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

GRAND RIVER HOSPITAL
your health, your hospital

Grand River Hospital Corporation 835 King Street West P.O. Box 9056

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	3734*	15.73	≤14 hours	FY2014_15 December YTD performance is 13.8 hours. Provincial performance if 23.9 hours. HSAA target 8 hours. Stretch target 8 hours.	1) Reinforce and sustain processes to "pull" patients admitted from the emergency department.	Clinical programs to monitor and report against scorecard indicators to senior quality team. Clinical program leadership to attend daily bed rounds. Clinical programs to monitor compliance to overcapacity policy and protocol by unit.	90th percentile time to inpatient bed (hours) from decision to admit when an inpatient bed is available. 90th percentile time to inpatient bed (hours) from decision to admit when an inpatient bed is not available.	1 hour 8 hours	This initiative takes the concerted efforts of all staff in the organization to work collaboratively to achieve this outcome measure.
									2) Improve patient flow in the medicine program.	Implement and evaluate effectiveness of medicine discharge lounges.	Time from discharge to patient assigned to registered practice nurse caseload. Time to transfer from patient bed to discharge lounge. Percent of discharges achieved before 11:00 AM. Time to inpatient bed from decision to admit in emergency when an inpatient bed is available in medicine 90th percentile.	Target to be determined. Target to be determined. 40% 1 hour	This initiative aligns with P4R funding.
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)	930*	0.11	≥0%	Consistent with HSAA	1) Develop mechanisms to provide improved access to financial data to inform decision-making.	Implement case costing.	Achieve Ministry of Health and Long-Term Care case costing status.	Case costing status achieved Q1.	This initiative aligns with a FY2015-16 operational milestone.
									2) Improve the ability to obtain consolidated information in a more timely manner to inform decision making.	Continue the development of the data warehouse by further integrating laboratory, complex continuing care, mental health and addictions sources systems and data mart integration.	Percent integration complete.	100% complete.	This priority aligns with a FY2015-16 operational priority milestone.
									3) Improve the capture of clinical data for complex continuing care and mental health and addictions.	Implement the Mental Health Ontario Common Assessment of Need/Resident Assessment Instrument-Mental Health and Common Data Set and Complex Continuing Care program assessment: Resident Assessment Instrument-Minimum Data Set.	Implementation and use of software.	Go live and utilization Q3.	This initiative aligns with a FY2015-16 operational priority milestone.
									4) Implement evidence informed practices aligned with FY2015_16 planned quality based procedures.	Develop and implement practices as defined by Clinical Handbooks for cancer surgery- colorectal and knee arthroscopy.	Pathways implemented. Indicators and targets to be developed.	Q4.	This initiative aligns with a FY2015-16 operational priority milestone.

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Effectiveness	**Reduce unnecessary deaths in hospitals**	HSMR: Number of observed deaths/number of expected deaths x 100.	Ratio (No unit) / All patients	DAD, CIHI / April 1, 2013 to March 31, 2014	3734*	FY2013-14 = 82 (using re-baselined reference year of 2012-13). This performance is better than the top quartile performance of CIHI Peer I group of 86.	≤83	This target represents better than the 25th percentile performance of CIHI peer group 1 for 2012-13 as the baseline year.	1) Improve early identification and management of sepsis in the emergency department.	Conduct chart review. Revise and implement emergency department admission sepsis order set. Develop and implement monitoring process for uptake of sepsis order set.	Results of chart review presented to Emergency Department and Quality Council. Order set implemented. Monitoring process implemented.	Q1 Q2 Q3	
									2) Improve the quality of surgical care.	Participate in the National Surgical Quality Improvement Program.	Initiate collection and reporting of data. Submit Surgery Quality Improvement Plan to Health Quality Ontario. Submit Sustainability Plan to Health Quality Ontario.	Q1 Q2 Q4	
									3) Improve patient safety through the use of evidence informed practices.	Implement Patient Orders Sets.	Order sets implemented.	Q4	This is aligned with WWLHIN initiative.
Integrated	**Reduce unnecessary time spent in acute care**	Alternate Level of Care Days - Percentage of inpatient days where a physician has indicated that a patient occupying an acute care hospital bed does not require the intensity of resources/service provided in this care setting.	% / All acute patients	CCO iPort Access / FY2014_15 December YTD	930*	10.44	≤11%	Target takes into consideration access to community based service may be constrained in the current environment.	1) Improve data quality for submission of wait time day.	Standardize workflows. Educate staff on information management principles and importance of correct data entry. Track volume and work effort for manual wait time information system corrections.	ALC Forms and Assessment Module for Wait Time Information System implemented. Deliver staff education sessions. Reduce in number of data entry errors. Reduce waste (re-work) for data entry corrections.	Q1 100% staff receive education Baseline being collected for data entry errors and re-work. Target to be determined.	
									2) Reinforce and sustain "Home First" practices and monitoring of alternate level of care utilization.	Sustain expedited discharge processes and reviews within clinical programs. Sustain weekly alternate level of care rounds. Sustain senior leadership and management collaborative meetings.	Rounds sustained.	100%	
	Reduce unnecessary hospital readmission	Readmissions to Grand River Hospital within 30 days for selected case mix groups	% / All acute patients	DAD, CIHI / FY2014_15 November YTD	930*	12.8	≤12%	Based on historical trend.	1) Investigate variables and gaps associated with readmissions.	Conduct in-depth data analysis and health record review of readmissions.	Analysis completed. Gaps identified. Priorities established. Current and future state mapping conducted. Improvement opportunities initiated.	Analysis completed and priorities established Q2. Improvement opportunities initiated Q3.	
									2) Improve access to medical consultant services.	Implement a General Internal Medicine Rapid Assessment Clinic.	Time of referral to time of medical specialist consult. % of emergency department diversions. % of patients who attend medical specialist consult visit. % of patients who re-visit the emergency department within 48 and 72 hours. % of patients who re-visit the emergency department within 7 days. Emergency department length of stay for admitted patients.	Targets for indicators to be determined.	This initiative aligns with FY2015_16 operating plan priority.
									3) Enable the electronic transmission of hospital patient information to electronic medical records systems used by health care providers.	Implement Hospital Report Manager(HRM). Integrate hospital laboratory system with the Ontario Laboratory Information System (OLIS). Implement an Emergency Department Information System.	Implementation complete. Implementation complete. Discharge instructions, e-prescriptions.	Q1 Q4 Discharge instructions, e-prescriptions implemented.	These initiatives aligns with FY2015_16 operating plan priority. HRM and OLIS align with provincial strategies.

