ANNUAL REPORT 2015/16 QUALITY AND PATIENT SAFETY INFECTION CONTROL COMMUNITY ENGAGEMENT









VCH Visioning Session February 2016

live graphic Drawing recording Change



This document was produced on behalf of Vancouver Coastal Health by the Infection Control Quality & Patient Safety Department. This document can also be found online by visiting vch.ca



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Vision Statement:

Quality & Patient Safety advocates for excellence through collaborative partnerships, and by integrating sustainable best practices and measurable strategic quality initiatives, achieves the best possible outcomes while providing a patient and family-centered experience that can be spread across all settings of care.

Executive Summary

This year was one of organizational change and transformation. We said our goodbyes and heartfelt "thank you's" to our Director Jacqueline Per and our VP Dr. Patrick O'Connor. Their long-term commitment and passion for quality patient safety and infection control were fundamental to creating the strong department that we have today - focused on continuous improvement and client family centered care. We will continue to pursue Patrick's motto of "making it hard to do the wrong thing". We also extend our best wishes to the Community Engagement team as the small but mighty team move to the Communications Department where the patients' voices will continue to be at the forefront.

We welcomed Nancy Desrosiers as our new Executive Director who, prior to Patrick's departure, reviewed the strategic plan with the team and held an off-site retreat to realign our departmental priorities with the new Ministerial and SET directions. We are also pleased to introduce Dr. Dean Chittock in as our new VP as of March 2016. Having been with the organization for many years, we look forward to working under his leadership.

Our workload has continually increased over the years and - in order to position ourselves for success a reorganization of roles and responsibilities occurred within the department. Our new organizational chart is on page 4.

We were challenged this year with some of our key performance indicators. C.difficile and MRSA rates increased as did central catheter-related infections in the ICU. The first two were addressed and we are pleased to say with a multi-disciplinary team approach and increased healthcare worker engagement, rates of C.difficile and MRSA are trending down. A chart review of all central venous catheter infections was conducted and results will help guide improvement measures for the ICU. On a positive note, surgical site infection rates continue to be some of the lowest in Canada. The introduction of flow cytometry has increased our ability to diagnose urinary tract infections and will hopefully lead to a reduction in inappropriate treatment which is linked to one of our patient care improvement indicators.

National Surgical Quality Improvement Program (NSQIP) is in its fifth year of operation. At VGH, Enhanced Recovery after Surgery (ERAS) has gained momentum with a 40% drop in morbidity rates in elective radical cystectomy patients. The program is in sustainment mode at VGH with plans to expand the program to RH and LGH and move towards targeted procedures in the New Year.

The Antimicrobial Stewardship Programme (ASPIRES) is working with Clinical Systems and Transformation (CST) on antibiotic order sets, produced a pocket guide for antibiotic use in collaboration with Medical Microbiology and has also developed a common infections treatment card. A statistically significant reduction in IV antibiotic use at VGH has occurred. RH has implemented Audit and Feedback for antibiotic prescribing and a champion has been identified for LGH.

Our primary focus this year has been dedicated towards two major initiatives: a successful accreditation status occurring in September 2016 and (CST) implementation live at LGH. The Accreditation team has expanded significantly and is diligently working directly with the personnel to support our first health authority-wide Accreditation Canada review that will take place the week of September 18 to 23rd 2016. Our team is actively involved in ensuring that patient safety and quality is embedded in the culture as Accreditation is "what we do every day...".

Collaboration as our key driver, we continue to work with our internal and external partners, to address care sensitive adverse events and to improve our surveillance, coding and reporting of results.

We would like to end with recognizing UBC for being awarded the prestigious 2014 Meritorious Award for the second year in a row, and send our sincere congratulations to the Leukemia/BMT program who successfully received their Accredited status by the Foundation for the Accreditation of Cellular Therapy (FACT). We are also very grateful to our donors for the continued support of our VCH Improvement Strategy (Releasing Time to Care) which provides the opportunity for front-line healthcare workers to lead change.



NANCY DESROSIERS, Executive Director of Quality and Patient Safety and Infection Control

DR. ELIZABETH BRYCE, Regional Medical Director for Infection Control

4 Cornerstones Antimicrobial Stewardship Programme (ASPIRES)



The Antimicrobial Stewardship Programme (ASPIRES) at Vancouver Coastal Health (VCH) began in November of 2012 with the goal to improve patient care by optimally treating infections, while preserving antibiotic effectiveness. ASPIRES promotes appropriate antibiotic prescribing practices through:

- 1. Prospective Audit and Feedback of Targeted Antibiotic Prescriptions
- 2. Quality Improvement Initiatives and Clinical Guidelines

I. PROSPECTIVE AUDIT AND FEEDBACK OF TARGETED ANTIBIOTIC PRESCRIPTIONS

Audit and Feedback is an evidence-based practice of reviewing patients' antibiotic therapies with prescribers and making recommendations to optimize treatments. For Audit and Feedback, ASPIRES targets broad-spectrum, reserved, and intravenous antibiotics. Audit and feedback is part of an integrated educational programme, which includes the use of clinical practice guidelines and tools to improve prescribing practices.

- 3. Research and Evaluation
- 4. Education and Presentations

	VGH	RH	LGH		
Measures	Mar 15, 2013 –	Apr 11, 2014 –	Oct 1, 2013 –		
	Mar 31, 2016	Mar 31, 2016	Mar 31, 2016		
Number of Treatment Recommendations (N Patients)	1,825	222	433		
Recommendations	79%	97% (actual)	60%		
Accepted by	(based on a		(based on a		
Prescriber (%)	sample)		sample)		

Table 1. Summary of Audit and Feedback of Targeted Antibiotics Prescriptions at VCH

Our clinical team has made over 2,000 recommendations

across Vancouver General Hospital (VGH), Richmond Hospital (RH), and Lions Gate Hospital (LGH) (see Table 1).

II. QUALITY IMPROVEMENT INITIATIVES AND CLINICAL GUIDELINES

CLOSTRIDIUM DIFFICILE INFECTION (CDI) QUALITY ASSURANCE INITIATIVE: PHARMACY ASSESSMENT OF CDI THERAPY AND PHYSICIAN COMPLIANCE WITH VCH TREATMENT POLICY.

ASPIRES continues to collaborate with Pharmacy on CDI initiative to ensure all CDI patients receive optimal therapy (see Figures 1 & 2).



Figure 1. CDI Pharmacy Assessment: Proportion of CDI cases who were assessed by Pharmacy for appropriateness of therapy, FY 2015/16

ASPIRES' CLINICAL TOOLS & GUIDELINES

- Anti-infective comparison card
- Antibiogram (collaboration with Medical Microbiology)
- Clinical tidbits (practical tips for clinicians)
- Common infections treatment card
- Community-acquired pneumonia guidelines



Figure 2. Physician Compliance: Proportion of assessed CDI cases who were prescribed initial therapy by the physicians according to the CDI Treatment Policy, FY 2015/16

- Hospital-acquired pneumonia guidelines
- · Reserved antibiotics pre-printed physician order
- Skin and soft tissue infections guidelines
- Surgical antibiotic prophylaxis guidelines
- CST order sets (for introduction in 2017)

III. RESEARCH AND EVALUATION

ANTIBIOTIC UTILIZATION: Since the introduction of Audit and Feedback, utilization of target antibiotics has decreased compared to baseline at VGH and RH (Figures 3 & 4).



Figure 3. Utilization of Target Antibiotics at Acute Care Wards, VGH Audit and Feedback Start Date: Mar 2013



Figure 4. Utilization of Target Antibiotics at Acute Care Wards, RH Audit and Feedback Start Date: Apr 2014



Figure 5. Time-series Plot Showing Decreased IV Antibiotics Use at VGH (all nursing units) Audit and Feedback Start Date: FY 2013/14 - P1 Results of the time-series analyses (Figure 5) have shown a statistically significant reduction in intravenous (IV) antibiotics use at VGH (p<0.05), thereby preventing complications associated with IV administration.

Defined Daily Dose (DDD) definition: Average dose per day for a drug used for its main indication in adults.

POINT-PREVALENCE SURVEY TO DETERMINE ANTIBIOTIC PRESCRIPTIONS APPROPRIATENESS

In February 2016, ASPIRES (in collaboration with specialty trainees from infectious diseases and medical microbiology) evaluated the appropriateness of all antibiotic prescriptions on target wards at VGH to measure the magnitude of suboptimal antibiotic use (Table 2 and Figure 6). This information will be used to identify priority areas for education and intervention. ASPIRES plans to conduct point-prevalence surveys on an annual basis.

Measures	Ν	%
Total Number of Patients Surveyed	136	
Number of Patients Receiving Antibiotics	65	47.8%
Patients whose antibiotic prescriptions were optimal	34	53.1%



Table 2. Point Prevalence Survey of Antibiotic Prescriptions, VGH



IV. EDUCATION AND PRESENTATIONS

ASPIRES regularly engages in medical resident education, and has presented at invited lectures and research posters at the Canadian Society of Hospital Pharmacists Annual General Meeting 2015, Quality Forum 2016, and the Canadian Association for Clinical Microbiology and Infectious Diseases Annual Conference 2016.

4 Cornerstones Environmental

In 2000, Canada reported over 200,000 HAIs (Healthcare Associated Infections) at a cost of approximately \$1 billion per year (Auditor General of BC 2007). Increasing HAIs was the impetus for the VCH 'Four Cornerstones' initiative which began in 2012.

