

Excellent Care
For All.



2011-12

Quality Improvement Plan

(Short Form)

Hotel Dieu Hospital, Kingston Ontario

2011 March 30

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

Purpose of this section: Quality Improvement Plans (QIPs) are, as the name suggests, all about improvement. They are an opportunity for organizations to focus on how and what to improve, in the name of better patient-focused care. As such, they will be unique documents, designed by, and for, each individual organization. Overall, a QIP should be seen as a tool, providing a structured format and common language that focuses an organization on change. The QIP will drive change by formalizing a plan and facilitating shared dialogue to support continuous quality improvement processes. This introductory section should highlight the main points of your hospital's plan and describe how it aligns overall with other planning processes within your organization. In addition, this section provides you with an opportunity to describe your priorities and change plan for the next year.

Please refer to **Appendix D** in the [QIP Guidance Document](#) for more information on completing this section.

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

[A general statement (100 words maximum) that is inspiring and situates the objectives within the Vision, Mission and Values of your organization]

The Hotel Dieu Hospital 2011-2012 Quality Improvement Plan outlines the hospital's commitment to clinical and organizational excellence, consistent with the hospital's strategic directions and its mission, vision and values. This year, the hospital will enhance its focus on creating positive patient experiences, measuring patient satisfaction, enhancing safety, access and patient-centredness. Guided by our strategy, our commitment to delivering high quality health care to patients from across the Southeast region continues with efforts to ensure that we provide excellent care and an excellent experience to all who come to HDH. We will identify indicators sensitive to the ambulatory care experience.

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

[A description of the objectives that have been identified to improve quality of services and care in your hospital. This section describes the specific aims, measures and change ideas that form the core of the plan. You should also indicate how resources will be used to ensure that the correct financial levers are in place to execute the activities listed in your QIP]

During the coming year Hotel Dieu Hospital will focus on the following initiatives:

Safety:

- Improve provider hand hygiene compliance. We will do this by participating in a trial of an electronic hand hygiene audit tool through CAHO's HandyAudit program beginning in March 2011. This tool is reported to increase ease and efficiency of hand hygiene auditing. This tool will provide more reliable information about hand hygiene. The HandyAudit team expects to be able to advise us about 6 months after our enrolment on what might be a reasonable target to submit, based on data that has been captured at that point in time. We expect to enter as an initial target the number of auditing sessions done over 2011-12 as a process measure, and our goal will also include that our observation sessions be 20 minutes in length, per the Ministry's recommendations. This will provide the necessary data to set realistic, evidence-based targets for improvement. It is important to note that the HandyAudit program has found already in those hospitals where it has been implemented that the old manual system of auditing showed a higher percentage of compliance than through the HandyAudit program. It will be important, then, to first develop new baseline information through the new tool before setting specific improvement targets. In addition, we are committed to working with other ambulatory care providers to identify strategies to enhance hand hygiene within outpatient settings, and to

determine how, in an ambulatory setting, we can evaluate hand hygiene effectiveness re: infection prevention. We will also work hard to encourage effective hand hygiene practices through focused efforts by team and organizational hand-hygiene champions to promote, encourage and facilitate improvements. Funds to purchase the HandyAudit program have been identified in the operating budget.

- Implement formal medication reconciliation in one client service area, in accordance with Accreditation Canada standards for ambulatory care. Medication reconciliation is an important patient safety practice; however, there are unique challenges associated with implementing formal medication reconciliation in ambulatory settings. HDH has worked with Accreditation Canada to revise medication reconciliation standards for ambulatory care. We will use the new standards to implement medication reconciliation when medication therapy is a significant component of care. We will begin by conducting a risk assessment to select the patient populations and types of clinic where medication reconciliation is expected to have the biggest impact on patient safety with a goal of implementation by December 2011. Medication reconciliation is a labour-intensive activity. Work is currently underway to quantify resource requirements.
- Analyze each critical incident, develop plans to avoid or reduce the risk of similar events occurring in the future, and monitor the implementation of those plans. Critical incidents occur less frequently and are generally different in nature than those in an inpatient setting; however, we are committed to investigating them and learning from them when they occur. Each critical event will be reported to the MAC and CEO and aggregate critical incident data will be reported to the Quality Committee at least twice each year. We will also conduct root cause analyses based on specific severity levels of incidents.
- We are committed to conducting one Failure Modes Effects Analysis in compliance with expectations identified by Accreditation Canada.

