

Excellent Care For All.



BEFORE YOU BEGIN...

As part of the **ECFAA Legislation**, the annual quality improvement plan must be developed having regard to:

- The results of the surveys (patient and staff - if available)
- Data relating to the patient relations process
- Aggregated critical incident data

Please ensure this information is reviewed and considered in the process of developing your plan.

Helpful hints for how to review this information are provided in the guidance document.

[Link to Online Updates](#)

Key messages	Technical Information
PART B: Improvement Targets and Initiatives	
Measures (columns B-F) –There is a core set of measures identified within this spreadsheet. This is to ensure alignment, consistency and standardization of reporting. There is however, an expectation that measures will be added that align with your own hospital and regional priorities	<u>Current performance:</u> What is your organization’s current performance data/rate? <u>A timeframe is specified within the table for core indicators.</u>
	<u>Performance goal 2011/12:</u> At the end of the improvement initiative, what is the outcome your organization expects to achieve? <u>Priority:</u> Only indicators assigned as Priority 1 require a change plan (columns G-K). Please see the guidance document for more information.
Change plan (columns G-K) – These columns should be completed where you have flagged a measure as Priority 1 (column F). Understanding that hospitals do not all have the same priorities, we expect these plans to be developed with your own hospital's priorities in mind. Change priorities should be focused on areas where improvement is necessary.	<u>High-level improvement plan:</u> This section defines the details of the quality improvement initiative. Hospitals are required to complete the change section for all high priority (1) initiatives.
	<u>Methods and results tracking:</u> Include your measures/current data (i.e. process measures) as appropriate
	<u>Target for 2011/12:</u> All Priority 1 indicators must have a target defined for 2011/2012. Organizations should aim to review their existing data over time to set “stretch targets” on a select number of objectives. Please see the Guidance document for more information on target setting.
	<u>Target justification:</u> Why was the specific target selected? i.e. is the target based on research literature; best practice; provincial or other defined benchmarks; scientific evidence; organizational targeting exercise?
	<u>Comments:</u> If there are any additional comments that you would like to make about the initiative, please indicate these here.

PART B: Improvement Targets and Initiatives

[Insert Hospital Logo]

[Hospital Name | Hospital Address]

Please do not edit or modify provided text in Columns A, B & C

AIM		MEASURE				CHANGE				
Quality dimension	Objective	Outcome Measure/Indicator	Current performance	Performance goal 2011/12	Priority	Improvement initiative	Methods and results tracking	Target for 2011/12	Target justification	Comments
Safety	Reduce clostridium difficile associated diseases (CDI)	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1,000 - Average for Jan-Dec. 2010, consistent with publicly reportable patient safety data	Jan-Dec 2010 = 0.13	At or below provincial average	3	1) See interventions listed under hand hygiene	Quarterly reporting to MOHLTC & Accreditation Canada and the GBHS Board of Directors. Post surveillance information in each clinical setting	CDI rate less than 0.28/1,000 patient days	0.28/1,000 patient days was the provincial average in 2010 for this indicator. Our CDI rates are low in relation and we will strive to maintain this achievement	Surveillance for C. difficile is supported through our electronic health record. Our last hospital to go "live" with the electronic health record will be in 2011-2012.
						2) Continue to follow PIDAC standards for Clostridium Difficile	Report to Quality of Care Committee	Compliance with PIDAC standards		
						3) Reduce environmental spread by installing wall mounted isolation units throughout all clinical settings	Report to Quality of Care Committee	Wall mounted isolation units available in each clinical setting		
	Reduce incidence of Ventilator Associated Pneumonia (VAP)	VAP rate per 1,000 ventilator days: the total number of newly diagnosed VAP cases in the ICU after at least 48 hours of mechanical ventilation, divided by the number of ventilator days in that reporting period, multiplied by 1,000 - Average for Jan-Dec. 2010, consistent with publicly reportable patient safety data	Jan-Dec 2010 = 1.55	At or below provincial average	3	1) Continue to utilize the Safer Health Care Now VAP Bundle	Quarterly reporting of outcomes to MOHLTC and the GBHS Board of Directors	Continue to have no or small volumes of VAP.	1.46/1,000 patient days was the provincial average in 2010 for this indicator	There was one VAP case in 2010 with 646 vent days.
						2) See interventions listed under hand hygiene				
	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-April 2010 = 79.5%	Maintain or exceed current compliance levels	2	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	65.73% was the provincial average in 2010 for this indicator. GBHS' current performance exceeds provincial average by 14%	This indicator has been tied to Executive Compensation
						2) Continue mandatory annual training for hand washing		100% of mandatory training complete		
						3) Implement positive deviance approach 4) Debrief outbreaks and ensure followup on outstanding items 5) Implement Infection Control Immersion program		infection control immersion program for rural hospitals implemented		
	Reduce rate of central line blood stream infections	Rate of central line blood stream infections per 1,000 central line days: total number of newly diagnosed CLI cases in the ICU after at least 48 hours of being placed on a central line, divided by the number of central line days in that reporting period, multiplied by 1,000 - Average for Jan-Dec. 2010, consistent with publicly reportable patient safety data	Jan-Dec 2010 = 0.13	At or below provincial average	3	1) Continue to utilize the Safer Health Care Now CLI Bundle	Quarterly reporting to MOHLTC and the GBHS Board of Directors	Continue to have no or small volumes of CLI	0.75/1,000 patient days was the provincial average in 2010 for this indicator	There were 778 central line days in 2010
						2) We will be moving the use of the CLI bundle into our medical surgical settings in 2011	Report to Quality of Care Committee			
	Avoid new pressure ulcers	Pressure Ulcers: Percent of complex continuing care residents with new pressure ulcer in the last three months (stage 2 or higher) - FY 2009/10, CCRS	N/A							
	Avoid falls	Falls: Percent of complex continuing care residents who do not have a recent prior history of falling, but fell in the last 90 days - FY 2009/10, CCRS	N/A							
Space for additional indicators	Avoid new pressure ulcers	Pressure Ulcers: Percent of acute care patients with new pressure ulcer during hospitalization .	Prevalance study done in February 2010 - results not available yet	Target to be identified	3	1) Currently completing prevalence study 2) Compare results and identify target 3) Compare current practices against RNAO best practice guidelines	Progress report to be provided to Board of Directors. Unit based results to be posted in clinical setting	Determine prevalence and improvement targets	This is a build year for this indicator.	

