

Excellent Care
For All.



2012/13

Quality Improvement Plan

(Short Form)



St. Joseph's Health Care, London

March 2012

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 HQO in the format described herein.

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Part A:

Overview of Our Hospital's Quality Improvement Plan

In pursuit of St. Joseph's vision "From the shortest visit to the longest stay, we earn complete confidence in the care we provide, and make a lasting difference in the quest to live fully", we are pleased to share St. Joseph's Quality Improvement Plan for 2012-2013. Excellence in quality and patient safety is a key strategic priority for St. Joseph's and is something that we strive to provide on a daily basis to those we serve.

Annually, St. Joseph's develops and publicly posts its Quality Improvement Plan which outlines the key quality improvement priorities for the upcoming year, targets we are striving to achieve and strategies to achieve the highest priorities. The 2012-2013 Quality Improvement Plan for St. Joseph's is provided below. We will achieve these goals in collaboration with staff, physicians, patients, families, and healthcare partners in a manner consistent with our values of respect, excellence and compassion.

Quality Improvement Priorities for 2012-2013

Priority: Achieve 85% hand hygiene compliance

Proper washing of hands before patient contact is a key component to protecting patients from getting an infection while in hospital. Based on currently available comparative data, a compliance of 85% is more than 10% above the provincial average and would place St. Joseph's among the high performers in Ontario. This goal builds on St. Joseph's target for 2011-2012 (75%) and is the next step in our ongoing effort to continuously improve our performance in this area. Strategies to achieve this goal include enhanced auditing and reporting of hand hygiene, leveraging infection safety champions to coach staff on an ongoing basis, and strengthening the visibility and processes of staff commitment to hand hygiene (e.g. staff and unit pledge statements).

Objective: Achieve 50% reduction in hospital-acquired methicillin-resistant staphylococcus aureus (MRSA) at Parkwood Hospital

We are committed to reducing our rates of MRSA at Parkwood Hospital. In 2011-2012, approximately 85 patients acquired MRSA while at Parkwood Hospital. The great majority of patients who acquire MRSA do not have any immediate medical adverse effects from it. However, this is an area where we are striving for further improvements. Our goal for 2012-2013 is to reduce the number of MRSA cases acquired at Parkwood Hospital by 50%. Strategies to achieve this will include enhanced environmental cleaning, training of new infection safety champions, and learning from and implementing best practices from other organizations that have similar patient populations.

Objective: Achieve staff influenza vaccination rates of 55%

Receiving the influenza vaccination is an important strategy to protect both our staff and patients from getting influenza and reducing the severity of the impact on those who do. St. Joseph's made gains in its influenza vaccination rate in 2011-2012 and want to continue to build on those gains in 2012-2013. Strategies to achieve a vaccination rate of 55% will include increasing availability of peer vaccinators, creating e-learning training modules, and development of additional strategies to engage staff.

Objective: Achieve a median wait time from abnormal mammography screen to surgery for patients with breast cancer from 16 weeks to 13 weeks

St. Joseph's has developed and opened an integrated interdisciplinary breast care centre involving surgery and imaging teams to pull patients through the assessment to treatment phases smoothly and consistently, eliminating unnecessary waste and waits. This is a major change that consolidates several services at St. Joseph's Health Care. The volume of patients receiving mammography procedures increased by approximately 1,500 patients per quarter compared to the previous year and has impacted the ability of St. Joseph's to achieve targeted improvements in wait times. Strategies to improve access in 2012-13 will include increasing physician and staff resources, increasing diagnostic appointments, purchasing of additional capital, and improving scheduling and patient flow. The completion of the construction to consolidate the Breast Care Program all in one space will also occur in 2012-13 and will lead to further efficiencies.