HAIs are caused by multifactorial factors which we can mitigate by :

- 1. Best Hand Hygiene practices 100% of the time by staff, visitors, and patients
- 2. Best Antimicrobial Stewardship practices
- 3. Best IPAC (Infection Prevention & Control) resources kept current in 'real time' (e.g. Guidelines, Policies and Procedures)
- 4. Best Environmental cleaning and disinfection practices by Environmental Services (EVS) and Clinical staff; use of new cleaning and disinfection strategies products and technologies to eliminate microorganisms

SUSTAINED REDUCTION OF HAIS

The Environmental 'cornerstone' provides education and strategies for decluttering, cleaning and disinfection, and equipment management. The Environmental cornerstone is a key element that works in close partnership with the other three cornerstones.

FOUR CORNERSTONES



For example, decluttering initiatives:

- Reduce HAIs by getting rid of worn, torn, broken and obsolete items which pose infection control risks and allows items and surfaces to be thoroughly cleaned and disinfected.
- Added benefit of preventing slips, trips, falls, reducing injuries to patients, visitors, and staff.
- Patients and families feel 'safe' in clean, disinfected and organized environments.

This multidisciplinary approach, in conjunction with a regionally standardized IPAC Program, addresses strategies to reduce HAIs.

AIM Decrease HAIs

DRIVERS

- Increased Morbidity and Mortality
- Increased length of stay
- Increased resources and costs
- Readmissions
- Negative patient outcomes
- Poor quality experience for patients

OBJECTIVES

Infection Prevention and Control webpage on intranet and internet, user-friendly resource for stakeholders and partners, kept up to date in 'real time'

Sustained mobile equipment cleaning and disinfection program and organized management of equipment facilitybased depots for storage of excess items on Units

On-going management of Regional Master Equipment Cleaning and disinfection Manual that identifies responsibilities, frequencies, and products

Implementation of UVC Therapy as an adjunct to thorough cleaning and disinfection.

Systematic and on-going decluttering

Systematic and on-going review of Unit stock to prevent over-stocking or hoarding

CURRENT AND ON-GOING ENVIRONMENTAL INITIATIVES

- Daily and Annual Decluttering of physical items and visual (i.e. posters/signage)
- Standardized on-going Cleaning and Disinfection of the environment and equipment, including review of new products, strategies, and technologies
- Standardized and on-going Infection Prevention and Control "Back to Basics" Education
- Current IPAC (Infection Prevention & Control) webpage on the intranet and intranet to allow easy access for partners and stakeholders for disease management which is kept current in 'real time'
- On-going review and update of VCH Regional Master Equipment Cleaning and Disinfection Manual
- Checklist Tool for Reduction of HAIs (Healthcare Associated Infections) for use by Unit staff
- Use of 'Enhanced Cleaning' to mitigate clusters and prevent outbreaks
- On-going use of ATP tool to identify protein on environmental surfaces and equipment potentially from infectious microorganisms
- On-going facility-based surplus clean equipment storage areas
- On-going mobile equipment cleaning and disinfection program (e.g. pumps, wheelchairs)
- On-going use of Audit Tools (e.g. Clean Equipment Depot Audit Tool, Unit Environmental Declutter Audit Tool
- Consideration of a Regional Central Equipment Depot as facility-based equipment depot locations have over-flow surplus beyond their capacity

MRSA Annual Nosocomial Rates by Fiscal Year





CDI Annual Nosocomial Rates by Fiscal Year







Lions Gate Hospital Pediatrics, 3 East.

48/6



48/6 is a Provincial Ministry of Health (MoH) Clinical Care Management (CCM) Guideline. Core elements of 48/6 are the assessment of functional care areas through standard screening questions, and the initiation of an interdisciplinary care plan, both within 48 hours of the decision to admit to acute care. Care areas include:

"Planning together to go home better"



PROCESS

SCREEN	• Obtain baseline status by asking the 48/6 screening questions during the admission assessment (this guides care planning to help patients return to their previous level of function).
CARE PLAN	• Initiate care plan (care plan is personalized for the patient, interdisciplinary, and a "one-stop shop" so that all health care providers know what to do, each shift, to support patients in their recovery, and prepare them for a seamless discharge.
UPDATE	Review care plan with the interdisciplinary team, ideally during rounds.Care plans are living documents that are updated and revised daily.

WHAT HAVE WE ACCOMPLISHED THIS YEAR?

IMPLEMENTATION:

- Worked with point-of-care staff to streamline 48/6 documents, and supporting documents, to reduce redundancies, and increase efficiencies.
- Worked with teams and provided education in preparation for full implementation by September, 2016.

"I really like 48/6.....especially when I have a new patient. I know exactly what I need to do to look after my patient from the care plan"

(RN T5B, VGH)

CLINICAL SYSTEMS AND TRANSFORMATION (CST):

- 48/6 aligns with CST processes such as standard admissions and care planning.
- Standard 48/6 Screening Questions were revised and forwarded to CST.

ACCREDITATION:

• Meets Accreditation Canada standards and Required Organizational Practices such as information transfer at transitions and involving patients in care planning.

PARTNERS:

- Worked with Community Engagement Advisory Network (CEAN) and the Provincial Networking Group on devising 48/6 information pamphlets for patients and families.
- Finalized a regional document for transfers from Residential Care to Emergency that incorporates the 48/6 care areas. This provides valuable information regarding the resident's baseline status if the resident is admitted to acute care.

QUALITY FORUM:

• Continued to work on a tool to measure dependency levels of medical patients on admission, and then to compare the scores at discharge. The goal is to demonstrate the impact of 48/6. This was presented at the Quality Forum where there was considerable interest in validating this tool.

METRICS:

- The target set by the Ministry is 80% for screening completed and care plan initiated within 48 hours of admission. Quarterly reports are forwarded to the Ministry.
- We continue to work toward target scores and sustainment. Some sites/units are above target.
- Where 48/6 is well integrated in the workflow it has been exciting to see the quality of the care plans. On many units they are ongoing, interdisciplinary, and comprehensive.

PLAN FOR NEXT YEAR:

- Complete 48/6 roll-out at UBC Hospital and remaining units at VGH.
- Achieve Ministry target of 80% on all units and sustain it.
- Continue quality auditing on units.
- Share more patient stories.
- Continue to work with CST and the Accreditation Team.

"The core elements of 48/6 are now part of our standard work. This model of care enables us to provide the best quality of care through comprehensive assessment and screening to optimize effective care planning. It provides patient-centered care through the structure to better understand the initial baseline status of our patients, so care providers are better able to plan for successful discharge from admission."

Human Factors

Human Factors involvement occurred on a variety of projects across VCH and with Clinical Systems Transformation (CST). The work aligned with mandated and operational priorities for Quality & Patient Safety as set forth by our Senior Executive Team, Community of Care leaders, and provincial requests. Some of the areas of focus include:

HYBRID OR DESIGN: As VGH embarks on a Renewal project of the operating rooms (ORs) and interfacing areas, the first phase of this work involved the design and construction of a 'Hybrid' OR that integrates medical imaging into the operating suite. Working with clinicians, capital project planners, operations directors, architects, medical device vendors and project management consultants, Human Factors has been involved in the detailed design phase for the Hybrid OR.



Part of this work involved the use of a simulation space in which a mock hybrid OR was constructed in the basement of VGH. Props were built to simulate various equipment and structures within the OR space. Detailed scenarios depicting surgical cases to be done in the Hybrid suite were conducted, with surgeons, anesthesiologists, radiology and nursing all playing their various roles. The Human Factors assessment focused on the movement of people and equipment within the space to determine the optimal layout of the room and placement of the equipment, particularly the medical imaging C-arm. This analysis demonstrated differences in the congestion of people and equipment based on the different potential configurations.

INFORMATION TRANSFER AT CARE TRANSITIONS: In preparation for the Regional Accreditation site visit in September 2016, Human Factors has been leading the Regional working group to embed the required organizational practices around communication of patient information during transitions of care into everyday clinical practice. The scope of this work covers the entire continuum from acute care in hospital and outpatient clinics to residential care, home and community services. Transitions of care include admissions, handovers at shift changes, movement of patient within the hospital from one unit to another (e.g. from the Emergency to an inpatient unit), transfers of patients between facilities and services (e.g. from a hospital to a residential care facility) and patient discharges. In addition to preparing individual teams to meet this standard, part of this work has involved drafting a regional level policy outlining minimum requirements for effective communication at transitions (handover).

OPERATIONAL PROJECTS ACROSS VCH:

Many other projects involved Human Factors expertise over the year including:

- Usability heuristic assessments for a variety of Ultraviolet-emitting devices for decontamination of portable electronics and patient areas;
- Quality improvement work with the Clinical Teaching Unit (Internal Medicine) at VGH to improve the morning patient assignment process and discharge rounds;
- Trauma 6 (T6) pre-trial evaluation for trauma activations at VGH. This project included conducting a current state assessment, future state assessment, and heuristic evaluation, facilitating the clinical evaluation, and conducting a gap analysis and risk assessment on the integration of the product;
- Planning for the implementation of Omnicell carts to be integrated into anesthesiology workflow at VGH. This work included designing medication drawer layouts and conducting future state assessments to identify workflow changes;
- Documentation design and form development for pharmacy, professional practice and critical care nursing;
- Working with Business Initiatives and Support Services to improve separation of medical waste into appropriate recycling and waste streams.

Tissue Banking and Stem Cell Transplantation

Within VCH exists the Eye Bank of British Columbia (EBBC), BC Tissue Bank, and the Leukemia/Bone Marrow Transplant Program of BC, all of which work in conjunction with Health Canada, and other health agencies and professionals in ensuring the safety, efficacy and quality of all transplanted tissues and cellular products used in our health authority and beyond. The QPS Department supports these programs with ongoing reviews of and improvements to their Quality Management Systems.

