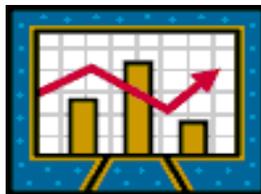




Capital Health

# **CAPITAL HEALTH'S STRATEGIC INDICATORS REPORT**

AUGUST 2014



**Prepared for the Board of Directors and  
The Quality and Patient Safety Committee of the Board**

Prepared by Decision Support

August 26, 2014

## Table of Contents and Indicator Summary

The indicators in this report are summarized in the table below. A short description of the current status is also provided. Note the icons below used in the summary under the “Target” column. A summary of indicators related to patient safety can be found in Appendix A and a summary of indicators related to access (wait times) can be found in Appendix B. Appendix C will provide a summary of the progress of the 14 Areas of Focus when progress measures become available.

- |   |   |
|---|---|
|  Meeting target or on track to meet target |  Trending toward target                                    |
|  Not meeting or will not meet target       | <b>B</b> Baseline measure only  |
|  Caution – needs work to meet target       |  Being tracked but with no established target or standard. |

[\\* Click on an indicator name to go directly to that section \\*](#)

Target	Indicator Name	Status / Comment	Page
<b>Transforming the Person-Centred Health Care Experience</b>			
<b>Access Indicators</b>			
	Surgery Cancellation Rates	The April rate was very high due to a nursing strike (10.6%). In both May and June the rate was 2.3%. This is within the usual range but short of the target of 1.7%	8
	Wait Times – Elective CT	The June 2014 wait time was 25 days—3 days shorter than the target of 28 days.	10
	Wait Times – Elective MRI	In June 2014, the average wait time for MRI was 220 days—almost 8 times longer than the target of 28 days; however, a trend of improvement can be seen since December 2013.	11
 	Wait Times - Radiotherapy Treatment	In June 2014, radiotherapy wait times were meeting target for urgent cases but not for intermediate cases.	12
	Wait Times – Hip Fracture Surgery	In Q1 of 2014/15, only 69% of cases met the target wait time.	14
	Wait Times – Hip Replacement	In Q1 of 2014/15, only 58% of cases met the target wait time.	15
	Wait Times – Knee Replacement	In Q1 of 2014/15, only 37% of cases met the target wait time.	16
	Wait Times – Cataract Surgery	In Q1 of 2014/15, only 74% of cases met the target wait time, but there has been a trend of improvement over the past several quarters.	17
  	Wait Times – Open Heart Surgery	In June 2014, the targets were met for the scheduled and urgent categories, but not for the semi-urgent category.	18
 	Wait Times – From Triage to Admission in the Emergency Department	Both the QEII and DGH are above the target of 8 hours for the 90 <sup>th</sup> percentile wait time.	19

Target	Indicator Name	Status / Comment	Page
	Wait Times – From Triage to Physician in the Emergency Department	None of the four sites is meeting the target of 30 minutes.	20
	Wait Times – Priority Interventions	None of the four priority interventions is meeting its target.	21
<b>Patient Safety Indicators</b>			
	Transmission Rates – MRSA	The transmission rates at CDHA are far below the 2011 national incidence rate.	22
	Incidence Rate – VRE	The rates at CDHA are below the 2012 national rate.	23
	Infection Rate – C. difficile	The rates at CDHA are below the 2012 national rate.	24
	Hand Hygiene Compliance	For Jan–Mar 2014, the “before patient/patient environment contact” rate was 65%—short of the target of 80%. The “after” rate was 81%—better than the target of 80%.	25
	Hospital Standardized Mortality Ratio	For Q1–Q3 2013/14 CDHA’s HSMR showed no statistically significant difference from the 2009/10 national average.	26
	Patient Experience Survey	In 2013/14, the positive response target of 90% was exceeded in four of the eight patient experience dimensions.	27
	Patient Safety Culture	No target set. The 2012 survey shows improvement over the 2010 and 2006 surveys.	28
	Completion of Patient Safety Training	For April to June of 2014/15, 33% completed at least one patient safety training course.	29
<b>Additional Transforming the Person-Centred Health Care Experience Indicators</b>			
	Length of Stay – Number of Conservable Days	If the trend seen in the first two months of 2014/15 continues for the remainder of the fiscal year, the target will be met.	30
	Occupancy Rates	For 2013/14, the DGH occupancy rate was above the target of 90% (unfavourable), but the rate for the QEII was just below this target (favourable). This trend continued into April–June of 2014/15.	31
	Emergency Department – Left Without Being Seen	All sites are over the 2% target except Hants.	33
	Long Term Care – Patients Placed & Waiting to be Placed	In March 2014, there were 77 patients waiting to be placed. This is very close to the target of 75.	34
<b>B</b>	Strengthen Community-Based Care for Chronic Disease	Baseline measurement only at this time	36
	Improve Quality of Care in Transitions	In 2013/14, the compliance with inclusion of patient instructions/ education in discharge summary reports was 59.9%. This exceeds both the 2013/14 target of 25% and the three-year, 2015/16 target of 50%.	37
<b>B</b>	Build a Culture of Customer Service	Baseline measurement only at this time	38

Target	Indicator Name	Status / Comment	Page
<b>Citizen and Stakeholder Engagement and Accountability</b>			
<b>B</b>	Partner with the Public so Individuals and Communities can Play a Key Role in Managing Their Own Health	Baseline measurement only at this time	39
<b>B</b>	Involve Patients Directly in Their Care	Baseline measurement only at this time	40
<b>B</b>	Lead Dialogue with the Public Addressing Appropriateness of Care	Baseline measurement only at this time	41
<b>Transformational Leadership</b>			
	Absenteeism	For the complete 2013/14 fiscal year, the average monthly sick hours was above target, but was an improvement over the previous year. The average for the first three months of 2014/15 shows an increase over the 2013/14 average.	42
	Overtime	For April–June 2014 the average rate of overtime hours worked was lower than the 1.89% target (favourable).	43
◆	Employee Survey	Pride, trust in peers, & spiritual wellness are areas to celebrate. Areas for improvement include psychological safety, involvement in decision making, & trust in management.	44
◆	Employee Survey – Accreditation Canada Worklife Pulse	Employee ratings of ‘job satisfaction’ and ‘clarity about expectations’ remained high for 2012. However, there were slight increases in the number of ‘unfavourable’ responses in almost all dimensions	45
◆	Physician Survey	Of the 6 sections presented, trust in colleagues and respect had the highest percentage of favourable responses, while trust in Capital Health management and engagement with Capital Health had the lowest.	46
<b>B</b>	Improve Leadership Capacity at all Levels	Baseline measurement only at this time	47
<b>B</b>	Strengthen Accountability of Employees and Physicians.	Baseline measurement only at this time	48
<b>Innovating Health and Learning</b>			
◆	Research Funds from Grants & Contracts	For 2013/14, both grants and contracts were up from the previous year. Funds from grants rose significantly.	49
<b>B</b>	Focus on Innovation that has Benefits for Patients & Aligns with Our Mission.	Baseline measurement only at this time	50
<b>B</b>	Strengthen Partnerships with Learning Institutions	Baseline measurement only at this time	51
<b>B</b>	Build our Capacity for Interprofessional Research and Interprofessional Education	Baseline measurement only at this time	52

Target	Indicator Name	Status / Comment	Page
<b>Sustainability</b>			
	Innovate Systems and Processes for Greater Efficiency	For the 2013/14 fiscal year, the percentage of typical cases for the three CMGs with an ALOS equal to or less than the ELOS was 48%—short of the target of 52%.	53
<b>B</b>	Develop Funding Models Based on our Priorities	Baseline measurement only at this time	54
<b>B</b>	Be Better Environmental Stewards	Baseline measurement only at this time	55
<b>n/a</b>	Implementation of the Electronic Health Record	Capital Health’s efforts to implement an EHR have stalled due to the province’s desire to have a single health information solution.	56
	Actual Expenditure to Approved Budget	Actual expenditure showed a variance of 0.44 % over the approved budget.	57
	Focus on Sustainability	Percentage of approved funding requests was below target for infrastructure, clinical equipment, and equipment.	58
	Improve Population Health	In 2013-14 Capital Health actively contributed to five major public policies. This is just short of the target of six.	59

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Appendix B: Access (Wait Times) Scorecard		61
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Appendix F: Summary of the 14 Areas of Focus with Respect to the 2013/14 Targets		66
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# Introduction

Capital Health's Strategic Indicators Report is a stimulus for quality improvement as it provides multi-year data on key indicators identified by Capital Health stakeholders. Over the summer and fall of 2009, leaders within Capital Health were asked to identify strategic indicators which would aid in their work to fulfill "Our Promise" to become a world-leading haven for people-centred health, healing, and learning. This process resulted in the creation of the Capital Health Indicator Development document which itemizes indicators by five Strategic Streams:

- 1. Transforming Person-Centred Health Care Experience**
- 2. Sustainability**
- 3. Transformational Leadership**
- 4. Citizen and Stakeholder Engagement & Accountability**
- 5. Innovating Health & Learning**

Appendix C provides a detailed description of the strategic streams. Indicators in this report fall under these five streams.

The Quality and Patient Safety Framework is also based around these five strategic streams (Appendix D) (as well as the eight Qmentum Quality Dimensions outlined by Accreditation Canada).

The *Our Promise Milestones* timeline came to an end in March 2013 and the final reporting on their progress was done in the July 2013 version of this report. Even though the time frame for the Milestones has ended, several of the milestones are being carried forward in this report for continued monitoring.

## **Strategic Plan Renewal: Beyond 2013**

With the input of hundreds of patients, family members, citizens, staff and physicians, Capital Health's strategic plan has been renewed for the next three years (2013 to 2016). The renewed plan, entitled "Our Promise in Action," remains anchored around the same five key streams or strategies mentioned above.

Details surrounding these five strategies, as well as the 14 Areas of Focus within the strategies, are outlined in the "Our Promise in Action" poster which can be found in Appendix E. The 14 areas of focus are presented in this report under their own section. So far, only baseline measures are presented. When some measureable progress is available, it will be summarized in a table in Appendix F.

For additional information on Capital Health's "Our Promise in Action", please visit the Capital Health website at <http://www.cdha.nshealth.ca/our-promise-action>

## Indicator Sections

Each indicator in this report is summarized by answering the following four questions:

1. What is being measured?
2. Why is it important?
3. How are we doing?
4. What are we doing about this?

As this is a new format for the report, not all indicator sections yet have information for each of the four questions. This will be added as the information is collected. Progress for each indicator is also shown visually on an accompanying graph.

As well, the following icons appear at the top of selected indicator pages:



The **Patients First** icon specifies a **patient safety** indicator.



The **Our Promise in Action** icon specifies an **Area of Focus** indicator

This report provides a consistent set of key strategic indicators and an analysis of the results. All indicators will be reported in each publication, although some indicators will be updated less frequently. For example, data regarding research funds from grants and contracts are updated annually; however, the indicator will remain in each publication. This will ensure regular, consistent access to key strategic indicators. Where possible, indicators are reported at the district level to provide an overall picture of district-wide activities. The Capital Health Strategic Indicators Report will be posted on the Capital District Health Authority's website to ensure easy and broad access.

High level, overview summaries of patient safety indicators and access (wait times) indicators are provided in Appendices E and F respectively. The most recent measures as well as colour coding with respect to meeting targets are provided.

## Data Quality and Revisions

The numbers presented in the graphs, tables, and narratives of this report come from a variety of sources. Every effort is made to ensure the data are accurate at the time of publication. Each publication only provides updated data for the most recently available time periods. Data from past time periods are not revised each time the report is published, so changes or corrections made to historical source data are not reflected in this report. Historical changes are carried over to the report when indicator definitions or data collection methods

are changed. It should be noted that when such changes are made, they are not made to older versions of this report.

### **External Links**

This report may provide links to other Internet sites only for the convenience of readers. Capital Health is not responsible for the availability or content of these external sites and cannot guarantee that the information is current or accurate. This information is provided as a public service. Readers should verify the information before acting on it. Capital Health does not endorse, warrant or guarantee the products, services or information described or offered at any other Internet sites. Capital Health does not assume and is not responsible for any liability whatsoever arising from the linking to any linked website, the operation or content (including the right to display such information) of any linked website, or for any of the information, interpretation, comments, or opinions expressed in any linked website. Any comments or inquiries regarding the linked websites are to be directed to the organization operating the website.

### **Contributors**

This report would not be possible without the contributions of data, background information, and insights provided by many people at Capital Health. Those who are to be acknowledged for their valued contributions are listed in Appendix G.

# 1 Transforming the Person-Centred Health Care Experience

## Access Indicators

### 1.1 Surgery Cancellation Rates

#### What is being measured?

Cancelled surgeries are classified into two categories: 1) those cancelled for reasons originating in the hospital (resource related or preventable) and 2) those cancelled for reasons originating from the patient.

The cancellation rate (%) is calculated by dividing the number of patient- or hospital-related cancellations by the total number of elective surgical cases and then multiplying by 100.

The *Our Promise: 2013 Milestone* was to decrease *preventable* (resource-related) cancellations by 50% by 2012/13 (target of a 1.8% cancellation rate). January 2010 is the baseline time period when there was a cancellation rate of 3.4%.

#### How are we doing?

The graph below shows monthly cancellation rates for the most recent two-year period. The rate of resource-related cancellations has been higher than target (unfavorable) since December 2012, but dipped below target (favorable) in February 2014. In March, the rate went back to being higher than target. In April the resource-related

cancellation rate shot up to 10.6% because of the nursing strike that took place. The rate came back down to 2.3% in May and was the same in June. Patient-related cancellations have been below target for three months.

Two key contributing factors in June were:

- Emergency bumps (26 cases) for all sites. The services most affected were CV, plastics, vascular and neurosurgery.
- A lack of elective time (25 cases), the majority of which were at the VG (12) for gen surgery & thoracic.