We have a patient safety coordinator in place at HDH as well as dedicated Infection Control resources to support an enhanced focus on hand hygiene and safety. Through our strategic plan, we are also focused on decision-support tools that will support implementation of our QIP and operational plans.

Effectiveness:

- Achieve a balanced budget and improve financial health. More broadly, HDH is committed to improving financial health by finding ways to improve working capital and reinvest in aging assets and infrastructure. We have a specific strategic direction around “enhancing performance, accountability and safety” which will support these goals.
- Measure staff and physician satisfaction/engagement in 2011, analyze results and take actions to make improvements. This, too, is reflected within our Strategic Plan 2010-15. HDH has not conducted regular staff and physician satisfaction/engagement surveys in recent years. Improvement opportunities and targets for 2012-2013 will be determined after initial results have been analyzed. Funds required for survey administration have been identified in the 2011-2012 operating budget.

Access:

- Maintain currently acceptable wait times for patients in the HDH Urgent Care Centre. Wait times for non-admit, low acuity patients (CTAS 4 and 5) and non-admit high acuity patients (CTAS 1 – 3) are considerably better than provincial averages and targets.
- Meet HSAA wait time performance targets for 2011/12 for the following surgeries and procedures: cataracts, hip replacements, knee replacements, CT Scans. (Please note that at the time of finalizing our QIP, the performance targets had not yet been finalized by the SE LHIN. These may change slightly as the SE LHIN confirms the targets for 2011/12.)

Patient-centered:

- Measure patient satisfaction (% of patients that would definitely recommend HDH to friends and family), analyze results and take actions as appropriate to make improvements. Until now HDH has conducted patient satisfaction surveys in the Urgent Care Centre (UCC) and Pediatric Urgent Care Clinic (Pedi UCC) only. 74.8% of respondents from these 2 areas said they would “definitely recommend” HDH to friends and family during the time period of October 2009 to September 2010. This was consistent with the current Ontario average of 74%. HDH plans to measure patient satisfaction across the hospital in 2011-2012. The overall target for HDH will remain at 75% until hospital-wide baseline satisfaction data are available and can be analyzed to determine improvement opportunities and targets for 2012-2013. Funds required for increased survey volumes have been identified in the 2011-2012 operating budget.
- Continue to value, respond to, and monitor patient feedback in accordance with the hospital’s patient feedback policy.

3. How the plan aligns with other planning processes

In 2010 HDH consulted widely across the community and region with patients, staff, physicians, volunteers, learners and others to inform the development of six key strategic directions to guide us in providing excellent patient care, engaging our staff, and advancing our academic mission for the next five years. The Quality Improvement Plan (QIP) aligns closely with these strategies. Both documents emphasize our commitment to putting patients and families at the core of all we do so they will experience the best and safest care provided by staff, physicians, volunteers and learners who understand and embrace their role in creating excellent patient care experiences. Both documents underscore our commitment to gather the right information for making sound clinical and corporate decisions, for measuring outcomes and for embedding quality and safety processes within the organization. Our process to consult widely about our Draft Patient Declaration of Values also allows us to ensure that our QIP supports activities and metrics consistent with what our patients and other stakeholders value.

The QIP aligns closely with Accreditation Canada Patient Safety Required Organizational Practices pertaining to medication reconciliation and hand hygiene. In addition, the patient safety indicators outlined in the HDH QIP are consistent with HDH Patient Safety Council priorities for the coming year. Hotel Dieu Hospital was granted full accreditation status by Accreditation Canada in 2009. As HDH prepares for the next accreditation survey in 2012 we are committed to implementing medication reconciliation on admission and in at least one outpatient clinical area.

The Hospital Service Accountability Agreement (HSAA) is an agreement between HDH and the SELHIN in which the hospital agrees to perform certain levels of service for a specific level of funding. In addition, certain performance obligations are undertaken by the hospital (for example, the commitment to a balanced budget and to specific length of stay (LOS) targets in various areas such as UCC/ER and OR). The QIP and the HSAA are complementary. We have included specific interim wait time targets for key clinical procedures from our HSAA in our QIP and are awaiting confirmation from the LHIN about the final targets. We will update the QIP once those final targets have been announced.

