2017/18 Quality Improvement Plan
"Improvement Targets and Initiatives"

RENFREW VICTORIA HOSPITAL

Renfrew Victoria Hospital 499 Raglan Street North

	Measure							Change				
Issue	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Coordinating care	Percentage of patients identified with multiple conditions and complex needs (Health Link criteria) who are offered access to Health Links approach	% / Patients meeting Health Link criteria	Hospital collected data / Most recent 3 month period	788*	55.00	60.00	New indicator for a new program; will be lower for the first year	1)Health Links staff to attend bullet rounds at the hospital regularly	Support/promote health link referrals for appropriate patients	Track number of referrals from hospital bullet rounds	Percentage of patients that are referred to health links from hospital setting	
								2)Conduct education for all hospital staff and physicians on potential health link clients	Create education in both Learning Management System and in-services by health link staff	Percentage of staff that complete education	80% of staff complete education related to health links	
								3)Ensure health link newsletters with success stories to all hospital staff and physicians	Circulate newsletters to all staff and physicians	Newsletters circulated to all staff and physicians	Referrals continue to be generated from hospital staff and physicians	
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?	% / Survey respondents	CIHI CPES / April - June 2016 (Q1 FY 2016/17)	788*	55.3	60.00	New indicator with only a year's worth of data so need to set targets carefully	1)Continue discharge planner follow-up phone calls for all patients over 65 years of age	Phone calls to be completed 24 to 48 hours post discharge	Discharge planners provide summary reports to admission/discharge and Patient and Family Advisory Committee on a regular basis	80% of patients indicate they had all of the information they needed at discharge. 20% that were not well informed get additional information during the follow-up phone call to ensure successful	
								2)Implement patient oriented discharge summary for all patients over 65 years of age, GEM patients in the Emergency Department and Health Link clients for Health Link #9 in the Champlain LHIN	Hospital is part of a provincial initiative to implement patients oriented discharge summary (PODS)	The project will be implemented in 2017 with funding provided through the ARTIC project	Number of patient oriented discharge summaries provided to the identified patient groups. Percentage of compliance for the patient group identified.	
	Percentage of acute hospital inpatients discharged with selected HBAM Inpatient Grouper (HIG) that are readmitted to any acute inpatient hospital for non-elective patient care within 30 days of the discharge for index admission.	% / Discharged patients with selected HIG conditions	CIHI DAD / July 2015 - June 2016	788*	16.57	14.00	Will try to bring our number down during 17/18 year	1)Review "huddle boards" to enhance team communication daily to maximize patient flow and care coordination	Daily rounds led by unit team leader with all members of interdisciplinary team and physicians	Percentage of staff attendance	100% of interdisciplinary team and CCAC attend and actively participate in rounds	
								2)Implement electronic TVs/whiteboards to enhance patient and family centered care through communication	Frequent discussion with families/patients to ensure white boards contain appropriate timely information to plan for discharge; bring white board template to Patient and Family Advisory Committee for endorsement	Surveys with patients/families to ensure white boards are effective for communication	Surveys indicate that patients/families satisfied with information and communication during hospital stay	
								3)Home First Joint Discharge Rounds (JDR) to ensure appropriate decisions to avoid long-term care	All discharges will be presented at JDR if long-term care being considered	Quarterly audits with trending and tracking information	Process followed 100% of patients that are complex >65 and reduction of patients who become ALC during hospital stay	
								4)Discharge follow-up phone calls	Discharge Planner will be presented at JDR if long-term care being considered	Data reviewed quarterly at Board CQI; Data reviewed at Admission & Discharge Committee to ensure internal reviews completed and changes implemented	Aggregate data required for tracking/trending; aggregate data will be used to make changes in discharge process so patients return home safely	
								5)Health Links to continue to admit greater than 30 clients for Health Links 9 per year	Key data elements related to patient group will be monitored i.e. ED visits, readmissions, interventions completed and patient satisfaction	Monitor LHIN data elements and patients family satisfaction with care	100% of patients accepted to health Links will have improved metrics for hospital readmission and ED visits improved metrics were seen in 2016/17 and will continue in 2017/18	

		Proportion of patients discharged between POD 3 and POD 4 **(NSQIP)**	Unit: Number of days Population: Patients having elective colorectal surgery	NSQIP raw data 01/01/2016-12/31/2016	ALOS 3.5 days	ALOS 3.5 days		Best Practice in General Surgery (BPIGS) Evidence Based Guidelines	Best Practice in General Surgery (BPIGS) Evidence Based Guidelines	ERAS practice guidelines utilizing clinical pathway, standardized order sets and patient teaching information	Percentage of patients who completed surveys	100% patient completion	
