ROSS MEMORIAL HOSPITAL
Kawartha Lakes

Ross Memorial Hospital: 2017/18 QIP Work Plan

AIM		MEASURE						CHANGE			
Quality Dimension	Objective	Measure/ Indicator	Unit/ Population	Source/ Period	Current Performance	Target	Target Justification	Change Ideas	Methods	Process Measures	Goal for Change
Effective	**Reduce readmission rates for Chronic Obstructive Pulmonary Disease (COPD)**	Risk-adjusted 30-Day all-cause Readmission Rate for patients for COPD	%/COPD QBP Cohort	DAD, CIHI / April - December 2016	27.42%	23.31%	The COPD indicator was chosen over stroke and CHF due to it being the highest prevalence and readmission rate. Target was determined by reviewing current performance using crude data for 2016 and determining strategies to maintain and improve gains.	Investigate the possibility of establishing a COPD Clinic.	1. Perform cost/benefit analysis to determine if COPD clinic would be feasible.	Cost-benefit analysis completed.	Review completed with recommendation vetted.
								Improve information provided on discharge to patients who are diagnosed with COPD.	1. Implement a patient-oriented discharge summary (PODS) on COPD patients.	% of COPD patients with PODS completed on discharge	85%
								Improve utilization of the COPD digital QBP order set.	1. Audit % of patients who are placed on digital COPD order set. 2. Education to physicians regarding best practice use of digital COPD order set. 3. Identify and acknowledge physician champions.	% of patients with COPD as primary diagnosis who are placed on digital QBP Order Set.	75%
	Improve patient experience: Did you receive enough information when you left the hospital?	"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?" – Number of respondents who answered "Completely" as divided by total number of respondents.	% / All patients	NRC Picker / April 2016 - March 2017	45.70%	56.60%	Based on the data available, a score of 56.6% is required to show a statistically significant increase.	Improve communication between patients and providers on discharge.	1. Implement a patient-oriented discharge summary (PODS) on specified patient populations.	% of patients with PODS completed on discharge	85%
									2. Increase proportion of patients who receive follow-up phone calls from staff.	% of patients with follow-up phone call	85%
									3. Increase proportion of patients who have core information completed on whiteboards.	% of patients with whiteboard information complete.	70%
	Strengthen Physician Partnerships.	"I have meaningful input into changes where I care for my patients" - Number of respondents who answered "Strongly Agree" and "Agree" as a proportion of total number of respondents.	%/ all physicians who answer favourably	Hospital collected data (Work Life Pulse Physician Survey 2015)	57.60%	Combined average of ≥70%	This is a stretch target based on observing a 12% increase in both areas.	Improve hospital-physician relationship.	1. Host clinical department focus groups and develop work plan for improving physician engagement.	% of work plan completed by April 1, 2018.	80%
		"I have adequate opportunities to improve patient care, quality and safety"- Number of respondents who answered "Strongly Agree" and "Agree" as a proportion of total number of respondents.			57.60%				2. Implement quarterly "Breakfast with the Chief of Staff and CEO".	# of attendees	4 per quarter.
								Invest in professional development opportunities for our physicians.	1. Provide leadership education series.	# of participants who complete education sessions	5

