Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for the 2015/16 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 2015/16	Org Id	Current Performance as stated on QIP2015/16	Target as stated on QIP 2015/16	Current Performance 2016	Comments
1	"Would you recommend this hospital (inpatient care) to your friends and family?" add the 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). (%; All patients; October 2013 - September 2014; NRC Picker)	606	72.00	82.00	73.00	RVH increased our patient experience rating for top box, but we did not achieve our stretch target of 82%. We will continue to focus on this target in the year ahead.

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Change Ideas from Last Years QIP (QIP 2015/16)	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?
Leader rounding with every patient daily.	Yes	Coaching leaders rounding on patients in an effective manner that uses time wisely while still gathering important information was crucial. This is key at our clinical manager level rounding with patients to move our performance with patient experience metrics.
Provide clinical staff with skills training to improve communication with patients.	Yes	We have made Crucial Conversations part of our on-going learning academy offering. It is offered quarterly and is well attended by front line clinical staff and medical staff to enhance their communication with patients. An evidence informed communications plan has been

		scheduled for all in-patient units and Emergency Department for this coming year.
Discharge Phone calls – with follow-up of outstanding issues.	No	Post care calls are conducted, but our target of follow up on outstanding issues was not implemented due to resource intensity with other priorities.
The Patient Family Advisory Council enables direct patient and/or family engagement to improve the patient experience throughout the continuum of care.	Yes	RVH's PFAC continued to meet on a monthly basis to provide input, endorse organizational initiatives and prioritize work to improve the patient and family experience. RVH's PFAC has been very busy working on various initiatives to enhance the patient and family experience including, but not limited to: • Family Presence Policy • Rehabilitation Information Packages • Hearing Loss Toolkit Trial • Meals on Wheels - changes • Baby Chimes • Privacy Pledge • Pet Visitation Policy • Parking Feedback • QIP Feedback • HR Plan Feedback • Accessibility Policy Feedback • Accessibility Multi Year Action Plan Feedback • Education Plan Feedback • IT Tech Pod Service Desk Feedback • Accreditation 2015 • Accreditation 2015 Stroke Distinction • ED Kaizen Event • Panel interviews of key staff members • Senior's Strategy Working Group • End of Life/Palliative Care Working Group • Family Presence Working Group • My Part for Heart Campaign • LEIs • IGNITE Conference
Develop further actions with front line staff based on NRC Picker results.	No	Transformation coaches have been working side by side with leaders throughout the organization to develop action plans for departments based on the feedback received within out NRC Canada survey results. The most successful improvement was within the Obstetrics Unit wherein changes in language used enhanced performance.

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2	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; Q3 FY 2014/15 (cumulative from April 1, 2014 to December 31, 2014); OHRS, MOH)	606	-0.08	0.00	-0.30	No longer capturing as part of QIP

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Ramp up of surgical cases by 10% to increase weighted cases in alignment with PCOP funding.	Yes	A plan was implemented starting in June 2015. April-December 2015 comparison to 2014 Year Over Year comparison, the program has enhanced number of surgical cases completed by 434 in the Main Operating Rooms (192 of which are inpatient and 242 were outpatient). Jan-Dec 2014 to Jan-Dec 2015 Year Over Year comparison has demonstrated increases of 427 cases from the Main Operating Rooms. We were fortunate enough to open an additional OR space and optimize surgical block time to achieve this.
Make model of care changes in all inpatient medical units resulting in lower cost per patient day.	Yes	This commitment was fully implemented as per the 15/16 schedule. This model was rolled out on three medical inpatient units. The initiative involved the following elements: • 3 successful Kaizen events (1 for each unit) • Full scope of practice of all regulated health providers was rolled out as per schedule • Patient Care Assistants (PCAs) were introduced to the organization including role description and interprofessional orientation • This resulted for nursing staff to focus their time on patient care, full scope and skills competencies • Rounding with patients by managers reaping feedback • Increased frequency of rounding and documentation of such realized • Standard work for each team member for clarity of expectations and efficiency • Decreased

		staffing costs by “right health care provider doing the right job at the right time"
Increase Uninsured/Non-resident Revenue Rates.	No	Few changes for uninsured and non-resident rates were increased due to transitions in leadership team for this department.

