

Excellent Care  
For All.



2011-12

# Quality Improvement Plan

(Short Form)



Hôpital Général de Hawkesbury  
& District General Hospital Inc.

March 30, 2011

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.

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## Part A:

# Overview of Our Hospital's Quality Improvement Plan

At the Hôpital Général de Hawkesbury & District General Hospital Inc., a common objective of all processes takes into consideration our mission, vision and values. As a reference point for the following subsections we have included these in their entirety.

**Mission:** Lives saved, lives improved, lives prolonged and lives lost, without loss of dignity.

**Vision:** A model hospital that serves the evolving needs of its community and is recognized for clinical excellence, its culture of compassion and staff commitment.

**Values:** Compassion, Quality, Respect, Integrity and Collaboration

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

The quality vision adopted at H&DGH for the 2011-2012 year is one of continued quality improvement demonstrated through the collaboration, communication and behavior of all employees, physicians and volunteers and recognized by our clients and stakeholders as meeting high standards of quality and client service.

Specifically, the plan is focused on improved awareness of hand hygiene, a reduction in wait times for targeted programs, improved clinical resource utilization and reduction of costs related to employee overtime and sick time. We also intend to maintain our successful track record for ALC days and total margin.

All initiatives within this plan demonstrate a commitment towards becoming a model hospital focused on the evolving needs of our community.

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

The major priorities pursued in this quality improvement plan are:

- Improve hand hygiene compliance;
- Reduce overtime costs to yield improved financial efficiencies, increase staff satisfaction and improved organizational wellness;
- Improve wait times to yield enhanced patient safety, delivery of service and patient satisfaction.

These initiatives will require significant planning, resourcing and staff mobilization. These measures, as well as other quality initiatives, are developed in Part B: Targets and Initiatives of H&DGH QIP.

Change processes are based on the use of LEAN<sup>®</sup> in the review and development of work processes, the utilization of task force groups and clear, transparent communication to all stakeholders.

Several key resource-persons will play lead roles in the execution of the QIP at H&DGH.

A financial analyst helps support financial control including overtime management. Designated financial accounts are used for special projects. Training has been provided to all management specific to Business Case Development and Project Management to help support the correlation of financial leverage for program development and utilization.

The Director of Quality and Risk Management plays a key role in overseeing the organization-wide quality and risk program, the multi-disciplinary Quality, Risk and Performance Committee, incident reporting, audits and patient complaint processes.

A Project Director is charged with the planning and project management of Accreditation 2011, a major compliance process to meet the requirements of Accreditation Canada and achieve a successful site inspection in November 2011.

Clinical managers are involved in major initiatives for wait times management and clinical improvement in ED and OR.

### **3. How the plan aligns with the other planning processes**

This quality improvement plan is directly linked to the annual organizational plan of H&DGH for 2011-2012 which elaborates the clinical, IT and administrative priorities of the organization that have been established by internal stakeholders and are in alignment with the LHIN and Ministry strategies. Direct links to the organizational priorities have been made in this plan such as emergency room wait times, hand hygiene and overtime management. Also the OMA quality improvement plan requirements have been taken into consideration in the development of this plan.

### **4. Challenges, risks and mitigation strategies**

The challenges related to this plan revolve around assignment of QIP tasks and work plans to a limited number of management personnel, the availability of physician leaders for administrative functions, the assignment and replacement of staff for task groups. The hospital faces growth pressures in key departments and functions that require accessibility and resource utilization improvements, i.e. growing volume in ALC classified patients, ED visits, OR booked procedures.

Identifiable risks for the achievement of the plan include staff recruitment and retention, physician engagement and recruitment, mobilization of front-line staff for timely execution of key strategies. QIP efforts are also competing with major work occurring in preparation of the Accreditation visit and final stage planning for a major redevelopment project, all occurring in 2011.

Mitigation strategies will depend on our financial ability to add temporary support resources and seconded front-line staff to dedicated major tasks in support of QIP.

