Excellent Care For All.

2011-12

Quality Improvement Plan

(Short Form)

Grey Bruce Health Services

2011/2012

This document is intended to provide public hospitals with guidance as to how they can satisfy the requirements related to quality improvement plans in the *Excellent Care for All Act, 2010* (ECFAA). While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and hospitals should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, hospitals are free to design their own public quality improvement plans using alternative formats and contents, provided that they comply with the relevant requirements in ECFAA, and provided that they submit a version of their quality improvement plan to the OHQC in the format described herein.

Part A:

Overview of Our Hospital's Quality Improvement Plan

Purpose of this section: Quality Improvement Plans (QIPs) are, as the name suggests, all about improvement. They are an opportunity for organizations to focus on how and what to improve, in the name of better patient-focused care. As such, they will be unique documents, designed by, and for, each individual organization. Overall, a QIP should be seen as a tool, providing a structured format and common language that focuses an organization on change. The QIP will drive change by formalizing a plan and facilitating shared dialogue to support continuous quality improvement processes. This introductory section should highlight the main points of your hospital's plan and describe how it aligns overall with other planning processes within your organization. In addition, this section provides you with an opportunity to describe your priorities and change plan for the next year.

Please refer to ***Appendix D*** *in the* *QIP Guidance Document* *for more information on completing this section.*

1. Overview of our quality improvement plan for 2011-12

[A general statement (100 words maximum) that is inspiring and situates the objectives within the Vision, Mission and Values of your organization

GBHS' Quality Improvement Plan is tied closely to our mission to "Ensure excellence in health care for our communities." Our core value of *Continuous Improvement* and our Strategic Goal devoted to Safety have been central to our long standing commitment to quality and patient safety.

In the 2011/12 Quality Plan we want to match the best wait times for emergency care in the province, increase our commitment to hand hygiene to reduce the risk of infection for patients in hospital, ensure that medications patients are taking at home match the medications provided to them while receiving care in our hospitals and maintain the organization's financial health.

2. What we will be focusing on and how these objectives will be achieved

[A description of the objectives that have been identified to improve quality of services and care in your hospital. This section describes the specific aims, measures and change ideas that form the core of the plan. You should also indicate how resources will be used to ensure that the correct financial levers are in place to execute the activities listed in your QIP]

The 2011/12 Quality Improvement Plan is focused on a number of measures to improve patient safety. These measures range from efforts to reduce infections patients might acquire in hospitals to measures that reduce the risk of falling for elderly patients. We also want to improve on the overall experience our patients have while receiving care in our six hospitals while ensuring that our financial health remains strong.

Good hand washing is the best defense we have against the spread of infection in hospital. While our current hand hygiene rates are above provincial standards, we are committed to reducing the transfer of infection between patients in hospital. Our nurses, physicians and other staff are following the recommended "Four Moments of Hand Hygiene" in their daily routines. We measure compliance with hand washing every month and post the results for each nursing unit and will provide opportunities for front line nursing staff to work directly with our infection control staff to increase their awareness of prevention tools for improving infection control across our hospitals. Auditing of hand hygiene compliance at the nursing unit level will be in place across the corporation by year end.

GBHS' emergency wait times are generally very good relative to current provincial averages and targets. Our Owen Sound hospital received one time funding last year under the 'Pay for Results' program to reduce wait times. These measures are having a very positive effect on reducing wait times but we want to monitor these initiatives and introduce further improvements over the 2011-12 year.

In 2009-10 the hospital achieved a balanced budget position. The 2010-11 fiscal year has just ended and audited final results are not available yet. It is expected that the financial performance will be favourable next year. Funding allocations for the 2011-12 fiscal year are not yet known but there are likely to be challenges in balancing the budget in the coming fiscal year. GBHS is committed to maintaining its balanced budget position. Total margin is an indicator of financial health and will be closely tracked in the coming year.

Currently our patients indicate that 72.8% of our patients would definitely recommend our hospitals to their friends and family. This is a very important indicator of how satisfied our patients are with their care. GBHS has participated in patient satisfaction surveys for many years and uses the results of those surveys to improve the care we provide. Our results on this indicator are better than the provincial average for our emergency departments and between the average result for community hospitals

and all Ontario hospitals for our inpatient results. We believe that we can improve this result to 75% with more focus on patient-centered care.

