

Excellent Care
For All.



2011-12

Quality Improvement Plan

(Short Form)



LENNOX AND ADDINGTON COUNTY GENERAL HOSPITAL

March, 2011



Part A:

Overview of Our Hospital's Quality Improvement Plan

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

The Lennox and Addington County General Hospital is committed to providing the highest possible Quality of care to our patients. Patient safety has always been a central focus of our Quality plan. Consequently, we have included three objectives related to this topic in our Quality Improvement Plan.

We will be closely monitoring the rates of our patient satisfaction to enable us to identify any areas for improvement and continue to focus on our strengths.

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

By March 31, 2012:

- We will improve our hand hygiene compliance before patient contact from 77% to 90%. We will increase the frequency of performing our audits to 12 per year and we will increase the number of audits from 54 per year to 120 per year.
- We will reduce the number of in-patient falls by 15%. In order to reach this target we will introduce a learning initiative called 'leaves'. This program will focus on providing staff with an approach to understanding and enhancing care for individuals with complex physical conditions that could contribute to their risk of having a fall.
- We will have 75% of our incident reports fully completed with follow up and interventions documented. We currently use a paper based system for reporting our incidents. Our goal is to introduce an electronic reporting system to help streamline this process and provide us with more timely and accurate data.
- We will reduce the total number of in-patient days that Alternate Level Care (ALC) patients are spending in beds designated as Acute Care to 10.1%
- We will reduce the number of patients that have been readmitted within 30 days with specific case mix groups (CMG) that have been identified by the Ministry of Health and Long Term Care from 17.2% to 14.3%.
- We will reduce our surgical cost per weighted case from 6642 to 5974 which represents the 75th percentile from the Ontario Cost Distribution Methodology.
- We will continue to maintain strong financial health and target to keep our total margin above the HAPS target of equal to or greater than 0. Our target is 2.0.
- We will reduce ER wait times for admitted patients to meet the Provincial 90th percentile targets. 8 hours for CTAS II and 6 hours for CTAS III
- We will have 80% of our Emergency Department patients say they would recommend our hospital to friends or family.



3. How the plan aligns with the other planning processes

In order to demonstrate our commitment to our Mission, “To be a progressive hospital meeting the needs of our local communities, and then some”, it was important to align our Quality Improvement Plan with our Strategic Plan 2010-2013. We have incorporated six of the strategic imperatives into our Quality Improvement plan:

- 1) Patient and Staff Safety
- 2) Quality Culture
- 3) Customer Expectations
- 4) Balanced Budget
- 5) Risk Management
- 6) Learning and knowledge organizations

Our Quality Improvement plan also aligns with the Falls initiatives found in our Client Safety Plan which was developed as part of our Accreditation recommendations. This plan involves the Implementation of the 'leaves' program which focuses on strategies to prevent falls. It will also provide staff with the tools needed to assess patients after a fall and to provide the best possible preventative strategies.

The integration of the Quality Improvement Plan, the Strategic Plan and the Client Safety plan helps ensure financial responsibility, accountability to patients, and high quality care.

4. Challenges, risks and mitigation strategies

- As the population ages it will impact the average age of our clients and subsequently increase the risk of falling while in the hospital. The hospital must be diligent in monitoring fall trends, increasing awareness and continually being proactive in preventing falls.
- Recruitment and retention of medical and clinical staff in a small community is a potential risk. Some mitigating strategies in place are cross training of nurses from our Emergency Department to our Operating room and Special Care Unit. Our Chief of Staff is also working on a physician human resources plan which includes the recruitment of surgical and anesthesia positions.
- As our hospital grows we will need to ensure financial stability to support our expanded services. It will be very important to continue to work in harmony with the Foundation and community partners to purchase the necessary major equipment.
- In order to ensure ongoing credibility and confidence in the community we need to ensure plans are in place for good public relations and communications and provide opportunities for community engagement. Focus groups have been planned with diverse groups from our community to provide input into our Patient Declaration of Values.
- In order to reduce the time waiting in Acute Care for a long term care bed, we work very closely with our CCAC placement coordinator. She participates as a member of our multidisciplinary team that meets weekly to review all of our Alternate Level of Care patients awaiting placement. Availability of beds in Long Term Care Facilities could be a challenge to achieving this target.
- The hospital has the necessary resources available to carry out the implementation of the Plan.



