Excellent Care For All.

2012/13

Quality Improvement Plan

(Short Form)

Geraldton District Hospital

Part A:

Overview of Geraldton District Hospital's Quality Improvement Plan

1. Overview:

The Geraldton District Hospital has a quality improvement process, which has been in place for the past eight years. The process starts at the grass roots level, where volunteers participate on Quality Improvement Teams. There are seven 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 seven teams reports 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 of Directors on a monthly basis.

2. Objectives

1. **Safety** – Where people should not be harmed in any way when they receive care in the hospital.
2. **Effectiveness** – Where people should receive the best possible care in the most efficient manner.
3. **Access** – Where people should receive the best possible care within a reasonable time.
4. **Patient-Centered** – Where people should receive the best possible care centered on their individual needs.
5. **Integrated** – Where, if Geraldton District Hospital cannot give the best possible care, the hospital can refer people to an external partner.

All of these categories reflect the Hospital's overall quality position. The master score card is posted on the hospital's website and updated monthly.

3. Alignment:

All of the indicators in schedule D of the Hospital Service Accountability Agreement are included in the Quality Improvement Plan, plus there are more indicators as suggested by the Ontario Health Quality Council. 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)

4. Integration:

Indicators have been developed to track how well the Geraldton District Hospital works with its partners.
- Thunder Bay Regional Sciences Centre (TBRHSC)
- Community Care Access Centre (CCAC)
- Greenstone Family Health Team (GFHT)
- Geraldton Medical Group (GMG)

5. Challenges:

The hospital's 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 consistency 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.

Another big challenge is changing the measurement system of indicators from the Hospital's historical measurement system to the MOHLTC/LHIN measurement system. An example is average wait time compared to the 90th percentile.

Part B:
Our Improvement Targets and Initiatives

Geraldton District Hospital's Improvement Targets and Initiatives are listed as follows; (Please also refer to the Improvement Targets and Initiatives Excel Worksheet for more in-depth information).

Safety:

- Reduce C-Difficile rates
- Improve proper hand hygiene
- Reduce incidence of new pressure ulcers
- Avoid patient falls

Effectiveness:

- Improve organizational financial health – Total Margin
- Improve organizational health – Current Ratio

Access:

- Reduce wait times in the Emergency Department – Admitted Patients
- Reduce wait times in the Emergency Department – Non-Admitted Complex Patients
- Reduce wait times in the Emergency Department – Non-Admitted Minor Uncomplicated Patients
- Reduce unplanned emergency room visits – Mental Health
- Reduce unplanned emergency room visits – Substance Abuse

Patient Centered:

- Improve patient satisfaction – "Would you recommend this hospital to family and friends?"
- Improve patient satisfaction – "Overall, how would you rate the care and services you received?"
- Improve staff satisfaction - Metrics @ Work – grand average of external survey

Integrated:

- Reduce any unnecessary time spent on Acute Care - % Alternate Level of Care patients
- Reduce any unnecessary hospital readmission – selected Case Mix Groups to any facility
- Transferring patients on Form 1 to Thunder Bay Regional Health Sciences Centre
- Referring patients to Community Care Access Centre
- Referring patients to Greenstone Family Health Team
- Referring patients to Geraldton Medical Group

