Ross Memorial Hospital

Quality Improvement Plan (QIP): Annual Progress Report for 2016/17 QIP

The Progress Report is a tool that will help Ross Memorial Hospital make linkages between change ideas and improvement, and gain insight into how our change ideas might be refined in the future. It also serves as a transparent report aimed to inform the public of our progress.

Each priority indicator from the 2016/17 QIP is listed in this report with detailed lessons learned outlined for each change idea that was identified. Below is an overall snapshot of our QIP progress over the 2016/17 year.

Indicator/Measure		Target	Current Performance	Status
Reduce Caesarean sections as a percentage of low risk pregnancies.	↓	17.5	22.50	
Reduce number of patients newly diagnosed with hospital-acquired Clostridium Difficile Infections (CDI) measured per 1,000 patient days.	↓	0.28	0.22	
Reduce Emergency Department Length of Stay (LOS) for admitted patients.	↓	29.4 hours	26.9 hours	
Increase level of home support for discharged Palliative patients.	↑	95%	100%	
Increase number of patient and family members involved in quality improvement planning on program teams.	↑	3/6 teams (50%).	3/6 teams (50%).	
Increase the proportion of patients receiving Medication Reconciliation upon admission.	↑	85%	82.3%	
Reduce readmission rates for Stroke patients (Process Measure).	↑	100%	75%	

Status Legend	
	Improved performance and met target.
	Room for improvement –performance has improved but did not meet target.
	Room for improvement – did not meet target and performance has declined.

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Indicator/Measure: Reduce Caesarean sections as a percentage of low risk pregnancies.

(Rate per 100; low risk births (CIHI definition); January 2015 to December 2015; CIHI DAD)

Performance as stated on QIP 2016/17		Target	Current Performance 2017	Status
20.00	⬇	17.5	22.50	

Change ideas from 2016/17 QIP	Was this change idea implemented?	Lessons learned:
Interdisciplinary team review and refresh of current data including peer benchmarks and best practices regarding Caesarian Sections (C/S).		Our team has monthly quality meetings. During this meeting we discuss our C-section data. The group has shared articles on best practice. We discuss patient choice and the team's role in informed consent and the risk of this surgical procedure. This change idea has increased awareness.
Review and evaluate data regarding induction of labour as a factor influencing C/S.		Our team reviews all C-sections with each MD, in a case-by-case review. It is during this forum that we assess if an induction of labour was a factor in influencing our C/S rate.
Monitor and post C/S rate from BORN data.		Monthly we monitor and post our C/S rate from the BORN data. This data allows us to benchmark with level one hospitals, low delivery hospitals and the province as a whole.
Physician retrospective review.		Reviewing each health record with the MD's, has been helpful to understand the reason the C/S was completed. It is only through this process that we can truly understand why our C/S rates are higher than other hospitals our size with our risk level.

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Indicator/Measure: Reduce number of patients newly diagnosed with hospital-acquired Clostridium Difficile Infections (CDI) measured per 1,000 patient days.

(Rate per 1,000 patient days; All patients; January 2015 to December 2015; Publicly Reported, MOH)

Performance as stated on QIP 2016/17		Target	Current Performance 2017	Status
0.45	⬇	0.28	0.22	

The multi-faceted approach taken this past year with the various interventions implemented has had a positive impact on the nosocomial CDI rate for 2016/17.

