# 2020/21 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 | 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 | 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* | 51.2% | 65.0% | Continue to improve relative to peer hospitals. | Expand use of "auto-authenticate" processes and discharge summary templates. | 1) Identify local consultant and resident champions.<br><br>2) Share results quarterly at Medical Advisory Committee (MAC) meeting<br><br>3) Distribute performance results quarterly to department chiefs<br><br>4) Provide detailed data and analysis support as requested<br><br>5) Perform Peer Review analysis and literature review. | 1) Number of clinical areas engaged in discharge summary QI activities/projects.<br><br>2) Quarterly feedback mechanism operational.<br><br>3a) Patient discharge to dictation (hours).<br>3b) Dictation to Transcription (hours).<br>3c) Transcription to Authentication (hours). | 1) Four new discharge summary QI projects.<br><br>2) 65% of discharge summaries delivered to primary care within 48 hours.<br><br>3) 48 hours (total). | |
| Safe | Wellness | Wellness of Our People: Understanding our staff, physicians, learners, and volunteers level of stress and feelings of support from leaders | P | %/our people that completed survey | Hospital collected data /June 2020-March 2021 | 936* | Stress 38%<br>Support 65% | Stress 38%<br>Support 65% | Maintain performance | Revise and re-launch our people wellness survey as part of our organization-wide wellness strategy. | 1) Revise survey questions based on literature reviews and evidence<br>2) Re-launch survey to all staff, physicians, learners, and volunteers through a planned communication roll-out<br>3) Educate leaders on the meaning of the results and effective strategies to improve staff wellness | 1) % of our people responding to survey | 1) 50% response rate | LHSC recognizes the COVID-19 pandemic and crisis conditions has a psychological impact on our staff, physicians, learners, and volunteers. To support our people during this crisis LHSC implemented a COVID-19 City-wide Wellness Task Force with the intent to provide our people with a variety of different resources and supports to help us manage during this stressful period. This year we plan on building on the work of this task force by implementing our organization wide wellness strategy. Part of this strategy will be to monitor wellness through a revised our people survey. |
| Safe | 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 / April 2020 - March 2021 | 936* | 1057 (Q4 result) | 760 | Reduce number of incidents | Evaluate effectiveness of existing controls. | Analyze injury severity levels of workplace violence incidents over last 3 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. | Train 100% of LHSC leaders within the first 6 months of assignment. | |
| | | | | | | | | | | 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. | |
| | Patient Safety | Never Events & Falls with Serious Harm: Patient safety incidents that result in the occurrence of a patient fall causing serious harm or one the fifteen identified Canadian Never Events. | P | Count/All Patients | AEMS/April 2020-March 2021 | 936* | N/A | CB | Collect Baseline | Develop the infrastructure for reporting and monitoring Never Events. | Develop key operational definitions to support Never Event identification and consistency of reporting. | Number of Never Events and Falls with Serious Harm entered into AEMS. | Collect baseline data over 2020/2021 with a plan to develop mitigation strategies and set target. | |
| | | | | | | | | | | | Educate leaders on the importance of identifying and follow-up on Never Events. | | | |
| | | | | | | | | | | | Develop a Never Events indicator for the balanced scorecard to monitor progress in data collection on a quarterly basis. | | | |
| Timely | 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 | MANDATORY | Hours / All emergency visits | CIHI NACRS / Q3 FY 2019/20 | 936* | 21.7 | 17 | Maintain performance | Implement Patient Flow Bundle across LHSC using a phased approach to standardize Access & Flow. | With support from the Central Access & Flow team, service leaders:<br>1)Involve interdisciplinary team in customization & implementation of the Bundle<br>2)Partner with physicians for implementation success<br>3)Communicate to the interdisciplinary team about the Bundle, implementation process & expectations<br>4)Provide strong leadership to manage change<br>5)Enable sustainability and track key discharge metrics for the service<br>6)Tie key discharge metrics & expectations to performance management | Discharges completed before 11AM | For services that have implemented Patient Flow Bundle (1) improve number of discharges before 11 am by minimum of 25% within 6 months of the implementation, (2) sustain the improvement | |