Objective: Achieve a 25 percent decrease in the number of falls resulting in injury at Mount Hope Centre for Long Term Care and Parkwood Hospital

Minimization of patient falls and in particular injury due to falls is a high priority for St. Joseph's. Many of the patients and residents we serve have long stays and are at risk of falling. Improvements related to this indicator will be initially targeted to Parkwood Hospital and Mount Hope Centre for Long Term Care, as 80 percent of patient falls with injury occur at these two sites. Planned improvement initiatives and methods will be implemented in 2012, and a number of process measures will be tracked. The average number of falls with injury per quarter at these two sites is targeted to be reduced by 25% in the fourth quarter of 2012-2013.

Alignment of the Quality Improvement Plan with the other planning processes

Our quality improvement plan is aligned with other internal planning processes including budgeting, volume planning, allocation of resources for strategic investment, and space allocation. Our QIP is also aligned with external reporting and accountability requirements. Patient safety and access to care are key priorities for the Ministry of Health and Long-Term Care and the indicators that St. Joseph's is focused on improving in 2012-2013 are closely aligned with the indicators reported publicly. Our hospital service accountability agreement with the South West LHIN also includes specific requirements captured in this plan such as improving access to care, patient safety and balancing the budget.

Integration and Coordination Care

Achievement of our strategic priorities is not possible without working collaboratively with our healthcare partners. For example, improving wait times for breast care will only be achieved by working with Cancer Care Ontario and our partner hospitals. Strategies to reduce infection rates and improve infection control practices require collaboration with several partners including the Middlesex London Public Health Unit, the academic organizations from which our students and new graduates come from, and our referring hospitals. Improving access to care requires collaboration with referring physicians, partner hospitals and Community Care Access Centre. St. Joseph's is fully committed to working outside of our walls and looking for opportunities to partner and collaborate to achieve our patient safety and quality goals.

Challenges

Success in reducing infection rates at Parkwood Hospital is impacted by the high prevalence of methicillin resistant staphylococcus aureus (MRSA) at the time of admission. Reducing breast care wait times will continue to be challenging if volumes continue to increase. Reducing falls requires a balance between individual patient choice regarding use of restraint and mobility aids and the risk of falling. Improving access to cancer diagnostics and surgery requires a combination of improving data quality, increasing volume, and better coordination and management of referrals with our partner organizations. For all initiatives, it will continue to be a challenge to implement changes required to achieve our targets in light of limited financial and human resources. This work requires agreement and collaboration with multiple parties including physicians, South West LHIN, Cancer Care Ontario and our regional hospitals. We are actively engaging in this work with our partners to improve quality and patient safety to our community.

Part B: Our Improvement Targets and Initiatives

Specific improvement targets and strategies are outlined in attached spreadsheet.

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

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

- The CEO has 5% of their annual salary compensation at risk related to achievement of annual Quality Improvement Plan indicator targets outlined below
- All Senior Leaders (those leaders reporting directly to the CEO with the exception of the St. Joseph's Health Care Foundation President & CEO) have 3% of their current annual salary compensation at risk related to the achievement of annual Quality Improvement Plan indicator targets outlined below
- Integrated senior leaders (those who work at both London Health Sciences Centre and St. Joseph's Health Care, London) will have their 3% at risk split between each organization equivalent to the current cost sharing for their respective roles
- The CEO and Senior Leaders reporting to the CEO will have the same targets
- The following four indicators will be tied to performance based compensation:
 - Hand hygiene compliance
 - Influenza vaccination rate
 - Breast care - wait time from abnormal screen to surgical care
 - MRSA at Parkwood Hospital
- Compensation will be awarded as follows:
 - The four indicators carry equal weight (each one is worth 25%)
 - For each indicator:
 - Less than 50% of target achieved = none of the compensation at risk will be awarded for that indicator
 - 50%-99% of target achieved = compensation at risk will be awarded for that indicator prorated based on percent of target achieved
 - 100% or more of target achieved = 100% of compensation awarded for that indicator
 -

	Current	50% of Target	Target
Hand hygiene	75%	80%	85%
Influenza vaccination rate	49%	52%	55%
Breast care wait time	16 weeks	14.5 weeks	13 weeks
MRSA at Parkwood Hospital	0.6/1000 patient days	0.45/1000 patient days	0.3/1000 patient days

* It should be noted that Bill 55 is currently being interpreted and could result in changes to the above performance-based compensation plan

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.