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Patient-centred	**Improve patient satisfaction**	From NRC Canada: "Overall, how would you rate the care and services you received at the hospital (inpatient care)?" (add together % of those who responded "Excellent, Very Good and Good").	% / All patients	NRC Picker / October 2013 - September 2014	930*	92	≥93%	Improvement of current performance.	1) Measure the patient experience as a means of identifying quality improvement initiatives.	Sustain current practices for longitudinal surveys using telephone mode for the emergency department and face-to-face mode for the medicine, surgery, intensive care, childbirth, children's, stroke and cancer programs. Expand longitudinal survey to mental health and addictions program.	Surveys conducted. Quality improvement initiatives initiated based on results. Annual report developed for Quality and Patient Safety Committee of the Board.	Quarterly results published. Report delivered Q1 of FY2016_17.	This initiative aligns with both our draft 2015-17 strategic and 2015-16 operating plan priorities.
Safety	**Increase proportion of patients receiving medication reconciliation upon admission**	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	In-house survey / FY2014_15 Q3	930*	96	≥90%	Indicator refreshed from previous year. Limited amount of data. Need to ensure data validity.	1) Improve completeness and accuracy of best possible medication history.	Auditing process in place for medicine program, adult mental health in patient unit and surgical pre-admit clinic. Expand audit process pending approval of resources.	% of patients with best possible medication histories reviewed by patient. % of best possible medication histories with significant errors.	Medicine and inpatient mental health 70%; pre admit surgery clinic 90%. Decrease significant errors -target to be determined.	This initiative aligns with both our draft 2015-17 strategic and 2015-16 operating plan priorities.
	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	930*	0.14	≤0.20	Clinical opinion is that Clostridium difficile activity in FY2014-15 year is unusual provincially. The target represents a 23% reduction from the previous year of 0.26.	1) Sustain gains made in hand hygiene practices.	Hand hygiene audits conducted in clinical programs with just in time feedback. Publication of internal results quarterly in hospital newsletter. Internal monitoring of clinical programs using scorecards and quarterly report on performance.	Hand hygiene before patient contact.	95%	
									2) Expand patient hand hygiene program.	Develop and implement an awareness/education program.	Implement in two clinical areas.	Implemented by Q1.	
									3) Optimize use of antimicrobials in the medicine program through antimicrobial stewardship.	Staff and physician education. Prospective audit and feedback. Use of dose optimization program.	Number of clostridium difficile outbreaks.	0	

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Safety	**Avoid Patient Falls**	Percent of complex continuing care (CCC) residents who fell in the last 30 days.	% / Complex continuing care residents	CCRS, CIHI (eReports) / Q2 FY 2014/15 rolling 4 quarter average (October 1, 2013 - September 30, 2014)	3735*	11.11	≤7%	Seeks to achieve better than the median performance of GRH peers.	1)Develop infrastructure to support falls risk assessment and prevention.	Leadership to established Falls Steering Committee with defined role accountability. Leadership to develop driver diagram of primary and secondary drivers. Leadership and staff to identify improvement opportunities to reduce falls with harm.	Number of falls with harm.	Steering Committee established and operational Q1. Reduction in falls with harm.	
									2)Improve patient/family communication to anticipate care needs and reduce patient safety risk.	Implement intentional rounding.	Staff compliance to conduct intentional rounding. Daily monitoring of falls.	Q1 implementation with hourly intentional rounding maintained by staff for all patients.	
									3)Improve patient/family understanding of risks for falls and methods of prevention.	Develop patient/family education tools.	Educational tools developed.	Q2	