2018/19 Quality Improvement Plan
"Improvement Targets and Initiatives"

Renfrew Victoria Hospital 499 Raglan Street North

M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) A= Additional (do not select from drop down menu if you are not working on this indicator) C = custom (add any other indicators you are working on)

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	CIHI CPES / April - June 2017(Q1 FY 2017/18)	788*	52	60.00	Still relatively new indicator; will continue to implement changes	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 ER and Health Link clients for Health Link #9 in the Champlain LHIN	Hospital is part of a provincial initiative to implement patient oriented discharge summary (PODS)	The project will be implemented in 2018 with funding provided through the ARTIC project and evaluation of project will take place over 2018/19 year	Number of patient oriented discharge summaries provided to the identified patient groups. Percentage of compliance for the patient group identified.	PODS are individualized discharge instructions which help to ensure patients are better informed at discharge
										3)Educate staff about appropriate discharge practices and how to verify patients are well informed at discharges	Educate care providers at discharge best practice; use teach back when giving discharge instructions to patients and caregivers	Verify with patients that they were well informed in discharge follow-up phone calls	90% of patients indicate they were well informed	
	Coordinating care	Percentage of patients identified with multiple conditions and complex needs (Health Link criteria) who are offered access to Health Links approach	A	% / Patients meeting Health Link criteria	Hospital collected data / most recent 3 month period	788*	69	72.00	Still a relatively new indicator; we will continue to strive to reach more clients	1)Health Link 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)Continue 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 newsletter to all staff and physicians	Newsletters circulated to all staff and physicians	Referrals continue to be generated from hospital staff and physicians	
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	P	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July - September 2017	788*	20.51	18.00	Will continue to work to reduce ALC days	1)Measure compliance with completion of Barthel Index on admission to measure functional ability; continue sharing tools to predict functional decline	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	
										2)Implement patient 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 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 identified will receive a follow-up phone call	
										5)Implement bedside discharge rounds	Discharge planners, GEM nurse will lead discharge rounds	Discharge rounds will be done 24-48 hours after admission with complex patients	Bedside Discharge rounds will be completed on all complex patients	
										6)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	
										7)Implement new Home First philosophies, policies and procedures	Discharge planners will lead implementation	Educate all staff, physicians and Senior Management on policies	80% compliance with all new policies and processes	

Person experience	"Would you recommend this emergency department to your friends and family?"	P	% / Survey respondents	EDPEC / April - June 2017 (Q1 FY 2017/18)	788*	77.5	78.00	Survey still new; difficult to set appropriate benchmarks	1)Conduct follow-up phone calls at discharge for patients >65 admitted through ER	Highlight ideas for change and positive scores to Emergency Dept team	Patient and Family Advisory Committee will continue to provide opportunity for patient feedback and input for change	A minimum high of 5 ideas for changes will be implemented and endorsed by this committee	
									2)Continue Patient and Family Advisory Committee in 2018/19 to ensure patient and family perspectives are key drivers to improve care	Evaluate effectiveness of change through recommendations and changes implemented	Continue to implement PFAC recommendations	100% of recommendations implemented by March 2019	
									3)Implement patient oriented discharge summary	Implement for all hospital discharges	The summaries will be implemented and evaluated in 2018/19	90-100% of discharges will have patient oriented discharge summary	
									4)Implement Hourly Rounding in waiting room for care areas	Evaluate effectiveness of change through monitoring patient's satisfaction, fall rates and incident reduction	Question asked to all patients at right time	100% of time question asked to appropriate patients	
									5)Bring patient experiences to hospital Board leadership team	Bring patient stories to at least 3 board meetings per year	Number of patient stories	100% of board members will indicate value added by the patient story	
									6)Increase GEM nursing hours in the ER Department to support safe elderly transitions	GEM assessments will increase 30%	Goal to improve patient satisfaction and implement services where required	GEM assessments will increase by 30%	
	"Would you recommend this hospital to your friends and family?" (Inpatient care)	P	% / Survey respondents	CIHI CPES / April - June 2017 (Q1 FY 2017/18)	788*	81.4	82.00	Survey still new; difficult to set appropriate benchmarks	1)Conduct follow-up phone calls 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 based on feedback	Continue to hold Patient and Family Advisory Committee meetings and provide feedback quarterly on discharge follow-up phone call data	
									2)Patient and Family Advisory Committee in 2018/19 to ensure patient/family perspectives are key drivers to improve care	Evaluate effectiveness of change through recommendations and changes implemented	Continue to implement PFAC changes	90-100% of recommendations implemented by March 2019	
									3)Implement patient oriented discharge summary	Implement for all hospital discharges	The summaries will be implemented and evaluated in 2018/19	90-100% of patients will have patient oriented discharge summary	
									4)Continue Hourly Rounding	Evaluate effectiveness of change through monitoring patient satisfaction, fall rates and incident reduction	Monitor indicators for improvement	100% staff educated on changes and recommendations implemented by March 2019. All recommendations for change implemented with endorsement of Patient and Family Advisory Committee	
									5)Evaluate effectiveness of new patient whiteboards	Audit usage an patient satisfaction	Patients will report satisfaction with whiteboards	90% of whiteboards will have up to date relevant information	
	Percentage of complaints acknowledged to the individual who made a complaint within three to five business days.	A	% / All patients	Local data collection / Most recent 12 month period	788*	100	100.00	We will continue to strive to meet 100	1)All complaints will be acknowledged in the time frame	Alter policies to ensure follow-up is timely	Monitor compliance and report to Board CQI	100% of concerns will be acknowledged in time frame	

