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

Royal Victoria Regional Health Centre 201 Georgian Drive

AIM		Measure							Change				
Quality dimension	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
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)	606*	18.57	18.00	Continue to improve upon performance over the last three QIP cycles. Alignment with HSAA.	1)Introduction of a utilization management tool.	Daily review of all patients who have targeted estimated length of stays and planned discharged dates as a means of proactive preparedness pre-discharge.	Reviewing daily report of all patients to be discharged within 24 hours to address and resolve any barriers to discharge.	100% of patients will be reviewed 7 days a week.	N/A
									2)Launch of "Helping Hands".	All patients whose acute care stay is completed, who are waiting to be discharged to their permanent destination will be transferred to Helping Hands on an interim basis until such permanent destination is prepared or available.	All patients suitable to transition to Helping Hands will be transferred provided capacity is available.	Helping Hands to be launched Fall 2017.	N/A
									3)Appropriate admissions criteria.	Development of a process and criteria for patients arriving in the ED without an acute diagnosis will be transitioned safely to an appropriate destination, ensuring only those with acute care needs to be admitted.	Through the consultation and collaboration of a variety of sub-specialty physicians, the criteria will be developed.	Appropriate admissions criteria will go live commencing Q3 2017.	N/A
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)	606*	50	51.00	Top Box only. NACRS data used for current measurement.	1)Launch CQI (e.g. PDSA, Kaizen, 5S etc.) with focus on enhancing the patient experience.	Physicians, nurses, clerks and patient advisory members utilize LEAN methodology to identify process and space improvements to reduce ED LOS and improve patient experience.	Physician Initial Assessment Time , Left Without Being Seen numbers. ED LOS.	Reduce Physician Initial Assessment Time by 1%. Achieve the target of less than 4% LWBS. Achieve 30 minute EMS Offload times.	N/A
									2)Nurse assigned to waiting room for patient reassessment/ EMS offload.	Hourly rounding in waiting rooms, Leader and Senior Leader rounding in the ED.	EMS offload times.	Achieve 30 minute EMS Offload times.	N/A
									3)Redesign Triage area: both processes and physical space.	Physicians, nurses, clerks and patient advisory members utilize LEAN methodology to identify process and space improvements to reduce ED LOS and improve patient experience.	Reduced time for Triage and Registration and improve patient and family experience.	Achieve CTAS targets. Improve patient and family experience by 2%.	N/A

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									4)Patient Family Advisory Council (PFAC) member to sit on Emergency Department Quality and Operations Committee and involved in all improvement planning.	Obtain dedicated PFAC members for ED.	PFAC participation at Quality and Operations meeting and all process improvement initiatives.	100% of all process improvement initiatives will engage a patient or family member to ensure their perspective is provided on any change management.	N/A
									5)Purposeful rounding.	Dedicated assigned regulated staff conduct hourly purposeful rounding.	Patient and family experience.	Improve patient and family experience by 2%.	N/A
		"Would you recommend this hospital to your friends and family?" (Inpatient care)	% / Survey respondents	CIHI CPES / April - June 2016 (Q1 FY 2016/17)	606*	65	66.00	Top Box only for Medical/Surgical patients only.	1)Launch CQI (e.g. PDSA, Kaizen, 5S etc.) with focus on enhancing the patient experience.	Redevelopment of the discharge package.	Patient complaint and compliment data. NRC survey results. Post care call results. Positive increase in score related to "right information at discharge" question on patient satisfaction scores. Number of patients receiving discharge package before going home.	A robust discharge package appropriate from each service for 100% of patients being discharged. Reduction of patient complaints in Datix system of 3%. Increase of patient compliments in Datix system of 3%. NRC survey results show steady increase of 0.5% over each quarter.	N/A
									2)Leverage PFAC members across every committee and within every quality improvement process to ensure patients add their lens and guide decisions.	Partner with patients and family advisers to design and deliver health care experiences. Build on success by cascading Patient and Family Advisory Council members as key members of internal quality/operations committees.	Every inpatient unit will have PFAC members participate in all process improvements and all patient education work and material. PFAC will be engaged for all front line leadership recruitment activities.	100% quality improvement initiatives will have PFAC representation. 100% of front line leadership recruitment will have PFAC representation.	N/A
									3)Ensure smooth transitions to home for all discharges.	Build on our existing partnership with CCAC to ensure no gaps in care plans related to the services required as a means of smooth transitions in care. Build on our existing partnership with Health Links to ensure all patients are aligned with a family doctor.	Monthly meetings will occur to review individual cases ensuring no gaps in service and to develop action plans for those patients at risk. To ensure RVH has presence at all Health Links meetings to enable the voice of the patient needs from the acute care to community environment.	100% review of all patients.	N/A
									4)Ensure all technology is in good working order and easy to use.	Compliance of preventative maintenance.	Routine auditing of all technology. Feedback from Senior Leader rounding.	100% compliance of preventative maintenance audits. 100% of technology working safely.	N/A

