Let's Make Healthy Change Happen.

Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

4/3/2018

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a Quality Improvement Plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein.

Overview

The Lennox and Addington County General Hospital is committed to providing the highest quality of care possible for the communities we serve. Our goal is to embed our core values – Teamwork, Respect and Communication into all the services we provide. Our Quality Improvement Plan is driven by our corporate mission to be a progressive hospital meeting the needs of our local communities through our people. Our 2018/19 Quality Improvement plan (QIP) sets out key strategies to enhance our quality of care, improve safety, increase satisfaction and achieve better clinical outcomes for patients and residents.

Again this year, we have aligned our QIP with our strategic plan, service accountability agreements, accreditation standards and best practices. This alignment allows better use of resources to the areas where they will have the greatest impact on improving patient satisfaction.

Our Quality Improvement Plan was developed in consultation with clinical teams, staff, patients, residents and members of our Patient and Family Advisory Council. Feedback from Patient/Resident Surveys, Incident Reviews and the Patient Relations Process were reviewed and provided assistance with the development of change ideas in the QIP.

QI Achievements from the past year

As part of the Accreditation program in June of 2017, our hospital underwent a rigorous evaluation process. Following a comprehensive self-assessment, two external peer surveyors conducted an on-site survey where they assessed our leadership, governance, clinical programs and services against Accreditation Canada Standards and Required Organizational Practices for quality and safety. Lennox & Addington Hospital attained the highest level of performance, achieving Exemplary standing. This accreditation decision reflects the extraordinary work that all staff, physicians and volunteers provide each and every day at the hospital while caring for patients and their families. In the Accreditation Report, the surveyors highlighted that “Lennox and Addington County General Hospital has a long history of being a quality driven, learning hospital. It is their way of doing their work. Community partners report that the organization focuses on what is best for the patient and how they can work together to make improvements.”

One of the leading quality improvement projects from the past year was to reduce the admitted patient’s length of stay in the Emergency Department. The length of stay in the Emergency Department for admitted patients is a well-recognized metric to measure capacity and efficiency. This has been an indicator on L&A’s Quality Improvement Plan for a number of years as well. The delays have a negative impact on patient safety and quality of care. In 2016/17, baseline data for Q4 found that it took on average 805 minutes for ED patients with a decision to admit until the time they arrived to their bed on the In-Patient unit. In an attempt to expedite this flow, the nursing department lead a QI project to eliminate delays and reduce the time admitted patients were spending unnecessarily in the Emergency Department. This new process was piloted and the results have shown a significant improvement. In the first quarter of 2017/18 our admitted patient’s length of stay in ED was reduced to 377 minutes. Since then, we have sustained the changes and our monthly average ED length of stay for admitted patients is 123 minutes.

Resident, Patient, Client Engagement and Relations

We have a variety of methods to engage patients and families in our quality improvement planning and our quality improvement activities. Information is gathered through:

- Patient satisfaction surveys from various departments in the organization
- Post discharge phone calls to ask about their total care experience. A scripted dialogue encourages feedback about their hospital stay, what we could improve on as well as confirming whether they are settling in well at home and whether they feel they had all the resources they needed when they arrived home.
- Patient and Family Advisory Council, who are actively involved as partners in driving quality and safety in all aspects of the patient experience. One member from our PFAC sits on our Board, as well as another member sits on our Quality Committee.
- Feedback received through compliments and complaints.

The information gathered from our patients, residents, caregivers and family members is used to identify successes and opportunities for improvement. Suggested improvements are used to identify areas of focus which drives the development of our QIP and quality improvement activities.

Collaboration and Integration

Our priorities are to provide efficient and timely access for patients and to improve our partnerships with external health care providers. We will continue to work collaboratively with the South East Local Health Integration Network (SELHIN), the SELHN Home and Community Care program, local Health Links, Community Mental Health, Long Term Care and other health care providers. The Lennox and Addington County General hospital continues to collaborate with our community healthcare providers with an understanding that an integrated healthcare system creates efficiency, improves outcomes and supports continuous improvement in quality.

The Ministry of Health and Long-Term Care Health Links initiative, in partnership with the South East LHIN, brings our partner healthcare organizations together to better and more quickly coordinate care for patients in our community who have complex needs by creating joint care plans.

