

Excellent Care
For All.



2011-12

Quality Improvement Plan

(Short Form)



This document is intended to provide public hospitals with guidance as to how they can satisfy the requirements related to quality improvement plans in the *Excellent Care for All Act, 2010* (ECFAA). While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and hospitals should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, hospitals are free to design their own public quality improvement plans using alternative formats and contents, provided that they comply with the relevant requirements in ECFAA, and provided that they submit a version of their quality improvement plan to the OHQC in the format described herein.

Orillia Soldiers' Memorial Hospital
170 Colborne St. West,
Orillia, ON, L3v 2Z3

Part A:

Overview of Our Hospital's Quality Improvement Plan

1. Overview of our Quality Improvement Plan (QIP) for 2011-12

Our strategic goals include being a hospital known for patient and staff safety. In the next year we will:

- 1) Reduce the risk of our patients developing blood clots and being hurt in a fall while at OSMH.
- 2) Identify and treat critically ill patients faster.
- 3) Prevent and treat infections more efficiently.
- 4) Reduce unnecessary days patients spend at OSMH.
- 5) Improve our processes to transition patients into and out of the hospital
- 6) Keep patients and staff safe by ensuring that safe lifting and transfer techniques are being used by staff
- 7) Improve overall patient satisfaction indicator for OSMH, which already surpasses the Ontario average for community hospitals.

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

To improve the safety of the care we provide to our patients, we are implementing best practice tools that will make it easier for our staff and physicians to use best practices effectively and consistently when treating our patients. Our specific **safety** improvement initiatives are:

- 1) **Improve Hand Hygiene:** Increase staff and physician hand hygiene compliance before patient contact to 70%, by encouraging proper hand hygiene habits, conducting audits and giving frequent feedback to managers, staff and physicians. Specific plans will be implemented in areas needing extra support.
- 2) **Prevention of Pressure Ulcers (Bed Sores):** Reducing the number of new pressure ulcers that Complex Continuing Care patients develop while at OSMH from 8% to 4% by:
 - a. improving consistent application;
 - b. following up with people that are at risk; and
 - c. continuing to implement the use of preventative devices such as heel boots.
- 3) **Reduce Harm from Falls:** Reducing the number of patient falls that result in serious injury from 4 to 0 by:
 - a. implementing a specific harm prevention program including standards for use of bedrails, low beds, bed alarms, falls cushioning devices;
 - b. educating staff/physicians about these standards;
 - c. monitoring their use and providing feedback frequently to help change practice; and
 - d. developing standards related to the care of elderly patients with confusion and dementia as we have found these patients are most at risk for serious harm from falls.

- 4) **Improve Surgical Safety:** Improving consistent use of a safety checklist before surgery from 79% to 95%. We will do this by:
 - a. shifting from manual to electronic tracking in order to improve accuracy;
 - b. implementing a new checklist for surgeries that we do most; and
 - c. by having the Program Manager and Chief of Surgery investigate each case of incomplete checklist.

- 5) **Ensure Before Surgery Antibiotics:** Improve the percentage of patients that receive recommended antibiotics before their surgery to 95% for specific types of surgery by:
 - a. implementing a documentation double check process; and
 - b. tracking this on the new electronic tracking form described above.We will also be following each case that doesn't meet the standard and conducting a review through our Infection Prevention and Control team.

- 6) **Identify and Treat Critical Patients Faster:** Continuing our implementation of a Critical Care Outreach Team (CCOT). This team is based out of our Intensive Care Unit (ICU) and will be available to staff and physicians in other parts of the hospital if they have concerns about a patient who seems to be deteriorating. Our goal is to reduce the number of resuscitation codes (Code Blue) that happen on the inpatient units outside the ICU with early intervention by the CCOT.

- 7) **Improve Management of Sepsis** (a very serious infection that has spread to the blood stream, affecting many body systems and organs): Our improvement goal is that 50% of patients with a diagnosis of sepsis will receive antibiotics within 4 hours. We will improve identification and treatment of patients with sepsis by:
 - a. introducing a tool in our Emergency Room (ER) to detect sepsis earlier;
 - b. developing and implementing a standard set of treatment orders to manage sepsis once it is diagnosed; and
 - c. educating staff and physicians on the use of these new tools.

