2016/17 Quality Improvement Plan
"Improvement Targets and Initiatives"

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
Effective	**Reduce 30 day readmission rates for select HIGs**	Percentage of acute hospital inpatients discharged with selected HBAM Inpatient Grouper (HIG) that are readmitted to any acute inpatient hospital for non-elective patient care within 30 days of the discharge for index admission.	% / All acute patients	DAD, CIHI / July 2014 – June 2015	606*	17.02	4.00	To reflect RVH site only. PY performance based on all sites. Does not align with HSAA 30 day readmit indicator. Although ministry/LHIN has not defined technical specifications for HSAA indicator, RVH does use CIHI 28 day readmit for same select HIGs and therefore choosing to report target for this indicator in this QIP.	1)Enhance provision of integrated and coordinated care, so a patient can receive the right care from the right provider at the right time.	Expand upon the inpatient and outpatient CHF program to include dedicated heart function nurses and nurse practitioners and access to nine cardiologists Review and revise pre-printed orders and the clinical pathways for COPD, CHF and stroke in collaboration with the department of internal medicine. Conduct the six minute walk test with all appropriate heart failure patients per best practices. Review and revise electronic documentation fields to align with evidence-based Quality Based Procedures(QBPs). Audit compliance with CHF QBP standards, share resultant data sets and conduct iterative improvement cycles as indicated. Explore opportunities to introduce an electronic alert for heart function patients presenting in the Emergency Department (ED) to facilitate consultation and avoid unnecessary readmissions. Retrospective chart reviews will also be conducted on this patient to enhance discharge transitions. Regional approach to CHF has been employed with team of multi-disciplinary stakeholders to develop standardized protocols and policies that will prevent hospitalization and enhance the ability to keep patients safely supported in the community. Actively participate in partnership for INTEGRATE project for smooth transitions for palliative patients along the continuum of care. Lead and intensively collaborate in the Integrated Funding Model wave II for stroke patients in the North Simcoe Muskoka Local Health Integration Network (LHIN).	Number of FTE health care providers quarterly in the CHF programs (including physicians) meets service level standards. Percentage of PPO reviews and revisions. Percentage of compliance with six minute walk test for all heart failure walk test. Percentage of electronic documentation field revisions for CHF QBP. Audit compliance by April 1 2016 and then review and share data. Electronic alert embedded by July 1 2016.	Reduce readmission to RVH Enhance partnerships for smoother transitions in patient care Meet QBP targets for CHF, stroke and COPD	
									2)Collaborate with our health system partners to smooth transitions in care for patients receiving care.	Review and revise pre-printed orders and the clinical pathways for stroke, CHF and COPD diagnoses in collaboration with the department of internal medicine. Explore opportunities to work with the Barrie Family Health Team to develop and trial an electronic transition of care referral tool. Enhance our post care telephone call completion rate and implement iterative change plans for improving upon identified opportunities to smooth transitions in care. Open an intravenous lasix clinic with our community partners. Leverage partnership with NSM Community Care Access Centre (CCAC) for ensuring safe and quality transitions for patients out of the hospital with consistent, appropriate referrals to the CHF and COPD Telehomecare program (support for moderately to severely affected patients initiated in October 2015). Lead the Integrated Funding Model wave II participation for stroke patients in our region. Consistently assess risk of readmission as an element of our individualized discharge planning processes. Facilitate arrangement of a primary care appointment before patients at high risk of readmission are discharged from RVH. Promote self-management and effective education to patients and their families with demonstrated teach backs. Introduce medication reconciliation upon discharge for patients admitted with their primary diagnosis of stroke.	Percentage of PPO reviews and revisions by the July 1 2016. Percentage of post care call completion rate. Percentage of referrals to the CHF and COPD Telehomecare program. Percentage of risk of readmission completed for patients. Percentage of interdisciplinary staff participating in teach back educational sessions. Percentage of primary care provider appointments are scheduled prior to discharge for patients deemed high risk of readmission. Percentage of stroke patients with a completed medication reconciliation.	Reduce readmission to RVH Enhance partnerships for smoother transitions in patient care Meet QBP targets for CHF, stroke and COPD	

