QUALITY COMMITTEE AGENDA

DATE:	Monday, February 9, 2015 @ 1200 hours
LOCATION:	10th floor Boardroom

AGENDA ITEM TYPE LEGEND: I = information, F = feedback, R = recommendation, D = decision * = attachment

Item	Topic	Page #	Type	Responsibility	Time in Minutes
	Main OR – meet inside OR doors on 2nd floor				1200 - 1220
1.	**Call to Order and Introduction**			T. Motz	1220 - 1225
2.	**Opening Prayer/ Reflection**			G. Ringwood	
3.	**Approval of Agenda and previous minutes** – November 10, 2014	5-10		T Motz	
4.	**Business Arising** 4.1 Follow-up/action items log*	11	F	T Motz	1225 - 1230
5.	**PRESENTATIONS AND REPORTS** 5.1 Patient Story		I/F	T. Willemsen	1230 - 1240
	5.2 Surgical Services, Operating Room*	12-19	I/F	T. Willemsen	1240 - 1255
6.	**NEW BUSINESS** 6.1 Accreditation Update		I/F	T. Quigley	1255 - 1305
	6.2 QIP*	20-34	I/F	T. Quigley	1305 - 1315
7.	**Reports Circulated for Review:** • Patient Safety and Quality Monitoring Minutes*	35-37	I/F	L. Chudleigh	1315 - 1320
	• Chief Nursing Executive Report*	38-39	I/F	B. Guidolin	1320 – 1325
8.	Discussion, Current Issues/Topics, Questions and Answers		F	All	
9.	**Evaluation/ Discussion: Effectiveness of this meeting***	40		T. Motz	1325 - 1335
10.	**In Camera Session**				
11.	**Adjournment**				1400

Next Meeting Date: **Monday, March 9, 2015 in the 10th Floor Boardroom**
Reflection: Ms. Lydia Chudleigh

QUALITY COMMITTEE
Attendance Sheet 2014-15

✓ = Present; R = Regrets

VOTING MEMBERS										
Name	September 2014	October 2014	November 2014	December 2014	January 2015	February 2015	March 2015	April 2015	May 2015	June 2015
Acting CNE, Boshart, Terry	√	R	-	-	-	-	-	-	-	-
Guidolin, Barbara	-	-	√	No Meeting	R					
Henhoeffer, Christine	√	R	√		√					
Hunter, Tom	R	R	R		R					
Motz, Tom (Chair)	√	√	√		√					
Nahrgang, Stan	√	√	√		√					
O'Sullivan, Terry (CR)	√	√	√		√					
Reinders, Dr. Frank	√	√	R		R					
Ringwood, Gloria (CR)	√	√	√		R					
Sharma, Dr. Ashok	√	√	√		√					
Smith, Scott	√	R	√		√					
Shilton, Don	R	√	√		√					
Way, Michele	√	√	√		√					
Number of voting members required present for quorum: 6										

RESOURCE MEMBERS										
Name	September 2014	October 2014	November 2014	December 2014	January 2015	February 2015	March 2015	April 2015	May 2015	June 2015
Chudleigh, Lydia	√	√	√	No Meeting	√					
Du, Gina	√	√	√		√					
Quigley, Tammy	√	√	√		√					
Niesen, Tamara	R	√	√		√					

Sept 2014

In the tradition of the Sisters of St. Joseph,
Leading our Community in Health Care.

Our Mission

- To continue the healing ministry of Christ consistent with our Catholic traditions and values

We Believe in:

- The sacredness of life and the dignity of all people

We are committed to:

- Heal, comfort, teach and promote health
- Care for the whole person -- body, mind and spirit
- Encourage independence and self-responsibility
- Serve those in need, especially the poor and vulnerable
- Be a responsible corporate citizen and neighbour
- Use our resources wisely
- Be excellent, innovative and compassionate in all we do
- Promote an organizational spirit by encouraging participation, responsibility, continued learning and mutual respect

VISION STATEMENT

St. Mary's will be the safest and most effective hospital in Canada characterized by innovation, compassion and respect.

STRATEGIC DIRECTIONS

QUALITY & SAFETY

We will eliminate preventable harm.

PATIENT AND FAMILY-CENTRED CARE

We will improve the patient experience.

OUR PEOPLE

We will eliminate staff injuries

FINANCIAL STEWARDSHIP

We will reduce the cost of quality healthcare.

Approved by the Board of Trustees, March 26, 2014

QUALITY COMMITTEE
Monday, January 12, 2015
Minutes

Present:	Mr. Tom Motz, Chair	Mr. Terry O'Sullivan	Mr. Scott Smith
	Ms. Christine Henhoeffer	Dr. Ashok Sharma	Ms. Michele Way
	Mr. Stan Nahrgang	Mr. Don Shilton	
Regrets:	Ms. Barb Guidolin	Dr. Frank Reinders	Ms. Gloria Ringwood
	Mr. Tom Hunter		
Resource:	Ms. Lydia Chudleigh	Ms. Tammy Quigley	Ms. Tamara Niesen
Guests:	Ms. Kathleen Demers	Ms. Cathy Hurley	

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1. Call to Order
The meeting was called to order at 1205 hours by the Chair.

2. Opening Prayer/ Reflection
Dr. Sharma provided the opening reflection/prayer.

3. Approval of Agenda and Previous Minutes
Moved by Stan Nahrgang, seconded by Christine Henhoeffer that the agenda and the minutes from the previous meeting dated November 10, 2014 be approved as circulated. Carried

4. Business Arising
4.1 Follow up/action items log
The action log was reviewed.

5. Presentations and Reports
5.1 Patient Story
Kathleen Demers, Clinical Manager, Emergency Department shared a patient story about an 84-year-old female patient with multiple visits to St. Mary's General Hospital through a three month period last winter. These visits included Pacemaker Clinic visits, Emergency Department visits, an inpatient stay as well as a trip to the Operating Room to have the battery pack of her pacemaker replaced. She had a medical history of significant lung disease and tachycardia/bradycardia syndrome with a pacemaker in place.

In January 2014 the patient visited the pacemaker clinic to have her pacemaker checked. Her assessment indicated that the pacemaker battery did not have to be changed yet but was getting close to elective replacement indicator or end of life. She was advised to monitor closely and was booked with a follow up appointment in four months. She was asymptomatic at the time.

In February 2014, she came to the Emergency Department with complaints of shortness of breath and ankle swelling. There was a question as to whether or not she also had a blood clot in her lung. She received intravenous medication to remove fluid from her lungs and body with good results. She was admitted under the Hospitalist with symptoms and x-ray findings consistent with congestive heart failure and had a two day length of stay as an inpatient.

The patient called the Pacemaker Clinic sometime between her discharge as an inpatient in February and her scheduled echocardiogram appointment in March 2014. She was told that her device could be checked at the time of this scheduled test.

The patient had an echocardiogram and Pacemaker Clinic visit in March 2014. The pacemaker was checked and it was found that the device had changed to "elective replacement indicator" or end of life on February 6th, 2014. The battery change could have occurred on the day of the clinic visit but at the patient's request it was deferred to a later date. On the next day, the patient returned to the Emergency department with complaints of shortness of breath. Testing was completed to rule out a blood clot and then she was taken to the operating room to have the battery pack of her pacemaker changed. She went to the Clinic shortly after she was discharged. At that time, she expressed anger and a loss of confidence in SMGH.

A Quality of Care review took place involving multiple departments and stakeholders, resulting in several recommendations below:

- Patients who are admitted with symptoms of congestive heart failure (CHF) and have a pacemaker need to have their device checked by the clinic.
- Patients who are admitted to the hospital and have an implanted cardiac defibrillator (ICD) need to have their device checked by the clinic.
- Implement an automatic trigger for any patient who presents to the Emergency Department and had a pacemaker/ICD that prints a notification to the Pacemaker Clinic.
- Have educational sessions with Cardiology and Emergency Department physicians to discuss device related issues.