Change ideas from 2016/17 QIP	Was this change idea implemented?	Lessons learned:
Implement improved cleaning practices of high touch areas and direct patient care equipment with the focus to reduce the risk of CDI transmission.	✓	The number of wall mounted disinfectant wipes at the point of care has been increased throughout the hospital. Signage indicates which disinfectant wipe is to be used for specific tasks. These have been posted in all the soiled utility rooms and on all the wall mounted PPE stations for reference. In June 2016 environmental cleaning ATP audits of patient rooms and small multi-use patient care equipment began with the implementation of placing green tape on cleaned items. The ATP audit results have improved from 20% to 70% on some units. Compliance with the green tape is a continuing opportunity for improvement.
Continue collaborative efforts with the CDI Working Group.	✓	The CDI Working Group continues to meet on an “as need” basis. An inventory of all the commodes in the hospital has been conducted. A standard commode has been selected by the group that meets the need for ease of cleaning and use. This commode has been added to the Procurement Catalogue to ensure this is the only commode that can be ordered at RMH.
Hand Hygiene audits.	✓	The Hand Hygiene Audit Group met earlier in 2016, with the focus of changing the auditors to clinical managers and educators only. A schedule was developed, assigning specific units/departments to each auditor. The group will meet again to review and revise the auditing schedule so that the auditors are assigned to different units.
Analyze trends for possible prediction of increasing CDI rates after antimicrobial usage rate increased.	✓	Current CDI rate end of 2016/17 third quarter = 0.21/1000 patient days (9 cases); compared to 0.38/1000 patient days (16 cases) in the same time frame of 2015/16.

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Indicator/Measure: Reduce Emergency Department Length of Stay (LOS) for admitted patients.

(90th percentile; Hours; ED patients; January 2015 - December 2015; CCO iPort Access)

Performance as stated on QIP 2016/17		Target	Current Performance 2017	Status
32.7 hours	⬇	29.4 hours	26.9 hours	

Change ideas from 2016/17 QIP	Was this change idea implemented?	Lessons learned:
Improve time from triage to decision to admit.	✓	Some progress was made with this indicator but more work is required. Education to the physicians in the ED to decrease hand offs of patient from shift to shift. A successful change was with physician practice. The past practice was for the patient to be held overnight until the hospitalist admitted in the morning. The change was the ED physicians admitting into the short stay unit.
Decrease Alternative Level of Care (ALC) in hospital beds.	✓	Key stakeholders both internally and externally to the hospital formed a team and developed an ALC Action Plan with 13 objectives. The success was in the interdisciplinary team coming together to work on the action plan. Another success was site visits to other successful hospitals that had been effective at decreasing ALC rate.
Decrease time from decision to admit to ICU.	✓	Some progress was made with this indicator. More work is planned next year as we develop goals and objectives for a new model of physician leadership. Some gaps in response is related to days without Internal Medicine available for call. A process is being developed to ensure 100% coverage going forward.
Minimize ambulance offload delay.	✓	A mini kaizen event was held with a group of front line nurses, educator, and leadership from the hospital and key staff from Paramedic Services to improve the Ambulance Off Load time. A new process was developed and then PDSA for improvement. In addition we dedicated 37.5 hours a week of nursing time to function in the role of the ambulance off load nurse. The results during the third quarter showed an improvement for the 90th percentile from 26 minutes to 20 minutes. Lessons learned: Success is the result of involving the front line staff and partners in the improvement process.
Optimize Consultant response time.	✗	There are challenges with accurate data collection. The physicians are not consistent in documenting response times. Often this is left to the ward clerk. The ward clerk has many other duties and is not staffed 24/7 so gaps in recording is an issue. Another issue is physician juggling competing priorities, for example, around OR times and office responsibilities. Recommend this initiative needs corporate, cultural change and will be a gradual change not completed in a single year.

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Indicator/Measure: Increase level of home support for discharged Palliative patients.

(%; Palliative Care Patients; January 2015 to December 2016; Hospital collected data)

Performance as stated on QIP 2016/17		Target	Current Performance 2017	Status
Collecting Baseline Data	⬆	95%	100%	

Change ideas from 2016/17 QIP	Was this change idea implemented?	Lessons learned:
Establish and implement process flow for direct admission to the Palliative Unit (PU) from the community rostered to the PCCT-goal to bypass ER.	✓	There was great collaboration with our community partners and commitment from the EMS. A Memorandum of Understanding (MOU) was established between the partners. It was essential to have clear communication with key internal and external palliative navigators to drive the process. The admitting physician needs to be confirmed prior to acceptance of the patient to the unit.
All patients with Palliative Performance Scale (PPS) score 30% or higher will be assessed for home supports at daily huddles.	✓	All patients on the palliative care unit will be reviewed at daily bullet rounds Monday-Friday to determine if their care needs could be met in the community with palliative home supports. The physician is a key driver to this process. Lack on continuity of physician coverage or locum support can impact this process.
95-100% of patients discharged from the Palliative Unit will be referred to the CCAC and the PCCT.	✓	This change idea was easily met due to the collaboration between the CCAC and the PCCT. The patient's consent was required for this referral. Clear communication of what each service provides is key to success in the discharge transition.