- 8) **Prevent Blood Clots (VTE Prophylaxis):** Improve the number of patients at high risk of developing blood clots that receive preventative medication to 85% by:
 - a. developing and implementing standard sets of treatment orders;
 - b. auditing order set use;
 - c. providing frequent feedback to our physicians and staff so that they can change their practice;
 - d. educating staff and physicians about best practices and how the use of the order sets can improve care; and
 - e. joining a learning collaborative to help us achieve this improvement.

Our plan contains a group of objectives to improve the effectiveness of care, specifically by reducing unnecessary days spent in hospital while also reducing readmissions. These **effectiveness** initiatives are:

- 1) **Reduce days in hospital in excess of Ontario standards:** Reducing the length of stay of patients with specific health conditions, such as hip fractures, pneumonia and those that have had Cesarean sections by:
 - a. developing and implementing standard order sets;
 - b. implementing a predictive discharge process to make sure patients are discharged as soon as they can be, to the right destination and with the supportive care they need;
 - c. using an electronic assessment and tracking system to identify patient readiness for discharge and communicating this information to physicians quickly;
 - d. implementing a new Patient Navigator role to improve discharge processes; and
 - e. educating physicians to classify patients accurately in the documentation coding process and implementing coding tools to help with this.

- 2) **Reduce days in hospital for patients needing an alternate level of care (ALC):** Our goal is to reduce these days from 21.4% to 18%. To do this we are:
 - a. implementing a new Patient Navigator role to improve discharge processes;
 - b. working with community partners to help people stay in their homes as long as possible by reducing falls in the home, by helping people manage dementia and other health conditions of the elderly; and
 - c. using nursing outreach roles to prevent unnecessary admissions through the ER and to help people to move from the hospital to other health care facilities such as long term care homes.

- 3) **Improve financial effectiveness:** Continue implementation of a LHIN and Board approved financial recovery plan to reduce our operating deficit. However, given the potential of an increasing gap between government revenues and expenses our deficit may increase. The measure of financial effectiveness on our plan is called Total Margin. This is a measure of financial health that describes the percent by which a hospital's total revenues differ from its total expenses. A "positive" Total Margin value suggests that there is operational efficiency, ensuring that we have the resources required to purchase any necessary equipment and provide care to patients.

Our other Quality Improvement Plan elements include:

- 1) **Improve Access by Reducing Emergency Room (ER) Wait times:** Focus on reducing the maximum time that 90% of admitted patients spend in ER from 25.4 hrs to 22 hrs, using strategies outlined above in Effectiveness #1 and #3 (predictive discharge, use of standard order sets, use of electronic tracking of patient readiness for discharge) and the use of a Clinical Decision Unit (CDU) to support patients that need ongoing monitoring for a period of time.

- 2) **Improve Patient Satisfaction:** Overall patient satisfaction exceeds the Ontario community hospital average but we want to consistently have 80% of our patients recommend our hospital to others. We will do this by better meeting our patients needs for health and discharge information and by providing more consistent emotional support and addressing patient and family anxieties.

- 3) **Reduce Staff Injuries:** Goal is a 25% reduction of injuries related to patient transfers and other activities from 62 to 46. We will do this by:
- a. having staff and managers attend injury prevention education/training;
 - b. providing ongoing education via our newsletter;
 - c. investigating all staff injuries and addressing root causes; and
 - d. purchasing more transfer equipment in high risk areas; e) developing a staff exercise program.

3. How the plan aligns with the other planning processes

Safety has been identified as a top priority in the OSMH Strategic Plan and on the hospital's balanced score card. Most of the safety improvement initiatives in this QIP are also Required Organizational Practices in our [Accreditation](#) process. Our QIP reflects many partnerships within our region (wound care guidelines, regional aging at home strategies, regional falls program, regional ALC strategies (<http://www.nsmhlin.on.ca/>)) as well as provincial improvement priorities such as improved ER access and reduction of unnecessary time spent in hospitals. In addition we are working in partnership with the NSM LHIN to include Regional indicators aligned with the QIPs of the Hospitals.

