Excellent Care
For All.

2012/13

Quality Improvement Plan

(Short Form)

Lennox & Addington County General Hospital;

March 2012

Part A:

Overview of Our Hospital's Quality Improvement Plan

The Lennox and Addington County General Hospital is committed to providing the highest possible Quality of care to our patients. The plan is linked to the hospital's mission statement "To be a progressive hospital meeting the needs of our local communities, and then some".

The Quality Improvement Plan for 2012/13 includes improvements identified by the patients through surveys and patient feedback, identified improvements that aligns us with provincial indicators, priorities identified through incident reporting, and Accreditation Canada standards and recommendations.

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.

The Lennox And Addington Quality Improvement goals for 2012/13 will include the following corporate indicators:

- We will improve our hand hygiene compliance before patient contact from 83% to 90%. We will continue to ensure monthly audits are conducted and ensure we have a minimum of 120 audits done by March 31, 2013. We will ensure we share and communicate our hand hygiene results with all staff and physicians to increase awareness and introduce 'celebrations' for departments achieving 100% compliance.
- We will reduce the number of in-patient falls by 4%. In order to reach this target we will implement initiatives such as monthly inspections of bed alarms, audit charts to ensure risk assessments have been documented, encourage patients to wear non-slip footwear, ensure sustainability of our falls prevention program and introduce the requirement for physiotherapy to do a consult for all new admissions to the Complex Continuing Care Unit as well as high risk patients admitted to our Acute unit.
- We will reduce the number of medication incidents involving high risk medications by 50%. We will achieve this by implementing a 24 hour MAR check, educate nursing staff on the revised CADD pump policy and by identifying which high risk medications are resulting in the most incidents causing harm.
- We will reduce the total number of in-patient days that are designated as Alternate Level Care (ALC). We will achieve this by working together with our local CCAC to implement the 'Home First' program and continue to improve on the effectiveness of our weekly multidisciplinary rounds.
- We will reduce the number of patients that are readmitted within 30 days for selected diagnosis. We will focus our attention on CHF patients this year. We will work with the local health unit and the Ministry of Health - Promotion branch, to develop a smoking cessation program for patients, and staff. We will also partner with the CHF clinic in Kingston to set up a process for CHF patients in our community to access services from Kingston.
- We will continue to maintain strong financial health and will maintain a balanced budget. We will focus our attention on educating staff on the recently updated Attendance Management Program as well as reducing energy costs by installing motion sensor lights where appropriate across the organization.

- We will reduce ER wait times for 90% of the admitted patients by 60 minutes. We will be implementing the Daily Access Reporting Tool (DART) to help identify any flow problems which will allow follow up to occur in a timely fashion. We will also continue to review outliers and trend to help identify process improvements.
- We will improve our patient satisfaction from 83 % to 88% of patients who would "recommend the hospital to family and friends" and will work to improve all measures of patient satisfaction. We will develop a hospital wide customer service education program as well as providing our ER staff with CTAS recertification training which will include a customer service module.

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 seven of our strategic imperatives into our Quality Improvement plan:

1) Patient and Staff Safety
2) Quality Culture
3) Customer Expectations
4) Balanced Budget
5) Learning and Knowledge Organization
6) Risk Management
7) Alliance Building

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

The risks we face in relation to the proposed quality improvement plan are as follows:

- The limited number of available beds in the community for complex care, long-term care and rehabilitation is a challenge and at times affects our ability to increase patient throughput, which will impact ER wait times and ALC days.
- We have submitted a request to participate in the tobacco use cessation demonstration project. If we are successful we would receive resources to develop our proposed smoking cessation program. If we are not successful in this bid it will require the hospital to find resources from within its own budget.
- Arbitrated compensation increases beyond our base funding adjustments are a concern and have a long term impact on the cost of operations
- 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 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 waiting placement. Availability of beds in Long Term Care Facilities could be a challenge to achieving this target.