5.2 Emergency Department

Ms. Demers provided a pre-recorded presentation which all members reviewed prior to the meeting. It can be found here: http://www.slideshare.net/SMGH2012/2014-15-board-quality-committee-january

Discussion:

- Directives regarding the Ebola virus are provided by the Ministry of Health and Long Term Care. It was wondered if there are any mechanisms in place to calculate the direct cost associated with these directives. Expenses are being charged to a specific cost centre so that costs related to Ebola can be tracked.
- Attendance at bi-monthly death reviews is rotated amongst the physicians and nurses. Recommendations developed from these reviews are acted on and incorporated into practice. Some are broader and require full department involvement while other recommendations are more for individual follow-up.
- Because of some of the recent staffing challenges, the complement of full-time staff has been increased as we are no longer in a position to accommodate the additional workload from the part-time pool.

- With regard to those patients recorded as left without being seen (LWBS), most leave because of the wait times, others come to the Emergency Department (ED) as a first recourse and while waiting their symptoms may improve or perhaps since presenting to the ED they have been able to gain an appointment with their family physician. This information is captured and patients are asked to sign off before they leave and asked to report the reason why. This data is correlated with the day of the week to see if there are any trends.
- As it pertains to the structure Lean Management System (LMS) training and how this is affecting the climate and ability to sustain improvements, staff are aware that lean is now our way of doing business. The ED started to take part in September and 2 resource nurses are very active in this and sharing what LMS is all about with those in the unit who have not taken part. It will still take some time before all staff understand, but in the long term, LMS will certainly help us sustain the gains made to date.
- In response to a question regarding the process for medication reconciliation upon admission, it was noted that the triage nurse will ask a patient what medications they are using and document the dosage and frequency. This may also involve contacting the pharmacy if a patient does not recall all the details.

6. New Business

6.1 Quality Improvement Plan (QIP)

The improvement targets and initiatives for the 2015-2016 QIP were circulated with meeting package. Ms. Quigley indicated that a special meeting of the Quality Committee has been scheduled for next Monday specifically to review the QIP in more depth. We have now been provided the templates for completing the 2015-16 QIP and there are really no changes to the core set of indicators. Since Health Quality Ontario (HQO) does not give us the uploaded data until mid-February, she has asked for the most recent data from our decision support people. A narrative report will be prepared to accompany the targets and initiatives as well as a progress report on this 2014-2015 QIP. A draft will be sent to the committee before the meeting and it was suggested it might be helpful for members to refresh their memory on last year's QIP by visiting the St. Mary's website.

The Senior Leadership Team has been discussing rolling over our current corporate operational goals to 2015-16 and will hence be part of the QIP. Targets have not yet been determined.

6.2 Legal Summary

It was added to this year's Quality Committee work plan that a summary of legal claims be brought to the committee twice a year as well as to the Resource Planning and Utilization Committee as both have responsibility with respect to claims that come to the hospital. The presentation slides that were provided with the agenda package were reviewed. In terms of files currently open, some do date back to as far as 2008/2009. Legal cases in hospitals can go very slowly and can be very frustrating and weigh on the shoulders of staff involved.

Ms. Quigley briefly reviewed the 2 new claims that have been received since the last report. The insurer's total loss reserve value for St. Mary's is very low compared to other hospitals. Our insurer Marsh is under contract with the St. Joseph's Health System which goes out to RFP every 3 years. Marsh does not provide comparative hospital data.

6.3 Q2 Performance and Quality Scorecard

Ms. Chudleigh provided a pre-recorded presentation which all members reviewed prior to the meeting. It can be found here: http://www.slideshare.net/SMGH2012/quality-committee-q2-201415-quality-and-performance-dec-2014

Operational Goals:

- The ED Length of stay rolling twelve month trend charts were appreciated as it shows more data aggregated over a longer period of time. Overall they indicate that we are progressing towards our targets.
- The operational goals align with the QIP. It was suggested that there be a financial stewardship goal. Also, it was requested that a goal related to achieving a certain number of improvement ideas implemented be established.

6.4 Accreditation

A briefing note on the upcoming accreditation on-site survey was distributed with the agenda package. The accreditation self-assessment surveys have been completed which assist us in taking stock of current practices versus the accreditation standards and Required Organizational Practices (ROPs). The 3 areas of focus that staff have been working on improving were listed in the briefing note. There are no concerns with this but provided for information.

Staff are beginning to undergo mock tracers to help them understand and give them a sense of comfort as to what is going to occur when the surveyors visit and the types of questions that may ask. It can be intimidating for those staff who have not experienced an accreditation survey. This is a collaborative process with the surveyors.

6.5 SJHS Quality Framework Self-Assessment & Quality Generative Discussion

Included in the package were results from the SJHS quality framework evaluation, an article regarding the Board's role in quality and patient safety, and 2 pages from the Governance Centre for Excellence 'Quality and Patient Safety Governance Toolkit'.

Articles:

- In considering the questions posed in the second article, it was felt that these could be answered positively for the St. Mary's Board. We also have addressed many of the points raised in the 1st article. Perhaps twice a year at the Board we should have a more focussed discussion on our fiduciary responsibility with respect to quality.
- We frequently hear that we are to aspire to the best performance, but what is the best performance? St. Mary's has begun conversations through our partnership with KPMG with a group that originated in the United Kingdom where they are collecting common data sets to identify what best practice looks like. So far there are no Canadian hospitals participating and we have requested more information on this.
- It might be helpful for Board members to see more of the hospital. This past year they were encouraged to attend a department huddle. Perhaps this activity might be beneficial for community representatives as well. Having more information is important to assist committee members to make decisions. Providing links to further educational documents for those interested would give members an opportunity to learn more. Three unit tours related to Quality Committee presentations have been added to the work plan.

SJHS Quality Framework:

- It is difficult for new committee members to complete such an evaluation in the first few months of their term.
- With regard to choosing patient stories, departments are given guidelines of what is useful and informative for this committee. The point of the story is to identify problems and how they might be resolved. It sets the tone for the meeting and reminds us of who we are serving. The patient story is also part of the Quality Committee report to the Board of Trustees.
- The intent is to complete this evaluation once a year. It was felt that this was carried out too early in the year for new members and that it should be done in January next year.

- Regarding question 3, this is for both customers and the organization. We do have data posted on our website and the live ED wait time clock. For external viewers, while there is an abundance of information it could be simplified somewhat.

7. Reports Circulated for Review:

7.1 Patient Safety and Quality Monitoring Minutes – September

The Patient Safety and Quality Monitoring minutes from November 5, 2014 were circulated with the agenda package. Processes have changed again with respect to Ebola and the extent that a patient would be handled at St. Mary's, i.e., the patient would be transferred to Hamilton much earlier in the process. A lot of training and set up has been done regarding personal protective equipment (PPE).

7.2 Chief Nursing Executive Report

The Chief Nursing Executive report was circulated with the agenda package. There were no questions or concerns raised.

8. Discussion, Current Issues/ Topics, Questions and Answers

None.

9. Evaluation/ Discussion: Effectiveness of this meeting

Assuming a former patient attended our meeting today, would this patient have felt that our discussion helped move us forward in providing higher quality, safe patient care (using the scale below):

1 – Not at all
2 – Somewhat no
3 – Somewhat yes
4 – Absolutely

The average score was 3.2. The comments made by committee members included:

- The passionate presentation about the work in the ED would have given a patient a lot of confidence that we are concerned about patient's issues and address them.
- As a committee we are discussing the QIP and reviewing legal cases as brought forward because we are concerned with patient care.
- From a patient perspective, they would likely think we already know if they have a pacemaker and this should be known by all departments. It would be good to have a system where we can access medications, maybe tied to health cards.
- It would have added value to the ED program presentation if one of the ED physicians was present with Ms. Demers.
- The ED patient satisfaction score on the most recent survey was impressive.

10. In Camera Session: None.

11. Adjournment

The meeting was adjourned at 1405 hours.

Moved by Terry O'Sullivan, seconded by Stan Nahrgang that the Quality Committee be adjourned. Carried

12. Next Meeting

The next meeting is scheduled for Monday, February 9, 2015 at 1200 hours in the 10th Floor Boardroom.

