2023/24 Quality Improvement Plan
"Improvement Targets and Initiatives"

London Health Sciences Centre 800 Commissioners Rd E, London , ON, N6A5W9

AIM		Measure							Change			
Issue	Quality dimension	Measure/Indicator	Unit / Population	Source / Period	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure
Theme I: Timely and Efficient Transitions	**Timely & Efficient**	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	Canadian Institute for Healthcare Information National Ambulatory Care Reporting System (NACRS)/most recent 3 month period	28.1 hours Q3 fiscal year 2022/23	24 hours	Results trending and peer benchmarks. In fiscal year 2022/23 Q2, the provincial 90th percentile Emergency Department wait time for an inpatient bed was 34.5 hours and Ontario teaching hospitals 31.5 hours. Our performance currently is better than our peers, however this target is anchored in data from the last several quarters and realistic with current system issues.	Repatriation agreements with hospital partners and partnerships with community housing	Capacity creation and accountability mechanisms for patient pull and centralizing core bed functions	• Creating Alternate Level of Care (ALC) cohort units • Establishing Partnerships with community housing • Updating repatriation agreements with hospital partners • Building Emergency Department decant units • Implementing the new LHSC Access and Flow Toolkit o The Toolkit includes Standard Operations Procedures (SOPs) for patient transfers - Internal Admissions and Discharge Procedure, which outlines the responsibilities, patient transfer guidelines, and bed assignment guidelines for internal patient admissions and transfers. o The toolkit was developed using a working group comprised of clinical leaders from a variety of clinical areas. o This will see standardization of access and flow practices to improve patient transfer times e.g. Emergency Department Time to Inpatient Bed. o Weekly Working group sessions with programs in the early stages of implementation. Each clinical area has identified physician(s) and clinical staff to: support their clinical teams roll-out and implementation; provide assistance and expertise to develop a team-specific implementation plan with their clinical area; and attend meetings to discuss and plan roll out activities for their area.	• Alternate Level of Care Rate • Anticipated Date of Discharge Recorded	• Alternate Level of Care Rate 5.9% • Baseline data collection
									Real time Occupancy Dashboard in Capacity Management to enable real time interventions	• Implement with clinical Directors • Implement with Managers	• 90th percentile Emergency Department Length of Stay for Non-admitted High Acuity patients • 90th percentile Emergency Department Length of Stay for Non-admitted Low Acuity patients *And other metrics that will be on the Emergency Department Dashboard such as Emergency Department census, average new visits per hour, and Emergency Department return visits	• High Acuity 7.7 Hours • Low Acuity 5.8 hours • Baseline data collection for dashboard
									Development and implementation of the 2023/24 Pay-for-Results (P4R) Action Plan	• Development and implementation of the 2023/24 Pay-for-Results (P4R) Action Plan will be data driven utilizing driver diagrams	• Completion of the 2023/24 Pay-for-Results (P4R) Action Plan.	Completed
	Timely & Efficient	Time to Physician Initial Assessment 90th Percentile	Time to Physician Initial Assessment 90th Percentile/Total Assessment times *adult patient population only	Canadian Institute for Healthcare Information National Ambulatory Care Reporting System (NACRS)/most recent 3 month period	6.5 hours Q3 fiscal year 2022/23	6 hours	Results trending and peer benchmarks. In fiscal year 2022/23 Q3 the provincial average was 4.4 hours, teaching hospitals in Canada was 5.7 hours, which includes paediatrics and adult. We are focusing on the adult time only. The target is also based on current data trends, and similar to other Emergency Department's in Ontario, data demonstrates ongoing pressures experienced.		Development and implementation of the 2023/24 Pay-for-Results (P4R) Action Plan	• Length of Emergency Department Wait for Bed at 90th percentile strategies as detailed above • Development of a data driven action plan for 2023/24 Pay-for-Results (P4R)	*Metrics that will be on the Emergency Department Dashboard such as Emergency Department census, average new visits per hour, and Emergency Department return visits • Balancing Measure - Number of Patients Who Leave without Being Seen	Baseline collection year

								Secure staffing resources/health human resources	• We have and continue to hire to meet demand • New staff training	• Staff ratios • Staff vacancies	• Resourced to meet demand/no