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3	Readmission within 30 days for Selected Case Mix Groups (%; All acute patients; July 1, 2013 - Jun 30, 2014; DAD, CIHI)	606	17.38	17.10	17.02	RVH has made progress in this area and continues to focus on this metric. Initiatives such as working with our community partners as well as conducting post discharge calls ensures patients are being properly monitored after discharge. Readmission rate is reviewed with action plans presented through the Utilization Management Committee

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Research last 24 months to determine who the top 3 readmits are to RVH only.	Yes	The review of our RVH readmissions was conducted early in the year revealing seniors, COPD and CHF patients are often readmitted. Deeper dives into the data are underway for COPD and CHF. Readmission rates have been established as the priority for our internal Utilization Management Committee. Participation in the EXTRA project development in conjunction with Canadian Foundation of Health Improvement.
Based on this develop a Quality Initiative with appropriate stakeholders to reduce readmissions.	Yes	Initially, data revealing that seniors were most often readmitted was addressed by the Utilization Management Committee with developed plans. COPD, CHF and Surgery department action plans are underway. True impact may not be realized until more recent data is available. RVH has launched a Comprehensive Senior's Strategy, a Discharge Checklist and a Health Promotion Post Care Phone call with patients and has realized a 77% reduction in seniors' representation rates to the Emergency Department and significant reduction in readmissions in less than seven days as well as stabilization of readmissions in less than 28 days.

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4	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; Jan 1, 2014 - Dec 31, 2014; Publicly Reported, MOH)	606	0.12	0.22	0.16	CDI numbers remain below our target and RVH continues to promote safe best practices and standards throughout the health centre that prevent CDI occurrences.

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Screening and communication of “High risk”admitted patients in the ED to inpatient units.	Yes	A communications plan complimented with individual patient care plans has been executed in the Emergency Department. Staff were also educated on the placement of patients who were coming from facilities on outbreak. Screened for EVD has been fully endorsed. Use of SBARD as it relates to transfer of accountabilities has been fully implemented from the Emergency Department to the in-patient units. Infection Prevention and Control conducted a three month audit of completion of the IPAC component of the SBARD tool from ED to inpatient unit and noted opportunity of resourcing staff to ensure this component of communications is completed.
Infection Control Team will continue to use the CDI trigger tool as a pre-outbreak strategy for CDI.	Yes	The trigger tool was successfully implemented March 2015. The tool was embraced when there was a ‘burning platform’ with three nosocomial cases on one unit. With use of the trigger tool, declarations of further outbreaks were thought to be averted.
Provide units with Infection Control Scorecard.	Yes	All units now receive monthly/quarterly information and data for hand hygiene, Antibiotic Resistant Organisms, and Surgical Site Infection

		information. Information is available for Quality Practice Councils and can be shared with all staff on patient care units. Effectively embedding the data and information provided into meaningful daily activities and ensuring it is shared broadly with all members of the care team, including physicians.
Monitoring prophylactic antibiotic utilization (type/amount) in Inpatient Surgery for four target groups: Elective Hip, Elective Knee, C-Section & Colorectal Surgeries.	Yes	Antibiotic Stewardship Programs (ASP) began in June 2015 for the targeted populations in surgery. All surgical patients are currently monitored. ASP recommendations have over an 80% acceptance rate by the Most Responsible Physicians (MRP). Sustaining ASP on our Medicine units has proven to be a challenge. Pharmacists are consulting with the ASP team & providing recommendations, but MRP uptake is less than favourable after 2 years of the journey. The ASP team is reviewing research into behavioural changes as it pertains to learning new prescribing habits.
Complete best practice cleaning and disinfection of commodes and bedpan bases.	Yes	We completed development and implementation of an algorithm that can be used by clinical units related to commode cleaning. Q4 Newsletter from IPAC presented the concept of MDRD and types of disinfection. Part of this is the algorithm for commode cleaning in the organization. It is reflective of new practice and, thus, will require ongoing monitoring.