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									5)Implement process with inpatient leaders that will influence behaviors that will improve patient and family experience.	Implement SLT approved Studor coaching plan.	Ensure each leader adheres to the coaching plan.	100% adherence.	N/A
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	606*	69	73.00	Similar target to PY based on underachievement during 2016-17. This initiative remains a priority target for our organization.	1)Build upon our success in the last couple of years by sustaining the quantity of medication reconciliations completed and enhance the quality of the medication reconciliation upon admission as it is rolled out through the entire organization.	Sustain medication reconciliation performance with strong leadership support, physician champions, substantive information technology support and a comprehensive staff education plan. Leverage the resources and tools available from Safer Healthcare Now, ISMP Canada, Accreditation Canada, Canadian Patient Safety Institute etc. to ensure best practices and evidence based tools and processes are adopted. Consistently monitor and improve the quality of medication reconciliation processes using established qualitative indicators and plan-do-study-act cycles.	Percentage of patients admitted with a Best Possible Medication History as defined by Safer Healthcare Now.	73% of all Medical/Surgical inpatient admissions will have a Best Possible Medication History based on the roll out plan for each inpatient unit. Each unit will have one month grace period post implementation to meet target before data is collected.	Measure evaluated based on programs 30 days post roll-out.
		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	606*	22	35.00	Similar target to PY based on underachievement during 2016-17. This initiative remains a priority target for our organization.	1)Build upon our success in the last couple of years by increasing the total percentage of discharge medication reconciliations completed, in conjunction with the quality of the medication reconciliation upon admission, as it is rolled out throughout the entire organization.	Sustain medication reconciliation performance with strong leadership support, physician champions, substantive information technology support and a comprehensive staff education plan. Leverage the resources and tools available from Safer Healthcare Now, ISMP Canada, Accreditation Canada, Canadian Patient Safety Institute etc. to ensure best practices and evidence based tools and processes are adopted. Consistently monitor and improve the quality of medication reconciliation processes using established qualitative indicators and plan-do-study-act cycles. Implement use of a Meditech tool to facilitate the Med Rec discharge process.	Percentage of patients discharged with a Best Possible Medication Discharge Plan as defined by Safer Healthcare Now.	35% of all Medical/Surgical inpatient discharges with a Best Possible Medication History (73% target) will have a Best Possible Medication Discharge Plan based on the roll out plan for each inpatient unit. Each unit will have one month grace period post implementation to meet target before data is collected.	Measure evaluated based on programs 30 days post roll-out.

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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	606*	13.6	0.00	N/A	1)N/A	N/A	N/A	N/A	RVH has chosen not to include this Priority Indicator as a QIP metric for 2017/18. We do report our LOS metrics on our performance score card and will continue to monitor.
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?	% / Survey respondents	CIHI CPES / April - June 2016 (Q1 FY 2016/17)	606*	0	0.00	N/A	1)N/A	N/A	N/A	N/A	RVH has chosen not to include this Priority Indicator as a QIP metric for 2017/18. Our patient satisfaction scores do report this metric and we will continue to monitor.
		Risk-adjusted 30-day all-cause readmission rate for patients with CHF (QBP cohort)	Rate / CHF QBP Cohort	CIHI DAD / January 2015 - December 2015	606*	24.74	0.00	N/A	1)N/A	N/A	N/A	N/A	RVH has chosen not to include this Priority Indicator as a QIP metric for 2017/18. We have been reporting our readmission rates on our performance score card and to the Board of Directors and will continue to monitor.
		Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort)	Rate / COPD QBP Cohort	CIHI DAD / January 2015 – December 2015	606*	17.58	0.00	N/A	1)N/A	N/A	N/A	N/A	RVH has chosen not to include this Priority Indicator as a QIP metric for 2017/18. We do report our readmission rates at our monthly Utilization Management Committee and will continue to monitor.
		Risk-adjusted 30-day all-cause readmission rate for patients with stroke (QBP cohort)	Rate / Stroke QBP Cohort	CIHI DAD / January 2015 - December 2015	606*	9.14	0.00	N/A	1)N/A	N/A	N/A	N/A	RVH has chosen not to include this Priority Indicator as a QIP metric for 2017/18. We do report our readmission rates at our monthly Utilization Management Committee and will continue to monitor.
Patient-centred	**Palliative care**	Percent of palliative care patients discharged from hospital with the discharge status "Home with Support".	% / Palliative patients	CIHI DAD / April 2015 – March 2016	606*	84.88	84.88	N/A	1)N/A	N/A	N/A	N/A	RVH has chosen not to include this Priority Indicator as a QIP metric for 2017/18, however metric is closely monitored with the North Simcoe Muskoka Palliative Care Network.