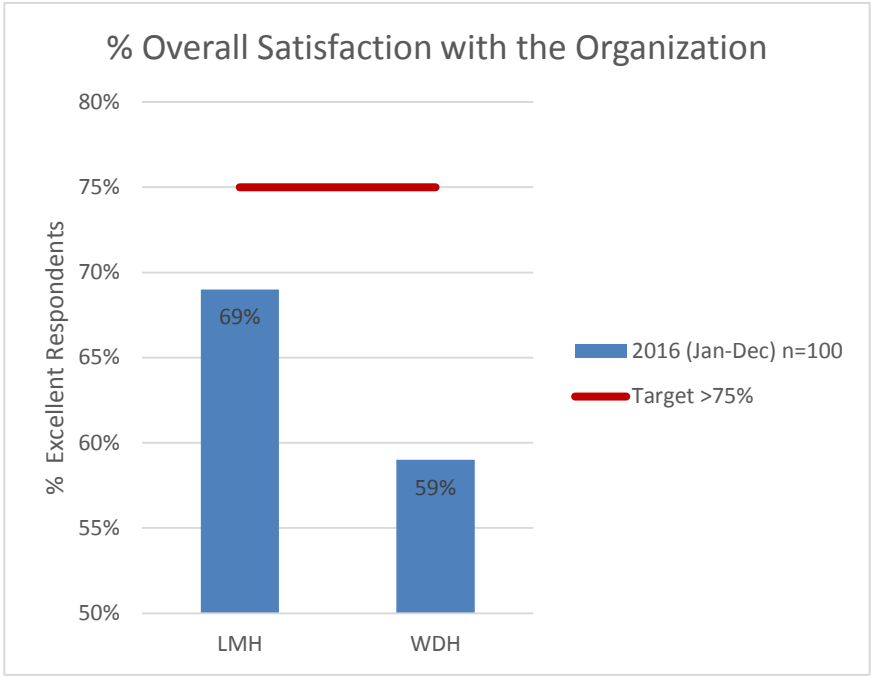
The organization has traditionally scored very high in patient satisfaction. In 2014 we moved from using NRC Picker to an internal survey tool. The organization is implementing patient experience surveys per department, as a way of obtaining meaningful feedback from patients and families. The target of 75% may require adjustment, as the overall satisfaction question has been revamped from previous, with the new adjustments as excellent, good or poor and the old rating scale as excellent, very good, good, fair, poor.

Current Performance Reporting Period

Jan 1, 2016 - December 31, 2016

Risks and Mitigation

Implementation of a new feedback process requires time and resources. The organization continues to ask patients for feedback and is looking at ways to sustain this program long term. Low sample rate return is a moderate risk of this indicator. Online and paper surveys will be utilized to mitigate this risk.



Goal 6 Improve patient centered care by focusing on increasing overall patient satisfaction with the care provided by the organization