Mr. Tom Motz, Chair

Ms. Lydia Chudleigh, Resource

Ms. Susie Bell, Recorder

Quality Committee
Items for follow-up/action
February 2015

FOLLOW-UP/ACTION ITEM	MOST RESPONSIBLE	Date added to list	Target Date for Completion	Status
Patient Story Question following patient story – to promote strategic fiduciary or generative discussion?	Research article, check with Romeo Lydia	June 9/14	How does this affect us from a strategic and policy perspective October 2014	Outstanding
Engage patient and family in QIP development 2015-16	Tom Motz	June 9/14	Jan 2015	Outstanding

Board Quality Committee
Surgical Services, Operating Room
Tara Willemsen
February 4th, 2015

Presentation Agenda

- General program information
- Program scorecard
- 2013-14 Goals
- Initiatives from the improvement board
- 2014-15 Goals
- Best practices
- Quality Assurance
- New Procedures
- Challenges

General Information

Program Description

Scope of Services:

- Operating Room: 9 ORs including 2 CVORs
- Ambulatory Care: Minor Outpatient and Local Cystoscopy Procedures
- Perfusion Services
- Medical Device Reprocessing (MDR)

Client Group:

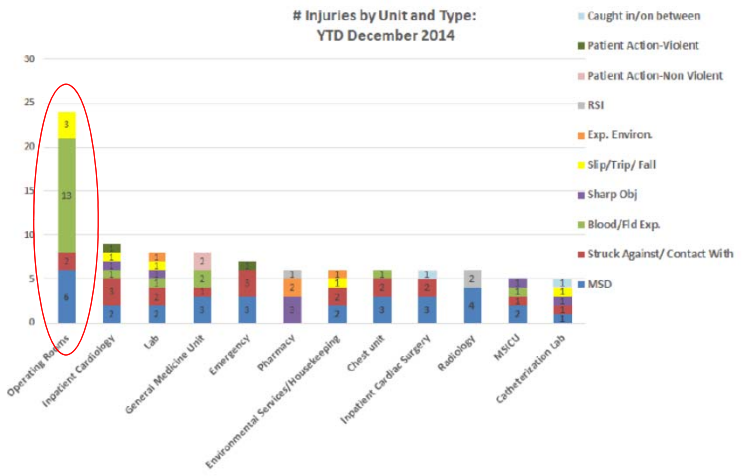
- Adults (typically over the age of 16)

Program/ Unit Scorecard

Strategic Theme	Driver or Watch	Indicator	Performance	April	May	June	July	August	September	October	November	December
Quality and Safety	Driver	# of Musculoskeletal Injuries	Monthly Value	1.00	1.00	1.00	2.00	1.00	2.00	0.00	1.00	0.00
			FY14 Baseline	0.92	0.92	0.92	0.92	0.92	0.92	0.92	0.92	0.92
			Annual Target	0.67	0.67	0.67	0.67	0.67	0.67	0.67	0.67	0.67
Our People	Driver	# of Blood born pathogen exposures by sharps	Monthly Value	1.00	2.00	1.00	2.00	2.00	1.00	1.00	0.00	1.00
			FY14 Baseline	0.67	0.67	0.67	0.67	0.67	0.67	0.67	0.67	0.67
			Annual Target	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50
Our People	Driver	# of Blood born pathogen exposures by splash	Monthly Value	0.00	0.00	0.00	0.00	0.00	0.00	1.00	0.00	0.00
			FY14 Baseline	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25
			Annual Target	0.17	0.17	0.17	0.17	0.17	0.17	0.17	0.17	0.17

Our People	Watch	# of Shifts not replaced (Staff Absenteeism)
Quality and Safety	Watch	# of Incomplete Pre-op Chart: Inpatient
Quality and Safety	Watch	# of times required surgical supply is NOT available at scheduled time

Program Data



2014/ 15 Goals

Goals	Status
Strategic Direction – Quality & Safety	
Goal 1 – To reduce the number of musculoskeletal injuries of OR Staff	Target of 8/ YTD 9
Strategic Direction – Our People	
Goal 2 – To reduce the number of blood exposure incidents by sharps of OR staff	Target of 8/ YTD 11
Strategic Direction – Our People	
Goal 3 – To reduce the number of blood exposure incidents by splash of OR staff	Target of 2/ YTD 1

Initiatives from the Improvement Board

- 42 lean improvements completed
- Implemented an "Alert" system
- 5 S: lead cart, storage areas, cardiac room set up, 4th floor PACU
- A3 on Standardized back table set-up

2015-16 Goals

Goal 1: Quality and Safety

Description: Reduce the number of OR Staff who endure a Musculoskeletal Injuries

- Target – 8
- Action Plan: Develop a culture of safety ie. Staff have courage to report injury

Goal 2: Our People/Quality and Safety

Description: Reduce the number of OR staff who have Blood exposures or incidents by sharps

- Target – 8
- Action Plan: Neutral Zone and Safety Blades

Goal 3: Our People/Quality and Safety

Description: Increase staff replacement for Absenteeism

- Target – 5
- Action Plan: New driver, A3 has just began

Best Practices

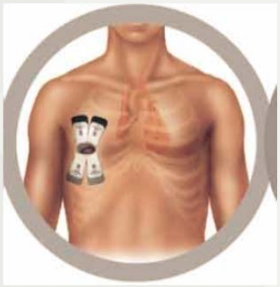
Double Gloving

- Scrubbed personnel should wear double gloves during invasive procedures. Wearing two pairs of gloves significantly reduces the number of perforations to the inner glove.
- Small pilot group (RNFA) trialed change in practice, expanded to all nursing staff
- 100 % compliance

New Procedures

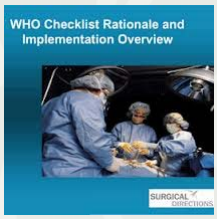
Surgical Advancement at SMGH:

- MICS – Minimally Invasive Cardiac Surgery
- Sutureless Aortic Valve replacement



Quality Assurance Practices

- SSCL - Surgical Safety Checklist
- Audit



Quality Outcomes

- Wait Time Information System (WTIS)
- Surgical Efficiency Target Program (SETP)
  - SSCL
  - 1st case start time

Challenges

- Supply Chain Management
  - Custom Pack Conversion
  - Backorders
  - Staff resources for scoring
- Change fatigue
- Obsolete or failing technology equipment
- Staff vacancies
  - Maternity Leaves
  - Lack of specialized staff

Reflections

- We have a dedicated team of staff and physician
- We are expanding services provided
- Continue to work with finance and the foundation on securing dollars for equipment replacement
- Continue to apply lean principals to our daily work
- Strive to make the OR a safer environment for patients and staff

THANK YOU

2015/16 Quality Improvement Plan for Ontario Hospitals
"Improvement Targets and Initiatives"