4. Challenges, risks and mitigation strategies

OSMH has an engaged and dedicated staff and physician population, who have been motivated by a supportive Board of Directors and Senior Leadership Team who approved a strategic plan focused on improving patient and staff safety.

Our challenge is that our desire to change and improve surpasses the resources available to accomplish everything we would like. Our strategy is to choose initiatives that will impact many indicators and build on one another. We will project manage the initiatives to spread out the work to be done over the course of the year and set realistic goals. We will apply LEAN process improvement and LEAN leadership to support projects and to improve efficiency, find savings and reinvest them in staff and patient safety.

Part B:
Our Improvement Targets and Initiatives

(see table below)

PART B: Improvement Targets and Initiatives



Orillia Soldiers' Memorial Hospital 170 Colborne Street West, Orillia Ontario L3V 2Z3

Please do not edit or modify provided text in Columns A, B & C

AIM	MEASURE	CHANGE								
Quality dimension	Objective	Outcome Measure/Indicator	Current performance	Performance goal 2011/12	Priority	Improvement initiative	Methods and results tracking	Target for 2011/12	Target justification	Comments
Safety	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 - 2009/10, consistent with publicly reportable patient safety data	48.2%	70% in Quarter 4, 2011/12	1	1. Hand hygiene audits - total 1,000/fiscal year (minimum) for facility with equal distribution between all in-patient patient care areas, including Emergency Department and Dialysis	Monthly results are posted on all Quality Boards; discussion at Care Team meetings for inclusion in minutes; Patient Care Services Managers visibility; 'just in time' education ;reinforcement of best practices	70%	Based on target set by Ministry of Health & Long Term Care Just Clean Your Hands program	Further discussion regarding incremental increases (i.e. 20% / fiscal yr) should continue
						2. Patient Care areas that do not meet 70% compliance by September 2011 will be required to file an action plan to the Infection Prevention and Control Committee indicating how the target will be met	Infection Prevention & Control will notify Program Directors of areas where improvement has not reached the target	70%	Action planning increases awareness and will assist in increasing compliance	
						3. All staff complete Ministry of Health & Long Term Care "Just Clean Your Hands" web based Learning Package by 31 March 2012	Mandatory Infection Prevention & Control education program in place since 2009. All staff required to complete the Hand Hygiene learning package with results submitted to Managers	100%	Additional and ongoing educational activities assist in reinforcement and understanding of best practices	
Safety	Avoid new pressure ulcers	Percentage of CCC residents with a facility acquired pressure ulcer, Stage 2 or higher. Quarter 4 2010-2011, CIHI Revised November 2011	8%	4%	2	1. Implement a standardized wound assessment/documentation tool 2. Improve consistency of high risk screening and follow up				
Safety	Avoid falls	Falls Harm Mitigation: Critical incidents. Quarter 3 (Year to Date) 2010-11	4	0	1	1. Falls prevention program	Falls rate (Quarter 3 Year-to-Date) = 4.13 per 1000 patient days. Track and report through Falls Working Group; committee structure	Falls Rate: 3 falls per 1000 patient days	Internal target	
						2. Falls harm mitigation program	Minor fall injury rate = 35.1 per 100 falls Major fall injury rate = 2.13 per 100 falls *Based on Q3 Year-to-Date 2010-11	Minor fall injury rate = 23 per 100 falls Major fall injury rate = 0.0 per 100 falls *Based on Quarter 3 Year-to-Date 2010-12	Internal targets	