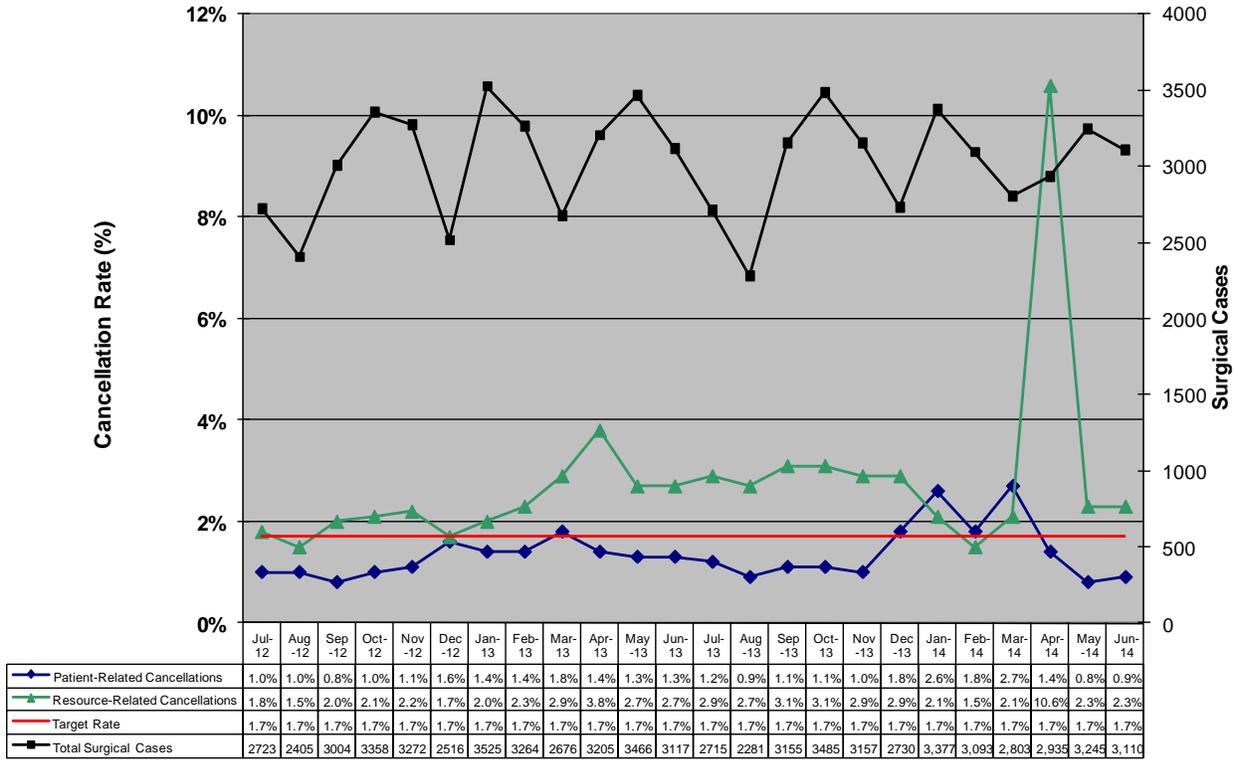
#### What are we doing about this?

Monthly meetings are held with the perioperative management team at which time case cancellations are reviewed to ensure there is prompt action to address the influencing factors.

Review of data will be done at OR executive in the fall as well.

[Text last updated August 2014]

### Capital District Surgical Cancellation Rates Resource- & Patient-Related Reasons



### Patient- and Hospital-Related Surgical Cancellation Rates & Total Surgeries for Recent Months

Facility	May 2014			June 2014		
	Patient-Related Cancellations	Resource-Related Cancellation	Total Surgeries	Patient-Related Cancellations	Resource-Related Cancellations	Total Surgeries
HI	0.1%	1.8%	1,103	0.4%	3.3%	1,060
VG	0.8%	2.2%	1,577	0.8%	1.7%	1,443
DGH	2.3%	3.6%	476	2.1%	2.1%	518
HCH	0.0%	3.4%	89	2.2%	0.0%	89

Frequency of Data Updates: Monthly

Data Last Updated: Aug. 2014

Next Data Update Expected: Sep. 2014

# 1.2 Wait Times – Elective CT

## What is being measured?

Computed tomography (CT) is a special radiographic technique that uses a computer to assimilate multiple x-ray images into a two-dimensional cross-sectional image. This can reveal many soft tissue structures not shown by conventional radiography. Scans may also be dynamic in which movement of a dye within the body is tracked.

This indicator is the weighted average wait time for elective CT (weighted as 23% cranial, 7% spine, 19% chest, 25% musculoskeletal and 25% abdominal).

## Why is it important?

In order to support the health and wellbeing of our community, it is critical to provide timely access to supportive diagnostic procedures. Capital Health is committed to reducing wait times and providing better health care for you and your family. Shorter wait times are important to you and it's a priority for us. CT scans serve a very important role in the identification and proper diagnosis of many health conditions. Early access to diagnostic services allows health providers to make

timely decisions about further care options and can make a real difference in the outcome for the patient.

## How are we doing?

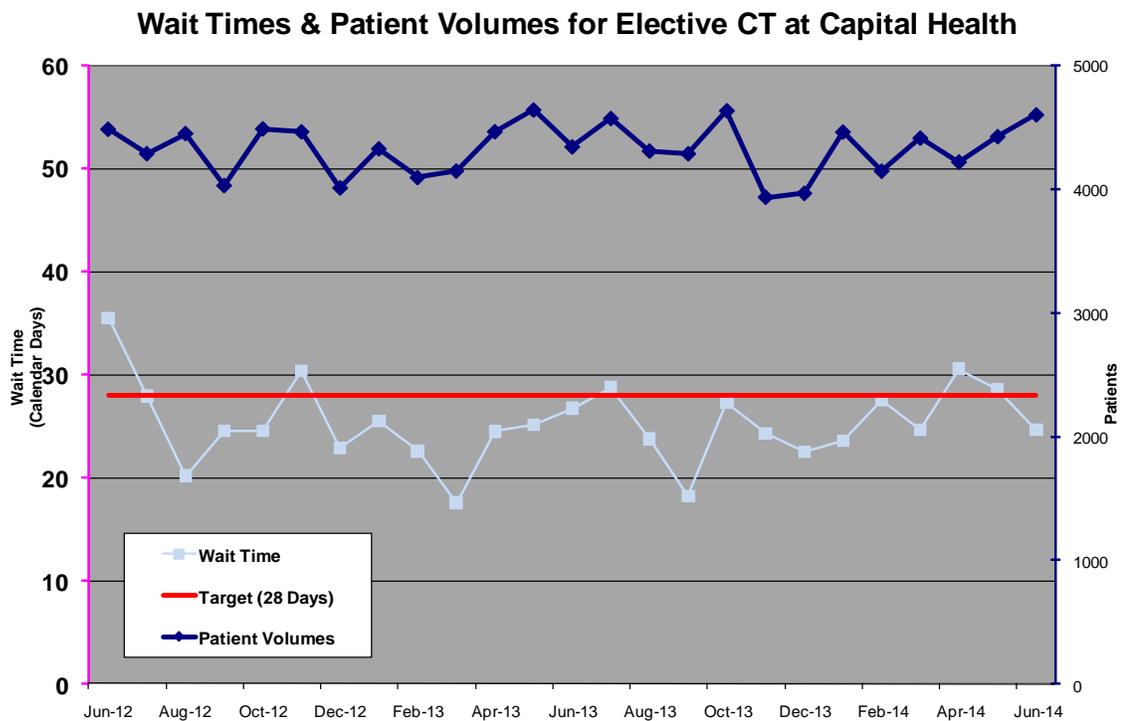
The graph below shows the wait times and patient volumes for elective CT at Capital Health. This is the average for the QEII, Dartmouth General, and the Cobequid Community Health Centre combined. The target wait time is 28 days. The June 2014 wait time was 25 days—3 days shorter than the target of 28 days.

To see recent wait times for elective CT at all locations in Nova Scotia click [here](#).

## What are we doing about this?

Capital Health continues to work to reduce wait times for CT exams. Capital Health received funding from the Department of Health and Wellness to replace an end-of-life CT scanner at the Victoria General site of the QEII. The new scanner began operation March 24, 2014 and should help to improve the care for patients at the Victoria General Hospital.

[Text last updated March 2014]



Graph Update Frequency: Monthly

Graph Last Updated: Aug. 2014

Next Graph Update Expected: Sep. 2014

# 1.3 Wait Times – Elective MRI

## What is being measured?

Magnetic Resonance Imaging (MRI) is a special imaging technique used to image internal structures of the body, particularly the soft tissues. MRI uses a powerful magnet, radio frequency waves, and computers to produce detailed images of the body in any plane. It provides much greater contrast between the different soft tissues of the body than does computed tomography (CT).

The average time from referral until procedure is weighted (72% neuro, 15% bone, and 13% body). Waits do not include QEII patients who have elective MRI procedures performed at the IWK. The target wait time is 28 days.

## Why is it important?

In order to support the health and wellbeing of our community, it is critical to provide timely access to supportive diagnostic procedures. Capital Health is committed to reducing wait times and providing better health care for you and your family. Shorter wait times are important to you and it's a priority for us. MRI scans serve a very important role in the identification and proper diagnosis of many health conditions. Early access to diagnostic services allows health providers to make timely

decisions about further care options and can make a real difference in the outcome for the patient.

## How are we doing?

In June 2014, the average wait time for MRI was 220 days—almost 8 times longer than the target of 28 days; however, a trend of improvement can be seen since December 2013.

All requests for MRI exams are triaged by radiologists for appropriateness and urgency level.

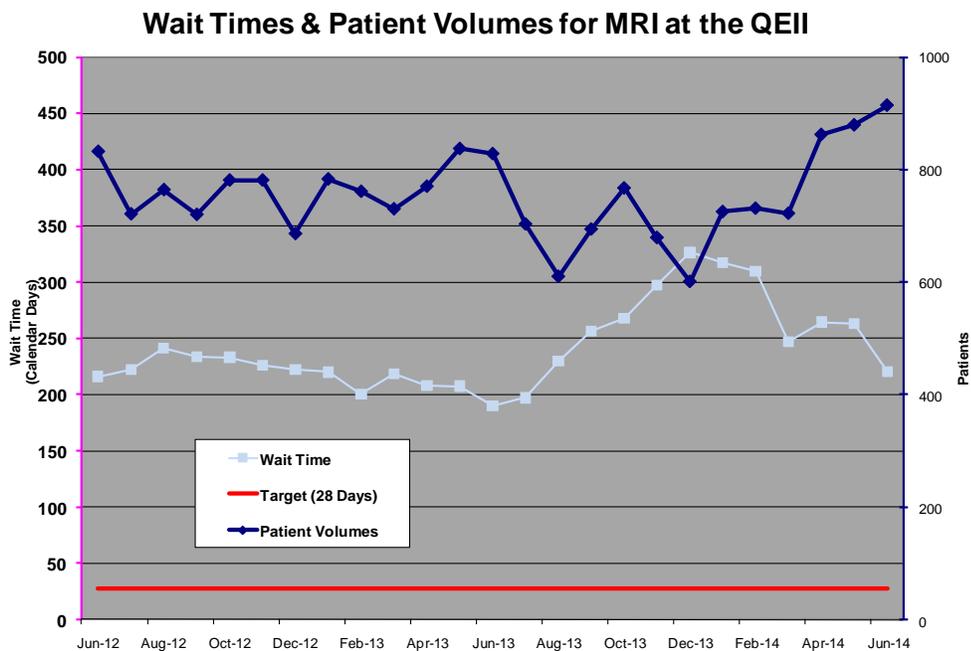
Over the last 6 months there has been a struggle to fill vacancies left by retirements and staff moving to other positions.

To see recent wait times for elective MRI at locations in Nova Scotia click [here](#).

## What are we doing about this?

All of the vacant MR positions have now been filled. New staff is being oriented to Capital Health and we will see increased capacity in early April 2014. As well, Dalhousie University implemented an MRI Specialty Practice Program in July 2013 and the first student is expected to graduate from the program in May 2014.

[Last updated March 2014]



Graph Update Frequency: Monthly

Graph Last Updated: Aug. 2014

Next Graph Update Expected: Sep. 2014

## 1.4 Wait Times - Radiotherapy Treatment

### What is being measured?

This indicator measures the wait time, in days, from date of receipt of referral for radiation therapy to the date that the treatment starts. Values shown are the average wait times for a one-month period.

### Why is it important?

In radiotherapy (also called radiation therapy), high-energy photons are used to damage cancer cells and stop them from growing and dividing. Target wait times for radiotherapy treatment are based on acuity level. Patients are assigned to an acuity level based on assessment by a radiation oncologist, a specialist in radiation therapy.

Examples of criteria for intermediate cases are inpatients in hospital for radiation services or patients having head and neck tumors. Subacute neurological dysfunction, tumor hemorrhage or severe uncontrolled pain are examples of cases requiring urgent radiotherapy.

### How are we doing?

The two graphs below show the average monthly wait times for patients in the urgent and intermediate categories. Patient volumes are also shown.

Wait times for *urgent* cases have been below the target (favourable) for the last year, except in January 2014, when the wait went slightly higher than the target. In early January, flooding in the Dickson Building affected the CT

simulator used for radiotherapy treatment planning and likely contributed to this increase in wait times.

Wait times for *intermediate* cases have been consistently longer than the target of 14 days, but have been less than 21 days for almost the past two years with the introduction of new equipment. The January 2014 average wait time showed a slight increase to 20.70 days which would also be a result of the flooding mentioned above. The June 2014 wait time was 19 days.

To see recent wait times for radiotherapy treatment at locations across Nova Scotia click [here](#).

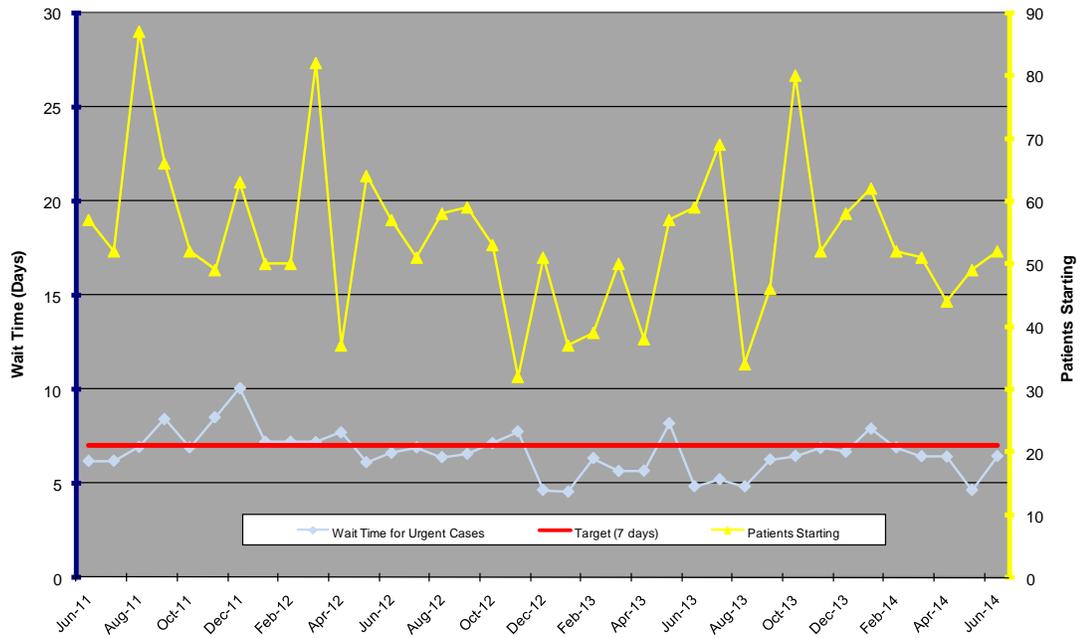
### What are we doing about this?

