Appendix 3 - 2021/22 Quality Improvement Plan
"Improvement Targets and Initiatives"

London Health Sciences Centre

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	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*	58.5%	65.0%	Continue to improve relative to peer hospitals.	Set performance expectations and increase accountability to drive performance	1) Share results quarterly at Medical Advisory Committee (MAC) meeting 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.	Monthly & Quarterly feedback mechanism operational. Reports include: -Patient discharge to dictation (hours) -Dictation to Transcription (hours) -Transcription to Authentication (hours) -Identify the bottom 50% of departments for referral to work with Centre for Quality, Innovation and Safety (CQuInS) to develop improvement strategies	65% of discharge summaries delivered to primary care within 48 hours	
										Review electronic functionality and resident/fellow/consultant workflows to identify improvement opportunities	1) Collaborate with Health Records/ITS to understand if notifications or message centre can be utilized as an improvement strategy 2) Ongoing PDSA cycles with residents/fellows/consultants to assess adoption and success of an improvement strategy	Fidelity measure for adoption of workflow improvement strategies and improved outcomes	No specific target for fidelity measure rather identifies adoption of workflow improvement strategy	
										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 2)Communicate resources available through LearnNow toolkit 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 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	
Safe	Wellness	Wellness of Our People: Understanding our staff, physicians, learners, and volunteers' level of stress and feelings of support from leaders *Self-Perception of Stress* *Self-Perception of Support*	P	%/our people that completed survey	Hospital collected data /most recent 3 month period	936*	Stress 40.8% Support 59.8%	Stress 38% Support 65%	Target was set in FY19/20 based on baseline data. Continue to improve towards targets.	Improve response rates to wellness survey	1) Update messaging on the survey to emphasize why and how the results are shared with leaders 2) Communicate instructions on how to access work email on cell phones to complete survey 3) Utilize Wellness Response team check-ins and local Wellness Champions to remind leaders when surveys are sent out so they can encourage staff to complete	% of our people responding to survey	45% response rate	
										Continue to offer and promote "Where Wellness Works" programs and wellness training to all staff and physicians	Implement mandatory Compassion Fatigue Training for all	% of our staff and physicians that have completed compassion fatigue training	Train 100% of our staff and physicians	
										Wellness Response Teams embedded across LHSC with area leaders and Wellness Champions	Six-week interval check-ins to include in person rounding on the unit	Create a Wellness Response Team audit/tracking tool	Wellness Response Team active in all program areas	

Safe	Workplace violence	Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.	P	Count / Worker	Local data collection / January - December 2020	936*	949	760	Maintain performance	Focus on transparent reporting of incidents and trends	Analyze injury severity levels of workplace violence incidents year over year	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 Health and Safety Program - 4 modules)	Supervisory competency training compliance rates.	Train 100% of LHSC leaders within the first 6 months of assignment	
	Patient Safety	Never Events & Falls with Significant: 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/most recent 3 month period	936*	Never Events 10 Falls with Significant Injury 10	CB	Collect Baseline Data	Support units with high incidence of Never Events in the development of strategies to address the incidents of Never Events and Falls with Significant Injury	With support from Patient Safety and the CIC team, the Surgical Services team will implement specific interventions focused on reducing the number of unintended retained objects following a surgical procedure that have resulted in patient harm events	Implement strategies developed through root cause analysis to improve: - count policy and process -surgical field -case review process -education and communication	Implement improvement strategies by end of FY 21/22*	*The implementation of these strategies will be dependent on the impact of efforts required to manage the COVID-19 pandemic throughout FY 21/22
											With support from Patient Safety and the CIC team, the Mental Health and Addictions team will conduct a root cause analysis to determine strategies focused on reducing number of patients under highest level of observation leaving a secured facility without staff knowledge	Develop countermeasures through the A3 process to address Mental Health and Addictions incidence of Never Events	Develop improvement strategies and identify key implementation leads by end of FY 21/22*	
											Develop a process for reporting and tracking patient falls (that result in significant injury) within the existing Adverse Events Monitoring System (AEMS)	Implement new reporting process within AEMS system	Falls with significant injury reporting process in place within AEMS	
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	P	Hours / All emergency visits	CIHI NACRS / most recent 3 month period	936*	16.56	17	Maintain performance	In alignment with the corporate patient flow strategy, focused improvement on programs with the longest wait times for ED to inpatient bed	Refresh the patient flow bundle across both medicine programs and streamline care processes to eliminate variation	ED wait time to inpatient bed (90P) ED Pull to bed within 8 hours	17 hours 68%	
											Implement the patient flow bundle in Mental Health & Addictions as part of the VINE initiative			