Excellent Care For All.

2012/13

Quality Improvement Plan

(Short Form)

Glengarry Memorial Hospital
March 5, 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 HQO in the format described herein.

Ontario

Part A:

Overview of Our Hospital's Quality Improvement Plan

HGMH's mission "to provide innovative, accessible and quality healthcare services for the residents of the Eastern Counties and its surrounding population in both official languages" remains evident within our corporate Quality of Care Action Plan, developed to provide patients with appropriate, consistent, timely health care in a safe environment in which the best possible results are achieved while endorsing our workplace values.

The Mission Statement is at the core of our Balanced Scorecard; quadrants are Growth & Learning, Human Resources & Financial Management, Quality of Care, and System Integration & Partnership. The Quality of Care quadrant is further divided into four sub-quadrants: Access, Appropriateness (Effectiveness), Patient Safety, and Patient Satisfaction. These sub-quadrants are included within corporate, departmental, committee and managerial goals and objectives annually, and within performance appraisals. These sub-quadrants and the System Integration & Partnership quadrant align with the 5 Quality Dimensions of the 2012-2013 Quality Improvement Plan.

The HGMH 2012-2013 Quality Improvement plan includes objectives in all 5 Quality Dimensions. We will be utilizing best practice standards/guidelines and standardized processes to achieve success for our patients' with regard to access, effectiveness, safety and satisfaction.

The HGMH QIP for 2012-2013 encompasses quality initiatives directly related to the Provincial Strategic Plan and the Champlain LHIN Integrated Health Services Plan strategies, as well as goals to improve the patient's experience in all areas of our organization.

Specific objectives are as follows:

- Maintain hospital-acquired Clostridium difficile associated diseases at the rate of <0.38 cases per 1000 patient days.

  This will be achieved by initiating an HGMH Antibiotic Stewardship Program, conducting audits for the proper donning, wearing, and doffing of personal protective equipment, and providing PPE education for our visitors.
- Improve hand hygiene compliance prior to initial patient contact to 76% or greater.

  This will be achieved by enhancing our Hand Hygiene Program to target the 4 Moments of Hand Hygiene by increased education by various means/media, conducting on-the-spot real-time audits with feedback by trained auditors, and involving managers in the auditing process of their own departmental staff.
- Maintain HGMH's financial health to a consolidated total margin of at least 0.3% or greater. This will ensure the stability of patients' services and programs.
- Reduce length of stay in the Emergency Department for admitted patients to 20.0 hours. This will improve patient flow and ensure patients receive care in a timely fashion.
- Attain 81% patient satisfaction in our inpatient unit as indicated by the question: "Would you recommend our hospital to others?" Attain 78% satisfaction in the ER.

  This will be achieved by providing various educational opportunities to the patient and maintaining quality patient care at the focus of all we do.
- Reduce the percentage of ALC patients to 13.5%. This is the target set by the Champlain LHIN. This will help to transition patients to the most appropriate place of care.

  This will be achieved by educating the nursing staff to a new bullet-round process, introducing and implementing an integrated Discharge Review Committee to clinicians and ensuring that 100% of our patients are referred to CCAC for consultation.
- Reduce the readmission rate within 30 days for provincially-selected CMGs to 10.0%.

  This will be achieved by researching and drafting patient-friendly medication lists for discharge, a series of questions for post-discharge phone call connection with the patient, and the recruitment of a late-career nurse for this follow-up initiative.
- Reduce ALOS for typical cases to 7.0 from 7.46 days.

This will be achieved by conducting case conference reviews to identify gaps that are a barrier to discharge. The Nursing Continuous Quality Improvement Committee will review common barriers and develop an action plan.

Reduce medication errors by performing Medication Reconciliation on admission, transfer and discharge to attain compliance of 98.5%. This will ensure patient safety in medication management.