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

Executive Performance Based Compensation- 2012/13

Our executives' compensation, including the percentage of salary at risk and targets that the executive team is accountable for achieving is linked to performance in the following way:

Senior Team Members	Performance Based Compensation as a Percentage of Annual Salary Total variable pay linked to achieving QIP targets
Chief Executive Officer	3%
Chief of Medical Staff	3%
Director, Patient Care Services	3%
Director, Quality and Accreditation	3%
Director, Finance and Utilization Management	3%
Director, Human Resources and Clinical Support Services	3%
Director, Plant Operations and Maintenance	3%

The performance allocation plan is used to determine the magnitude of allocation as set forward in the table below.

Quality Dimension	Objective	Current Performance	Target	Weighting
Safety	-Improve provider hand hygiene compliance before contact - Reduce patient falls	84%	91%	20% 20%
Effectiveness	-Sustain organizational financial health	3.84	>/= 1	15%
Access	- Reduce weight times in the ED	17.3	16.3	15%
Patient-Centered	- Patient satisfaction using three questions identified?	83%	88%	15%
Integrated	-Reduce unnecessary hospital readmissions	11.24	10	15%

Terms

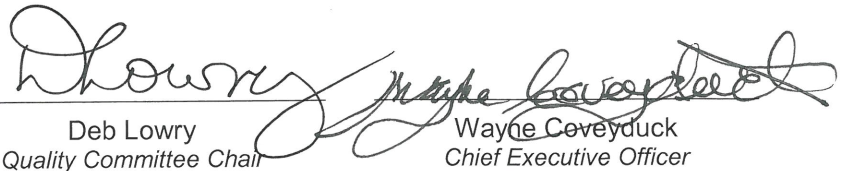
Attainment will be determined on monthly performance results for each indicator as reported to the Quality Committee of the Board. Variances will be identified and explained. Success in one month is based on 50% plus one. Level of attainment will be determined by the Board.
Calculation:
Safety indicators: (x/12) *.20= y*.03 annual salary
Other indicators: (x/12) *.15= y*.03 annual salary

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/service provider surveys, and aggregated critical incident data
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 processes and considers other organizational and provincial priorities *(refer to the guidance document for more information)*.

Peggy Rice
Board Chair



Deb Lowry
Quality Committee Chair

Wayne Coveyduck
Chief Executive Officer

PART B: Improvement Targets and Initiatives 2012/13

Lennox & Addington County General Hospital 8 Richmond Park Drive, Napanee, Ontario K7R 2Z4

