

Excellent Care
For All.



2011-12

Quality Improvement Plan

(Short Form)



Runnymede Healthcare Centre

April 1, 2011

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]

At Runnymede Healthcare Centre we are committed to providing high quality patient care and services, while improving every patient's quality of life. We understand that in a high quality health care system, care must be accessible, appropriate, effective, efficient, equitable, integrated, patient centred, population health focused and safe. We will ensure patient care processes are aligned with these quality attributes. Our Quality Improvement Plan demonstrates to the public that we are committed to creating a positive patient experience through the delivery of high quality patient care. We will continue to identify opportunities for quality improvement and will continue to implement best practices to enhance patient safety and satisfaction.

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]

In an effort to improve the overall quality of care within our organization and to align ourselves with the requirements of the *Excellent Care For All Act*, we have chosen to focus on three of the recommended quality dimensions as determined by the Ontario Health Quality Council for 2011-2012. Throughout the year, we will continually monitor these quality indicators to ensure we are meeting and/or exceeding our target goals for the fiscal year. To ensure the correct resources are in place to execute our quality improvement initiatives, the executive team will ensure the correct financial levers are in place.

The objectives and change ideas that have been identified to improve quality of services and care are listed below. The specific aims and measures are outlined in the attached spreadsheet.

Objective	Change ideas
Reduce clostridium difficile associated diseases	Continue with the Antimicrobial stewardship education for physicians, development and distribution of CDI education materials for patients, create educational materials and improve staff accessibility to information regarding CDI
Improve provider hand hygiene compliance	Continue to educate and communicate regarding hand hygiene targets and improvement initiatives, launch hospital wide Hand Care Program for new hires, develop implementation plan for “Train the Trainer” model for hand hygiene education
Avoid new pressure ulcers	Review skin and ulcer prevention care program
Avoid falls	Consistent monitoring of adherence to Fall Prevention Program, monitor performance of the percentage of residents who fell in the last 30 days
Improve organizational financial health	An approved balanced budget, an approved capital budget, new monthly operating statements issued to department heads
Improve patient satisfaction	Complete patient satisfaction survey, obtain feedback on survey process and develop improvement plan based on survey results

3. How the plan aligns with the other planning processes

[An explanation of how this document links to the other planning documents developed by your organization (such as H-SAA) and key external partners such as the LHIN and CCACs.]

Our QIP is corporate in scope. It assists us in making evidence-based decisions about the management of quality, safety and risk issues by providing a framework for articulating quality improvement priorities and for conveying quality improvement strategies. Our QIP is closely aligned with our strategic plan. One of our key strategic directions is operational excellence. To enable growth within operational excellence, we will excel in the area of quality and safety to maintain our high standard of care to our patients. Our new building provides us with the opportunity to maintain a strong culture of continuous quality improvement by enhancing our care processes while building a strong quality and safety infrastructure. It is our goal to ensure all levels of the organization will be relentless in efforts to identify opportunities for improvement and implement best practices to enhance patient safety and satisfaction. The strategic directions outlined in our strategic plan are aligned with our mission, vision and values.

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.]

The risks and mitigating strategies that may inhibit the accomplishment of our proposed 2011/2012 targets may include:

1. Rapid growth: There is the potential that we will be required to increase the number of beds more quickly than anticipated due to external drivers. The strategies that have been identified to lower this risk include being flexible to expand the number of beds and/or patients, continue to expand clinical programs and services to meet the needs of the patients and ensure financial sustainability to enable the growth and expansion.
2. Low Tolerance Long Duration Rehabilitation (LTLTD Rehab) patients: We are anticipating the admission of LTLTD Rehab patients. There is a risk that admitting these patients will result in increased incidents of falls. The strategies that have been put into place to lower this risk include consistently monitoring the

adherence to the Fall Prevention Program and monitoring the performance of the percentage of residents who have fallen in the last 30 days.

3. Environmental factors: There is the risk of environmental factors which will inhibit our ability to meet our proposed goals, i.e. a flu outbreak. The strategies that have been identified to lower this risk include implementing infection control measures throughout the hospital and monitoring the status of human resource staffing to identify the need to bring in additional staff.

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.]

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BEFORE YOU BEGIN...

As part of the **ECFAA Legislation**, the annual quality improvement plan must be developed having regard to:

- The results of the surveys (patient and staff - if available)
- Data relating to the patient relations process
- Aggregated critical incident data

Please ensure this information is reviewed and considered in the process of developing your plan.

Helpful hints for how to review this information are provided in the guidance document.

[Link to Online Updates](#)

Key messages	Technical Information
PART B: Improvement Targets and Initiatives	
Measures (columns B-F) –There is a core set of measures identified within this spreadsheet. This is to ensure alignment, consistency and standardization of reporting. There is however, an expectation that measures will be added that align with your own hospital and regional priorities	<u>Current performance:</u> What is your organization’s current performance data/rate? A timeframe is specified within the table for core indicators.
	<u>Performance goal 2011/12:</u> At the end of the improvement initiative, what is the outcome your organization expects to achieve? <u>Priority:</u> Only indicators assigned as Priority 1 require a change plan (columns G-K). Please see the guidance document for more information.
Change plan (columns G-K) – These columns should be completed where you have flagged a measure as Priority 1 (column F). Understanding that hospitals do not all have the same priorities, we expect these plans to be developed with your own hospital's priorities in mind. Change priorities should be focused on areas where improvement is necessary.	<u>High-level improvement plan:</u> This section defines the details of the quality improvement initiative. Hospitals are required to complete the change section for all high priority (1) initiatives .
	<u>Methods and results tracking:</u> Include your measures/current data (i.e. process measures) as appropriate
	<u>Target for 2011/12:</u> All Priority 1 indicators must have a target defined for 2011/2012. Organizations should aim to review their existing data over time to set “stretch targets” on a select number of objectives. Please see the Guidance document for more information on target setting .
	<u>Target justification:</u> Why was the specific target selected? i.e. is the target based on research literature; best practice; provincial or other defined benchmarks; scientific evidence; organizational targeting exercise?
	<u>Comments:</u> If there are any additional comments that you would like to make about the initiative, please indicate these here.

