

Excellent Care
For All.



2011-12

Quality Improvement Plan

(Short Form)



Brockville
General Hospital

March 24, 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.

Part A:

Overview of Our Hospital's Quality Improvement Plan

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 BGH Board of Governors and Senior Leadership Team are committed to our vision of Healthy People, Outstanding Care. Our focus for the 2011-12 Quality Improvement Plan (QIP) is to improve our collaborative, patient centred, interprofessional approach and culture of safety for the people we serve. A part of our culture of safety is to improve hand hygiene, implement a new model of care at the bedside, and decrease falls and medication incidents. This will result in shorter length of stay, fewer complications and improved patient satisfaction.

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

a) The specific aims that Brockville General Hospital will be focusing on from April 2011 to March 2012:

Aim

- 1) To improve compliance with BGH standardized medication reconciliation process that prevents adverse drug events, at all interfaces of care in the Emergency Department (ED).

Measures

- o Percentage of charts that demonstrate evidence of medication reconciliation at:
 - Admission (at initial assessment at Triage)

Changes

- o Implement the BGH Medication Reconciliation Education Training Program for our Interprofessional Teams including the Registered Nurses working in Emergency that includes orientation to the following:
 - Responsibility and Accountability for Acquiring Home Medication list Algorithm
 - o Policy
 - o Best Possible Medication History (BPMH) Sheet
 - o Nursing Database
 - o Patient's MR Number
 - o Electronic Admission Medication Form for admission, transfer and discharge
 - o Physician medication reconciliation order process
 - o Faxing process to pharmacy at admission, transfer and discharge
- o Identify Physician Champions and work closely with physicians and manage issues, concerns and changes that relate to the Physician Medication Reconciliation responsibilities
- o Work closely with Pharmacy Staff, Hospital Information Staff to adapt technology and with Health Records Staff in their roles of Medication Reconciliation
- o Implement having a pharmacy technician in the Emergency Department to assist with Medication Reconciliation
- o Report monthly medication reconciliation data to the Chief Nursing Executive, Clinical Managers and Quality/Accreditation Manager.
- o Implement Quadramed upgrade (Caché).

Resources

- o No material, financial impact is anticipated from the planned compliance improvement related to the Medication Reconciliation Program.

Aim

2) To re-engage hospital staff and physicians in the process of fall and injury prevention, continuing education about fall risk reduction and harm will be offered during orientation, Departmental Staff Meetings and In-service Education.

Measures

- Percentage of designated (full time, part time and casual) staff who attend Fall Risk Reduction and Prevention Education Sessions.
- Establish a baseline Falls Rate.

Changes

- Implement new care delivery model
- Implement BGH Falls Protocol
- Regular communication about the Fall Risk Assessment and Enhancement tool to hospital staff
- Posting of Fall Data on individual inpatient units.
- Enhance assessment of root cause analysis of the fall.
- Complete systemic analysis of falls.
- Engage physicians in fall prevention education and program.

Resources

No anticipated material financial impact. Continuing Education and Ongoing Training is included in the 2011/12 budget.

Aim

3) Ensure hand hygiene compliance before and after patient contact.

Measures

- Direct observation hand hygiene audits reporting :
 - First Moment – Before initial patient /patient environment contact
 - Fourth Moment – After patient contact

Changes:

- Perform hospital wide audits - showing compliance rate before patient contact and after patient contact.
- To strengthen and complement the work already being done to improve hand hygiene, the following will be required:
 - Evaluation of the present hand hygiene strategies will be completed;
 - Implement new evidence based strategies that will improve compliance;
 - Evaluate success of meeting hand hygiene aims.
- Engage physicians in hand hygiene education and protocols.
- Engage volunteers in hand hygiene education
- Expand hand hygiene signage on both sites

Resources: No anticipated financial impact. Hand Hygiene Promotion, Auditing and Continuing Education is included in the 2011/12 budget.

