

Excellent Care
For All.



2011-12 Quality Improvement Plan



Perth and
Smiths Falls
District Hospital

March 31, 2011

Part A:

Overview of Our Hospital's Quality Improvement Plan

1. Overview of quality improvement plan for 2011-12

The PSFDH Board of Directors and Leadership are committed to patient safety in pursuit of excellence and efficiency in patient care and quality services. The focus is to improve the patient centered approach and culture of safety. The Hospital is focused on being one of the top ten community hospitals for patient satisfaction. A part of the culture of safety is to improve hand hygiene, timeliness of care, and decrease falls and medication incidents. This will result in shorter length of stay, fewer complications and improved patient satisfaction.

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

2. a) The specific aims that Perth and Smiths Falls District Hospital will be focusing on from April 2011 to March 2012:

1. **Aim** – *To implement the PSFDH standardized medication reconciliation process on the 3rd Floor (23 bed medicine, rehabilitation and complex continuing care unit) at the GWM site, thereby preventing adverse drug events, at all interfaces of care.*

Measures

Percentage of charts that demonstrate evidence of medication reconciliation on:

- Admission at initial Assessment

Changes

- Implement the PSFDH Medication Reconciliation Education Training Program for Inter-professional Teams and the Registered Nurses working on 3rd Floor that includes orientation.

Resources

- No financial impact is expected with moving to the next phase of the Medication Reconciliation Program.

2. **Aim** – *To engage all hospital staff, physicians and volunteers in the process of fall and injury prevention. Continuing education related to fall risk reduction and harm will be offered during the annual 2011 "Better Safe Than Sorry" Education Training.*

Measures

- Percentage of staff who attend Fall Risk Reduction and Prevention Sessions during the "2011 Better Safe Than Sorry" education period.
- Establish a baseline fall rate.

Changes

- Regular communication about the Fall Risk Assessment and Enhancement of the tool to hospital staff, physicians and volunteers.
- Posting of Fall Data on inpatient units.
- Patient Safety Committee to enhance assessment through systematic root cause analysis.
- Engagement of all care givers and hospital staff in the Fall Prevention education and programs.

Resources

- No financial impact. Annual Patient Safety Training is included in the 2011/12 budget.

3. Aim – To improve hand hygiene compliance before patient contact.

Measures

- Direct observation - hand hygiene audits reporting :
- First Moment – Before initial patient /patient environment contact

Changes:

- Perform hospital wide audits - showing compliance before patient contact.
- To strengthen and complement the work already be done to improve hand hygiene the following will be required:
 - Evaluation of the present hand hygiene strategies will be completed;
 - Implement new evidenced based strategies that improve compliance;
 - Evaluate success of meeting hand hygiene aims;
 - Engage physicians in hand hygiene education and protocols.

Resources:

- No financial impact. Hand Hygiene Promotion, Auditing and Continuing Education is included in the 2011/12 budget.

2 b) The Ideas to Improve include the following:

- i) Research has shown that inadequate communication of medical information each time a patient moves from one setting to another is a contributing factor to adverse medication events. The Hospital will begin the next stage of the medication reconciliation process on 3rd floor (23 bed medical, rehabilitation and complex continuing care unit) to provide a safer environment for patients. This was a focus of Accreditation Canada's recommendations from the Final Report in October 2010 that Medication Reconciliation be an important focus over the next two years.
- ii) To reduce the fall rate, the Hospital will focus on education, training, auditing and root cause analysis along with following Best Practice Guidelines from the Registered Nurses Association of Ontario (RNAO).
- iii) To improve hand hygiene compliance the measurement of the results and assessment of strategies will demonstrate that changes are leading to an improved, safer patient and staff environment.

3. How the plan aligns with the other planning resources

The following aims within the plan links with the following systems:

1. Medication:

- PSFDH Safety Reporting System that provides monthly and quarterly data on Incident Reports
- Accreditation Canada – Managing Medication and Required Organization Practices
- Institute for Safe Medication Practice
- Safer Healthcare Now!
- Integrated Health Services Plan 2 – quality of care pillar
- *Excellent Care For All* Legislation

2. Falls:

- PSFDH Safety Reporting System that provides monthly and quarterly data on Incident Reports
- Accreditation Canada – Required Organization Practices- Implementing a Fall Preventative Program
- Southeast LHIN Restorative and End of Life Care Clinical Services Roadmap
- Safer Healthcare Now!
- Integrated Health Services Plan 2 – quality of care pillar
- Registered Nurses Association of Ontario
- *Excellent Care For All* Legislation

3. Hand Hygiene

- PSFDH Medical Quality Assurance Committee - Infection Prevention and Control reports infection control and safety indicators
- Public Reporting of Hand Hygiene
- SE LHIN Healthcare Acquired Infection Clinical Service Roadmap
- Integrated Health Services Plan 2 – quality of care pillar
- *Excellent Care For All* Legislation

4. Challenges, risks and mitigation strategies

Challenges:

- Clinical Manager (s) Span of Control
- Infection Control Coordinator Span of Control
- Staff Development Planning
- Clarity of Role Expectations
- Organizational Development Planning
- Physician Support
- Staff (Nursing and Pharmacy) Support
- Electronic Access

Mitigating Strategies:

- Staff Engagement
- Physician Engagement
- Evaluating Education Priorities
- Quality Improvement Plan that sets out priorities
- Electronic Access

Part B: Our Improvement Targets and Initiatives

Please complete the "[Improvement Targets and Initiatives – Part B](#)" spreadsheet (Excel file). 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.

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

Purpose of Performance-based compensation:

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

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

A regulation describing the definition of “executive” under the Excellent Care for All Act (ECFAA) came into effect January 1, 2011. The following individuals are linked to the PSFDH Quality Improvement Plan:

- President & CEO
- Chief of Staff
- Vice President Patient Care and CNE
- Vice President Finance & Support Services

The percentage of salary at risk for each individual has been set at 3% of base salary. Our executives' compensation is linked to performance in the following way (equal portion of the 3% bonus will be attached to each of the four indicators):

- President & CEO – 3% of base salary is linked to achieving the targets set out in our QIP on the below indicators
- Chief of Staff – 3% of base salary is linked to achieving the targets set out in our QIP on the following indicators
- Vice President, Patient Care & Chief Nursing Executive – 3% of base salary is linked to achieving the targets set out in our QIP on the following indicators
- Vice President, Finance & Support Services – 3% of base salary is linked to achieving the targets set out in our QIP on the following indicators

Indicators:

- Hand Hygiene – Meet Provincial Average
- Falls Prevention – Establish Baseline
- Patient Satisfaction (Inpatient/ED) – Top Quartile
- Medication Reconciliation – 70% on admission

The below performance allocation plan is used to determine the magnitude of the performance allocation.

Performance Allocation Plan:

Progress against Quality and Safety Target	% of available incentive
Worse than previous year performance and no special considerations	0%
Maintained previous year performance and special considerations	50%
Better than previous year performance but not met all targets	75%
Achieved four (4) Targets	100%

Part D: Accountability Sign-off

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:

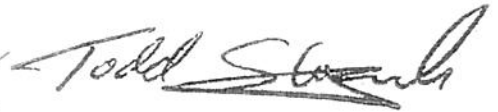
1. Was developed with consideration of data from the patient relations process, patient and employee/provider surveys, aggregated critical incident data, and patient safety indicators;
2. Contains annual performance improvement targets, and justification for these targets;
3. Describes the manner in 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.



Larry Sparks
Board Chair



Lynda Hendriks
Quality Committee Chair



Todd Stepanuik
President & Chief Executive
Officer