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
						5) Implement certificates and visible award to those who have completed training	Introduce and carry on awarding MOHLTC recommended certificate and button for all new hires and existing staff when trained by champions as part of the hospital wide orientation program.			
						6) Complete self assessment and benchmarking against best practices	GAP analysis of our Hand Hygiene policy and procedure with Provincial Infectious Disease Advisory Council (PIDAS) best practice document published January 2009.			
	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	N/A	N/A		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	0.90%	Review skin care and ulcer prevention program by September 2011	2	1) Review skin care & ulcer prevention care program	a) Reconvene Skin and Wound Care Committee. b) Partner with suppliers to leverage opportunities for support including education. c) Develop project plan to review skin care program including rounds, skin care and ulcer prevention protocol by September 2011.	Review skin care and ulcer prevention program by September 2011	Our performance is better than benchmarks.	
	Avoid falls	Falls: Percent of complex continuing care residents who fell in the last 30 days - FY 2009/10, CCRS	7.50%	Implement quarterly reports regarding adherence to Fall Prevention Program	2	1) Consistent monitoring of adherence to Fall Prevention Program: Provide quarterly reports of chart audit results detailing compliance with the Fall Prevention Program to the Inter-Professional Care Committee 2) Monitor Performance of % residents who fell in the last 30 days	a) Obtain access to detailed incident report data. b) Create audit tool template including findings and recommendations. c) Develop report template. d) Begin to produce reports and recommendations. e) Clinical managers to implement report recommendations. a) Update Clinical Indicator Report: - Add % residents who fell in the last 30 days to clinical indicator report - Remove Patients Newly Falling from Clinical Indicator report. b) Monitor performance on quarterly basis as per Clinical Indicator Reporting process and formulate action plan for improvement.	Implement quarterly reports regarding adherence to Fall Prevention Program	Our performance is better than benchmarks. The 2009/10 performance data may be underestimating the actual percentage of falls and it is anticipated that admission of Low Tolerance Long Duration Rehabilitation patients will result in an increased incidents of falls despite fall prevention strategies in place due to an emphasis on increasing mobility which may place patients at an increased falls risk.	
	Space for additional indicators									
Effectiveness	Reduce unnecessary deaths in hospitals	HSMR: number of observed deaths/number of expected deaths x 100 - FY 2009/10, CIHI	N/A	N/A		1) 2) ... N)				
	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 2010/11, DAD, CIHI	N/A	N/A		1) 2) ... N)				
	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 2010/11, DAD, CIHI	N/A	N/A		1) 2) ... N)				
	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	1.11%	0%	1	1) An approved balanced budget in advance of the fiscal year, or end of first quarter	a) Complete H-SAA extension document. b) Ensure funding of new programs is adequate to maintain a balanced budget. c) Present revised budget to CEO and Board of Directors.	0%	Ensures maximum amount of funds are spent on the provision of care to patients and meets government legislation of a balanced budget.	
						2) An approved capital budget before the end of the second quarter of the fiscal year	a) Establish capital planning process policy & procedure. b) Assess capital needs of the hospital. c) Present capital list to CEO for approval.			

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:

A percentage of an executive's base salary is linked to the achievement of a defined number of performance improvement indicators set out in this Quality Improvement Plan (QIP). The listing of executives, percentage of base salary at risk, and payment of the salary at risk, are as follows:

Chief Executive Officer: 5% of base salary is linked to achieving at least three of the six indicator targets set out in this QIP.

Chief of Staff: 5% of stipend is linked to achieving at least three of the six indicator targets set out in this QIP.

Chief Operating Officer: 3% of base salary is linked to achieving at least three of the six indicator targets set out in this QIP.

Vice President Clinical Programs, Vice President Risk Management, Chief Information Officer and Chief Privacy Officer: 3% of base salary is linked to achieving at least three of the six indicator targets set out in this QIP.

Chief Nursing Executive: 2% of base salary is linked to achieving at least three of the six indicator targets set out in this QIP.

Senior Director Human Resources, Senior Director Corporate Planning and Communications: 2% of base salary is linked to achieving at least three of the six indicator targets set out in this QIP.

If three indicator targets are achieved then the executive will receive 100% of that component of the base salary that is linked to achievement of the indicator targets set out in this QIP.

If two indicator targets are achieved then the executive will receive 66.67% of that component of the base salary that is linked to achievement of the indicator targets set out in this QIP.

If one indicator target is achieved then the executive will receive 33.33% of that component of the base salary that is linked to achievement of the indicator targets set out in this QIP.

If none of the indicator targets are achieved then the executive will receive 0% of that component of the base salary that is linked to achievement of the indicator targets set out in this QIP.

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.



George Cushing
Board Chair



Isabelle O'Connor
Quality Committee Chair



Connie Dejak
Chief Executive Officer