2015/16 Quality Improvement Plan for Ontario Hospitals
"Improvement Targets and Initiatives"

Royal Victoria Regional Health Centre

Royal Victoria Regional Health Centre 201 Georgian Drive

AIM		Measure							Change				
Quality dimension	**Objective**	**Measure/Indicator**	**Unit / Population**	**Source / Period**	**Organization Id**	**Current performance**	**Target**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	Methods	Process measures	Goal for change ideas	Comments
Access	**Reduce wait times in the ED**	ED Wait times: 90th percentile ED length of stay for Admitted patients.	Hours / ED patients	CCO iPort Access / Jan 1, 2014 - Dec 31, 2014	606*	26.6	21.3	This was our 2014/15 goal and was not achieved however we feel we can hit this target with new strategies in place.	1)A new strategic approach to patients admitted in the ED will be executed April 1, 2015. The creation of a new in-patient unit directly adjacent to the Emergency Department will be branded as the "Medical Transition Unit". This unit will be utilized for patients requiring admission but for short periods of time. Additional strategic tactics include: Enhancement of the GEM nurse (Geriatric Emergency Management nurse), Health Links, MVP clinic and "new Mgmt requirement" at all bed meetings so a "pull" philosophy will be formally executed.	Open new MTU; enhanced GEM nurse presence, HL, MVP clinic all to drive lower wait times in the ED.	As per current wait time methodology for measurement.	Achieve Wait Times, Enhance value of GEM nurse and maximize access to HL and MVP clinic.	
									2)Mulitple in-patient LEAN events including Model of Care to commence March 30th, 2015.	These LEAN events combined with Model of Care will enhance the "pull" actions required by all in-patient units.	Time to pull patients from ED to units.	Reduce ED pull times by 10% per unit.	
Effectiveness	**Improve organizational financial health**	Total Margin (consolidated): % by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expense, excluding the impact of facility amortization, in a given year.	% / N/a	OHRS, MOH / Q3 FY 2014/15 (cumulative from April 1, 2014 to December 31, 2014)	606*	-0.08	0	A balanced budget has been achieved for the 5th year in a row and we will continue to maintain this.	1)Ramp up of surgical cases by 10% to increase weighted cases in alignment with PCOP funding.	Increased utilization of ORs during down time focused around summer closures.	Track case volumes and Weighted cases generated by surgical interventions.	Goal is 400 additional Operating Suite Cases.	
									2)Make model of care changes in all inpatient medical units resulting in lower cost per patient day.	Engage front line staff to maximze scope of practice of exisiting and new health care positions.	Medical Cost per Patient day.	Implement model of care on three units.	
									3)Increase Uninsured/Non-resident Revenue Rates.	Develop new policies and roll out policy to ensure collection of funds from Non-Resident and Non-OHIP covered patients.	Increased billing and collection from non-resident and non-OHIP patients.	New policy developed within 6 months.	