AIM		MEASURE				CHANGE				
Quality dimension	Objective	Outcome Measure/Indicator	Current performance	Performance goal 2011/12	Priority	Improvement initiative	Methods and results tracking	Target for 2011/12	Target justification	Comments
Safety	Reduce surgical morbidity and mortality	Percent compliance with the Surgical Safety Checklist. Access to Care, Cancer Care Ontario Surgical Efficiency Target Program, Surgical Checklist Compliance Report (December 2009 - November 2010)	79%	95% In Quarter 4, 2011/12	1	1. Change to computer automated tracking system	Monthly report to Operating Room Benchmark Collaborative and Ministry of Health & Long Term Care; Surgical Care Team quarterly	98%	Small percentage of emergency surgeries for which the surgical safety checklist would not be completed.	
						2. Case by case follow up by Program Manager / Chief of Surgery with circulating nurse and/or Surgeon regarding incomplete checklist	Daily review of perioperative record with follow up as required.	98%		
						3. High volume checklist under development for surgeries such as cataracts, endoscopy				
Safety	Reduce incidence of surgical site infections	The percentage of patients with antibiotic administration within the appropriate time prior to surgery. Quarter 3 Year to date 2010-11	Colorectal Surgery = 44.1% Hysterectomy = 90% Total Hip/Knee Arthroplasty = 73.2% * Quarter 3 Year-to-Date (2010-11)	95% each In Quarter 4, 2011/12	1	1. Clerical double check to ensure or secure complete documentation	Increased electronic data capture to facilitate reporting and auditing	All preoperative antibiotics will be entered in the appropriate space on the Surgical Safety Checklist	June 2011 interim targets for preoperative antibiotic administration is 20% higher for Hysterectomy and Total Hip/Knee Arthroplasty & 50% higher for Colorectal Surgery.	Since total number of hip/knee procedures is low, a single instance of missing the timeframe will have a dramatic impact on overall success rates
						2. Infection Prevention & Control chart review to determine cause of missing information ('miss' versus incomplete documentation)	Case by case follow up by Program Manager / Chief of Surgery. Quarterly review by Surgical Services Committee	All missing documentation/orders will be followed up by the appropriate person	Best Practice, supported by peer reviewed evidence, supports the use of preoperative antibiotic prophylaxis in surgical procedures	This process has begun February 2011
Safety	Improve identification and management of adult patients at risk of critical illness	Percentage of resuscitation codes (Code Blue) outside the Intensive Care Unit, Emergency Department, and Operating Room.	N/A Codes per 1000 discharges	Decrease baseline by 10% Quarter 4 Year-to-Date, 2011/12	1	1. Critical Care Outreach Team	Audit schedule; monthly meetings of Critical Care Outreach Team	Update project charter Validate baseline data. Educate staff; Implement protocol on Medical & Surgical units		

AIM		MEASURE				CHANGE				
Quality dimension	Objective	Outcome Measure/Indicator	Current performance	Performance goal 2011/12	Priority	Improvement initiative	Methods and results tracking	Target for 2011/12	Target justification	Comments
Safety	Improve sepsis management	Percentage of patients with a diagnosis of sepsis in the Emergency Department who receive antibiotic treatment within 4 hours. Quarter 4 2010/11	N/A	50%	1	1. Triage triggers	Triage triggers pilot project by the end of Quarter 3	50% of patients with an admission diagnosis of sepsis have positive triage sepsis trigger		
						2. Sepsis order set	Order set pilot project by the end of Quarter 3	50% of patients with admission diagnosis of sepsis will have order set initiated	Institute for Clinical Evaluative Sciences report March 2010 - development of a consensus on evidenced-based quality of care indicators for Canadian emergency departments	
						3. Education to all care providers in emergency department on early recognition of sepsis	Emergency Department staff and physicians will have received education related to early identification of sepsis by end of Quarter 3	75% of Emergency Department staff and physicians will have received education related to early identification of sepsis by Quarter 3		
Safety	Reduce hospital-acquired venous thromboembolism (VTE)	VTE prophylaxis for high risk patients. December 1-15, 2010.	68.3%	85%	2	1. Present Continuing Medical Education program - Deep Vein Thrombosis prophylaxis at grand rounds	audit		Evidence-based practice; provincial standards	
						2. Plan and implement intervention(s) per Safer Healthcare Now VTE Learning Collaborative	audit			
						3. Alerts to physicians re: patients without deep vein thrombosis prophylaxis orders with no apparent exclusions	audit			
Effectiveness	Reduce unnecessary time spent in acute care	Percentage Alternate Level of Care days: Total number of inpatient days designated as Alternate Level of Care, divided by the total number of inpatient days. Quarter 2 2010/11, Discharge Abstract Database, Canadian Institute for Health Information	21.4% * Quarter 2 YTD, 2010/11	18%	2	1. Reduce number of non-acute patients admitted through Emergency Department				
						2. Prompt identification of patients likely to need an Alternate Level of Care; prompt referral to Community Care Access Centre				
						3. Reduce length of stay for patients with an Alternate Level of Care length of stay greater than 30 days				