SIGNED

Marcella Grail
Board Chair

SIGNED

David van Trigt
Quality Committee Chair

SIGNED

Dr. Gillian Kernaghan
Chief Executive Officer

PART B: Improvement Targets and Initiatives

2012/13



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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	Reduce MRSA (Parkwood Hospital)	MRSA rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired MRSA, divided by the number of patient days in that month, multiplied by 1,000	0.6 per 1000 patient days for first 3 quarters of 2011-2012	0.30 per 1,000 patient days	Comparative data not available - 50% reduction a stretch target	1	1) Consultation with similar organizations to determine practices that have been successful.	Identification of similar organizations	Implement successful initiatives from other similar organizations	
							2) Ongoing collaboration with Environmental Services to review cubicle curtain cleaning schedules	Frequency of cleaning	Ensure recommended standards for cleaning of all cubicle curtains are met	
							3) Review of Standards for cleaning window curtains	Tracking process for number of curtains washed per month	Ensure recommended standards for cleaning of window curtains are met	
							4) Training additional Infection Safety Champions	Number of new Infection Safety Champions trained in 2012-13	Establish sustainable educational resources within infection control	
Increase Influenza Vaccination	Employee Influenza Vaccination Rate: The percent of paid St. Joseph's employees who receive their annual influenza vaccination and provide to Occupational Health and Safety Services (OHSS) documented evidence of vaccination or self report vaccination received by March 31, 2013.	49%	55%	Internally defined target - set as a stretch target for 2012-2013. In 2011-2012, a 6% increase in vaccination was achieved and this stretches the organization to achieve an additional 6%	1	1) Obtain feedback from staff regarding vaccination choices	a) Focus groups b) Staff survey			
						2) Enhance availability of peer vaccinators across clinical programs - leadership reporting of peers identified within their programs	a) Percentage of clinical programs with a peer vaccinator identified b) Percentage of clinical programs with leadership confirmation of peer vaccinator availability across shifts both measures to be reported by each clinical leader	Increased percentage of units with peer vaccinators compared to 2011	Strategy in response to continued reporting of importance to staff to have vaccination available on units, during multiple shifts	
						3) Create e-learning program for staff re influenza vaccination, and determine if support present to mandate all staff to complete	a) Requirements are defined related to staff education re influenza vaccination b) Percentage of staff who complete e-learning program	100% staff complete learning, if defined requirements supports mandatory learning	Strategy to improve communication to staff to ensure they receive credible evidence, facts and key messages re importance of vaccination	
						4) Refresh influencer plan with task force to review and revise components of program	a) Influencer plan refreshed by June 30, 2012			
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	Comprehensive year end audit of compliance currently underway. Initial results suggest we will be approximately 75%	85%	85% is 10% higher than current comparative provincial average and would place St. Joseph's among the high performers of hospitals in Ontario	1	1) Complete training of 15 new Hand Hygiene Auditors	Infection Control Practitioner will complete return demonstration of audit processes. Each auditor will then be available to support completion of audits on unit	100 audits per unit per quarter to be completed		
						2) Develop standard for ambulatory care auditing	SJH clinical leadership will determine number of audits for clinics	Audits performed per decision		
						3) Develop process for collecting audit results quarterly and reporting results to teams to provide feedback	Consider electronic data collection or clerical support to increase ability to submit data and produce unit based reports	Teams receive timely information re compliance with 4 moments in Hand Hygiene		