									SSI Prevention Bundle; Chlorhexidine shower night before and morning of surgery; Appropriate hair removal; Timely administration of antibiotics; Glucose control	Creation of custom fields for data collection; Audits to ensure patient preparation with chlorhexidine; Audits to ensure appropriate hair removal outside the OR; Audits to ensure timely administration of antibiotics •Audits to ensure adequate glucose control	Percentage of patients who used chlorhexidine pre-op (exception carpal tunnel procedures); Percentage of times hair removal is completed in the Day Surgery Unit; Percentage of patients who received timely antibiotic administration •Percentage of diabetic patients with a glucose below 11.1 mmol/L	100% patient use of chlorhexidine sponges; 100% rate of hair removal outside the OR; 100% timely administration of prophylactic antibiotics; 100% of patients entering the OR will have adequate glucose control	
Efficient	**Access to right level of care**	Total number of alternate level of care (ALC) days contributed by ALC patients within the specific reporting month/quarter using near-real time acute and post-acute ALC information and monthly bed census data	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July – September 2016 (Q2 FY 2016/17 report)	788*	29.33	27.00	Will try to reduce our ALC days further in 2017/18	1)Review "huddle boards" to enhance team communication daily to maximize patient flow and care coordination	Daily rounds led by unit team leader with all members of interdisciplinary team and physicians	Surveys with patients/families to ensure white boards are effective for communication	Surveys indicate that patients/families satisfied with information and communication during hospital stay	
									2)Implement electronic white boards on TVs to enhance patient and family centered care through communication	Frequent discussion with families/patients to ensure white boards contain appropriate timely information to plan for discharge. Bring white board template to Patient and Family Advisory Committee for endorsement	Quarterly audits with trending and tracking information	Process followed for 100% of patients that are complex >65 and reduction of patients who become ALC during hospital stay	
									3)Home First Joint Discharge Rounds (JDR) to ensure appropriate decisions to avoid long-term care	All discharges will be presented at JDR if long-term care being considered	Data reviewed quarterly at Board CQI; Data reviewed at Admission & Discharge Committee to ensure internal reviews completed and changes implemented	Aggregate data required for tracking/trending; aggregate data will be used to make changes in discharge process so patients return home safely	
									4)Discharge follow-up phone calls	Discharge planner calls all patients >65 after discharge to ensure smooth seamless transition home	Monitor LHIN data elements and patient and family satisfaction with care	100% of patients accepted to Health Links will have improved metrics for hospital readmission and ED visits improved metrics were seen in 2016/17 and this success will continue for 2017/18	
									5)Health Links to continue to admit greater than 30 clients for Health Link 9 per year	Key data elements related to patient group will be monitored i.e. ED visits, readmission; interventions completed and patient satisfaction	Monitor number of patients that return to retirement home post discharge	80% of patients return to retirement home post discharge from hospital	
									6)Generate discussion with retirement homes and admitted patients	Discharge Planners to monitor all retirement home clients admitted	Monitor number of patients that return to retirement home post discharge	80% of patients return to retirement home post discharge from hospital	
		Reduce Functional Decline amongst seniors in hospital	% / All inpatients	In-house survey / 2016	788*	90.00	90.00	Continue to strive for compliance with Barthel Index	1)Attend specialized geriatric education follow-up for hospitals who were part of Senior Friendly cohort 1	RVH successful in funding request for Senior Friendly Hospital training in 2015 and training completed; project implemented on one unit March 2016 and will continue with other units; ongoing education will continue in 2017/18	100% of staff leading initiative attends follow-up days in Toronto	Implement third phase of project developed on functional assessment which will be hospital wide in 2017/18	
									2)Measure compliance with Up For Meals initiative	Documentation tools developed for implementation	Percentage of compliance with Up For Meals	60-80% of appropriate patients are Up For All Meals	
									3)Measure compliance with risk stratification	Audit compliance with current risk stratification (delirium, falls risk, braden scale) done on admission	Percentage of compliance with risk stratification through quarterly audits	80% of patients will have all risk stratification completed on admission	
									4)Measure compliance with completion of Barthel Index on admission to measure functional ability	Audit compliance with Barthel Index completion 24-48 hours post admission	Percentage of compliance with Barthel Index completion	80-100% of patients will have Barthel Index completed on admission	
									5)Build functional assessment into electronic chart development at RVH	Determine appropriate measures to build into electronic chart	Electronic chart contains functional assessment and implemented 2016	Functional assessment is completed on 100% of patients >65; audits to be completed from electronic chart	

		Reduce rate and/or duration of delirium episodes amongst seniors in hospital	% / All inpatients	In-house survey / 2016	788*	95	96.00	CAM Assessment fully implemented; will try to improve percentage	1)Monitor CAM Assessment	Monitor usage and provide feedback and education when required	Number of patients ?75 who are screened after admission	80% of patients who meet criteria will have CAM assessment completed	