The opening of the James and Edna Claydon Radiation Therapy Clinic in October 2012 has provided additional radiation therapy capacity along with state of the art radiation therapy equipment. With the implementation of all of the new equipment by end of April 2013, it is expected wait times for intermediate and standard cases will decrease over this fiscal year.

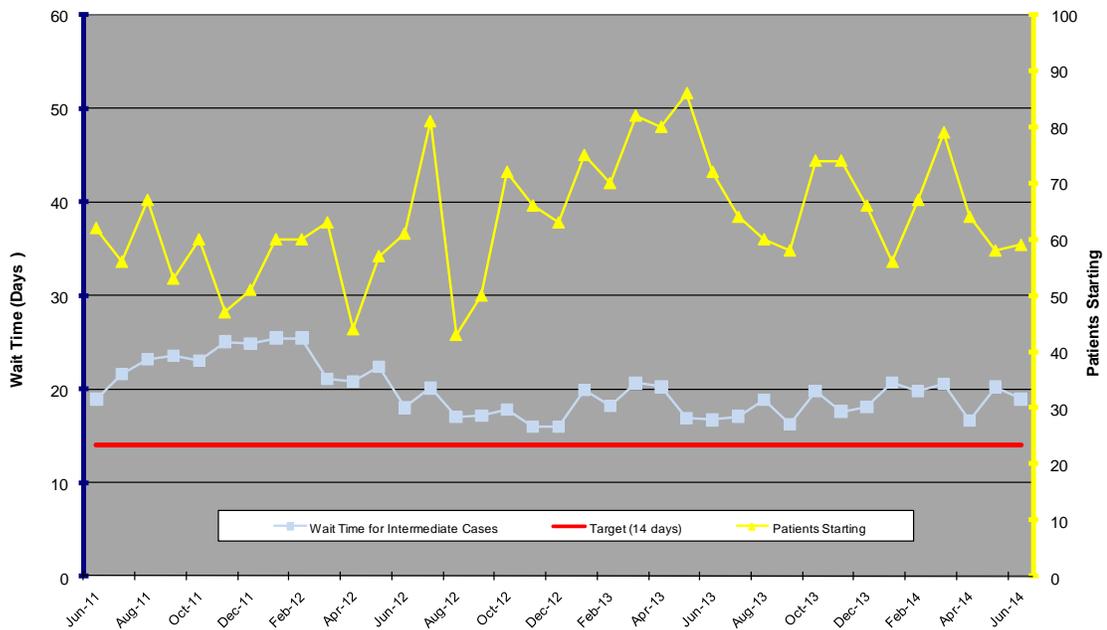
The new radiotherapy machines are more technologically advanced with better imaging. This will allow a decrease in patient treatment time along with a decrease in the number of fractions per patient, which means more patients can be treated and many patients will be on treatment for a shorter time. In addition, several process improvements, as well as an electronic medical record, have been implemented to reduce wait times.

[Last updated April 2013]

### Wait Times and Patient Volumes for Radiotherapy Treatment - Urgent



### Wait Times and Patient Volumes for Radiotherapy Treatment - Intermediate



Frequency of Graph Updates: Monthly

Graphs Last Updated: Aug. 2014

Next Graph Update Expected: Sep. 2014

# 1.5 Wait Times – Hip Fracture Surgery

## What is being measured?

This indicator is the percentage of patients who have fractured their hip and received repair surgery within the national benchmark target of 48 hours. Hip fracture repair is a procedure to fix a fracture of the femur bone (thigh bone) near the hip joint. The majority of cases are due to a fall or minor trauma in a person with weakened osteoporotic bones.

## Why is it important?

When a patient fractures their hip, clinical evidence shows patients have better clinical outcomes if surgical repair of the hip fracture takes place within 48 hours. The national benchmark for hip fracture repair is 48 hours.

## How are we doing?

The target is to have 100% of all cases of hip fracture repair receive their surgery in 48 hours. In Q1 of 2014/15, only 69% met the target (see graph below). Trauma for ortho has been very high and continues to be a challenge to manage with the OR resources available.

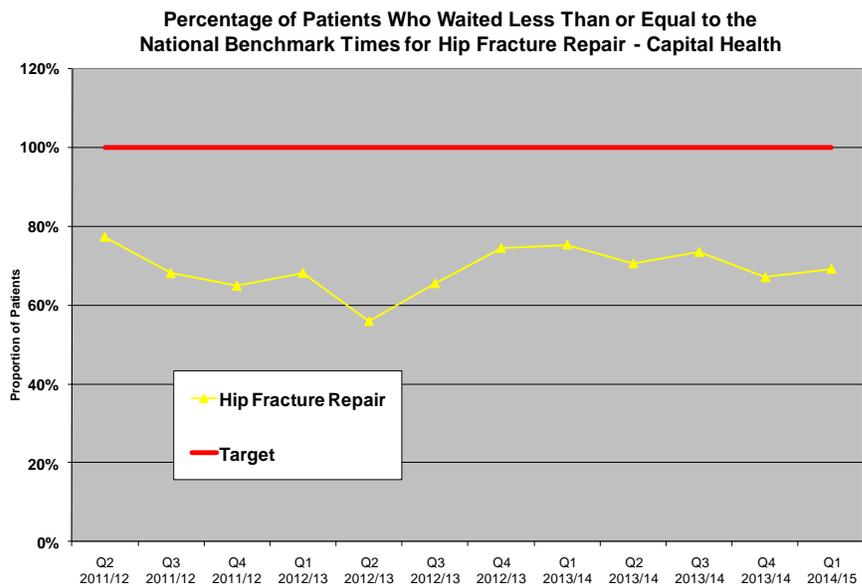
## What are we doing about this?

Strategies are in place to increase the number of patients with hip fractures who receive surgery within 48 hours.

These include:

- When number of ortho patients per day on the list is greater than 10, the OR manager/ortho navigator & trauma physician or Division Chief meet to review strategies to address.
- The Inpatient Team gets daily updates on the waitlist and what can be completed that day. This continues on the units to ensure discharges are done in a timely manner.
- Any last minute available OR time is being realigned to support orthopedic trauma.
- Elective ortho cases are cancelled when the list is greater than 12-14 ortho patients. However this then has a negative impact on elective cases such as hip arthroplasty.
- Inpatient Ortho Leadership meetings take place on a monthly basis (with the managers and Dr. Amirault) during which discussions take place related to long-stay patients; challenges with discharges; and resident rounds for each of the three units ensuring accuracy of discharge orders, prescriptions, and care that may be required upon discharge in the community.

[Last updated August 2014]



Frequency of Graph Updates: Quarterly

Graph Last Updated: Aug. 2014

Next Graph Update Expected: Nov. 2014

# 1.6 Wait Times – Hip Replacement

## What is being measured?

Hip replacement is a surgical procedure in which the hip joint is replaced by a prosthetic implant. This procedure is generally done to relieve arthritis pain, or fix severe physical joint damage as part of hip fracture treatment. Measuring the time between when the orthopedic surgeon confirms the patient requires a hip replacement to the time the patient undergoes hip replacement surgery (wait time 2) is an important indicator of access to healthcare services. The national benchmark for wait time for hip replacement surgery is 182 days.

## Why is it important?

National benchmarks express the amount of time that clinical evidence shows is appropriate to wait for such a procedure. Over the past decade wait times for several surgical procedures such as hip replacement surgery have become a focus of Canadian healthcare as these wait times are a means of measuring access to healthcare services for Canadians.

## How are we doing?

The graph below shows the percentage of patients who had their hip replacement surgery within the target wait time of 182 days. The target is to have 100% of hip

replacement surgeries completed within this target time. In Q1 of 2014/15, only 58% of patients had their surgery within the benchmark of 182 days.

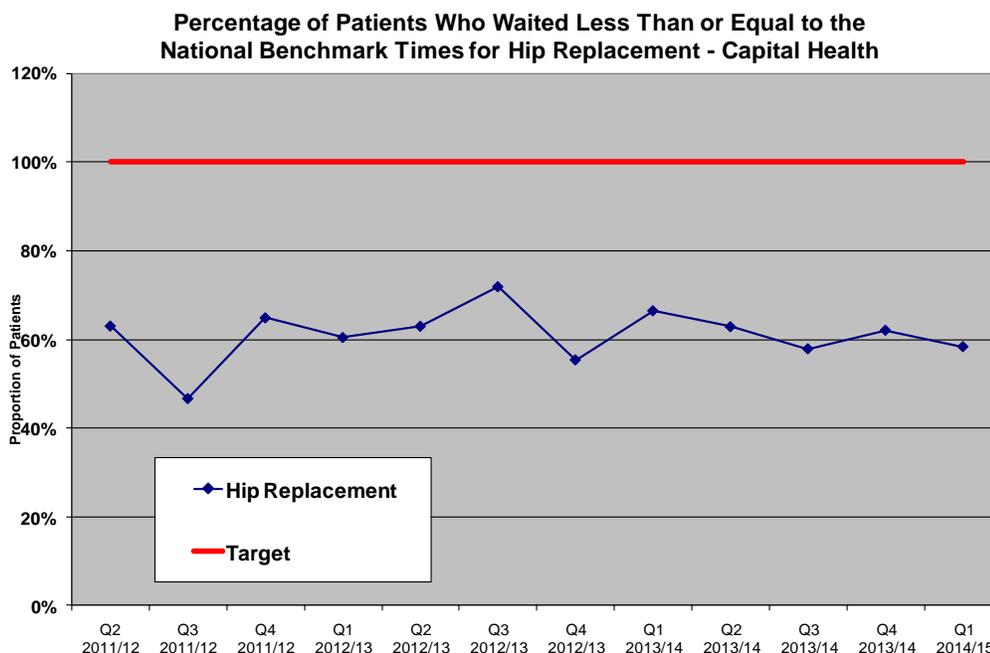
To see recent wait times for hip replacement surgery at different locations across Nova Scotia click [here](#).

## What are we doing about this?

Several strategies are being undertaken:

- A proposal for 2014/15 joint procedures was submitted to the Department of Health and Wellness. Due to nursing & anesthesia resource challenges, there is no ability to provide additional joint procedures in Q1 and Q2 of 2014/15. We are on track with nursing recruitment to achieve this.
- Ortho Leadership meetings take place on a monthly basis (with the managers and Dr. Amirault) during which discussions take place related to long-stay patients; challenges with discharges; and resident rounds for each of the three units ensuring accuracy of discharge orders, prescriptions, and care that may be required upon discharge in the community.

[Text last updated August 2014]



Frequency of Graph Updates: Quarterly

Graph Last Updated: Aug. 2014

Next Graph Update Expected: Nov. 2014

# 1.7 Wait Times – Knee Replacement

## What is being measured?

Knee replacement is a surgical procedure in which the weight-bearing surface of the knee joint is replaced to relieve the pain and disability of osteoarthritis. Measuring the time between when the orthopedic surgeon confirms the patient requires a knee replacement to the time the patient undergoes the surgery (wait time 2) is an important indicator of access to healthcare services. The national wait time benchmark for knee replacement surgery is 182 days.

## Why is it important?

National benchmarks express the amount of time that clinical evidence shows is appropriate to wait for such a procedure. Over the past decade wait times for several surgical procedures including knee replacement surgery have become a focus in Canadian healthcare as these wait times are a means of measuring access to healthcare services for Canadians.

## How are we doing?

The graph below shows the percentage of patients who had their knee replacement surgery within the target wait time of 182 days. The target is to have 100% of all patients' knee replacement surgery performed within 182 days. In

Q1 of 2014/15, only 37% of patients had their knee replacement surgery within the target time.

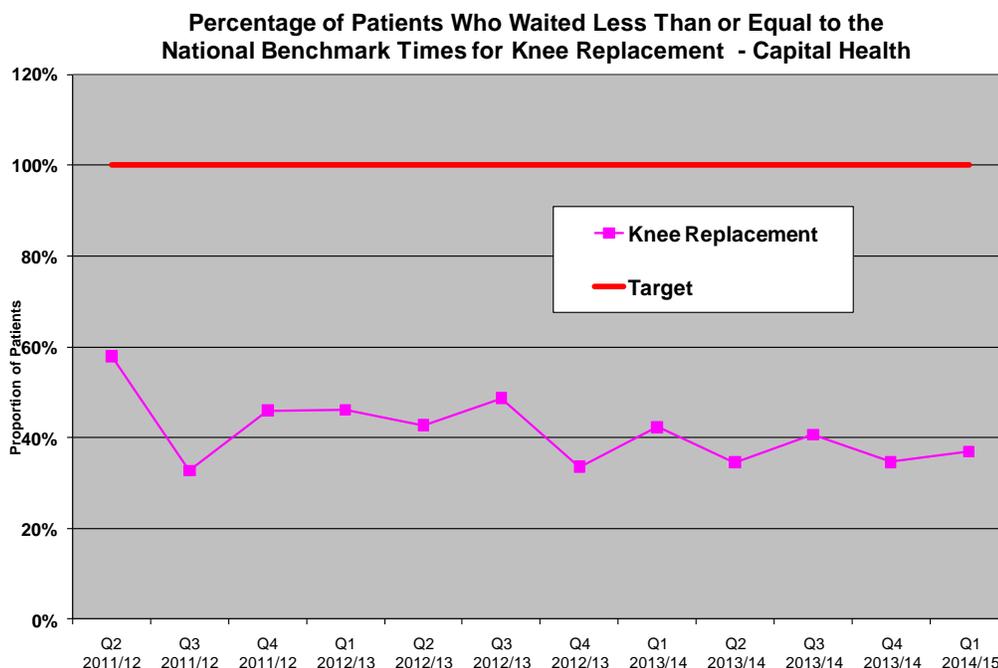
To see recent wait times for knee replacement surgery at different locations across Nova Scotia click [here](#).

## What are we doing about this?

Several strategies are being undertaken:

- Proposal for 2014/15 joints was submitted to the Department of Health and Wellness. Unable to deliver additional joints in Q1 and Q2 due to nursing & anesthesia resource challenges. We are on track with nursing recruitment to achieve this.
- Ortho Leadership meetings take place on a monthly basis (with the managers and Dr. Amirault) during which discussions take place related to long-stay patients, challenges with discharges, resident rounds for each of the three units ensuring accuracy of discharge orders, prescriptions, and care that may be required upon discharge in the community.

[Last updated August 2014]



Frequency of Graph Updates: Quarterly

Graph Last Updated: Aug. 2014

Next Graph Update Expected: Nov. 2014

# 1.8 Wait Times – Cataract Surgery

## What is being measured?

Cataract surgery is the removal of a clouded lens (or cataract) from the eye to improve vision. The nationally recognized benchmark wait time for cataract surgery is 16 weeks. This indicator is the number of patients who had their procedure done in a given quarter who waited less than or equal to the national benchmark time frame, divided by the total number of patients who had the procedure completed in the given month, multiplied by 100.