The HGMH QIP aligns with other planning processes in our organization as follows:

1. The QIP is aligned with the hospital strategic priorities through improving patient safety, reducing ALC and unnecessary readmissions. As a primary care hospital, chronic diseases such as congestive heart failure, COPD, pneumonia and diabetes are the most frequent reasons for admission. The QIP aligns with the MRP Quality Improvement Plan on "safe discharge" ensuring timely discharges with copies of the discharge summaries being sent to the primary care providers within 2 weeks of discharge.
2. The QIP aligns to the Champlain LHIN strategic priorities of the frail elderly with complex conditions and chronic disease. The reduction in ALC is a priority for the LHIN. The plan also aligns to the HSAA.
3. The QIP aligns to the provincial strategies with reduced ED Wait Time Strategy and the ALC improvement plans.

The HGMH QIP allows for integration and continuity of care as we follow the patient from admission to discharge and beyond:

- ensuring proper coding,
- safety measures to prevent medication errors, falls, and nosocomial infections
- transition to home or placement
- follow-up to prevent readmission

There continues to be close collaboration and integration of the CCAC staff through a shared position of Case Manager and Discharge Planner.

Challenges and Risks:

1. Staff engagement remains a challenge; natural leaders and champions for various programs and initiatives will be appealed to via surveys, advertisements in our Hospital Post newsletter and face-to-face appraisals and discussions; opportunities for education around change management will be offered to the HGMH Leadership Team.
2. Physician engagement into the continued efforts of infection control and hand hygiene remains a challenge.
3. Although there is a provincial definition of ALC, the various practices of admitting physicians makes determining a patient ALC inconsistent.
4. Physician and family relationships that make discharge difficult if the family is not comfortable with the most appropriate discharge plan.

Part B:
Our Improvement Targets and Initiatives

Purpose of this section: Please complete the "Part B - Improvement Targets and Initiatives" spreadsheet (Excel file). Please remember to include the spreadsheet (Excel file) as part of the QIP Short Form package for submission to HQO (QIP@HQOntario.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

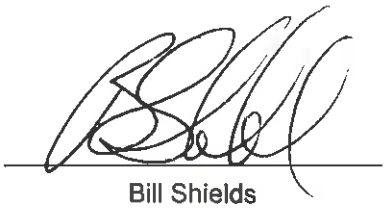
2012-2013		
Indicator	**Target**	**Weight of Tied Executive Compensation**
Hand hygiene performance on initial patient contact	≥ 76%	20%
Patient Satisfaction overall for inpatients and emergency	≥ 81%	20%
ER Wait times for admitted patients	≤ 20 hrs	20%
Medication reconciliation on admission, discharge and transfer	≥ 97.5%	20%
Total margin	≥ 0.30%	20%

Total Executive Compensation tied to Performance-based indicators: 2%

Part D:
Accountability Sign-off

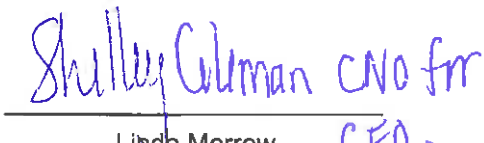
I have reviewed and approved our hospital's Quality Improvement Plan and attest that our organization fulfills the requirements of the *Excellent Care for All Act*. In particular, our hospital's Quality Improvement Plan:

1. Was developed with consideration of data from the patient relations process, patient and employee/service provider surveys, and aggregated critical incident data
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 processes and considers other organizational and provincial priorities *(refer to the guidance document for more information)*.