Priority

Change Ideas	Process Measures and Goals	Planned Actions
Implement departmental patient feedback processes with overall satisfaction as an organizational focus.	# of patients that participate in patient surveying per site per month **Target: 10 patients (online, paper surveys with drop boxes, patient rounding)** % overall satisfaction with the ED LWHA (rating excellent) **Target: 75%** % overall satisfaction with the OB LMH (rating excellent) **Target: 75%** % overall satisfaction with the Oncology WDH (rating excellent) **Target: 75%** % overall satisfaction with the Inpatient LWHA (rating excellent) **Target: 75%** % overall satisfaction with the Surgical Services LWHA (rating excellent) **Target: 75%** % overall satisfaction with the Ambulatory Care LWHA (rating excellent) **Target: 75%** % overall satisfaction with the DI LWHA (rating excellent) **Target: 75%** % overall satisfaction with the Lab LWHA (rating excellent) **Target: 75%**	1. Implement and sustain internal process for patient feedback collection per department (to include online link, paper surveys with drop boxes, patient rounding) 2. Develop process to input paper surveys onto online link (via Executive Assistant manually inputting weekly) 3. Publish departmental results on quality boards quarterly. Data may also be disseminated to staff via newsletters, staff meetings, forums, etc. 4. Update patient feedback policy to reflect changes in practice 5. investigation of issues / comments brought forward on surveys via department managers, with data collated by the Patient Experience Coordinator
Inquire with patients regarding discharge information and determine needs of the patient.	% inpatients that answer strongly agree and agree to “I am satisfied with the discharge information that I received” **Target: 75%** % obstetrical patients that answer strongly agree and agree to “I am satisfied with the discharge information that I received” **Target: 75%** % surgical patients that answer strongly agree and agree to “My discharge instructions were discussed, easy to understand and follow” **Target: 75%**	1. Patients and/or family members to complete patient experience survey, whether online or via paper copy in department. 2. Data to be collated to the side questions by the Patient Experience Coordinator 3. Data to be shared quarterly with staff via quality boards, staff meetings, etc
Implementation of patient and family centered care framework	Patient and family centered care framework developed and education provided to all staff **Target: maintain** # Patient representation on care committees by end of 2018 **Target: 2 patients per committee** Care committees include (but not limited to) ED, OR, Medicine, Rehabilitation, OB, Lab, Pharmacy + Therapeutics, Infection Prevention and Control, ePractice and possibly oncology.	1. Develop an organizational plan to include patients in decision making 2. Provide education to staff and providers about patient centered care and the importance of communication 3. Solicit patient representative for Rehabilitation committee from a patient who participates in the new Rehab Program in Wingham 4. Include interest question on patient surveys.

QI Achievements from Previous Year (2016-17)

Indicator from 2016/2017	Current Performance 2016/2017	Target stated on QIP	Change Ideas	Change idea implement as intended (Y/N)	Lessons Learned
Reduce the ED length of stay for admitted patients	LMH 7.59 hours WDH 8.21 hours Reporting Period January 1 – December 31, 2016	6.5 hours	Implement changes to patient movement in the ED that are identified through VSM and reflect leading practices - % Triage training - % Triage reassessment audits - # PDSA patient movement from ED to inpatient unit - % Transfer of accountability - Monitor Turnaround times for patients that require DI from the ED	 Yes Yes Yes No Yes	- Transfer of accountability monitoring not completed due to a vacant position at WDH and use of resources - Communication working group established process for admissions from ED to Inpatient Unit in WDH (Jan-March), process taken to LMH Sept 12, 2016 - VSM movement of patients to ensure we are minimizing non value add time spent for patients. - Turnaround times for DI from the ED saw Order to Completion time in minutes as high. We will focus on this turnaround time in the upcoming fiscal year. Completed exam to Final results to physician timing was faster than anticipated. We will continue to monitor this time as 24 hr radiologist coverage is extended. - Auditing tool not developed for CNL's to focus on transfer of accountability. This will become a goal of next fiscal year under ED wait times again.
			Improve access for patients with mental health disease to specialized services - Increase patients utilizing OTN for mental health	Yes	- Mental health 24-hr crisis service now available, face-to-face or over the phone. - Internal method of tracking OTN usage developed
			Improve access to community support for patients with complex need (health links) - # pts frequently visiting ED that meet CCP criteria have one	Yes	- No tracking method for CCP completed through the Family Health Team, CCAC
			Additional process measure not included in QIP document: Manager reviews of charts of patients with admit times > 6.5 hours in the organization.	Yes	- Learnings: busy departments with multiple admissions waiting, call back for coverage Lab, DI, etc