# PART B: Improvement Targets and Initiatives



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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	
Quality	Reduce incidence of Ventilator Associated Pneumonia (VAP)	<b>VAP rate per 1,000 ventilator days:</b> 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	Not applicable			1) ... N)					
	Improve provider hand hygiene compliance	<b>Hand hygiene compliance before patient contact:</b> 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	56%	66%	1	1) Information articles to appear in Le Dialogue 2) Perform audits 3) Action plans to be developed with directors and champions following audits	Review related articles published in Le Dialogue (10/yr) Review audit results Status report provided on a regular basis to VP Clinical	5/year twice/year 2 status reports /year	Internal targeting aimed at reaching provincial benchmark over next two years		
	Reduce rate of central line blood stream infections	<b>Rate of central line blood stream infections per 1,000 central line days:</b> total number of newly diagnosed CLSI 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	Not applicable			1) ... N)					
	Avoid new pressure ulcers	<b>Pressure Ulcers:</b> Percent of complex continuing care residents with new pressure ulcer in the last three months (stage 2 or higher) - FY 2009/10, CCRS	Not applicable			1) ... N)					
	Avoid falls	<b>Falls:</b> 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	Not applicable			1) ... N)					
	Avoid surgery errors	<b>Surgical safety checklist:</b> Number of surgical safety checklist completed divided by the number of surgeries performed multiplied by 100 - Q2 & Q3 2010/2011	93%	95%	2						
	Avoid delays in treatment of stroke patients	<b>Telestroke program target:</b> Number of head CT's performed within Telestroke target divided by the number of head CT's performed on stroke patients (new cases through ED only) multiplied by 100	No results available - New program January 2011	100%	2						
	Effectiveness	Reduce unnecessary deaths in hospitals	<b>HSMR:</b> number of observed deaths/number of expected deaths x 100 - FY 2009/10, CIHI	Not applicable			1) ... N)				
		Reduce unnecessary hospital readmission	<b>Readmission within 30 days for selected CMGs to any facility:</b> 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	139 - COPD 7.69% 196 - Heart Failure w/out cardiac cath 17.65% (Calculated over 28 days)	10% improvement on CMG readmission rate	2	1) ... N)				
		Reduce unnecessary time spent in acute care	<b>Percentage ALC days:</b> Total number of inpatient days designated as ALC, divided by the total number of inpatient days. Q2 2010/11, DAD, CIHI	5%	5%	2	1) ... N)				
Improve organizational financial health		<b>Total Margin (consolidated):</b> 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	9.22%	0.50%	1	1) Put in place all efficiency measures identified in HSA 2011-2012	Monthly financial report Quarterly report submitted to the ministry, the LHIN and the Board				
Reduce expenses associated with Overtime and Sick pay			<b>Paid Overtime for full-time personnel:</b> Number of hours paid in overtime for full-time employees divided by the total number of hours paid multiplied by 100 - FY 2009-2010	3.06%	2.80%	2					
			<b>Paid Overtime for part-time personnel:</b> Number of hours paid in overtime for part-time employees divided by the total number of hours paid multiplied by 100 - FY 2009-2010	5.10%	4.80%						
			<b>Paid Sick time replacement:</b> Number of hours paid in sick time for full-time employees divided by the total number of hours paid multiplied by 100 - FY 2009-2010	5.63%	4.95%						
Access	Reduce wait times in the ED	<b>ER Wait times:</b> 90th Percentile ER length of stay for <u>Admitted</u> patients. Q3 2010/11, NACRS, CIHI	57.4 hours	37 hours	1	1) Assisted living initiative with LHIN	Assignment of 20 off-site spaces for HGH under the LHIN program		Initiated aimed at reaching targets set out in the HSA report	Year 2 of ongoing project, transformation committees in effect	
						2) Bed management meetings twice daily at change of shift to optimize bed utilization	Utilization reports	Quarterly review of utilization reports			
						3) Meet LOS benchmarks	QR&P committee reviews LOS	3-4 times/year			
						4) Establish hospital avoidance initiative for the patients of FHT	Liaison meetings with FHT	Quarterly			
						5) Participate in ED/ALC LHIN steering committee	Regional reports	Bi-weekly			
						6) On-going GEM initiative with RGP					
						7) Monitor and review ALC	Champlain-wide data reports	weekly			