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	Strengthen staff engagement.	"Overall, how would you rate your organization as a place to work?" - Number of respondents who answered "Excellent" or "Very Good" as a proportion of total number of respondents.	%/ all staff who answer favourably	Hospital collected data (Work Life Pulse Staff Survey 2015)	56.00%	Combined average of ≥68%	A 10% increase in engagement scores is seen as a stretch target (of the 339 staff who answered the survey, this would be 34 staff moving from a 'disengaged' to 'engaged' answer).	Improve hospital-employee relationship.	1.Host staff focus groups and develop a work plan for improving staff engagement.	% of work plan completed by April 1, 2018.	80%
									2. Increase celebration of successes and review rewards/recognition program.	# program teams with refreshed rewards and recognition programs implemented.	3
		"How frequently do you look forward to going to work?" - Number of respondents who answered "Always" and "Usually" as a proportion of total number of respondents.			67.10%			Improve mechanisms for staff to provide feedback.	1. Implement formal system for submitting and tracking front-line change ideas.	# front line change ideas implemented.	15
									2. Expand on and sustain Senior Team Rounds.	# FAQ documents from senior team rounds posted on internal website.	10
									3. Initiate front-line Quality Council.	# meetings held in fiscal year	5
Safe	**Increase proportion of patients receiving Medication Reconciliation (MedRec) on admission**	The total number of acute patients with medications reconciled by Pharmacy within 24 hours of admission as a proportion of the total number of patients admitted to the hospital through the Emergency Department.	% / All admissions from ED.	Hospital collected data / most recent month available	82.3%	85%	Target of 85% was set last year which we did not meet. We plan to continue to work towards this target by placing increased focus on interdisciplinary improvement efforts.	Improve data collection to enable RMH to track overall proportion of patients receiving MedRec on Admission to Hospital.	1. Measure admissions to Obstetrics, Mental Health and Pre-Operative.	Number of patients admitted to Obs, MH, Pre-Op who are audited for Best Possible Medication History (BPMH) completed.	20 per month.
								Focus on sustainability of prior Medication Reconciliation projects.	1. Medication Reconciliation Working Group to review prior projects and audit compliance.	% compliance for prior project outcomes.	90%
								Improve process for Medication Reconciliation for direct admissions to palliative, ICU, rehabilitation and integrated stroke unit.	1. Educate nurses on specified units on procedure for completing BPMH.	% direct admissions to palliative, ICU, rehabilitation and integrated stroke unit who receive BPMH.	75%
	Increase proportion of patients receiving Medication Reconciliation (MedRec) on discharge	The total number of patients with medications reconciled prior to discharge as a proportion of the total number of patients discharged from the hospital	% / All discharges	Hospital collected data / most recent month available	57.6%	67.6%	Current performance data was obtained through a spot-audit of discharges over 4 days hospital-wide. A more formal mechanism to measure hospital-wide Medication Reconciliation on discharge is planned to be developed. An increase of 10% is a stretch target.	Improve tracking process for Medication Reconciliation on discharge.	1. MedRec Working Group to determine best practice for tracking MedRec on discharge.	% process implemented.	100%
								Improve MedRec on transfer.	1. Focus on transfer between acute units and continuing care.	% patients transferred between acute and continuing care who have received transfer MedRec.	75%
								Provide comprehensive discharge medication information to primary care physician.	1. Expand faxing of discharge prescription and BPMH to family health team on acute inpatients.	% patients discharged to family health team with prescription and BPMH faxed.	80%

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Patient-Centered	**Improve overall patient experience.**	"Would you recommend this hospital (inpatient care) to your friends and family?" Number of respondents who answered "Definitely Yes" and divide by total number of patients who responded to that question.	% / All patients	NRC Picker / April 2016 - Dec 2016	59.40%	70%	Based on the data available, a score of 69.9% is required to show a statistically significant increase.	Improve patient experience with regards to food.	1. Increase proportion of patients who are visited by nutrition services staff within 24 hours of admission.	% new admissions who receive visit from nutrition services.	90%
								Implement plan to increase exposure of patient experience data from NRCC Picker Patient Experience surveys.	1. Survey management team to determine needs. 2. Hold training session for management team. 3. Develop automatic reports generated monthly/quarterly.	Patients experience data exposure plan implemented.	100%
								Implement more just-in-time survey tools to address issues in a more timely fashion.	1. Use tablets to survey patients regarding housekeeping. 2. Implement comment cards on continuing care units.	# of survey tools developed and implemented.	3
		"Would you recommend this Emergency Department to your friends and family?" Number of respondents who answered "Definitely Yes" and divide by total number of patients who responded to that question.	% / All patients	NRC Picker / April 2016 - March 2017	52.70%	60%	Based on the data available, a score of 59.5% is required to show a statistically significant increase.	Implement more just-in-time survey tools to address issues in a more timely fashion.	1. Use tablets to survey patients in Emergency Department.	# patients surveyed in fiscal year.	200
								Implement plan to increase exposure of patient experience data from NRCC Picker Surveys.	1. Survey management team to determine needs. 2. Hold training session for management team. 3. Develop automatic reports generated monthly/quarterly.	Patients experience data exposure plan implemented.	100%
								Promote patient-and-family centered care environment in the Emergency Department	1. Strengthen client-centered care practices in ED.	% of staff and physicians who receive training.	100%
									2. Review physical environment to ensure ED is 'waiting-friendly'.	% patients who indicate satisfaction with physical environment in real-time survey.	75%

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Timely	**Reduce wait times in the Emergency Department.**	90th percentile ED length of stay non-admitted low acuity patients.	Hours/ED patients	CCO i-port Access/ January - December 2016	4.4	3.8	Stretch target based on prior years' performance.	Determine optimal staffing mix and schedules to address ED wait times.	1. Review alternate providers in sub-acute areas such as Nurse Practitioner or Physician Assistant.	Cost-benefit analysis completed.	Review completed with recommendation vetted.
									2. Review process for creating physician schedules.	Cost-benefit analysis completed.	Review completed with recommendation vetted.
								Investigate alternate workflow for providing care to CTAS 4 and 5 patients.	1. Trial physician at triage.	Review and communicate findings at Medical Advisory Committee (MAC) and Patient Care Advisory Committee (PCAC).	Recommendation is discussed at MAC and PCAC.
									2. Investigate feasibility of alternate treatment area for CTAS 4 and 5 patients.	Review and communicate findings at Medical Advisory Committee (MAC) and Patient Care Advisory Committee (PCAC).	Cost benefit analysis completed with recommendation.