Excellent Care
For All.

2011-12

Quality Improvement Plan

(Short Form)

Almonte General Hospital

April 1, 2011

Part A:
Overview of Our Hospital's Quality Improvement Plan

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

At the Almonte General Hospital / Fairview Manor, we have a passion for the pursuit of excellence. We are proud of our accomplishments, but even more, we are proud that our team is constantly striving for ways to be better. Improving safety and quality of care for our patients and residents is our top priority and our promise.

Our mission statement identifies our commitment to provide a continuum of healthcare with a focus on quality care, personal attention, accountability and fiscal responsibility. To that end, the focus of our Quality Improvement Plan is on a variety of important safety strategies, patient satisfaction and fiscal performance.

Many safety improvement initiatives are included in the plan, including: hand hygiene enhancement, medication reconciliation, and implementation of best practice standards for antibiotic use prior to surgery and falls prevention. These are widely recognized as key elements of safer care.

With regard to satisfaction, we want to be known as the place where patients, residents and their families feel safe and supported and receive compassionate care. We need your feedback to guide our improvement efforts.

> To help us obtain patient satisfaction feedback, the NRC Picker company mails confidential surveys to a random sample of people who have received care here and provides reports to us quarterly.
>
> We encourage everyone who receives the NRC Picker survey, to complete and return it.
>
> As well we encourage anyone who has concerns while receiving care to tell us so we can deal with these concerns promptly.

Fiscal performance is also a priority. As always, we will work to achieve the best outcomes and services possible within our resources.

Overall, our goal is to ensure that Almonte General Hospital / Fairview Manor is a source of excellent care and pride for our community.

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

Hand Hygiene

Although Almonte General Hospital staff score higher than the provincial average when audited for hand hygiene, further performance improvement is a key goal for the organization. This is because Hand Hygiene is widely recognized as one of the most effective means to prevent and control the spread of infection. We will be providing education to patients and residents. To heighten awareness and commitment, we will be sharing the results of Hand Hygiene audits with the care teams and engaging them in planning for improvement.

Medication Reconciliation

Medication reconciliation is one of the best practices that are being implemented widely in hospitals, to improve medication safety. It involves using a structured approach to obtaining and documenting a thorough medication history. This practice helps the care team to ensure that medication orders are safe, comprehensive, appropriate and effective. Our goal is to meet or exceed the Accreditation Canada standard for this practice. We will continue to educate staff and patients, audit performance quarterly, share audit results with care teams and engage them in planning to achieve and sustain our performance target.

Prophylactic Antibiotics prior to surgery (Cesarean Section and Hysterectomy)

Antibiotic prophylaxis involves administering antibiotics according to the guidelines of a best practice standard, prior to surgery. The purpose is to reduce the risk of post-surgical infections. We intend to meet or exceed the performance target set by Accreditation Canada for this practice. Our plan includes quarterly performance audits, sharing of audit results with the surgical team, and engaging them in planning to achieve and sustain these best practices.

Falls Prevention

In the upcoming year, we will develop and implement enhanced evidence-based Falls Prevention and Management protocols. Prevention of falls and related injuries are a key safety concern for all healthcare organizations. Although this is addressed routinely in all patient and resident care units already, we have an opportunity to improve and standardize care, through the adoption of best practices, throughout the organization. As well, we will be enhancing our tracking and analysis of falls data.

Total Margin

Total margin is the percent by which total corporate revenues exceed or (fall short of) total corporate expenses. Our current total margin is 1%, which we will strive to maintain in the upcoming fiscal year. Our plan is to offset expected inflationary pressures with initiatives designed to increase revenue or decrease expenses. Some planned initiatives include increased use of group purchasing programs and strategies to reduce utility and overtime costs. Our goal is to optimize expenditures for patient / resident services while maintaining a financial buffer for unforeseen circumstances.

Improve Completion of Performance Appraisals

Regular, constructive communication between employees and managers is important to support employee satisfaction and organizational effectiveness. Performance appraisal is a structured approach to this communication. It provides an opportunity for individualized discussion, constructive feedback, recognition for a job well done, professional development planning and discussion regarding improvement of the workplace and work practices. Our goal is to implement consistent performance appraisal standards and tools across the organization and increase the completion of performance appraisals.

Patient Satisfaction

Almonte General Hospital patient satisfaction data is collected by NRC Picker, a company that specializes in surveying and analyzing results. They send confidential surveys to a random sample of people who have received care here and provide summary reports to us quarterly.

Our patient satisfaction score is above the provincial average but the annual rate of return is 26.5%. Therefore our goal for the upcoming year is to maintain our patient satisfaction results within a range of the current score, and to implement strategies to increase the number of surveys that are returned. Having more surveys returned will increase our confidence that the feedback we receive is truly representative of a broad sample of our patients. As well, we will expand surveying to include Obstetrics patients.