## Why is it important?

National benchmarks express the amount of time that clinical evidence shows is appropriate to wait for a procedure. Over the past decade, wait times for several surgical procedures, including cataract surgery, have become a focus in Canadian healthcare because these wait times are a means of measuring access to healthcare services for Canadians.

## How are we doing?

The goal is to have 100% of patients have their cataract surgery within the benchmark wait time of 16 weeks. The graph below shows the quarterly percentages of patients who had their cataract surgery within the benchmark wait time. In Q1 of 2014/15, the rate was 74%. Over the past several quarters, there has been a trend of improvement.

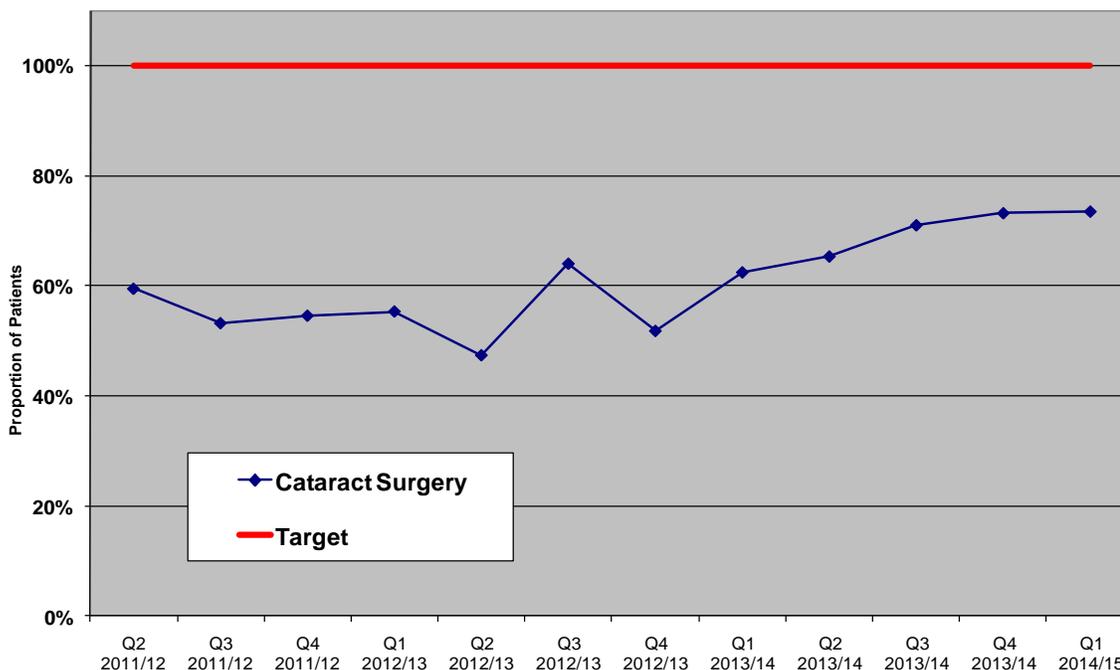
To see recent wait times for cataract surgery at different locations across Nova Scotia click [here](#).

## What are we doing about this?

OR efficiencies have resulted in the ability of the clinical team to increase the number of cataract surgeries performed per room per day. The trend shown below in the graph below demonstrates this has been effective in increasing the number of cataract surgeries being performed within the target timeline.

[Last updated August 2014]

**Percentage of Patients Who Waited Less Than or Equal to the National Benchmark Time for Cataract Surgery - Capital Health**



Frequency of Graph Updates: Quarterly

Graph Last Updated: Aug. 2014

Next Graph Update Expected: Nov. 2014

# 1.9 Wait Times – Open Heart Surgery

## What is being measured?

This indicator is the median wait time for coronary artery bypass graft (CABG) procedures. Median wait time is the time half of the patients waited for their procedure.

## Why is it important?

The chances of dying or having a heart attack increase as wait times exceed standards. Longer wait lists impact on the quality of life for patients awaiting surgery. An article published August 21, 2001 in the Canadian Medical Association Journal found a significant decrease in physical and social functioning, both before and after surgery, for patients waiting more than three months for their surgery. Patients waiting greater than three months also had a higher perioperative event rate than those waiting less than three months. Longer wait lists are associated with reduced likelihood of returning to gainful employment and thus lost productivity to society

## How are we doing?

Median wait times for CABGs are shown in the graph below. The median wait time for *urgent* cases has fluctuated a great deal over the past few months but was just under target (favourable) for May and June 2014.

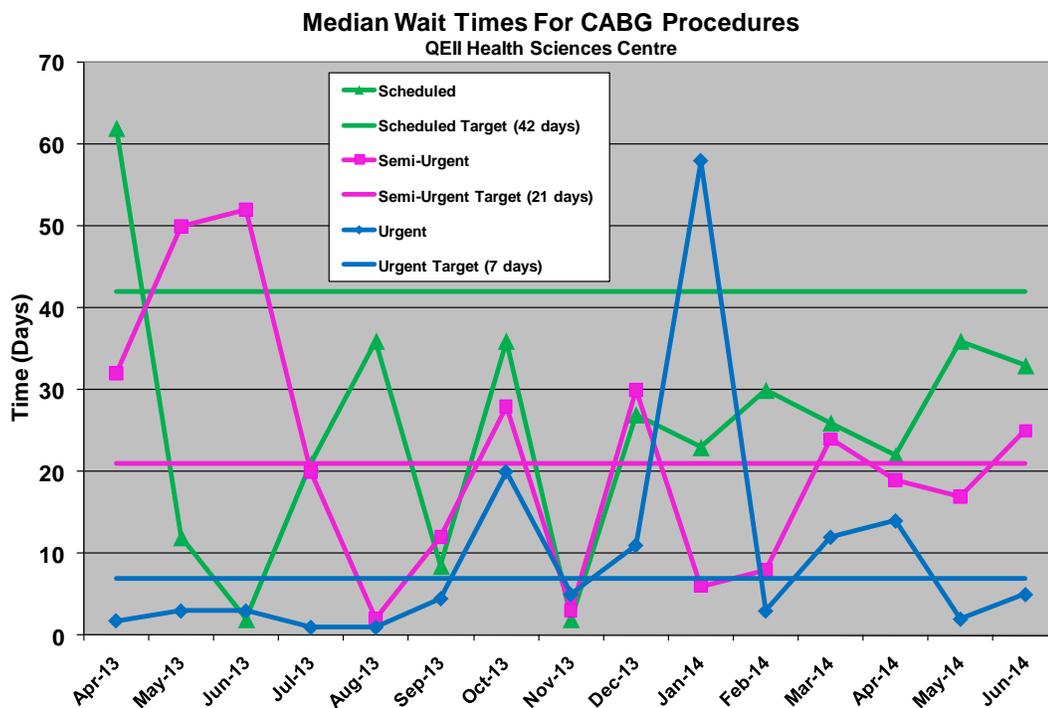
The median wait times for *scheduled* cases have been better than target since May 2013. Several patients who no longer needed to be on the list were removed that month.

*Semi-urgent* cases have been fluctuating above and below the target for the past year. Most recently, in April and May 2014, the median wait time was better than the target of 21 days; however, the wait went over target in June.

## What are we doing about this?

Bed capacity is the most challenging factor affecting these wait times. Options for managing long-term ventilated patients and model of care for ICUs are being explored.

[Last updated February 2014]



Frequency of Graph Updates: Monthly

Graph Last Updated: Aug. 2014

Next Graph Update Expected: Sep. 2014

# 1.10 Wait Times – From Triage to Admission in the Emergency Department

## What is being measured?

This indicator is the 90th percentile emergency department (ED) wait time from the time of triage to the time of admission. The 90th percentile wait time is the time in which 90% of patients wait. Clinical Decision Unit patients are not included.

## Why is it important?

In 2010, the Institute of Clinical Evaluative Sciences identified the ED 90th percentile length of stay for admitted patients as the most important strategic indicator for quality in the ED and as a surrogate marker of overall hospital functioning.

Patients waiting in the ED for admission to an inpatient unit increase the overall ED wait times, the percentage of patients leaving the ED without being seen, and ambulance offload intervals, and are also associated with increased adverse events, mortality, inpatient lengths of stay, and overall costs.

## How are we doing?

The goal is to have the 90th percentile wait time meet the target of eight hours—as outlined in *Better Care Sooner*, the plan to improve emergency care in Nova Scotia. Both the QEII and DGH sites have 90th percentile waits that are well over the target of eight hours. See the graph below.

For additional emergency-department indicators, click [here](#) to go to the CDHA ED Quarterly Performance Reports web page.

## What are we doing about this?

Since January 2012 the staffing levels at the DGH ED have slowly improved. In the spring of 2012, various initiatives to focus on improving wait times were implemented: 1) a nurse liaison role was implemented which provides a second assessment point for patients in the waiting room. This nurse begins to complete blood work and ECGs for patients ensuring test results are available

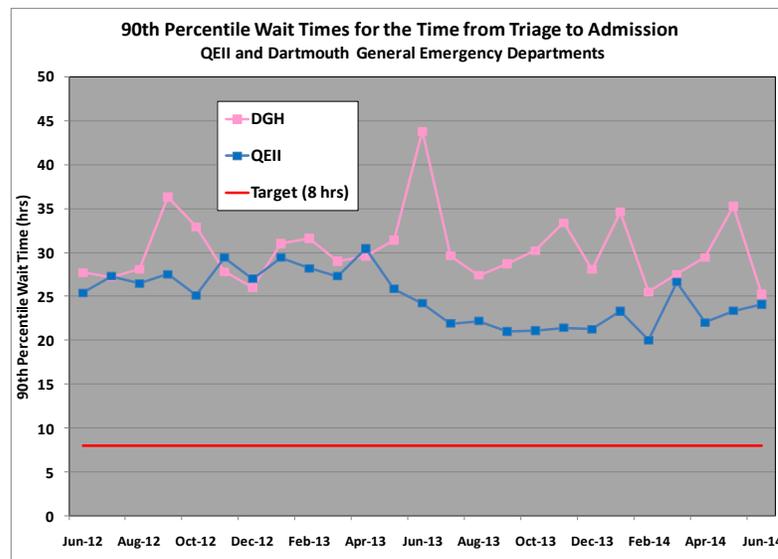
when the patient is seen by the physician. 2) An Offload Team staffed by a nurse and paramedic has been implemented to offload ambulances and allow them to get back into the community. The Offload Team begins care for patients and there are times when more acutely ill patients are seen by the physician in this area before beds are available. 3) In October of 2013, a new process for transferring admitted patients and their information to inpatient units was implemented which should significantly decrease the time it takes for patients to leave the department when inpatient beds are assigned.

The Flow Committee continues to look at flow within the ED and make changes to how beds are filled and how patients no longer requiring beds can receive follow-up care in alternative locations, thus freeing beds for those who need them.

The following changes have been implemented at the HI ED:

- Expansion of the patient flow manager role to 7 days a week
- Wait times & patients leaving without being seen are addressed by having Pod 5 open 24/7 since Sept. 2013. The care model now includes CTAs to allow flex in the system to increase bed capacity as necessary.
- Off-load initiatives continue to reduce off-load times
- Expansion of the Rapid Assessment Area to include weekend access
- District initiation for ambulance smoothing
- Collaboration with services for rapid access clinics i.e., atrial fibrillation and TIA's
- Protocols in place for stroke and STEMI access and care

[Last updated November 2013]



# 1.11 Wait Times – From Triage to *Physician* in the Emergency Department

### What is being measured?

This indicator is the average emergency department (ED) wait time from the time of triage to the time seen by a physician for Canadian Triage and Acuity Scale (CTAS) level III cases only.

### Why is this important?

CTAS Level III cases are considered urgent because they could potentially progress to a serious problem.

### How are we doing?

The graph below shows the average wait times from triage to physician for CTAS Level III for the last three years. A breakdown by ED site is provided. The target time is 30 minutes. All sites have wait times longer than the target.

At Hants, wait times are a result of admissions remaining in the ED due to inpatient beds being at capacity, increased time to consult/tertiary care, and having only a single ED physician.

For additional ED indicators, click [here](#) to go to the Capital Health ED Quarterly Performance Reports web page.

### What are we doing about this?

Since January 2012 the staffing levels at the DGH ED have slowly improved. In the spring of 2012, various initiatives to focus on improving wait times were implemented: 1) A nurse liaison role was implemented which provides a second assessment point for patients in the waiting room. This nurse begins to complete blood work and ECGs for patients ensuring test results are available

when the patient is seen by the physician. 2) An Offload Team staffed by a nurse and paramedic has been implemented to offload ambulances and allow them to get back into the community. The Offload Team begins care for patients and there are times when more acutely ill patients are seen by the physician in this area before beds are available. 3) In October of 2013, a new process for transferring admitted patients to inpatient beds was implemented which should significantly decrease the time it takes for patients to leave the department when inpatient beds are assigned. 4) While this indicator shows average wait time for CTAS 3 patients, there has been a significant reduction in wait times for CTAS 4 & 5 patients by changing processes in the fast track area where lower acuity patients are seen faster, thus reducing door-to-physician time & their total ED length of stay.

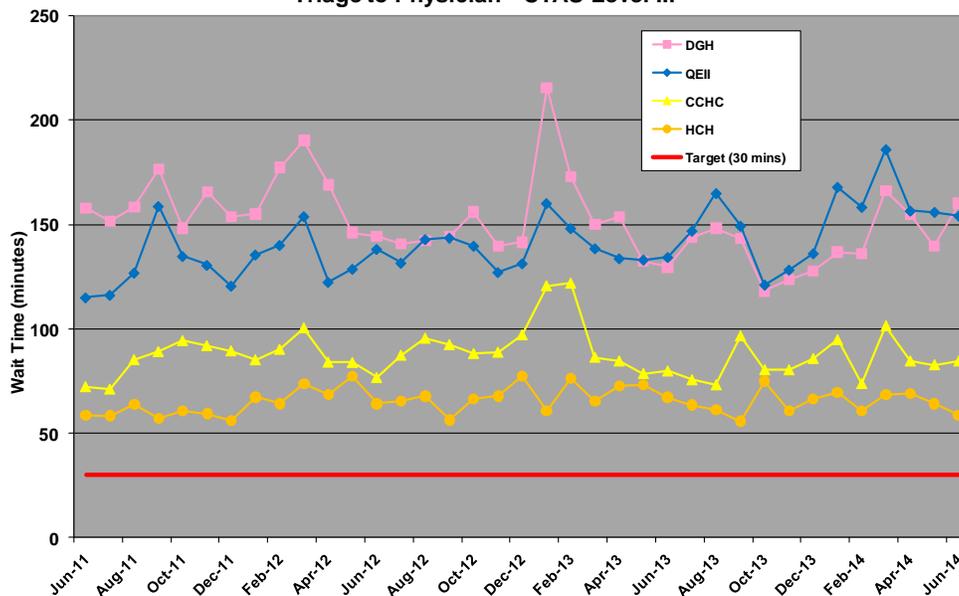
The Flow Committee continues to look at flow within the department and make changes to how beds are filled and how patients no longer requiring beds can receive follow-up care in alternative locations, thus freeing beds up for those in need.