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
		<b>ER Wait times:</b> 90th percentile ER Length of Stay for Complex conditions. Q3 2010/11, NACRS, CIHI	9.8 hours	8.6 hours	1	1) Physician scheduling - ensure core shifts are covered and fast track open	CHYMA review of physician scheduling	Core coverage 100% Fast track coverage 80%	Initiatives aimed at reaching targets set out in the HSAA report	Smaller volumes create greater fluctuations. QC patients have longer wait times for transfer - affects overall wait times of complex cases
					2) Use CriticalI for transfer of all Ontario patients to other facilities	Review periodical report from CriticalI				
					3) ED physician lead to participate monthly in Champlain Emergency Services Network		10 times/year			
					4) Continue implementation of CDU within ED					
	Improve surgery wait times	<b>Surgery wait times:</b> Numer of general surgeries performed within priority driven timeline divided by the total number of general surgeries performed multiplied by 100 - November 2010	30%	40%	1	1) Determine and monitor start time	Review progress notes	90% of time for all cases	Standardization of practices including prioritizing requests, level of urgency definitions and program development are preliminary requirements	Improvement project initiated 05/2010. Patient flow and process task force committees actively overseeing project initiatives
					2) Turn around time for OR suite less than 20 minutes	Chart review - nurse documentation	90% of all cases daily			
					3) Implement electronic tracking of wait times related to surgical request	IS implementation - audit reports				
					4) Monitor completion of surgery-related documentation prior to surgery	Chart review by OR nurses	100% compliance documentation (priority code, booking ard, consent)			
					5) Standardize emergent, urgent and elective definitions	Establish and review standardization				
					6) Improve surgical capacity by removing endoscopies	Comparison of volume data post endoscopy suite construction				
	Improve wait time for diagnostic imaging procedures	<b>DI wait times:</b> Number of cardio echos performed within 7 days of request divided by total number of cardio echos performed multiplied by 100 - FY 2010-2011 <b>DI wait times:</b> Number of mammograms performed within 7 days of request divided by total number of mammograms performed multiplied by 100 - FY 2010-2011 <b>DI wait times:</b> Number of CT scans performed within 28 days of request divided by total number of CT scans performed multiplied by 100 - FY 2010-2011	35%	65%	2					
	Reduce colonoscopy wait times	<b>Meet CCO target wait times:</b> Number of positive FOBT colonoscopies performed within CCO target divided by total number of positive FOBT colonoscopies performed multiplied by 100 - Q1, Q2, Q3 2010/2011 <b>Meet CCO target wait times:</b> Number of family history colonoscopies performed within CCO target divided by total number of family history colonoscopies performed multiplied by 100 - Q1, Q2, Q3 2010/2011	14%	50%	1	1) Standardize colonoscopy documentation - requisition	Audit of receptionists review of forms received at request	70% compliance with new form	Internal target aimed at reaching provincial benchmarks within two years	
			36%	50%	2) Clear patient on existing colonoscopy wait list that have surpassed CCO wait times target	Comparison of performance - present vs post changes in methodology and process	80% reduction in existing wait list (+ve FOBT and family history only)			
					3) Create and utilize electronic wait list	After installation of software - ensure electronic list is part of daily operations				
					4) Improve colonoscopy capacity by developing a dedicated endoscopy suite	Compare volumes pre and post modifications and process				
<b>Patient-centred</b>	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") 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)	NRC Picker 80.2%	85%	2	1) 2) ...N)				
	Improve patient satisfaction of Ambulatory services	<b>Diabetes clinic Education program:</b> Percent response of patients who responded "yes, definitely" to the question: Would you recommend this program to a family member or friend with diabetes	Results not currently calculated	80%	2					

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

*Purpose of Performance-based compensation for our Leadership Team is based on the following principles:*

- 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*

*Organizational full-time positions for which performance-based compensation applies:*

- Chief Executive Officer*
- Chief Nursing Officer and Vice-President, Clinical Programs*
- Chief Financial Officer and Vice-President Administrative and Support Services*
- Vice-President, Human Resources and Organizational Development*

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

In compliance with government regulation and current executive remuneration policies approved by the Board, the performance incentive to be paid to H&DGH executives is set at 5%. This incentive plan is within the current total compensation of Executive employees.

For 2011-2012, the performance incentive will be based on overall achievement of the plan and will not include specific weighting for the various initiatives or individual exclusions. The Board elects to favor a concerted executive team approach to the successful achievement of the plan.

In May of 2012, the Quality Committee of the Board will be appraised of the results of the QIP and will proceed to a performance review of the CEO and Executive Team based on an objective process. A final recommendation will be made at the Board meeting of June 2012.