Quality Improvement Plans

Quality improvement is a priority at the Pembroke Regional Hospital. One of the ways in which we demonstrate this is through the development of an annual Quality Improvement Plan (QIP). Our QIP helps us to plan, document and review performance in the areas of safety, effectiveness, access, patient centeredness, and integration of care. Our QIP helps us to identify new and better ways of doing things in order to improve care for our patients, increase satisfaction levels and achieve better clinical outcomes. It is a tool to help us measure and improve our performance.

The *Excellent Care for All Act, 2010* (ECFAA) requires all hospitals to produce a QIP annually, make it available to the public and document progress against the plan.

Our QIP provides us with a meaningful way to clearly articulate our accountability to our community, patients and staff. Our QIP is focused on creating a positive patient experience and delivering high quality patient care.

As with all Ontario hospitals, our Quality Improvement Plan (QIP) is made up of two parts:

1) A document that provides a brief overview of our quality improvement plan, highlighting and listing our Hospital's top priorities for the year.

2) A chart format document which outlines our improvement targets and initiatives. This includes a core set of initiatives and measures that hospitals across the province may include in their plan.

The Ontario Health Quality Council has requested that hospitals select and report on some of the core indicators to support province-wide comparability where possible. Not all indicators apply to all hospitals.

You may find some of the questions and answers below helpful in understanding the QIP process.

How is the QIP developed?

The Pembroke Regional Hospital Board of Directors is responsible for overseeing the development of the QIP. The members of our Board work closely with our management team and various healthcare professionals to determine areas for improvement. Once areas for improvement have been identified,

targets are set for improvement. Once QIPs are finalized, they are posted on our website and a copy is submitted to the Ontario Health Quality Council.

What timeframe does the QIP cover?

QIPs are developed annually for a twelve month period beginning April 1st.

How do we know if progress is being made?

We take quality improvement very seriously and are committed to achieving the targets that we set out in our annual plans.

Measuring progress against our established targets is the primary way in which we hold ourselves accountable to our stakeholders. Reports on progress are provided to our Board of Directors throughout the year and a summary report is posted on our website annually.

Where can I find out more information about the *Excellent Care for All Act* and quality improvement plans?

Please visit ***www.ontario.ca/excellentcare*** for more information about the legislation and its requirements.

Excellent Care for All

Pembroke Regional Hospital
Progress Report on Quality Improvement Plan 2011/12

Priority Indicator (year 1)	Performance as stated in the year 1 QIP	Performance Goal as stated in the year 1 QIP	Progress to date	Comments
Surgical Safety Checklist (SSCL) Completion of the SSCL: Percentage of surgical patients who have the checklist completed	100%	100%	PRH met its performance targets in 2011/12 with 100% compliance in SSCL. Safety practices such as SSCL require continued focus to maintain the behavioural changes expected and to embed them into the OR culture.	PRH will continue to target 100% compliance in 2012/13 and will include as an improvement process a review of the SSCL checklists twice this year by RN lead and Chiefs of Surgery/Anesthesia. Challenges to maintain 100% compliance include staff and physician turnover and competing priorities with limited resources.
Reduce clostridium difficile associated diseases (CDI) CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient	0.84 (Jan- Dec 2010)	Reduce to the provincial rate of 0.28 (Jan-Dec 2011)	0.95 (Jan – Dec 2011) PRH's rate did not move to the provincial average in 2011/12. (It is noteworthy that PRH has a small sample size for this measure). Improvement initiatives for 2011/12 were completed as planned and included maintaining Infection Control Practitioner (ICP) worked hours at benchmark to	Reducing Hospital acquired C diff will remain a priority 1 objective for 2012/13. The performance target will be adjusted to 0.72 which is a more reasonable target focusing on improvement over this past year. In 2011/12 there were three months when the number of C Diff cases in a month was greater than five. The new target challenges us to ensure that there will be no months in 2012/13 where the C Diff rate exceeds four.