The following changes have been implemented at the HI ED:

- Continuous process improvements in the use of Pod 1
- Physician role and schedule alterations based on flow patterns
- Expansion of RAU hours to include weekend access

[Last updated November 2013]

**Average Emergency Wait Times**  
Triage to Physician - CTAS Level III



Frequency of Graph Updates: Monthly

Graph Last Updated: August 2014

Next Graph Update Expected: September 2014



## 1.12 Wait Times – Priority Interventions

**Strategy:** Patient-Centred Health Care

**Goal:** Meet national benchmarks for service access

**Measure:** Access wait times for designated clinical areas (MRI, hip, knee, and ED (triage to admission))

### What is being measured?

Indicators in this section are average, 90<sup>th</sup> percentile wait times, or the percentage of cases completed with the target time.

### Why is it important?

National benchmarks express the amount of time that clinical evidence shows is appropriate to wait for such a procedure. Over the past decade wait times for several surgical procedures such as hip and knee replacement surgery, MRIs and emergency waits have become a focus of Canadian healthcare as these wait times are a means of measuring access to healthcare services for Canadians.

### How are we doing?

The table below shows the wait time results for MRI, hip replacement, knee replacement, and for triage to admission in the ED.

To see recent wait times for key health interventions at different locations across Nova Scotia click [here](#).

### What are we doing about this?

All of the vacant MR positions have now been filled. New staff is being oriented to Capital Health and we will see increased capacity in early April 2014. As well, Dalhousie University implemented an MRI Specialty Practice Program

in July 2013 and the first student is expected to graduate from the program in May 2014.

Several strategies are in place to increase the number of patients with hip fractures who receive surgery within 48 hours including:

- Any last minute available OR time is being realigned to support orthopedic trauma
- Inpatient Ortho Leadership meetings take place on a monthly basis during which discussions take place related to long-stay patients, challenges with discharges, resident rounds for each of the three units ensuring accuracy of discharge orders, prescriptions, and care that may be required upon discharge in the community

Strategies are being undertaken to reduce the wait time for knee replacement surgery including:

- Between November/13 & March/14 a total of 130 additional hip/knee joint patients that were long waiters were completed – 35 above target
- A proposal for 2014/15 joints will be submitted to the Department of Health and Wellness.
- A team gets daily updates on the waitlist and what can be completed that day. This continues on the units to ensure discharges are done in a timely manner.

[Last updated July 2014]

LEGEND	Not meeting target	Almost meeting target	Meeting target
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Treatment / Procedure	Target Wait Time	Location	Wait Times for June 2014 (except where noted)
Magnetic Resonance Imaging (MRI)	28 days	QEII	220 days (average)
Hip Replacement	100% of cases completed within 26 weeks	Capital Health	58% of cases completed within target (Q1 2014/15)
Knee Replacement	100% of cases completed within 26 weeks	Capital Health	37% of cases completed within target (Q1 2014/15)
ED – 90 <sup>th</sup> Percentile Wait Time from Triage to Admission	8 hours	QEII	24 hours (90 <sup>th</sup> percentile)
		DGH	25 hours (90 <sup>th</sup> percentile)

# Patient Safety Indicators

## 1.13 Transmission Rates – MRSA

### What is being measured?

MRSA transmissions are those cases that are acquired by patients while admitted to a Capital Health facility over a defined period of time.

### Why is it important?

MRSA is one of the most significant antibiotic-resistant organisms that can cause healthcare-associated infections. If an infection occurs, antibiotic treatment choices are limited and the infection may be more difficult to treat.

In the health care setting, the primary ways in which MRSA is transmitted are the unwashed hands of caregivers, breaches in isolation precautions, and patient contact with contaminated and improperly cleaned communal equipment. MRSA is not airborne. MRSA does not cause one specific type of infection, but it may cause a variety of infections such as pneumonia, surgical wound infection, and urinary tract infection.

Careful hand hygiene before and after contact with the positive patient or their environment is one of the most important control measures for health care providers in preventing MRSA transmission.

### How are we doing?

In 2011, according to the Canadian Nosocomial Infection Surveillance Program (CNISP) the national incidence rate

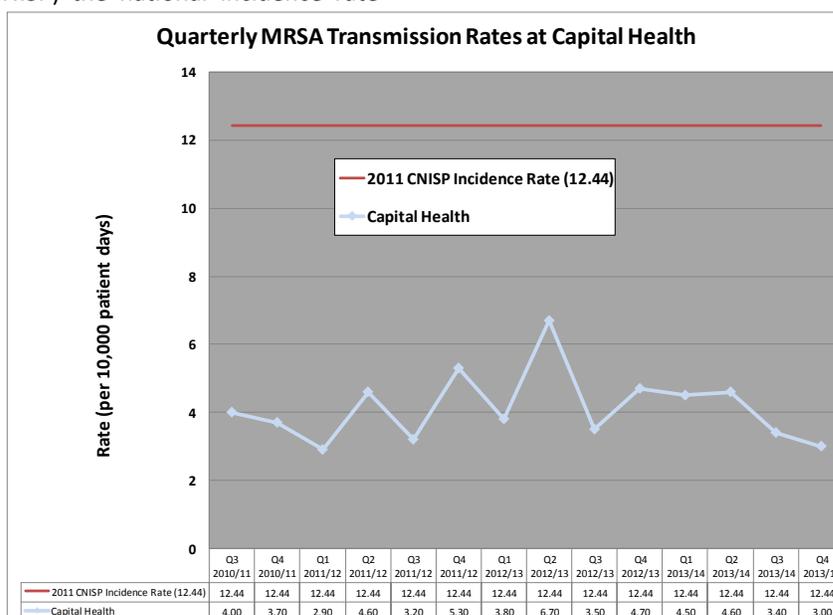
was 12.44 per 10,000 patient days. The transmission rates at Capital Health have been far below this national rate.

### What are we doing about this?

The following prevention and control measures are in place at Capital Health:

- All patients with MRSA are provided with a single room with dedicated toileting facilities. If a private room is not available, patients are co-horted, based on risk assessment with Infection Control.
- Staff and visitors are to wear a gown & gloves (no mask) when providing care or are in close contact with the patient/patient environment. Discard before leaving the room.
- Dedicate patient equipment (if this is not possible, clean and disinfect shared equipment after patient use). Thoroughly clean & disinfect all touch surfaces and equipment within the patient environment.
- Inform receiving departments/caregivers that Contact Precautions are required. Ensure that Transfer and Discharge Swabs are completed as per policy.
- Housekeepers spend extra time cleaning the environment after patients are discharged.
- Targeted approach to promote good Hand Hygiene.

[Text last updated Sept 2013]



Graph Update Frequency: Quarterly

Graph Last Updated: June 2014

Next Graph Update Expected: Summer 2014

# 1.14 Incidence Rate – VRE

## What is being measured?

This indicator measures the rate of newly identified cases of VRE among patients admitted to a Capital Health facility over a defined period of time.

## Why is it important?

VRE can cause a variety of infections, most commonly surgical site infection and urinary tract infections. VRE is, however, one of the most significant antibiotic-resistant organisms. So if an infection occurs, antibiotic treatment choices are limited and the infection can be more difficult to treat.

VRE is spread in health care settings primarily by the hands of health care workers, from breaches in isolation precautions, and from contact with contaminated equipment, or other surfaces. It is not airborne. Careful hand hygiene before and after contact with the infected patient or their environment is the most important control measure in preventing transmission.

## How are we doing?

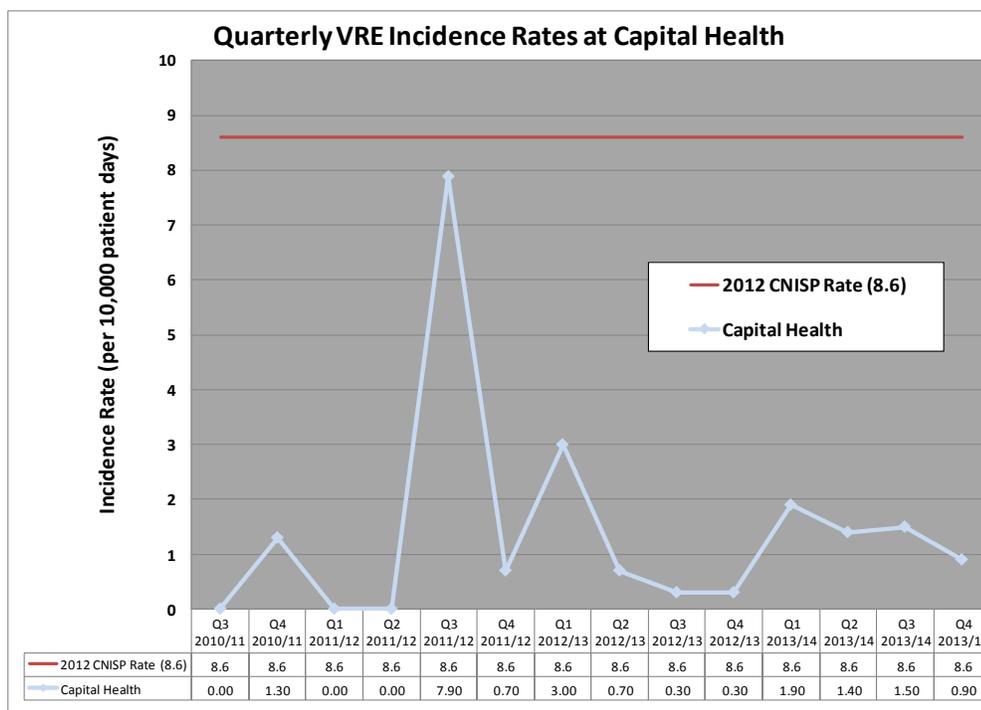
According to the Canadian Nosocomial Infection Surveillance Program (CNISP), the most recent national rate was 8.6 per 10,000 patient days (2012). The rates at Capital Health have been consistently below this national rate.

## What are we doing about this?

The following prevention and control measures are in place at Capital Health:

- All patients with VRE are provided with a single room with dedicated toileting facilities. If a private room is not available, patients are co-horted, based on risk assessment with Infection Control.
- Staff and visitors are to wear a gown & gloves (no mask) when providing care or are in close contact with the patient/patient environment. Discard before leaving the room.
- Dedicate patient equipment (if this is not possible, clean and disinfect shared equipment after patient use). Thoroughly clean & disinfect all touch surfaces and equipment within the patient environment.
- Inform receiving departments/caregivers that Contact Precautions are required. Ensure that Transfer and Discharge Swabs are completed as per policy.
- Housekeepers spend extra time cleaning the environment and follow stringent protocols. VRE is tenacious and it is killed by regular hospital disinfectants but is hardy so we have to scrub to destroy it with enhanced cleaning protocols.

[Text last updated Sept 2013]



Graph Update Frequency: Monthly

Graph Last Updated: June 2014

Next Graph Update Expected: Summer 2014

# 1.15 Infection Rate – C. difficile

## What is being measured?

This indicator measures the incidence (number of new infections over a defined period of time) of *C. difficile* among hospitalized patients in Capital Health.

## Why is it important?

*C. difficile* is a type of bacteria that causes diarrhea. It is the most common cause of infectious diarrhea in hospitalized patients. It is also one of the most common infections in hospitals and long-term care facilities. The use of antibiotics increases the chances of developing *C. difficile* diarrhea.

*C. difficile* infections can range from uncomplicated diarrhea to severe illness that requires prolonged treatment with antibiotics and sometimes surgery. In rare situations, a *C. difficile* infection can result in death.

## How are we doing?

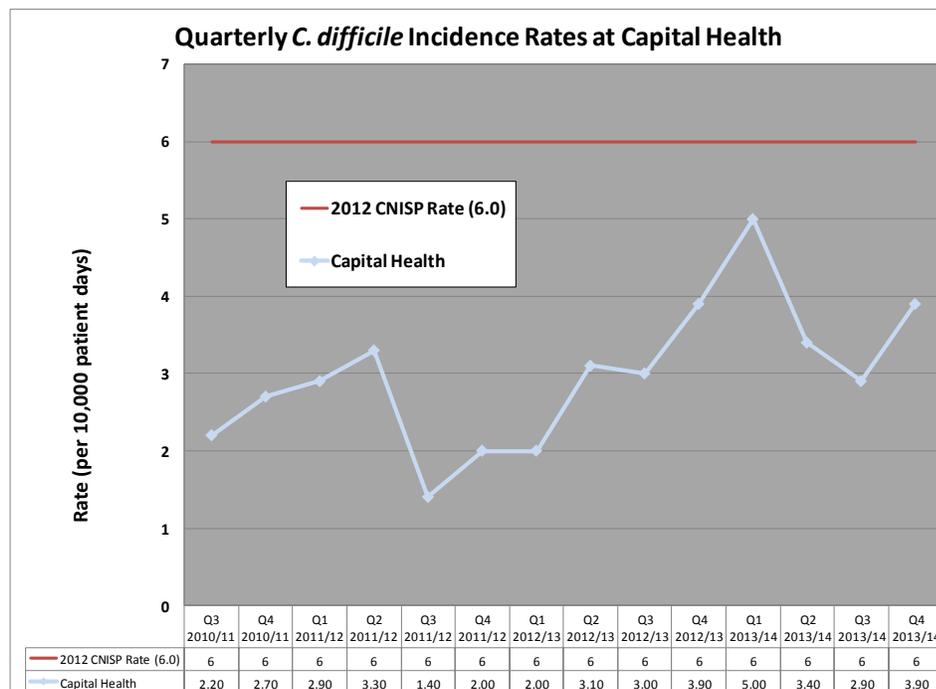
The 2012 national rate reported by the Canadian Nosocomial Infection Surveillance Program (CNISP) was 6.0 per 10,000 patient days. The rate at Capital Health has been consistently below this national rate. See the graph below.