The Grey Bruce region has a higher than average elderly population. We have recently begun a falls prevention program that ensures our more elderly patients are assessed for their risk of falling when they come to our emergency departments for care. If their risk is high we link our seniors to resources in the community to follow up with a home visit. If the patient is admitted to hospital, special note is made of their risk of falling and measures to reduce the risk are provided. This project began as a pilot in our Wiarton hospital and is now being introduced across the corporation. Full introduction across the corporation is expected to lead to a reduction in severity and number of falls.

When patients lie in bed for a long period of time in one position their skin can become very irritated. This type of wound is called a pressure ulcer and can affect patients who are elderly, have circulation problems, or are very obese. This year we are focusing on better understanding the number of patients who acquire pressure ulcers while patients in our hospitals. While many measures are already in place to reduce the frequency and severity of these wounds, with a better understanding of our current prevalence we can introduce measures to reduce pressure ulcers. GBHS has recently increased its inventory of equipment for very obese patients to better support their needs and reduce the possibility that they will acquire pressure ulcers.

When patients are admitted to hospital, when they move from one area of the hospital to another and when they are discharged, it is critical their medications are reviewed and confirmed as accurate. Serious errors in the dosage, timing or types of drugs can occur if this review is missed or is incomplete. This process is called medication reconciliation.

Nurses, doctors and pharmacists have always played a key role in ensuring medication orders and deliveries are accurate. Our first formal medication reconciliation program was in our Day Surgery program at the Owen Sound hospital and was very successful. Part of our Quality Improvement Program this year will involve introducing a formal medication reconciliation program within our Emergency departments. We are creating an electronic link between the hospital and the family health team physician offices that will allow for immediate transmission of the patient's medications when they are discharged from hospital. This is especially important when the patient has been cared for by a different doctor in hospital and will receive follow-up care from their family doctor. Our goal this year is to have 90% of emergency room patients admitted to our Owen Sound hospital with medication reconciliation completed.

Three additional patient safety indicators, ventilator acquired pneumonia, central line infection rates and C-difficile infection rates, are regularly monitored by the hospital. Our performance on all three indicators is below provincial standards. We will continue the measures in place to maintain or eliminate any cases of these infections through the next year. The hospital's compliance with the completion of surgical safety checklists prior to a patient undergoing surgery is 99% and we will continue to support strict compliance with this safety practice.

Patients in hospital can develop blood clots during their inpatient stay. GBHS will be implementing the Safer Health Care Now program for reducing the possibility of developing clots with the goal of having 100% of patients receiving preventative treatment to avoid the risk of clot development by December 2011.

HSMR (Hospital Standardized Mortality Ratio) assesses whether a hospital's actual mortality (death) rate is higher or lower when the acuity of our patients is taken into account. It reflects overall quality and reliability of care. A ratio of less than100 is considered better than expected. GBHS' ratio was 94 last year. Many factors contribute to this indicator and GBHS will be working to reduce its HSMR in the coming year to 90.

3. How the plan aligns with the other planning processes

[An explanation of how this document links to the other planning documents developed by your organization (such as H-SAA) and key external partners such as the LHIN and CCACs.]

Grey Bruce Health Services has been tracking its performance on many quality and patient safety improvement efforts for years as part of its annual work plans and to achieve the goals set out in our Strategic Plan. These annual plans are reviewed by the board's Quality Committee and approved by the Board of Directors. Many improvements in our performance, like reducing the waiting time for emergency care or surgery are also part of the hospital's Accountability Agreement with the South West Local Health Integration Network.

The purpose of this Quality Improvement plan is to align the many quality-driven projects underway at Grey Bruce Health Services. Multiple internal strategies support our Quality initiatives, including a Patient Safety Framework that gives rise to an annual Patient Safety Plan; a Risk Management Framework, a Human Resources Plan, Information Management Plan, Ethical Framework and Strategy, Infection Control Plan and a Leadership Development Strategy. Our Board of Directors is currently renewing our Strategic Plan, which will lead us to reassessing our initiative focused performance indicators which make up our corporate balanced scorecard. From this new focus, we will realign our program based performance scorecards.