Priority Indicator (year 1)	Performance as stated in the year 1 QIP	Performance Goal as stated in the year 1 QIP	Progress to date	Comments
days in that month, multiplied by 1,000			support knowledge transfer and securing an identified physician champion with responsibility to support C Diff management.	The 2012/13 plan will focus greater attention on antibiotic stewardship , increased housekeeping hours, reductions in shared equipment as well as using the fourth case as the "trigger" to assess the need for adding "outbreak interventions" earlier where deemed appropriate. The key challenges remain embedding behavioural and practice changes into our culture and the susceptibility of our patient population due to over occupancy and environmental risks in our built space such as shared spaces, certain equipment and some bathroom facilities.
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	56% at Moment One (Jan - Dec 2010)	Improve rate by 5%	51% at Moment One (Jan - Dec 2011) The improvement initiatives completed to support this behaviour change included increasing the number of hand hygiene audits and feedback to staff and physicians , developing a hand hygiene e-learning program with roll out to a champion group and to 50% of clinical staff, and using posters in each patient room to ensure patients are involved in	Increasing Hand Hygiene Compliance rates at Moment One will remain a priority 1 objective for 2012/13. The target for 2012/13 will be to increase compliance at Moment One by 10% from the 2011/12 rate. The challenge remains one of embedding these practices into the everyday behaviours of physicians and staff so that it becomes a habit which takes time, diligence and resources. The 2012/13 initiatives will build on work started in 2011/12. A Hand hygiene working group will have a lead physician champion working more actively on the efforts. A

Priority Indicator (year 1)	Performance as stated in the year 1 QIP	Performance Goal as stated in the year 1 QIP	Progress to date	Comments
hygiene indications for before initial patient contact multiplied by 100.			this initiative (8 steps to a safer stay).	targeted improvement of 20% in physician compliance will be built into the 2012/13 performance target. Reporting on performance will be done quarterly with new reports demonstrating compliance by healthcare worker and physician groupings. Performance reports will be posted and shared broadly including at reporting at the Medical Advisory Committee. Hand hygiene coaches, including physician leads, will help support spread. We will ensure that the balance of our clinical staff complete the e-learning hand hygiene program. A new Infection Control Practitioner schedule will provide 7 day per week coverage to support knowledge transfer and feedback and knowledge transfer.
Improve organizational financial health Total Margin (consolidated): Percent by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expense, excluding	0.3 (Q3) 2010/11	0.0	Total Margin is 1.0 (Q3 projection) 2011/12 Target met for 2011/12. In this past year the focus to improve financial health was placed on support for conserving days within the Medical Program. The Medical Program actual length of stay (LOS) to expected length of stay (eLOS) was maintained below 1.3 as targeted and is trending downwards. A key	Total Margin will remain a priority 1 objective in 2012/13 with a target of 0- 3%. The improvement initiative planned is to reduce the use of outside "on call coverage" for on call physician groups by 10% and is supported by plans to review "On Call" coverage at each MAC and align contracts in services where required. Compliance audits are to be continued in 2012/13 with VTE and Diabetes care pathways being added. The key challenge in maintaining financial is

Priority Indicator (year 1)	Performance as stated in the year 1 QIP	Performance Goal as stated in the year 1 QIP	Progress to date	Comments
the impact of facility amortization, in a given year. Q3 2010/11, OHRS			initiative was the implementation of clinical pathways. Clinical pathway utilization compliance targets of between 65%-85% were met for Acute Coronary Syndrome, Congestive Heart Failure, and Transient Ischemic Attacks.	the unknown around funding levels for 2012/13.
Reduce wait times in the ER ER Wait times: (proportion of non-admitted low acuity patients treated within the eLOS of 4 hours or less)	80% for Q3	Maintain current performance (80% for Q3)	78% for Q3 (2011-12) (Non admitted CTAS category 4 and 5 treated within the LOS of 4 hours or less) Target was not met at Q3. The improvement initiative identified for 2011/12 was to set up an “assess and treat area” staffed by an RN (EC). We were unable to recruit an RN (EC) despite significant efforts. Alternative approaches for the development of a "rapid assessment zone" will continue to be explored in 2012/13.	The 2012/13 plan will focus on decreasing wait times for admitted patients. This will be measured by ER length of stay at the 90th percentile for Q3. The improvement plans will focus on effective use of medical beds through optimizing clinical pathways utilization and by reducing the number of admissions which do not require hospitalization.