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Integrated	**Reduce unnecessary time spent in acute care**	Percentage ALC days: Total number of acute inpatient days designated as ALC, divided by the total number of acute inpatient days. *100	% / All acute patients	Ministry of Health Portal / Oct 1, 2013 - Sept 30, 2014	606*	15.34	17.1	ALC is a systems issue. Our 24 month baseline average is 17.1% which is a more realistic target.	1)CCAC/RVH enhanced relationship. D/C planning process to commence earlier, and tighter management of EDD.	CCAC and CNE working group to target ALC population requiring placement. First meeting launched Feb 2015. EDD to be reviewed with VP monthly for all programs.	Monthly meetings for both strategic alignment with CCAC as well as reivew "action plans" of all ALC patients hospital-wide.	Monthly review of EDD for 100% of all clinical programs.	
	Reduce unnecessary hospital readmission	Readmission within 30 days for Selected Case Mix Groups	% / All acute patients	DAD, CIHI / July 1, 2013 - Jun 30, 2014	606*	17.38	17.1	Hospital readmission is a systems issue. Our 24 month baseline average is 17.1% which is a more realistic target.	1)Research last 24 months to determine who the top 3 readmits are to RVH only.	Complete a retrospective QI project to study the utilization patterns of three patient populations/case mix groups (CMGs) that impact RVH readmission rates.	Number of CMGs studies completed by project.	100% of studies (3 of 3 CMGs) September 30, 2015.	
									2)Based on this develop a Quality Initiative with appropriate stakeholders to reduce readmissions.	Using results of QI study outlined above, develop and implement plans to reduce readmissions for three CMGs identified.	1. Number of completed plans implemented; 2. Reduction in readmission within three CMGs.	1. 100% (3 of 3) plans implemented by December 31, 2015; 2. For each of the three CMGs, reduce hospital readmissions by 40% by March 31, 2016.	
Patient-centred	**Improve patient satisfaction**	From NRC Canada: "Would you recommend this hospital (inpatient care) to your friends and family?" (add together % of those who responded "Definitely Yes" or "Yes, definitely").	% / All patients	NRC Picker / October 2013 - September 2014	606*	72	82	This was our 2014/15 goal and was not achieved however we feel we can hit this target with new strategies in place.	1)Leader rounding with every patient daily.	Leaders of clinical units will round with every patient on a daily basis (M-F) which incorporates monitoring of quality/safety and service tactics including purposeful/ hourly rounding, bedside shift report, falls protocol, etc - determined by the specific needs of each unit. Leaders track this data in an electronic database as well as monitoring with a custom question on NRC Patient Experience Survey for select units.	Percent compliance with tactic = Number of patients rounded with per month/Number of beds occupied by patients per month.	90% compliance rate.	
									2)Provide clinical staff with skills training to improve communication with patients.	Organization will track the completion rate of skills training for the determined target population of 'Clinical team leaders/educators'. Patient Experience data is available via quarterly patient experience surveys from National Research Corp.	1. % Completion Rate: Number of "clinical team leaders/educators" that have completed training/Number of "Clinical team leaders/educators"; 2. Improved results on key patient Experience Item: Nurse discussed	1. Completion rate = TBD (LS); 2. x% improvement on each question.	
									3)Discharge Phone calls – with follow-up of outstanding issues.	Organization will attempt to place follow up phone call to patients post inpatient discharge/outpatient service with four days. Call statistics including attempt and completion rates tracked in electronic database.	1. % Phone Calls Attempted (Number of calls attempted/Number of patients discharged/ served); 2. % Calls dropped due to time (# calls dropped due to lack of attempts within four days).	1. % attempt rate; 2. % drop rate due to lack of attempts.	
									4)The Patient Family Advisory Council enables direct patient and/or family engagement to improve the patient experience throughout the continuum of care.	Organization places high priority on ensuring patients are included in decision making and committees. PFAC tracks (?) the progress of this initiative by the number of committees/ councils that have a patient representative in the terms of reference and as an active member.	Inclusion rate = # of committees with active patient representative / # active identified committees in organization.	Achieve an inclusion rate of x %.	
									5)Develop further actions with front line staff based on NRC Picker results.	Utilizing key drivers for 'WYR-yes definitely', leaders in clinical units are accountable to develop and implement action plans to create improvement aligned to specific drivers in their units. Data is tracked utilizing an action plan template and electronic database.	1. Alignment of Action Plans = # of action plans aligned to top priority key drivers as per priority matrix/# of action plans completed; 2. % Action Plans completed by unit = # of action plans completed/# of action plans submitted.	1. 100% action plans aligned to key drivers; 2. 90% of action plans completed.	

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Safety	Increase proportion of patients receiving medication reconciliation upon admission	Medication reconciliation at admission: The total number of patients with medications	% / All patients	Hospital collected data / most recent quarter available	606*	84	90	Targetting specific patient populations will allow for better quality measrues.	1)Identification of patients who meet criteria for Med Rec versus All Patients.	Monthly reports.	% patients admitted meeting criteria for a BPMH to be generated versus all admitted patients for Surgery, Cardiac/Renal & Oncology Outpatients.	Adjust target to 90% of eligible patients.	
	Reduce hospital acquired infection rates	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1,000 - Average for Jan-Dec. 2014, consistent with HQO's Patient Safety public reporting website.	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / Jan 1, 2014 - Dec 31, 2014	606*	0.12	0.22	Our 24 month baseline is 0.22 and we believe we can sustain this target.	1)Screening and communication of "High risk"admitted patients in the ED to inpatient units.	ED Staff will communicate to inpatient staff using SBARD each high risk patient being admitted from ED to an inpatient unit.	1. Percentage compliance with screening tactic = # of times screening tool used at triage/# of patients triaged; 2. Percentage compliance with communication tactic = # of times SBARD tactic used/# of patients identified as high risk at triage.	1. Compliance rate with screening = x%; 2. Compliance rate with SBARD tool = y%.	
									2)Infection Control Team will continue to use the CDI trigger tool as a pre-outbreak strategy for CDI.	CDI trigger tool applied to inpatient units with CDI cases to minimize outbreak.	Compliance rate with trigger tool = Number of times trigger tool enacted/number of times threshold hit.	Compliance rate wth trigger tool = 100%.	
									3)Provide units with Infection Control Scorecard.	IPAC will provide units with scorecard quarterly with 4-6 performance indicators re: Infection prevention.	# of quarterly scorecards sent out on time / # of quarters (4).	100%	
									4)Monitoring prophylactic antibiotic utilization (type/amount) in Inpatient Surgery for four target groups: Elective Hip, Elective Knee, C-Section & Colorectal Surgeries.	IPAC will conduct data analysis and report results to departments. Departments will receive, deseminate and utilize data for improvement.	# of appropriate prophylactic antibiotics/# of surgeries (in four target groups).	95% utilization of appropriate prophylactic antibiotic.	
									5)Complete best practice cleaning and disinfection of commodes and bedpan bases.	Development and role out of guidelines for appropriate cleaning and disinfecting of commodes and bedpan bases.	100% of appropriate staff trained on new guidelines.	100% of commodes and bed pan bases cleaned and disinfected as per guidelines.	