4. Challenges, risks and mitigation strategies

[This section describes the relative risks that may inhibit the accomplishment of the objectives and the mitigating strategies that have been identified to lower those risks.]

GBHS has included patient safety as one of its seven strategic goals in its current strategic plan which was released in 2005. There will be a strong focus on quality improvement and patient safety in the new Strategic Plan currently under development. However, the hospital is also experiencing the pressures on its services to manage the care needs of our aging communities. We do face challenges with large numbers of patients who no longer require acute treatment but may not be able to return to their homes or gain admission to long term care facilities. A large number of front line staff and managers are engaged in quality and patient safety improvements currently. We will focus on providing staff with the time and training to pursue quality as a core objective of GBHS within our available resources. While the hospital will continue to face financial uncertainty given the current challenges of the Ontario economy we believe that quality improvement efforts can result in decreased cost to the health care system.

Part B:
Our Improvement Targets and Initiatives

Please complete the "Improvement Targets and Initiatives – Part B" spreadsheet (Excel file). Please remember to include the spreadsheet (Excel file) as part of the QIP Short Form package for submission to the OHQC (QIP@ohqc.ca), and to include a link to this material on your hospital's website.

[Please see the QIP Guidance Document for more information on completing this section.]

Part C:
The Link to Performance-based Compensation of Our Executives

Purpose of Performance-based compensation:

1. *To drive performance and improve quality care*
2. *To establish clear performance expectations*
3. *To create clarity about expected outcomes*
4. *To ensure consistency in application of the performance incentive*
5. *To drive transparency in the performance incentive process*
6. *To drive accountability of the team to deliver on the Quality Improvement Plan*
7. *To enable team work and a shared purpose*

Please refer to Appendix E in the QIP Guidance Document for more information on completing this section of the QIP Short Form.

Manner in and extent to which compensation of our executives is tied to achievement of targets

[Compensation should be linked to targets for those members of the senior management group who report directly to the CEO, including the chief of staff (where there is one) and the chief nursing executive. Please refer to the regulation (Ontario Regulation 444/10)]

GBHS executives are identified as follows:

- President and CEO
- Chief of Staff
- Vice President, Clinical Services (CNO)
- Vice President, Finance and Support Services (CFO)
- Chief Human Resources Officer
- Chief Information Officer
- Chief Quality Officer
- Sr. Director, Clinical Support Services

As per regulations, a component of compensation for our executives is linked to our organization's achievement of quality improvement targets set out in our Quality Improvement Plan (QIP) and are identified as linked to compensation on the QIP:

- Safety – Improve Hand hygiene compliance
- Safety – Medication Reconciliation
- Effectiveness – Improve Organizational Financial Health
- Access – ER Wait Times
- Patient Centered – Improve Patient Satisfaction

Executives at GBHS are paid within a salary range. The top of the salary range is identified as the job rate (50th percentile) of the established comparator group (other community hospitals with a similar size operating budget). With the exception of the Chief of Staff, GBHS executives are not at the top of their pay range. The percentage of base salary at risk and linked to achieving the above performance targets is identified as a step increment within the existing range as permitted under the Compensation Restraint Act. The percentage at risk for the period April 1, 2001 to March 31, 2012 is as follows:

President and CEO (5.26%) of base salary
Chief of Staff (5%) of base salary – salary will be reduced and can be earned back if performance goals are reached.
Vice President, Clinical Services and CNO (5%)
Vice President, Finance and Support Services, CFO (5.6%)
Chief Human Resources Officer (5%)
Chief Information Officer (5%)
Chief Quality Officer (5%)
Sr. Director, Clinical Support Services (5%)

The following Performance Allocation Plan will be used to determine the magnitude of the performance allocation:

Rating	Progress against Quality and Safety Target	% Available
A	*Achieved or Exceeded Target*	*Based on full step increase % and/or as identified above*
M	*Maintained Previous Year Performance*	*1-3%*
W/SC	*Worse than previous year performance and special considerations**	*0.5%-1%*
W	*Worse than previous year and no special considerations***	***0%***