HDH invited comments from the SE LHIN during the development of its QIP to ensure consistency with the SE LHIN Integrated Health Services Plan (IHSP). In future years, we will also aim to align our QIP with the clinical services roadmap (CSR).

4. Challenges, risks and mitigation strategies

[This section describes the relative risks that may inhibit the accomplishment of the objectives and the mitigating strategies that have been identified to lower those risks.]

Recent developments have resulted in HDH facing some significant staffing challenges in key patient care leadership positions. We are committed to recruiting and developing staff to assume key leadership roles within the organization. An aging workforce also challenges our ability to ensure that we have the resources required to meet increasingly complex patient needs. Our new strategic plan is designed with both a robust human resources strategy and a comprehensive staff education/development plan. It is anticipated that this will enhance both talent management and succession planning. It will be incumbent on HDH to ensure that we provide our organizational leaders with the time and resources to successfully execute and evaluate strategy. To that end, we are committed to investing in a more broad-based decision support strategy to ensure that staff have the tools to implement and evaluate care delivery, making adjustments as necessary to enhance the patient experience and patient outcomes.

In addition, the hospital is facing practical challenges including aging equipment, insufficient resources spent on capital equipment, inadequate working capital, etc. These challenges place pressure on the organization and require dedicated resources. Adding new projects/initiatives within the QIP may put additional pressure on our limited financial and people resources and thus, must be carefully managed and monitored.

Effective hand hygiene is important in hospitals for the safety of patients and caregivers and we are keen to use the new HandyAudit tool to measure our compliance rate more effectively so we can then develop appropriate improvement targets. As noted above, we are committed to working with other ambulatory care providers to identify strategies to enhance hand hygiene within outpatient settings, and to determine how, in an ambulatory setting, we can evaluate hand hygiene effectiveness re: infection prevention.

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.

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

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

Please refer to Appendix E in the [QIP Guidance Document](#) for more information on completing this section of the QIP Short Form.

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

[Compensation should be linked to targets for those members of the senior management group who report directly to the CEO, including the chief of staff (where there is one) and the chief nursing executive. Please refer to the [regulation](#) (Ontario Regulation 444/10)]

Our executives' compensation is linked to performance in the following way:

Each employee of the Hospital who is a member of the executive team will have incentive pay linked to the Quality Improvement Plan. This includes the Chief Executive Officer; Chief Nursing Executive; Chief of Staff; Chief Financial Officer; Chief Human Resources Officer; Chief of Education, Quality & Risk Management; and the Chief of Communications & Public Engagement. The amount of the incentive pay will be 3-5% of each executive team members' base pay. The incentive pay will be tied to specific equally-weighted metrics within the Quality Improvement Plan effective April 1, 2011 and April 1 of subsequent years. The payment of incentive pay will occur in each year following evaluation on a scale of the extent to which thresholds were met in the previous fiscal year. For fiscal 2011/12, the performance objectives will be the same for all members of the Senior Leadership Team:

- ◆ Improve provide hand hygiene compliance. The target will be set six months from the time HandyAudits begin at Hotel Dieu Hospital so that the target relates to actual measured results (baseline) using the new tool. (See section 2 of this QIP document)
- ◆ Implement medication reconciliation in one adult clinic
- ◆ Achieve an average patient satisfaction score of 75% on the question "Would you recommend Hotel Dieu Hospital to your friends and family?" in one patient care area and collect baseline data in other newly surveyed patient care areas.
- ◆ Achieve the UCC/ER wait time target of treating 91% of non-admit, low acuity patients (CTAS 4 and 5) within a wait time target of <4 hours.

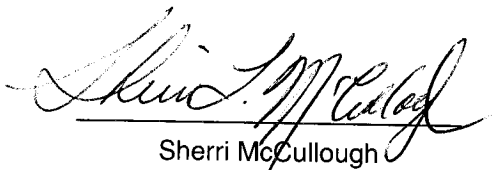
Part D:

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.



Sherri McCullough
Board Chair



Rod King
Quality Committee Chair



Dr. David Pichora
Chief Executive Officer