Priority Indicator (year 1)	Performance as stated in the year 1 QIP	Performance Goal as stated in the year 1 QIP	Progress to date	Comments
Improve patient satisfaction NRC Picker: Overall rating of care (April - June 2010) for the ER	81% (Apr-June 2010)	84.2% (Apr-June 2011) Community Hospital Average	81.9% (Apr-Jun 2011) Although there was some improvement in this measure the target was not met. We were unsuccessful in implementing a proposed "assess and treat" initiative due to the unavailability of RN (EC) candidates to staff the area. Alternatives will continue to be explored in 2012/13 to improve flow within the ED which is a major influencer on satisfaction levels.	For 2012-13 plan will focus on improving inpatient scores for the overall rating of care. A target will be set to maintain an overall inpatient satisfaction rating of care at 90% or greater. Since the QIP in 2012/13 will be focused primarily on inpatient quality and safety initiatives, it is felt to be more appropriate to select a satisfaction measure in this area for 2012/13.

Excellent Care
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2012/13
Quality Improvement Plan
(Short Form)

Pembroke Regional Hospital

April 1, 2012 – March 31, 2013

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.

Part A:
Overview of Our Hospital's Quality Improvement Plan

1. Overview of our Quality Improvement Plan (QIP) for 2012-13

Pembroke Regional Hospital (PRH) places quality care and safety for patients, their family, staff, physicians and the public as a high priority and includes these as a strategic priority for the organization.

This year's plan builds on the first published QIP (2011/12) and places significant effort and commitment of resources on the safety dimension. There are four (4) objectives focused on improving safety and support a focus on eliminating preventable harm.

Two other objectives focus on improving admitted patient movement from the ER to inpatient medical beds with an aim of conserving acute patient days and ensuring that acute care beds are available through the implementation of the Home First Program.

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

PRH QIP focuses on:

- Reductions in Clostridium Difficile Infections (CDI) targeting a rate improvement from 0.95 to 0.72 by establishing an antibiotic stewardship work team, increasing environmental cleaning, implementing an objective audit for cleaning effectiveness, decreasing use of shared equipment in high risk areas and setting a threshold case number at the 4th case to trigger a launch of pre-outbreak interventions.
- Improved hand hygiene compliance before patient contact (1st moment) targeting an improvement by 10% through implementing a 7 day per week schedule for Infection Control Practitioners, establishing physician champions and a physician hand hygiene work team reporting to the Medical Advisory Committee (MAC), completing the roll out of an e-learning health provider education, and the changeover to "preferred" foam alcohol- based hand cleanser.
- Total compliance with surgical safety checks maintaining a rate at 100%.
- Reduction in musculoskeletal injury (MSD) of staff targeting a10% improvement by redesigning a teaching program supported by a champions model.
- Reductions in Alternate Level of Care (ALC) levels by 10% by full Home First Implementation in partnership with the Community Care Access Center (CCAC), the Champlain Local Health Integration Network (LHIN) and others.
- Reductions in ER wait times for inpatient admissions targeting a 10% improvement by continuing to focus on length of stays, continuing with Care Pathways implementation, and auditing and reviewing ER case types (CMG's) that may not require inpatient hospitalization.

In addition PRH will continue to ensure organizational financial health with a target of keeping total margin (fiscal measure of financial stewardship) between 0-3%. As well, we will strive to maintain our overall patient satisfaction rates in acute inpatient care at their current high level.

3. How the plan aligns with the other planning processes

The development of this Quality Improvement Plan for PRH has taken into account:

- Provincial, Champlain LHIN and PRH Priorities
- Best Practice standards for patient safety and quality
- The population we serve and the programs that support their care
- Accreditation Canada Standards

If we are successful in our improvements, we will fulfill obligations in our Hospital Service Accountability Agreement and in the Ministry's Emergency Departments Pay for Results Program. Efforts in infection prevention and control, including a focus on hand hygiene and safety processes such as surgical checklists, are required organizational practices (ROP's) established by Accreditation Canada to support safer healthcare delivery. Emergency and Alternate Level of Care (ALC) targets are designed to support provincial and LHIN priorities. The commitment to quality improvement techniques and use of research and best practices supports a growth in patient-centered care consistent with our Hospital's stated strategic priority to promote a culture of quality and safety for patients, staff and visitors.

4. Challenges, risks and mitigation strategies

C-difficile management, hand hygiene and infection prevention and control all involve staff, physicians and patients. Striving to do better does not preclude the fact there can be susceptibility in patients beyond organizational control. Culture, behavioural and practice changes require time and resources.