## What are we doing about this?

The following interventions have been instituted to prevent and manage *C. difficile* infections:

- Infection Control Practitioners review all new CDI cases to ensure appropriate precautions & interventions are in place & treatment is being considered when required.
- Antimicrobial handbook developed by pharmacy to optimize the appropriate use of antibiotics
- Environmental & housekeeping auditing with feedback
- Room cleaning checklist
- Enhanced Infection Control Measures outlined in new policy and procedure (based on national guidelines) to prevent transmission of C Difficile.
- Infection Control recommendations for design of future infrastructure include decentralized bedpan waste disposal, dedicated hand hygiene sinks, and single rooms
- Improved technology and modified cleaning procedures

[Text last updated Sept 2013]



Graph Update Frequency: Quarterly

Graph Last Updated: June 2014

Next Graph Update Expected: Summer 2014

# 1.16 Hand Hygiene Compliance

## What is being measured?

Measuring adherence and providing feedback with accepted hand hygiene practices is an important quality improvement tool. The Accreditation Canada Qmentum Program now includes hand hygiene audits as one of the required organizational practices within the Infection Prevention and Control Standards. As a part of Accreditation, Capital Health is required to audit compliance with hand hygiene practices, share these results, and use the results to make improvements to current practices. The audit (and compliance) is based on the Four Moments for Hand Hygiene, the times at which hand hygiene should occur:

1. Before initial patient/patient environment contact
2. Before aseptic procedure
3. After body fluid exposure risk
4. After patient/ patient environment contact

## Why is it important?

Promoting hand hygiene is considered the cornerstone of infection prevention and control programs and of preventing healthcare-associated infections. The World Health Organization has suggested improvements in hand hygiene compliance can prevent 50% of hospital-associated infections, making it the single most important practice in reducing the rate of such infections. As caregivers move from patient to patient and room to room caring for people, their hands pick up microorganisms which can cause infections. Hand hygiene works by interrupting this transmission of microorganisms.

## How are we doing?

For Jan-Mar 2014, the overall rate was 74%. This is the highest overall rate yet, but still short of the target of 80%. The “before” rate was 65% (under target) and the “after” rate was 81% (exceeding target). Greater detail is shown in the graph below.

## What are we doing about this?

A targeted focus on Hand Hygiene practices will continue. Ongoing efforts include advancing staff and physician training

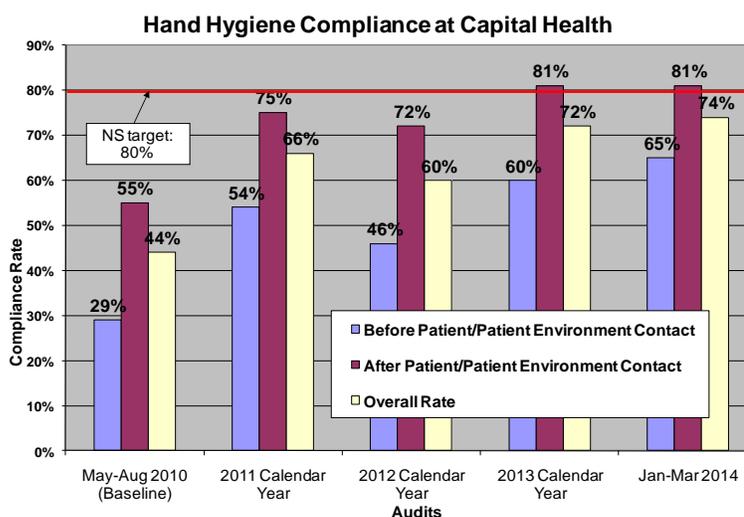
across Capital Health. Patients are being educated through pamphlets and signage and are encouraged to wash hands when visiting the organization. A multi-modal campaign is ongoing and includes:

- Launch of new LMS (SHN) training module
- 2012/13 Hand Hygiene campaign (poster, screen saver, etc.)
- Targeted intervention for work groups
- Stop and Clean your hands day!
- Placement of alcohol-based hand rub product available at point of care
- Continued use of the automated hand hygiene audit tool
- “One stop shop” Internet site: educational supports through videos, guides, and additional information on the IPAC intranet site
- Facilitated access to compliance reports and enhanced the data available for front line leaders
- Just-in-time feedback to front line staff
- Patient Education pamphlet: Hand Hygiene
- Patient & Family Engagement Pilot Project (implementation late 2013/early 2014)

As well, Audits are done monthly in Heart Health and the results are posted for all staff to view. In Ambulatory Care at the Halifax Infirmary, requests have been made to Infection Control for completion of hand hygiene audits, but the audits have not yet been possible due to limited resources. Some Ambulatory Care staff members have been trained to perform audits, but these are not done regularly because of competing work commitments.

Several inpatient areas have worked with infection control to develop information sheets that are now being used on the units to advise both patients, families, and staff about the importance of hand washing.

[Text last updated Sept 2013]



Graph Update Frequency: Quarterly

Graph Last Updated: June 2014

Next Graph Update Expected: Summer 2014

# 1.17 Hospital Standardized Mortality Ratio

## What is being measured?

Hospital standardized mortality ratio (HSMR) is the ratio of actual deaths to expected deaths, multiplied by 100. This indicator is calculated by the Canadian Institute for Health Information (CIHI).

The HSMR compares the actual number of deaths in a hospital with the average Canadian experience, after adjusting for several factors that may affect in-hospital mortality rates, such as differences in age, sex, length of stay, admission category (planned vs. urgent/emergent), diagnosis group, selected comorbidities, and transfer from another acute care institution. CIHI calculates the ratios using data submitted from hospitals across the country. It only includes the 72 diagnosis groups that account for the top 80% of in-hospital deaths in Canada.

Fiscal year 2009/10 is the baseline year in which the national average has been designated as 100. As such, an HSMR greater than 100 suggests the local mortality rate is higher than the national experience in 2009/10 (unfavourable). Conversely, HSMR scores less than 100 suggest the local mortality rate is lower than the national experience in 2009/10 (favourable).

## Why is it important?

HSMR is a high-level measure that can be influenced by a wide variety of factors, some of which are beyond the control of an individual hospital. Nevertheless, it

provides an important means for a hospital or health region to compare their patient outcomes over time and in this way provides a starting point for identifying potential areas for improving the quality of care.

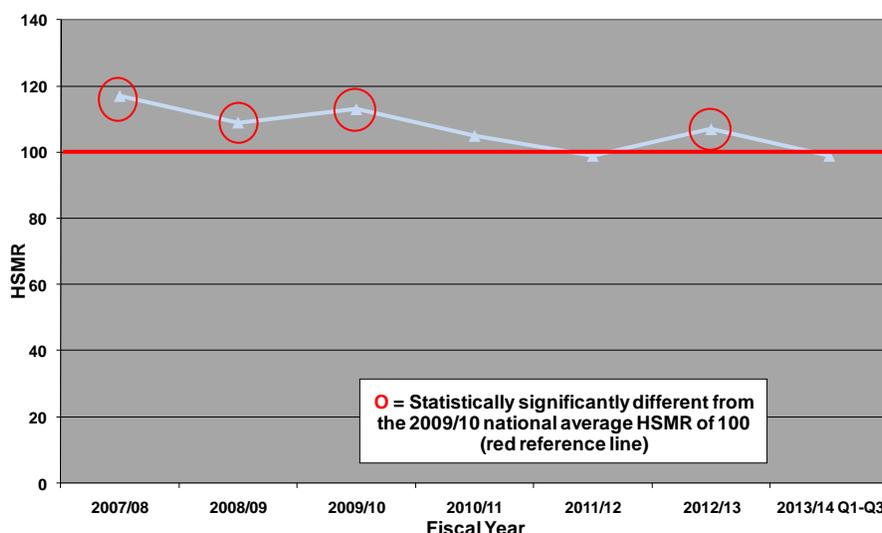
## How are we doing?

The graph below shows the HSMR for CDHA for fiscal years 2007/08 to 201/14 Q1-Q3. In fiscal years 2007/08 to 2009/10, CDHA had HSMRs that were statistically significantly worse than the 2009/10 national average (i.e. greater than 100), but had HSMRs that were on par with the 2009/10 national average for fiscal years 2010/11 and 2011/12. In 2012/13 CDHA's HSMR score returned to a level that was statistically significantly higher (worse) than the 2009/10 national average. For Q1-Q3 of 2013/14, CDHA's HSMR score returned to being on par with the national average.

## What are we doing about this?

Capital Health has developed a process to review HSMR data results in further detail. Based on findings from this initial review, further assessment is done with co-leads and quality teams to better understand circumstances and practice related issues which may affect the cases contributing to the HSMR. Findings from the review inform the development of quality improvement initiatives. [Text last updated April 2013]

**Hospital Standardized Mortality Ratio at CDHA**



Graph Update Frequency: Quarterly

Graph Last Updated: May 2014

Next Graph Update Expected: Fall 2014

# 1.18 Patient Experience Survey

## What is being measured?

Throughout the year, patients in inpatient, ambulatory and rehabilitation services are randomly sampled to partake in the patient experience survey and the results are reported annually. This indicator shows the proportion of “agree” or “disagree” responses in a particular dimension or section of the survey. The data presented here summarize the Inpatient and Ambulatory Patient Experience Surveys. Mental Health & Addictions, Cancer Care and Emergency Department patients are not included; they are surveyed separately using a different tool.

## Why is it important?

The survey results can be used to identify strengths and opportunities for quality improvement initiatives and accreditation requirements. The positive patient experience target has been set at 90%.

## How are we doing?

In 2013/14, our positive response target of 90% was exceeded in four out of eight patient experience dimensions. At an organizational-level, patients rated Overall Assessment of Care Received, as well as Care Received from Health Professionals at 94% satisfaction. Respect for Rights was rated at 93% positive response; and Accessibility of Services was rated at 91%.

Queries related to Respect for Privacy, Opportunity to Ask Questions Regarding Condition, and Doctors, Nurses and Other Health Care Professional Collaboration all both had high positive response rates (96%).

Ambulatory Services were generally rated higher with an overall assessment rate of 94%. Ambulatory Quality of Care

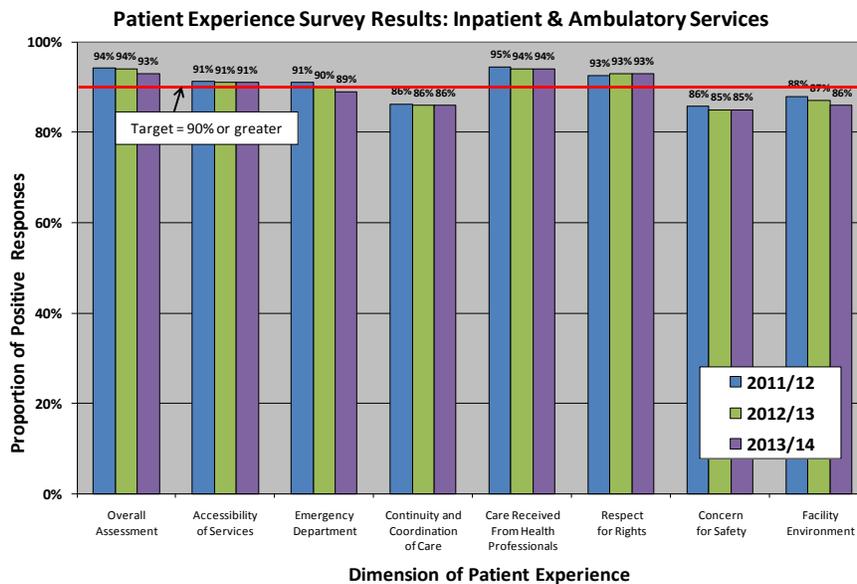
Received was rated 97% and Recommendation of Hospital received a 98% satisfaction rate. Of particular note were satisfaction ratings for Care Professionals Showed Care and Concern and Opportunity to Ask Questions both received a satisfaction rating of 98%.

## What are we doing about this?

Organizationally, we work under the belief that a focus on quality and patient safety is integral to becoming a world-leading haven for people-centred health, healing and learning. Quality is achieved by ensuring the services and supports we provide have a positive effect on the health and safety of our citizens. This past year we underwent the national accreditation process. Capital Health was awarded the highest rating of “Accreditation with Exemplary.” We have implemented a Patients First Safety strategy, which states that getting involved in patients safety at Capital Health is everyone's responsibility. We have also created and implemented tools to support teams in their quality improvement journey, such as Quality and Patient Scorecards.

Results from the Patient Experience survey are used to guide improvement project and assess progress at an organizational and team level. For example, one strategic area of focus is: “Involve patients directly in their care.” We measure our progress through responses to that specific survey question. The Improving Quality of Care in Transitions project gauges progress by reviewing results from survey questions such as: “Information about my care was communicated to my family doctor”; and “I received information about whom to contact if I had a problem once I was at home.” Team-level results are used to guide quality team plans and activities.

[Last Updated August 2014]



Graph Update Frequency: Yearly

Graph Last Updated: July 2014

Next Graph Update Expected: Summer 2015

# 1.19 Patient Safety Culture

## What is being measured?

Patient safety culture measures and assesses staff awareness about patient safety. Patient safety culture exists when people within a health care organization are compelled to take action when faced with safety challenges, and consistently work towards changes that improve patient safety. Accreditation Canada’s Patient Safety Culture Survey was first administered to staff and physicians in 2006, and repeated in 2010 and 2012. It consists of 40+ questions about the culture of patient safety within our organization. Of particular interest within this survey is the question: “Please give the organization an overall grade on patient safety” with five possible responses: Excellent, Very Good, Acceptable, Poor, or Failing.

## Why is it important?

Culture is widely recognized and accepted as an essential element in changing both behaviour and expectations in order to improve patient safety in health care organizations. This measure is important as it helps to identify strengths and areas for patient safety culture improvement in our organization. It also helps examine trends in patient safety culture change over time. Staff perceptions of the ‘overall patient safety’ measure provides insight into the degree to which patient safety culture exists, and further evaluates the cultural impact of patient safety initiatives and interventions.

## How are we doing?

In all years, the majority of survey responses fell under the “Very Good” and “Acceptable” response categories. Over time, there has been a trend of a decreasing proportion of “Acceptable”, “Poor”, and “Failing” responses, and an increasing proportion of “Excellent” and “Very Good” responses.

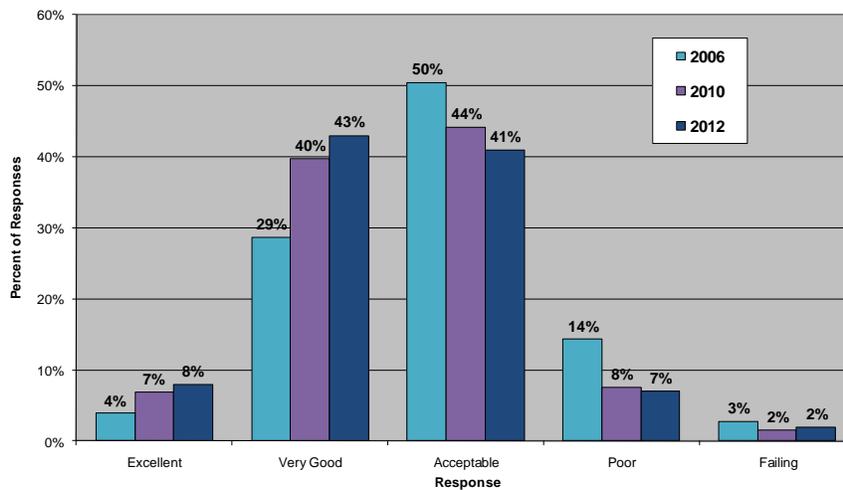
## What are we doing about this?