Bill Shields
Board Chair

Kathryn Brunton
Quality Committee Chair



Linda Morrow
Chief Executive Officer

PART B: Improvement Targets and Initiatives 2012/13

Hôpital Glengarry Memorial Hospital

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

AIM		MEASURE					CHANGE			
Quality dimension	**Objective**	**Measure/Indicator**	**Current performance**	**Target for 2012/13**	**Target justification**	**Priority level**	**Planned improvement initiatives (Change Ideas)**	**Methods and process measures**	**Goal for change ideas (2012/13)**	**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. 2011, consistent with publicly reportable patient safety data	**0.1906**	**0.2**	Small volumes, .2 represents 2 cases per year	**1**	1) Introduce a antibiotic stewardship program with the clinical team.	A framework and implementation plan will be developed over the current year.	One year	
							Environmental audit program will be set up for regular auditing. Encompass monitoring tool will be used.	Environmental audits will demonstrate environment is cleaned using best practice.	100%	
	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 - Jan-Dec. 2011, consistent with publicly reportable patient safety data	**72%**	**76%**	Above current performance	1	Focus group of front line staff both clinical and support to discuss reasons for decreased hand hygiene compliance. Action plan for improved hand hygiene compliance	40 monthly audits on 4 moments of hand hygiene to monitor results.	100%	
							New accountability model for hand hygiene follow up. Change from peer to peer mini audits to staff leaders doing the mini audits to promote engagement of front line staff	Target performance will be met monthly	76%	
							Patient and visitor engagement in hand hygiene.by develop a teaching tool on hand washing and PPE.	Patient safety checklist for hand hygiene performance on Patient Safety Rounds	Within 90 days	
	Reduce incidence of 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 Q3 2011/12, CCRS	**4.5**	**4.5**	Low volumes, difficult when admitted with pressure ulcer to make change	**2**	1)			
							2)			
	Avoid patient falls	**Falls**: Percent of complex continuing care residents who fell in the last 30 days - FY Q3 2011/12, CCRS	**29%**	**20%**		**1**	1)Chair alarms to reduce falls from the chair and continue with bed alarms	#Falls from chairs or bed per month	Falls from chairs or bed will be less than 2 per month	
							Review risk assessments that are high and followup on tools and prevention through assessment by rehabilitation team for appropriate ambulation and tranfer techniques.	# patients with a fall that are assessed by the rehabilitation team	100%	
	Reduce medication errors	**Medication reconciliation on admission, discharge and transfer**	**97.0%**	**97.5%**		**3**				

AIM		MEASURE					CHANGE			
	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 2011/12, OHRS	**0.94**	**0.30**	Currently in a surplus position as budgeted FTE position not yet hired and an accrual reversed for labor relations. Not anticipated in the next fiscal year.	**3**	1)			
							2)			
							… N)			
Access	Reduce wait times in the ED	**ER Wait times:** 90th Percentile ER length of stay for Admitted patients. Q3 2011/12, NACRS, CIHI	**20.6**	**20.0**		**3**	1)			
Patient-centred	Improve patient satisfaction	*Please choose the question that is relevant to your hospital:*					… N)			
		From NRC Picker / HCAPHS: "Would you recommend this hospital to your friends and family?"	**79.6%**	**81%**		**1**	1)Patient satisfaction rounds with inpatient manager, CNO and infection control practitioner	Checklist on patient satisfaction rounds	Bimonthly	
		From NRC Picker: "Overall, how would you rate the care and services you received at the hospital?"	**N/A**	**85%**			2)White boards for communication to patient and family of the name of care providers, expected discharge date, needs.	Question as a part of rounds on whether this is helpful	100%	
Integrated	Reduce unecessary 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 2011/12, DAD, CIHI	**17%**	**13.50%**		**1**	1)Educate all nurses that 100% of patients who are ALC must be referred to the CCAC for consult	% ALC patients referred to CCAC	100%	
							Ongoing education to all nurses on the integrated discharge planning team daily bullet rounds. Bull et rounds to focus on barriers for discharge	Reduction of % ALC patients	13.50%	
							Discharges to LTC must be reviewed by the interprofessional Discharge Review Team which includes senior management , CCAC Manager of Client Servcies and the discharge planne. Educate the clinical staff on the role of the Discharge Review Committee	95% of clinical staff who work on the inpatient units are educated on the Discharge Review Committee	Within 90days	
	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 2011/12, DAD, CIHI	**10.00%**	**10.00%**	Only reached this target in one quarter of the prior year.	**2**	1)Draft a patient friendly medication list for discharge.	#readmissions due to not understanding medications	0	
							Draft a list of questions for follow up phone calls post patient discharge.	# readmissions for lack of follow up planning	0	
							Recruit a late career nurse under the initiative to do follow up phone calls within one week post discharge.	1 late career nurse will be hired	Within 90days	
	Reduction of length of stay for typical cases	Reduce Average LOS 2011-2012	**7.46**	**7.0**		**1**	Case conference reviews to look at barriers for discharge.	# case conferences with LOS >7.0 days reviewed.	95%	