

Excellent Care
For All.



2011-12

Quality Improvement Plan

(Short Form)

Red Lake Margaret Cochenour Memorial Hospital

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

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

The Quality Plan reflects the Mission, Vision and Values of the RLMCM Hospital. We strive to provide care that is safe and of excellent quality. We are diligent in our infection control practices as reflected in the data reported to the MOHLTC. The organization achieves its' goals by ensuring services and programs are delivered by highly skilled and competent professionals. Everyone with a health care need will receive the care required to restore health and prevent / minimize future health care concerns. Staff treat all patients, families and visitors with respect, compassion and dignity. Patients will recommend our community hospital as the best hospital to receive quality and safe care with a personal touch.

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

The Quality Improvement Plan will ensure that indicators are monitored and targets are met to enable the hospital to benchmark against other hospitals in terms of performance. Indicators are formulated to meet the quality areas of safety; effectiveness; access and patient-centered. Such indicators include monitoring for pressure ulcers in complex continuing care residents; readmission rates in acute care; ALC; wait times in ER for those patients to be admitted; and improvements in patient satisfaction.

The Hospital has signed on to participate in the Canadian Open Source Order Set project. The project is a unique physician decision support tool that allows collaboration and sharing of best practices with all hospitals on its network. This is particularly important in our setting where we have nursing staff and physicians with varied levels of experience and locum physicians practicing in the hospital during physician shortages. We are confident that utilizing these order sets will standardize our orders and ensure best practices at all times ultimately enhancing patient safety. This project will assist us to achieve improved patient experiences as physician orders will be comprehensive for the specific illness. We expect average length of stay for the patient to be reduced as care will be based on best practice. In addition, the order set project will help us to minimize ER wait times.

Quality of services will improve with the recent completion of programs to bring RPNs up to full scope of practice. Along with other Hospitals in our Region we are currently working on a tool for patient assignment. The patient tools will ensure that care is provided by the appropriate care provider and the assignment will be based on acuity of the patient not patient numbers. This will ensure that patients receive appropriate, quality and safe care provided at the right time by the right provider. This will help us achieve improved patient experiences and minimize ER wait times.

Our objective to maintain our current low C-difficile rates will be achieved through the services of our 0.5 FTE Infection Control Professional (ICP) who actively monitors infection rates and hand hygiene compliance. The ICP has a close working relationship with all hospital departments to ensure departments understand their role in reducing infections such as C-difficile.

To reduce pressure ulcers we have implemented best practices in the care of patients with pressure ulcers as well as those patients susceptible to pressure ulcers. Our staff has access to wound specialists through Ontario Telemedicine Network consultations. Two Registered Nurses on staff have specialized training and certification in wound care and foot care and act as a resource to physicians and nurses.

We have an active Fall Prevention Program in place. We have designated a Falls Champion who participates on a regional basis in Fall Prevention Education and programming. All patients are assessed at the onset of care for falls risk and pre-determined steps are implemented to mitigate the patient's risk.

To reduce Hospital Readmission Rates, Alternate Level of Care patients and ER wait times, the Hospital is working closely with the Family Health Team, CCAC, CCAS, Red Lake Diabetes Program and other community agencies to review statistics for readmissions and ensure there is a plan of care for the patient being discharged from Hospital. We are working to improve our discharge planning and coordinating with community support services to ensure seamless continuity of care for the patient, thereby reducing readmissions through the emergency department. We support the "Home First" philosophy, chronic disease management and aging at home strategies. Continuing our work with community agencies will ensure that patients with complex care requirements are managed in the community for as long as possible.

Our Hospital is participating in the NW LHIN integration planning. We are currently looking at opportunities to share resources and manage limitations imposed by current funding levels as well as lack of expertise in many areas such as back office; education and training; supply chain; benefits administration; technology and staffing. Moving forward with initiatives to share resources may lead to filling gaps with expertise required to maintain systems and delivery of quality care to patients and ultimately improve the organization's overall financial health.

The Hospital monitors financial indicators and reports to the Board of Directors on a monthly basis. The Hospital maintains a commitment to a balanced budget while continuing to provide safe and high quality care to patients.

3. How the plan aligns with the other planning processes

The RLMCM Hospital's Quality Plan is linked very closely with the Strategic plan developed in 2010. The Strategic Plan identifies actions to be taken to maintain and grow partnerships, develop our board and staff and plan for staffing shortages all leading to a focus on quality of care and patient safety. Indicators are being linked to the H-SAA and M-SAA.

Since safety and quality are inherent in all of the Hospital's activities and recognizing that the Hospital is acutely aware of the needs of the Community in terms of Health Care requirements, the Quality Plan is reviewed when Strategic Planning, preparing H-SAAs, preparing for Accreditation and growing linkages and partnerships with other agencies and stakeholders. Elements of the plan are extrapolated where appropriate to the other planning documents.

4. Challenges, risks and mitigation strategies

Our Hospital has experienced significant pressures in recruitment and retention of professional staff. However challenging, the Hospital has prepared contingency plans during these shortages to mitigate the effects of accessibility to care and ensure the delivery of safe patient care.

Our small, remote, northern community lacks a significant number of resources for supporting patients with chronic diseases in the community. Such limitations include non-existent supportive housing; limited and delayed CCAC services; lack of mental health services and lack of specialty services. These factors directly impact our readmission rates.

Another challenge in our very small community is that there are a minimal number of long term care beds, and coupled with the limited CCAC services, no supportive housing and only 12 acute care beds available in our facility, there is a very real potential to have all acute beds full with ALC patients and not be able to provide acute care services to our community.

Challenges are related to other factors such as our geographic remoteness. We rely on tertiary care centers in Winnipeg and Thunder Bay to transfer patients who require specialty diagnostics and care.

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.

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*

Manner in and extent to which compensation of our executives is tied to achievement of targets

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

CEO's performance compensation will be identified as 3% of the current base salary. The 3% performance compensation will be awarded based upon meeting the targets at the end of the year for the selected indicators. A pro-rated percentage of the performance compensation will be deducted from the final performance compensation at the end of each fiscal year end for each unmet target.

Similarly the CNO's performance compensation will be identified as 1% of the current base salary. The 1% performance compensation will be awarded based upon meeting the targets at the end of the year for the selected indicators. A pro-rated percentage of the performance compensation will be deducted from the final performance compensation at the end of each fiscal year end for each unmet target.


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:

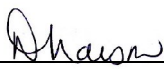
1. Was developed with consideration of data from the patient relations process, patient and employee/provider surveys, aggregated critical incident data, and patient safety indicators;
2. Contains annual performance improvement targets, and justification for these targets;
3. Describes the manner in 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.



Eleanor Vachon
Board Chair



Alana Procyk
Quality Committee Chair



Hal Fjeldsted
Chief Executive Officer