									3)Leverage technology to enhance access to service, connect patients with the right providers and inform and educate patients.	Explore opportunities to work with the Barrie Family Health Team to develop and trial an electronic transition of care referral tool. Leverage partnership with NSM Community Care Access Centre (CCAC) for ensuring safe and quality transitions for patients out of the hospital with consistent, appropriate referrals to the CHF and COPD Telehomecare program (support for moderately to severely affected patients initiated in October 2015).	Percentage of referrals to the CHF and COPD Telehomecare program.	Reduce readmission to RVH Enhance partnerships for smoother transitions in patient care	
									4)Engage in Plan-Do-Study-Act cycles for continuous quality improvement focused on reducing unnecessary hospital readmission.	Implement standardized process for morbidity and mortality reviews in all medical departments including a trigger for reviews with readmissions within 30 days to our own hospital. Enhance our post care telephone call completion rate and implement iterative change plans for improving upon identified opportunities to smooth transitions in care. Lead the Integrated Funding Model wave II participation for stroke patients in our region. Promote self-management and effective education to patients and their families with demonstrated teach backs. Audit compliance with CHF QBP standards, share resultant data sets and conduct iterative improvement cycles as indicated.	Percentage of mortality reviews completed each quarter. Percentage of post care call completion rate.	Reduce readmission to RVH. Enhance partnerships for smoother transitions in patient care. Meet QBP targets for CHF, Stroke and COPD.	
Efficient	**Reduce unnecessary time spent in acute care**	Total number of ALC inpatient days contributed by ALC patients within the specific reporting period (open, discharged and discontinued cases), divided by the total number of patient days for open, discharged and discontinued cases (Bed Census Summary) in the same period.	% / All acute patients	WTIS, CCO, BCS, MOHLTC / July 2015 – September 2015	606*	19.4	19.40	Improve upon performance in the last two QIP cycles. Note that last year's performance was based off ALC days/% whereas this year's target is reflective of ALC rate. Progress Report measurement for last year (15.95) represents ALC days therefore slight inconsistency in metrics between Work Plan and Progress Report.	1)Enhance provision of integrated and coordinated care, so a patient can receive the right care from the right provider at the right time.	Review and revise the discharge planning model to identify patients who have complex discharge planning needs and facilitate safe transition from hospital to the community. Proactively prepare discharge options and alternatives for patients with complex discharge needs. Implement visual management tools and engage in an educational campaign for care providers , patients and families to promote 'There's No Place Like Home' philosophy rather than awaiting long term care bed placement while in an acute care bed. Engage a bioethicist in an ethics quality improvement plan to enhance consistency and appropriateness of discharge planning discussions. Build on our successes and maintain our heightened attention on patient flow throughout the hospital. Consider opportunities to engage a physician champion in discharge planning.	Number of ALC patients on census daily. Percentage of patients discharged and departed on or before the identified EDD. Number of ALC patients awaiting long term care placement. Percentage of attendance at daily bed meetings. Percentage of interdisciplinary staff participating in teach back educational sessions. Number of teach back education opportunities offered.	Avoidance of ALC and conservable bed days	
									2)Collaborate with our health system partners to smooth transitions in care for patients receiving care.	Partner with NSM CCAC to identify and address barriers to discharge early for inpatients. Proactively prepare discharge options and alternatives for patients with complex discharge needs. Implement visual management tools and engage in an educational campaign for care providers , patients and families to promote 'There's No Place Like Home' philosophy rather than awaiting long term care bed placement while in an acute care bed. Institute an integrated discharge planning review committee for ALC patients or those with complex discharge planning needs. Maintain commitment to Home First initiative and actively participate as partners in regional ALC strategies.	Number of patients discharged on Home First programming. Number of ALC patients awaiting long term care placement.	Avoidance of ALC and conservable bed days.	
									3)Leverage technology to enhance access to service, connect patients with the right providers and inform and educate patients.	Introduce a real-time application for hospital leadership to access ALC and census data. Implement visual management tools and engage in an educational campaign for care providers , patients and families to promote 'There's No Place Like Home' philosophy rather than awaiting long term care bed placement while in an acute care bed.	Number of ALC patients awaiting long term care placement. Percentage of leaders with access to real time data on census and bed availability.	Avoidance of ALC and conservable bed days.	