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	**Improve provider hand hygiene compliance**	**Hand hygiene compliance before patient contact**: The number of times that proper 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	83 This measurement is YTD for Q3.	90%	Improve hand hygiene before patient contact by 7% with the longer term goal of reaching 100% (small hospital best performer)	1	1) Provide quarterly hand hygiene data to Clinical Teams and MAC	Compliance data is provided to Clinical Teams. Posted in Nursing Units and provided to MAC the month after the data is made available.	Within 30 days of availability	Celebrations for departments achieving 100%
							2) Improve communication of the compliance data	Establish a Quality Board in the staff service corridor and compliance data is posted quarterly once the data is made available	Within 7 days of availability	
							3) Conduct a patient engagement initiative	During Hand Hygiene week engage patients using the 'Ask me' campaign	100 % of capable patients receives one on one education at time of admission	
	Avoid patient falls	**Falls:** Percent of complex continuing care patients who fell in the last 30 days - FY Q3 2011/12, CCRS	14%	10%	Below provincial target of 13.7 %	1	1) Enhanced falls prevention program	Ensure that all hospital beds have a working bed alarm. Monthly audits of patients charts for documentation of risk assessments. For high risk patients ensure appropriate strategies are in place All Admissions to the Complex Continuing Care Unit will receive a Physiotherapy/OT consultation as well as high risk patients on the Acute unit. Establish routine elimination protocol.	100% of patient beds have a working bed alarm 100% compliance 100% Compliance By May 1, 2012	
	Reduce rates of Medication Incidents for high risk drugs	**Medication Incidents:** The number of medication incidents involving high risk medications. Data from our own in house incident reporting system. Q3 YTD 2011/12	29 (Average 10/Q)	<= 5/Q	Reduce our medication incidents involving high risk medications by 50 %	1	1) High risk medication incidents are a safety concern. Reduce the number of incidents involving High Risk Medications. Perform a Failure Modes Effect Analysis (FMEA) on the high risk medication process.	Perform a FMEA on the high risk medication process. Analys results and make improvements. Monitor indicators before and after to measure outcomes.	Complete FMEA and implement changes by May 31, 2012. Monitor indicators monthly.	
							2)Educate Nursing staff on revised Continuous Ambulatory Delivery Device (CADD) Pump policy	Policy review by all registered staff. Staff will successfully demonstrate competency to tester.	100 % of nursing staff will receive education and be required to successfully demonstrate competency to tester by June 1, 2012	
Effectiveness	**Sustain 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	3.84	**>= 1**	Revenues to exceed expenses	2	1) Educate staff on the updated Attendance Management Program (AMP)	Attendance Management Program (AMP) is communicated to 100% of staff 100% of staff counseling occurs based on the AMP	Educate 100% of staff by May 30, 2012 100% Attendance counseling will be conducted within two weeks after being notified by HR 100% of new staff will receive AMP education during their orientation	
							2) Reduce energy costs	Install motion sensor lights in all administration and support areas	Motion sensor lights will be installed by Sept. 29 2012	
Access	**Reduce wait times in the ER**	**ER Wait times:** 90th Percentile ER length of stay for <u>Admitted</u> patients. Q3 2011/12, NACRS, CIHI	17.3	16.3	Reduce the admission times by 60 minutes	2	1) Implement the Daily Access Reporting Tool (DART) to track and monitor daily ER flow and to identify any flow problems in 'real time'.	Utilize the 12 DART tool measures and monitor daily	By June 30, 2012 the DART tool will be 'live' and monitored daily for trends	
							2) Data analysis of outliers.	Implement process improvements from identified opportunities	Review process changes and monitor for impact on admission times	

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Patient Centered	**Improve patient satisfaction**	**Internal survey :** The percent response to the following three questions from our internal surveys: - What is the likelihood you would recommend the hospital to your friends and family. (Possible responses - Yes, No) - How would you rate the overall care you received during your visit (Possible responses Excellent, Very Good, Good, Fair Poor) - If you had to wait to be seen, how well did someone from the Emergency Department communicate the reason for the delay? (Possible responses - Excellent, Very Good, Good, Fair, Poor)	83	88	Improve Patient satisfaction by 5% Best Ontario Small Community Hospital = 81%	1	1) Share results of all internal patient surveys with all staff and physicians.	Summary of results are posted on the Quality Board once data is available. Bring results to clinical teams, MAC	Posted within a week of data being available. Share with clinical teams within 30 dys of data being available	
							2) Implement a hospital wide customer service program.	By December 31, 2012 50% of our Nursing staff will have attended a customer experience training session	50%	
							3) Provide Triage education to all ER staff - CTAS recertification.	Implement and review current CTAS guidelines which includes a customer service module Audit % LWBS	100% of ER staff receive the training by May 1, 2012 < 4%	
Integrated	**Reduce unnecessary time spent in acute care**	**Percentage ALC days:** Total number of inpatient days designated as ALC, divided by the total number of inpatient days. Q2 2011/12, DAD, CIHI	22.91	15	Proposed HSAA target	3				In anticipation of Home First being implemented in our Community.
	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 Readmission within 30 days for selected CMG's to our facility. Q1 2011/12 hospital data	21.35 11.24	19.2 10	Improve by 10%	3	1)Establish process to integrate Congestive Heart Failure (CHF) patients to the Kingston CHF Clinic.	Set up a referral process with CHF clinic in Kingston or set up an Ontario Telehealth Network (OTN) process so patients can been seen while in LACGH	Set up a process by June 30, 2012	
							2) Implement a smoking cessation program for patients.	Create a consistent evidence based approach to smoking cessation. Develop and implement care pathways.	Set up the program by November 30, 2012 Behaviour measures and outcomes will be measured	