Engagement of Clinicians, Leadership & Staff

The Lennox and Addington County General Hospital engages its staff, leadership team and physicians at all levels when developing the QIP. Department specific goals and metrics are developed to support and monitor strategic goals and quality improvement plans. Clinical teams, departmental meetings, Patient and Family Advisory Council, Medical Advisory Committee and Board meetings are just a few examples of engagement opportunities. The QIP was presented to the Quality committee and the Board for feedback and input as well.

Population Health and Equity Considerations

Chronic Obstructive Pulmonary Disease (COPD) is the fourth leading cause of death in Canada and a leading cause of morbidity in Canadian adults. Acute exacerbations of COPD are associated with accelerated decline in health and a substantial mortality rate. These acute exacerbations of COPD are a major cause of hospitalization and emergency department visits in our region.

A COPD Clinical Steering Team was launched in January 2016 with regional representation from Medicine, Nursing, Allied Professionals, SELHIN and Patient Advisors from all seven hospitals. The goal of this Steering Committee is to help patients manage COPD at home and decrease ER visits and hospital admissions related to COPD by providing a standardized approach across the region. L&A Hospital is the pilot site for this program in our region and has put the following plans in place to help patients manage better at home. Patients are screened during their admission and those are assessed to have a MRC Breathless Scale of 4 or 5 (moderately severe to severe disease) are entered into the Breathe Program. This involves the following:

- Referral to Respiratory Therapist who coordinates care with the Hospitalist to involve the Physiotherapist, Dietitian, Social Worker
- Assurance that baseline spirometry for diagnosis and staging has been done and if not, then testing will be arranged.
- Evaluate, engage, assess and educate patients
- Provide support through Hospice
- Following a hospital visit, their discharge summary is forwarded to their family physician, Hospice and a copy is sent home with the patient.
- Smoking cessation interventions are offered with follow up in the community, if the patient consents.
- A help line has been implemented.
- Access to Health Links is provided
- Referral to SOB (Shortness of Breath) Dyspnea Clinic in Kingston, where appropriate.
- Home Care Rapid Response Nurse will visit within 48 hours of discharge.
- Follow up with a primary care provider within 2 weeks or COPD clinic, if patient is unattached.
- A BREATHE Clinic has been established on Monday afternoons for any discharged patients to attend and review management with the RRT or the NP.
- Pulmonary Rehab Program is offered and initiated within 4 weeks of discharge from hospital.
- Prior to discharge, patients will be provided with a discharge planning check list and a COPD Action Plan.
- Telemedicine is available for patients in their homes and can have access to the RRT or NP by videoconference during business hours.

Access to the right level of Care – Addressing ALC

LACGH participates in a regional patient flow group that focuses on ensuring patients receive the best care as close to home as possible. This has resulted in a standardized regional repatriation process that has been endorsed and implemented in all seven regional hospitals.

The Convalescent Care unit at LACGH focuses on restoration of strength following deconditioning. The deconditioning could be as a result of hospitalization, surgery or general functional decline. Residents are admitted from anywhere throughout the region and stay for up to 90 days. The goal of the program is to recondition seniors to a point where they are able to return safely to their own homes.

Home First is an ongoing philosophy of care that has recently been refreshed at LACGH. The goal is to avoid ALC admissions by supporting patients to return home to wait for the most appropriate setting. The Home First initiative coupled with effective discharge planning has resulted in a decreased number of ALC patients at LACGH. We have made great progress this year in reducing our ALC patients with a goal to sustain the progress we've made in the upcoming year.

Finally, effective regional chronic disease management, specifically with COPD, will create a standardized, best practice approach to care that will decrease the demands on acute care facilities and the potential of ALC for these patients.

Opioid Prescribing for the Treatment of Pain and Opioid Use Disorder

Health Quality Ontario has reported that despite the increasing numbers of opioid-related deaths and the growing prevalence of opioid addiction, the total number of prescriptions filled in Ontario continues to rise. L&A Hospital Clinicians have implemented several processes to support better prescribing practices and reduce easy access to unnecessary opioids to improve prevention, treatment and harm reduction associated with problematic opioid use. These include:

