Quality
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Ross Memorial Hospital: 2018/19 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
Experience	**Improve patient experience on discharge**	“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.	% / Med, Surg & Rehab survey respondents	NRC Health / April 2017 - June 2017	45.80%	56.60%	This is the target set for last year which we have not yet achieved.	1. Complete SMART discharge project roll-out throughout Hospital.	1. Expand project and implement on all in-patient units throughout the Hospital. 2. Sustain project accomplishments through continued auditing, evaluation and celebration of successes. 3. Evaluate and optimize SMART tool with feedback from patients, families, physicians and staff.	% discharged patients with SMART discharged tool completed.	90%
								2. Organize a 'Discharge Planning Month' to focus on progress to-date and re-energize stakeholders.	1. Post-discharge satisfaction phone calls to patients. 2. Education for staff. 3. Re-survey of staff satisfaction with new discharge processes.	% patients & staff surveyed who are satisfied with discharge process.	80%
	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.	% / Med, Surg & Rehab survey respondents	NRC Health / April 2017 - June 2017 (Q1)	57.10%	70%	This is the target set for last year which we have not yet achieved.	1. Create a culture of Service Excellence.	1. Embed Service Excellence in the corporate Strategic Directions, Goals and Objectives. 2. Provide training for all staff on how to deliver Service Excellence. 3. Ensure that the physical environment supports Service Excellence (ex: after-hours accommodations for parking, beverages, nutrition, public spaces are safe and clean, etc.)	% staff trained	90% by Q4
								2. Create more opportunities to obtain individualized, real-time feedback from patients and enhance our ability to make improvements based on this feedback.	1. Perform in-depth analysis of NRC data to determine key drivers of recommending Hospital. 2. Promote equity in health service surveying methods. 3. Expand PEP rounding project throughout Hospital from 1 patient care area to 5 patient care areas.	Standardized real-time survey process developed	100%
								3. Enhance communication with patients and families about integrated plan of care.	1. Improve communication with patients and families through bedside whiteboards and audit utilization compliance. 2. Develop tools to communicate plan of care to patient upon admission.	# complaints related to communication issues.	Reduction by 10%

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Experience	**Improve overall patient experience**	"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.	% / ED survey respondents	NRC Health / April 2017 - June 2017 (Q1)	51.60%	60%	This is the target set for last year which we have not yet achieved.	1. Create a culture of Service Excellence.	1. Embed Service Excellence in the corporate Strategic Directions, Goals and Objectives. 2. Provide training for all staff on how to deliver Service Excellence. 3. Ensure that the physical environment supports Service Excellence (ex: after-hours accommodations for parking, beverages, nutrition, public spaces are safe and clean, etc.)	% staff trained	90% by Q4
								2. Create more opportunities to obtain individualized, real-time feedback from patients and enhance our ability to make improvements based on this feedback.	1. Perform in-depth analysis of NRC data to determine key drivers of recommending Hospital 2. Promote equity in health service surveying methods. 3. Expand PEP rounding project throughout Hospital.	Standardized real-time survey process developed	100%
								3. Enhance communication with patients and families.	1. Improve communication with patients and families through interactive TV with up-to-date wait times and relevant information. 2. Install patient tracking board to improve communication among team members. 3. Enroll ED staff in Gentle Persuasive Approach (GPA) training to enhance communications with patients who demonstrate responsive behaviours.	# complaints related to communication issues.	Reduction by 10%

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	Improve Physician Experience	"How satisfied are you with this organization as a place to practice medicine?" - Number of respondents who answered "Very satisfied" and "Satisfied" as a proportion of the total number of respondents.	%/ survey respondents	Hospital collected data / most recent data available	66.50%	Combined average of ≥70%	This is the target set for last year which we have not yet achieved.	1. Ensure physicians are engaged in informed decision-making for Hospital change initiatives.	1. All primary and secondary stakeholders are involved in change initiatives. 2. Revise engagement tracking and ensure it is used for all relevant change initiatives. 3. Review and revise terms of reference for committees which require physician attendance to ensure structure promotes physician attendance.	Revised tracking sheet developed and used for policy and care plan (ex: order sets) revisions.	100% in Q4
								2. Improve physician scheduling practices.	1. Promote predictability of physician schedules to improve work life experience.	"Access to facilities, equipment and resources" Worklife Pulse question.	80%
		"I have adequate opportunities to improve patient care, quality and safety" - Number of respondents who answered "Strongly Agree" or "Agree" as a proportion of total number of respondents.						3. Improve teamwork, collegiality and work environment for professional staff.	1. Review physical space (ex: office, unit work space) to ensure it is designed to optimize physician's ability to provide exceptional care and promote teamwork. 2. Encourage participation of physicians, physician leaders, and administrative leaders in departmental and corporate initiatives.	"Your relationship with other physicians" Worklife Pulse question.	90%

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Experience	**Improve Staff Experience**	"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.	%/ survey respondents	Hospital collected data / most recent data available	50.00%	Average of ≥60%	10% increase is considered a stretch target for employee satisfaction surveys.	1. Promote "fun at work."	1. Establish Wellness (social and psychological health) Working Group with representation from across the Hospital. 2. Investigate ways to promote fun at work (ex: prizes, departmental team-identification, social events, sports teams/events etc). 3. Implement one 'fun' event per month organized by Wellness Working Group.	Participation in wellness events.	80% of target participation goals met.
		"I feel I belong to a team." - Number of respondents who answered "Strongly Agree" and "Agree" as a proportion of total number of respondents.						2. Implement and sustain Service Excellence behaviours.	1. Implement Service Excellence program and ensure all staff are trained through internal subject-matter experts. 2. Establish a supportive environment for staff to provide Service Excellence (ex: access to manager when needed, open, transparent communication etc.).	# complaints related to attitude/ courtesy	Decrease by 20%
								3. Take care of our workplace inside and out.	1. Conduct a review of our team and individual work spaces and make improvements to promote efficiency and waste reduction (imbed Lean principles, establish champions). 2. Evaluate our external environment (Hospital Grounds) for potential improvements and risks (safety, aesthetics etc).	Review of work spaces completed by Q4.	100%