LEUKEMIA/BONE MARROW TRANSPLANT PROGRAM OF BC

The clinical program, which resides within two health authorities (VCHA and PHSA) is responsible for the provision of care for adult patients with hematological malignancies in BC including chemotherapy and stem cell transplant.

The program has unique areas that are responsible for different processes involving: diagnosis and development of a treatment plan for referred patients, which may or may not result in a transplant; canvassing for a donor, if needed, anywhere in the world. Some patients are candidates for autologous transplants; harvesting the cellular product which can be performed by apheresis, the removal of a specific constituent of whole blood and returning the remaining to the donor, or by the surgical removal of bone marrow, mostly from pelvic bones, by using a needle. The program also collects product for other transplant centres, anywhere in the world; processing and preservation of the cellular product for future use if required; transporting the product to the transplant centre, locally or worldwide; data gathering and monitoring outcomes; innovation and research activities; and working with many partners and stakeholders.

"They realized through the severity of my injury that the best place for me to go for optimal care would be to VGH. After the surgery, I spent most of my time in hospital with my eyes closed... that really helped me imagine what my life would be like had I lost vision in both my eyes. I am so grateful. Grateful that I can see. Grateful that I have an amazing support system and grateful for everyone at VGH." – Lesley Kim, VGH patient



Global BC News' Elaine Yong gives a wonderful report on what the Eye Bank does behind the scenes to provide sight to British Columbians.



Nanaimo Palliative Care Unit supported 66 families in giving the gift of sight which resulted in the highest number of eye donors per site in BC in 2014





Lesley's Story - VGH UBC Hospital Foundation

National Surgical Quality Improvement Program (NSQIP)

NSQIP systematically samples just over 7,500 cases annually between the 4 sites: UBC, LGH, RH and VGH. This is our 5th year contributing to the database. Data is collected by Clinical Quality and Safety Coordinators reviewing patient records and conducting 30 day post-surgery patient follow up which includes telephone surveys. The data collected is rich in pre/intra/postoperative information and provides risk adjusted reports as well as non-risk adjusted reports. This data is used to provide metrics to quality improvement teams for a number of VCH quality initiatives. The Coordinators help facilitate the local teams with their quality improvement goals.

EMERGENCY GENERAL SURGERY PILOT

The VGH Acute General Emergency Surgery Team was one of 15 hospitals invited to participate in a 12 month pilot capturing data on operative and non-operative patients with acute appendiceal disease, acute cholecystitis and small bowel obstruction. The collaborative results will have the potential to improve care for this patient population. The team will be adopting ERAS orders for operative and non-operative small bowel obstructions.

ENHANCED RECOVERY AFTER SURGERY (ERAS)

This is a multimodal evidence based peri-operative care pathway benefiting colorectal and cystectomy patients at VGH. The tools created by the VGH ERAS team are an invaluable resource for the teams that will be adopting these best practices in the near future. RH and LGH are planning to adopt the ERAS order sets and pathways for colorectal and cystectomy patients towards the fall of 2016.

VGH Elective Radical Cystectomy patients have benefited from ERAS implementation. Overall morbidity fell by 40% and UTI decreased by 9%.

The next steps for VGH ERAS involve sustainment for colorectal and radical cystectomy and spread to urgent/emergent colorectal patients. Gynecology and Hepato-Pancreatic Biliary (HPB) are the next services planning to create ERAS orders.

Patient Outcomes: Elective Radical Cystectomy								
	Pre-ERAS May 2011 - Sept 2014 n=90	Post-ERAS Oct 2014 - Nov 2015 n=91						
Overall Morbidity	31.1%	18.7% (40% reduction)						
Transfusion within 72 hr of OR start time	43.3%	29.7%						
Urinary Tract Infection (UTI)	10.0%	1.1%						
Superficial Surgical Site Infection (SSI)	12.2%	7.7%						
Sepsis/Septic Shock	14.4%	7.7%						
Readmissions	16.7%	12.1%						
Median LOS, days	7.5	7						

IMPROVING TEAMWORK AND CULTURE

Our coordinators have assisted The Productive Operating Room (TPOT) at RH and LGH, through facilitation of team meetings and date analysis. We will continue to support these teams with their continuous quality improvement journey. Our future goals include helping support surgical teams with their TPOT journey.



LGH TPOT team

SURGICAL SITE INFECTION (SSI) PREVENTION

NSQIP continues to be involved with surgical teams to reduce the number of SSI infection per year. SSI prevention protocols are also embedded in ERAS. Through the best practices adopted in ERAS, all surgical patients at VCH benefit from hypothermia prevention protocols, weight based dosing or pre-operative prophylactic antibiotics, intra-op re-dosing of antibiotics if required, and the elimination of pre-operative fasting. These new diet guidelines help manage hyperglycemia which is a risk factor for SSI. The plan for this coming year is to continue the collaboration with Infection Control and professional Practice and create SSI working groups with other surgical services at VCH to help improve surgical care.

URINARY TRACT INFECTION (UTI) PREVENTION:

This is an ongoing collaboration throughout the organization with local surgical teams, Professional Practice and Infection Control Practitioners. NSQIP is currently working with the OR Orthopedic team to prevent catheter associated UTIs. A catheter insertion algorithm is being developed to help guide the decision making around what patients require a urinary catheter.

PNEUMONIA PREVENTION:

The ICOUGH program has continued to evolve and spread through VCH over the last few years. The ICOUGH principles and poster are used at LGH, RH and on various surgical units at VGH. The units that have embedded the ICOUGH principles in their daily care continue to show a decline in their pneumonia rates. NSQIP will continue to work with these units and help other units implement the ICOUGH bundle.

AWARDS & ACHIEVEMENTS

Congratulations to UBC for being awarded the 2014 Meritorious Award for the second year in a row. This prestigious award is in recognition for meritorious outcomes from the American College of Surgeons. UBC is one of 52 participating NSQIP hospitals that achieved meritorious outcomes for surgical patient care. There are over 650 hospitals

The ACS NSQIP recognition program commends a select group of hospitals for achieving meritorious outcome performances related to patient management in eight clinical areas: mortality, unplanned intubation, ventilator > 48 hours, renal failure, cardiac incidents (cardiac arrest and myocardial infarction); respiratory (pneumonia); SSI (surgical site infections-superficial and deep incisional and organ-space SSIs); or urinary tract infection. UBC achieved this distinction based on their outstanding composite quality score in the eight areas listed above. Risk-adjusted data from the July 2015 ACS NSQIP Semiannual Report, which presents data from the 2014 calendar year, were used to determine which hospitals demonstrated meritorious outcomes.

VCH News story here: http://vchnews.ca/news/2015/11/05/its-likewinning-the-world-series-twice/#.VzpJ 30rlgs



Clinical Guidelines Initiative (CGI)

ABOUT CG1

The Clinical Guidelines Initiative (CGI) was started in 2010 with the twin goals of supporting the provincial Clinical Care Management (CCM) initiative and tackling system level barriers to the implementation of regional guidelines within VCH.

ACCOMPLISHMENTS: THREE HIGHLIGHTS

1.CLINICAL CARE MANAGEMENT (CCM):

CGI is the CCM lead for VCH, facilitating the reporting of VCH/PHC's CCM data to the Ministry of Health. Current CCM topics include:



2. DATA FOR IMPROVEMENT: COLLECTING AND VISUALIZING DATA TO ENGAGE HEARTS AND MINDS

CGI's original mandate was to tackle challenges at VCH that prevent staff from providing best care. Though clinicians receive a lot of helpful data from various VCH sources, clinicians sometimes need additional unit-level QI data to improve patient care. It's about the right data, in the right place, at the right time.

CGI works with VCH partners and collaborators from Emily Carr University of Art + Design (ECUAD) to find new ways to collect and visualize unit-level quality improvement data for point of care staff at VCH. Our goal is to encourage use of evidence-based clinical guidelines by creating templates and data displays for clinicians and staff in a way that celebrates success and clearly illustrates opportunities for improvement. Here are three projects we've been working on:

FALLS AUDIT & REPORTING

CGI and QPS partners built an easy to use tool in MS Access that collects data and links it to a real-time reporting tool in Excel. It means that right after an audit, point of care staff can select customized posters (ECUAD designed) to show the data they want to display. Testing of the database and reporting functionality began in Spring 2016. The intent is to transition the database and its customizable reports to the new QPS server in Fall 2016.



Preventing Patient Falls One Step at a Time



STEMI DATA TOOL

It used to take a data manager 16 hours to enter data and create a visual summary. CGI worked with a designer to create a form to streamline data entry and automatically export data to a poster that stakeholders can easily read, using visuals to highlight key indicators. Now, only 1 hour is needed to enter data and create a report. Plus that report more effectively communicates the data to stakeholders. It's a win-win!

DISCHARGE BOARD

Richmond Hospital (RH) is working to enhance patient flow through timely discharge. By partnering with a designer to apply principles of visual communication design, we created an engaging tool for measuring improvement in discharge times. The front line leaders told us they didn't want bar graphs and charts for the visual – they just wanted to know what is pertinent to them, and how they are influencing and supporting patient flow. The wall-mounted board we created for them compares unit-level planned vs. actual discharge times on a daily basis.

RH has told us that as a result of the improved data display, RH has literally changed how they look at the problem. This has led to massive improvements. This board gives front line leaders the right information at the right time, in a way that makes it easy for them to understand the problems and how to fix them.