- Current opioid and other pain medications are documented on admission in the Best Possible Medication History (including time of most recent dose taken)
- Pain is assessed and documented by nurses on admission and during every shift; a detailed pain assessment tool is available for patients with acute pain requiring "as needed" analgesics
- An independent double check is required for opioids administered by injection; an independent double check is required for wastage of fentanyl transdermal patches and used narcotic infusion pump cassettes
- All prescribing is done electronically and order sets are available for narcotic infusion pumps used in palliative care and severe chronic pain
- Methadone is available for patients on methadone maintenance therapy
- An interdisciplinary approach is used to manage severe pain and Anesthesia may be consulted to provide alternatives or adjuncts to opioids
- Opioids are supplied in unit of use strengths, whenever possible
- Discharge prescriptions are generated electronically and reviewed by a pharmacist; prescriptions are faxed to a community pharmacy and quantities of prescribed opioids are minimized to reduce potential misuse

Workplace Violence Prevention

Updates to many of the Hospitals' policies, including Workplace Violence and Harassment were performed in 2017/18. Additional revisions included an expanded definition of workplace harassment, including sexual harassment, and a detailed process regarding complaints and investigation procedures.

Incidents of workplace violence (patient to staff) are documented in the incident reporting system and followed up by management and presented to the JOHSC. Reports of internal complaints (staff to staff) are reported and investigated as detailed in the Hospital's Workplace Violence and Harassment Prevention policy.

New employees complete Workplace Violence and Harassment Prevention training during their orientation, and all employees are required to complete an annual review of this policy. This training includes definitions of workplace violence and harassment, reviewing roles and responsibilities, reporting and investigation procedures and handling of complaints.

The JOHSC facilitates the assessment of risks associated with workplace violence and identifies any action required to eliminate or minimize violence in the workplace. These assessments are reviewed at least annually, or as required following an incident or concern.

During 2017, the Hospital implemented a new Non-Violent Crisis Intervention training for all ER staff and select staff in Acute Care. Two individuals were selected and have been trained as program trainers and have now begun to conduct the training sessions for identified staff.

In addition, an assessment of the security Guard coverage was reviewed and the hours were increased to 10 hours per day from 8 hours per day.

For the upcoming year, we will be implementing many of the Public Services Health & Safety Association's Violence, Aggression & Responsive Behaviour (VARB) tools.

Performance Based Compensation

It is mandatory under the Excellent Care for All Act (ECFAA) to link compensation for the Chief Executive Officer (CEO) and other executives reporting to the CEO to the achievement of performance targets in our organizations Quality Improvement Plan (QIP).

Performance-based executive compensation is linked to achieving specific QIP targets, as well as achieving success on selected corporate goals and objectives.

The amount of compensation that is performance-based for the executive team has been set at 3% for 2018/19 year. The performance-based compensation will be tied to the achievement of the following QIP indicators as well as the achievement of selected corporate goals and objectives:

1) Setting up a process with Health Links to identify in-patients that meet the criteria for Health Links and offering them access to the program.
2) Develop a malnutrition screening tool and include it in the Meditech admission profile. Conduct monthly audits to ensure the tool is being used.
3) Conduct a workplace violence risk assessment using the new VARB tool and develop/implement controls to avoid risk.
4) Develop a flagging system on the Inpatient unit to identify potentially violent or aggressive patients. The goal is to have the final process in place and implemented by April or May of 2018.

Contact Information

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Sign-off

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

Board Chair _____ (signature)
Allan MacGregor

Quality Committee Chair _____ (signature)
Elaine Stillwell

Chief Executive Officer _____ (signature)
Wayne Coveyduck

Director Quality, Support Services and Operational Efficiencies

_____ (signature)
Nancy Manion

2018/19 Quality Improvement Plan
"Improvement Targets and Initiatives"