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Indicator/Measure: Increase number of patient and family members involved in quality improvement planning on program teams.

(%; program teams; April 2015 to March 2016; Hospital collected data)

Performance as stated on QIP 2016/17		Target	Current Performance 2017	Status
2 of 6 program teams (33%) had a patient/family advisor.	⬆	3/6 teams (50%).	3/6 teams (50%).	

Change ideas from 2016/17 QIP	Was this change idea implemented?	Lessons learned:
Implement Patient and Family Centered Care (PFCC) assessment findings.	✓	The RMH staff and physician survey results identified 3 key focus areas to beginning implementation of PFCC; 1. Methods to improve communication /information for patients and families 2. Resources for patients and families to partner at the bedside and patient experience partners 3. Education and orientation for staff and physicians on PFCC. As of January 31, 2017, The Better Together Project Committee has: a) improved external and internal welcome signage and way finding at all entrances including accessible maps which has improved way finding to our difficult to navigate areas such as Parkway Nuclear, Health First and ACU. b) developed and implemented a patient and family resource on tips to effectively and respectfully partner with the health care team, c) developed the policy, process and procedure as well as supporting documents for the recruitment of Patient Experience Partners, d) provided education at Lets get Educated Together days on the concept of patient and family centred care along with the resources, e) developed a tool sheet for the health care team that helps to clarify what information staff, within their scope of practice, can share with patients and family members. f) Developed in the moment patient/family feedback cards which are being trialed on the CCP units. Five patient experience partners have been recruited thus far. Lessons learned included the fact that resources/tools are needed for both staff, patients and families that outline the "rules of engagement." Staff require increased knowledge, experience and support in working through conflict or difficult situations with patient and families. Bedside communication boards are instrumental to sharing information but are still underutilized for many reasons ranging from accountability for updating the bedside board to the simple logistics of having magic markers and erasers. PFCC is a shift in culture and comes with time, experience, setting communication standards, and collaboration.
Add at least two patient representatives to team operations.	✓	There were many lessons learned with regards to formalizing the process for on-boarding patient and family experience partners (PEPs): 1. Ensuring that the language used in our established agendas and minutes is accessible to PEPs when they join operation committees (plain language; no acronyms). 2. There needs to be a very clear sole point of contact for PEPs.

		3. To make PEPs feel welcome at meetings, provide them with the names of all attendees and their positions at the hospital.
Evaluate patient relations process.		Evaluation of the process was initiated in December through completing surveys with patients/family members that have gone through the process. It was difficult to obtain direct feedback once the concern was closed. Some patients were uncomfortable discussing the process with the person closing the concern and did not want a follow up call. As our current system is manual, one recommendation from discussions included a more centralized approach with a mechanism to identify trends.

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Indicator/Measure: Increase the proportion of patients receiving Medication Reconciliation upon admission.

(Rate per total number of admitted patients; Hospital admitted patients; most recent quarter available; Hospital collected data)

Performance as stated on QIP 2016/17		Target	Current Performance 2017	Status
80%	⬆	85%	82.3%	

This indicator applied to Pharmacy Best Possible Medication History (BPMH) for Emergency Department (ED) admissions only. BPMHs are also done prior to admission by obstetrics, pre-operative nurses and mental health crisis workers, reflecting the shared responsibility for medication reconciliation across the organization. Pharmacy has implemented a regular Quality Assurance audit of BPMHs; this should be considered for all BPMHs completed at RMH to ensure ongoing quality.