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Safe	**Decrease incidents of Workplace Violence**	The total number of workplace violence incidents reported by hospital workers.	All patients & staff	Hospital collected data / Jan - Dec 2017	177	195	10% increase as we want to build awareness of staff and enhance safety culture	1. Refresh violence prevention program by utilizing the Workplace Violence Toolkit developed by PSHSA which includes conducting organizational, departmental, and direct care risk assessments, patient assessments & flagging for violence, enhancing security measures, enhancing personal safety response systems, implementing renewed safety measures and care approaches to keep our staff and patients safe.	1. Workplace Violence Steering Committee to work through each of the components within the workplace violence toolkit developed by PSHSA for gap analysis and action planning to decrease risk. 2. Enhance / encourage reporting mechanisms, and create awareness through education of staff. 3. Ensure staff has the knowledge and skill to effectively manage patients with violent behaviours. 4. Ensuring compliance with the RMH Code of Conduct throughout RMH. 5. Promoting Violence-Free workplace in high risk areas.	% action plan implemented by Q4 2018/19.	100%
	Decrease incidents of Falls with Harm	The total number of Falls with Harm reported per 1,000 patient days.	All Patients	Hospital collected data (RL6) / Jan - Dec 2017	1.24	<1.0	20% decrease	1. Refresh corporate Falls Prevention Program.	1. Bring interdisciplinary working group together to develop an action plan including equipment inventory, on-going patient and staff education etc. 2. Perform gap analysis to determine where improvements need to be made in current Falls Prevention Program. 3. Conduct environmental scan to update program with leading practices. 4. Optimize reporting tool for Falls.	% action plan implemented by Q4 2018/19.	100%
	Decrease incidents of failure to appreciate status change/deterioration	The number of Medical Emergency Team (MET) call patients transferred to the ICU with a noted deterioration 24 hours prior to the call.	MET call patients	Hospital collected data / most recent quarter available	Collecting Baseline.	TBD	There will be an expected increase related to Early Warning Sign Project rollout	1. Utilize Early Warning Scores (EWS) to improve patient outcomes and standardize assessments of acute illness.	1. Establish a Steering Committee to oversee the implementation of an EWS. 2. Review all present Medical Emergency Team (MET) directives with the Critical Care Committee and align them with the chosen EWS. 3. Review and further develop the MET roles and responsibilities with the closed ICU perspective. 4. Develop action plan.	% action plan implemented by Q4 2018/19.	80%

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Safe	**Decrease incidents of hospital-acquired pressure ulcers**	% of inpatients with Stage 1 or higher Hospital-Acquired Pressure Injury.	113 inpatients	Hill-Rom Pressure Injury Prevalence Study; Feb 22, 2017	12.40%	8%	Target to reduce by 4% each year to reach Acute Care Benchmark	1. Re-establish the wound care team with representation from nursing, physio, Dietician, Quality and Risk; Adhoc - Pharmacy and Support Services.	1. Analyze the Pressure Ulcer/Injury Point Prevalence (IPUP) Survey data from 2017. 2. Complete a 2018 IPUP survey. 3. Compare the results of the 2017 to 2018 IPUP. 4. Evaluate current state (inventory, knowledge and implementation of best practice etc) and establish areas for improvement. 5. Develop an education plan and roll out to front line health care providers.	% nursing staff educated	90%
	Improve Medication Reconciliation on admission	The total number of patients with medications reconciled within 24 hours of admission as a proportion of the total number of patients admitted to the hospital.	% / All admissions	Hospital collected data / most recent month available	82%	90%	Accreditation Required Organizational Practice (ROP).	1. Consolidate data from all areas of the hospital that perform admissions.	1. Expand current data collection model for ED to include all areas of the Hospital (ex: outpatient dialysis, mental health, OR, Obstetrics etc.). 2. Ensure regular reporting of MedRec stats quarterly to Department Managers.	% Hospital Patient Care services included in MedRec Stats.	100%
	Improve Medication Reconciliation on transition within Hospital	The total number of patients with medications reconciled within 24 hours of transfer as a proportion of the total number of patients transferred to a different level of care within the hospital.	% / All transfers	Hospital collected data / most recent month available	Collecting Baseline.	90%	Accreditation Required Organizational Practice (ROP).	1. Formalize MedRec on Transfer process to include tracking mechanism.	1. MedRec Working Group to review current process. 2. Establish formal standardized process and roles. 3. Trial revised process on acute units.	# acute units standard process is implemented on by Q4	2
	Improve Medication Reconciliation 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	79%	90%	Accreditation Required Organizational Practice (ROP).	1. Formalize MedRec on Discharge process to include tracking mechanism.	1. Add information to the SMART Discharge program encouraging patients to schedule a MedsCheck follow up with their community Pharmacy when discharge date has been determined. 2. MedRec Working Group to review current process. 3. Establish formal standardized process and roles. 4. Trial revised process on acute units.	# acute units standard process is implemented on by Q4	4