Lennox And Addington County General Hospital 8 Richmond Park Drive

AIM		Measure								Change				
Quality dimension	Issue	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for Measure	Comments
Effective	Coordinating care	Percentage of patients identified with multiple conditions and complex needs (Health Link criteria) who are offered access to Health Links approach	A	% / Patients meeting Health Link criteria	Hospital collected data / most recent 3 month period	592*	No Data	90%	To improve coordination of care between the Hospital and Health Links.	To identify weekly the inpatients with multiple conditions and complex needs that meet Health Links criteria. Ensure there is a process in place to offer them access to Health Links prior to discharge.	The Social Worker and Health Links will work together to identify patients and offer them access to Health Links.	Target is to offer 90% of eligible inpatients access to Health Links prior to discharge.	Jun-18	
	Effective transitions	Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?	P	% / Survey respondents	In-house Survey Question #16 2017 Survey Results	592*	91%	95%	Improving current performance.	Identify whether patients have any additional questions and ensure they have the appropriate resources after discharge.	Continue to conduct post discharge phone calls within 72 hours of discharge and review results with the PFAC and clinical teams.	Review post discharge phone call data monthly at clinical team meetings and bimonthly at PFAC to trend for communication gaps, opportunities to improve or identify support for patients.	Monthly review of data.	
										Improve information sharing at discharge.	Improve the use of the standardized discharge summary.	# of patients provided with a completed discharge summary.	Monthly Audit	
		Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort)	P	Rate / COPD QBP Cohort	CIHI DAD / January - December 2016	592*	19.03	17.12	Internal target 10% reduction.	Assist patients to manage COPD at home which will decrease ER visits and hospital admissions related to COPD.	1. Develop and implement an evidence based COPD order set. 2. Home care rapid response nurse will visit within 48 hours of discharge.	Audit the use of the COPD order set . Audit the use of Home Care rapid response Nurse.	Review audit results. To Quality Committee Quarterly.	Regional COPD work is ongoing. LACGH has implemented the BREATHE Program.
	Effective Transitions	Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	P	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / October 2016 - September 2017	54783*	5.43	5.0	Reduce by a further 0.5% (Reduced by 25% last year) Low volumes affect fluctuating variance.	Ambulatory care sensitive conditions will be addressed early by the Nurse Practitioner and LTC physician. Any situations where failure to rescue results in an ED visit will be reviewed by the team.	Conduct case by case review when ED visit occurs to determine root cause and make recommendations to prevent reoccurrences.	Charge nurse to conduct case review on every ED transfer with presentation of findings to the CVC clinical team.	Ongoing	
		The percent of residents with an EMS score of <10 on admission and >10 at discharge.	A	% LTC Home Residents.	In-house collection. 2017	54783	76%	80%	Residents with a score of <10 are dependent in their level of function. Score of >10 are reaching independence in their level of function which may prevent LTC and/or increased CCAC services. Our goal is to improve our residents EMS score to >10 prior to discharge.	On admission every resident is assessed to identify their EMS score.	Within 7 days of admission every resident will have a rehab care plan developed.	EMS scores are re-assessed prior to discharge and compared to admission scores. Surveillance tool set up to collect data.	Ongoing	

AIM		Measure								Change				
Quality dimension	Issue	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for Measure	Comments
Efficient	**Access to right level of care**	Total number of alternate level of care (ALC) days contributed by ALC patients within the specific reporting month/quarter using near-real time acute and post-acute ALC information and monthly bed census data	P	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July - September 2017	592*	28.8	39	SELHIN target identified in HSAA. (Numbers really fluctuate from month to month. Current performance is for Q2 which was exceptionally low)	To continue to coordinate discharge planning process with both LHIN HACC and Health Links.	Review at weekly rounds, the ALC patients occupying Acute Care beds. Conduct full multidisciplinary meetings with families and patients to plan for discharge.	Monitor daily, the numbers of ALC in Acute Care beds and report on Monthly QIP Summary report and Balanced Scorecard to Quality Committee.	Monitor daily and report monthly	We have had a great success over the past year and would like to build on that momentum.
										Prevent further deconditioning of residents by improving nutrition.	Implement a process to identify and assist patients who require meal set up and those requiring assistance with feeding.	Begin using new process to assist patients during meal.	Jun-18	
Safe	**Safe care**	Percentage of residents who fell during the 30 days preceding their resident assessment	A	% / LTC home residents patient days	In-house data	54783*	6.56 Oct - Dec 2017	6.5	The goal of our residents is to increase mobility so the risk of falls is higher. We need to ensure resident safety and mitigate high risk. Continue to monitor.	Our resident population is rehab and, therefore encouraging mobility is a key focus, which increases our resident risk of falls. All resident falls will be reviewed by the multidisciplinary team.	For each resident fall, registered staff will complete an incident report, fall assessment and progress note and suggested interventions that need to be implemented.	Falls will be tracked on a monthly basis, reviewed by the multidisciplinary team and reported to the quality committee monthly.	Ongoing	CIHI limits data at >92 days. Most of our patients are here <90 days, therefore we use In-house data.
	Safe care/Medication safety	Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion of the total number of patients discharged.	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / October – December (Q3) 2017	592*	98.78% Apr. 2017 - Jan. 2018	100%	Goal is to achieve and Maintain 100%	Monitor compliance monthly and address gaps with all missed opportunities on an individual physician bases.	Pharmacist attends daily rounds and highlights missed opportunities to ensure timely follow up with hospitalist. Optimization of electronic documentation.	Monthly compliance rates reviewed by Quality Committee.	Ongoing	
	Workplace Violence	**Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.**	**M**	**Count / Worker**	**Local data collection / January - December 2017**	**592***	**CB**	**CB**	**Provide a safe environment for staff and visitors. Collect baseline data.**	**Use the Violence Aggressions & Responsive Behavior (VARB) tools to reduce workplace violence incidents and impact of aggressions, violence and responsive behaviors.**	**Conduct a workplace violence risk assessment using the VARB tool**	**With input from the JOHSC, the hospital will review the workplace violence assessment, categorize hazards and develop controls.**	**Review the results of the assessment tool with the JOHS. June 2018**	192 FTE's.