	Timely & Efficient	Surgical Wait 2-Priority 3 and 4 closed cases within target (Surgical wait times for lower priority surgeries - not life saving)	%/Total number of completed surgical cases	iPort Access/most recent 3 month period	61.5% Q3 fiscal year 2022/23	80%	Current performance and peer benchmark. In fiscal year 2022/23 Q3, the Ontario result for P3 & P4 closed cases is 76%. We created a stretch goal for LHSC and recognize while change plans will be put in place we may not meet the target. This stretch goal was imperative for us to signal to our community that we are focused in addressing surgical wait lists.		Block Allocation and Operating Room Grid Optimization	•Develop framework for ensuring patient wait times and grid allocation are appropriate by service •Review same day admission booking practices to ensure surgical capacity •Optimize operating room booking process LHSC wide as well as operating room grids •Review, revise LHSC wide booking policies and accountability framework •Work with surgical teams to ensure 2 week bookings for scheduled cases (to best of ability) •Development and testing of Occupancy tool with Ivey Business to support surgical booking process	•Complete current state analysis to support Grid Optimization.	Completed
								Bed Map Optimization	•Develop current state bed map to support surgical volumes •Determine bed map optimization strategies •Draft, validate, reconcile funding for surgical beds •Initiation of bed flow analysis/simulation with Ivey Business	•Completion of the current state grid optimization.	Completed
	Timely & Efficient	Discharge summary sent from hospital to primary care provider within 48 hours of discharge	%/Discharged Patients	Hospital collected data CERNER/most recent 3 month period	63.8% Q3 fiscal year 2022/24	80%	The target rationale is based on both higher peer targets and higher peer performance. Of the 13 large hospitals who have this indicator on their public Quality Improvement Plan this year, the average performance at the end of Fiscal Year 2021/22 was 78.6% and average target was over 80%.		Utilization of technology to improve consistency of discharge summary quality (completeness	•Enable use with various departments via Plan-Do-Study-Act (PDSA) cycles – example high volume programs/divisions •Facilitate integration of technology (only if made available) into discharge summary process of care	•New tool development (Yes/No) and number	Completed
									Integration into competency-based education	•Build quality based criteria for discharge summary and incorporate into core trainee competency of physicians to reduce time to review discharge notes prior to signing	•Criteria development • Champion list of those leaders or areas lessons learned have been share with/spread to	Completed
									Coordinate distribution or systems challenges	•Standardize methods of discharge summary creation and distribution to reduce variation in process and data capture	•Development/creation of summary document •Variation rates	Completed
									Identify high volume/quantity users and low performers	•Target improvement strategies and spread to those high volume areas in greatest need of improvement	•Champion list of those leaders or areas lessons learned have been share with/spread to	Completed
									Enhancing data availability and information sharing. Use the data to provide information that will assist in improved outcomes	•Continue to increase visibility and understandability of the data (better graphs and trending), expand use of storytelling, using the data to inform change	•LHSC intranet stories, presentations at department or quality council meetings, or published journal articles	Baseline collection year
									Implement Sustainability Plan	•Leverage College of Physicians and Surgeons of Ontario (CPSO) standard for Timely Discharge Summaries •Medical Advisory Committee and LHSC leadership to address accountability process for this metric and communicate clearly to all stakeholders LHSC has new leaders for fiscal year 2023/24: a new Medical Advisory Committee chair and Corporate Medical Executive	•Monitor results-to-target for areas that were best practice spreaders/early adopters	Completed

Theme II: Service Excellence	**Patient-centred**	Percentage of respondents who responded "completely" to the following question: Were you involved as much as you wanted to be in decisions about your care and treatment?	% / Survey respondents	Canadian Patient Experience of Care Canadian Patient Experience of Care Survey/ Most recent consecutive 12-month period	64.4% Q4 fiscal year 2021/22 (n-size 139/219)	65%	The FY 2020/21 Teaching Hospital Average was 62.6% (n-size 13,563) thus we strive to be 3 percentage points above the teaching average, which was higher than the nonacademic hospital average.	The Middlesex London Ontario Health Team Coordinating Council are building a patient, client, caregiver network for the region. LHSC's Patient Experience Advisory Council and Cancer Care Patient and Family Advisory Council have both met with the Middlesex London Ontario Health Team Patient, Client, Caregiver Partner Council and will continue to meet over 2023/24.	