Excellent Care For All.

2012/13

Quality Improvement Plan

(Short Form)

St. Thomas Elgin General Hospital
April 1, 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

The St. Thomas Elgin General Hospital has been on a journey to redefine its future, focused first on transforming care and then building new facilities to match. Transforming Care requires that first we develop a better understanding of our care pathways and processes through the patients eyes, making changes that keep the patient at the centre of our work and systems. We must then build our capacity to meet the needs of a new clinical population (mental health services) and translate this work into a facility design that matches and enables the work that happens at the hospital. This work will help us deliver on our STEGH promise, our vision "to deliver an excellent care experience".

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

Our Quality Improvement Plan for 2012/13 highlights five high priority objectives for improvement. Each objective is deemed high priority for at least one of the following reasons: the objective aligns directly with our hospital's vision and strategic goals; our current performance is below the established organizational or field benchmark; the objective is clearly defined as a required accreditation priority, and/or the objective is linked to a funding source or government priority.

1) ***Improve health care provider hand hygiene compliance before patient contact:*** **Consistent hand washing is proven to help reduce the spread of infection in hospital. Our aim is to achieve no less than 85% hand hygiene compliance before patient contact. Compliance is measured by regular, but random, observations (audits) of provider hand washing behavior across the hospital. These audits are documented electronically to ensure consistent, valid and real-time data reporting. A comprehensive strategy will drive behaviour change through real-time provider feedback, team-based improvement huddles, enhanced individual, team and leader accountability and use of targeted audits and education. Current Infection Prevention and Control specialists will provide hand hygiene expertise and education support. Encouraging patients and families to take a more active role in hand hygiene promotion will further reinforce accountability to the patient. This may include the creation of tools that educate them on when, why and where hand hygiene tasks should be performed and give them explicit permission to ask or remind healthcare providers to follow hand hygiene protocol.**

2) ***Reduce wait times in the Emergency Department:*** **Prolonged wait times increase the likelihood of patients leaving without being seen, is disrespectful of people's time and generates undue stress for patients and those who have accompanied them. Our aim is to continue to improve our wait times for ER admitted patients to within 8 hours. This requires organization-wide and systematic approach that balances bed availability with patient needs in a consistent, daily, collaborative and focused effort. Our tools, like our Bed Optimization System and Continuum, provide reliable and current data allowing us to make real-time decisions. This includes getting patients into an appropriate bed in an appropriate timeframe following the decision to admit, and begin the process for their effective and safe discharge. Process improvements underway include the reallocation of our in-patient beds to reflect evidence demonstrating current and preferred patterns of use, changing the current nurse patient ratio to reflect census patterns, the continued deployment of a Rapid Assessment Zone in the Emergency, an improved ability to manage times of high hospital bed occupancy and the implementation of the Home First Program. All are process improvements that result in improved/increased bed availability, an important factor in the reduction of emergency wait times and creating a seamless journey for patients.**

3) ***Improve patient satisfaction:*** **Patient feedback is critical to the effective identification of improvement opportunities. Their level of satisfaction is a measure of our capacity to listen to our patients and our ability to make improvements that they value. Our aim is to increase the percent**

of patients who respond 'definitely yes' to the question "Would you recommend our hospital to their friends and family" to 85% from our internal survey results. This addresses the length of time to receive responses from often many weeks post discharge to daily as surveys are distributed and returned upon discharge and increases the number of responses received. Our short, five question in- house survey is personally handed to all in-patients on their day of discharge, as well as to a random sample of patients in the emergency department each day. Results will continue to be tabulated and reported weekly to the patient care unit and the Quality Team. Frequent, regular and timely feedback will enable the unit care teams to identify areas of concern and respond in a timely manner with improvements designed to enhance the patient experience.

4) *Improve the amount of ALC days:* Integrating and coordinating care is critical for the appropriate and timely discharge of patients. Lack of integration in healthcare means coordination tends to break down at transition points – where one patient moves from one service provider to another. Our aim is to reduce the percentage of ALC days to no more than 12.5%. To achieve this we will continue to strengthen our collaboration with our health care partners by beginning multidisciplinary discharge planning discussions upon admittance to hospital, following the 'Home First' Program model. This program identifies options available to patients and families upon discharge to get them where they need to be. Seniors who receive care in their homes and communities are generally more satisfied and comfortable in a familiar setting. Further identification of root causes will be investigated and process improvements implemented along with education for patients, families and the community.

5) *Improve medication reconciliation for all admitted to our medical unit:* Medication discrepancies put patients at risk of medication errors. This happens when someone enters or leaves the hospital, and there is confusion about what medications he or she was on previously. One step in avoiding readmission is to ensure patients are discharged on the correct medications, and that the patients, families and care givers are aware of any changes in dose, type or frequency of medication. Our aim is to improve the percentage of medication reconciliations completed on discharge from the medical units to 80%. This will be accomplished by encouraging hospital staff to review medications with patients prior to discharge and ensure that patients leave hospital with printed information. Providers can use the "teach back" method to ensure information has been understood by patients and caregivers including why they are on certain medications, what side effects or complications to look for, which activities they should do or avoid and who to call with problems or questions. Encouraging patients to keep medication lists also keeps them engaged in their own care. We will continue to enhance collaborations with our health care partners to ensure system alignment.

3. How the plan aligns with the other planning processes

This plan is tightly aligned to our STEGH strategic plan developed in 2009. It includes a vision of an excellent patient care experience, a mission statement, five strategic goals and our core values of compassion, accountability, respect, excellence and safety.

Our current Health Services Accountability Agreement (HSAA), which references among other measures the range of volume of in-patients and emergency patients that we expect to serve in 2012/13 is supported by our strategic plan and the specific process improvements identified in this Quality Improvement Plan.