AIM		Measure								Change				
Quality dimension	Issue	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for Measure	Comments
										Improve communication regarding potentially violent patients.	Provide workers on the Inpatient unit with information about a history of violence.	Develop a flagging system on the Inpatient unit to identify potentially violent or aggressive patients.	100% of patients who are identified at risk of violence will have a flag applied to their electronic chart and a symbol posted at the bedside. April 2018	

Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2017/18 QIP

The Progress Report is a tool that will help organizations make linkages between change ideas and improvement, and gain insight into how their change ideas might be refined in the future. The new Progress Report is mostly automated, so very little data entry is required, freeing up time for reflection and quality improvement activities.

Health Quality Ontario (HQO) will use the updated Progress Reports to share effective change initiatives, spread successful change ideas, and inform robust curriculum for future educational sessions.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
1	"Would you recommend this emergency department to your friends and family?" (%; Survey respondents; April - June 2016 (Q1 FY 2016/17); EDPEC)	592	88.00	93.00	92.00	We continue to work on wait time initiatives.

Realizing that the QIP is a living document and the change ideas may fluctuate as you test and implement throughout the year, we want you to reflect on which change ideas had an impact and which ones you were able to adopt, adapt or abandon. This learning will help build capacity across the province.

Change Ideas from Last Years QIP (QIP 2017/18)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Improve the flow of patients in the ER in order to reduce wait times.	Yes	The addition of an RPN to the ER team to assist with timely flow of admitted patients and assist with improving the flow in the department.
Improve wait times for ER admits to IPU bed.	Yes	The ER team and IP team conducted a quality improvement initiative to design a process to move admitted patients to the IP unit in a timelier manner. This new process requires the ER & IPU teams to work together to get patients to an IPU bed as quickly as possible. Wait times for ER admits have improved by 81%.
Decrease repeat visits for Mental Health patients.	Yes	Community Mental Health (CMH) provides support in the hospital ER department. Implemented a suicide assessment tool.
Increase support available to Mental Health patients.	Yes	CMH is now present in the ER after hours and on weekends. Pilot started in the winter of 2017 and has been successful. A case will be developed by CMH to expand services even further.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
2	"Would you recommend this hospital to your friends and family?" (Inpatient care) (%; Survey respondents; April - June 2016 (Q1 FY 2016/17); CIHI CPES)	592	1.00	100.00	100.00	Very positive feedback. We will continue to make improvements based on patient recommendations from feedback.

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Change Ideas from Last Years QIP (QIP 2017/18)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Use visual management tools to communicate expected date of discharge (EDD) to patients and families.	Yes	Communication boards are located at each bedside. EDD is written on the board. The healthcare team works with the patient and family to meet the discharge goal. Physicians receive EDD reports. Multidisciplinary team conducts daily rounds and use the rounding board as a visual tool which summarizes the progress of all patient on the In Patient unit.
Improve patient experience by consistent communication with health care provider.	Yes	Standardized discharge summary implemented in August 2017. Health Links participates in weekly rounds. ELOS & ALOS are concurrently coded for each admitted patient Post discharge phone calls are conducted within 2 weeks of discharge.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
3	Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital? (%; Survey respondents; April - June 2016 (Q1 FY 2016/17); CIHI CPES)	592	CB	CB	91.00	Question has been added to patient satisfaction surveys.