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) 2017	788*	87	90.00	We anticipate this will be maintained or improved in 2018/19	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 & Therapeutic 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	Monitor change ideas	80% of change ideas will be implemented	
										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 of staff in education	100% of staff complete education	
	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 2017**	**788***	**4**	**6.00**	**Current number of incidents is low. No comparison data available on the expected number of Workplace Violence incidents that is expected for a hospital our size. Number based on a 50% increase.**	**1)Ensure workplace violence incidents are reported**	**Workplace Violence Reporting Tool was developed in 2007. Ensure that all staff are re-educated on the Violence Reporting Tool; Send out communication in staff newsletter; follow-up after incidents that should have form completed and provide re-education to staff involved; review current policy for ease of completion; send to Dept Heads for all staff to review the policy**	**Number of Workplace Violence incidents reported**	**6 Workplace Violence reports**	**FTE=258**
										2)Ensure the Code White Emergency Response is used for applicable incidents	Although staff use the Code White system, RVH has few documented Code White episodes annually. Ensure that all staff are familiar with the system and are comfortable with activating a Code White; perform regular mock code white drills (2 annually); follow-up with employee incidents when a code white was not called for a workplace violence episode	Number of code white episodes called	6 Code White episodes	
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	A	Hours / Patients with complex conditions	CIHI NACRS / January - December 2017	788*	6.35	6.00	Occupancy pressures in our LHIN may effect this metric	1)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 compliance with rounds	90% of compliance with bullet rounds on all units	
										2)Daily bed meeting to facilitate transfers from the Emergency Dept an dearly 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, 2019	
										3)Audit use of medical directives/order sets	Educate all staff and physicians on new medical directive	Continue to monitor the data post change to ensure that length of stay for admitted patients has decreased	ER length of stay will reduced by one hour with change improvements	
										4)Review length of stay data at ED/Acute care committee meetings	Data reviews for all key areas of process show improvements are required 2018/19 year	Audit success	100% of minutes will reflect discussion and changes made	
										5)Continue procedures out of the ER Dept to Medical Day Care Unit when appropriate	Moved phlebotomies/blood transfusions to Day Care area; to move allergy shots and other procedures to medical day care	Audit number of procedures moved	100% of cases will be conducted outside of the Emergency Department	
										6)GEM nurse to conduct follow-up phone calls for patients seen outside GEM hours	Compile interventions with phone calls	Audit compliance and determine interventions put in place	Readmission/re-visits to Emergency Dept will be reduced by 60%for the patients called	
										7)Increase GEM nurse hours in the ER to support safe elderly transitions	GEM assessments will increase by 30%	Goal to improve patient satisfaction and implement services where required	GEM assessments will increase by 30%	