2b) The "Ideas to Improve" include the following:

- 1) Research has shown that poor communication of medical information each time a patient moves from one setting to another is a contributing factor to adverse medication events. We are planning to improve medication reconciliation processes in the ED to provide a safer environment for our patients.
- 2) To reduce our fall rate, we will implement a new model of care, which also supports the already existing practice of Hourly Rounding.
The "Four Ps" vital for successful rounding, consists of:
 - Positioning: Making sure the patient is comfortable and assessing risk of pressure ulcers

- Personal Needs: Scheduling patient trips to the bathroom to avoid unsafe conditions
 - Pain: Asking patients to describe their pain level on a scale of 0-10.
 - Placement: Making sure the items a patient needs are within reach - such as call bell, tissues, the TV remote control, and the telephone.
- 3) To improve our hand hygiene compliance, the measurement of the results and assessment of strategies will tell us if changes are leading to an improved, safer patient and staff environment.

3. How the plan aligns with the other planning processes

The following aims within the plan link with the following systems:

- **Medication:**
 - BGH Occurrence Reporting System that provides monthly and quarterly data on Incident Reports
 - Accreditation Canada – Managing Medication and Required Organization Practices
 - Institute for Safe Medication Practice
 - Safer Healthcare Now!
 - Integrated Health Services Plan 2 – quality of care pillar
 - *Excellent Care For All* Legislation
- **Falls:**
 - BGH Occurrence Reporting System that provides monthly and quarterly data on Incident Reports
 - Accreditation Canada – Required Organization Practices- Implementing a Fall Preventative Program
 - SE LHIN Restorative and End of Life Care Clinical Services Roadmap
 - Safer Healthcare Now!
 - Integrated Health Services Plan 2 – quality of care pillar
 - *Excellent Care For All* Legislation
- **Hand Hygiene:**
 - BGH monitors Hand Hygiene through the Quality and Patient Safety Committee and the Infection Control Committee.
 - Public Reporting of Hand Hygiene
 - SE LHIN Healthcare Acquired Infection Clinical Services Roadmap
 - Integrated Health Services Plan 2 – quality of care pillar
 - *Excellent Care For All Act* Legislation

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.]

Challenges:

- Clinical Director (s) Span of Control
- Manager (s) Span of Control
- Infection Control Coordinator Span of Control
- Clarity of Role Expectations
- Organizational Development Planning
- Physician Support
- Staff (Nursing and Pharmacy) Support
- Participation of casual staff in education
- Electronic access

Mitigating Strategies:

- Staff Engagement
- Physician Engagement
- Evaluating Education Priorities

- Quality Improvement Plan that sets out priorities
- Electronic access

• 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 attached BGH Improvement Target Sheet

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)]

Indicators:

1. Medication Reconciliation (75% on admission in Emergency Department)
2. Falls Prevention – (75% compliance with attendance at education session and establish a baseline Fall Rate)
3. Hand Hygiene – Meet or exceed 75% compliance before and 75% compliance after patient contact for each quarter measurement

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

- ❖ Chief Executive Officer, 3% of base salary is linked to achieving the targets set out in our QIP on the above indicators
- ❖ Chief of Medical Staff, 3% of base salary is linked to achieving the targets set out in our QIP on the above indicators

- ❖ Vice President of Clinical Services/Chief Nursing Executive, 3% of base salary is linked to achieving the targets set out in our QIP on the above indicators
- ❖ VP Corporate Services/Chief Financial Officer, 3% of base salary is linked to achieving the targets set out in our QIP on the above indicators
- ❖ VP Human Resources/Chief Human Resources Officer, 3% of base salary is linked to achieving the targets set out in our QIP on the above indicators

The performance allocation plan below is used to determine the percentages of the performance allocation.

Performance Allocation Plan

Medication Reconciliation:

1% of base salary allocated to this indicator, no baseline data, if performance is below target, performance pay will be prorated on a straight line basis.

Falls Prevention:

1% of base salary allocated to this indicator, no baseline data, if performance is below target, performance pay will be prorated on a straight line basis.

Hand Hygiene:

1% of base salary allocated to this indicator. 0.5% to each moment performance trigger will be 65% compliance, performance pay will be prorated between 65% and 75% on a straight line basis.

Part D: Accountability Sign-off

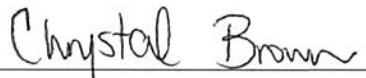
[Please see the QIP Guidance Document for more information on completing this section.]

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.



Hugh Bates
Board Chair



Chrystal Brown
Quality Committee Chair



Ray Marshall
Chief Executive Officer