- ***Special considerations eg, community infectious disease outbreaks, catastrophic failure of systems, baseline affected by unusual circumstances.***

Performance Indicators and Measures

Dimension	Performance Indicator	Outcome Measure	Current Performance	Improvement Initiative	Methods and Results Tracking	Target for 2011/12* and Justification	Weighting
Safety	Improve provider hand hygiene compliance	Hand hygiene compliance before patient contact: The number of times that hand hygiene was performed before initial patient contact divided by the number of observed hand hygiene indications for before initial patient contact multiplied by 100 – 2009/10, consistent with publicly reportable patient safety data.	Corporate Average April 09 to April 10 79.5%	1) Complete roll out of unit based hand hygiene auditing following "4 Moments of Hand Hygiene" MOHLTC program	Quarterly reporting to MOHLTC and the GBHS Board of Directors. Post unit results monthly in each clinical setting.	100% of units will have a hand hygiene auditing program in place by March 2012	20%
Safety	Reduce Medication Error	Medication Reconciliation – percentage of patients for whom medication reconciliation was completed at admission.	Currently have medication reconciliation for 59% of admitted patients at the Owen Sound hospital.	1)Continue trial of pharmacy technician support of BMPH in Owen Sound ER 2)Continue pharmacy technician	Reporting quarterly to Accreditation Canada	75% of patients admitted to the Owen Sound hospital have a “best Possible Medication	20%

				assistance with BMPH in Owen Sound pre-surgical 3)Establish plan for medication reconciliation on admission to the remaining GBHS hospitals. 4)Support initial steps in medication reconciliation on discharge through the implementation of SPIRE software. This will give the family health team physicians the medication profile on patient discharge		History BPMH completed by March 2012	
Effectiveness	Improve organizational financial health	Total Margin (consolidated): Percent 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. Q3, 2010/11, OHRS	Q2 2010-11 = 2.46%	1)Quarterly meetings with each manager to ensure alignment with budget 2)Close monitoring of funded wait time initiatives 3) Continue to pursue operational efficiencies	Reported monthly to the GBHS Board of Directors and quarterly to MOHLTC	Balanced financial position (greater than 0%) as per the Hospital Services Accountability Agreement	20%
Access	Reduce wait times in the ED	ER Wait times: 90th Percentile ER length of stay for Admitted patients. Q3 2010/11, NACRS, CIHI	Q3 2010 Owen Sound hospital 8.9	1)Monitor the sustainability of the ER improvement initiatives that took place in 2010-11 under the Pay for Results project. Work on patient flow for admitted patients throughout the corporation. 2)Through LEAN training for ER leaders will initiate further process improvement	1) ER balanced scorecard used for monitoring our ER metrics on a daily basis. This is posted daily on our intranet and for our staff.	ER wait time at the Owen Sound hospital below provincial target and reduce length of Owen Sound ER stay by 10% 2)100% of ER leaders will complete LEAN	20%

				activities for patient transfer and discharge. 3)Establish steering committee to oversee patient flow projects.		training. 3)Steering committee in place.	
Patient Centered	Improve Patient Satisfaction	NRC Picker/HCAPHS: “Would you recommend this hospital to your friends and family?” (add together percent of those who responded “Definitely yes”)	2010 “Definitely yes” 72.88%	1)Complete implementation of our Transfer of Accountability project 2)Start initial roll out of our Patient centered care model	NRC Picker patient satisfaction survey data	Target “Definitely Yes” at 75%	20%

Part D:
Accountability Sign-off

[Please see the QIP Guidance Document for more information on completing this section.]

I have reviewed and approved our hospital's Quality Improvement Plan and attest that our organization fulfills the requirements of the *Excellent Care for All Act*. In particular, our hospital's Quality Improvement Plan:

1. Was developed with consideration of data from the patient relations process, patient and employee/provider surveys, aggregated critical incident data, and patient safety indicators;
2. Contains annual performance improvement targets, and justification for these targets;
3. Describes the manner in and extent to which, executive compensation is tied to achievement of QIP targets; and
4. Was reviewed as part of the planning submission process and is aligned with the organization's operational planning.

Craig Curran
Board Chair

Joan Homer
Quality Committee Chair

Maureen Solecki
Chief Executive Officer