3. ENHANCING ACCESS TO ORDER SETS

Eventually, all VCH order sets will be embedded within CST (Clinical & Systems Transformation). Until that time, clinicians rely on the VCH intranet to find the order sets. In 2014, CGI worked with colleagues in Pharmacy & Therapeutics, IMITS, and Regional Programs to create a new SharePoint platform for order sets, which allowed users to search for orders using key words.

That function was limited to full words, so to make it even easier to find the right order set, CGI is currently working with IMITS to upgrade the search capacity to include a partial word search function. For example, now clinicians can search orders by typing in only the first part of a long (and hard to spell) drug name. Clinicians also won't need to remember whether a search term should be singular or plural – when you have only the ability to search for full words, forgetting an 's' at the end of a search term means some order sets won't be retrieved. This improvement in function will help clinicians find the best possible order set to provide best patient care.

OUR PLAN FOR NEXT YEAR

In addition to the work mentioned above, CGI is interested in beginning a VCH community of practice for clinicians and staff who would like to revitalize data displays to point of care staff.

CGI also wants to communicate what we've learned about innovations in data display with the wider healthcare community. We've spoken at several conferences about data display (Quality Forum, and an international conference on Information Design), and we'll continue by developing an online portfolio to enable us to share what we've learned and to connect with colleagues in BC and beyond.

Patient discharge times: How are we doing?



Rich Dillon, Manager Patient Flow & Transitions, RH

Quality and Patient Safety: Department Evaluation and Strategic Planning

In June 2015, the Quality and Patient Safety staff participated in the evaluation of our performance as a team and took part in the planning for the future direction of the department by identifying:

- 1. Our department's (QPS-IPAC) strengths
- 2. Priority areas for the department in the fiscal year 2016-17
- 3. And the Challenges faced by each team within the department



Quality and Patient Safety and Infection Control Staff at our 2016 retreat!

The following is a condensed summary of the valuable information provided by the QPS-IPAC staff.

I. QPS-IPAC STRENGTHS

- QPS and IPAC innovative leadership VCH executive leadership support
- Quality Academy training
- Partnerships with other VCH departments that share our mandate

• Skilled, dedicated staff

II. PRIORITY AREAS FOR THE DEPARTMENT IN THE FISCAL YEAR 2016/17

- Accreditation 2016
- Clinical and Systems Transformation: CST is perceived as an opportunity to embed QPS principles and accreditation requirements into workflows and best practices
- QPS-IPAC Data Portal: Supporting unit level data collection and real-time reporting
- Patient and Family Centered Care: Improving information sharing with patients, and providing patient satisfaction measures to care units as bases for their Quality Improvement Initiatives
- Expanding the following initiatives regionally: Releasing Time to Care, TPOT, Four Cornerstones, Surgical Site Infection Surveillance
- Enhancing QPS-IPAC initiatives in the community and residential care
- Vacation/sick-leave ICP coverage for rural and remote sites
- Improving communications and information sharing within QPS-IPAC
- Measuring QPS-IPAC staff satisfaction and creating an avenue for the leaders to receive staff input directly or anonymously
- Strengthening partnerships with Professional Practice, Client Relations and Risk Management, Operations, LEAN, Strategy deployment, and Clinical Education

III. CHALLENGES IN THE FUNCTIONING OF THE DEPARTMENT

STRATEGIC PLANNING FOR THE DEPARTMENT - PRIORITY SETTING AND RESOURCE MANAGEMENT:

There is a lack of formalized processes to assess QPS initiatives in relation to organizational priorities, and to ensure resources and staff time are best utilized to achieve priority goals.

INITIATIVE PLANNING:

Many Quality Improvement initiatives have lacked planning for

- The resources required for the initiative
- Strategies to share information with all stakeholders
- The expansion of the initiatives across VCH, especially in rural and remote sites that lack strategy deployment resources
- The formal evaluation of the initiative and the sharing of outcomes with frontline staff and stakeholders
- The long-term sustainment of the positive outcomes

III. CHALLENGES IN THE FUNCTIONING OF THE DEPARTMENT - CONTINUED

COMMUNICATIONS AND INFORMATION SHARING WITHIN THE DEPARTMENT

There is a need for more effective, regular communications between leaders and staff, to communicate the department's priorities and plans for the future and receive staff input.

PARTNERSHIPS AND COLLABORATIONS WITH OTHER DEPARTMENTS

There is a need for strengthening partnerships with teams and departments that share our mandate (E.g. Professional Practice, Risk Management) and merging resources for better outcomes and increased efficiency.



Quality and Patient Safety and Infection Communications Board

TAKING ACTION

THE RETREAT

On February 19, 2016, the QPS-IPAC staff attended the department's retreat session; to respond to input received from the staff, the retreat was appropriately themed around:

- Organizational Goals and Priorities: The staff were given presentations on Vancouver Coastal Health's True North goals and strategic priorities by department's leaders.
- **Department's Initiatives and Performance:** Each team provided a comprehensive inventory of their initiatives and took part in an exercise to align initiatives with organizational goals. The staff also participated in discussions to prioritize their initiatives in the context of departmental goals and desired outcomes.
- Staff's Vision for the Department: and finally, the staff took an active part in creating a vision for the department's future and formulated mission statements that best define our goals and our role within Vancouver Coastal Health.

NEXT STEPS

The Executive Director of Quality and Patient Safety and Infection Control is planning to:

- Organize **initiative review sessions** with each team to prioritize current initiatives and together ensure the best use of resources as well as the best outcomes for our department.
- Set up an **anonymous suggestions-box** to receive private recommendations for the better functioning of the department and **worklife-pulse jars** to measure staff happiness at work.
- Organize **Speak Easy** sessions with staff (excluding management) to discuss the challenges faced by all staff in an open and friendly environment and together find the best solutions for the challenges.
- Set up a **Quality and Patient Safety Communications Board and monthly huddles** to regularly inform staff of departmental updates, share news regarding priority initiatives such as Accreditation, and provide the most recent infection control and NSQIP data.
- Bring staff together for **annual retreats** to share information and collaboratively find creative ways to ensure our success in the years to come.

"I would like to thank everyone for participating in the evaluation and planning exercises for the department and attending the retreat! Your dedication to the continued improvement of our performance as a team is the backbone of our success!" Nancy Desrosiers, Executive Director, Quality and Patient Safety and Infection Control

Surgical Site Infection (SSI) Rate

A surgical site infection (SSI) is an infection of the tissue in and around a surgical wound. To be considered a SSI the infection must occur within a designated time following surgery. A SSI is a potential major complication after surgery leading to a longer hospital stay, prolonged recovery, higher costs and patient dissatisfaction.

Measuring the incidence of SSIs is an important measure of surgical quality. It allows IPAC to identify potential infection-related sources and work collaboratively with surgeons and our National Surgical Quality Improvement Program (NSQIP) team to reduce the risk of infection to patients. Using internationally-accepted standard definitions (CDC/NHSN 2015) we perform surveillance on targeted cardiac, orthopedic, spinal, vascular, thoracic and neurosurgical procedures.

In 2015, a total of 8849 targeted procedures were performed in VCH hospitals, of which 47 developed a SSI for a rate of 0.53 per 100 procedures. This rate is lower than 2014 (0.74). Four VCH hospitals perform total hip and knee (primary) replacements. Combined, the four hospitals performed 3227 total hip and knee replacements in 2015 of which, 15 developed a SSI for an overall rate of 0.46 per 100 procedures.

In addition to orthopedics, Vancouver General Hospital (VGH) performed surveillance on 2956 targeted cardiac, spinal, vascular, thoracic and neurosurgical procedures. Of these, 26 developed a SSI for an overall rate of 0.88 which is lower than the 2014 rate of 1.21 per 100 procedures.

We completed an extensive review (2011 – 2014 inclusive) of all orthopedic SSIs identified by IPAC and NSQIP and presented our results at the 2016 BC Quality Forum (Click here to view the poster.pdf). Our review highlighted the uniqueness and complementary nature of the two programs for monitoring SSIs. We continue to work with our NSQIP partners to share information on SSIs, identify opportunities for improvement and support local quality improvement work.

SSI Rates: Hip and Knee Replacement (Primary)











Surgical Safety Checklist

VCH is committed to ensuring that the Surgical Safety Checklist (SSCL) and other surgical safety tools are used in all operating rooms within VCH, all the time and for all patients. Compliance with the checklist may help to reduce the incidence of complications experienced within operating room settings.

The SSCL is designed to promote effective team functioning, by developing an interactive tool to empower healthcare teams, improve team dynamics, and increase team communication in high-risk healthcare procedures. A high risk procedure is one that involves two or more healthcare professionals who rely on each other in completing a multistep procedure together. By applying human factors principles to the development and implementation of the SSCL, improvements to safe practices, greater situational awareness, increased leadership and management, compliance with infection control policies, and increased team communication can be achieved between clinical disciplines.

The SSCL is used as an opportunity to verify that all critical safety steps are consistently completed during three strategies phases: Briefing before the induction of anesthesia; Time Out before skin incision and **Debrief** before the patient leaves the operating room.

As an example, the SSCL used at VCH includes asking if antibiotic prophylaxis has been administered and whether VTE prophylaxis has been given. We have observed improved compliance in both antibiotic prophylaxis and VTE prophylaxis compliance in part due to use of the SSCL in our operating rooms.

The graph below shows the percentage of completed surgical cases compliant on the use of all three components of the SSCL.



In addition to the SSCL, we have been working to develop and evaluate safety checklists for interventional procedures. Currently, procedural safety checklists have been designed for interventional radiology, bronchoscopy, cardioversion, burns shower, Entriflex insertion, peripherally inserted central IV catheters (PICC), and endoscopy. Our next steps include development of safety checklists for cardiac catheterization, ultrasound and dentistry.