DRAFT February 3,2015

St. Mary's General Hospital 911 Queen's Boulevard

AIM		Measure							Change				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
Access	Reduce wait times in the ED	ED Wait times: 90th percentile ED length of stay for Admitted patients.	Hours / ED patients	CCO iPort Access / Jan 1, 2014 - Dec 31, 2014	699*	18.7 Jan 1, 2014 to Nov 30, 2014	8	Provincial Target	1) Reduce the LOS for Inpatients (not just Medicine). 2) Proactively develop contingency plans for peaks and slow downs (overall bed planning strategy). 3) Improve Flow to Inpatient Bed from ED. 4) Reduce time to PIA and PIA to Decision to Admit.	1a) Daily meetings with care team for all patients exceeding 5 days. 1b) Implement electronic patient tracking whiteboard (improved access and visibility to patient status for all disciplines - Medicine Pilot) 2a) Analyze historical inpatient trends - including occupancy by month, LOS by month etc. Develop plans for matching demand and capacity. 3a) Create hospitlal-wide flow coordinator. 3b) Create standard work and decision matrix for bed flow process to ease decision-making and decrease variation in practice. 4a) Improve ATA process (various changes - increased physician hours in ATA, revised schedule to match capacity and demand, change process for no waiting in waiting room - straight to treatment area and reduction in stretchers etc.) 4b) Improve consultant and diagnostic turnaround times.	1a) Percentage of patients exceeding 5 day LOS. 1b) On time delivery of project implementation. 1b) Utilization of system by staff and physicians. 2a) Decrease in ED LOS during known variable times (ie flu season, Christmas Holidays etc) 3a) Reduction in time from Bed empty to Patient in Bed. 3b) Reduction in time from Bed empty to Patient in Bed. 4a) Reduction of PIA time for all patients. 4a) Reduction of PIA time for ATA patients. 4b) Reduction in Triage to Orders initiated. 4b) Reduction in turnaround times for U/S, CT and Lab. 4b) Reduction in Consult Requested to Consult Seen times.	1a) 75% of Medicine inpatients have LOS <= 5 days 1b) Project implemented on time. 1b) 100% of staff and physicians using electronic patient status board. 2a) Monthly variation in ED LOS will not exceed 4 hours. 3a) 90th Percentil Bed empty to Patient in bed <30M. 3b) 90th Percentil Bed empty to Patient in bed <30M. 4a) 90th Percentile PIA for all patients <3 hours. 4a) 90th Percentile PIA for ATA patients <2 hours. 4b) 90 percent of orders initiated within 60M of triage. 4b) 90 percent of patients receiving U/S or CT will have results within 3 hours of order. 4b) 90th Percentile Consult Requested to Consult Seen < 1.5 hours	4b) Data is via the DART as opposed to coded.
Effectiveness	Improve organizational financial health	Total Margin (consolidated): % 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.	% / N/a	OHRS, MOH / Q3 FY 2014/15 (cumulative from April 1, 2014 to December 31, 2014)	699*	-1.34% Apr14-Sep14	1.00%	Internal target	HSFR committee will investigate areas of opportunity to improve efficiency and productivity in the Inpatient and ED HBAM areas along with optimizing our QBPs				
Integrated	Reduce unnecessary time spent in acute care	Percentage ALC days: Total number of acute inpatient days designated as ALC, divided by the total number of acute inpatient days. *100	% / All acute patients	Ministry of Health Portal / Oct 1, 2013 - Sept 30, 2014	699*	14.66% Oct13-Sep14	9.50%	Provincial Target					
	Reduce unnecessary hospital readmission	Readmission within 30 days for Selected Case Mix Groups	% / All acute patients	DAD, CIHI / July 1, 2013 - Jun 30, 2014	699*	9.7% July 1, 2013 to June 30, 2014	14.00%	Provincial Target	**Performing well, no need to have improvement initiatives**				
Patient-centred	Improve patient satisfaction	From NRC Canada: "Would you recommend this hospital (inpatient care) to your friends and family?" (add together % of those who responded "Definitely Yes" or "Yes, definitely").	% / All patients	NRC Picker / October 2013 - September 2014	699*	86.17%	81.80%	HQO Benchmark					
		From NRC Canada: "Overall, how would you rate the care and services you received at the hospital (inpatient care)?" (add together % of those who responded "Excellent, Very Good and Good").	% / All patients	NRC Picker / October 2013 - September 2014	699*	96.49%	96.40%	HQO Benchmark					
		From NRC Canada: Would you recommend this ED to your friends and family?" (add together % of those who responded "Definitely Yes" or "Yes, definitely")	% / ED patients	NRC Picker / October 2013 - September 2014	699*	67.69%	70.60%	HQO Benchmark					
		From NRC Canada: "Overall, how would you rate the care and services you received at the ED?" (add together % of those who responded "Excellent, Very Good	% / ED patients	NRC Picker / October 2013 - September 2014	699*	89.67%	91.80%	HQO Benchmark					

AIM		Measure							Change				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
Safety	**Increase proportion of patients receiving medication reconciliation upon admission**	Medication reconciliation at admission: The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital.	% / All patients	Hospital collected data / most recent quarter available	699*	93%	90%	Internal Benchmark					Focus this year will be on medication reconciliation upon transfer to LTC/Rehab and for Ambulatory Care visits
	Reduce hospital acquired infection rates	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. 2014, consistent with HQO's Patient Safety public reporting website.	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / Jan 1, 2014 - Dec 31, 2014	699*	0.238	0.23	HQO Benchmark	1. Improve Hand Hygiene compliance 2. Antibiotic stewardship Interventions 3. Staff education 4. Monitor Cleaning Standards	1. Multifaceted hand hygiene campaign 2. Continue to audit antibiotic use in the hospital and provide consultation and feedback to prescribers 3. Provide education on infection control core competencies 4. Verification of audit scores; Visual audits; Policy	1. Hand Hygiene Audit results 2. Defined daily dose of antimicrobial therapy 3. Audit compliance with policies; evaluation/feedback from staff 4. Cleaning Audit compliance	1. > 85% performance on Hand Hygiene audits for moments #1 and #4 2. Decrease in use of antibiotics and effective/appropriate use of antibiotics 3. > 60% Uptake 4. Audit compliance >85% at 48 hours	
	Reduce hospital acquired infection rates	Incidence of MRSA colonization and infection rate. Number of patients newly identified as having hospital acquired MRSA	Number of cases	Hospital data	699	approx 60 cases anticipated by March 31st 2015	<48 (20% reduction from 2014-15)	Internal target	1. Improve hand hygiene compliance 2. Implementation of pre emptive isolation across the facility 3. staff education 4. Implement PCR based technology for contacts 5. Improve cleaning standards	1. Multifaceted hand hygiene campaign 2. Staff Inservicing 3. Provide education on infection control core competencies 4. Use PCR for all MRSA contacts on Day 3 following exposure 5. Verification of audit scores; visual audit; policy	1. Hand Hygiene Audit results 2. Surveillance of patient admissions 3. Audit compliance with polcies; evaluation/feedback from staff 4. Tracking; HAI MRSA Stats 5. Cleaning audit compliance	1. > 85% performance on Hand Hygiene audits for moments #1 and #4 2. Reduced number of contacts 3. > 60% Uptake 4. >90% of contacts screened using eswab with PCR 5. Cleaning audit compliance >85% at 48hrs	
	Avoid Patient falls	Reduce patient falls	Counts / All acute patients	Hospital collected data / 2014/15	699*	On Target for greater than 25% reduction in Falls	>25% reduction (256 to 192 or less). Current Target. 2015/16 target not	Internal target	1. Implement "Serial Faller" initiative 2. FRAT Tool Pilot and roll out 3. Roll out program to all hospital units	A3 development, Unit ownership of Targets and Initiatives, Fanatical Senior Team Sponsor oversight,	Complete devotion to auditing all initiatives, immediate Root Cause Analysis of all Falls, immediate Senior Team Sponsor notification of Falls, Monthly Status updates and Process Analysis with Directors, Weekly Senior Team Sponsor attendence at all Unit Huddles	To develop appropriate targets for 2015/16, to solidify gains, to inculcate a durable change in culture such that no fall is acceptable, to develop new approaches and initiatives to reduce the incidents of falls even further throughout the entire organization.	We will be relentless in achieving our targets.
	Reduce staff injuries	Staff injuries at work	Counts / N/a	Hospital collected data / 2014/15	699*	141 (Dec 2013 - Nov 2014)	25% reduction (from 2014/15 baseline)	Internal target	1. Broaden scope of departments that are focusing on staff injury reductions. 2. Build stronger culture of staff safety. 3. Continue focus on injury reduction in Operating Rooms. 4. Improve tools and knowledge for repositioning and transferring patients.	1. Prioritize staff injury reduction as a driver metric if unit has the Lean Management System (LMS) in place. Prioritize as a goal for other relevant units that do not have LMS in place. 2. Develop process for injury incident review/analysis, mitigation and sustainability that builds accountablity. 3. Initiatives specific to Blood/fluid exposure and MSD injuries (i.e.safety blades, PPE, Neutral Zone) 4. Improved standard work/visual guidelines and training for repositioning and lifting patients. New lifting/repositioning tools where relevant/required.	1. Minimum of 5 units with staff injury reduction as driver metric. 2. Time to investigation & Time to resolution/mitigation 3. # of Blood Fluid Exposures; # of MSD injuries 4. # Patient handling MSD's	1. ≥5 units with staff injury as driver metric. 2. To be determined 3. To be determined 4. To be determined	

Let's Make Healthy Change Happen.

Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

Draft #4 February 2, 2015

St. Mary's GENERAL HOSPITAL

12/8/2014

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a Quality Improvement Plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein.

Overview

Make reference to:
• The overall objectives of your QIP for the following year; and
• How your QIP aligns with other planning processes in your organization, including the strategic plan, operational plan, Service Accountability Agreements, accreditation requirements, and other contractual/accountability requirements

2014/15 was an exciting, challenging and rewarding year for St. Mary's General Hospital. There are many things for us to be proud of as an organization as we continue to work towards our vision "to be the safest and most effective hospital in Canada characterized by innovation, compassion and respect." Staff, physicians and volunteers continue to work very hard and remain dedicated to providing our patients with the safest and highest quality care possible. Some achievements over the past year at St. Mary's I'd like to highlight are:

- For a second year in a row, we achieved some of the top scores in Ontario for patient satisfaction.
- [add in Accreditation results once received]
- St. Mary's announced and rolled out a pilot project for large scale remote monitoring for pacemaker patients. St. Mary's is the first hospital in Ontario to broadly offer pacemaker patients remote monitoring as an option, allowing many patients to visit a setting closer to home where the remote monitoring equipment will be located rather than coming into the hospital for regular check-ups.
- The addition of new, specially trained security guards throughout the hospital to help keep staff and patients safe.
- The launch of a pilot clinic for medically complex geriatric patients, a first of its kind in the Waterloo-Wellington region, designed specifically for geriatric medically complex patients in need of geriatric medicine consultation with the support of an interdisciplinary team in a clinical setting.
- The celebration of our 90th anniversary, and 10 years of Thoracic and Respiratory excellence.
- We were featured as a National leader in Lean health care on CBC's White Coat, Black Art radio show, hosted by Dr. Brian Goldman which aired across Canada.
- Our expanded visiting hours to further encourage families to be involved in the care of their loved ones.
- We won a prestigious Canadian technology award for our real-time ED wait time clock website.
- We were recognized as a top employer in Waterloo Region and Guelph.
- St. Mary's General Hospital Foundation continued to support the hospital in incredible ways, including $5.7 million raised for a new cardiac catheterization camera, new CT and much more.
- We have developed a human capital strategy that uses our LEGACY system to develop our people. Our Board has charged us with developing succession planning and leadership development. We are in the midst of this exercise and it is a strategic project that will include physicians as well as staff.

- We have developed a number of tools for our managers: budget, capital, recruiting, incident reporting, and decision support and human resources portals.
- Patient services and corporate services have joined to create a quarterly report for management and the board that is integrated and addresses risks and opportunities by program and department.
- We reduced patient falls by [over 25%], significantly improving the safety of our patients

We continued the evolution of our Lean Management System as we rolled it out to fourteen clinical and support units and departments. We began the fourth wave in early 2015, and we look forward to continuing these efforts hospital wide.

Financially, we balanced our budget in 2013/14 thanks to the efforts of many to identify and eliminate waste. We continue to perform well financially, and anticipate that we will finish 2014/15 balanced.

These successes and many others were possible because of the commitment by staff, volunteers, physicians the Board and the community, all in support of St. Mary's providing the best patient care and experience possible through innovation, compassion and respect.

St. Mary's Board of Trustees has agreed on four initiatives as part of our new Strategic Plan between 2014 and 2016/17, which support:

- Developing strategic plans for the Cardiac and Chest programs
- Developing a culture of problem solvers
- Facilitating integration across the WWLHIN
- Investigating and developing IT strategy

The hospital's Senior Team and the Board will continue with the overall strategic planning and work towards an action plan for each of the above in early 2015 and begin working towards these plans immediately.

Major initiatives for St. Mary's into 2015/16 include:

- Continued progression of our Lean Management System and further roll out to all units and departments hospital wide, including clinical and support services.
- Communicating and implementing our new three year strategic plan with staff, physicians and volunteers hospital wide, patients, and the community at large.
- Continued development of our arrhythmia centre which will require MOHLTC, LHIN and Cardiac Care Network support to have Electrophysiology Studies and Ablations added to our heart rhythm services. This will also involve a capital project that will require support by the funding and operating agencies and additional support from our Foundation to raise our share of the capital including specialized equipment

This Quality Improvement Plan (QIP) for 2015/16 links with other planning initiatives within and external to St. Mary's. Some examples of documents that are linked with this plan include our three year strategic plan (2014-2017), Accreditation Canada Required Organization Practices and standards, and St. Mary's annual operational goals which are aligned with the Ministry, and WWLHIN's plans and priorities. Many of the initiatives that are part of the QIP involve working with external partners such as the Waterloo Wellington Community Access Centre, community support agencies, and hospitals within and outside of the WWLHIN.

		Operational Goals	Operational Targets April 1, 2015 – March 31, 2016
VISION ***St. Mary's will be the safest and most effective hospital in Canada characterized by innovation, compassion and respect.*** **MISSION** ***To continue the healing ministry of Christ consistent with our Catholic traditions and values.***	1	**QUALITY & SAFETY** *We will eliminate preventable harm.*	• Patient falls will be reduced by at least TBD% by March 31, 2016.
	2	**PATIENT AND FAMILY-CENTRED CARE** *We will improve the patient experience.*	• The ED length of stay for at least 90% of admitted patients will be ≤ TBD hours by March 31, 2016 as we work towards our overall target of ≤ 8 hours.
	3	**OUR PEOPLE** *We will eliminate staff injuries.*	• Staff injuries will be reduced by at least TBD% by Mar 31, 2016.
	4	**FINANCIAL STEWARDSHIP** *We will reduce the cost of quality healthcare.*	• *Financial target still being developed*

Integration & Continuity of Care

St. Mary's recognizes that for patients, we are only one part of the care they receive and it is therefore critical that we partner with primary care providers, the CCAC, community support agencies and other health care organizations. We know that achieving our QIP goal of reduced length of stay for admitted patients requires partnerships and collaboration with the entire circle of care for each patient. [Kim/Cathy – examples of upcoming collaboration projects?]

Challenges, Risks & Mitigation Strategies

St. Mary's faces many of the same challenges as other Ontario hospitals in ensuring achievement of its QIP targets.

The corporate risks that are relevant to St. Mary's achieving the objectives in this QIP include:

Risk	Mitigation Strategy
• With changing standards, an increase in the number of patients who have to be isolated for infection prevention & control purposes	• Sustained focus on reducing infections, adherence to cleaning protocols, antibiotic stewardship program, hand hygiene, use of lab screening tests with faster turnaround time for results.
• Funding gaps	• Continue to manage within available resources/budget. Maximize performance for Quality Based Procedures and for funded procedures. Continue to remove "non-value add" activity and/or waste from processes/systems.
• Inpatient areas of our 1960s building lack space leading to overcrowding of patients, lack of private rooms and thus compromising infection prevention and control and accessibility	• Master planning process is almost complete which will develop a plan for future physical space that is more appropriate for patient care and infection prevention • Our coping plan supports the master plan for the facility and will ensure that we continue to provide the services in our facility that are required until such a time that our master facility plan is approved. • Sustain current infection control practices in place (see above)
• Availability of Long Term Care and community resources	• Continue Home First Philosophy • Continue to work closely with Community Care Access Centre • Continue to expand Integrated Comprehensive Care program
• Aging staff & staff shortages	• Strengthening workplace wellness and return to work programs • Recruitment of new graduates and support for student placements

Information Management

Describe how your organization is using its information management systems (e.g., Electronic Medical Records) to better understand the needs of your patient/client/resident populations and how data is used to inform quality improvements, target setting and to improve quality of care.

St. Mary's uses an integrated health information management system and the vast majority of patient documentation is completed electronically. In 2014, St Mary's partnered with Grand River Hospital to host and deliver integrated online electrocardiogram (ECG/EKG) and echocardiogram (ECHO) tests across both hospitals that allows for greater access to patient information, reduced error rates, and better data analysis. In 2015, St Mary's and other local hospitals will begin to implement joint plans to establish a common hospital information system. The ability to extract data from our online systems allows us to identify areas for opportunity and to measure progress on our quality goals. Our Board of Trustees receives detailed reports on key benchmarks throughout the year.