PART B: Improvement Targets and Initiatives 2012/13

Geraldton District Hospital

Please do not edit or modify provided text in Columns A, B & C

AIM		MEASURE					CHANGE			
Quality dimension	**Objective**	**Measure/Indicator**	**Current performance**	**Target for 2012/13**	**Target justification**	**Priority level**	**Planned improvement initiatives (Change Ideas)**	**Methods and process measures**	**Goal for change ideas (2012/13)**	**Comments**
Safety	Reduce clostridium difficile associated diseases (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. 2011, consistent with publicly reportable patient safety data	0	0	Remain @ current rate of 0 for C.diff	3	Continue with Universal Precautions training and awareness	Continue mandatory annual staff education		
	Reduce incidence of Ventilator Associated Pnemonia (VAP)	**VAP rate per 1,000 ventilator days**: 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. 2011, consistent with publicly reportable patient safety data	Not Applicable	Not Applicable	there is not an ICU in this facility	N/A				
	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 - Jan-Dec. 2011, consistent with publicly reportable patient safety data	100%	100%	Remain @ current rate of 100% for hand hygeine	3	Continue hand hygiene training and awareness	Continue mandatory annual staff education		
	Reduce rate of central line blood stream infections	**Rate of central line blood stream infections per 1,000 central line days**: total number of newly diagnosed CLI 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. 2011, consistent with publicly reportable patient safety data	Not Applicable	Not Applicable	there is not an ICU in this facility	N/A				
	Reduce incidence of new pressure ulcers	**Pressure Ulcers**: Percent of complex continuing care residents with new pressure ulcer in the last three months (stage 2 or higher) - FY 2010/11, CCRS	0.10%	0%	There has only been 1 stage 2 pressure ulcer in this facility in the last fiscal year.	3	Continue to monitor the skin integrity of CCC patients	Continue to participate with North West Wound Community of Practice formerly known as LHIN Wide Wound		
	Avoid patient falls	**Falls**: Percent of complex continuing care residents who fell in the last 30 days - FY 2010/11, CCRS	0.84%	0.76%		2	Purchase more bed and chair alarms	Continue to participate on Regional Falls Committee	10% Improvement	Following the provincial "No Restraint Policy", there is a higher number of falls
	Reduce rates of deaths and complications associated with surgical care	**Surgical Safety Checklist:** number of times all three phases of the surgical safety checklist was performed ('briefing', 'time out' and 'debriefing') divided by the total number of surgeries performed, multiplied by 100 - Jan-Dec. 2011, consistent with publicly reportable patient safety data	Not Applicable	Not Applicable	There is not a surgical unit in this facility	N/A				
	Reduce use of physical restraints	**Physical Restraints:** The number of patients who are physically restrained at least once in the 3 days prior to initial assessment divided by all cases with a full admission assessment - Q4 FY 2009/10 - Q3 FY 2010/11, OMHRS	Not Applicable	Not Applicable	There are no mental health Beds in this facility	N/A				
Effectiveness	Reduce unnecessary deaths in hospitals	**HSMR:** number of observed deaths/number of expected deaths x 100 - FY 2010/11, as of December 2011, CIHI	Not Applicable	Not Applicable	Volume of patients is too low to measure	N/A				
	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 2011/12, OHRS	7.0	>0.0	This target is determined by LHIN	3	Continue to be open and transparent, and abide by new provincial procurement and perquisite guidelines	Continue to monitor monthly		Resources are being saved for future redevelopment

AIM		MEASURE					CHANGE			
	Improve organizational financial health	**Current Ratio:** The target is determined by LHIN. It is calculated by subtracting the operating expenses from the revenues and dividing by the revenues.	5.1	>2.0	This target is determined by LHIN	3	Continue to be open and transparent, and abide by new provincial procurement and perquisite guidelines	Continue to monitor monthly		The current performance is high, partially due to staffing vacancies associated with northern rural hospitals.
Access	Reduce wait times in the ED	**ER Wait times:** 90th Percentile ER length of stay for Admitted patients. Q3 2011/12, NACRS, CIHI	11.9 hours	<9.1 hours	This target is determined by LHIN	2	Will work with physicians to reduce their observation times. Continue recruiting physicians.	Continue to monitor monthly	23% Improvement	There has been a chronic shortage of physicians for 6 years which results in fewer appointments at the Medical Clinic and more visits to the Emergency Department.
	Reduce wait times in the ED	**ER Wait times:** 90th Percentile ER length of stay for Non-Admitted Complex patients.	8.9 hours	<7.2 hours	This target is determined by LHIN	2	Will work with physicians to reduce their observation times. Continue recruiting physicians.	Continue to monitor monthly	19% Improvement	There has been a chronic shortage of physicians. Patients awaiting transfer wait many hours for Air Ambulance.
	Reduce wait times in the ED	**ER Wait times:** 90th Percentile ER length of stay for Non-Admitted Minor Uncomplicated patients.	4.4 hours	<4.2 hours	This target is determined by LHIN	2	Will work with physicians to reduce their observation times. Continue recruiting physicians.	Continue to monitor monthly	5% Improvement	There has been a chronic shortage of physicians for 6 years which results in fewer appointments at the Medical Clinic and more visits to the Emergency Department.
	Reduce unplanned ER visits	**Repeat visits to ER:** Total number of patients with Mental Health issues to revisit the emergency room within 30 days, divided by the amount of ER days, multiplied by 1,000 for the fiscal year (April 2012 - March 2013)	14.5	<18.3	This target is determined by LHIN	3	The Hospital has been collaborating with North of Superior Programs and Canadian Mental Health Association for better follow-up with patients.	Continue to monitor monthly		
	Reduce unplanned ER visits	**Repeat visits to ER**: Total number of patients with Substance Abuse issues to revisit the emergency room within 30 days, divided by the amount of ER days, multiplied by 1,000 for the fiscal year (April 2012 - March 2013)	0	<24.9	This target is determined by LHIN	3	The Hospital has been in collaboration with North of Superior Programs and Canadian Menatal Health Association for better follow-up with patients. Continue to attempt to retrieve same information as LHIN from CIHI.	Continue to monitor monthly		The data collected by the Northwest LHIN varies from the data collected by the Hospital.
Patient-centred	Improve patient satisfaction	*Please choose the question that is relevant to your hospital:*								
		From NRC Picker / HCAPHS: "Would you recommend this hospital to your friends and family?" (add together percent of those who responded "Definitely Yes")	Not Applicable	Not Applicable	Not Applicable	N/A				
		From NRC Picker: "Overall, how would you rate the care and services you received at the hospital?" (add together percent of those who responded "Excellent, Very Good and Good")	Not Applicable	Not Applicable	Not Applicable	N/A				
		In-house survey: "Would you recommend this hospital to friends and family?"	92%	>93%		3	Distribute more comment cards	Continue to monitor monthly	1% Improvement	This is the only hospital within 2 hours drive in any direction
		In-house survey: "Overall, how would you rate the care and services you received at the hospital?" (add together percent of those who responded "Excellent, Very Good and Good")	82%	>85%		2	Distribute more comment cards	Continue to monitor monthly	4% Improvement	This is the only hospital within 2 hours drive in any direction
	Improve staff satisfaction	**Metrics @ Work Inc.:** Grand average of external survey	71%	>74.5%		3	Encourage more staff to complete the survey	Continue to monitor yearly	5% Improvement	