Most of the improvements through the "QIP" 2012/13 involve significant physician and clinical staff investment, practice change and will take time and resources. Best practices such as Home First adoption, care pathways and complication prevention programs like Venous Thromboembolism (VTE) Prevention, and Surgical Safety Checklist compliance require staff education, audits and ultimately practice change.

The implementation of the Home First strategy requires ongoing support and diligence as well as efforts and resources from partners to assure its success. Home First implementation can only successfully occur with strong staff, physician, CCAC and LHIN support.

The fiscal environment will make it challenging for us to make additional investments despite the fact these efforts should help us reduce waste and costs in the long-run. However, in order to manage the impact of the fiscal environment we will continue to pursue waste reduction and efficiency efforts.

Part B:
Our Improvement Targets and Initiatives

Purpose of this section: Please complete the "Part B - Improvement Targets and Initiatives" spreadsheet (Excel file). Please remember to include the spreadsheet (Excel file) as part of the QIP Short Form package for submission to HQO (QIP@HQOntario.ca), and to include a link to this material on your hospital's website.

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

PART B: Improvement Targets and Initiatives 2012/13

Pembroke Regional Hospital | 705 Mackay Street Pembroke, ON K8A 1G8

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 clostridium difficile associated diseases (CDI)	**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. 2011, consistent with publicly reportable patient safety data	Jan - Dec 2011 rate is 0.95	Target 0.72 (Jan-Dec 2012)	In 2011/12 three months were over 5 cases . Assume four cases in these months then rate would have been 0.72 **Caution small sample site**	1	1) An antibiotic stewardship improvement project to implement best practices will have a lead physician, pharmacist and infection control practitioner (ICP) assigned. There will be an established Antibiotic Stewardship Work Team with a written work plan based on best practices documents.	3 assigned / planned positions; Formal work group established; Action plan written and monitored at Medical Advisory Committee (MAC)	Established physician leader and work team to champion the antibiotic stewardship project, implement work plan and report progress to MAC	Physician and pharmacist leadership is essential component for success. Will be an accreditation Required Organizational Practice (ROP) in 2014. Provincial rate of 0.34
							2) Increase housekeeping hours for environmental cleaning in high risk areas (Medical 3B & 2A). Implement an objective cleaning audit (emerging best practice) focused on objective monitoring of physical cleaning and compliance (" Dazo" audit protocol). Provide "just in time" education with audit completion as needed.	worked hours/planned worked hours # Dazo audits completed / 100 planned audits	Reduce risk of spread through added housekeeping hours and new audit for cleaning effectiveness.	Targeted Investment. Process improvement (Objective audit is an emerging best practice). Planned increase in houskeeping audits monthly in higher risk areas as follows ICU surgical Medical Rehab and in ER the trauma room and the precautions room will be done monthly, other areas will be done quarterly, during an outbreak anywhere in the hospital weekly audits will be done.
							3) Decrease use of shared equipment; BP manometers, thermometers on 3B, 2A and 3A (higher risk areas).	# Isolation Rooms Equipped /Total # Isolation Rooms #BP Manometers at Bedside /# of Patient Beds Staffed & in Operation on high risk areas (3B, 2A, 3A)	Reduce risks of spread.	Targeted investment (one time).
							4) Set a threshold of "4th" case in the month to initiate C-diff Alert and "Trigger to Launch" Pre-Outbreak Interventions to enhance and focus added attention and diligence as appropriate	4th case in month used as trigger to assess need to implement "pre outbreak interventions"	Maintain new Hospital Acquired C-diff below 5 new cases each month (3 months last year were above).	Trigger escalation process. Measurement and Feedback. Process Improvement.
	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 - Jan-Dec. 2011, consistent with publicly reportable patient safety data	Jan 2011-Dec 2011 at moment one, is 51%(all groups)	target 56.1% moment one	Hand hygiene is a behavioural change. Target is a 10% improvement overall (moment one)	1	1) Implement new staffing schedule for Infection Control Practitioners (ICP's) over 7 days.	worked hours/planned worked hours New ICP schedule with weekends.	ICP support over 7 days instead of just weekdays.	Structural support
							2) Implement physician hand hygiene work group with lead physician as assigned by Medical Advisory Committee (MAC). Provide physician specific Hand Hygiene rates as part of Medical Care Committee (bimonthly) and MAC Agenda.	MAC to identify and support the physician-led hand hygiene workgroup. Improvement expected: physician hand hygiene improved by 20% (1st moment). Present rate for physicans 41% (Jan-Dec 2011).Target 50.4% (Jan-Dec 2012)	Improve physician rate by 20% (1st moment).	Measurement and Feedback Physician Lead to be established by MAC. Audits as standing agenda item for 2012/13 MAC.
							3) Make available and monitor the completion of an electronic health care provider education for clinical and relevant support staff built on "Just Clean Your Hands" Education Program.	Complete educational initiative identified in QIP 2011/12 for remaining clinical nursing and relevant support staff (housekeeping, laboratory and dietary) actual #completed / #remaining to be completed	Completion by identified staff of an electronic education program based on best practices (remaining 50%).	Educational Support, Knowledge and Skills Development