Indicator from 2016/2017	Current Performance 2016/2017	Target stated on QIP	Change Ideas	Change idea implement as intended (Y/N)	Lessons Learned
Improve access to inpatient beds by reducing the percentage of Alternate Level of Care patients	LMH 5.5% WDH 15% Reporting Period October 1 2015- September 30 2016	LMH 5% WDH 8%	Implement early identification of patients that may have complex discharge needs at admission and daily at rounds - % escreener used - % staff education on escreener	 Yes Yes	Patients are identified during discharge rounds daily. We did implement the e screener but we found poor engagement. The discussion went to the fact that any of these patients with complex issues would be identified during daily discharge rounds and CCAC would be aware at rounds. There was discussion that it would be more beneficial for patients seen in the ED and discharged home but the form was developed for admitted patients. LWHA inquired regionally about Inpatient vs ED screening and it seems that everyone is doing different things. Some are not doing it at all, some are doing it on admission patients as they don't do discharge rounds and others were doing it but with poor engagement.
			Implement processes that assist patients with complex discharges to return home after hospital admission - # patients accessing home first - # CPP initiated in hospital - % staff education on CCP/health links - # patients responding 4/5 to discharge question in survey	 No Yes Yes Yes	Discharge survey questions were adjusted, as patients were not discharged at the time of manager rounding. Discharge question focused on "are you aware of/do you understand your discharge plans? Are you satisfied with these plans?" Home First is discussed at bullet rounds, individual must meet certain criteria to be eligible. Unable to track raw number of CCP initiated or identified in hospital due to various involvement of staff (ie. CCAC, Social work,etc) not being at the table for each CCP. LHIN was contacted and they are able to regionally track CCP, however, no specific data per local or hospital. Staff education electronically and through health link staff coming on site. Now part of general orientation.

Indicator from 2016/2017	Current Performance 2016/2017	Target stated on QIP	Change Ideas	Change idea implement as intended (Y/N)	Lessons Learned
Improving the integrated care provided to patients that is evidenced by the reduction of unplanned readmission rates for patients with COPD	LMH 13% WDH 20% Reporting Period January – Dec 2016 LWHA December data was calculated outside of coded data (therefore potential for # to adjust once coded data entered)	15%	Implement evidence informed care pathways for patients with COPD - % patients started on COPD care pathway - % patients that have COPD power plan initiated on admission	 Yes Yes	Small patient population Implemented care pathway and powerplan at WDH, move to LMH Continue to improve this fiscal year Established working group and steering committee for COPD work
			Improve primary care follow-up for patients with COPD - % patients seeing primary care provider within 7 days of discharge - % patients have CCP initiated in hospital - Discharge notes completed and transmitted within 48 hours	 Yes Yes No	Collaborated with the FHT Work ongoing and will continue into this fiscal year Education for nursing staff will be rolled out Feb 2017. Transitioning PDSA trial to Listowel Feb 2017. Discharge summary times was not reviewed internally, thus we will begin to review in the new fiscal year.
Improving patient safety by increasing the number of patients that receive medication reconciliation on admission	LMH 89.1% WDH 92.2% Reporting Period Q3 2016-17 (Oct 1 – Dec 31, 2016)	95% complete	Implement delegated role of BPMH collection to pharmacy technicians and expand role of pharmacists to review bpmh - % patients with BPMH reviewed by pharmacist/pharmacy tech after admission	 Yes	A PDSA regarding the completion of a patients' BPMH within 72 hours of admission is completed at Listowel Memorial Hospital. The pharmacy technicians found that they were dealing with a wide range of retail pharmacies and also found patient's own medications had frequently already gone home by the time they were able to do the BPMH
			Implementation of quality monitoring of BPMH and medication reconciliation completion - % patients with BPMH completed within 24 hours of admission - # PDSA completed to improve medication reconciliation	 Yes Yes	Continuing to audit and sharing overall results with physicians Clinical informatics team very involved, assist physicians with incomplete med recs with 1:1process Target low med rec compliance area (OB) PDSA trail in one hospital and move to other site once complete (see above process measure)