AIM		MEASURE					CHANGE			
Integrated	Reduce unecessary time spent in acute care	**Percentage Alternate Level of Care days:** Total number of inpatient days designated as ALC, divided by the total number of inpatient days. Q2 2011/12, DAD, CIHI	37.9%	<26.1%	This target is determined by LHIN	2	Continue working with partners such as CCAC and the municipality to improve home support services	Continue to monitor monthly	There are no pressures for acute care beds in this hospital at this time. ALC patients generate revenue for this hospital.	This indicator is always higher than the target, due to lower levels of community services in Northern Rural Ontario
	Reduce unnecessary hospital readmission	**Readmission within 30 days for selected CMGs to any facility:** 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 2011/12, DAD, CIHI	5.2%	<12.8%	This target is determined by LHIN	3		Continue to monitor monthly		
	Form 1 beds (TBRHSC)	Percent of patients accepted to Thunder Bay Regional Health Sciences Centre on Form 1 (monthly) within 72 hours.	82%	100%		1	Currently in discussion with Thunder Bay Regional Health Sciences Centre and St Joseph's Care Group	Monitor monthly	To get emergency psychiatric consults by videoconference	**New indicator**
	CCAC acceptance of patients	Percent of patients accepted into care of Community Care Access Centre monthly	100%	100%		3	Ensure that patients receive appropriate follow-up care at home.	Monitor monthly		**New indicator**
	GFHT referral of patients	Percent of patients accepted by Greenstone Family Health Team for appointment (referred by ER for non-urgent appointments) - monthly				3	Help ensure non-urgent patients receive primary care in a more appropriate setting	Monitor monthly		**New indicator**
	GMG referral of patients	Percent of patients accepted by Geraldton Medical Group for appointment (referred by ER for non-urgent appointments) - monthly				3	Help ensure non-urgent patients receive primary care in a more appropriate setting	Monitor monthly		**New indicator**

The Link to Performance-Based Compensation of Our Executives

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 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 2012/13 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 approach:

Year	Executive Positions				
April 1	CEO	COS	CNO	CCS	NM(s)
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:

Executive Position	Quality Dimension	Core Indicator	Target
CEO	Effectiveness	Total Margin	>0.0
	Effectiveness	Current Ratio	>2.0
COS	Access	Reduce Wait Times in ED -Admitted Patients	<9.1 hours
	Access	Reduce Wait Times in ED -Non-Admitted Complex Patients	<7.2 hours
CNO	Patient Safety	Improve Hand Hygiene	>90%
	Patient Safety	Reduce Infection rates	<5%
CCS	Effectiveness	Total Margin	>0.0
	Effectiveness	Current Ratio	>2.0
NM	Patient Safety	Improve Hand Hygiene	>90%
	Patient Safety	Reduce Infection rates	<5%

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. Should one or more of the above targets not be met because of extenuating circumstances beyond the control of the Executive Position, then the Board of Directors may amend the percentage of salary at risk for the respective Executive.

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.

____________________	____________________	____________________
Deanna Thibault	Audrey Johnston	Kurt Pristanski
Board Chair	*Quality Committee Chair*	*Chief Executive Officer*