									2)Provide support to nurse completing CAM assessment	Nurse champions will be a resource to nurses on unit	Nurse champions will review charts and provide feedback	Ongoing education and support for understanding CAM assessment	
									3)Monitor use of physician order sets and patient education material developed	Chart reviews will include review of this aspect of care and provide feedback to both staff and physicians	Nurse Managers will review charts and provide feedback	Ongoing education and support for understanding importance of using new tools developed during implementation. 80% of patients will have tools used when CAM positive	
									4)Provide ongoing education on CAM assessments	Use audit results and chart reviews to re-educate and support CAM assessment implemented 2014/15	Number of staff who have completed ongoing education	80% of nursing staff will have received re-education	
Patient-centred	**Person experience**	"Would you recommend this emergency department to your friends and family?"	% / Survey respondents	EDPEC / April - June 2016 (Q1 FY 2016/17)	788*	68.8	70.00	New questions on NRCC Picker Survey so need another year of data before stretch targets can be set	1)Utilize teach back method to ensure patients understand what has been explained to them	80% of nursing staff receive education on teach back strategy	Analyze data compiled to develop quality improvement as required	100% of patients >65 have had after discharge follow-up call	
									2)Conduct follow-up phone call at discharge for patients >65 admitted through ER	Highlight ideas for change and positive scores to Emergency Dept team	Advisory Committee will continue to provide opportunity for patient feedback and input for change	A minimum high of 10 ideas for changes will be implemented and endorsed by this committee (17 ideas put forward)	
									3)Continue Patient and Family Advisory Committee in 2017/18	Evaluate effectiveness of change through recommendations and changes implemented and changes implemented/endorsed by the committee	Continue to implement 17 recommendations in 2017/18	100% staff educated on changes and 100% recommendations implemented by March 2018. All recommendations for change implemented with endorsement of Patient and Family Advisory Committee	
									4)Implement RNAO best practice client centered care	RVH successful in application to become Best Practice Spotlight Organization	Analyze data compiled to ensure success	100% compliance with hourly rounding and decrease in incidents	
									5)Implement Hourly Rounding in waiting room for care areas	Evaluate effectiveness of change through monitoring patients satisfaction, fall rates and incident reduction	Question asked to all patients at right time	100% of time question asked to appropriate patients	
									6)Ask Domestic Violence question at triage	Nursing staff education policy form changes	Monitor attendance and value added	100% of staff completed training	
									7)Safety culture training complete for 25 staff at RVH	On-line training for one day provided by Ottawa	Changes made as a result of attendance	4 new change ideas implemented to improve patient satisfaction based on PFAC participation	
									8)Patient advisor to attend care team meetings twice yearly	Attendance and active participation of member	Goal to improve patient satisfaction and understanding; decrease number of times patient reports they were not prepared for discharge	Increase patient satisfaction	
		"Would you recommend this hospital to your friends and family?" (Inpatient care)	% / Survey respondents	CIHI CPES / April - June 2016 (Q1 FY 2016/17)	788*	86.8	87.00	New questions on NRCC Picker Survey so need another year of data before stretch targets can be set	1)Utilize teach back method to ensure patients understand what has been explained to them	80% of nursing staff receive education on teach back strategy	analyze data compiled to develop quality improvement as required	100% of patients >65 have after discharge follow-up phone call	
									2)Conduct follow-up phone call at discharge for patients >65	Highlight ideas for change and positive scores to Active Care team	Advisory Committee will provide opportunity for patient feedback and input for change	Continue to hold Patient and Family Advisory Committee meetings	
									3)Explore opportunity to implement patient family advisory committee	Evaluate effectiveness of change	Documentation complete	100% of patients have bedside documentation completed hourly in conjunction with hourly rounding	
									4)Bedside documentation	Evaluate effectiveness of change	Analyze data compiled to ensure success	100% compliance with hourly rounding and decrease in incidents overall	
									5)Implement hourly rounding	Evaluate effectiveness of change through monitoring patient satisfaction, fall rates and incident reduction	17 recommendations continue to be implemented in 2017/18	100% staff educated on changes and 100% recommendations implemented by March 2018. All recommendations for change implemented with endorsement of Patient and Family Advisory Committee	
									6)Implement RNAO Best Practice client centered care	RVH successful in application to become Best Spotlight Practice Organization	Monitor attendance and value added	100% of staff completed training	
									7)Safety culture training complete for 25 staff at RVH	On-line training for one day provided by Ottawa	Changes made as a result of attendance	4 new change ideas implemented to improve patient satisfaction based on PFAC participation	