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Change Ideas from Last Years QIP (QIP 2017/18)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Improve information sharing at discharge.	Yes	Electronic discharge Summary sheet implemented. Completed by physician and nurse and printed out at discharge. Includes medications, follow up appointment etc.
Identify whether patients have any additional questions and ensure they have the appropriate resources after discharge.	Yes	Post discharge phone calls (within 2 weeks of discharge) help to identify patient concerns. Concerns are addressed as information is received.
Partner with patients to determine whether they feel they are receiving enough information.	Yes	Post discharge phone calls are conducted within 2 weeks of discharge. Patients are asked if they received enough information at discharge as well as additional questions to ensure they are coping well at home.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
4	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 (Rate per total number of admitted patients; Hospital admitted patients; Most recent 3 month period; Hospital collected data)	592	94.00	100.00	97.00	We are above the provincial average for this indicator.

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Change Ideas from Last Years QIP (QIP 2017/18)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Monitor compliance monthly and address gaps with all missed opportunities on an individual physician basis.	Yes	Monthly compliance is sent to the Chief of Staff. COS follows up with physicians for all missed opportunities.
Reduce medication errors and improve patient safety.	Yes	Medication incident reports are reviewed as they occur by the Pharmacist and Nursing. The Medication Safety Team reviews bimonthly and develops and implements strategies for improvement.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
5	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. (Rate per total number of discharged patients; Discharged patients ; Most recent quarter available; Hospital collected data)	592	99.00	100.00	98.78	We are exceeding the provincial average. Monthly rates are between 95 are 100%.

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Change Ideas from Last Years QIP (QIP 2017/18)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Monitor compliance monthly and address gaps with all missed opportunities on an individual physician basis.	Yes	Monthly report is sent to the Chief of Staff. COS follows up on all missed opportunities with physician.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
6	Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (Rate per 100 residents; LTC home residents; October 2015 - September 2016; CIHI CCRS, CIHI NACRS)	54783	7.02	5.30	5.43	The number of admissions from LTC are very low.

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Change Ideas from Last Years QIP (QIP 2017/18)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Ambulatory care sensitive conditions will be addressed early by the Nurse Practitioner and LTC physician, therefore, reducing the need for ED visits.	Yes	Nurse Practitioner and CVC Medical Director work together to address resident's medical concerns and to avoid ER admissions.
Identify situations where failure to rescue occurred resulting in resident transfer to the ED.	Yes	All ER visits from LTC are reviewed case by case. There were no **avoidable** visits in 2017.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
7	Percent of palliative care patients discharged from hospital with the discharge status "Home with Support". (%; Discharged patients ; April 2015 – March 2016; CIHI DAD)	592	100.00	100.00	100.00	Majority of patients admitted to Palliative Care are at end of life. Very few return home.

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Change Ideas from Last Years QIP (QIP 2017/18)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Ensure that patients discharged from hospital to community to receive end of care at home, are supported by resources needed.	Yes	LACGH partners with HOSPICE L&A and Home Care to ensure patients/families receive support and to ensure that all needs are met. HOSPICE L&A and the Home Care coordinators are located on site at the hospital.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
8	Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (%; LTC home residents; April 2016 - March 2017; In house data, NHCAHPS survey)	54783	93.00	98.00	95.00	This indicator is reviewed by the CVC Clinical team. Improved by 2% over last year.

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Change Ideas from Last Years QIP (QIP 2017/18)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Satisfaction survey given to resident at discharge.	Yes	All discharged residents receive a survey before leaving. Survey response rate is 87%. Survey results for “Would you recommend” was 100% for 2017/18 surveys.
Post discharge phone calls conducted to every resident.	Yes	Post discharge phone calls occur within 30 days of discharge. Recommendations for improvement are identified and improvements made.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
9	Percentage of residents who respond positively to the question: "would you recommend our Convalescent Care program to others? (%; Residents; April 1, 2017 - March 31, 2018; In-house survey)	54783	100.00	100.00	100.00	Residents are very satisfied with the program. We get many positive comments.

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Change Ideas from Last Years QIP (QIP 2017/18)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Satisfaction survey given to residents at discharge.	Yes	Paper surveys are given to each resident at discharge. Results of survey and comments are shared with the CVC team and reviewed at Quality. Suggestions from feedback are followed up with and improvements made whenever possible. Survey results for “Would you recommend” was 100% for 2017/18 surveys
Post discharge phone calls conducted on every resident.	Yes	Phone calls are a great way to obtain a more detailed verbal feedback through direct dialogue with the resident.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
10	Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (%; LTC home residents; April 2016 - March 2017; In house data, interRAI survey)	54783	98.00	100.00	97.00	100% goal is stretch target. 1 resident can prevent goal from being achieved.