Indicator from 2016/2017	Current Performance 2016/2017	Target stated on QIP	Change Ideas	Change idea implement as intended (Y/N)	Lessons Learned
Improving safety by decreasing the number of injuries associated with falls	LMH 23.8% *(20/84 total falls)* WDH 31.7% *(19/60 total falls)* Reporting Period Sev 3,4,5,6 from April 1 2015 – March 31, 2016	Reduction in injury from falls by 10% (24.4% 2016-17) This Target was for 2016-17, however the current reporting period is 2015-16.	Implement intraprofessional care conferences with patients that have more than 1 fall - % of patients that meet the criteria for care conferences have one - % of patients that are satisfied with care conference process	Yes Yes	Completed PDSA trial, it was evident that patients/families were not satisfied, but rather it was seen as punitive and other patients/families had declined. Decision made to stop care conferences and approach from multidisciplinary rounds.
			Implementation of pharmaceutical review of medications for patients at risk of falling - % of patients screened as high risk have pharmaceutical review of medications - % of pharmacists' recommendations that are followed as a result of the review	Yes No	Process was implemented with the new falls policy. Education was rolled out to current staff and on orientation. When pharmacist has been involved in medication reviews post fall, recommendations were utilized by the ordering physicians. This practice of notifying the pharmacist for a medication review for high fall risk patients is not consistent across the organization. We were unable to successfully track implementation of pharmacist recommendations by physicians as recommendations are made verbally or via telephone.
			Implementation of a functional decline program (SFH indicator) - Program is developed and PDSAs are implemented	No	We are incorporating structure to lay down the foundation for this within the rehab program. So while we have not implemented a functional decline program, we are providing structure to build upon for this. This work will extend into CCC but not until 2017/18.

Indicator from 2016/2017	Current Performance 2016/2017	Target stated on QIP	Change Ideas	Change idea implement as intended (Y/N)	Lessons Learned
Improving patient safety by increasing the number of near misses reported Improving safety by decreasing the number of medication errors that reach the patient	Reporting Period April 1, 2015 – March 31, 2016 LMH 31.4% *(11/35 incidents)* WDH 51.3% *(39/76 incidents)* LMH 68.6% *(24/35 incidents)* WDH 48.7% *(37/76 incidents)*	Increased reporting of near miss and reportable incidents by 10% (49.5%) Decreased reporting in the number of errors reaching the patient by 10% (49.5%)	Further development of medication administration processes that support the safe delivery of care to patients - % of physicians that participate in CPOE education annually - % of staff that participate in eMAR and closed loop medication administration annually - % of bypassed medication scans - Cerner related issues reported on the Reporting Tool are resolved or communicated about within # business days	Yes Yes Yes Yes	Lists created for Accreditation purposes. Bypassed scan rates are audited and reviewed. High scanning rates in inpatient and operating room departments. Low scanning rates on OB. Group determined issues are related to workflow and education.
			Implement pharmacist review of discharge medication lists - # of patients that have a pharmacist's review of discharge medication list prior to medication reconciliation by provider	No	To be developed and implemented in this upcoming fiscal year to coincide with med reconciliation on discharge. Clear BPMH input allows for precise/accurate discharge medication reconciliation.
Improve patient and family centered care by implementing the Seniors Friendly Hospital Framework	LMH 86% WDH 86% Reporting Period Internal 2016/17 performance	75% indicators implemented	Development and implementation of a SFH improvement plan - Board adoption of SFH as a strategic direction - % of Board members that receive annual education on SFH - % of staff members that received education on SFH - # of environmental scans of hospital completed with a SFH lens - # of PDSAs completed on SFH indicators	Yes Yes Yes Yes Yes	Senior friendly is a part of hospital orientation through ageism training. Senior friendly practice nurse leads have been secured at both sites. Delirium screening continues on patients meeting the criteria. A working group to support, manage and prevent delirium is developing additional strategies to support these patients. The senior friendly committee is involved with the CT program to ensure they meet the needs of seniors. Senior friendly was adapted by the board as a strategic direction