3. How the plan aligns with the other planning processes

While the annual Quality Improvement Plan is a critical component of our hospital's strategic and operational planning, it does not in itself communicate everything we are doing. It is aligned with our mission, vision and values and other key initiatives - such as accreditation, but it does not address all of the performance and reporting requirements of the Champlain Local Health Integration Network, the Ministry of Health and Long Term Care and legislation. We are preparing for accreditation in November, 2011, so a major focus for all departments will be to continue our work on implementation of the 35 Required Organizational Practices (ROPs) that are assessed by the Canadian Council on Health Services Accreditation. Strengthening our institution wide culture of quality improvement will be a key success factor in achieving accreditation standards and excellence in care.

For more information please access our website (almontegeneral.com) where you will find numerous useful links.

4. Challenges, risks and mitigation strategies

As a small hospital with limited resources and a small leadership team with multiple responsibilities, our main challenge is to sustain progress on multiple, simultaneous projects. The size of our team permits very little flexibility in dealing with additional, unexpected events. The main risk to success would be if the team experienced vacancies / turnover or if unexpected problems (e.g. H1NI) or situations (e.g. additional legislated / administrative requirements) arise that require significant re-direction of efforts. Any of these would impede our ability to achieve our stated goals.

In order to achieve our goals for the year:

- The Quality Improvement and Risk Management Committee (QIRM) will:
    - oversee, monitor and facilitate the work associated with the quality improvement plan
    - liaise with Senior Management and identify challenges and support requirements
    - ensure that work groups, work plans and timelines are established
    - ensure that work groups include staff and physicians in action planning so that proposed quality improvement strategies are credible and effective

- The Senior Management team members will:
    - communicate and demonstrate commitment to the quality improvement plan and process
    - participate directly in work groups as appropriate
    - provide support and guidance as needed
    - ensure that progress is communicated and celebrated

- The Quality Committee of the Board will:
    - receive regular reports and feedback from the QIRM and Senior Management
    - oversee the implementation of the quality improvement plan and progress toward targets
    - monitor challenges and mitigating strategies
    - make recommendations as needed

We believe that this structured "Team" approach will ensure that progress is made towards the achievement of our goals, even if unforeseen events occur that prevent us from reaching our stated performance targets.

PART B: Improvement Targets and Initiatives

ALMONTE GENERAL HOSPITAL 75 Spring St., Almonte, Ontario, K0A 1K0

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

AIM		MEASURE				CHANGE				
Quality dimension	Objective	Outcome Measure/Indicator	Current performance	Performance goal 2011/12	Priority	Improvement initiative	Methods and results tracking	Target for 2011/12	Target justification	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. 2010, consistent with publicly reportable patient safety data	0			1)				
						2)				
						... N)				
	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. 2010, consistent with publicly reportable patient safety data	na			1)				
						2)				
						... N)				
	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 - 2009/10, consistent with publicly reportable patient safety data	AGH audit results for Feb-March 2010 75.93% No data for FVM - HH auditing program will begin this year	Increase HH Compliance Before patient contact, by 5% to 79.73%, at the 4th quarter audit for FY2011-2012	1	Enhance staff and physician awareness of audit results and angagement in action planning	Quarterly HH awareness activity - either audit or education in all AGH clinical areas 104 Audits completed per year. Audit results and follow-up planning discussed at Staff, Leadership and MAC meetings x2/yr	4th quarter FY 2011-2012 score: Compliance ≥ 79.73%;	Last score of 75.93% is above the provincial average of 65.73%	
						2) Enhance communication / education with Patient / resident / visitor re HH	HH handout provided to each patient/resident on admission. Article in local newspaper re HH initiative.	Starting July 2011: All patients / residents receive HH information on admission		
	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. 2010, consistent with publicly reportable patient safety data	na			1)				
						2)				
						... N)				
	Avoid 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 2009/10, CCRS	na			1)				
						2)				
						... N)				
	Avoid falls	**Falls**: Percent of complex continuing care residents who fell in the last 30 days - FY 2009/10, CCRS	na							
						2)				
						... N)				
	Medication reconciliation	**Medication Reconciliation:** Percent of in-patients who have are using 3 or more medications at the time of admission, who have medication reconciliation done on admission.	80% F2011 Q2	≥ 90%	1	1) Revise AGH Medication Reconciliation policy - Med Rec to be done on all admissions regardless of number of medications (already done this way in FVM) 2) Staff / physician education 3) Audit quarterly in AGH - Share results with clinical team and MAC and hold team discussion re improvement	Quarterly audits completed Results shared at team meeting Team develops action plan	4th quarter score FY 2011-12 ≥ 90%	Target set by CCHSA	Required organizational practice for Accreditation
	Prophylactic antibiotic use - Cesarean Section	**Prophylactic antibiotics**: percent of patients who receive prophylactic antibiotics prior to cesarean section	85% F2011 Q2	≥ 90%	1	1) Discussion with surgical teams to clarify practice expectation re antibiotic administration and verification processes 2) Audit quarterly - Share results with clinical team and MAC and hold team discussion re improvement	Quarterly audits completed Results shared at team meeting Team develops action plan	4th quarter score FY 2011-12 ≥ 90%	Target set by CCHSA	Required organizational practice for Accreditation