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Quality dimension	Objective	Outcome Measure/Indicator	Current performance	Performance goal 2011/12	Priority	Improvement initiative	Methods and results tracking	Target for 2011/12	Target justification	Comments
	Reduce Falls	Falls: Percent of at risk elderly Emergency Department patients who are assessed for fall risk. For those with high risk, the percentage that are referred to community services for followup.	100% patients over the age of 75 registered to the Warton ER department are screened for fall risk	Program implemented in Markdale, Meaford and Southampton hospitals	3	1) Complete roll out of ER falls initiative into Markdale, Meaford and Southampton hospitals 2) Continue to complete Morse Falls tool on all elderly inpatient admissions 3) Where the screening tool indicates risk, appropriate interventions are put into place	Monitor in electronic incident reporting system Monthly reports to managers	Roll out 100% complete for ER falls initiative Audit completion of Morse Falls tool. Identify the percentage of high risk fall patients that have a plan implemented	Grey Bruce counties have a high percentage of elderly. Falls are a significant problem. We are working toward screening our elderly patients in our ER facilities for the purpose of linking them with a community program which will work toward reducing their risk	
	Prevent wrong site/side surgery	The Safe Surgical Checklist developed by the World Health Organization covers the most common tasks and items that operating room teams carry out and has been shown to reduce rates of death and complications among patients. The Safe Surgical Checklist compliance indicators is a process measure, and refers to the percentage of surgeries in which the checklist was performed.	99%	At or above provincial average	3	1) Continue to maintain high compliance rate	Quarterly reporting to MOHLTC and the GBHS Board of Directors	Maintain performance	97.82% is the provincial average in 2010 for this indicator. GBHS was at 99.72%	
	Reduce clots	DVT: Reduce the number of admitted patients who develop a clot during their hospital admission.	Prevalance study being done in 2010	Target to be identified	3	1) Implement Safer Health Care Now program for deep venous thrombosis (DVT) prophylaxis 2) Establish tools that will be used to assess patient risk, align intervention with risk and create transfer of accountability processes.	Chart audit of patients receiving preventative treatment. The measurement is the percentage of at risk patients who develop a clot divided by the number of patients who were determined to be at risk.	To increase the percentage of admitted patients who are receiving appropriate thromboprophylaxis to 100% by December 2011.	Accreditation Canada has established this target as a Required Organizational Practice in 2011. We are next surveyed in September 2013	
	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.	75% of patients admitted to the Owen Sound hospital have a "Best Possible Medication History (BPMH)" completed by March 2012	1	1) Continue trial of pharmacy technician support of BMPH in Owen Sound ER 2) Continue pharmacy technician assistance with BMPH in Owen Sound pre-surgical clinic 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 physicians the medication profile on patient discharge	Reporting quarterly to Accreditation Canada	75% of patients admitted to the Owen Sound hospital have a "Best Possible Medication History (BPMH)" completed by March 2012	Plan is consistent with Accreditation Canada targets	This indicator has been tied to Executive Compensation
Effectiveness	Reduce unnecessary deaths in hospitals	HSMR: number of observed deaths/number of expected deaths x 100 - FY 2009/10, CIHI	2009/10 94	90 or below	3	1) All Medical Advisory Committees and clinical departments receive education regarding HSMR	Quarterly reporting to MOHLTC and the GBHS Board of Directors	Corporate HSMR of 90 or below		
	Reduce unnecessary hospital readmission	Readmission within 30 days for selected CMGs to any facility: The number of patients with specified CMGs readmitted to any facility for non-elective inpatient care within 30 days of discharge, compared to the number of expected non-elective readmissions - Q1 2010/11, DAD, CIHI	2008/09 Actual 16.6% Expected 14.6%	15%	3	1) Identify performance indicators for readmission on program balanced scorecards.	Monitored through Quality Committee & Utilization Management	Process targets established	This is a build year for this indicator.	
						2) Create a re-admission task force		Task force established by May 2011		
						3) Identify major contributing factors that cause readmission for quality improvement initiatives for 2012/13		Report to Quality of Care Committee by February 2012		
Reduce unnecessary time spent in acute care	Percentage ALC days: Total number of inpatient days designated as ALC, divided by the total number of inpatient days. Q2 2010/11, DAD, CIHI	Q2 2010 19.4% 2009/10 17.1%	19%	2	1) Implement behavioural support mechanisms for Grey Bruce in collaboration with Lpmg Term Care and CCAC. 2) Participate on the LHIN steering committee for the end-of-life care plan for Grey and Bruce 3) Seek approval for the project charter to establish a restorative care unit in Grey Bruce Health Services	CIHI data on psychogeriatric patients reported quarterly	Evaluation targets established	This is a new program starting in 2011/12.	Q3 2010 result was 20.4%	