As with compliance audits conducted for the SSCL, observations were conducted around use of the endoscopy checklist and found improvements in the way staff communicate and work together. These observations also guided further work around education for endoscopy nurses to improve understanding concerning the use of safety checklists and to facilitate a formal process for embedding the checklist in everyday endoscopy practice.

SSCL compliance is further evaluated by each of its three components. The graph below shows compliance for Briefing, Time Out and Debrief.



Antibiotic Prophylaxis

Appropriate timing of pre-operative prophylaxis plays a key role in reducing the risk of surgical site infections and is a key component of a surgical quality program.

Antibiotics should be fully administered within 60 minutes of surgical incision. We monitor compliance on the timeliness of antibiotic prophylaxis administration and report the results by facility and surgical service every fiscal period supporting surgical teams in monitoring performance. Reports are posted to our portal every period.

Compliance has been very high for over two years with quarterly results ranging from 95% to 98%.

The graph below shows the percentage of completed surgical cases compliant on the timely administration of antibiotic prophylaxis.



Hand Hygiene

Hand hygiene includes washing your hands with soap and water and cleaning your hands with an alcohol based hand rub. VCH has a Hand Hygiene Policy in place that requires all healthcare providers including physicians, contracted employees and students to **perform hand hygiene before and after touching the patient and/or their environment**. Hand hygiene is universally accepted as the single most important method of infection prevention and control.

Hand hygiene compliance is measured using the Canadian Patient Safety Institute (CPSI) audit tool. Each acute care ward/unit is audited at least three times per month by independent observers trained in performing hand hygiene audits. Inter-rater reliability (which measures whether auditors agree in their assessment) is evaluated periodically to ensure that auditing is performed consistently.

The VCH annual target for hand hygiene compliance is 100% in non-emergency situations – a goal that will significantly reduce the transmission of infection. In 2015/16 we audited a total of 25,126 opportunities in our acute care facilities and observed an overall percent compliance of 78%.

Long-term/Residential care hand hygiene compliance is also measured using the CPSI audit tool. Each facility is audited at least once per month using peer auditors, trained by the Regional Hand Hygiene Coordinator. The number of opportunities audited increased in quarter four with additional LTC facilities submitting data.

Over the 2015/16 fiscal year hand hygiene auditors continue to focus on targeted "in the moment" feedback, both negative and positive to all staff, with extra attention given to the lower performing units. VCH continues to be an active member of the Provincial Hand Hygiene Working Group and participate in World Hand Hygiene Day.

In 2016/17 VCH is working to meet the expanded Hand Hygiene Required Organizational Practice (ROP) from Accreditation Canada, which now includes Public, Home, and Mental Health. We have developed an updated 4 Moments for Hand Hygiene Poster, Public, Home, & Mental Health and a Hand Hygiene module/self-assessment available on CCRS or via an APP downloadable on to staff phones targeting staff who work in nonacute care settings.





Quarterly Hand Hygiene Compliance: Before and After





Hand Hygiene: Percent Compliance by Site(s)

Clostridium difficile Infection (CDI) Incidence Rate

Clostridium difficile is a bacterium that can cause infections of the gastrointestinal system. *Clostridium difficile* infection (CDI) happens when antibiotics kill the good bacteria in the gut and allow *Clostridium difficile* to grow and produce toxins that can damage the bowel. CDI can cause infections ranging from diarrhea to rare but serious complications.

The CDI incidence rate measures the incidence of CDI infections among hospitalized patients considered to be due to a stay within a VCH hospital. All patients diagnosed with CDI are followed for 30 days or up until discharge/transfer for complications (i.e., toxic megacolon, total or partial colectomy, bowel perforation, gastrointestinal bleed and secondary bacteremia). Measuring the incidence of CDI and the locations in facilities where it occurs allows us to identify potential sources and target our interventions.

Over the 2015/16 fiscal year there was a total of 713 cases of CDI identified among admitted patients. Of these 508 (71.2%) were healthcare associated, 200 (28.1%) community acquired and 5 (0.7%) of unknown origin. Of the 508 healthcare associated cases, 383 (75.4%) were acquired within a VCH acute care hospital and 121 (23.8%) from another healthcare facility and 4 (0.8%) were associated with another healthcare exposure (e.g., outpatient treatment).

Our annual rate increased to 7.0 from 4.3 per 10,000 patient days last fiscal year. As noted in the second graph, there was a sharp increase in the first quarter of 2015/16 which slowly trended downwards in the last two quarters. The increases were observed in all of our communities of care but most notably at LGH and RH. Relapses increased from 9.8% to 17.5%, however, complications remained low at 1.0%.

Thanks to the efforts of a multidisciplinary team that focused on decreasing clutter, reviewing housekeeping practices and ensuring that ultraviolet C light was used where possible, rates have continued to fall into 2016.









VCH Complications, Relapse and All Cause Mortality by Fiscal Year

Mycobacterium tuberculosis (MTB)

In 2015/16 a total of 33 MTB cases were identified of which 10 (30.3%) required patient screening for exposure. A total of 102 exposed patients were screened. This compares to 26 cases identified in 2014/15 of which 11 (42.3%) required patient screening and 30 exposed patients screened.

Compared to 2014/15 there has been an increase both in the number of MTB cases identified and the number of cases requiring screening as a result of exposure.

It is important to note that some cases of MTB are identified in patients who have no apparent symptoms and therefore would not have met the criteria for isolation and enhanced precautions with the respiratory algorithm.

Tuberculosis is a disease caused by Mycobacterium tuberculosis complex (MTB). The bacterium usually attacks the lungs. Tuberculosis is spread through the air from person to person.

Cases of MTB that are not promptly identified can have a significant impact on the hospital resulting in the screening of many other patients and hospital staff that may have been exposed to the patient with MTB. All VCH acute care facilities use the following algorithm for the immediate management of patients with undiagnosed respiratory and/or febrile illness. The aim of the protocol is to quickly identify at-risk patients for isolation to prevent potential transmission to other patients and/or staff.

We monitor the number of MTB cases identified in hospital that required patient screening for exposure.

M. tuberculosis in Acute Care: TB Cases Requiring Screening for Patient Exposure by Fiscal Year





References: PHAC, http://publications.gc.ca/collections/collection_2013/aspc-phac/HP40-83-2013-eng.pdf accessed 24 Sept 2014 CDC HICPAC, http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf accessed 11 September 2014

Laboratory Confirmed Influenza

Influenza (commonly referred to as the flu) is an infectious respiratory illness caused by influenza viruses. Influenza is transmitted through the air by coughs or sneezes which create aerosols containing the virus. Influenza can also be transmitted by direct contact with nasal secretions or contact with contaminated surfaces. Though frequently confused with the common cold, influenza is severe and remains a significant cause of morbidity, mortality and hospital costs during influenza season.

Surveillance for laboratory-confirmed influenza among hospitalized adults (i.e. 16 years old or greater) is performed in all acute care facilities and runs from November 1st to May 31st every year.

There were 175 cases of laboratory-confirmed influenza identified among hospitalized patients in 2015/16 compared to 190 last fiscal year. The vast majority were community acquired (N = 156; 89.1%). A total of 19 (10.9%) cases were healthcare associated of which 8 (4.6%) were acquired in a VCH hospital (VCH AC) and three (1.7%) were acquired in a VCH directly funded long term care facility (VCH LTC). An additional 8 cases were from another healthcare facility (Other HCA).

The Patient Vaccination Program at VGH and GF Strong provides influenza and pneumococcal vaccination to patients. It is a model that achieves compliance with hospital accreditation requirements and with the Public Health Agency of Canada's recommendation to vaccinate high risk patients that are being discharged from hospital.

The provincial **Healthcare Worker Flu Policy** requires that all healthcare workers, physicians as well as other staff including administration and volunteers working in publicly funded healthcare facilities get vaccinated against influenza or wear surgical mask when in areas where patient contact may be expected. The policy is aimed at protecting patients and residents of residential care facilities as well as reducing illness among healthcare workers.

Laboratory-Confirmed Influenza Among Hospitalized Patients



The trend for the 2015/16 influenza season followed a different trend from what was observed in the prior two years. Compared with 2013/14 and 2014/15 which had peaks in the months of January, this year the peak occurred in February and extended into March.



Medication Reconciliation

Medication reconciliation is a formal, systematic process in which health care professionals partner with patients to ensure accurate and complete medication information transfer at interfaces of care. Prescribers are expected to reconcile patient/client/resident medications at admission, transfer, discharge and/or end of care utilizing the Best Possible Medication History (BPMH).

Medication reconciliation is widely recognized as an important patient safety issue and is an Accreditation Canada required organizational practice (ROP) and a BC Ministry of Health Clinical Care Management initiative. Research indicates that over 50% of patients have at least one medication discrepancy upon admission to hospital. Many medication discrepancies can potentially lead to adverse drug events.

Within VCH, we assess compliance with medication reconciliation in both acute and residential care. Specifically, we measure the percent of admissions/re-admissions where medication reconciliation was performed. The performance target for 2015/16 was 75%.

Residential Care: The data show that both overall and for each Community of Care (i.e. Vancouver, Richmond and Coastal) the percent compliance exceeds the target of 75%. The 2015/16 average percent compliance for VCH was 95%.