Our plan also aligns with the Ministry of Health and Long Term Care approval of a rebuilding project, creating new facilities for STEGH (including Emergency, Mental Health, Surgical Suite, CSD and new central circulation route) linking to our transforming care agenda by making changes that keep the patient at the centre of our work and systems. We are building capacity to meet the needs of our new clinical population (mental health services) and translating this work into a facility design that matches and enables the work that happens at STEGH. We have put together

multidisciplinary teams that will help to develop a deeper understanding of our processes and help identify and remove barriers to making those processes better.

4. Challenges, risks and mitigation strategies

Challenges, risks and mitigation strategies

Priority Objectives	Relative Risk	Mitigation Strategy
Improve health care provider hand hygiene compliance before patient contact	*Medium:* Remain focused on the goal; complacency.	• Regular and timely measurement feedback, education and performance management.
Reduce wait times in the Emergency Department	*High:* High hospital census limits bed availability; capacity in the ER. *Medium:* Outbreak emergency. *Low:* Changes to Community Care Access Centre funding; partner organizations program or policy changes	• Deploy Full Hospital policy to use all available hospital space within safety constraints; Fully utilize electronic Bed Optimization System and comprehensive discharge planning to support bed management and patient flow; Dedicate hospital staff to expedite admissions. • Employ code orange emergency response plan if warranted • Enhanced collaboration with our health care partners to ensure system alignment
Improve patient satisfaction	*Medium:* Failure to meet Quality Improvement Plan objectives	• Ensure resources to support all objectives are in place and sustainable • Timely reporting on progress related to performance to all stakeholders • Focused effort to routinely evaluate and sustain improvements made to care delivery processes
Improve ALC days	*Medium:* Patients are at higher risk of infection and falls; Resources in the community are limited.	• Ensure falls assessment and interventions implemented • Ensure good hand hygiene • Ongoing collaboration with community partners; Home First Program implementation
Improve Medication Reconciliation for all patients on our acute medical unit	*High: Multidisciplinary buy-in; lack of resources; manual processes; time constraints.*	• Involvement of all stakeholders • Ensure efficient auditing and documentation processes

Part B:
Our Improvement Targets and Initiatives

See the "Improvement Targets and Initiatives – Part "B" spreadsheet (Excel file).

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

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

Our executives' compensation is linked to performance in the following way:

Performance based compensation applies to each executive on the STEGH executive team that includes Chief Executive Officer, Chief of Staff/VP Medical Affairs; Chief Financial Officer/VP Corporate Services, and Chief Nursing Officer.

The at risk salary component is 5% of 2012/2013 salary equally applied to all executive roles and divided equally across 5 priorities (see table below) as selected by the STEGH Board of Governors.

Performance compensation decisions regarding the at risk salary component will be made by the Board by March 31, 2013. The decision will be based on the achievement of the stated targets for 2012/13. In light of the presumption of a salary freeze for the 2012/13 year, which may result in a salary clawback, the Board will evaluate and a decision will be made regarding the 5% salary at risk component.

Where there is only partial achievement for any or all of the targets at year-end 2012/13 the Board will evaluate and a decision will be made regarding the relative proportion of the 5% at risk to be awarded.

Objective	Target for 2012/13	Salary at risk component
Hand hygiene before patient contact – 2012 calendar year average	85%	1%
ER wait times: 90th percentile ER length of stay for admitted patients – 2012 calendar year average	8 hrs	1%
Patient satisfaction: Percent Definitely Yes response to question "Would you recommend this hospital to friends and family?" – 2012 calendar year average	85%	1%
Decrease number of ALC days in acute care beds – 2012 calendar year average	12.5%	1%
Improve Medication Reconciliation completed on discharge from the acute medical units – target of 80% reached by the end of December 2012.	80%	1%

Total at risk executive compensation 5%.

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/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.**

Bruce Babcock ***Board Chair***	**Deborah-Anne Hennessey** ***Quality Committee Chair***	**Paul Collins** ***Chief Executive Officer***

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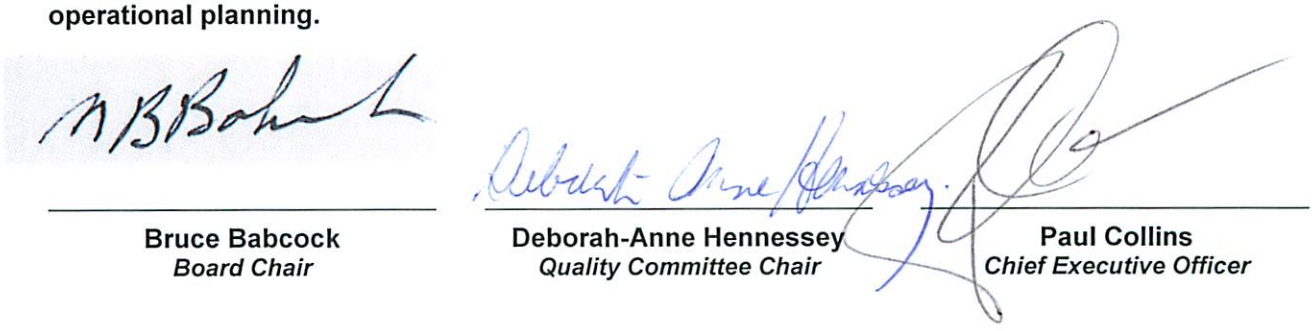

Bruce Babcock *Board Chair*	Deborah-Anne Hennessey *Quality Committee Chair*	Paul Collins *Chief Executive Officer*