Patient-centred	**Improve patient satisfaction**	"Would you recommend this hospital (inpatient care) to your friends and family?" add the	% / All patients	NRC Picker / October 2014 – September 2015	606*	73	82.00	Continue with multi-year QIP stretch target of 82%.	1)Engage in Plan-Do-Study-Act cycles for continuous quality improvement focused on enhancing the patient experience.	Promote self-management and effective education to patients and their families with demonstrated teach backs. Ongoing participation in bed utilization evaluation and monitor changes based on recent revisions of bed type complements in Mental Health.	Percentage of interdisciplinary staff participating in teach back educational sessions. Number of teach back education opportunities offered. Number of visits to youth mental health urgent consult clinic. Number of admissions and discharges from mental health urgent	Patient experience improvement.	

		number of respondents who responded "Yes, definitely" (for NRC Canada) or "Definitely yes" (for HCAHPS) and divide by number of respondents who registered any response to this question (do not include non-respondents).							2)Implement services to meet community needs while exceeding their expectations and use patient feedback to influence optimization of space and capital expenditures.	Partner with patients and family advisors to design and deliver health care experiences. Consider use of patient helpers willing to share their knowledge and expertise with others. Build on success by cascading Patient and Family Advisory Council members as key members of internal quality committees. Eliminate visiting hours for patients by February 2016 with a new Family Presence Policy. Develop program-level scorecards for patient experience in the MY CARE philosophy. Build on our success using 'Key Words at Key Times' to reduce patient anxieties. Build on our success with hourly rounding with patients to determine effect of changes in models of care to include Patient Care Assistants and team-based nursing. Build on our success with daily leadership rounding with patients. Develop and externally post a Patient Feedback Policy and Procedure. Review and revise the organizational pain management strategy. Promote self-management and effective education to patients and their families with demonstrated teach backs. Implement a new end of life care strategy policy and procedure that provides patients and families with enhancing opportunities to improve the quality of end of life experiences. Sustain the information technology pod for troubleshooting patient and visitor technology questions and concerns. Develop a health equity strategy to address trends within patient feedback mechanisms. Improve wayfinding strategies within the main hospital building. Replace as many aging bedside and over bed tables within the building as possible. Renaming the streets on the hospital grounds for easier wayfinding and communications with emergency responders. Revising public entrances and parking lot accesses in response to patient feedback, changing services and Family	Number of patient helpers onboarded. Number of PFAC members/representatives on internal committees. Percentage of internal quality committees with PFAC members on the membership. % of patients with 100% hourly rounding completed and signed off per inpatient unit measured monthly on departmental scorecards. Number of leaders meeting established targets for rounding with patients within the Leadership Evaluation Module. % of interdisciplinary staff participating in teach back educational sessions. Number of teach back education opportunities offered. % of professional staff participating in education sessions for new resuscitation policy and procedure. Number of bedside and over bed tables replaced. Monthly monitoring of outpatient wait lists for service. Number of complaints/concerns logged year over year regarding the patient experience.	Enhance patient and family experience	
									3)Leverage technology to enhance access to service, connect patients with the right providers and inform and educate patients.	Further our partnership with CCAC with use of alerts for patients with unplanned visits to our hospital, team-based care coordination for high-users of services and participation as a member of Health Links by 2018. Sustain the information technology pod for troubleshooting patient and visitor technology questions and concerns.	Volumes of patient, staff and visitor questions and concerns addressed at the technology pod.	Enhance the patient experience.	
									4)Collaborate with our health system partners to smooth transitions in care for patients receiving care.	Further our partnership with CCAC with use of alerts for patients with unplanned visits to our hospital, team-based care coordination for high-users of services and participation as a member of Health Links. Continue partnership and participation in continuous quality improvement initiatives with the MVP HealthLinks as an ED presentation diversion tactic.	Percentage of patients CTAS 4 and 5 presenting ED. Wait times in ED for admitted patients, non admitted complex patients and non admitted non complex patients.	Reduce ED wait times. Enhance the patient experience. Enhance continuity of patient care.	
