

Excellent Care  
For All.



2011-12

# Quality Improvement Plan

(Short Form)

**West Haldimand General Hospital**

**March 31, 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.

[ontario.ca/excellentcare](http://ontario.ca/excellentcare)

## Part A:

# Overview of Our Hospital's Quality Improvement Plan

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

West Haldimand General Hospital is an exemplary rural hospital providing quality healthcare and promoting good health to our diverse population in collaboration with our community partners. We will improve patient safety and demonstrate our core values of: innovation, communication, accountability, respect and excellence through the quality improvement plan initiatives. The main areas of focus will include: improved hand hygiene compliance, reduced patient falls, reduced unnecessary readmissions, reduced Emergency Department (ED) wait times and improved patient satisfaction. WHGH is also committed to financial health and will undertake these initiatives while maintaining a balanced budget.

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

West Haldimand General Hospital will allocate the funds provided through the Small and Rural Hospital program to implement the Excellent Care for All Act in the following ways: implement staff training regarding the Excellent Care For All Act, Hospital-wide Quality Improvement initiatives, results and new targets, obtain a more automated, cost-saving method for obtaining patient satisfaction results and institute a staff quality award program. All activities will be completed in-house by WHGH staff.

1. Improve provider hand hygiene compliance
  - Increase staff awareness through education with stringent attendance standards
  - Increase compliance through staff awareness of current rate, improvement initiatives and hospital-wide target
2. Avoid Falls
  - WHGH will add this performance indicator for acute care, although this is not currently mandated as it only applies to Complex Continuing Care beds
  - The Falls and Injury Prevention Program will be re-implemented throughout the organization to increase staff compliance and reduce patient falls
  - We will increase the rate of compliance for completion of the falls assessment on acute inpatients
3. Reduce unnecessary hospital readmission
  - Conduct effective admission and discharge planning, ensuring appropriate supports are in place to discharge each patient to the next level of care
  - Work with Community Care Access Center (CCAC) to ensure at home resources are in place
  - Increase chart completion rates within current standards to enable authorized community partners to have access to the most accurate patient data
4. Reduce unnecessary time spent in acute care
  - By continuing to focus on rigorous admission and discharge planning, WHGH will maintain the acute Alternate Level of Care (ALC) rate at LHIN targets
5. Improve organizational financial health
  - Maintain rigorous spending controls
  - Partner with other organizations in purchase of service and clinical integration activities to reduce direct costs and improve patient care for the citizens of our catchment area and beyond
6. Reduce wait times in the ED for both admitted and non-admitted patients
  - WHGH will initiate activities to reduce ED triage-to-discharge times for both admitted and non-admitted patients.
7. Improve patient satisfaction
  - Improve hospital wide satisfaction scores to meet or exceed provincial standards

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

Seventy five percent of the WHGH strategic goals and directions created in March of 2010 align with the Quality Improvement Plan (QIP) and its performance targets.

The WHGH QIP is linked to the Hospital Specific Accountability Agreement through common performance targets, with the overall goals of increasing patient safety, improving the co-ordination of care, decreasing duplication and improving health promotion.

The Home First Strategy has been adopted in both the ED and acute inpatient care.

## 4. Challenges, risks and mitigation strategies

1. Improve organizational financial health
  - Unexpected ID outbreaks and related expenditures associated with ending the outbreak
  - Potential for unexpected increased demand for hospital services and therefore, increased costs
  - Mitigation: Conduct education with all staff on proper hand hygiene and also for appropriate staff and credentialed staff, antibiotic stewardship.
2. Reduce unnecessary time spent in acute care
  - Unexpected community pressures where both WHGH and surrounding healthcare facilities experience high ALC rates which decreases the availability of beds, particularly in long-term care
  - Complications and delays with CCAC and Long Term Care placements causing increased length of stay
  - Mitigation strategy: Apply for Crisis 1A status and provide more resources to ensure all patients are promptly discharged to the next level of care after their acute care stay is complete.
3. Reduce wait times in the ED for both admitted and non-admitted patients
  - Increase in demand for services causing a decline in access to available beds which would put ED wait times at risk
  - Mitigation: conduct ED flow analysis to identify areas contributing to unnecessary delays. Implement improvement activities. Evaluate and make necessary changes.
4. Improve the organization's financial health
  - Unexpected costs (e.g. – arbitration awards, failure of a key piece of medical or systems equipment) or decreases in previous/expected sources of funding can jeopardize this target.
  - Mitigation: maintain rigorous operational spending controls; implement a more robust project management system with appropriate controls. Plan to end the fiscal year with an operational "year end positive balance", which can be allocated in the future for equipment.