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Change Ideas from Last Years QIP (QIP 2017/18)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Continue with patient centred care strategies to include patients in decision making.	Yes	Care plans are developed with resident and family input and goals are set on admissions. Both residents and HCP have embraced the team approach of involving residents and families in their plan of care and goal setting.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018
11	Percentage of residents who were given antipsychotic medication without psychosis in the 7 days preceding their resident assessment (%; LTC home residents; July - September 2016; CIHI CCRS)	54783	0.00	4.00	The provincial average for LTC antipsychotic use is 28%.

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Change Ideas from Last Years QIP (QIP 2017/18)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Optimize drug utilization. Our resident population is rehab and therefore the use of antipsychotics is quite low.	Yes	A small number of residents are admitted with antipsychotics previously prescribed. In these cases, the Medical Director and the Nurse Practitioner work with the resident to wean them off of the medication during their stay if possible.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
12	Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort) (Rate; COPD QBP Cohort; January 2015 – December 2015; CIHI DAD)	592	21.69	17.35	19.03	Data from CIHI continues to be delayed. In-house data used.

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Change Ideas from Last Years QIP (QIP 2017/18)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Create a standardized discharge checklist of safe discharge practices for COPD patients.	Yes	The multidisciplinary team developed and implemented the standardized discharge checklist.
Support people in our community with COPD by providing education and an exercise program to ensure they are functioning at their highest possible level.	Yes	Respiratory Therapist has been assigned the role of COPD navigator. Patients receive home visits, access to online resources, follow up phone calls, access to 24/hr hotline.
Develop regional COPD care plan for patients in the SE LHIN to improve consistency of care, reduce need for hospital admission, urgent/emergent care. The original plan developed in 2016/17 has been modified to include implementation of CFHI's INSPIRED COPD care plan, thus involving community care providers. Resources to adopt "INSPIRED".	Yes	Breathe Program has been implemented at LACGH based in the regional INSPIRE program. During the upcoming year we will define and develop quality indicators to determine the impact the Breathe Program has had on readmissions rates and implement further strategies as necessary.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
13	Total ED length of stay (defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ED) where 9 out of 10 complex patients completed their visits (Hours; Patients with complex conditions; January 2016 – December 2016; CIHI NACRS)	592	9.68	1.00	7.47	

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Change Ideas from Last Years QIP (QIP 2017/18)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Trial an over capacity ER clinic to reduce the numbers of CTAS 4 & 5 patients in ER and increase flow, therefore, reducing the PIA for patients.	Yes	After hours clinic trial was conducted from February 27, 2017 to June 29, 2017. Patients were able to pre-book appointments which reduced PIA and provided an after hour service for CTAS 4 & 5 patients.
Improve process to transfer admitted patients from the ER to the IP unit.	Yes	The ER team and IP team conducted a quality improvement initiative to design a process to move admitted patients to the IP unit in a timelier manner. This new process requires the ER & IPU teams work together to get patients to an IPU bed as quickly as possible. Wait times for ER admits have improved by 81%.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
14	Total number of alternate level of care (ALC) days contributed by ALC patients within the specific reporting month/quarter using near-real time acute and post-acute ALC information and monthly bed census data (Rate per 100 inpatient days; All inpatients; July – September 2016 (Q2 FY 2016/17 report); WTIS, CCO, BCS, MOHLTC)	592	43.75	30.25	28.8	Data is calculated cumulative. Has showed 8% improvement over last year.

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Change Ideas from Last Years QIP (QIP 2017/18)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Conduct Home First refresh hospital wide.	Yes	Six Home First Philosophy educations sessions offered hospital wide in February 2017. 93 staff members attended education sessions.
Find alternate setting for patients awaiting LTC placement in order to free up hospital acute care beds.	Yes	The multidisciplinary team made up of the Social Worker, Home and Community Care and Health Links work together to move ALC patients to the most appropriate setting to wait for their preferred LTC home. Home and community Care work in partnership to support patients as much as possible while they wait at home for an available LTC bed.