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

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

The individuals from within our Hospital who are impacted by Performance-based Compensation consideration include:

- Dr. Tom Touzel, Chief of Staff
- Wayne Coveyduck, Chief Executive Officer (CEO)
- Tracy Kent-Hillis, Chief Nursing Officer (CNO)

And those reporting directly to the CEO

- Gert Switzer, Director of Finance and Utilization Management
- Shari Sampson, Director of HR and Clinical Support Services
- Nancy Manion, Director of Quality and Accreditation Coordinator
- Ray Trowhill, Director of Support Services/Project Manager

The Board of LACGH has set the Performance-based Compensation bonus for the Senior Management Team, Chief of Staff, CEO and CNO at 3%.

Within our Quality Improvement Plan, we have selected a total of ten initiatives with each initiative having improvement targets assigned to it. We have three initiatives under the (Safety) Quality Dimension which includes:

- Improving provider hand hygiene compliance;
- Falls avoidance; and
- Incident Reporting.

For the (Effectiveness) Quality Dimension, we have included:

- Reducing unnecessary time spent in acute care;
- Reducing unnecessary hospital admissions;
- Reducing the cost per weighted case;
- Increasing the number of surgical cases; and
- Improving organizational Financial health.



For the (Access) Quality Dimension, we have identified one item:

- Reducing wait times in the Emergency Department.

For the (Patient Centred) Quality Dimension, we have identified:

- Improving patient satisfaction.

From the ten initiatives that we have selected, we see three of them being of a CORE type. By explanation, CORE type means that each and all of us will maintain an Interdependent Relationship with one another to ensure that our desired Quality Improvement Outcomes are met. The remaining seven initiatives are individually assigned to specific members of our group. For team members that are not assigned any of the seven initiatives noted above, these people have been assigned appropriate Administrative goals which have been selected as Key initiatives to support the health and prosperity of the Hospital.

The result of this allocation methodology is captured in the following schedules:

DR. TOM TOUZEL

- Reduce the cost per weighted case;
- Improve the organizational financial health;
- Improve patient satisfaction;
- Reduce the unnecessary time spent in acute care; and
- Reduce the unnecessary hospital readmission.

TRACY KENT-HILLIS

- Reduce the cost per weighted case;
- Improve the organizational financial health;
- Improve patient satisfaction;
- Increase the number of surgical cases; and
- Reduce the wait times in the Emergency Department.

NANCY MANION

- Reduce the cost per weighted case;
- Improve the organizational financial health;
- Improve patient satisfaction;
- Improve provider hand hygiene compliance;
- Reduce the number of patient falls; and
- Improve the rate of incident reporting.

GERT SWITZER

- Reduce the cost per weighted case;
- Improve the organizational financial health;
- Improve patient satisfaction;
- Improve the physician chart completion times; and
- Improve the inpatient weighted case volumes.

RAY TROWHILL

- Reduce the cost per weighted case;
- Improve the organizational financial health;
- Improve patient satisfaction;
- Ensure organizational compliance with Emergency Preparedness; and
- Enhance after hours building security.



SHARI SAMPSON

- Reduce the cost per weighted case;
- Improve the organizational financial health;
- Improve patient satisfaction;
- Improve employee satisfaction rates; and
- Reduce overtime rate.

WAYNE COVEYDUCK

- Reduce the cost per weighted case;
- Improve the organizational financial health;
- Improve patient satisfaction;
- Improve physician satisfaction rates;
- Upgrade older sections of the Hospital; and
- Introduce appropriate new patient care services.

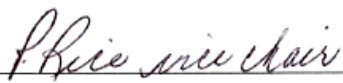
Each Senior Management team member and the Chief of Staff will have their initiatives valued by percentage. Some initiatives will be valued higher or lower based on the initiative. The total initiatives will add up to 100%.

A total score of 100% will mean that the team member will receive the held back 3% bonus. Any percentage lower than 100 will result in a reduction from the 3% by the failure rate of not meeting the target of 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.


Mrs. Peggy Rice
Acting Board Chair


Mrs. Deb Lowry
Quality Committee Chair


Mr. Wayne Coveyduck
Chief Executive Officer