									5)Enhance the employee experience at RVH to augment the correlate performance of the patient experience indicators.	Implement departmental employee engagement action plans and measure impact on patient experience indicators. Implement enhanced flex time initiatives for non-unionized staff members. Enhance transparency for staff members with respect to attendance management process and job descriptions. Introduce a new employee emotional wellness initiative throughout the corporation.	Percentage of employees rating RVH positively for overall engagement scores. Percentage of employees rating RVH job satisfaction. Percentage of employees rating RVH as a place to work favourably.	Enhance employee experience correlating to the patient experience.	
									6)Introduce communication education: (Caring, The Human Touch).	Roll out communication initiative across all in-patient units in 2016.	Obtain baseline patient experience scores pre-education sessions with quarterly monitoring of patient experience results.	Enhance patient experience correlating to patient experience.	
Safe	**Increase proportion of patients receiving medication reconciliation upon admission**	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	% / All patients	Hospital collected data / most recent quarter available	606*	89	75.00	Slightly lower target than PY as focus this year on quality and processes of an electronic solution throughout the entire organization, and not just in the Surgery department.	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 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.	Mean number of unintentional discrepancies per patient. Percentage of patients with at least one additional discrepancy outstanding.	Ensure quality of medication reconciliation completion.	

								2)Continue to prepare for electronic medication reconciliation processes throughout the entire organization.	Execute action plans for transitioning to an electronic process for medication reconciliation.	Percentage of units using electronic process.	Reduce readmissions. Smooth transitions in care. Enhance communications.	
	Increase proportion of patients receiving medication reconciliation upon discharge	Medication reconciliation at discharge: The total number of patients with medications reconciled as a proportion to the total number of patients discharged from the hospital	% / All patients	Hospital collected data / Most recent quarter available	606*	46	35.00	Slightly lower target than PY as focus this year on quality and processes of an electronic solution throughout the entire organization, and not just in the Surgery department.	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 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.	Mean number of unintentional discrepancies per patient. Percentage of patients with at least one additional discrepancy outstanding.	Ensure quality of medication reconciliation completion.
									2)Continue to prepare for electronic medication reconciliation processes throughout the entire organization.	Execute action plans for transitioning to an electronic process for medication reconciliation.	Percentage of units using electronic process.	Reduce readmissions. Smooth transitions in care. Enhance communications.
	Reduce hospital acquired infection rates	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI during the reporting period, divided by the number of patient days in the reporting period, multiplied by 1,000.	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / January 2015 – December 2015	606*	0.16	0.22	Maintain performance under the 10th percentile with peer comparators, but alignment of target with Hospital Service Accountability Agreement.	1)Sustain current practices that have facilitated success in last two years.	Leverage the bundle of strategies for identified c. diff cases and when c. diff burden is high including, but not limited to: sporicidal cleaning twice daily in patient rooms and bathrooms, consistent signage for visual management of risk, double cleaning on transfer or discharge from patient environment, supplies dedicated to a single patient or disinfected before re-use; and consistent, cautious waste management strategies.	Percentage of signage accurately posted for patients with suspected or confirmed c. diff.	Maintain current practices.
									2)Utilize capital expenditures to meet community needs.	Replace all non-infection prevention and control conforming chairs in clinical areas at all RVH sites.	Based on inventory, percentage of non IPAC-conforming chairs in clinical areas replaced at RVH. Number of new chairs purchased for RVH to replace non IAC conforming chairs.	Leverage generous capital donations for living our safety promise.
									3)Relentlessly improve hand hygiene rates.	Continue to monitor and share data on hand hygiene compliance.	Percentage rate of compliance with hand hygiene. Number of hand hygiene audits completed per month.	Continue to share data for hand hygiene to drive improvement.
									4)Sustain Antibiotic Stewardship programming.	Sustain focus on key antibiotic usage for clindamycin, moxifloxacin and levofloxacin.	Monitor number of times the key antibiotics are used and why.	Sustain current practices.
									5)Initiate IPAC trigger tool to prevent further C Difficile cases.	Utilize trigger tool in the early stages of identification.	Compliance tool utilized to review practice in all bed meetings until C Difficile has been eliminated.	Sustain current practices.