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
							4) Complete the installation of the preferred "Foam" alcohol-based hand rub at points of care to encourage use.	Complete the change over to " foam dispensers" # of foam dispensers / number of clinical dispensers recorded 100% completion	Completion of change over to foam alcohol product which is preferred for use by providers	Targeted Investment
							5) Pilot the use of a "code word " when missed hand hygiene opportunities are observed.	Create a "code word " to be used when missed hand hygiene opportunities are observed. Pilot implementation on one unit.	Implementation of "code word" in one unit as pilot site.	Reminders / Clinical Supports
							6) Educate new hires via e-learning program as part of orientation.	Hand hygiene e-learning will be completed by each new clinical staff hire as part of their orientation # completing e-hand hygiene hand hygiene / # of new clinical hires	New e-learning for hand hygiene will be included for all new clinical hires at orientation	Skills Development
							7) Provide hand hygiene compliance feedback to Directors for their clinical staff, focused on 1st moment.	Hand Hygiene metrics will be reviewed at each Patient Services Committee meeting. # reports / # meetings. Copy will be provided for Directors to post.	Hand hygiene metrics published for Directors as outlined (excluding July & August)	Measurement & Feedback
	Reduce rates of deaths and complications associated with surgical care	**Surgical Safety Checklist:** number of times all three phases of the surgical safety checklist was performed ('briefing', 'time out' and 'debriefing') divided by the total number of surgeries performed, multiplied by 100 - Jan-Dec. 2011, consistent with publicly reportable patient safety data	100%	100% Compliance	PRH expects 100% compliance and sustaining this change requires ongoing audit.	1	Surgical Safety Check List will be performed on all surgical procedures and Surgical Safety Checklist will be reviewed twice this year for identification of safety and risk issues by nursing lead and Chief of Surgery/ Anesthesia .	# completed checklists/ # of procedures. Two written reviews / 2	100% completion of surgical checklists and twice yearly review of tools to assure Surgical Safety Checklists (SSCL) remain current	Reminders / Clinical Supports
	Reduce Musculoskeletal Injury (MDS)in Staff	# of reported MSD related injuries over total # of reported incidents Calendar year multipled by 100 Jan-Dec 2011	47%	42.30%	Reasonable reduction based on peer experiences. Target is 10% reduction.	1	1) Establish a MSD / Client Handling Quality Improvement Work Team and develop a comprehensive client handling education program for all clinical staff at hospital, based on best practices (MSD Toolkit MOL; OSACH Handle with Care and RNAO Best Practices).	Members assigned to team. Update existing program to an more comprehensive client handling education program based on best practices. Program development completed by October 2012.	Work team in place. Development of new program before October 2012	Skills Development
							2) Establish Champions within designated areas and complete training program with them.	Well established and trained champion group.	100% assigned champions with training	Skills Development
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	Q3 2011/12 1%(projection)	0 to 3 %	target set based on peers	1	1) Reduce use of outside "on call coverage" for on call physician groups	Review "On Call" coverage at each MAC . Align contracts in services where required. Target 10% reduction in call costs	10% reduction overall in on call coverage costs	Process Improvement
Access	Reduce wait times in the ER	**ER Wait times:** 90th Percentile ER length of stay for Admitted patients. Q3 2011/12, NACRS, CIHI	Q3 2011/12 25.8 hours	23.2	Target s a 10% improvement	1	1) Audit Clinical Pathway Utilization for Acute Coronary Syndrome (ACS), Heart Failure (HF) , Transient Ischemic Attack (TIA) and Pneumonia.	Audit target compliance rates will be 85% for ACS and TIA and 65% for Heart Failure and pneumonia	Pathway compliance will be at levels of best practicing hospitals	Process Improvement, Measurement and Feedback

