Excellent Care For All.

2013/14

Quality Improvement Plan for Ontario Hospitals

(Short Form)

ST. THOMAS ELGIN GENERAL HOSPITAL
April 1, 2013

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

Overview of Our Organization's Quality Improvement Plan

Our Quality Improvement Plan for 2013/14 highlights six 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 92% 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 as well as looking into partner hospital's activities for success such as the 100% for 100 days campaign at London Health Sciences Center. In addition, we plan to develop and utilize communication scripts for front line staff and leadership when providing HH feedback including building in the concept of 200% accountability.**

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. Presently our 90th percentile ER wait time for admitted patients is less than 7 hours. We will continue to sustain this performance while switching our focus to reducing our 90th percentile PIA (physician initial assessment) time. Our present performance is 2.4 hours and our aim is to improve our PIA to less than 1.8 hours by Dec 2013. To achieve this target multiple strategies will be trialed to reduce PIA including: team triaging; evaluate potential role and impact of physician assistants / nurse practitioner; further enhance physician scorecard/performance indicators; evaluate need to increase capacity and physician coverage in Room 9; create visual triggers on FirstNet tracking board for LOS and PIA. In addition to the above strategies, we will continue to utilize our huddle boards to review and post our performance metrics on a daily basis.**

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 positively to the question "Our vision is to deliver an excellent patient experience. Did your experience meet our vision?" to 90%. We will utilize our in house survey, which is personally handed to all in-patients on their day of discharge or transfer to another unit within the hospital. Results will continue to be tabulated and reported weekly at our Quality Risk and Safety meeting as well as sharing results with staff and posting on our huddle boards throughout the organization. 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) *Decrease the number of ALC days:* **Integrating and coordinating care is critical for the appropriate and timely discharge of patients. Our aim is to reduce the percentage of ALC days to less than 6.6%. To achieve this we will continue to strengthen collaboration within our care team as well as our collaboration with our community health care partners by continuing to utilize daily multidisciplinary bullet rounds focused on discharge planning. In addition, we will continue to**

identify patients with complex discharge needs upon admission to hospital and will continue to utilize our successful "Home First" Program model in partnership with our CCAC providers.

5) *Improve medication reconciliation on discharge for all admitted medical patients:* One step in avoiding readmission is to ensure patients are discharged on the correct medications, and that the patients, families and caregivers 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 for all medical patients to 85% from our current performance of 80%. This will be accomplished by ensuring medication reconciliation is done on admission to hospital as well as at all transfer points within hospital based care and that a final reconciliation is done by the most responsible physician at the time of hospital discharge. This information will be shared directly with the patient, family, caregivers, community pharmacist, and family physician at the time of discharge from hospital using verbal and written communication. Hospital staff will review all medications with patients prior to discharge and ensure that patients leave hospital with relevant printed information. Providers will also use the "teach back" method to ensure patients and caregivers, including why they are on certain medications, what side effects or complications to look for and who to call with problems or questions, have understood information. In addition we will continue to enhance collaborations with our health care partners to ensure system alignment.

6) *Pressure ulcers:* Rate of New Pressure Ulcers (stage 2 or higher) in all patient care areas except maternal/child. We will utilize our in house weekly Quality Risk and Safety Report to track the number of new pressure ulcers stage 2 or higher per 1,000 patient days. Our current rate is 1.31 and our target is 1.20 by end of December 2013 (20% reduction). To reach this improvement target our planned improvement strategies include, standardization of wound care supplies across the hospital and, in alignment with our LHIN wide wound care protocols, development of a hospital based multidisciplinary wound care team and resource kits. Hospital staff education and training for identification, assessment and treatment of wounds will be developed in partnership with the SWLHIN.

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.

The Link to Performance –based Compensation of our Executives

Objective	Target for 2013/14	Salary at risk component
Hand Hygiene compliance before patient contact	92%	1%
Medication Reconciliation on discharge for all admitted medical patients	85%	1%
Pressure Ulcers	1.2	1%
90th percentile PIA (Physician Initial Assessment) all CTAS levels	1.8 hr	nil
Patient Satisfaction Survey from in house survey "Did your experience meet our vision"? (% positive response)	90%	1%
Percentage ALC days: Total number of inpatient days as ALC	6.6%	1%

Accountability Sign-off

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

Paul Bode
Board Chair

Deborah-Anne Hennessey
Quality Committee Chair

Paul Collins
Chief Executive Officer