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Quality dimension	Objective	Outcome Measure/Indicator	Current performance	Performance goal 2011/12	Priority	Improvement initiative	Methods and results tracking	Target for 2011/12	Target justification	Comments
	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%	Balanced financial position (greater than 0%)	1	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	H-SAA requirements and fiscal accountability requirements	This indicator has been tied to Executive Compensation
Access	Reduce wait times in the ED	ER Wait times: 90th Percentile ER length of stay for <u>Admitted</u> patients. Q3 2010/11, NACRS, CIHI	Q3 2010 Owen Sound 8.9	ER wait time at the Owen Sound hospital below provincial target and reduce length of Owen Sound ER stay by 10%	1	1) Monitor the sustainability of the ER improvement initiatives that took place in 2010 - 2011 under the Pay for Results project. work on patient flow for admitted patients throughout the corporation	Unit based balanced scorecard used for monitoring our ER metrics on a daily basis. This is posted daily on our intranet and for staff	ER wait time at the Owen Sound hospital below provincial target and reduce length of Owen Sound ER stay by 10%	Provincial target is 8 hours.	This indicator has been tied to Executive Compensation. Other corporate results are: Lion's Head 23.7 Markdale 12.0 Meaford 5.9 Southampton 10.8 Warton 14.0
						2) Through LEAN training for ER leaders will initiate further process improvement activities for patient transfer and discharge.		100% of ER leaders will complete LEAN training.		
						3) Establish steering committee to oversee patient flow projects.		Steering committee in place.		
		ER Wait times: 90th percentile ER Length of Stay for Complex conditions. Q3 2010/11, NACRS, CIHI	Q3 2010 Lions Head 14.4 Markdale 4.7 Meaford 5.4 Owen Sound 5.8 Southampton 6.9 Warton 3.9	At or below provincial target	1) Continue to track patient satisfaction and establish improvement activities based on identified opportunities	Monitor quarterly reports from NRC Picker at the ER Clinical Service Team	At or below provincial target	Our performance with this indicator is currently at 98%. The targets that we have chosen are therefore established to sustain our efforts.	Provincial target for complex conditions = 8 but the average is 12.5.	
	Space for additional indicators									
Patient-centred	Improve patient satisfaction	<i>Please choose the question that is relevant to your hospital:</i> NRC Picker / HCAPHs: "Would you recommend this hospital to your friends and family?" (add together percent of those who responded "Definitely Yes")	2010 yes definitely 72.88	Target 'definitely yes' 75%	1	1) Complete implementation of our Transfer of Accountability project 2) Start initial roll-out of our Patient Centred care model	NRC Picker patient satisfaction survey data	Target "definitely yes" of 75%	At this time, our ER averages for this question are above the Ontario average of 58.5% and the community hospital average of 56.4%. Our inpatient average is between the community hospital average of 69.4% and the Ontario average of 74.3%. This is where our improvement efforts will be focused	This indicator has been tied to Executive Compensation
		In-house survey (if available): provide the percent response to a summary question such as the "Willingness of patients to recommend the hospital to friends or family" (Please list the question and the range of possible responses when you return the QIP)	N/A							