Quality of Medication Reconciliation Process: In addition to measuring the overall percent compliance, we continue to audit to assess the quality of the medication reconciliation process within select acute care facilities (i.e. VGH, RH, LGH and SGH). The quality audits look at the section where the medication history is verified with the patient and/or family/care provider prior to reconciling and creating admission orders. The objective of this verification process is to obtain the Best Possible Medication History (BPMH) which is the cornerstone of the medication reconciliation process.

In 2015/16 a total of 33,332 medications were counted by auditors of which 25,302 (75.9%) had been verified. The quality of the medication reconciliation process was highest at VGH (88.1%) and RH (85.6%). There is room for improvement at both LGH and SGH.

Medication Reconciliation program leads for each of the Communities of Care continue to work with programs to improve medication reconciliation at transitions of care as well as the "quality" of the medication reconciliation process by focusing on collection of a BPMH prior to writing admission orders.

Medication Reconciliation in Residential Care



120.0 100.0 80.0 60.0 40.0 20.0 0.0 LGH RH VGH Total Medicine 47.8 87.1 91.3 76.2

77.5

98.0

81.4

90.4

75.0

76.6

Percent Reviewed

Surgery

ICU

59.2

44.0

Medication Reconciliation Quality: 2015/16



Outbreak Management

Control and management of respiratory and gastrointestinal illness (GI) is a key role of Infection Prevention and Control (IPAC) team. Hospitalized patients and residents of residential care facilities are at increased risk for such illnesses due to pre-existing medical conditions and advanced age. Early identification, management and containment of these illnesses requires a multidisciplinary team effort to prevent transmission to patients, residents and staff.

In 2015/16 there was a total of 20 outbreaks in VCH acute (AC) and long term care (LTC) facilities. Of these six were in AC (4 GI and 1 respiratory) and 14 (9 GI and 5 respiratory) in LTC. A total of 193 patients/residents were affected (27 AC and 166 LTC) and 37 staff (8 AC and 29 LTC). The total days closure of affected areas was 177 days of which 130 days were associated with outbreaks in LTC and 47 in AC.

A comparison of the viral gastrointestinal outbreaks over the last eight years shows that in 2015/16 we experienced an increase in GI outbreaks (N = 14) compared to last year (N = 6) though still within range of previous years. Ten of the outbreaks were associated with norovirus and four had no pathogen detected. The average closure was 10.2 days in duration with on average 11.5 patients/residents and 2.4 staff affected.



GI Outbreak Indicator	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
# GI Outbreaks	23	12	13	21	28	16	6	14
# GI Outbreaks LTC	12	4	8	8	11	7	4	9
# GI Outbreaks AC	11	8	5	13	17	9	2	5
Average Total Days closed	9.4	17.7	10.1	10.0	11.0	9.0	8.2	10.2
Average LTC Days closed	10.5	41.3	12.3	13.3	13.8	10.3	8.0	11.4
Average AC Days closed	8.3	7.1	10.8	7.8	9.1	8.0	8.5	8.0
Average # pts/residents affected	11.8	8.8	7.7	12.4	9.5	8.6	7.5	11.5
Average # LTC residents affected	16.6	14.5	24.8	25.0	14.2	9.6	7.0	15.1
Average # AC patients affected	7.0	6.0	3.6	8.6	6.5	7.8	8.5	6.4
Average # staff affected	9.9	3.9	7.2	4.8	5.9	0.9	0.7	2.4
Average # LTC staff affected	14.2	6.0	8.4	8.4	6.6	0.6	0.8	3.0
Average # AC staff affected	5.5	2.9	8.2	4.1	5.4	1.1	0.5	1.2

Venous Thromboembolism (VTE) Prophylaxis

VCH implemented evidence-based venous thromboembolism prophylaxis (VTE) protocols in 2011/12. VTE is the most preventable cause of hospital death and disability. Both hospital costs and median length of stay increases for patients who develop VTE. Long term consequences to patients of hospital acquired VTE are the risk of developing recurrent thrombolytic events as well as developing chronic leg swelling. Both impact the quality of life of the patient.

VCH is ensuring that all hospitalized patients in acute care assess assessed for risk of VTE and prescribed appropriate prophylaxis (pharmacological or mechanical) as their clinical presentation indicates. In cases where a clinical indication not to prescribe VTE prophylaxis is evident, documentation in the patients' chart communicates this to other members of the healthcare team.

Measurement for compliance is aligned with the BC Ministry of Health Clinical Care Management (CCM) Guidelines. Audits are performed every fiscal period on a sample of charts from critical care, medical and surgical patients. We audit on the following three process measures:

- VTE pre-printed admission order on the patient's chart;
- VTE risk assessment completed; and
- Appropriate prophylaxis ordered

Results by facility and hospital unit are posted to our portal every fiscal quarter.

Overall compliance with VTE prophylaxis is very high with an average of 95% of patients receiving appropriate treatment in 2015/16. There remains opportunities for improvement for both pre-printed orders on the chart and documentation that a risk assessment was performed.





VTE Appropriate Treatment

GF Strong Rehabilitation Centre

GF Strong is British Columbia's largest rehabilitation centre with 68 beds serving residents of BC and the Yukon. GF Strong provides inpatient, outpatient, outreach and clinical support services in four unique programs: Acquired Brain Injury (ABI), Spinal Cord Injury (SCI), Neuromusculoskeletal and Arthritis (NMA) and Adolescent and Young Adult (with congenital abnormalities).

The surveillance program at GF Strong includes Methicillin-Resistant *Staphylococcus aureus* (MRSA), *Clostridium difficile* infection (CDI), highly resistant gram negative bacilli (GNB) as well as urinary tract infections (UTIs) and catheter-associated urinary tract infections (CAUTI). VCH acute care admission screening was introduced at GF Strong in October 2010 which means that at risk clients are now screened for MRSA and GNB. Surveillance for UTIs and CAUTIs was initiated in April 2010.

The rates for both MRSA and CDI increased in 2015/16. The rate for MRSA increased to 7.7 (95% CI = 4.6 - 12.0) from 2.1 (95% CI = 0.7 - 4.9) per 10,000 client days in 2014/15 whereas the rate for CDI increased to 3.2 (95% CI = 1.4 - 6.4) from 0.4 (95% CI = 0.0 - 2.3) in 2014/15. The increases are not statistically significant.

The infection control practitioner and infection control officer met with senior management to review the increase in rates. Actions have been identified to reduce transmission of MRSA and CDI including: encouraging clients to not share cigarettes, start and end all rehabilitation sessions with cleaning of hands with alcohol-based hand rub, review routine cleaning and disinfection of equipment, particularly wheel chairs and commodes and collect environmental cultures looking for CDI and MRSA. GFS is considering purchase of their own UV machine to disinfect client rooms.

There were no cases of highly resistant GNB identified. Both UTI and CAUTI rates have increased for a third year. In 2014/15 a total of 181 episodes of UTI were identified among clients of which 150 were CAUTI compared to 159 UTIs and 137 CAUTIs the year prior. The annual incidence rate was 7.4 per 1000 client days (95% CI = 6.3 - 8.5) for UTIs and 6.1 (95% CI = 5.1 - 7.2) for CAUTIS.

MRSA and CDI Acquired at GFS: Rates by Fiscal Year







Clients on the spinal cord injury unit are much more likely to be catheterized for extended periods of time and consequently have a higher risk of CAUTI than other clients at GF Strong. The quarterly rates by unit graph shows that the rate of CAUTI among SCI clients has been increasing over the last three years.

Actions identified to decrease the incidence of UTI/CAUTI include: Medical microbiologist and physician review of clinical presentation, diagnosis and treatment of UTI/CAUTI cases among GSF clients; discontinue routine urine culturing; review sterile technique with staff; ensure that BID peri/catheter care becomes routine; review bladder emptying for clients with a UTI and no catheter; and develop a CAUTI/UTI checklist to monitor and take action on contributing factors.

Bloodstream Infection (BSI) Incidence Rate

Bloodstream infections (BSI) occur when bacteria enter the bloodstream either through a wound, surgery or other invasive procedure or as a consequence of a pre-existing disease. Measuring the incidence of BSI, and assessing the source of infection as well as the locations in facilities where it occurs allows IPAC to target interventions accordingly.

Comprehensive BSI surveillance is performed at Vancouver General Hospital (VGH), Richmond Hospital (RH) and Lions Gate Hospital (LGH). The focus of the surveillance is on bacteremias acquired as a result of a hospital stay. Cases associated with another healthcare encounter or acquired in the community are not included in the surveillance.

For 2015/16 there were 326 nosocomial BSI cases for an overall rate of 6.9 (95% CI = 6.2 - 7.7) per 10,000 patient days. This is an increase compared to last year when the rate was 6.0 (95% CI = 5.3 - 6.7). However, the difference is not statistically significant.

In 2015/16 we observed increases in bacteremias associated with central lines (CVC), respiratory tract, and surgical wounds. The increase of CVC-associated bacteremias in ICU at VGH was investigated and recommendations made.











Distribution of Nosocomial Bacteremia by Primary Site and Fiscal Year

Methicillin-Resistant Staphylococcus aureus (MRSA) Incidence Rate

Methicillin-Resistant *Staphylococcus aureus* (MRSA) is a strain of *Staphylococcus aureus* (*S. aureus*) bacterium that is resistant to a number of antibiotics. S. aureus normally lives on human skin and in the noses of about 25% of the general population (i.e. colonization). However, *S. aureus* can cause skin infections and more serious diseases such as bloodstream and respiratory infections.

The MRSA incidence rate measures the rate of newly identified cases of MRSA among hospitalized patients considered to be due to a stay within a VCH hospital. Measuring the incidence of MRSA and the locations in facilities where it occurs allows us to identify potential sources and target our interventions.