Engagement of Clinicians & Leadership

Expand on how your organization is engaging with its clinical staff and broader leadership in establishing shared quality improvement goals and commitments for the organization

As part of our annual operational planning process extensive consultation and engagement is undertaken with clinical staff (nurses, therapists, pharmacists, physicians, etc.). The entire management team, Board of Trustees, and Board Quality Committee provide input into the annual goals and the subsequent process measures used to achieve these goals. The Board Quality Committee holds a special meeting each January outside of its regularly scheduled meetings to specifically develop the annual Quality Improvement Plan.

Patient/ Resident/ Client Engagement

Describe how your organization engages with patients/residents/clients and their caregivers and the way in which these engagement activities inform the development of your QIP.

St. Mary's places tremendous value on the voice of our patients in all decision making. Through the use of patient experience surveying, leadership rounds with patients and families, and involvement of patients in the quality of care review process, we ensure that as we develop our QIP we know what is important to patients and their families. Additionally, this year marked the first "QIP Patient Focus Group" meeting, where patients and families were invited to provide direct input into our plan. [Revise after patient focus group feedback]

Accountability Management

Describe how organizational leadership will be held accountable for achieving the targets set out in your QIP.

St. Mary's QIP is aligned with its annual operating plan and goals, for which the senior team is held accountable by the Board of Trustees. Progress on each goal is reported weekly at meetings of the senior team and monthly at each Board meeting. Compensation as well as performance ratings of each senior team member is based on the achievement of the operational and QIP goals.

Performance Based Compensation [As part of Accountability Management]

ECFAA requires that the compensation of the CEO and executives reporting to the CEO be linked to the achievement of performance improvement targets laid out in your QIP. The purpose of performance based compensation related to ECFAA is to drive accountability for the delivery of QIPs, enhance transparency and motivate executives.

ECFAA mandates that hospital QIPs must include information about the manner in and extent to which executive compensation is linked to achievement of QIP targets.

Ensure the following information is included:
•For each executive, the percentage of salary that is linked to the achievement of QIP targets
•The specific QIP targets to which executive compensation is linked and justification/rationale for the selection of each
•A clear and comprehensive description of the way executive compensation and performance on QIP targets are linked, including the terms that are used to determine payout
For more information on how to complete the performance based compensation section of your QIP, including best practice examples of what information to include, refer to the Ministry of Health and Long-Term Cares website:MOHLTC website

Health System Funding Reform (HSFR)

Describe how your organization is incorporating HSFR into your larger quality processes, including the QIP. Consider some of the changes and processes the organization is undertaking to adopt the HSFR funding policy, how you are working with the LHIN(s) for service capacity planning and the role of organizational processes to drive and sustain change in the organization.

St. Mary's has been actively communicating with our staff and physicians about the new way that hospitals will be funded. More information about HSFR can be found here. As a 'case costing' hospital (we track the costs directly incurred by each patient visit), we are able to track both the cost and outcomes for patients that visit St. Mary's. As the Quality Based Procedure (QBP) Clinical Handbooks are released there is a clear structure of accountability to review and focus on any required practice changes to ensure quality through best practices. This structure and clinical accountability in partnership with decision support and finance helps us to understand the value we provide and to identify areas where we can do better both from a quality and a cost perspective. St. Mary's continues to support clinical and technical advancement of the QBPS in cardiac and respiratory areas by participation with data sharing and clinical handbook development. We have developed a structure that will mirror the funding methods and marry quality outcomes with appropriate costs.

Other

Space for additional information not covered by the headings above.

Sign-off

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan

Board Chair Click here to enter text.
Quality Committee Chair
Chief Executive Officer Click here to enter text.
CEO/Executive Director/Admin. Lead _____ (signature)
Other leadership as appropriate _____ (signature)

Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2014/15 QIP

The Progress Report is a tool that will help organizations make linkages between change ideas and improvement, and gain insight into how their change ideas might be refined in the future. The new Progress Report is mostly automated, so very little data entry is required, freeing up time for reflection and quality improvement activities.

Health Quality Ontario (HQO) will use the updated Progress Reports to share effective change initiatives, spread successful change ideas, and inform robust curriculum for future educational sessions.

ID	Measure/Indicator from 2014/2015	Current Performance as stated on QIP14/15	Target as stated on QIP 14/15	Current Performance 2015	Comments
1	ED Wait times: 90th percentile ED length of stay for Admitted patients. Hours ED patients Q4 2012/13 – Q3 2013/14 CCO iPort Access	21.13	8.00	17.8 (Q2 2014-15)	

Realizing that the QIP is a living document and the change ideas may fluctuate as you test and implement throughout the year, we want you to reflect on which change ideas had an impact and which ones you were able to adopt, adapt or abandon. This learning will help build capacity across the province.

Change Ideas from Last Year's QIP (QIP 2014/15)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Standardize/Improve Discharge Planning for Medical Unit.	Yes	Began in Feb. 2014 with a standardized discharge planning process focused on the multiple disciplines involved in patient care. Emergency Department (ED) length of stay (LOS) for admitted patients has dropped significantly since this was launched, as well as the average LOS on Medicine. It was important to involve EACH discipline individually as the customer - what do you need to send patients home? Standards were created around these needs which expedited discharge. Visual display of patient status ensured that all involved in care were aware of discharge status (e.g. patient status by discipline

		- obvious what discipline needs to be complete before d/c can happen).
Analyze and improve demand versus capacity on medical unit	Yes	Analysis showed that there was a sharp increase in d/c on Friday and a sharp decrease in d/c Sat/Sun. Discharged through the week remained steady. Changed process of bed closures on surgical floor - stopped closing these beds on weekends and transformed these beds into an ED Express unit. Strong use of data provided evidence to support this decision that anecdotally staff felt would provide improvement.
Transfer improvement process to other inpatient units	No	Recognized that each unit requires its own PI process around d/c planning and that we can't just take what works on one unit and transfer it to another. The process of spending time with the individual unit and understanding the needs of each discipline is what led to the success on the medicine unit - this same approach should be taken with other units.
Set new target for time to inpatient bed post bed assignment < 30 minutes	No	Did not complete this step.
Early initiation of medical directives in the Emergency Department (ED)	Yes	Was completed. Created a new shift in ED - "M" nurse whose priority is to perform medical directives on patients in the waiting room. Previous audits showed that medical directive were delayed in implementation (and were implemented close to the time the physician ended up seeing the patient). Now, the majority of patients eligible for a medical directive, will have them initiated within 1 hour of triage. ED LOS has dropped for all ED patients and subcategories. Orders to lab, DI for example, are happening much earlier in the patient's visit. Challenges - didn't have a good way to capture timing from medical directive identified to when the directive was actually initiated. This took 6 months working with decision support to capture this data correctly.
Further develop Ambulatory Treatment Area in the Emergency Department	Yes	Feb 2014 - ATA was launched as a concept without changing physician shifts/process. There was some initial improvement (Triage to in room times dropped over an hour and pt volume in this area increased from 25% to 50%). In Nov. 2014 we began staffing this area with dedicated ED physician support for 6 hours per day. This has resulted in PIA time dropping by more than 1 hour for all ED patients. As of Dec. 15th another 2 hours

		of physician support time will be added. This has been a key achievement in the ED. Challenges include physical space for nursing which has led to decreased nursing satisfaction with these changes.
Emergency Department Physician at Triage to improve time seen and onset of treatment	No	Modified to Physician at ATA (see above. Was trialed in triage, however determined that much greater impact in ATA.
Physician Practice Profiles Implemented	Yes	Physicians are provided semi-annually with an individualized practice profile which shows 25 indicators (e.g. number of CTs ordered per one hundred patients, number of patients seen per shift by CTAS level, productivity). Emphasis on decreasing variation in practice. Has been well received by physicians - share information with each other - e.g. pair new doc with more experienced doc to decrease number of CTs ordered. Key to the success of this is strong Physician leadership in the ED.