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5	ED Wait times: 90th percentile ED length of stay for Admitted patients. (Hours; ED patients; Jan 1, 2014 - Dec 31, 2014; CCO iPort Access)	606	26.60	21.30	27.90	RVH did not meet the targeted goal of 21.3 hours however has implemented 4 LEAN events to reduce wait time. This will continue to be a significant focus throughout the year.

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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.	Yes	The Medical Transition Unit (MTU) was operationalized on July 1st 2015. In order to ensure efficiency and effectiveness of the unit, length of stay and occupancy have been monitored closely. Full utilization of the MTU was variable throughout the year as the challenges related to medical coverage. The role of the GEM nurse has been enhanced however continues to be expanded to meet the needs of seniors entering the Emergency Department. We continue to partner with our community HealthLinks leaders including full representation at our Senior Strategy Committee. We continue to participate in the MVP clinic to reduce avoidable visits to the ED and wrap care around patients with complex needs. Consistent bed meetings have been established and are well attended by all leaders to ensure consistent use of our 'pull' philosophy. The 'pull' philosophy has been well accepted within the hospital with engagement from all levels of staff. We are monitoring and have noted continued improvement in wait times for admitted patients and small improvements have been noted.

Mulitple in-patient LEAN events including Model of Care to commence March 30th, 2015.	Yes	This commitment was fully implemented as per the 15/16 schedule. This model was rolled out on three medical inpatient units. The initiative involved the following elements: • 3 successful Kaizen events (1 for each unit) • Full scope of practice of all regulated health providers was rolled out as per schedule. • Patient Care Assistants (PCAs) were introduced to the organization, including role description and interprofessional orientation • This resulted for nursing staff to focus their time on patient care, full scope and skills competencies. • Rounding with patients by managers reaping feedback • Increased frequency of rounding and documentation of such realized • Standard work for each team member for clarity of expectations and efficiency • Decreased staffing costs by right health care provider doing the right job at the right time.
	Yes	

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6	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; most recent quarter available; Hospital collected data)	606	84.00	90.00	89.00	PY Performance based on Surgical IP only. Target adjusted to reflect organizational roll out. Pharmacy works closely with our clinicians to ensure medication safety standards are sustained.

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Identification of patients who meet criteria for Med Rec versus All Patients.	Yes	This change plan was implemented in June 2015. We are confident that we are better able to identify how well we are doing with improved data quality. Our initial attempt to make this process electronic was unsuccessful. When manually validating data, we found that there was anywhere from a 20 – 40% discrepancy. We have gone back to a manual process while we attempt to improve the cleanliness of the data for improved accuracy by tracking through our workload initiative.

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7	Total number of inpatient days where a physician (or designated other) has indicated that a patient occupying an acute care hospital bed has finished the acute care phase of his or her treatment, divided by the total number of inpatient days in a given period x 100. (%; All acute patients; October 2014 – September 2015; DAD, CIHI)	606	15.34	17.10	15.95	RVH continues to ensure patients are receiving the right level of care at the right time by the right care provider. This metric continues to be an organizational priority. Note 15.95 is reflective of ALC days rather than ALC rate. RVH hosted an ALC Planning Day with a composition of various health care agencies/leaders from across the LHIN. With over 50 participants key themes were identified of which all were aligned to our RVH Seniors Strategy. Utilizing both ethical frameworks (IDEA and A4R) a rehab ALC strategy was developed and implemented for every patient with a length of stay over 90 days. Positive clinical outcomes have been noted in every clinical case to date.

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CCAC/RVH enhanced relationship. D/C planning process to commence earlier, and tighter management of EDD.	Yes	RVH and CCAC continue to solidify our working relationship to address patient requiring discharge with CCAC support. Home First initiative are regularly monitored and reviewed through the Home First Steering Committee. Through this collaborative relationship we have achieved a reduction in the

number of patients transitioning from RVH to long term care with an increase in the percentage of patients discharged with ‘hospital to home services’ (HomeFirst). We are actively collaborating on a dispute resolution process related to utilization of CCC beds. Through this collaborative, CCAC has provided evidence that the population being discharged has a higher acuity and complexity than in past months. Management of Estimated Date of Discharge (EDDs) is reinforced daily at every bed meeting. Utilization tool is currently under assessment. RVH continues to work with physicians both related to documentation and to achieving the EDD.