The focus on developing a strong culture of patient safety continues. Ongoing efforts include multiple educational opportunities for staff and physicians related to patient safety. The multi-pronged approach also includes:

- An integrated Quality and Patient Safety Plan for the entire organization, which includes a campaign to raise awareness related to *just culture*.
- Bi-weekly Leadership Safety Rounds in which staff members on individual patient care areas address patient safety issues with representatives from multiple areas within the organization, including a representative from the executive team.
- Patient Safety Culture Flash discussion cards and an accompanying resource manual have been developed for use at the service level and have been presented to quality team leaders and managers across the organization.
- Fifteen patient safety modules in the LMS which are applicable to physicians and employees throughout the organization.
- Patient Safety First brochures and posters were refreshed and information added on inpatient and ambulatory falls, and safety tips for preventing falls.
- Quality rounds focused on patient safety culture.
- Patient Safety Week and Quality Week events which showcase the leadership and team specific actions in various service areas across the organization.
- Support for Patient Safety Action Plans at the team level.

[Last updated August 2014]

**Overall Grade on Patient Safety from Recent Capital Health Patient Safety Culture Surveys**



Frequency Tracked: Every two years

Graph Last Updated: October 2012

Next Graph Update Expected: 2014

# 1.20 Completion of Patient Safety Training

## What is being measured?

One of Accreditation Canada’s Required Organizational Practices is the delivery of client safety training and education at least annually to employees. A required organizational practice (ROP) is an essential practice organizations must have in place to enhance patient/client safety and minimize risk. To fulfill this ROP, CDHA requires all employees and volunteers to annually complete at least one patient safety course.

## Why is it important?

Everyone that works at Capital Health has a role in patient safety. Therefore, completion of annual patient safety training is a vital component of patient safety and quality improvement. Patient safety training has been shown to enhance patient care and minimize potential safety risks within the organization.

## How are we doing?

The graph below shows the percentage of CDHA employees, medical staff, learners, and volunteers who completed at least one patient safety course. The annual target is to reach 100%. So far in 2014/15 (April to June) 33% have completed a patient safety training course. It should be noted that as of the July 2014

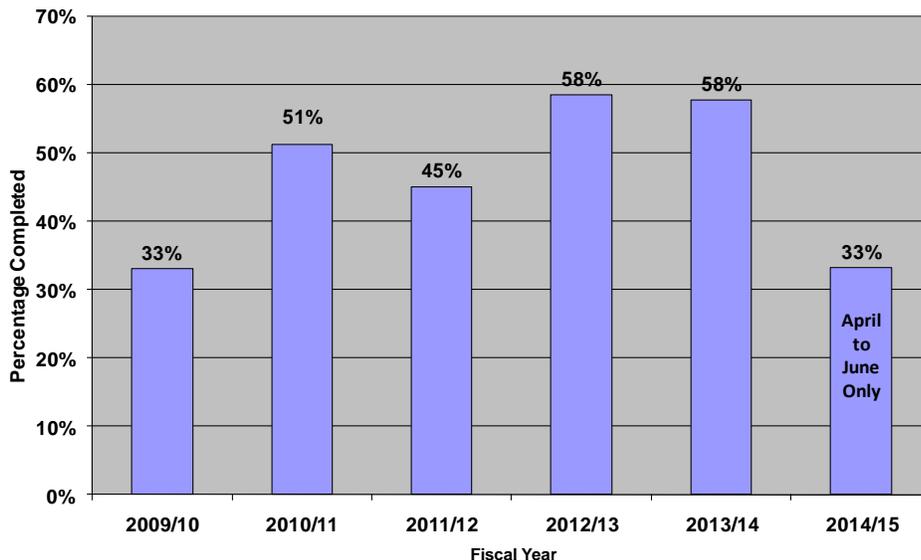
version of this report, all percentages for the fiscal years shown in the graph show an improvement over those shown in previous versions of this report. This is because it was discovered those on unpaid placements all complete patient safety training whereas previously it was thought they did not.

## What are we doing about this?

Annual education on patient safety is made available to the organization’s leaders, staff, service providers, and volunteers, and CH identifies specific patient safety focus areas such as safe medication use, using the reporting system for adverse events, human factors training, techniques for effective communication, equipment and facility sterilization, hand washing and hand hygiene, and infection prevention and control. Most employees can fulfill this requirement by completing one of the six online patient safety courses using the Learning Management System (LMS). Others, such as volunteers, are provided the training as part of orientation packages and presentations.

[Text last updated December 2012, except reference to graph]

Percentage of CDHA Employees, Medical Staff, Learners, and Volunteers Having Completed at Least One Patient Safety Training Course



As of the July 2014 version of this report, all percentages shown in the graph show an improvement over those shown in previous versions of this report. This is because it was discovered those on unpaid placements all complete patient safety training whereas previously it was thought they did not.

Graph Update Frequency: Quarterly

Graph Last Updated: Aug. 2014

Next Update Expected: November 2014

# Additional Transforming the Person-Centred Health Care Experience Indicators

## 1.21 Length of Stay – Number of Conservable Days

### What is being measured?

This indicator is the number of conservable days which is the average length of stay (ALOS) minus the expected length of stay (ELOS) multiplied by the total number of cases.

### Why is it Important?

Conservable Days is a measure of the days that patients remain in hospital beyond the expected ALOS expected for their diagnosis. Tracking of this information provides an indication of the hospitals success in discharging patients against an established benchmark.

### How are we doing?

Conservable days for typical cases are shown in the graph below. The target is 6,188 or fewer.

For the full 2013/14 fiscal year, conservable days totaled 6,223. This is an improvement over the past three years but just short of the target (unfavourable). If the trend seen in the first two months of 2014/15 continues for the remainder of the fiscal year, the target will be met.

### What are we doing about this?

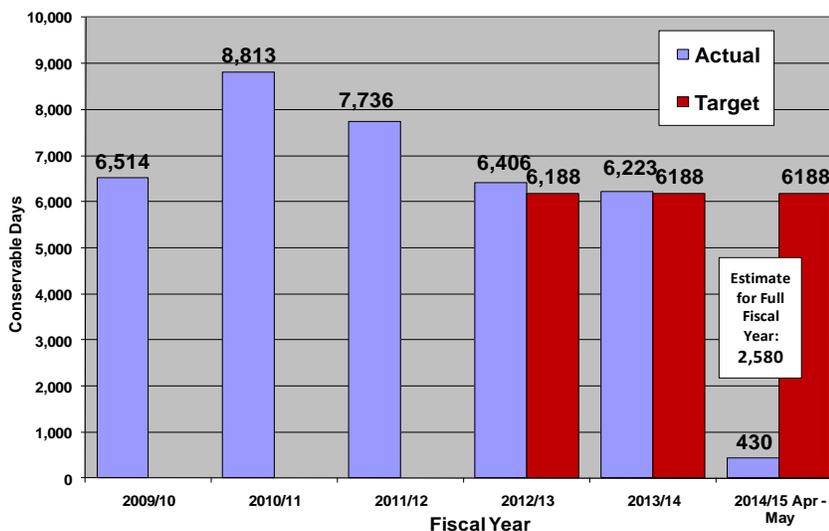
Capital Health has implemented a number of improvement initiatives:

- A Bed Utilization Management Process (BUMP) has been implemented in all acute medical/surgical care units, Intermediate Care Units and Critical Care Units across the district. Information from this tool is used daily to focus efforts on patient flow, and discharge planning.
- Home First strategies and community based supports have been implemented to promote home and community based care as an option to hospitalization.
- Patient Flow Management on a 24/7 basis has been implemented to leverage all opportunities to improve flow across systems at QEII.
- Physician models have been realigned especially in Internal Medicine and Community Medicine to address specific areas of patient flow.

At Hants, white boards and bullet rounds have been implemented to improve discharge planning and improve occupancy and length of stay. With this, staff feels there has been an increase in earlier discharge.

[Last updated October 2013]

**Conservable Days for Typical Cases at CDHA**



Graph Update Frequency: Monthly

Graph Last Updated: Aug. 2014

Next Graph Update Expected: Sep. 2014

# 1.22 Occupancy Rates

## What is being measured?

Occupancy rate is patient days (census days) divided by available hospital days, multiplied by 100. Total occupancy rates for this indicator do not include long term care/transitional care. This is because the occupancy rate target for long term care is 99% which differs from the target occupancy rates. Occupancy rates are also calculated for individual units and services.

## Why is it important?

Occupancy rate is used to show the actual utilization of the hospital for a given period of time and has a direct affect on inpatient and emergency department flow.

## How are we doing?

Capital Health’s target is to decrease the occupancy rate to 90%.

The graphs below show the yearly occupancy rates for services at the QEII and the Dartmouth General. For fiscal year 2013/14, the following services were below

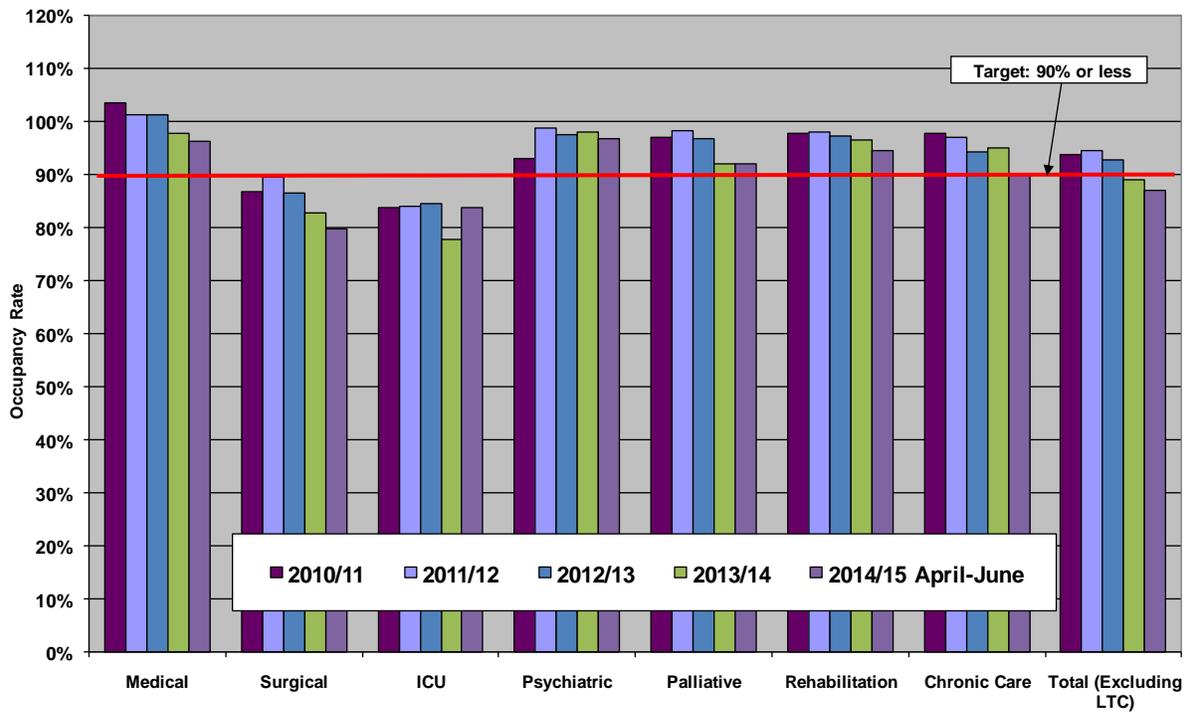
the target of 90% (favorable): QEII Surgical, QEII ICU, and DGH ICU/CCU. All other services were above the target (unfavourable).

The overall rate for the QEII was below the target (favourable) while the overall rate at the Dartmouth General was above target for this period.

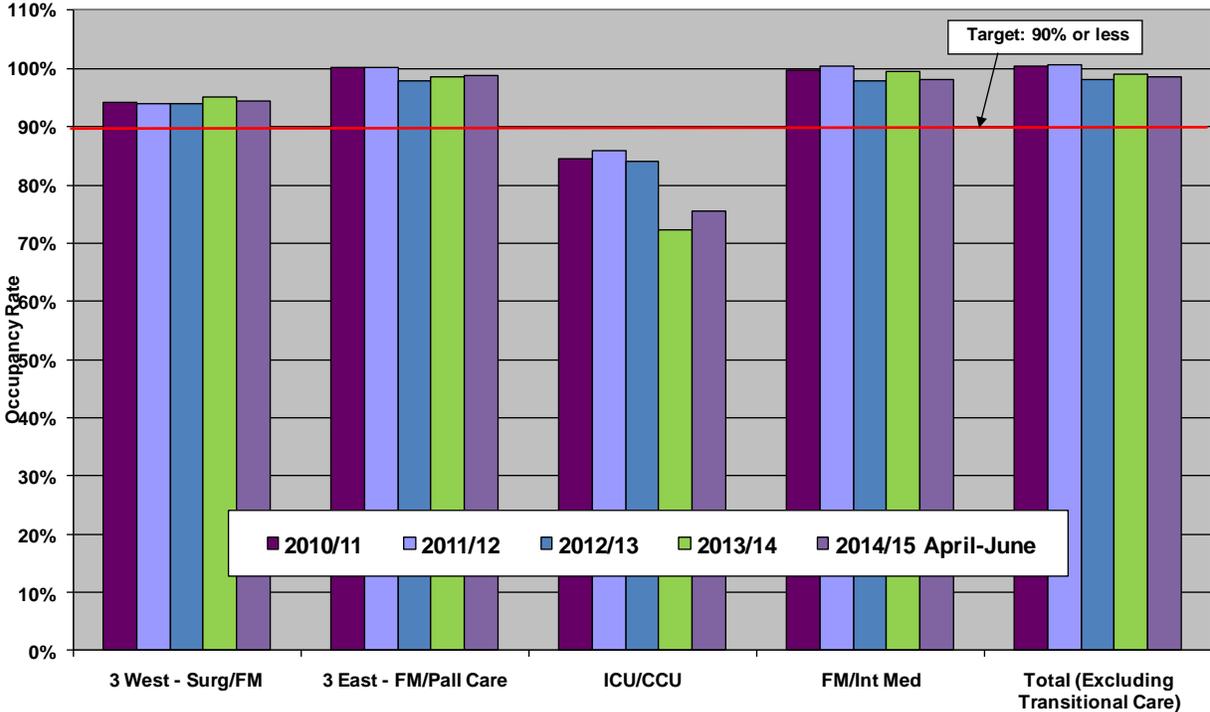
For April–June 2014/15, the same services and facilities were above and below the target with the exception of chronic care at the QEII which reduced its rate to meet the target of 90%.