Change ideas from 2016/17 QIP	Was this change idea implemented?	Lessons learned:
Improve the process for completing BPMH on patients post admission.	✓	15% of patients admitted via ER never receive a Best Possible Medication History (BPMH). The extent to which Pharmacists and Pharmacy Technicians can complete a BPMH after admission is entirely dependent on staffing and patient volumes. Various models to address this need have been considered, but no viable solution has been found to date. When fully staffed, Pharmacy is able to complete the post admission BPMH for 85% of patients. On weekends and other periods of reduced staffing, competing priorities in Pharmacy take precedence.
Improve pre-admission completion of BPMH through direct and timely communication with pharmacy technician.	✓	When fully staffed, Pharmacy is able to complete preadmission BPMHs for 100% of ER admissions. Communication with the pharmacy technician has been a challenge as they must now rely on the bed board to identify admissions, rather than be paged. This technician carries a pager because they have other duties to fulfill. Pharmacy has adjusted some drug distribution responsibilities in order to free up the technician for an extra 1 hour per week.
Determine root causes for delayed BPMH completion.	✓	85% of post admission BPMHs are completed within 24 hours, however, 15% of ER admits never receive a BPMH. The main cause for delayed BPMH completion is the addition of an evening Hospitalist without the addition of an evening BPMH technician. For the ER pharmacy technician, the pre-admission BPMH is a priority since this process is proactive, efficient and prevents errors. For the pharmacist, reviewing the new inpatient orders is the priority. As a result, post-admission BPMHs may not be completed. We tried to reduce missed BPMHs for ICU patients by training ICU nurses to complete a BPMH for weekend admissions, but this was not sustained.

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Indicator/Measure: Reduce readmission rates for Stroke patients (Process Measure).

(%; of new process measures completed; January 2015 to December 2015; Hospital collected data)

Performance as stated on QIP 2016/17		Target	Current Performance 2017	Status
0% process measures completed.	⬆	100%	75%	

Change ideas from 2016/17 QIP	Was this change idea implemented?	Lessons learned:
Implement discharge order set for stroke on the integrated stroke unit (ISU).	✓	In partnership with Think Research, a new digital QBP order set has been developed for stroke patients. This order set includes a discharge section with specific orders for follow-up with care providers in the community. Implementation of the digital order set will begin in Q4 which does not meet the goal for change of implementation in Q2 and 80% compliance by Q4 (rationale for 75% as current performance). Although we did not implement the separate discharge order set, this is still a pending goal that we see as valuable to ensure smooth discharge transition. We have implemented the Discharge Assessment form which is copied and given to the patient and family with their discharge education. This ensures that follow up appointments and treatments are arranged and communicated. A copy is also faxed to the health care provider in the community such as the Family Health Team.
Develop peer (patient and family) supports for discharge transition.	✓	We have partnered with the March of Dimes and have supported 2 volunteers to complete the 16 hour training to be Peers Fostering Hope volunteers. These volunteers have been visiting patients who have had a stroke and their families. They provide support through this process and offer their own life examples for transitions to community. They also equip patients and family with information regarding Stroke Survivors Groups and Rehabilitation. One of the volunteers have also been supporting the patient and family education. We partner with PRHC via OTN to provide our patients with the necessary stroke education. Our volunteer ensures that patients get education, and answers questions from our end. Key Learnings and Advice: Ensure that the volunteers feel that they are a part of the team and that they have a specific role. Have someone who is their communication partner and a communication binder is helpful. Impact: Although we do not have a quantitative measure, qualitatively, this role has been invaluable to our team and to the patients and their families. When the team does not have the time to sit and support, the volunteers are able to fill this gap.
Implement discharge follow-up phone calls for discharges from ISU.	✓	The OTN coordinator has taken this role. If there are any pressing issues, OTN coordinator would direct the feedback to the Manager to follow up. Otherwise, the follow up has been documented and stored for review. Key Learnings: To ensure that the follow up can happen, the name of the contact and phone number must be retained from the chart. The ward clerk copies

	the front page for our coordinator, which is shredded after use. Impact: Closer to real time feedback has been helpful to evaluate the effectiveness of the program, such as our communication strategies. Having follow-up phone calls have also been shown to increase patient satisfaction. It will be helpful to see if this makes a difference on NRC Picker survey.