Indicator from 2016/2017	Current Performance 2016/2017	Target stated on QIP	Change Ideas	Change idea implement as intended (Y/N)	Lessons Learned
Improve patient centered care by focusing on increasing patient satisfaction with the care provided by the organization – would you recommend this hospital?	LMH 89% WDH 91% Reporting Period: April 1, 2016-March 31, 2017 Data is from April 2016 to December 2016, no further surveys collected since this reporting period	89% to say Yes, they would recommend this hospital	Implement departmental specific patient feedback processes - % of patients that express satisfaction with care during patient rounding - Raw # of patients participating in patient rounding - % of satisfaction on DI and ED program specific feedback processes - % of patients that express satisfaction with care as a surgical outpatient	Yes Yes Yes No	Transitioned from mail out surveys to in house surveys. It was found that mail out surveys were very costly with a low response rate. In house surveys and online patient experience surveys are to be implemented organizationally. Staff education will be a large factor. A trial PDSA began on the obstetrical unit and will be rolled to all departments. It was found that many patients would recommend our hospital or services, reasons are unknown as this section was not widely used.
			Implementation of patient and family centred care framework - Patient and family centred care framework developed - # of initiatives implemented in order of priority (from Self-Assessment)	Yes No	Framework is under revision currently. LWHA experienced some internal position changes, thus impacting this work. The framework is being discussed at orientation with new hires and will be rolled through newsletter education with all staff.

Additional Narrative Requirements on HQO's Portal for 2017-18

Population Health

LWHA continues to reach out to our community healthcare providers and regional groups, such as the North Huron Family Health Team and North Perth Family Health Team (FHT), to facilitate patient flow and local coordination of patient care. Recent integrated project work includes a care pathway for patients admitted with COPD (Chronic Obstructive Pulmonary Disease). This unique patient population is at risk of re-admission due to lack of knowledge of community supports and patient management of COPD at home.

Upon discharge, these patients receive follow-up appointments with a primary health care provider within 7 days. Partnering with the FHT provides all involved parties with an understanding that an integrated healthcare system creates efficiency and allows for continuous improvement in quality. A key component to the success of all quality dimensions includes well informed staff and ongoing communication with our health care partners.

Equity

LWHA has provided cultural training for staff and at orientation in respect to patient centered care and involving the patient in his/her plan of care. While we cannot educate staff on the cultures they may encounter at our facilities, we can set an expectation of all staff to involve each patient on what his/her vision of culturally competent care involves. An LWHA patient experience survey asks patients if his/her cultural values were acknowledged by staff.

LWHW patient experience surveys also ask patients to identify and/or suggest any improvements that could be made to make our hospital more accessible, to the delivery of services, or for their overall experiences. Patients are able to make recommendations and all comments are internally reviewed and considered for improvement purposes.

Access to the Right Level of Care – Addressing ALC Issues

Alternate Level of Care (ALC) refers to patients who no longer need treatment in a hospital, but who continue to occupy hospital beds as they wait to be discharged or transferred to another care environment. LWHA, together with our partners such as FHT and the CCAC are active participants in the Huron Perth Health Link. The partnership allows collaboration to identify and/or develop coordinated care plans (CCP) for complex patients by discussing supports and programs available within the community for these patients. Over the 2017-18 fiscal year, LWHA hopes to continue to strengthen our partnerships and provide quality care for all patients. In addition, CCP involve discussions with patients, family members, caregivers to promote independence and to in turn decrease the burden on the hospital environment.

Staff Safety and Workplace Violence

Consistent with enhanced legislation, LWHA has undertaken a complete review of the LWHA Workplace Violence and Harassment policy, effective September 1, 2016 and have provided education for all staff. This includes enhanced screening for the risk of patient violence as well as communication processes among the healthcare team.

Employees report incidents into the RL6 electronic reporting system. An aggregate report of incidents by site is shared with the Joint Health and Safety Committee and the Leadership team on a quarterly basis. If there are trends of occurrences, these are discussed at either or both of these committees and efforts are put in place to reduce incidents. For example, we may need to staff up if there is a specific patient risk.

The Joint Health and Safety Committee has been consulted with respect to renovation drawings that may significantly change a layout (e.g. the Wingham Redevelopment drawings). These processes contribute to preventing staff safety risks when the committee assesses renovations from a risk perspective.