ID	Measure/Indicator from 2014/2015	Current Performance as stated on QIP14/15	Target as stated on QIP 14/15	Current Performance 2015	Comments
9	Number of injuries All employees	129.00	97.00	115 (April - December 2014)	Holding gains from previous year. Will be continuing to work on this in 2015-16.

Realizing that the QIP is a living document and the change ideas may fluctuate as you test and implement throughout the year, we want you to reflect on which change ideas had an impact and which ones you were able to adopt, adapt or abandon. This learning will help build capacity across the province.

Change Ideas from Last Year's QIP (QIP 2014/15)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Reduce MSD injuries	Yes	Installation of patient lifts is complete. Education and training with staff and managers has been completed. Development of standard work and guidelines for patient repositioning in progress. Need to spread to other inpatient units through remainder of 2014/15 and 2015/16. Development of standard work and guidelines for lifting patient from floor will take place with ED before year end. New patient transfer tools have been sourced/provided to OR and Diagnostic Imaging. Bariatric protocol to be addressed in 2015/16. Safe patient transfer criteria and standard work has been developed and implemented for Ophthalmology patients. A variety of changes are currently taking place to reduce repetitive strain injury for ultrasound staff (scheduling changes, maximum number of scans per technologist per shift, ergonomic scanning chair).
Reduce blood exposure injuries in OR and CVOR	Yes	Neutral zone standards by type of surgical procedure currently being developed. First area of focus is CVOR. Safety blades currently on trial. Double glove and eye/face protection (PPE) expectations have been established (auditing of compliance with policies to take place in January 2015). Leg lift devices for CVOR preparation being tested.
Reduce other injuries	Partial	New staff injury reporting system has been implemented. Process of response to notifications to be developed and implemented to support robust review of incidents, root cause analysis, and culture of staff safety.

ID	Measure/Indicator from 2014/2015	Current Performance as stated on QIP14/15	Target as stated on QIP 14/15	Current Performance 2015	Comments
10	All patient falls	256.00	192.00	140.00 (Apr- Nov 2014)	Likely will meet target

Realizing that the QIP is a living document and the change ideas may fluctuate as you test and implement throughout the year, we want you to reflect on which change ideas had an impact and which ones you were able to adopt, adapt or abandon. This learning will help build capacity across the province.

Change Ideas from Last Year's QIP (QIP 2014/15)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Root causes for patient falls to be determined for all units. Units mostly impacted are General Medicine, Chest, Cardiac Surgery, Elder Care, Cardiology	Yes	Units are reviewing all falls and determining root cause on a case by case basis. Timely root cause analysis has to be completed in depth with input from staff involved in care.
PEEP Rounding, night time tuck in procedure, improved motion sensor lighting in bathrooms, visual signals to alert staff about patients at risk of falling, more frequent falls risk assessments.	Yes	Different units have chosen different strategies (identified in the change ideas section) based on root cause analysis/review. Successful strategies are now being adopted in more than one unit (night time tuck in and PEEP rounding). It is very important to engage staff in an audit process to measure the implementation of change initiatives.
Other new initiatives since last year's QIP 1) Auditing of all initiatives on all units 2) Review of all preliminary Root Cause Analyses within 24 hours of the event 3) Sponsor attending Huddle on all identified units weekly 4) Monthly Report-out and analysis with Managers/Directors 5) Quarterly Review of all initiatives and challenging cases attended by all Managers, Directors, Lean Coaches and Executive Sponsor 6) Monthly Report to the Hospital Board		

PATIENT SAFETY AND QUALITY MONITORING COMMITTEE

Wednesday, January 7, 2015
0730 – 0900 hours
10th Floor Boardroom

MINUTES

Ms. L. Chudleigh, Co-Chair	P		Dr. E. Hentschel	P		Mr. D. Shilton	P	
Dr. A. Sharma, Co-Chair		R	Ms. C. Hurley	P		Ms. K. Siegel		R
Mr. T. Boshart		R	Dr. B. Kelly		R	Ms. V. Sills	P	
Dr. D. Divaris		R	Dr. B. Kalirai	P		Mr. M. Terlevic		R
Mr. V. D'Mello		R	Dr. B. McNamara		R	Dr. R. Wickett		R
Dr. R. Dubeau	P		Dr. M. Nikoo		R	Ms. G. Zinken		R
Dr. B. Egerdie		R	Ms. T. Quigley	P		Dr. W. Ciccotelli (ad hoc)		R
Dr. B. Fielder	P		Dr. M. Pearce		R			
Guest: Ms. K. Demers								

1. CALL TO ORDER/APPROVAL OF AGENDA

Ms. L. Chudleigh called the meeting to order at 7:35 a.m.

2. REFLECTION

Dr. B. Fielder provided a reflection regarding a patient incident to begin the meeting.

3. APPROVAL OF MINUTES OF PREVIOUS MEETING:

The minutes of the meeting held November 5, 2014 distributed with the agenda package were approved as presented.

4. BUSINESS ARISING

4.1. Drug Shortage

Ms. V. Sills spoke to the current drug shortage issues:

- Intravenous Penicillin G – usual strength is back ordered, our current supply is okay. Information has been provided to all healthcare workers. Watching closely to keep supply intact.
- Cefazolin - backordered – pharmacy takes longer to make compound.
- Amiordarone 18 ml – backordered, nurses need to use 6 vials to compound rather than one. Need to watch to ensure no medication errors are as a result.
- TamiFlu – had to use stockpile against contract – backorder waiting to see if it will arrive. There may be potential with lack of supply of Tamiflu for hospitals.
- TNK – this is still on special access. No issues have arisen at this time.

4.2. Ebola

Ms. Chudleigh shared that the hospital continues to be prepared for potential Ebola patients. All policies and procedures are up to date and training is going well throughout the hospital. The frequency of updates from the MOHLTC has decreased and we expect fewer changes in the upcoming weeks.

5. REPORTS/DISCUSSION

5.1. Emergency Program

Ms. Kathleen Demers, Program Manager of the Emergency Department, provided an overview of the department that articulated the program goals, priorities, achievements, anticipated challenges, quality assurance and best practices. Please refer to the presentation which was pre-circulated in the agenda package.

Discussion:

- Emergency Departments are scrutinized across the province based on performance. The province collects the data which is posted on a monthly basis. This provides hospitals the opportunity to compare with each other, and also provides the opportunity to speak to other hospitals to see what is working well for them and get new ideas.
- Targets are fine, but safety needs to be recognized to ensure quality is maintained with our patients. It was noted that while measures and targets are important, we should always ensure that we are doing things in the best interest of patients.

6. NEW BUSINESS

6.1. Patient Feedback report

Ms. Tammy Quigley provided an overview of the Patient Feedback Report. Please refer to the presentation which was pre-circulated in the agenda package.

Highlights:

- Oculys is developing a patient feedback real time survey. This will be conducted at the bedside with patients by a volunteer. This will provide the hospital with real time data that can be immediately shared with managers and staff. The current paper-based method for surveying patients, using NRC, does not provide timely data (lag of up to 6 months).

Discussion:

- A question was raised asking if we are mandated to use NRC. The OHA negotiated the NRC contract on behalf of Ontario hospitals, however we are not obligated to use them other than in the ED as our Pay for Results agreement requires the use of NRC surveying. Measuring patient satisfaction on an ongoing basis is required under the Excellent Care for All Act as well as part of the Accreditation Canada standards.

6.2. Q2 Corporate Quality Report

Defer to next meeting.

6.3. Risk Management Update

Ms. Tammy Quigley provided an overview of the Risk Management Report for Q1 and Q2. Please refer to the presentation which was pre-circulated in the agenda package.

Highlights:

As of October 1, 2014, definitions of severity levels have changed from 5 levels to 10 levels to assist users in choosing the appropriate severity level and more detailed analysis of the incident data. It was noted that there were no Critical Incidents in Q1 nor Q2 of this year.

6.4. Q2 Performance and Quality Scorecard

Deferred to next meeting.

6.5. Quality Improvement Plan

Deferred to next meeting.

6.6. Standardization of Dosing Time

Deferred to Medication Safety Committee and Clinical Priorities.

