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

RENFREW VICTORIA HOSPITAL

Renfrew Victoria Hospital 499 Raglan Street North

	Measure									Change				
Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Is must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) C = custom (add any other indicators you are working on)														
Theme I: Timely and Efficient Transitions	**Efficient**	Average number of inpatients receiving care in unconventional spaces or ER stretchers per day within a given time period.	P	Count / All patients	Daily BCS / October - December 2018	788*	0.1	0.10	A new indicator this year; targets will be modified once more data is available	Paramedics, Other Hospitals	1)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	
											2)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; data will be used to make changes in	
											3)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	
											4)Implement bedside discharge rounds	Discharge planners, GEM nurse will lead discharge rounds	Discharge rounds will done 24-48 hours after admission with complex patients	Bedside Discharge rounds will be completed on all complex patients	
											5)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	
		Total number of alternate level of care (ALC) days contributed by ALC patients within the	P	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July - September 2018	788*	18				1)				Not tracking as a priority this year
	Timely	Percentage of patients discharged from hospital for which discharge summaries are	P	% / Discharged patients	Hospital collected data / Most recent 3 month period	788*					1)				Not tracking as a priority this year
		The time interval between the Disposition Date/Time (as determined by the main service provider) and the Date/Time Patient Left Emergency Department (ED) for admission to an inpatient bed or operating room.	**MANDATORY**	**Hours / All patients**	**CIHI NACRS / October 2018 – December 2018**	**788***	**4.33**	**4.00**	**A new indicator this year; targets will be modified once more data is available**	**Home & Communicate Care- LHIN, Paramedics, Health Links**	**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 ER Dept and early discharge	Key units participate in daily beds meetings to enhance flow	100% participation by all team members on both inpatients units daily	To reach new target by March 31, 2020	
											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 be 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 2019/20 year	Audits will be conducted to gage success	100% of minutes will reflect discussion and changes made	
											5)Continue to move procedures out of the ER Dept to Medical Day 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 reflect discussion and changes made	
											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 ER Dept will be reduced by 60% for the patients called	
											7)Implement electronic tracking board with new EMR	ED staff and physicians w2ill have more sophisticated information to ensure timely transfers	Review new board on a daily basis and monitor staff satisfaction with information	Transfers will be monitored to ensure timely transfers take place	

Theme II: Service Excellence	**Patient-centred**	Percentage of complaints acknowledged to the individual who made a complaint within five business days	P	% / All patients	Local data collection / Most recent 12 month period	788*	100	100.00	Continue to strive for 100% compliance		1)All complaints will be acknowledged in the time frame`	After policies to ensure follow-up is timely	Monitor compliance and report to Board CQI	100% of concerns will be acknowledged in time frame	
											2)Follow-up will be done to determine if complaint was handled well	Track patient responses	Provide feedback to Board CQI	100% of patients will be asked if complaint was handled well	
		Percentage of respondents who responded positively to the following question: 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 / Most recent consecutive 12-month period	788*	61	65.00	NRC alteration of questionnaire has made it difficult to strive for higher percentages in line with provincial expectations		1)Continue discharge planner follow-up phone calls for all patients over 65 years of age	Phone calls to be completed 24-48 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	
											2)Continue patient oriented discharge summary for all patients over 65 years of age, GEM patients in the ER and Health Links clients for	Hospital is part of a provincial initiative to implement patient oriented discharge summary (PODS)	The project was implemented in 2018 with funding provided through the ARTIC project and evaluation of project will take place over 2019/20	Number of patient oriented discharge summaries provided to the identified patient	PODS are individualized discharge instruction which help to ensure
											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 method 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	
											4)Implement "MyCHart" with EPIC implementation of electronic medical record	All patients will have the opportunity to have access to "MyChart"	The number of patients that sign up for "MyChart"	80% of the patients will sign up for "MyChart"	
Theme III: Safe and Effective Care	**Effective**	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 2018	788*	93.5	95.00	Expect to achieve higher compliance with electronic medical record implementation in 2019/20		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; real time information will be available in EMR	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. This will be covered in EMR education	Monitor change ideas through new EMR	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; this will be done for all in EMR education	100% participation by all staff in education	100% of staff complete education	
											5)Implementation of new EMR improve medication reconciliation compliance	Electronic audits will provide better information for medication reconciliation	Audit compliance	100% compliance	
		Proportion of hospitalizations where patients with a progressive, life-threatening illness	P	Proportion / at-risk cohort	Local data collection / Most recent 6 month period	788*					1)				Not tracking as a priority this year
		Rate of mental health or addiction episodes of care that are followed within 30 days by another	P	Rate per 100 discharges / Discharged patients with mental health &	CIHI DAD,CIHI OHMRS,MOHTLC RPDB / January - December 2017	788*	X				1)				Not a mental health facility
	Safe	**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**	**788***	**18**	**18.00**	**Significant improvement in 2018/19; goal is to maintain in 2019/20**		**1)Ensure workplace violence flagging forms are being completed on admitted patients to alert staff of the patient violence risks**	**Asses each reported patient violence incident for completed flagging tool. Send out communication on "How to use the Violence Flagging Tool"**	**Number of Workplace violence incidents reported**	**18 workplace reports**	**FTE=258**
											2)Ensure Code White Emergency response is used for applicable incidents	RVH exceeded the target for the 2018 year (Total of 7 Code White calls for 2018 year). Ideally, staff will activate the Code White system as soon as possible to de-escalate the situation prior to injury. Ensure that all staff are familiar with the system and are comfortable	Number of Code White episodes called	18 Code White Episodes	