Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2016/17 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 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
1	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; January 2015 – December 2015; Publicly Reported, MOH)	930	0.19	0.18	0.17	Grand River Hospital performance for FY2016-17 December YTD is 0.16, which is below the target rate of 0.18. Hand hygiene before patient contact for FY2016-17 is 92 percent, which is consistent with FY2015-16 performance, and below the target of 95. Hand hygiene audits continue to occur with real time feedback delivered to healthcare providers. Both the clostridium difficile and hand hygiene indicators are displayed on the clinical program scorecards for review of trends and to identify opportunities for improvement. Microbial simulation audits are conducted regularly and results consistently demonstrate high compliance. Grand River Hospital currently monitors the use of antibiotics during prospective audit and feedback rounds. This year the antimicrobial stewardship program has been expanded to include an additional unit.

2	ED Wait times: 90th percentile ED length of stay for Admitted patients. (Hours; ED patients; January 2015 - December 2015; CCO iPort Access)	930	18.90	14.00	16.70	Grand River Hospital performance for FY2016-17 January YTD is 16.5, which is better than FY2015-16 January YTD performance of 17.4 hours. Contributing to the improved performance is the Emergency program physician staffing model changing to match patient flow. Physician recruitment has occurred to address scheduling gaps and physician schedules are being fully staffed to reflect the busiest seasons and days. These changes have also had a positive impact on the Emergency department wait time for physician initial assessment indicator. The Emergency program staff ensures consistent communication with the staff managing bed allocation as well as the Manager, Patient Access and Flow. Discussions about bed allocation occur at the daily bed meeting, which includes participation from all clinical programs. The clinical programs continually strive to ensure the maximum rate of patient flow, while ensuring the best quality of care.
3	Medication reconciliation admission daily snapshot - the total number of patients with a length of stay greater than 24 hours with medications reconciled divided by the total number of patients admitted to hospital. (%; All patients; FY2015-16; Hospital collected data)	930	95.00	95.00	96.00	Grand River Hospital performance for FY2016-17 is 96, which is an improvement from the FY2015-16 result of 95. Auditing processes are in place for medicine, stroke, surgery, mental health and addictions, inpatient cancer, critical care and complex continuing care. This year has seen the introduction of pharmacy students in the Critical Care program to sustain auditing of best possible medication histories (BPMH). The audits have transitioned to focus on the quality of the BPMHs.

4	Percent of complex continuing care (CCC) residents who fell in the last 30 days. (%; Complex continuing care residents; July – Sept 2015 (Q2 FY 2015/16 report); CIHI CCRS)	930	12.32	7.00	5.70	Grand River Hospital performance for FY2016-17 September YTD performance is 6.2 based on a rolling four quarter trend. GRH has continued to classify falls with harm as an important priority organizationally in the current fiscal year. As such, there is a dedicated Falls Steering Committee with representation from multiple programs and disciplines. The role of the committee is to develop an organization wide, evidence-based and comprehensive program focused on reducing the incidence of falls and the associated harm. Falls data is monitored by each clinical program and service through the scorecards. The Falls Committee is focused on examining incident reporting and data presentation to ensure that the reasons for patient falls are more thoroughly understood. The Medicine program developed a falls checklist to ensure all appropriate falls prevention strategies are in place. Several clinical programs have implemented new beds with alarms, which are connected to the call bell system, to aid in the prevention of falls. This implementation was supported by education for staff.
5	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. (%; Discharged patients with selected HIG conditions; July 2014 – June 2015 ; CIHI DAD)	930	17.32	16.00	16.45	Grand River Hospital has identified readmissions as a priority in FY2016-17. The clinical programs monitor the readmissions on the program scorecards. After examination of the trends, the Medicine program has established a working group, which includes a CCAC coordinator, to focus on reducing readmissions for patients with Gastrointestinal disease. As part of the

						National Surgical Quality Improvement Program, the Surgery program has implemented the Enhanced Recovery After Surgery model, which is linked to improved patient outcomes, including a reduction in readmissions. Although there is still work underway for this initiative. The program has also piloted the Meds-to-Beds program as a 'one stop shopping' experience for patients, with medications and education provided at the bedside. Patients have the opportunity to have questions answered prior to leaving and post-discharge phone calls to support this process.
6	Risk-adjusted 30-day all-cause readmission rate for patients with stroke (QBP cohort) (Rate; Stroke QBP Cohort; January 2014 – December 2014; CIHI DAD)	930	10.71	9.70	8.58	Grand River Hospital has implemented a stroke passport binder to be used as an education and communication tool for patients and families. The binder includes a number of resources, including information about what to expect from the care process as well as tracking the patient's journey and goals. The documentation supports continuity of care as the binder travels with the patient to the next program, such as rehabilitation and patients have the ability to take the binder home or to their next care location. The Stroke program also utilizes a discharge checklist to ensure a safe and effective discharge. Teach back practices are used by staff when providing discharge documentation to engage patients and ensure comprehension of the information. When possible, a discharge link meeting occurs; coordinated by CCAC, the meeting provides the opportunity for external care providers to meet with patients/families. For patients discharged home, CCAC coordinates a Rapid

						Response Nurse to meet with patients at home to support an effective transition and avoid readmission. All readmissions within the Stroke program are reviewed for further understanding of the causes and to prevent readmission.
7	Total number of alternate level of care (ALC) days contributed by ALC patients within the specific reporting month/quarter using near-real time acute and post-acute ALC information and monthly bed census data (Rate per 100 inpatient days; All inpatients; July 2015 – September 2015; WTIS, CCO, BCS, MOHLTC)	930	10.40	11.00	10.95	Grand River Hospital performance for FY2016-17 December YTD is 9.45. GRH continues to encompass the “Home First” philosophy within clinical practices so that patients can consider going home before making decisions regarding other options following treatment. Programs continue to work closely with CCAC. Bed utilization for alternate level of care beds is also tracked on the clinical programs’ scorecard to monitor performance and as an impetus to develop strategies for improvement.
8	Using any number from 0 to 10, where 0 is the worst care possible and 10 is the best care possible, what number would you use to rate your care during this emergency room visit? (%; ED patients; April 2016-March 2017; Hospital collected data)	930	CB	CB	CB	Grand River Hospital began implementing the use of the Ontario Emergency Department Patient Experience of Care surveys in the current fiscal year with the intention of collecting baseline results prior to establishing a target. The Emergency program continued to use the post discharge telephone contact methodology to obtain patient/family feedback. Performance for FY2016-17 January YTD is 44% for the Top-Box responses of 9 and 10. The Emergency program has reinforced the use of the AIDET framework as a communication tool with patients and families to enhance patient experience. Updated information about the Emergency department is also frequently posted on GRH's website with the ability to view the Emergency Wait Times tool.

9	Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay? (%; All acute patients; April 2016-March 2017; Hospital collected data)	930	CB	CB	CB	Grand River Hospital performance for FY2016-17 October YTD is 63% for the Top-Box responses of 9 and 10. Face to face surveying is currently conducted in the Cancer, Childbirth, Children's, Critical Care, Medicine, Rehabilitation, Stroke, and Surgery programs using the recommended CIHI instruments. The interRAI Self-Reported Quality of Life survey instrument was used in the Complex Continuing Care and Mental Health & Addictions programs. The clinical programs monitor the patient experience survey results and develop quality improvement initiatives as a result. The Cancer program has developed a discharge working group to focus on developing written teaching materials and the program continues to use the teach back methodology during the discharge process.