## Part B: Our Improvement Targets and Initiatives

*Please complete the “Improvement Targets and Initiatives – Part B” spreadsheet (See below end of document). Please remember to include the spreadsheet (Excel file) as part of the QIP Short Form package for submission to the OHQC (QIP@ohqc.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**

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

Commencing April 1, 2011 WHGH will introduce the performance based compensation model in accordance with the Excellent Care of All Act.

5% of the relevant executive base salary will be tied to the achievement of specific goals. From that 5%:

- 2% of the executive base salary will be tied to the achievement of specific goals as defined in the WHGH Quality Improvement Plan
- 3% of the relevant executive base salary will be tied to the achievement of other WHGH corporate and personal objectives

Measurement of the achievement of these objectives will occur during the 2011 / 2012 fiscal year, concluding in March of 2012.

## Part D: Accountability Sign-off

[Please see the QIP Guidance Document for more information on completing this section.]

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.

  
Marilyn Cooper  
Board Chair

  
Baete Anding  
Quality/Risk Management  
Coordinator

  
David Bird  
Chief Executive Officer

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)	<b>CDI rate per 1,000 patient days:</b> Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied								
	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								
	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,	65%	71.50%	1	1) Increase staff awareness through hand hygiene education and monitor attendance rate compliance.	Attendance auditing	85%	Maintain low infectious disease rate and prevent outbreaks..	*linked to Executive Compensation
						2) Increase compliance through staff awareness of current rate, improvement initiatives and hospital-wide target	Attendance auditing	85%	Maintain low infectious disease rate and prevent outbreaks.	
						3) Initiate specific training for credentialed staff	Attendance auditing	85%	Maintain low infectious disease rate and prevent outbreaks.	
	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 CLI cases in the ICU after at least 48 hours of being placed								
	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								
	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								
	Avoid Falls	<b>Falls:</b> Percent of falls assessments completed on acute care patients ~ FY 2009/10, CCRS	80%		1	1) Provide training, increase monitoring and compliance rate.	Revise auditing process	80 % compliance	Indicator is more than 10% greater than current rate.	This indicator is being added as a measurement of the acute care fall rate *linked to Executive Compensation
						2) Re-implement the Falls and Injury Prevention program through-out the organization to increase staff compliance and reduce patient falls	In-service training attendance monitoring	80 % attendance		
3) Increase the rate of compliance for completion of the falls assessment for acute in patients						Revise auditing process	80 % compliance			
Effectiveness	Reduce unnecessary deaths in hospitals	<b>HSMR:</b> number of observed deaths/number of expected deaths x 100 - FY 2009/10, CIHI								
	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 -	12.40%	13.90%	3	1) WHGH is currently 11% lower than the expected rate. Current strategies to maintain/improve this status will be maintained.				
	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		11%	2	1) Continue to focus on rigorous admission and discharge planning 2) Maintain the acute ALC rate at LHIN targets				

	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		0.8 -2.0%	3	Maintain current cost control strategies; partner with other organizations to provide cost reduction and clinical integration.				linked to Executive Compensation	
	<i>Space for additional indicators</i>										
Access	Reduce wait times in the ED	<b>ER Wait times:</b> 90th Percentile ER length of stay for Admitted patients. Q3 2010/11, NACRS, CIHI	not available	greater than the 80th percentile		1) WHGH will conduct an ED flow analysis to identify processes contributing to unnecessary delays to reduce ED triage-to-discharge times for both admitted and non-admitted patients.	LHIN and Ministry based NACRS data	80% ~ estimated 10% improvement over previous rates (based		Current measures of triage-to-discharge time are compared to an 8 hour limit, therefore, current performance for 6 hours is unknown	linked to Executive Compensation
		<b>ER Wait times:</b> 90th percentile ER Length of Stay for Complex conditions. Q3 2010/11, NACRS, CIHI	not available	greater than the 80th percentile		1) WHGH will conduct an ED flow analysis to identify processes contributing to unnecessary delays to reduce ED triage-to-discharge times for both admitted and non-admitted patients.	LHIN and Ministry based NACRS data	80% ~ estimated 10% improvement over previous rates (based on 8 hour		Current measures of triage-to-discharge time are compared to an 8 hour limit, therefore, current performance for 6 hours is unknown	
	<i>Space for additional indicators</i>										
Patient-centred	Improve patient satisfaction	<i>Please choose the question that is relevant to your hospital:</i>	not available	73%		1) Conduct a breakdown and analysis of overall hospital ratings to determine areas of low and high patient satisfaction. Use current data from additional questions to design and implement improvement activities.		73%		Past WHGH patient survey reporting does not match NRC Picker formats. Have completed changes to match NRC Picker question and response set and will use those for future comparisons Current rate is estimated from most likely comparison NRC Picker question.	
		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)									
	<i>Space for additional indicators</i>										