AIM		MEASURE				CHANGE				
Quality dimension	Objective	Outcome Measure/Indicator	Current performance	Performance goal 2011/12	Priority	Improvement initiative	Methods and results tracking	Target for 2011/12	Target justification	Comments
Effectiveness	Reduce unnecessary time spent in acute care	Conservable Days: Total number of inpatient days in excess of the provincial Case Mix Group benchmarks	* Awaiting Ministry of Health & Long Term Care benchmark data (Spring 2011)	* To be determined based on Ministry of Health & Long Term Care benchmark data	1	1. Predictive Discharge	Monitored as 'percentage of patients discharged by 2pm' through electronic Daily Access Reporting Tool; Corporate performance April 1, 2010 - January 31, 2011 = 64.7%	75% of patients discharged by 2pm (on select units). Quarter 4 2011/12		
						2. Implementation of standard order sets for Case Mix Groups with greatest conservable day margins - Vaginal birth; Primary Caesarean section; Chronic Obstructive Pulmonary Disorder; Congestive Heart Failure; Community Acquired Pneumonia; Pre-operative hip fracture; post-operative hip fracture; Post-operative bowel resection; Post-operative major general surgery	Monitor order set uptake Monitor individual Case Mix Group conservable days	35% Individual targets to be established once order sets are approved	Internal organizational target for Year I uptake; incremental increase over subsequent years Internal organizational target for select Case Mix Groups current performance vs. benchmark and projected order set utilization	
						3. Utilization Management System tracking and daily review	Monthly tracking (Utilization mgmt, programs)	Reduce "days waiting for discharge"		
						4. Physician standardized handover report tool				
						5. Coding tick sheets on patient chart	Project team to track % of inpatient charts with completed tick sheet; expected length of stay for charts with tick sheet vs. charts with no tick sheet			

AIM		MEASURE				CHANGE				
Quality dimension	Objective	Outcome Measure/Indicator	Current performance	Performance goal 2011/12	Priority	Improvement initiative	Methods and results tracking	Target for 2011/12	Target justification	Comments
Effectiveness	Improve organizational financial health	Total Margin (See A 2.3) (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. Quarter 3 2010/11, Ontario Health Reporting Standards Revised November 2011	-1.41%	0% for fiscal 2011/12	1	1. The Board and Local Health Integration Network approved Recovery Plan includes operational initiatives.	Monthly variance reporting by Programs/Services, Monthly Finance/HR Committee of the Board, Monthly report to the Local Health Integration Network	To Be Determined pending approval of Interim Hospital Service Accountability Agreement	Target will not be a "performance goal" but will articulate the anticipated and agreed upon performance level.	The budget process for 2011/12 will be completed through the summer/fall of 2011, as the funding announcements occur with the provincial government. The target for the Total Margin could be adjusted at that time.
Access	Reduce wait times in the Emergency Department	Emergency Department Wait times: 90th Percentile Emergency Department length of stay for Admitted patients. Quarter 3 2010/11, National Ambulatory Care Reporting System, Canadian Institute for Health Information	25.4hrs	22 hrs in Quarter 4, 2011/12	1	1. Predictive Discharge	Monitored as 'percentage of patients discharged by 2pm' through electronic Daily Access Reporting Tool; Corporate performance April 1, 2010 - January 31, 2011 = 64.7%	75% of patients discharged by 2pm (on select units). Quarter 4 2011/12		Early day discharge facilitates bed flow - seen as decreased wait times in Emergency Department
						2. Implementation of standard order sets for Case Mix Groups with greatest conservable day margins - Chronic Obstructive Pulmonary Disorder; Congestive Heart Failure; Community Acquired Pneumonia; Pre-operative hip fracture; post-operative hip fracture; Post-operative bowel resection; Post-operative major general surgery	Legacy order sets will be re-templated with input changes made and in use by teams at point of care Increased selection and use of pre-printed Order sets from PatientOrderSets.com	Order Set Committee to approve 6 order sets/month Legacy sets retemplated and in use in according to approved Standard Reference Order Set Top Case Mix Groups per program to be addressed - use of Pre-printed Physician Order Sets targeted for 35% Decreased length of stay via decrease in medication errors by 10% - i.e. - related to prescription, transcription, patient populations (adult vs. paediatric order sets)	Order sets in use will be based on evidence-based practice / best practice	
						3. Utilization Management System	Monthly tracking (Utilization mgmt, programs)	Reduce "days waiting for discharge"		

