

Geraldton District Hospital



Quality Improvement Plan

April 1, 2011 to March 31, 2012

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Part A

Overview of the Quality Improvement Plan

1. Overview:

The Geraldton District Hospital has a quality improvement process, which has been in place for the past seven years. The process starts at the grass roots level, where staff and volunteers participate on Quality Improvement Teams. There are eight Teams that meet monthly (excluding summer) to review indicators that are important to the provision of safe patient care in their respective service area. Each of the Teams report to the Quality Improvement Committee (QIC) 3 times per year on a rotating basis. The QIC submits minutes and a master score card to the Board on a monthly basis. The master score card is a synopsis of indicators in 4 categories (Financial Health, Patient Access, Patient Safety and Organizational Health) that reflects the Hospital's overall quality position. The master score card is posted on the Hospital's website and updated monthly.

Recently, the Board amended its Bylaw to accommodate the Quality Improvement Committee membership, as per the Excellent Care for All Act. Board membership increased from 3 to a minimum of 5 members on the QIC.

2. Focus:

The Geraldton District Hospital will be focusing on the following two Quality Improvement (QI) indicators:

a) Reduction of Medication Errors:

The Hospital for the past two years has provided in-house training to all RPNs to increase their skills/competency in "full scope of practice". With this now complete, "total patient care" was implemented, March 1, 2011.

It is anticipated that the new change will improve the safety of patients in regards to medication distribution.

Management is exploring other medication distribution systems such as a computerized dispensing cart.

b) Improve Patient Satisfaction:

The Hospital currently utilizes an in-house system for patient feedback. However, the feedback cards need to be updated to include a standard question that measures overall satisfaction. This will be implemented by April 1, 2011.

3. Alignment:

Many of the indicators on the master score card align with indicators in schedule D of the Hospital Service Accountability Agreement. Likewise, many of the indicators on the master score card align with the 3 overall goals in the North West LHIN's Integrated Health Services Plan, as follows:

- a) Optimizing health (population health)
- b) Optimizing care (patient satisfaction)
- c) Optimizing resources (per capita cost)

The only indicator that is not aligned with provincial or North West LHIN indicators is the Alternate Level of Care days. This is because:

- a) There is a lack of CCAC services and community supportive housing services.
- b) It is revenue generating.
- c) Patients may refuse an out of town LTC bed in order to stay closer to home, family and friends instead.
- d) There is no pressure on Acute Care beds.

4. Challenges, Risks and Mitigating Strategies:

The biggest challenge is human resources. Not only is there a high turnover rate (normal for rural, northern and small hospitals) for grass roots staff, but also for leaders and managers. It is difficult to have consistent data when there is a high turnover at all levels.

The Hospital spends over \$200,000 annually for initiatives to recruit and retain hospital staff and physicians.

Part B Improvement Targets and Initiatives

AIM		MEASURE					CHANGE				
Quality dimension	Objective	Outcome Measure/Indicator	Current Performance	Performance Goal 2011/12	Priority	Improvement Initiative	Methods & results tracking	Target for 2011/12	Target Justification	Comments	
Safety	Reduce Clostridium Difficile Infections (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. 2010, consistent with publicly reportable patient safety data	0	0	3	-	-	-	-	-	
	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 - 2009/10, consistent with publicly reportable patient safety data	63.6	100	2						
	Avoid new pressure ulcers	Pressure ulcers: Percent of long-term care residents with new pressure ulcers (stage 2 or higher) - FY 2009/10	0	0	3						
	Reduce falls	Number of resident falls per 1000 LTC patient days (2010)	6.4	< 5.8	2						
	Reduce medication errors	Number of medication errors per 1000 LTC patient days (2010)	7.6	< 6.8	1	Change staffing, full scope of practice, total patient care, Medication Error Committee	Monthly	Reduce med. errors by 10%			
	Effectiveness	Reduce unnecessary hospital readmissions	Readmission within 30 days for selected CMGs to any facility: The number of patients with specified case mix groups (CMGs) readmitted to any facility for non-elective inpatient care within 30 days of discharge, compared to number of expected non-elective readmissions - Q1 2010/11, Discharge Abstract Database (DAD), Canadian Institute for Health Information (CIHI)	1.3	< 2	3					
Reduce unnecessary time spent in acute care		Percentage Alternate Level of Care (ALC) days: Total number of patient days designated as ALC, divided by the total number of inpatient days, Q2 2010/11, DAD, CIHI	27.3	< 26.1	2						
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 2010/11, Ontario Healthcare Reporting Standards (OHRS)	6.6	> 2	3						

AIM		MEASURE					CHANGE				
Quality dimension	Objective	Outcome Measure/Indicator	Current Performance	Performance Goal 2011/12	Priority	Improvement Initiative	Methods & results tracking	Target for 2011/12	Target Justification	Comments	
Access	Reduce wait times in the Emergency Department (ED)	ED Wait Times: Average ED length of stay in minutes for all admitted patients (Q3 2010/11), National Ambulatory Care Reporting System (NACRS)	35	< 60	3						
		ED Wait Times: Average ED length of stay in minutes for all non-admitted Canadian Triage Acuity Scale (CTAS) 1-5 ER patients (Q3 2010/11)	147	< 180	3						
Patient-centred	Improve patient satisfaction	In-house survey (feedback cards): percentage of patients who would recommend this hospital to friends or family	N/A	> 75%	1	-Educate public & patients of importance to complete feedback cards to improve patient satisfaction. -Update feedback cards -Update website	Monthly audits	> 75%			
		Staff satisfaction survey Grand Average	60.7	> 63	2						

Part C

Executive Performance Based Compensation

The purpose of Performance Based Compensation is to drive accountability for the delivery of quality improvement.