Improved survey collection and dissemination process commencing	The Canadian Patient Experience of Care survey process at LHSC is undergoing innovative improvement which will: •Increase survey result data to be reflective of more programs and patient areas at the organization as survey distribution is planned to expand to more areas than the NRC Ontario Hospital Association method from fiscal year 2017-2022 •Increase survey response rates, survey administration per the Ontario Hospital Association is to be via email and we are encouraged that this change will increase response rates and thus increase patient and family perspective sharing at LHSC, we will look into options for populations who do not have access to email •Increase timeliness to survey results on LHSC leader scorecards, more real time, relative to the National Research Council (NRC) Ontario Hospital Association method from fiscal year 2017-2022 that had a three month or more survey response delay •Innovate on survey questions/survey forms posed - LHSC has signed on to the Canadian Institute for Healthcare Information (CIHI) pilot to trial the short form survey question set and the new long form survey set.	•Survey Response rates •Number of programs surveying that ask this survey question •Diverse and marginalized populations surveyed	Baseline collection year
									Patient and Family Partner teamwork	•Patient partner rounding with patients and families to dive deeper/root cause how we can help patients and families feel more involved. •Team with LHSC Patient and Family Partners on the LHSC Quality Improvement Plan to co-develop change ideas. Team sessions will be developed and a calendar set.	•Number and frequency of patient partner discussions on this survey question	Baseline collection year
									Children's Hospital Shared Decision Making	•Provide education/training that builds the skills needed for shared decision making and fostering a culture that embeds patient and parent values and engagement in the decision process this will help to improve parent's knowledge about their children's care options as well as increase participation in treatment decisions •Promote informed decision-making among parents and caregivers, through various interventions/tools that have been developed, such as patient (parental) decision aids, and family-centered educational programs to increase parents' capacity to make informed decision •Provide a series of patient/caregiver focused education sessions to high risk groups on a regular basis, including post-session follow up support and communication to patients as needed	•Shared decision making among parents, children and health professionals •Patient (parental) decision aids •Education and information provision to parents	Completed/ education provided
Theme III: Safe and Effective Care	**Safe**	Number of workplace violence incidents reported by hospital workers (as defined by Ontario Health ad Safety Act) within a 12 month period.	Count / Worker	Local data collection / most recent 3 month period	731 Q3 fiscal year 2022/23	1024	Analysis by quarter indicates the overall average number of events is 255.5 over the past 11 quarters. This would mean a 1,024 Q4 (cumulative) goal. 1238 incidents was the 2021 result, so this is an improvement target despite increase patient volume and staff challenges province wide.		Re-establish violence prevention sub-committee of Joint Health and Safety Committee	•Form committee with representation from areas with high incidents of violence. Set clear terms of reference to examine trends, perform root cause analysis, make recommendations for mitigating strategies. Focus of committee should be on incidents that meet the definition of violence under the Ontario Health and Safety Act. Consider extending membership to include key stakeholders who may not be members of Joint Health and Safety Committee (security leadership, mental health leadership, Emergency Department leadership)	•Quarterly reports from committee summarizing observations and recommendations	Completed
									Increase involvement of primary clinical department stakeholders in violence prevention	•Utilize existing reporting which reflects the incidents of violence at a departmental level. Increase reporting frequency to monthly basis in order to increase the timeliness of interventions.	Completion of steps: •Establish monthly report •Identify top 3 departments based on previous year data •Implement minimum one initiative by end of the first quarter of fiscal year 23/24 •Monitor incidents monthly to audit effectiveness of intervention	Completed
									Establish multidisciplinary teams to review care plans with respect to violence.	•Partner with clinical leadership in high incidence areas to establish method to quickly identify individual inpatients with high likelihood of escalated behavior and violent reactions. Build on existing patient flagging tools to identify inpatients who require care plan review beyond flagging.	Completion of steps: •Establish early flagging method for high risk patients by end of the first quarter of fiscal year 23/24 •Establish minimum one multidisciplinary team by end of the second quarter of fiscal year 23/24 •Baseline data collection on care plans developed	Completed and collect baseline data
									Engage professional practice as key stakeholder in violence prevention	•Partner with professional practice and subject matter experts to assist with literature review and perform gap analysis between current best practice and existing models of care with respect to violence prevention. Review aspects of existing care plans that could be enhanced or modified to reduce violence.	•Gap analysis complete by end of the third quarter of fiscal year 23/24	Completed