2019/20 Quality Improvement Plan
"Improvement Targets and Initiatives"

London Health Sciences Centre

London Health Sciences Centre 800 Commissioners Rd E

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 process measure	Comments
Effective	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	Most recent 12-month period=> FY 2018/19	936*	59.2% (Jan-Dec 2018)	65.0%	Continue to improve relative to provincial benchmark: Ontario IP academic hospitals.	Continue to develop and expand the patient oriented discharge summary (PODS) process.	1) Use tools and lessons learned from the pilot area and expand into high patient volume areas. 2) Monitor patient survey results	1) Number of clinical areas engaged in PODS process implementation. 2) CIHI CPES Survey results.	1) PODS process replicated in additional clinical areas by March 31,2020. 2) >65% Positive response.	Number of additional areas tbd based on availability of dedicated support.
										Develop and implement a patient experience survey feedback and process improvement process.	1) Share quarterly reports of patient experience top priorities and service alerts at the clinical unit level. 2) Implement accountability process for patient experience survey results follow-up.	Number of QI projects related to patient experience survey problem areas (Patient Experience Consult Database).	Quarter over quarter increase in consults initiated (baseline to be determined).	
		Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital.	P	% / Discharged patients	Hospital collected data / most recent 3 month period	936*	34.0%	50.0%	Continue to improve relative to peer hospitals.	Expand use of "auto-authenticate" processes and discharge summary templates.	1) Identify local consultant and resident champions. 2) Share results quarterly at Medical Advisory Committee (MAC) meeting 3) Distribute performance results quarterly to department chiefs 4)Provide detailed data and analysis support as requested	1) Number of clinical areas engaged in discharge summary QI activities. 2) Quarterly feedback mechanism operational. 3a) Patient discharge to dictation (hours). 3b) Dictation to Transcription (hours). 3c) Transcription to Authentication (hours).	1) Four new discharge summary QI projects. 2) 50.0% of discharge summaries delivered to primary care within 48 hours. 3) 48 hours (total).	
Safe	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 the total number of patients discharged.	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / October – December (Q3) 2018	936*	79.2%	85.0%	Continue to improve relative to peer hospitals.	Enhance monitoring, feedback, and reporting capability.	1) Distribute performance results quarterly to department chiefs 2) Share results quarterly at Medical Advisory Committee (MAC) meeting 3) Provide detailed data and analysis support as requested 4) Share leading performance improvement practices	1) Weekly compliance reviews conducted in target areas. 2) Quarterly department performance reporting reviews 3) Quarterly physician level performance reviews	10% performance improvement in target clinical areas. 5% performance improvement in all other clinical areas.	
	Workplace Violence	Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.	MANDATORY	Count / Worker	Local data collection / January - December 2018	936*	954	886.00	Maintain performance	Evaluate effectiveness of existing controls	Analyze injury severity levels of workplace violence incidents over last 2 fiscal years	Number of workplace violence incidents reported at each level of incident severity (Levels 1 through 5)	Overall consistency of reporting volume with a Year over year decrease in high severity incidents (Levels 4 & 5) of workplace violence.	
										Maintain training for all supervisors, managers, directors inclusive of in charge person (ICP) and charge nurses.	Supervisory Competency training (Public Services Health & Safety Association (PSHSA) Health and Safety Program - 4 modules)	Supervisory competency training compliance rates.	80% of LHSC leaders	
										Monitor compliance to hospital wide policy of behavioural safety alerts (BSAs) for individual's risk of violence.	Audit compliance to use of the PSHSA Acute Care Violence Assessment Tool (VAT)	Provide quarterly audit reports.	100% of inpatients are assessed for risk of violence.	
Timely	Timely access to care/services	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	MANDATORY	Hours / All emergency visits	CIHI NACRS / Q3 FY 2018/19	936*	19.1	17	Reduce gap in performance relative to best performing peer organization.	Implement Access and Flow strategic initiative projects.	Implement the following Access Strategy - Safer Patient Flow Bundle: •Operational Huddles •Clinical Criteria for Discharge (CCD) •Expected Date of Discharge (EDD) •Red2Green •Standard Rounding •Night Task List •Complex discharge screening tool	1)Strategic initiative status indicator. 2) % Adult occupancy 3) % Patient days exceeding the expected length of stay (ELOS) 4) % Discharges before 1100 hours 5) % Discharges before 1400 hours 6) ED pull to bed within 8 hours	1) to be developed 2) 95% 3) 17.8% 4) 50% 5) 80% 6) 68%	