Timely	Reduce wait times in the ED	ED Wait times: 90th percentile ED length of stay for Admitted patients.	Hours / ED patients	CCO iPort Access / January 2015 - December 2015	606*	27.9	25.11	10% reduction in this indicator this year is targeted, but there will be increased focus on this target in the following years' QIPs.	1)Enhance provision of integrated and coordinated care, so a patient can receive the right care from the right provider at the right time.	Execute LEAN processes in all four areas of the Emergency Department these areas include 1) Triage 2) Minor 3) Sub-Acute 4) Acute. Identify accountabilities for each health care provider in the Emergency Department with clarity of each others roles. Management rounding in all four areas completed daily. Management/staff/physicians daily huddle at white board to review wait times. Evaluation of temporary clerical position and its impact on patient flow within the department. Weekly review of wait times in all four areas plus PIA by the ED leadership team. Roll out of Emergency Department Intensive. Implement visual management tools and engage in an educational campaign for care all providers. Promote "There's No Place Like Home" philosophy as a means of waiting in the right location for long term care. Proactively prepare discharge options and alternatives for patients with complex discharge needs. Institute an integrated discharge planning review committee for ALC patients or those with complex discharge planning needs. Engage a bioethicist in an ethics quality improvement plan to enhance consistency and appropriateness of discharge planning discussions. Heighten our focus on patient flow through a bed management system, through bullet rounds through daily meetings and monthly data results reviewed. Maintain commitment to Home First initiative and actively participate as partners in regional ALC strategies. Monitor conservable days through the UM Committee: assess the value and result of each action plan to reduce conservable days and length of stay. Engage a third party to conduct a one week study on a sample of our patients facilitating reflection on opportunities to enhance organizational flow and reduce conservable days	The following indicators are going to be measured: 1) Left Without Being Seen 2)90th percentile non-admitted minor 3)90th percentile non-admitted complex 4)90th percentile admitted patients 5)PIA. Number of days for patients designated ALC Conservable bed days. Daily and monthly pull times for inpatient units. Number of patients discharged to the home environment with Home First supports.	Monitor for 10% improvement per quarter of each indicator. Maintain broad focus and accountabilities for patient flow.	
									2)Engage in Plan-Do-Study-Act cycles for continuous quality improvement focused on reducing length of stay in the ED for admitted patients.	Launch a PIP related to overall flow throughout the organization which includes the model of care.	iTOC schedule to be followed.	Improve patient flow throughout RVH.	
									3)Collaborate with our health system partners to ensure care required is accessible and timely including diversion of unnecessary ED visits.	Review and revise the discharge planning model to identify patients who have complex discharge planning needs and facilitate safe transition from hospital to the community. Partner with NSM CCAC to identify and address barriers to discharge early for inpatients. Proactively prepare discharge options and alternatives for patients with complex discharge needs. Implement visual management tools and engage in an educational campaign for care providers , patients and families to promote 'There's No Place Like Home' philosophy rather than awaiting long term care bed placement while in an acute care bed. Institute an integrated discharge planning review committee for ALC patients or those with complex discharge planning needs. Engage a bioethicist in an ethics quality improvement plan to enhance consistency and appropriateness of discharge planning discussions. Build on our successes and maintain our heightened attention on patient flow throughout the hospital.	The following indicators are going to be measured: 1) Left Without Being Seen 2)90th percentile non-admitted minor 3)90th percentile non-admitted complex 4)90th percentile admitted patients 5)PIA. Number of days for patients designated ALC Conservable bed days Percentage of CTAS 4 and 5 patients presenting in the ED. Percentage of CTAS 1, 2 and 3 patients presenting in the ED.	Improve patient flow throughout RVH.	
									4)Leverage technology to enhance access to service, connect patients with the right providers and inform and educate patients.	Implement a scanning and archiving functionality in the Health Records department to enhance availability of the electronic patient chart to care providers in the Emergency Department. Amend the Locating Department's naming convention and on call schedule functionality to guarantee up to date information. Promote Laboratory's discharge in time metric and prioritization system. Explore opportunity to prioritize creatinine level laboratory samples for patient flow. Explore technology for microbiological syndromic surveillance to enhance patient flow. Progress the consistent patient barcoding initiative for patient flow.	Number of on call schedule errors or misinterpretations monitored. ED wait times. ED time to physician initial assessment times.	Improve flow through the ED department.	