# 2022/23 Quality Improvement Plan
# "Improvement Targets and Initiatives"

London Health Sciences Centre

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| AIM | | Measure | | | | | | Change | | | | |
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| Quality Dimension | Issue | Measure/Indicator | Unit / Population | Source / Period | Current performance | Target | Target justification | Planned improvement initiatives (Change Ideas) | Methods | Process measures | Target for process measure | Comments |
| Safe | Wellness | Wellness of Our People: Understanding our staff, physicians, learners, and volunteers feelings of level of support from leaders<br><br>Self-Perception of Support | %/our people that completed survey | Hospital collected data /most recent 3 month period | 60% | 65% | Continue to improve towards target. | Launch a comprehensive, sustainable mental health strategy to support staff, leaders, professional staff, learners and affiliates | 1) Mental health education and training for leaders (mandatory)<br>2) Mental health education for all staff (optional) including a mobile app to track/refer in the moment<br>3) All Staff Support Team members to complete Applied Suicide Intervention Skills Training (ASIST)<br>Occupational Stress Injury Education and Prevention Training for staff, professional staff, affiliates, learners (optional) | % of leaders completing training<br><br>% of staff who attend training<br><br>% of staff who complete ASIST Training<br><br>Regularly scheduled sessions annually | 85% of leaders completed training at any time we audit<br><br>100% of staff support team<br><br>Training sessions offered each quarter and upon request by teams | |
| | | | | | | | | Targeted focus on leader wellness and engagement | 1) Workplace Wellness Certificate Program for Leaders (optional)<br>2) Launch iLearn module for all leaders (mandatory)<br>3) Leading with C-A-R-E Framework to support leaders doing wellness checks with staff<br>4) Joy at Work monthly engagement strategies done in collaboration with unit Wellness Champion | Cohort each year offered to leader with 8 months to complete all modules<br>iLearn assigned to all leaders<br>Leading with CARE embedded in units<br>Wellness Champions in each unit to assist with Joy at Work initiatives | 100% completion rate of cohort<br><br>100% compliance with iLearn completion<br><br>Each unit has assigned Wellness Champion | |
| | | | | | | | | Align wellness strategies to Excellence Canada's Healthy Workplace Standards for psychological safety | Create Healthy Workplace Standards Balanced Scorecard to track 13 +2 psychological factors to create a roadmap to obtain certification with Excellence Canada | Balanced scorecard (BSC) created | BSC updated quarterly | |
| Safe | Workplace violence | Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period. | Count / Worker | Local data collection / January - December 2021 | 1238 | 1238 | Reduce number of incidents. | Focus on transparent reporting of incidents and trends | 1) Analyze injury severity levels of workplace violence incidents year over year<br>2) Analyze type of incident (staff to staff vs. patient to staff)<br>3) Stratify the incidents from incivility to violence | 1) Number of workplace violence incidents reported at each level of incident severity (Levels 1 through 5)<br>2) Number of staff to staff incidents compared to patient to staff | 1) Overall consistency of reporting volume with a year over year decrease in high severity incidents (Levels 4 & 5) of workplace violence<br>2) Understand the difference in staff to staff incidents compared to patient to staff | |
| | | | | | | | | Maintain the Joint Health and Safety Committee (JHSC) workplace violence sub-committee to monitor trends and support the Internal Responsibility System (IRS). | JHSC subcommittee to :<br>1) Review Adverse Event Management System (AEMS) for trends<br>2) Support the functioning of the IRS in workplace violence resolution planning<br>3) Support the identification of the specific workplace hazard and recommend an action plan | JHSC subcommittee reports to Quality committee with analysis of trends, action plans and success stories | No target for this change idea | |
| | | | | | | | | Maintain training for all supervisors, managers, directors inclusive of in charge person (ICP) and charge nurses | Supervisory Competency training<br>(Public Services Health & Safety Association (PSHSA) Health and Safety Program - 4 modules) | Supervisory competency training compliance rates | Train 100% of LHSC leaders within the first 6 months of assignment | |
| | | | | | | | | Roll-out a new mandatory workplace violence prevention training program for all staff | In-class workplace violence prevention training is offered in four streams which are dependent on staff roles.<br>(Basic, Intermediate Allied Health, Intermediate Direct Care, and Advanced) | # of seats filled in each in person class (includes all four streams) | 80% of seats are filled in each class (includes all four streams) | |
| Effective | Safe & Effective Care | Proportion of patients discharged from hospital for whom medication reconciliation is provided | %/Discharge Patients | Hospital collected data /most recent 3 month period | 75.4% | 85% | Continue to improve towards target. | Increase provider accountability to drive performance | 1) Share results at Medical Advisory Committee (MAC) meeting (professional staff sensitive indicator)<br>2) Distribute monthly detailed data reports to department Chair-Chiefs and provide deeper analysis support as requested. Reports can be drilled down to show individual clinician performance to support increased compliance. | Monthly & Quarterly feedback mechanism: Medication Reconciliation at Discharge Report | 85% of patients discharged from hospital had medication reconciliation completed | |
| | | | | | | | | Establish Medication Reconciliation Optimization Committee | 1) Develop work plan that focuses on improvement towards performance target corporately by studying positive deviants and spreading this to other areas not meeting targets<br>2) Explore opportunities to align medication reconciliation improvements with discharge summaries focused improvement work<br>3) Review resources required to support improvements<br>4) Explore measuring quality of discharge medication reconciliation | To be determined | To be determined | |

