Excellent Care for All

**Quality Improvement Plans (QIP): Progress Report for 2017/18 QIP**

The Progress Report is a tool that will help organizations make linkages between change ideas and improvement, and gain insight into how their change ideas might be refined in the future. The new Progress Report is mostly automated, so very little data entry is required, freeing up time for reflection and quality improvement activities.

Health Quality Ontario (HQO) will use the updated Progress Reports to share effective change initiatives, spread successful change ideas, and inform robust curriculum for future educational sessions.

| ID | Measure/Indicator from 2017/18 | Org Id | Current Performance as stated on QIP2017/18 | Target as stated on QIP 2017/18 | Current Performance 2018 | Comments |
|---|---|---|---|---|---|---|
| 1 | "Would you recommend this emergency department to your friends and family?" ( %; Survey respondents; April - June 2016 (Q1 FY 2016/17); EDPEC) | 606 | 50.00 | 51.00 | 41.00 | As of December 2017. While RVH did not meet this target, we are mindful that it is reflective of Top Box only and continue to monitor both Top Box and Secondary Box. We strive to increase our Top Box measurement however have taken the approach to set incremental targets over the next several years so as to deliver a laser focus on the metrics and change ideas. |

Realizing that the QIP is a living document and the change ideas may fluctuate as you test and implement throughout the year, we want you to reflect on which change ideas had an impact and which ones you were able to adopt, adapt or abandon. This learning will help build capacity across the province.

| Change Ideas from Last Years QIP (QIP 2017/18) | Was this change idea implemented as intended? (Y/N button) | Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others? |
|---|---|---|
| Launch CQI (e.g. PDSA, Kaizen, 5S etc.) with focus on enhancing the patient experience. | Yes | All stakeholder engagement is key to the success of CQI. |
| Nurse assigned to waiting room for patient reassessment/ EMS offload. | Yes | Patients are better informed about wait times. Reassessments can occur in a more timely manner. Offload time reduced by 36% from prior year. |
| Redesign Triage area: both processes and physical space. | Yes | All stakeholders were provided opportunity to provide feedback in a mocked up environment. Adjustments made to final plan based on feedback. |

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| Patient Family Advisory Council (PFAC) member to sit on Emergency Department Quality and Operations Committee and involved in all improvement planning. | Yes | Rich learning gained from patient input. |
| Purposeful rounding. | Yes | |

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| 2 | "Would you recommend this hospital to your friends and family?" (Inpatient care) ( %; Survey respondents; April - June 2016 (Q1 FY 2016/17); CIHI CPES) | 606 | 65.00 | 66.00 | 64.00 | As of December 2017. We are mindful that it is reflective of Top Box only and continue to monitor both Top Box and Secondary Box. We strive to increase our Top Box measurement however have taken the approach to set incremental targets over the next several years so as to deliver a laser focus on the metrics and change ideas. |

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| Launch CQI (e.g. PDSA, Kaizen, 5S etc.) with focus on enhancing the patient experience. | Yes | A CQI framework has been developed with input from clinical leadership as well as Patient and Family Advisory Council. Several activities such as process mapping, gap analysis, spaghetti diagram, PDSA cycles occurred. |
| Leverage PFAC members across every committee and within every quality improvement process to ensure patients add their lens and guide decisions. | No | PFAC members have been engaged in several committees including P&T committee, Art Committee, Accreditation Committee as examples. While RVH has a robust Patient and Family Advisory Committee with members that do sit on some departmental quality committees, they are not assigned exclusively. Efforts will be made this year to ensure every committee includes patient and family engagement. |

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| Ensure smooth transitions to home for all discharges. | Yes | Patient Oriented Discharge Summary (PODS) Tool has been piloted in the inpatient medicine units with expected full implementation by Summer 2018. A centralized post discharge phone call process will be implemented by Summer 2018. |
| Ensure all technology is in good working order and easy to use. | Yes | Equipment is maintained within its End of Life Cycle and any equipment exceeding the cycle is replaced to ensure good working order. RVH has a very robust refresh policy and by ensuring we stay within that refresh cycle, equipment in good working order. RVH maintains software to manufacturers specs ensuring compliance with the systems. The wireless system at RVH was upgraded which has improved connectivity for our patients to the Guest wifi. Service models will continue to be reviewed to provide the best solutions for our patients and staff. |
| Implement process with inpatient leaders that will influence behaviors that will improve patient and family experience. | Yes | Front line leaders audited clinical tactics identified as demonstrated to enhance patient experience (e.g. shift to shift report, whiteboards in units). Ongoing coaching and accountability of these tactics ensured tactics are hardwired throughout the organization. |

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| 4 | 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; Most recent 3 month period; Hospital collected data) | 606 | 69.00 | 73.00 | 73.00 | As of December 2017. A strategic roll out plan by department has been implemented and we expect our numbers to continue to reach target over the next year by the prescribed timeline. |

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|---|---|---|

| | as intended? (Y/N button) | with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others? |
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| 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. | Yes | Leaving the definition vague makes it very difficult to give guidance as to how to capture Med Rec rates & what targets to set (as certain terminology is interpreted differently by different professions) It defines that Med Rec be done on all patients who meet the organization's definition to receive Med Rec (for example, by just saying 'the entire hospital' infers that newborns should also have Med Rec & this is not possible) |

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| 5 | 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 ; Most recent quarter available; Hospital collected data) | 606 | 22.00 | 35.00 | 39.00 | As of December 2017. A strategic roll out plan by department has been implemented and we expect our numbers to reach target over the next year by the prescribed timeline. |

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| 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 | Yes | N/A |

of the medication reconciliation upon admission, as it is rolled out throughout the entire organization.

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| 11 | 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; July – September 2016 (Q2 FY 2016/17 report); WTIS, CCO, BCS, MOHLTC) | 606 | 18.57 | 18.00 | 19.78 | As of November 2017. ALC has steadily increased throughout the year. While we did not meet the target, many of the ALC patients within the building are waiting for external services. Those that are within RVH control are well managed. |

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| Introduction of a utilization management tool. | Yes | Full implementation the utilization management tool occurred February 2018. Leaders maintained weekly calls to the software company to ensure timely resolution of issues. Calls continue to ensure optimization of the tool. Site visits occurred to partner hospitals that utilize this software to learn how to maximize utilization. Data assessment continues to occur. |
| Launch of "Helping Hands". | Yes | The Helping Hands Transitional beds experienced a delay in construction at their location. Given that the community organization leased space at a Retirement Home to ensure the opening of the beds and transition from acute care. Construction is expected to be completed in the Spring 2018. |
| Appropriate admissions criteria. | Yes | Admitting physicians utilize order sets and pathways for admitted patients. An Admissionist model was implemented in the ED and hours will be increased to 24/7 to ensure timely admissions for admitted patients. General Internal Medicine and ED physicians continue to work on |

the admissions criteria. Geriatric Emergency Management Nurse reviews all appropriate patients. ED work with Medication Treatment Clinic to maximize modality of care. Hospital funds through P4R Home and Community Care located in the ED for rapid access to community support to avoid admission.