Over the 2015/16 fiscal year there was a total of 761 cases of MRSA identified among admitted patients. Of these 629 (82.6%) were healthcare associated, 109 (14.3%) community acquired and 23 (3.0%) of unknown origin. Of the 629 healthcare associated cases, 326 (51.8%) were acquired within a VCH hospital, 264 (42.0%) from another healthcare facility and 39 (6.2%) were associated with another healthcare exposure (e.g., outpatient treatment).



Our annual rate increased to 7.0 from 6.5 per 10,000 patient days last fiscal year. As noted in the graph above, the rates were highest in the first two quarters of 2015/16 but trended downwards in the second two quarters. Our rate of infections has remained stable at 2.3 with skin/soft tissue/burn, sputum/ lower respiratory and surgical wounds accounting for 79% of infections.

Thanks to the efforts of a multidisciplinary team that focused on decreasing clutter, reviewing housekeeping practices and ensuring that ultraviolet C light was used where possible, rates continue to decline in 2016/17.

MRSA Annual Nosocomial Rates by Fiscal Year



VCH Nosocomial Rates of MRSA by Fiscal Year



Nosocomial MRSA Infections by Body Site and Fiscal Year

	250											
su	200											
ectio	150		-		_		_		_			
f Inf	100	_										
ber c	50	-										
Ę	0	2005/05	2005/07	2007/00	2000 (00	2000/110		0044/40	2042/42	2012/11	0.044/45	2015/110
Z		2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
other		24	23	3	7	3	5	4	7	12	5	4
blood		21	19	9	13	10	11	8	12	13	11	9
urine		23	32	50	40	35	27	12	24	19	16	11
surgical wou	ind	32	26	41	33	44	31	21	28	22	23	22
sputum/resp	biratory	40	52	52	45	31	36	16	41	22	38	34
skin/soft tiss	ue/burn	80	52	45	41	30	20	15	27	39	28	36

MRSA and CDI in Residential Care

There is no standardized provincial or national surveillance for MRSA or CDI in residential care. Screening of residents for MRSA at the time of admission to the facility is not performed consequently cases are identified if specimens are tested in the medical microbiology laboratory for clinical reasons and/or the resident was admitted to acute care and was screened on admission. Cases of CDI are identified from testing symptomatic residents.

VCH has 16 directly-funded facilities that provide residential care services to clients across the region. In total there are 1873 directly-funded residential care beds. The table shows each of the facilities along with its location and the number of beds.



MRSA: In total there were 47 cases of MRSA identified among residents in 2015/16 for a rate of 0.7 per 10,000 resident days compared to 30 in 2014/15 for a rate of 0.6.

Of the 47 MRSA cases 28 or 59.6% represented infections. This is up from last year where 30.2% were infections.

CDI: A total of 50 CDI cases were identified among residents for a rate of 0.7 per 10,000 resident days compared to 17 in 2014/15 for a rate of 0.2.

Of the 50 CDI cases 21 or 42.0% represented relapses. This is up from last year where 17.6% were relapses.

Residential Care Facility	Location	Number Beds
Banfield Pavilion	Vancouver	156
Bella Coola General Hospital	Bella Coola	5
Cedar View Lodge	North Shore	89
Dogwood Lodge	Vancouver	113
Evergreen Extended Care	Powell River	75
Evergreen House	North Shore	288
George Pearson Centre	Vancouver	114
Hilltop House	Squamish	86
Kiwanis Care Centre	North Shore	189
Lion's Manor	Richmond	93
Minoru Residence	Richmond	250
Purdy Pavilion	Vancouver	199
RW Large Memorial Hospital	Bella Coola	6
Shorncliffe	Sechelt	59
Totem Lodge	Sechelt	49
Willingdon Creek Village	Powell River	102

Table 1. Facilities and their directly-funded residential care beds

VCH Improvement Strategy-Releasing Time to Care

EMPOWERING FRONTLINE STAFF TO MAKE POSITIVE CHANGES IN THEIR WORK PROCESSES THAT CONTRIBUTE TO IMPROVING PATIENT EXPERIENCE AND HEALTH OUTCOMES.

WHY IS IT IMPORTANT?

Releasing Time to Care (RT2C) is a structured continuousqualityimprovementprogram that provides point-of-care staff and physicians with a systematic way to improve their work processes and environments, thereby releasing more time for patient-centred, quality care.

WHAT HAVE WE ACCOMPLISHED THIS YEAR?

"We treat all patients the way we want to be treated and Releasing Time to Care gives us a tool to have more time for the patients."

(Nurse, Medicine, Richmond Hospital)

"The changes made so far have been very effective and has improved some inefficiencies."

> (Nurse, Vancouver, South Community Health Centre)

Thirty units have implemented and sustained RT2C across VCH thus far and for 2015/2016, new teams include Emergency, Pediatrics, Rehabilitation, Medicine, Surgery and Community. A total of 325 nursing and allied health staff have undergone training for the program. Eighteen of these teams were supported to initiate the program through the generous support from Mr. Robert HN Ho and Mrs. Greta Ho and matching funds from VCH, the UBC/VGH Foundation and Lion's Gate Hospital Foundation. Over the next two years, the forecast is to increase the new team intake to two per year and to implement the VCH Improvement Strategy with 39 additional teams.

DEVELOPING LEADERS IN OUR FRONT LINE STAFF

Two Ward Leads who have anchored their teams in leading improvements and patient-centred care were honoured by their peers and leaders this year. Andra Grigore, LGH Operating Room Nurse and one of the Leads for The Productive Operating Theatre (TPOT) was recognized at the 9th Annual North Shore Health Care Award for Workplace Inspiration. Jacquie Steglich, Staff Nurse at SGH where both TPOT and RT2C have been implemented, received the VCH People First Award for Patient-Centred Care. SGH is one of the pilot sites for RT2C and the first unit to complete all eleven program modules which focused on developing standard work for Medication Management, Meals, Patient Observations, Shift Handover and Admissions &

Planned Discharges. The inclusion of multiple disciplines in daily huddles and change initiatives have led to reduced incidence of medication errors, complete medication review post-falls assessment, protected meal times for patients, streamlined admission process for mental health & addictions patients and individual care plans that empower patients to participate in steering their own hospital experience.



SGH RT2C Ward Leads Jacquie Steglich & Marcia Kent

FOCUSING ON THE PATIENT AND FAMILY

In collaboration with the Mental Health & Addictions Family Advisory Council, 2W at RH have a number of initiatives underway that promote patient and family-centred care. Spaces such as the activity room, exam room and patients belongings area have been decluttered and reorganized to provide a more welcoming space for patients and families. Information regarding the Mental Health Act (MHA) and patient rights are also given to the patient within 48 hours of admission on the unit as a result of standardizing the admission process. The team engages in regular measurement of violence and escalation incidences then discuss interventions in team huddles. This resulted in a downward trend in utilization of seclusion rooms in the last 12 months.

Based on feedback from patients, the T11 team at VGH developed a Visitor's Guideline that allow broader open hours for families to visit and have overnight stays to support care for their loved one. Staff partnered with Dietary Services to ensure snacks are available for patients who were NPO (nothing by mouth) for a procedure during the day and missed the dinner meal service.

HOpe 4 at LGH used their daily huddles to discuss their improvement efforts and decreased missed group sessions for their psychiatric patients by 50%. This allowed their patients to have more therapeutic interventions throughout their day and have also resulted in overall improved patient experience scores.

LESSONS LEARNED AND NEXT STEPS

Team based quality improvement is a challenging endeavor, requiring alignment of operational priorities across levels of leadership, change management, coaching, facilitation and project management support to be effective. The expansion of RT2C to new teams has provided the opportunity to learn about the type of support that is required to ensure that this framework becomes sustainable across our communities of care.

First, we learned that alignment of operational objectives from the senior leadership team right down to the ward lead in each RT2C unit must happen earlier than before, and become part of our pre-planning work before each intake. Particular attention will be given to supporting RT2C teams in their work on reducing Care Sensitive Adverse Events. Second, challenges with staff scheduling have encouraged us to begin to build an implementation tracking template for use with new teams, to help staff and leaders plan out expectations and resources needed on a month by month basis. Finally, challenges around data and reporting have sparked renewed interest in a system that could be used to track metrics associated with the quality and reliability of care, efficiency of care, staff well-being and patient experience on a unit by unit basis. We are fortunate to have the support of the BC Patient Safety and Quality Council in developing a tracking template for the most important indicators, and are working on a database driven system to make data entry and retrieval easier for RT2C teams across our three communities of care in the future.

Continuous quality improvement is a team effort. We are working more closely with the Lean team, strategy deployment, management development and professional practice to ensure that RT2C teams have the broad support they require to be successful in the long-term in embedding a culture of quality improvement within their programs and communities of care.



Figure 1. Patient Experience Scores HOpe 4 Centre, Inpatient Psychiatry, LGH



Figure 2. UTI rates on T4C at VGH have decreased by50%. Staff perform audits and track standards on best practices for preventing catheter-associated urinary tract infections (CAUTI). (*PCC=Patient Care Coordinator)



Robert & Lily Lee Family Community Health Centre team holding the recognition plaque from donor Mr. Robert HN Ho. The Enhancing Patient Care Fund is supporting 5 pillars, one being the VCH Improvement Strategy. L to R: Michelle Nichols, Cathy Anderson, Lori Earl, Janet Nordhagen.