7. ROUNDTABLE UPDATES:

- The Accreditation on site survey will be taking place February 9-11, 2015. This will be discussed in further detail next meeting.

8. NEXT MEETING

The next meeting of the Patient Safety and Quality Monitoring Committee is scheduled for Wednesday, February 4, 2015 from 0730 to 0900 hours in the 10th Floor Boardroom.

9. ADJOURNMENT: 9:05 am.

Chief Nursing Executive & VP Patient Services Report

To: SMGH Quality Board Committee, Joint Medical Advisory Committee. Nursing Advisory Committee and Professional Advisory Committee

Date: January 2015

Quality and Patient Safety Initiatives:

- Medication safety committee has formed a subcommittee to work three root causes identified by the failure mode analysis of order transcription. The three issues are distraction, standard process for double checking and medication record location. The subcommittee has met and are embarking on observation of transcription process and staff interviews.
- Pharmacy – maintaining service while working on a number of tasks to support Accreditation visit in February.
- Cleanable Linen cart covers have been ordered. These will be used on all the units to prevent contamination of linen
- IPAC is working with ICnet a software company, on the final stages of setting up an alert module in the infection control surveillance software which will support antibiotic stewardship initiatives
- Policy revisions and education and training related to Ebola preparedness is ongoing

Medicine, ED and Surgery

- Bed availability is an ongoing challenge. Census and acuity fluctuates and our ability to respond to increased demand is limited, particularly when Infection Control issues exist. Bed Management and Surge Capacity protocols are being reviewed and revisions are expected.
- Teams have been making final preparations for accreditation scheduled for February 8-12, 2015. Mock tracers are planned in the final weeks leading up to the arrival of the surveyors.
- Acute Treatment Area (ATA) in ED continues to make improvements. New strategies to enhance patient flow are being explored – i.e. quick registration process.
- Medicine continues to work on falls prevention strategies. Number of falls for January was below target!
- LMS training with teams from Medicine and Transitional Care unit, ED, and Day Surgery were completed in December. Ongoing support is required.
- OR staff injuries exceed target. Team continues to explore strategies to reduce musculoskeletal injuries and blood exposures. Neutral zone policy (a strategy to reduce blood exposures in OR) to Nursing Advisory committee in January for approval.
- Safety Eyewear for OR: new safety eye glasses with prescription option to be trialed
- OR light replacement planned for installation during summer slowdown (July-August). Strategies to minimize patient impacts are the priority during this necessary work.

Chest Program

- Chest Unit: Falls reduction strategies continue to be the focus –consistently meeting or exceeding target last 3 months
- Chest Unit: LMS –Wave 3. All elements of structure have now been implemented. Working to develop team comfort and initial leadership and to have consistent scorecard measures to review impacts of change initiatives
- QBP (Quality Based Procedure)–COPD: focus on patient teaching standards to improve indicator performance
- Vent weaning patient volumes and thoracic surgical volumes exceeding capacity of 4 bed Intermediate Care resources in the Chest unit. Beginning mid-January, have increased staffing and resources to operate 6 Intermediate Care beds.

Cardiac Program

- QBP – Heart Failure. Initial performance indicators reviewed with team. Driver metric and strategies for improvement are in development. L. Faulkner is leading the WWLHIN working group (through the WWLHIN Cardiac Council) to share practice standards and implementation strategies for HF QBP.
- Cardiology Unit: LMS –Wave 3. All elements of structure have now been implemented. Working to develop team comfort and initial leadership and to have consistent scorecard measures to review impacts of change initiatives
- Cardiology Unit and Inpatient CV Surgery Unit: Falls reduction strategies continue to be the focus –consistently meeting or exceeding target last 3 months
- Cath Lab and Heart Rhythm: Volumes of pacemakers and implantable cardiac devices inserted continue to exceed volume targets. Cath and PCI volumes are approaching target. CV Surgical volumes are behind target by 10 cases. Wait times had been up in December but resolving in January.

- Remote pacemaker pilot, collaborating with the Guelph YMCA, continues to go well. Pilot evaluation in progress with plan for review with the team in February.

Critical care

- Consistently exceeding critical care bed capacity, causing surge into CCU and CVICU and maximizing use of step-down beds on Cardiology and Chest Units. Increased difficulty in transferring patients out of CVICU, CCU and ICU.

Collaboration:

- As part of the WWLHIN Rehabilitation pathways (Frail Elderly) initiative we are meeting with GRH to discuss integrating the **Assessment Urgency Algorithm** (**AUA**) for patients 70 years and older in ED.
- WW ED Council: focus for 2015/16 will be reducing time from triage to Physician initial assessment
- Joint Endoscopy Committee (GRH and SMGH: ongoing work that supports Endoscopy Quality Based Procedure(QBP)
- IPAC is working collaboratively with an epidemiologist volunteer to perform some trending analysis on our HAI data
- **WWLHIN Cardiac Council update:** Heart Failure QBP working group working to share best practices and working with LHIN Decision Support team to develop a scorecard that will help us to compare and work to improve performance with the suggested QBP indicators. A second working group to look at transition of care from hospital has been initiated, led by Dr. N. Mercer.
- WW Surgical Program Council: Working group with representatives from the acute sites on WW LHIN Vision Plan. St. Mary's preparing briefing note for Specialty Services : plan to submit brief to Surgical Program Council in early 2015
- A Joint Ebola task force (SMGH and GRH) continues to meet twice weekly
- QBP-Tonsillectomy: St. Mary's and GRH have just begun working on this QBP.
- SMGH is participating in a WWLHIN project to implement standard prescriber order sets for QBPs across the LHIN. Partnering with Think Research a company with a repository of best practice order sets. With priority to QBPs, the goal is to implement 20 orders sets by 2016.

Professional Accountability:

- Diet Guidelines: Binders with new diet guidelines completed for Dietitians and Diet Clerks. . A review of any discrepancies will be done throughout the month of December with final revisions in January.
- An IPAC survey has been released to staff to request feedback on the IPAC programme so that we can incorporate the needs of the staff into the IPAC work plan for 2015-16
- Accreditation: Clinical ROPs for accreditation have been reviewed and documentation of evidence of compliance has been completed. Mock tracer interviews have been completed with positive responses among the clinical team.
- Course on conflict resolution for ED staff: Lyne Aubry-Yates reviewing: have followed up to inquire if this request is being pursued and will report back next month.

Professional Development:

- Our late career nursing application was successful and we had funding announced in January for 10 late career nurses to engage in project work. Projects include, wound prevalence study of in-patient wards and special focus on ICU, OR standard set up project, assist with unit falls initiatives and delirium screening. Our funding covers approximately 10 shifts per nurse to work on projects and funds to be spend by March 31 2015.
- SMGH will be sponsoring a half day education event ; Accountability in Nursing February 5, 2015 at Waterloo Regional Museum
- Winter Nursing skills days have begun. Skills day consists of four hour education sessions on a number of nursing focused skills. The education/skills topics are based on feedback from staff.
- IPAC has signed up for one year's access to international infection prevention and control teleconferences and webinars
- ED conference supported by the LHIN occurred in early January. Team from St. Mary's very engaged and reenergized. Numerous ideas are being explored by team members and plans to pilot are being developed.

Presentations and Publications:

- CTV filming of "a day in the life" of a cardiac surgeon featured Dr. Gary Salasidis, and filming in our CVOR on January 20th. http://kitchener.ctvnews.ca/video?clipId=539653&binId=1.1147261&playlistPageNum=1

Human Resources:

- Program Manager Retirement announced for March 2015: Linda Brooks. Recruitment in progress.
- Program Manager (Karen Gehan) for in-patient surgery/Day Surgery/PACU/Pre-admission clinic has resigned-recruitment is underway

Submitted
Terry Boshart

Meeting Evaluation

Let us assume that a former patient attended our meeting today.

Now think about the discussion we had today.

QUESTION:

Would this patient have felt that our discussion helped move us forward in providing higher quality, safe patient care?

1 – Not at all 2 – Somewhat No
3 – Somewhat Yes 4 - Absolutely

St.Mary's GENERAL HOSPITAL