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
	Reduce the number of patient falls causing injury at Parkwood Hospital and Mount Hope Centre for Long Term Care by 25%	Falls with injury: The number of patient falls with injury (falls categorized as severity level 3 and higher occurring at Parkwood Hospital and Mount Hope Centre for Long Term Care reported in the electronic Patient Safety Reporting System)	160 (average per quarter in first 3 quarters of 2011-2012)	120 (25% reduction) in Q4	Planned improvement initiatives and methods will be implemented in 2012. Process measures will be tracked. The performance target will be reached in Q4.	1	1) Process Improvement Ensure all patients identified as high falls risk have individualized fall prevention interventions targeted at their specific risk factors	Audit charts to determine the percentage of patients identified as high falls risk with individualized interventions documented on their care plan	75%	
							2) Measurement & Feedback Systems Unit-specific falls data posted on each unit	a) Percentage of units with a completed safety calendar visible in a shared staff/patient area per quarter (determined by audits/walkarounds) b) Percentage of units with quarterly detailed falls report displayed in staff area (determined by audits/walkarounds)	100%	
							3) Reminder Systems a) Development of a post fall guideline for staff b) Develop a checklist of common falls prevention interventions	a) Percentage of units with a post fall guideline visible and available for staff to reference (determined by audits/walkarounds) b) Percentage of completed checklists on patients identified as high risk for falls (determined by audits)	100%	
							4) Incentives/Motivation a) Make falls prevention a priority for leadership within the organization b) Recognition for units with most improved performance	a) Falls prevention listed as an indicator on the QIP and/or strategic plan b) Article published in Imprint on a quarterly basis highlighting a unit with most improved performance in falls reduction	100%	
	Minimize the use of Seclusion & Restraint in Regional Mental Health Care	Seclusion & Restraint (RMHC): The frequency of utilization of seclusion and restraints in regional mental health care	Q3 2011-12 data: Seclusion London 64.2 hours per 1000 patient days, St. Thomas 559 hours per 1,000 patient days; Restraint London 37.9 per 1,000 patient days, St. Thomas 7.1 hours per 1,000 patient days	25% reduction by Q4 2012-13	A new system for electronic documentation of seclusion and restraint hours was implemented in 2011-12. Data collected in Q3 is capturing all use of seclusion and restraint, including some categories which do not fall under the emergency use of seclusion.	2	Develop criteria for documentation of categories of seclusion and restraint	Further analysis of data to determine current state, including categories which do not fall under the emergency use of seclusion and restraint	1. In select patient populations, establish alternative options for seclusion and restraint 2. Develop targets for additional categories	
							Ensure implementation of best practice for all use of restraints and seclusion	Review of current practices against policies and best practice guidelines	Alignment of practice to best practice guidelines	
							The electronic process for documentation of seclusion and restraint hours requires further improvements	Monitor time for staff to document and error rate	Improved functionality and decrease error rate for documentation of seclusion and restraint hours, reduce time for audit and corrections	
Effectiveness	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 2011/12, OHRS	2.4	0	Balanced budget is a requirement	2	Implement efficiencies identified through the annual budget planning process	Monthly reporting, monitoring and analysis of financial results and variances from budget	Balanced budget	