Catheter Associated UTIs

Urinary tract infections (UTIs) are the most common type of healthcare-associated infection (HAI) accounting for more that 30% of infections reported by acute care hospitals. 70 – 80% of healthcare-associated UTI's result from the placement of an indwelling urethral catheter. Catheter associated urinary tract infections (CAUTI) have been associated with increased morbidity, mortality, hospital cost and length of stay. CAUTI is the leading cause of secondary healthcare-associated bloodstream infections. The CAUTI initiative is a multidisciplinary collaborative supported by Quality and Patient Safety in partnership with professional practice and in alignment with the regional antimicrobial stewardship program. The reduction of UTI/CAUTIs remains a key organizational priority. VCH is committed to improving the care we provide our patients by implementing the best evidence-based practices to prevent HAI's including CAUTI. Our goal, therefore, is to provide health care workers with the knowledge and tools required to prevent and minimize harm from the use of urinary catheters.

VCH continues to support the CAUTI initiative regionally but like every quality improvement initiative the work of improving patient outcomes happens right at the point of care driven by dedicated healthcare providers. Managers, educators and frontline staff have access to a comprehensive set of educational resources on the VCH intranet site as well as standardized clinical practice documents to support clinicians in preventing UTI/CAUTI.

PREVENTION STRATEGIES ARE FOCUSED ON 4 KEY DRIVERS:

Data is critical in any effort to drive change at the frontline which is why we're integrating outcome measures data from the National Surgical Quality Improvement Program (NSQIP), Canadian Institute for Health Information (CIHI) discharge abstract data and VCH urosepsis data. Staff on many units across VCH are actively monitoring outcomes and process measures related to UTI/ CAUTI through Safety Crosses and Lean Improvement Lanes. We encourage teams to review new cases of UTI/CAUTI in an effort to identify local opportunities for improvement.

During the past year professional practice, in collaboration with clinical education and learning and development, introduced a new education resource available through CCRS to support ongoing staff education. We continue to work toward the development of a



urinary retention Clinical Practice Document to support staff in managing those patients who require ongoing monitoring and evaluation for catheter placement. The evaluation of the all-in-one catheter kits was completed last year as part of the provincial RFP process for non-surgical urology products although we continue to explore strategies to integrate these new products into clinical practice.

"Staff proactively seek early removal of catheters in an effort to improve patient care by reducing catheter acquired UTIs."

Nursing Staff 3N Richmond Hospital

HOW ARE WE DOING?

VCH tracks UTI's as a proxy measure for the success of the CAUTI initiative. The annual UTI rate for VCH in 2015/16 was 18.1 per 1000 discharges. This represents a 5% reduction from the previous year. Overall, the UTI rates were highest across VCH during the baseline period of 2012/13 (31.2), declining in 2013/14 to their lowest level in P8 (12.3) consistent with the bulk of work and increased awareness surrounding UTI/CAUTI prevention. Clinical teams continue to make good progress in reducing UTI/ CAUTI across VCH as evidenced by the slight trend down during the past fiscal year.

LOOKING FORWARD

We've made great progress in reducing the incidence of UTI/CAUTI across VCH over the past 4 years but the work continues at all sites to ensure we provide the highest quality of care to our patients. One of the most important initiatives to this end is the monitoring of process and outcome measures by frontline staff on the units, which is supported through the introduction of Releasing Time to Care and Lean strategies meant to engage leadership and staff. Engaging staff in collecting data related to UTI/CAUTI events on individual units and facilitating discussions at unit based huddles will ensure we capture continuous improvement ideas that can only come from those caring for our patients on a daily basis. Other initiatives include; reducing the length of time a catheter is inserted by identifying and tracking patients with urinary



catheters; mechanisms to notify physicians in the chart of catheter placement without a valid indication; and working with our colleagues in the OR to standardize procedures that require catheter placement and removal of the catheter in the recovery room, where appropriate, prior to transfer to the inpatient unit.



Accreditation

Accreditation is one of the most effective ways for VCH to regularly and consistently examine and improve the quality of its services. We participate in Accreditation to evaluate and enhance our services and demonstrate that they meet national quality standards. The process is voluntary and all health authorities in BC participate. Accreditation is also an opportunity to showcase our leading practices and success stories, and celebrate the excellence of our staff, physicians and volunteers.

During an accreditation site visit, a team of trained Accreditation Canada surveyors tours our sites and conducts a number of observations and interviews with staff, physicians, patients and families to assess how our day-to-day delivery of care and services aligns with the Accreditation Canada Standards of Excellence.

ACHIEVEMENTS IN 2015/16

Historically, VCH participated in accreditation by undergoing separate site visits for each Community of Care (CoC), taking place in different years over the course of a four-year cycle. Over the course of 2015, VCH began transitioning to a more regionally integrated model, which will see VCH host its first health-authority-wide site visit in September 2016, and then every four years thereafter.

In order to transition to a single, VCH-wide site visit in September 2016, VCH hosted a supplementary, or "bridging" site visit in June 2015 to select acute programs in Coastal CoC, which successfully extended our accredited status for a year. VCH then began preparing for the 2016 site visit with a regionally coordinated approach.

Based on self-assessment results, six regional working groups were convened to address the highest-priority Required Organizational Practices (ROPs) across VCH, with leadership from both regional and local content experts. These regional working groups guided and collaborated closely with local operations leaders, clinical leaders and Professional Practice to implement regionally consistent standards of practice within local resources available. Program-level support was also provided, both regionally and locally, to ensure readiness for the clinical teams hosting site visit tracers .

Under the leadership of the Regional Trauma Program, VCH, PHC and PHSA were the first Canadian organizations to achieve the new Accreditation Canada Trauma Distinction designation. Accreditation Canada and the Trauma Association of Canada (TAC) launched Trauma Distinction in September 2014 as the new designation of excellence for trauma centres, an evolution of the now-discontinued TAC Trauma Accreditation program. In February 2016, VCH participated as a regional trauma network that included all VCH acute sites, Providence Healthcare hospitals, and BC Children's Hospital. The Trauma Distinction site visit included both centre-specific standards for all levels of trauma care, as well as trauma system-wide standards.

WHAT'S NEXT FOR 2016/2017

Accreditation is about the work that we do every day to provide great care. The transition to a four-year accreditation cycle provides a better opportunity for continuing to sustain the accreditation standards into day-to-day practice long past the site visit. Having all of VCH use the same version of the accreditation standards is also an opportunity to continue to align with other regional priorities such as CST and initiatives such as Care Sensitive Adverse Events, which rely on common definitions, systems and processes, and understanding of standard work.

As Providence Healthcare prepares for their own accreditation site visit in November 2017, they will be able to benefit from much of the preparation work already started by regional programs for the VCH 2016 site visit.



Patient Experience

In 2002, the BC Health Leadership Council launched a provincewide initiative to monitor patient experience of care in priority health care sectors, starting with BC's Emergency Department services.

The initiative's mandate was to implement a coordinated, cost-effective, scientifically rigorous, standardized, provincial approach to measuring patients' experience of care, which would achieve the dual aim of:

- Public accountability to measure and report the performance of the health care system from the perspective of our patients and clients, and
- Internal quality improvement to support and inform quality improvement initiatives at the point of service, both at the regional health authority strategic level and local care-unit tactical level.

Since 2003, the BC Patient Centered Measurement Steering Committee (BCPCM), with representation from the Ministry of Health and all BC Health Authorities, has conducted provincially coordinated surveys in a range of health care sectors, including Emergency Department Care, Long Term Care, Acute Inpatient Care, Mental Health and Substance Use, and Outpatient Cancer Care.

ACHIEVEMENT IN 2015/2016

With the introduction of new accreditation requirements around measuring patient experience and using the results for improvement, BCPCM worked closely with Accreditation Canada and, subsequently, Canadian Institute for Health Information (CIHI) to develop national standards for patient experience measurement in acute care. Under the leadership of CIHI, the new CPES-IC (Canadian Patient Experience Survey – Inpatient Care) was developed, and began being implemented across several Canadian provinces, as part of CIHI's Health System Performance reporting initiative.

BCPCM further developed the CPES-IC tool to add and cognitively test made-in-BC questions, including an expanded section on care transitions in and out of acute care, as well as a section on Patient Reported Outcome Measures (PROMs), making BC one of the first jurisdictions in Canada to integrate patient reported experience measures (PREMs) and PROMs into the same mandate of patient centered measurement. The survey of acute inpatient care using this new survey tool will be in field across BC hospitals between September 1, 2016 and February 28, 2017.

At the same time, BCPCM transitioned BC's current Emergency Department survey tool to one in the same family as the CPES-IC tool, with consistent question themes and response scales, with the aim to be able to integrate the two into a single modular survey that spans patients' end-to-end experience with hospital care. The survey of ED encounters is set to go to field in January 2017 across all emergency departments and urgent care centres in BC.

BCPCM partnered with the Office of the Seniors Advocate to coordinate BC's largest-scale survey of Long Term Care (27,000 residents across 303 publicly-funded facilities). The survey is in field between May-October 2016, using a combination of resident interviews and mail-out questionnaires to family/frequent visitors.

Over the course of 2015 and 2016, BCPCM successfully negotiated with Accreditation Canada an agreement that recognizes BC's mandate to survey patient experience provincially, and refers to the provincial work-plan of sector surveys instead of requiring each health authority to survey independently to meet their own site visit deadlines.

VCH has also been piloting different modalities for delivering frequent-feedback surveys closer to the point of care, with the aim of returning timely results that clinical teams can use for quality improvement, to augment the statistical reports that we receive from point-in-time provincial surveys. In partnership with CEAN, a number of nursing units participating in Releasing Time to Care have been piloting an electronic survey tool, while other mental health units have been piloting a paper version, both based on a subset of the provincial survey tools.





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