By linking compensation to the achievement of quality dimension core, indicator targets will help the Hospital to:

1. Drive performance and improve quality.
2. Establish clear performance expectations.
3. Create clarity about expected outcomes.
4. Ensure consistency in the application of performance incentives.
5. Drive transparency in the performance incentive process.
6. Drive accountability with respect to the delivery of the Quality Improvement Plan.
7. Enable team work and a shared purpose.

Performance based compensation applies to the following executive positions:

1. Chief Executive Officer (CEO)
2. Chief of Staff (COS)
3. All Senior Managers:
 - a. Chief Nursing Officer (CNO)
 - b. Chief of Clinical Services (CCS)
 - c. Nurse Manager(s) (NM)

Because the Public Sector Compensation Restraint Act stipulates that salaries of all non-union employees are frozen from March 24, 2010 to April 1, 2012 then the payment of a portion of the existing salary must be made contingent on the achievement of quality dimension core indicator targets without increasing the actual compensation in the 2011/12 fiscal year.

Higher levels of performance based compensation will be phased in over 5 years to enable the Board and applicable executives to evaluate, modify and become more comfortable with this type of compensation plan. The following chart shows the percentage of salary at risk in the phased in approach:

Year April 1	CEO	Executive Positions			NM(s)
		COS	CNO	CCS	
2011/12	2	1	1	1	1
2012/13	4	2	2	2	2
2013/14	6	3	3	3	3
2014/15	8	4	4	4	4
2015/16	10	5	5	5	5

The following are the quality dimension core indicator targets linked to each executive position:

Exec. Position	Quality Dimension	Core Indicator	Target
CEO	Effectiveness	Total Margin	> 3.0
CEO	Safety	Reduce medication errors	< 6.8 per 1000 LTC pt days
COS	Effectiveness	Reduce unnecessary hospital readmissions	< 2.0
CNO	Safety	Reduce medication errors	< 6.8 per 1000 LTC pt days
CCS	Effectiveness	Total Margin	> 3.0
NM	Safety	Reduce Medication errors	< 6.8 per 1000 LTC pt days

The above percentage of salary at risk chart and indicators may be amended from year to year at the discretion of the Board of Directors.

Part D Accountability Sign-Off

The Board Chair, the Quality Improvement Committee Chair and Chief Executive Officer certify that the Quality Improvement Plan has been informed in part by:

1. The patient relation process;
2. Patient and employee surveys;
3. Aggregated critical incident data; and
4. Information concerning indicators of the quality of health care provided by the organization pursuant to regulations made under the Public Hospitals Act.

The sign-off also certifies that the Quality Improvement Plan contains:

- Annual performance targets;
- Target justification, and
- Information concerning the manner in and extent to which executive compensation is linked to the achievement of the targets.

As well, the sign-off certifies that the Quality Improvement Plan was reviewed as part of the planning submission process and is aligned with the organization's Operating Plan.



D. Mannisto

Board Chair

April 5/11
Date



E. Mannisto

QI Committee Chair

April 5/11
Date



K. Pristanski

CEO

April 5/11
Date



Quality Improvement Statement

The Board of Directors of the Geraldton District Hospital certifies that an Annual Quality Improvement Plan is formulated and monitored on a regular basis as per the Excellent Care for All Act.

Quality

1. Promotes an environment where patient, staff, visitor and volunteer safety are a priority.
2. Assures the provision of quality care and services in an efficient and effective manner.
3. Focuses on accessible and appropriate services as close to home as possible.
4. Ensures patient centered care is provided to patients and their family members.

Goal:

The goal is to ensure the development, implementation, maintenance and monitoring of an effective Hospital wide Quality Improvement Plan that includes mechanisms to use QI principles to continuously improve processes within the Hospital.

Responsibilities:

The Board of Directors of the Geraldton District Hospital shall:

1. Appoint a minimum of five Directors to sit as members of the Quality Improvement Committee.
2. Receive minutes of the Quality Improvement Committee meetings on a monthly basis and review the minutes, looking for variance, explanation and a solution.
3. Ensure that the Quality Improvement Committee receive minutes and score cards from the eight internal Quality Improvement Teams on a quarterly rotating basis.
4. Ensure that opportunities for improvement have been addressed appropriately.
5. Receive reports on levels of satisfaction regarding services provided to the community by the Hospital and the satisfaction of staff in providing these services.

February 2011