AIM		MEASURE				CHANGE				
Quality dimension	Objective	Outcome Measure/Indicator	Current performance	Performance goal 2011/12	Priority	Improvement initiative	Methods and results tracking	Target for 2011/12	Target justification	Comments
	Prophylactic antibiotic use - Hysterectomy	**Prophylactic antibiotics**: percent of patients who receive prophylactic antibiotics prior to Hysterectomy	95% F2011 Q2 76.9% F2011 Q1	≥ 90%	1	1) Discussion with surgical teams to clarify practice expectation re antibiotic administration and verification processes 2) Audit quarterly - Share results with clinical team and MAC and hold team discussion re improvement	Quarterly audits completed Results shared at team meeting Team develops action plan	4th quarter score FY 2011-12 ≥ 90%	Target set by CCHSA	Required organizational practice for Accreditation
	Improve provider hand hygiene compliance - after patient / environment contact	Hand hygiene compliance **after 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 - 2009/10, consistent with publicly reportable patient safety data	AGH audit results for Feb-March 2010 84.13% No data for FVM - HH auditing program will begin this year	Increase HH Compliance AFTER patient contact, by 5% to 88.34%, at the 4th quarter audit for FY2011-2012	1	Enhance staff and physician awareness of audit results and angagement in action planning	Quarterly HH awareness activity - either audit or education in all hospital areas 104 Audits completed per year. Audit results and follow-up planning discussed at Staff, Leadership and MAC meetings x2/yr	4th quarter score FY 2011-2012: Compliance ≥ 88.34%;	Last score of 84.13% is above the provincial average of 78.61%	
						2) Enhance communication / education with Patient / resident / visitor re HH	HH handout provided to each patient/resident on admission. Article in local newspaper re HH initiative.	Starting July 2011: All patients / residents receive HH information on admission		
	Avoid falls	**Falls:** Enhance Falls prevention and management strategy and implement in Q4 FY 2011-2012	Fall Rate / 1000 Patient or Resident Days AGH 7.27 FVM 5.96 Overall 6.31		1	1) Develop and implement an enhanced Falls prevention and management program	Program developed Staff educated Program implemented	Jan 2012 - Program implementation starts		
						2) Enhance data collection processes and tools regarding Fall incidents - causes and outcomes	Incident report form revised Staff education (in Complex Continuing Care) re RAI data entry for falls	By Oct 2011 Revised incident report and tracking tool completed Staff education re RAI completed		
Effectiveness	Reduce unnecessary deaths in hospitals	**HSMR:** number of observed deaths/number of expected deaths x 100 - FY 2009/10, CIHI *NB - Not being reported because number of cases at AGH is below the CIHI threshold required to generate statisically reliable scores*	na			1)				
						2)				
						... N)				
	Reduce unecessary 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 2010/11, DAD, CIHI *< 5 of 34 cases - not considered reportable per Health Data Branch of MOHLTC*	Not Reportable			1)				
						2)				
						... N)				
	Reduce unecessary 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 2010/11, DAD, CIHI	Q2: 4.9%	< LHIN target - 12.9%	2	1)				Priority 2 because current performance is better than the LHIN target
						2)				
						... N)				