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| Timely | Timely and Efficient Transitions | Discharge summary sent from hospital to primary care provider within 48 hours of discharge | %/Discharged Patients | Hospital collected data /most recent 3 month period | 60.5% | 65% | Continue to improve towards target. | Set performance expectations and increase accountability to drive performance | 1) Share results quarterly at Medical Advisory Committee (MAC) meeting<br>2) Distribute monthly detailed data reports to department Chair-Chiefs and provide analysis support as requested. Reports can be drilled down to show individual clinician performance.<br>3) Develop a communication plan for professional staff that brings visibility to current performance and highlights the value add for primary care partners | Monthly & Quarterly feedback mechanism operational. Reports include:<br>-Patient discharge to dictation (hours)<br>-Dictation to Transcription (hours)<br>-Transcription to Authentication(hours) | 65% of discharge summaries delivered to primary care within 48 hours | |
| | | | | | | | | Provide education and communicate resources available to consultants/residents/fellows to support timely discharge summary completions | 1)On-going education linking 48 hr discharges to CPSO policy and OHIP billing requirements<br>2)Communicate resources available through LearnNow toolkit<br>3)Integrate the competency aspect for use of auto-authentication code and resident/fellow sign off of the discharge summaries into the competency-based curriculum | On-going communication as part of consultant/resident/fellow training to ensure staff are aware of all available resources<br>Tracking the use of auto-authentication code and resident sign off of discharge summaries | All new consultants/residents/fellows can access toolkit and are provided education regarding the completion of discharge summaries within 48 hours | |
| Efficient | Timely and Efficient Transitions | Time to Inpatient Bed: Time interval between the Disposition date/time and the date/time patient Left the Emergency Department (ED) for admission to an inpatient bed or operating room at the 90th percentile | Hours / All emergency visits | CIHI NACRS / most recent 3 month period | 20.6 | 17.0 | Continue to improve towards target. | Establish "simple to read" education for the ED and inpatient teams inclusive of physicians (consultants, fellows, residents), nursing and regulated health professionals to understand the measure and the relative impact of the measure on patient quality of care (e.g., experience, safety) | Develop a simple education 1-pager describing the metric, how it is calculated, and the importance of the metric from a patient perspective. Included on the 1-pager should be key steps to achieving the target | ED Team members awareness of 1-pager education | Goal of 100% of medical and regulated health professionals in the ED and inpatient units are aware of the metric and have read the education material | |
| | | | | | | | | Leverage data reporting tools to monitor admitted patient wait times and track when patients are nearing and over the target. Explore options to utilize the upcoming 3Terra pilot to track performance, report on adherence to the target, and identify causes for not achieving the target. | Create a weekly performance summary that is posted in the EDs and on inpatient units discuss outcomes in bullet rounds. Create an opportunity for teams to identify strategies to achieve the target (e.g., improvement ideas).<br><br>Implement improvement ideas and measure the impact | Review of performance results on a weekly basis within the ED/inpatient units<br><br>Reporting performance results to appropriate committees (TBD)<br><br>Number of ED/inpatient unit team identified solutions; number of successfully implemented ED/inpatient unit team identified solutions | Weekly review of metric performance results (confirmed by charge)<br><br>Implementation of 50% of the ED/inpatient team identified solutions | |
| Efficient | Timely and Efficient Transitions | Wait 2 - Priority 3&4 closed cases | %/Total # of completed surgical cases | iPort Access/YTD | 63% | 71% | Improve towards target. | Review data quality of wait list and monitor regular performance | 1)Complete a data quality review for each surgeon's wait list<br>2) Review wait list trending for each surgeon to reduce variability in practice<br>3) Engage with surgeons to explore the possibility of a centralized intake process | Regular wait list data quality auditing | To be determined | |
| | | | | | | | | Explore barriers to completing P3 &P4 cases within targets | 1) Complete root cause analysis to determine key factors that impact P3&P4 cases (i.e., Health Human Resources (HHR), medical imaging waits, OR performance)<br>2) Identify opportunities for improvement and resources required<br>3) Align improvement work with the organization's surgical optimization planning | HHR Measures<br>Medical Imaging wait times<br>OR Performance Efficiency Measures (i.e., room utilization, first case delay, turnover time) | To be determined | |
| | | | | | | | | Implementation of the surgical recovery plan | 1) The surgical recovery plan includes accountability for delivery on enhanced volume targets | To be determined | To be determined | |