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
Access	Reduce wait time from abnormal screening to surgical treatment for breast cancer	Breast Cancer Wait Time, Screening to Surgery Median wait time from an abnormal screening exam at St. Joseph's to surgery date for surgical cases classified as Oncology - Treatment, Priority Level 2, 3 or 4	16 weeks in Q3 2011	13 weeks	The volume of mammography procedures has increased by approximately 1,500 patients per quarter compared to the previous year. This has impacted the ability of St. Joseph's to achieve targeted improvements in wait times. Further improvements are expected in 2012-2013 and given volume increase this is considered a stretch target	1	1) Increased number of Radiologists from 1 to 2	Radiologist schedule	2 Radiologists present daily	
							2) Increased the number of Stero biopsy spots by 2 each week	Schedule changes	Additional Stereo biopsy appointments in schedule per week	
							3) Increased the number of breast assessment appointments from 20 to 35	Schedule changes	35 assessment appointments available daily	
							4) Hired additional ultrasound technologist	Recruit	Hired 1 technologist	
							5) Purchased an additional ultrasound unit and mammography unit.	Capital reassignment	Installed equipment	
							6) Conducted Value Stream Mapping process with London X-ray Associates for the referral of OBSP patients to St. Joseph's for Assessment	Complete Value Stream Mapping	Reduced time from screen to appointment given from 8 days to 2-3 days	
							7) Consolidate breast ultrasound and mammography into the Breast Care Centre	Develop new space	Achieve ideal space for patients and technologists to perform their work	
							8) Implement processes to assess data quality	Audits - establish regular audits of Provincial Wait Time Information System (WTIS) information to determine accuracy of classification, including priority level and reconciliation with Health Records	Improved accuracy from current state	
							9) Implement processes for follow-up and feedback.	a) Determine process for working with surgeons' offices and site chiefs related to compliance b) Ensure appropriate priority level procedure classification and Decision Affecting Readiness to Treat (DART) implementation.	Improved accuracy from current state	
							Reduce wait times for Rehabilitation	Rehabilitation Wait Times Percentage of patients admitted within wait time target	66%, 66%, 53% for the first 3 quarters of 2011-2012	75%
2) Undertake detailed review populations with specific diagnosis with best practice targets and readjust target population if necessary	Review completion of strokes, hip fractures, total knee, total hip, etc.	Meet or exceed wait time on special populations								
3) Monitor root causes of not meeting target	Monitor day of referral receipt, impact of expanded CCAC role, etc.	Root cause analysis and strategies to address								
Reduce Cancer Surgery 90th percentile wait time	Cancer Surgery Wait Time 90th percentile wait time for WTIS Oncology-Treatment cases. Priority 2, 3 and 4 cases.	79, 90 and 89 days for the first 3 quarters of 2011-2012	84 days	Current performance approaching expected provincial target of 84 days. Goal to reach 84 days in 2012-2013	2	1) Implement processes to assess data quality	Audits - establish regular audits of Provincial Wait Time Information System (WTIS) information to determine accuracy of classification, including priority level and reconciliation with Health Records	Improved accuracy from current state		
						2) Implement processes for follow-up and feedback.	a) Determine process for working with surgeons' offices and site chiefs related to compliance b) Ensure appropriate priority level procedure classification and Decision Affecting Readiness to Treat (DART) implementation.	Improved accuracy from current state		
Patient-Centred	NRC Picker / HCAPHS: "Would you recommend this hospital to your friends and family?" (add together percent of those who responded "Definitely Yes")					3				
	Inpatient Surgery	% would recommend organization	92.20%	>90%	Goal is to maintain above 90%					
	Day Surgery	% would recommend organization	92.00%	>90%	Goal is to maintain above 90%					
	Urgent Care	% would recommend organization	68.00%	5% above ave.	Goal is 5% or greater than the Ontario average of 60.5% in most recent reporting period					
	Rehabilitation	% would recommend organization	93.00%	>90%	Goal is to maintain above 90%					
	Mount Hope - Resident	% would recommend organization	69.80%	Currently being determined	Current results have just become available					
	Complex Care - Resident	% would recommend organization	81.00%	5% above ave.	Goal is 5% or greater than the Ontario average of 71.8% in most recent reporting period					
NRC Picker / HCAPHS: Rating of overall quality of care					3					
Inpatient Surgery	Overall quality of care (percent positive response)	98.40%	>90%	Goal is to maintain above 90%						

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
	Day Surgery	Overall quality of care (percent positive response)	100.00%	>90%	Goal is to maintain above 90%					
	Urgent Care	Overall quality of care (percent positive response)	87.90%	5% above ave.	Goal is 5% or greater than the Ontario average of 84.5% in most recent reporting period					
	Rehabilitation	Overall quality of care (percent positive response)	95.60%	>90%	Goal is to maintain above 90%					
	Mount Hope - Resident	Overall quality of care (percent positive response)	80.50%	Currently being determined	Current results have just become available					
	Complex Care - Resident	Overall quality of care (percent positive response)	91.80%	>90%	Goal is to maintain above 90%					
	RMHC	Overall quality of care (percent positive response)	58.60%	Currently being determined	Current performance is from Feb 2011 and an additional survey wave has just been completed					