AIM		MEASURE				CHANGE				
Quality dimension	Objective	Outcome Measure/Indicator	Current performance	Performance goal 2011/12	Priority	Improvement initiative	Methods and results tracking	Target for 2011/12	Target justification	Comments
Patient-centered	Improve patient satisfaction	NRC Picker / Hospital Consumer Assessment of Healthcare Providers & Systems: "Would you recommend this hospital to your friends and family?" (add together percent of those who responded "Definitely Yes"). Acute inpatients average of Quarter 3 (09/10) -- Quarter 2 (10/11)	74%	80%	2	Improvement projects for top three survey areas related to "would recommend"	Quarterly reports - Balanced Scorecard	80%	Currently above Ontario Community Hospital Average Quarter 3 (09/10) -- Q2 (10/11) = 68.75	
Worklife-workforce	Improve work environment	Staff Musculoskeletal (M/S) injuries: Includes patient transfer and non-transfer injuries. Annualized from April 1 2010 - January 31, 2011	62	46	1	Musculoskeletal injury prevention program: 1. Managers to attend a musculoskeletal injury prevention session 2. All staff who attend new employee orientation will receive musculoskeletal prevention training 3. Musculoskeletal prevention tip in Mirror newsletter every two months 4. Musculoskeletal injuries will have an accident investigation completed by Musculoskeletal Injury Prevention Program coordinator within 2 weeks of injury. 5. Purchase transfer equipment for high risk and at risk units 6. Update policy 7. Partner with wellness committee to develop an exercise training program	Monthly report to Joint Health & Safety Committee Balanced Scorecard	Reduce staff Musculoskeletal injuries by 25% 1. 90% of all managers to attend Musculoskeletal prevention session 2. 100% compliance Musculoskeletal prevention articles in Mirror in 2011/12 4. 85% of all Musculoskeletal injuries will be investigated within 2 weeks of injury 5. Purchase maxislides for each at risk unit 6. Policy updated and communicated by July 1, 2011	1. Ontario Health & Safety Act says that employers are to take every precaution reasonable in the circumstances for the protection of a worker. S. 25 (2)(h) Because of the number of Musculoskeletal injuries in the Health Care (HC) sector, in 2010, the Ministry of Labor targeted Musculoskeletal prevention. 2. Institute for Work and Health (2007) reports (1) moderate evidence that prevention programs in HealthCare settings have a positive effect on protecting workers' musculoskeletal health and (2) moderate evidence that these two interventions have a positive effect: (i) Patient handling program consisting of a worksite policy change, new patient handling equipment, training on the equipment and on patient handling (ii) Exercise training programs consisting of aerobic and/or strength training.	1. Musculoskeletal injuries have been increasing over the past 3 years from 43 in 08/09 to 52 to Jan 31/11. This has resulted in increase in Workplace Safety & Insurance Board charges to the organization, negative impact on staff morale and negative impact on departmental staffing.