									8)Patient advisor to attend care team meetings twice yearly	Attendance and active participation of member	Percentage of admission with medication reconciliation completed on the Active Care Unit	85% of admission will have medication reconciliation by March 2018	
Safe	**Medication safety**	Medication reconciliation at admission: The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital	Rate per total number of admitted patients / Hospital admitted patients	Hospital collected data / Most recent 3 month period	788*	92.7	93.00	Percentage already high; will strive to improve slightly	1)Measurement and feedback related to the compliance with medication reconciliation	Monthly audits will be completed on medication reconciliation. Audit will encompass the number of completed medication	Audit compliance with reports presented and get ideas for the change improvements when data presented	100% of reports will be brought forward to key stakeholders	
									2)Provide continual feedback related to the compliance with medication reconciliation	Provide monthly audit reports to Active Care, MAC, and Pharmacy & Therapeutics committees	Change ideas will be communicated to key team members	100% compliance with dissemination and at least one improvement developed	
									3)To develop an action plan with key stakeholders with defined accountabilities to maintain and sustain change	Nurse Managers will compile monthly data and generate change ideas from key stakeholders for improvement	Complaince/Percentage of staff completion of education	80% of staff complete education	
									4)Re-educate nursing staff on the importance of best possible medication history (BPMH) at discharge	Develop and implement education for Learning Management System to facilitate on line completion. Education will stress the importance of BPMH for safe hospital stay and discharge	Percentage of discharges with medication reconciliation completed on the Active Care Unit	85% of Discharges will have medication reconciliation by March 2018	
		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.	Rate per total number of discharged patients / Discharged patients	Hospital collected data / Most recent quarter available	788*	80.5	82.00	Continue to improve from previous year	1)Measurement and feedback related to the compliance with medication reconciliation	Monthly audits will be completed on medication reconciliation. Audit will encompass the number of completed medication	Audit compliance with reports presented and get ideas for the change improvements when data presented	100% of reports will be brought forward to key stakeholders	
									2)Provide continual feedback on the compliance with medication reconciliation	Provide monthly audit reports to Active Care, MAC, and Pharmacy & Therapeutics committees	Change ideas will be communicated to key team members	100% compliance with dissemination and at least one improvement developed	
									3)To develop an action plan with key stakeholders with defined accountabilities to maintain and sustain change	Nurse Managers will compile monthly data and generate change ideas from key stakeholders for improvement	Number of staff that attend education	80% of full/part time staff will completed education	
									4)Develop mandatory education that will be completed by all nursing staff in Learning Management System (LMS)	LMS will be used to ensure compliance	100% participation by all units in rounds process	To reach new target by March 31 2018	
Timely	**Timely access to care/services**	Total ED length of stay (defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ED) where 9 out of 10 complex patients completed their visits	Hours / Patients with complex conditions	CIHI NACRS / January 2016 – December 2016	788*	5.92	5.92	Target is significantly lower than provincial average therefore will strive to maintain	1)Daily bed meeting to facilitate transfers from the Emergency Dept and early discharge	Key units participate in daily bed meetings to enhance flow	100% participation by all team members on both inpatients units daily	To reach new target by March 31, 2018	
									2)Bullet Rounds will be conducted daily on all inpatient units prior to bed meetings to ensure timely discharges take place	Bullet Rounds will ensure key team members are up to date on planned discharges and responsibilities to ensure all care requirements are in place to get patient home	Monitor number of directives used	Medical directives used 80% of the time for common diagnosis	
									3)Audit use of medical directives/order sets	10 new directives implemented and 15 new order sets implemented in last 2 years	Continue to monitor the data post change to ensure that length of stay for admitted patients has decreased	ED length of stay will be reduced by one hour with change improvements implemented	
									4)Review length of stay data at ED/Acute Care committee meetings	Data reviews for all key areas of process show improvements are required for 2017/18 year	Audit Success	100% of cases will be conducted outside of ER Dept setting	
									5)Move procedures out of ER Dept to Medical Day Care Unit	ER/Am Care Manager moved phlebotomies/blood transfusions to Day Care area; to move allergy shots and other procedures to medical day care	Audit number of patients called	GEM patients that had phone all that come back to ER Dept	
									6)GEM nurse to conduct follow-up phone calls for patients seen outside GEM hours	Compile interventions with phone calls	Audit compliance with new form and determine with team if changes made are appropriate	ED length of stay reduced discharge planning consulted for all complex cases	
									7)Improve discharge planning and communication through alteration of discharge forms and process	Discharge Planners meeting with team to determine changes required for complex patients			