AIM		MEASURE				CHANGE				
Quality dimension	Objective	Outcome Measure/Indicator	Current performance	**Performance goal 2011/12**	Priority	Improvement initiative	Methods and results tracking	Target for 2011/12	Target justification	Comments
	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 2010/11, OHRS	1%	1%	1	To offset anticipated inflationary pressures: Reduce supply and equipment costs through increased use of group purchasing plans Reduce energy costs through Green Hospital and HIRF initiatives Implement revenue generating opportunities (eg ATM on-site) Reduce overtime through improved labour planning	Monthly financial reporting	1%	Internal consensus decision – Given that funding for the FY 2011-12 has not been announced, that collective agreements are under re-negotiation and annual salary increments will occur, our goal is to sustain current financial performance	
	Improve completion of performance appraisals	**Performance appraisal:** Update policies / tools for employee performance appraisal and schedule for implementation by Dec 2011	Current policies need to be reviewed and updated		2					
Access	Reduce wait times in the ED	**ER Wait times:** 90th Percentile ER length of stay for Admitted patients. Q3 2010/11, NACRS, CIHI	290 min (4.8 hours)	< Provincial target - 8 hours		1) 2) … N)				
		ER Wait times: 90th percentile ER Length of Stay for Complex conditions. Q3 2010/11, NACRS, CIHI NB: *not reported*	na			1) 2) … N)				
Patient-centred	Improve patient satisfaction	*Please choose the question that is relevant to your hospital:*								
		NRC Picker / HCAPHS: "Would you recommend this hospital to your friends and family?" (add together percent of those who responded "Definitely Yes")	Oct 2009- Sep 2010 average: AGH overall 83.28% (based on sampling of ER and Med-Surg patients) Survey Return rate overall = 26.5%	Maintain patient satisfaction score between 80-85% on average for the FY 2011-12 Increase overall survey return rate to 28% over 4 quarters of FY 2011-12	1	1) Share results with clinical teams: 1a) Discuss previous 4 quarters results at ER and M&S team meetings and MAC. 1 b) Post and discuss on-going results quarterly 2) Involve clinical teams in developing action plans to address survey results for their areas 3) Implement strategies to increase patient / caregiver awareness of survey and it's importance. e.g: provide letter at discharge, posters in ER, article in local newspaper, Increase scope of patient satisfaction data by initiating surveys of patients in Obstetrics	1) ER and M&S teams create action plan by June 2011 and update bi-annually 2) Survey results are made available to team members. 3) Results are updated and discussed at team meetings quarterly 4) Patient awareness measures implemented		Provincial average is 74% - North American leaders have achieved 85-90% (p16 Guidance)	
		In-house survey (if available): provide the percent response to a summary question such as the "Willingness of patients to recommend the hospital to friends or family" (Please list the question and the range of possible responses when you return the QIP) - NA	na							

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

In accordance with legislative requirements, the following positions are subject to performance-based compensation:

- Chief Executive Officer
- Chief of Staff
- Chief Financial Officer
- Assistant Executive Director Patient/Resident Services (Chief Nursing Officer)
- Assistant Executive Director Support Services and Clinical Services

All of the members of the Senior Team (“the Team”) are responsible for the operations of Almonte General Hospital and Fairview Manor. In addition, all members except the Chief of Staff support the operations of the Lanark County Ambulance Service.

The performance-based compensation plan (“the Plan”) reflects our corporate values of Accountability for fulfilling our obligations, Respect for the contribution that each member makes to the organization and the Teamwork that is necessary for the organization to succeed. As such, a Plan has been created that contains congruent, not conflicting, goals for each member of the Team, and which rewards the Team for working together towards achievement of the goals. The culture of the organization would not support a Plan which contained incentives for contrary behavior by different members of the team who were each striving to achieve their own objectives. Selection of the goals for compensation was based on this principle and the three that were chosen are those to which every member of the Team makes a contribution.

The amount of compensation at risk in 2011/12 is 2.5%.

One goal has been chosen from each quality dimension, except Access. In the Access dimension, AGH’s performance is superior to Provincial benchmarks in all ER wait time measures and in measures of ALC. While it is certainly the Team’s intention to sustain or improve the organization’s performance, it was not felt that inclusion of a goal in this dimension would provide a meaningful incentive.

Achievement of the goals is measured on a 5 point scale, with 3 being acceptable performance. If the Team achieves an average score of 3 or greater across the goals, each member will be paid 100% of the at-risk compensation. If the Team achieves an average score of 2, each member will be paid 50% and at an average score of 1, the Team will receive none of the at-risk compensation.

The goals and measurement structure are:

Quality Dimension	Activity	Measurement
Safety	Develop and implement an enhanced falls prevention and management program that is implemented by January 2012 Current overall falls rate is 6.31 per 1000 patient/resident days Maintain total margin on hospital operations at 1% Maintain patient satisfaction score between 80% and 85% for fiscal 2011-12.	5 is early implementation and improvement of 5% or greater in the rate 4 is on-time implementation and improvement of 5% or greater in the rate 3 is on-time implementation and no change in overall rate 2 is on-time implementation and deterioration in overall rate of 5% or greater 1 is late implementation
Effectiveness	Maintain total margin on hospital operations at 1%	5 is greater than 2% surplus 4 is 1.1 % to 1.9% surplus 3 is 0% to 1.0% surplus 2 is 0.1% to 1.5% deficit 1 is deficit of 1.5% or greater
Patient Centered	Maintain patient satisfaction score between 80% and 85% for fiscal 2011-12	5 is ≥90% 4 is 85-90% 3 is 75- 85% 2 is 70-74% 1 is ≤ 70%

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.

Carol Bean	David Martin	Mary Wilson Trider
Board Chair	*Quality Committee Chair*	*Chief Executive Officer*