Part C:

The Link to Performance-based Compensation of Our Executives

Purpose of Performance-based compensation:

- 1. To drive performance and improve quality care*
- 2. To establish clear performance expectations*
- 3. To create clarity about expected outcomes*
- 4. To ensure consistency in application of the performance incentive*
- 5. To drive transparency in the performance incentive process*
- 6. To drive accountability of the team to deliver on the Quality Improvement Plan*
- 7. To enable team work and a shared purpose*

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

Program Participants:

The positions included in the performance-based compensation program are:

CEO

Chief of Staff /VP Medical Affairs

Chief Nursing Executive/VP Patient Services

Interim CFO

VP People, Partnerships and Planning

Note: The position of VP Corporate Services/CFO is currently vacant. When filled, the individual will be included in the performance-based compensation program.

Program Design

The program period is in line with the fiscal year, running from April 1 to March 31. For the 2011/2012 fiscal year, the amount of pay at risk is equal to 3% of base pay for each of the impacted positions. This money will be equally divided between five indicators. All executives will share the same five indicators for 2011/2012. The program includes targets for 100%, 66% and 33% of the available incentive for each indicator as described in the attached Performance Allocation plan, 2011/2012. The calculations will be completed within 90 days of the end of the fiscal year.

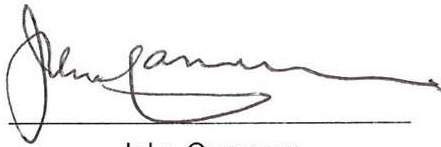
Performance allocation plan, 2011/2012

Quality dimension	Objective	Outcome Measure/Indicator	Performance as of March 2011	Performance goal 2011/12	Weighting	%of available incentive			
						100%	66%	33%	0%
Safe	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 - 2009/10, consistent with publicly reportable patient safety data	48.20%	70% (Quarter 4, 2011/2012)	20%	≥70%	65%	60%	<60%
Effective	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 2010/11, Onatario Health Reporting Standards	-1.41%	Revised Septemebr 2011 0%	20%	≥0%	>-0.7%	>-1.41%	≤-1.41%
Access	Reduce wait times in the ED	Emergency Department Wait times: 90th Percentile Emergency Department length of stay for <u>Admitted</u> patients. Q3 2010/11, National Ambulatory Care Reporting System, Canadian Institute for Health Information	25.4 hrs	22 hrs (Quarter 4, 2011/2012)	20%	≤22 hrs	23 hrs	24 hrs	>24 hrs
Patient-centred	Improve patient satisfaction	NRC Picker / Hospital Consumer Assessment of Healthcare Providers & Systems: "Would you recommend this hospital to your friends and family?" (add together percent of those who responded "Definitely Yes"). Acute inpatients average of Quarter 3 (09/10) -- Q2 (10/11)	74%	80%	20%	≥80%	78%	76%	<76%
Worklife / Workforce	Improve work environment	Staff Musculoskeletal (M/S) injuries: Includes patient transfer and non-transfer injuries. Annualized from April 1 2010 - January 31, 2011	62	46	20%	≤46	52	58	>58

Part D: Accountability Sign-off

I have reviewed and approved our hospital's Quality Improvement Plan and attest that our organization fulfills the requirements of the *Excellent Care for All Act*. In particular, our hospital's Quality Improvement Plan:

1. Was developed with consideration of data from the patient relations process, patient and employee/provider surveys, aggregated critical incident data, and patient safety indicators;
2. Contains annual performance improvement targets, and justification for these targets;
3. Describes the manner in and extent to which, executive compensation is tied to achievement of QIP targets; and
4. Was reviewed as part of the planning submission process and is aligned with the organization's operational planning.



John Cameron
Board Chair



Ken Brownlee
Quality & Safety Committee Chair



Elisabeth Riley
Chief Executive Officer

Dec. 9/11