Over the past two years, the organization has provided all staff with Non-Violent Crisis Education training. This training is a full-day mandatory course for our staff and all new hires. Re-certification is required every two years so we are just approaching our timeline for recertification requirements.

Some other general safety initiatives that we have in place:

- Two main entrances for each hospital that are unlocked by day. Swipe access for every other point of entry. Single point of entry on night shift.
- Emergency Response Training, including Code White (aggressive person).
- Parking lot lighting.
- Security surveillance.

Alignment with Quality Based Procedures and other Provincial Initiatives

Developing our QIP was not done in isolation. LWHA is only one partner in a complex system to support patients and their families, as such, Provincial and LHIN strategic directions played a significant role in this document.

Health System Funding Reform (HSFR) and Quality Based Procedures (QBPS)

The LWHA Board continues to actively support efforts and adjust practices to meet new funding models that we are currently operating under. The clinical service plans continues to be the "road map" for the organization as we navigate through the HSFR. Leaders continue to be active participants on LHIN committees that are looking at realignment of resources to meet the needs of the population.

Quality Based Procedures (QBP) continues to be implemented as appropriate at LWHA. 2016-17 primary focus was Systemic Therapy and Endoscopy, while Low Risk Births will be the focus of 2017-18. Leaders are actively engaged with system partners to ensure that needs of our population are well served while striving for Safe, Patient Centered, Equitable, Timely, Efficient, and Effective care. As we continue our journey on QBP implementation, more alignment with practice guidelines will be achieved. Focus this year will be on COPD.

Ontario Wait Time Strategy

While LWHA does not participate directly in Wait Time Strategy programs, we are actively seeking opportunities with partners to ensure resources are well utilized and provide system relief where appropriate.

Care of Seniors

As the majority of patients we serve are seniors, it is essential that the organization pays significant attention to quality of care we provide to them. Focusing on ALC days, readmission rates, and implementing the Senior Friendly Hospital Framework will compliment the provinces and LHIN's focus on finding Quality care.

Health Links

We are active partners in the Health Links initiative in Huron and Perth. A number of process measures that will impact QIP goals, are designed to implement Coordinated Care planning for patients with complex needs.

Building Ontario's e-Health Framework

Continuing to improve our electronic health record will aid our ongoing patient safety efforts, including medication reconciliation. LWHA, along with the Thames Valley Regional hospitals, will begin planning for future Clinical Documentation portion of Cerner charting.

Miscellaneous

Information Management

LWHA continues to improve upon our Electronic Health Record to ensure expedited access to data to improve processes, inform decision making and improve efficiencies within the organization. Cerner is the main platform used to achieve this function. We continue to be in partnership with 10 Hospitals within the SWLHIN on the ongoing development and implementation. Future implementations include clinical documentation, device integration and decision support which will further improve the quality of care we provide to our patients.

Dissemination of data continues to grow within the organization. Implementation of quality reporting boards and provider specific dashboards are examples of how we are ensuring that information about the quality of care we provide is communicated to those that can have the most impact, direct care providers.

Finally, LWHA continues to have a strong safety reporting culture utilizing an on line reporting mechanism that allows for rapid review and response to incidents and areas of risk. This information is disseminated to the leadership team for discussion and the board for oversite.

Accountability Management

LWHA leadership are accountable to the patients we serve and the Board that represents the community for reaching the targets established in the QIP. The board clearly understands that defining and monitoring performance indicators to establish quality is a key governance and fiduciary responsibility

Performance Based Compensation

LWHA did not have any performance pay during the performance cycle ending before the effective date of March 31, 2012 (2010/2011 performance cycle pay). As stipulated in the Broader Public Sector Accountability Act, executive within our organization do not have any pay for performance tied to the achievement of targets in our 2017/2018 QIP.

Sign Off

I have reviewed and approved our organization's Quality Improvement Plan

Mr. Gord Hunt
LWHA Board Chair

Mr. Karl Ellis
LWHA CEO