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
							2) Implement and audit Diabetes Pathway Implementation	Audit target compliance rates will be 25%	Implementation with lead physician and 25% compliance	Process Improvement, Best Practice. Physician leadership is key to successful implementation.
							3) Audit VTE(Venous Thromboembolism) Screening and Prevention Program Compliance	Audit target compliance rates will be 50%	Improve VTE compliance to 50%	Process Improvement, Best practice. Needs physician leadership. Most Responsible Physician (MRP) QIP initiative in 2011/12
							4) Reduce admissions which may not require hospitalization by analysis of admission data by CMG (Case Mix Group) through Conservable Days Physician Task Force.	Admission rates through ER will be reviewed through the conservable days quality improvement project.	Through data analysis those CMG's possible to focus admission diversion will be chosen and action plan developed.	Process Improvement
Patient-centred	Improve patient satisfaction									
		From NRC Picker: "Overall, how would you rate the care and services you received at the hospital?" (Oct 2010 to Sept 2011 is most current annual data available)	For acute inpatients overall rating of care is 90.37%	90.37	Performance will be maintained	1	1) Ensure all new staff receive orientation and sign off on the Bill of Rights and Responsibilities. Include review and signature of physicians as part of applications and reappointment process.	Orientation revised . Each new employee and physician will sign that they have read and understand PRH Bill of Rights.	Each new employee and physician will have read and signed the Bill of Rights	Skills Development
							2) Include courtesy and respect training in each staff orientation.	Orientation for new hires will include education on PRH's Code of Conduct and Bill of Rights	All new staff receive education on Code of Conduct and Bill or Rights	Skills Development
							3) Implement and support the newly revised "Caught You Caring".	Launch revisions to program.	Launch revised staff recognition program "Caught You Caring"	
Integrated	Reduce unnecessary time spent in acute care	**Percentage Alternat Level Care (ALC) days:** Total number of inpatient days designated as ALC, divided by the total number of inpatient days. Q2 2011/12, DAD, CIHI	Q2 2011-12 is 19.73 (MOHLTC FIM website)	Target 17.73	Targets a 10% reduction.	1	1) Working with Community Care Access Center (CCAC) and other partners as part of the Home First and the ALC strategy, increase the number of patient referrals to Home First Program over original baseline (April to June - 4 per month). Maintain the number of ALC awaiting LTC at zero (outside of an escalation process).	Increase the number of referrals to Home First. Baseline for referrals calculated at 48 for year. Increase # of referrals by 10%. Target 53 for year (outside of an escalation process). Target to be 0 for number of new ALC's awaiting LTC (outside of escalation process).	# of patients referrals to Home First will be increased by 10%. Designated new ALC-LTC will be zero (outside of escalation process).	Process improvement. PRH is one of the CLHIN pilot sites for Home First implementation. Note: ALC in this metric includes Medical, Surgical, ICU and excludes CCC, , Newborns, Peds, AMH & Rehab

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

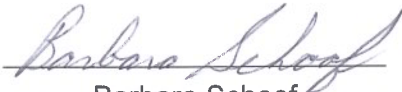
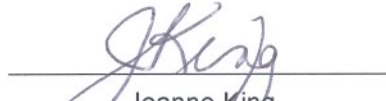
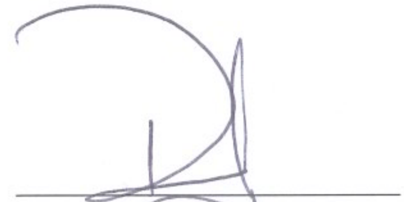
Manner in and extent to which compensation of our executives is tied to achievement of targets

Our Senior Leadership Team is made up of the CEO, the Vice-President of Patient Services, the Vice-President of Corporate and Support Services, and the Chief of Staff. For each of these executives, 5% of their total available compensation will be tied to the achievement of targets identified in the 2012/13 QIP.

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.

Barbara Schoof	Joanne King	Pierre Noel
Board Chair	*Quality Committee Vice-Chair*	*Chief Executive Officer*