It should be noted the occupancy rate for QEII psychiatry in 2010 are an underestimate because they had four beds that were listed as “open” in the STAR system, but weren’t actually available for use. An estimated correction would put the 2010 psychiatry rate higher than the target for these time periods. The bed counts were corrected in STAR in January 2011 and so occupancy rates for psychiatry after this date reflect the true situation on the service.

**QEII Service Occupancy Rates**



# DGH Occupancy Rates



Graph Update Frequency: Monthly

Graphs Last Updated: Aug. 2014

Next Graph Update Expected: Sep. 2014

# 1.23 Emergency Department – Left Without Being Seen

## What is being measured?

This indicator is the number of patients who left the emergency department without being seen by a physician divided by the total number of emergency registrations. The count of patients who left without being seen does not include those patients who were seen by a nurse in the emergency department instead of being seen by a physician.

## Why is it important?

Each month, hundreds of patients who arrive at emergency departments across Capital Health subsequently leave without being seen by a physician. While many of these patients may have symptoms or conditions that can be safely dealt with by alternative means, it is a concern that someone with a significant problem may leave and the consequences could be serious. At the Dartmouth General, a discharge planning nurse keeps a record of patients who leave without being seen and calls patients to provide follow up suggestions.

## How are we doing?

The graph below shows the percentage of patients who left the emergency department without being seen (all

triage acuity levels combined). A breakdown by emergency department site is shown. The target is to keep walkouts below 2% across Capital Health. All sites except Hants are over the 2% target.

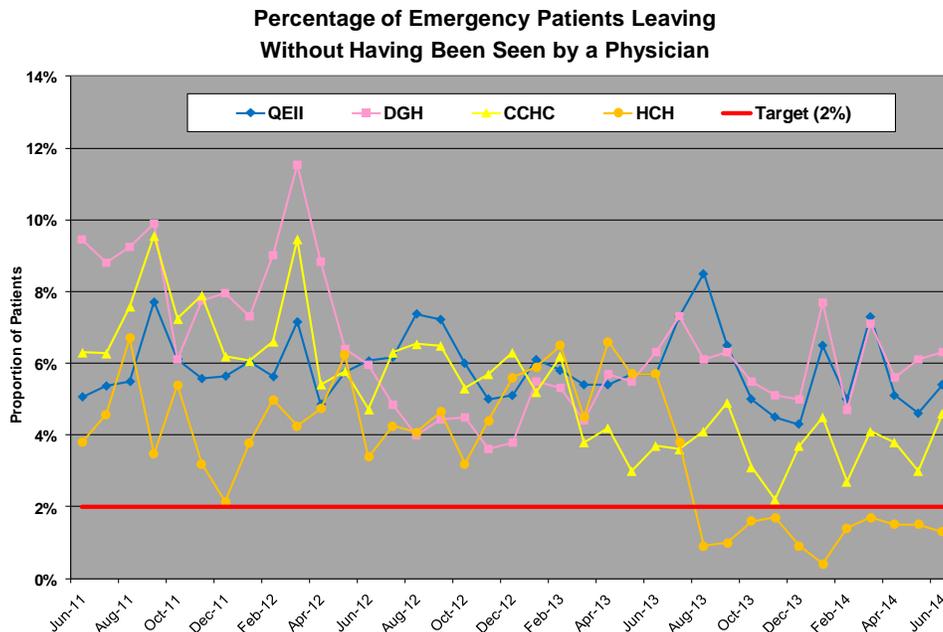
For additional emergency-department indicators, click [here](#) to go to the CDHA Emergency Departments Quarterly Performance Reports web page.

## What are we doing about this?

The following initiatives have been implemented at Hants:

- Nurse-initiated protocols allow nurses to start patient care prior to being seen by a physician. One example is for the treatment of sepsis patients.
- Waiting room rounds to improve communication between triage area, the department, and waiting room patients in an effort to keep patients who are waiting better informed and to allow them to make more informed decisions, increase patient satisfaction and decrease rates of patients leaving without being seen.

[last updated April 2014]



Graph Update Frequency: Monthly

Graph Last Updated: Aug. 2014

Next Graph Update Expected: Sep. 2014

## 1.24 Long Term Care – Patients Placed & Waiting to be Placed

### What is being measured?

This indicator is the number of patients placed and number of patients awaiting placement in long term care (LTC) facilities. It includes patients at all Capital Health sites. These graphs represent LTC patients from all Capital Health facilities. Both acute care and mental health LTC patients are included.

### Why is it important?

At any one time, patients who require care—but not acute care—may occupy a substantial number of beds in hospital facilities. Often they cannot be discharged from hospital until alternate services, such as residential care, are available. For this reason, a measure of the number of patients waiting to be placed is a measure of appropriate hospital utilization and the ability to respond to client needs.

Once a patient's application is approved, he or she remains on a waitlist until a bed in the appropriate type of facility becomes available, unless their medical status changes. The application process involves a standardized provincial application, consisting of both health and financial assessments.

### How are we doing?

The target is to have fewer than 75 patients waiting to be placed into LTC (excluding Mental Health). The graphs below show the number of Capital Health patients placed and waiting to be placed into LTC facilities. In March 2014, the total number of patients at all Capital Health facilities (excluding Mental Health) waiting to be placed was 77. This is the lowest the count has been in several years but still slightly above the target of 75.

Over the past year there has been dramatic improvement at the QEII in the number of patients waiting to be placed into LTC. In November 2012, there were over 80 patients waiting. Most recently, in March 2014, there were only 23.

In order to meet the LTC needs of their patient population, the Mental Health Program works with the Department of Health and Wellness (DoHW) for traditional LTC (nursing home) placements, as well as with the Department of Community Services (DCS) for non-traditional LTC placements such as Adult Residential and Small Options. DCS operates under a different set of rules & guidelines than DoHW and in a more risk averse and cautious manner. This results in Mental Health experiencing a much higher percentage of beds being occupied by patients awaiting placement, by comparison.

In Capital Health, as of April 30<sup>th</sup>, 2014, there were 750 people in the community waiting to be placed in LTC facilities. The number of people waiting in the community last year (May 1<sup>st</sup>, 2013) was 777 (source: Department of Health and Wellness SEAscape database).

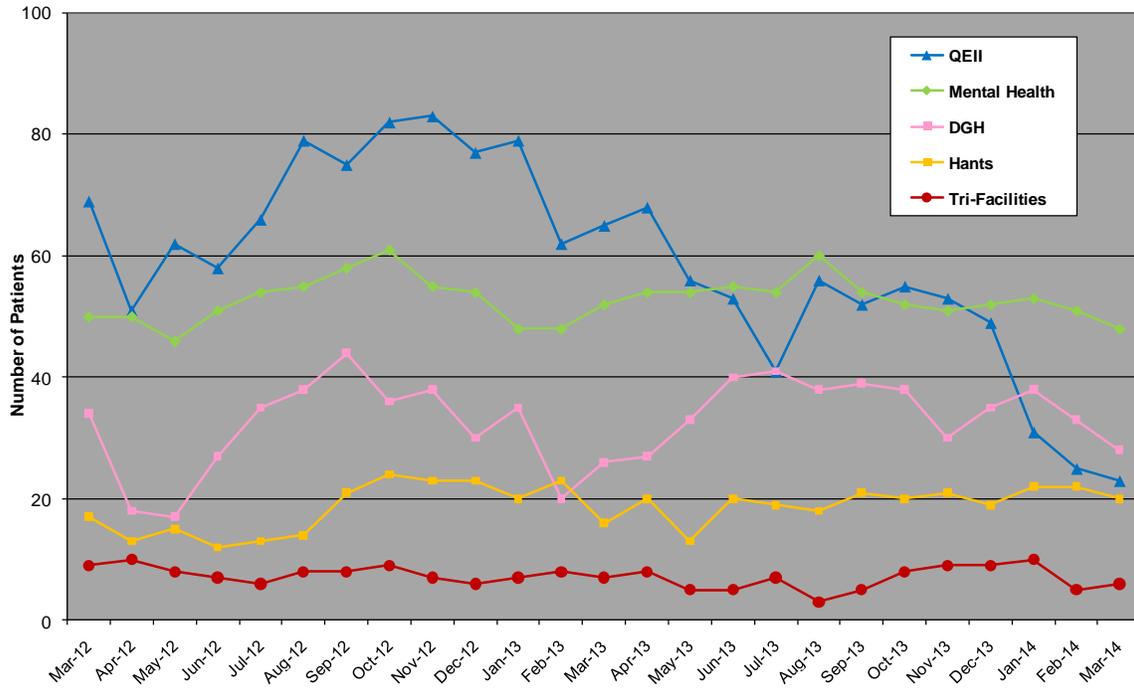
### What are we doing about this?

The Home First Philosophy was rolled out at Hants a month ago. All staff and physicians received education and a new agency was contracted in the area for home care for those leaving hospital. Early success was seen when one hospitalized ALC patient returned home with additional supports. The team culture is changing to one supporting clients being in their homes with supports instead of requiring hospitalization. Historically, Hants has had 20 or more ALC patients awaiting placement in hospital.

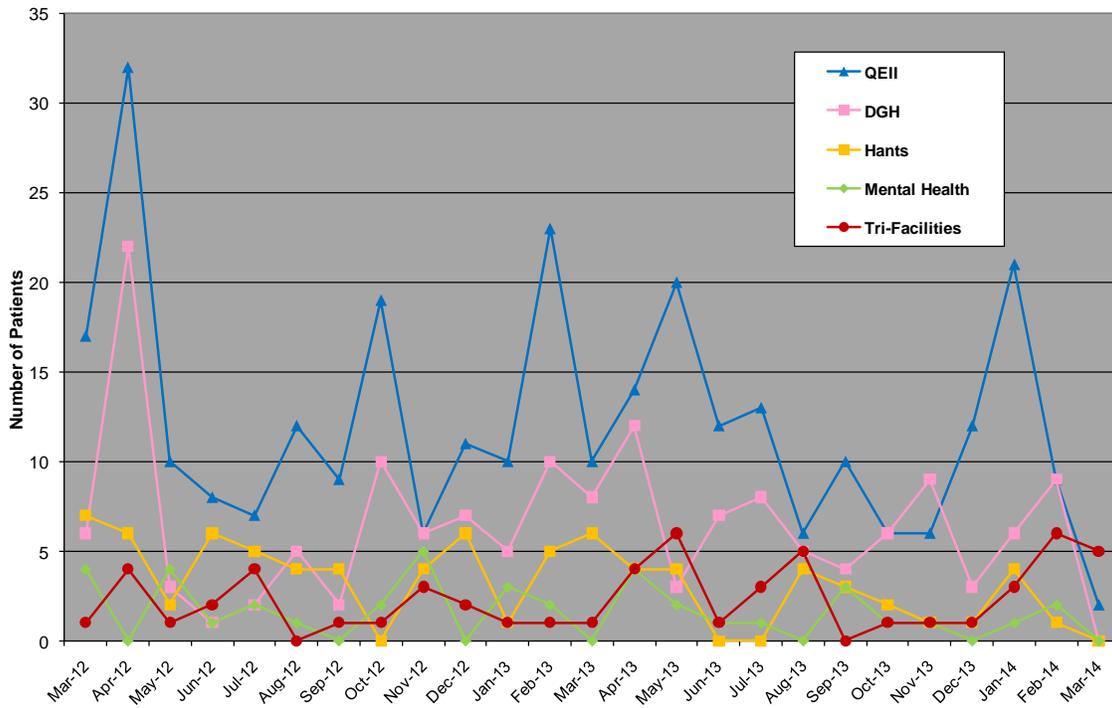
At the Halifax Infirmary site, units 7.3 and 8.1 have been working with Continuing Care on Home First as well as nursing home placement and have seen a decrease in the number of patients waiting for placement.

[Last updated April 2014]

### Capital Health Patients *Waiting to be Placed* in LTC



### Capital Health Patients *Placed* in LTC



Graph Update Frequency: Monthly

Graphs Last Updated: May 2014

Next Update Expected: Aug. 2014



## 1.25 Strengthen Community-Based Care for Chronic Disease

**Strategy:** Transforming Person-Centred Health Care Experience

**Goal:** Significant increase over baseline of chronic disease management in the community where appropriate

**Measure:** 5% reduction in the number of return outpatient visits annually at selected clinics in relation to hypertension, heart disease, COPD, and diabetes.

### What is being measured?

An increase of chronic disease management occurring in the community will translate into, and will best be measured by, a reduction in the number of return clinic visits related to key chronic diseases.

The focus will be on the most common chronic diseases – hypertension, heart disease, COPD, and diabetes.

The target is to achieve a 5 % reduction, or 425 fewer return visits, by 2015/16. This will indicate success in diverting patients from the hospital into a community setting. The goal is to avoid bringing stable patients into the hospital when they can be better supported in the community.

We have been projecting a 5 to 10 % increase demand at Capital Health clinics, so the 5 % net reduction from the baseline calls for an effective decrease (from projections) of 10 to 15 %. Given the aging population and the rising rates of chronic disease, this is felt to be a challenging target.

### Why is it important?

The aging population and growth in chronic disease means that community-based models are crucial. There is a need to move out to the community, upstream, and care for patients with chronic diseases as a single person—in their entirety—in a way that is convenient and empowering.

### How are we doing?

As a baseline, total return visits to the clinics directly related to hypertension, heart disease, COPD, and diabetes in 2011/12 was 8,500.

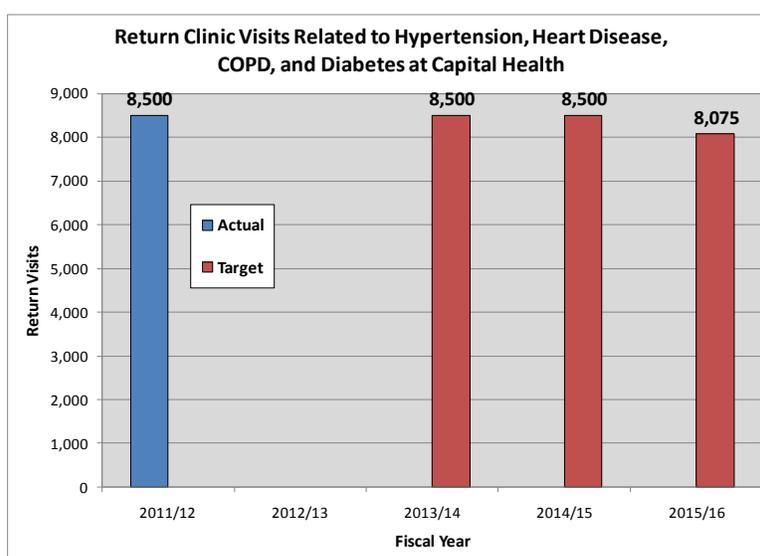
### What are we doing about this?

Barbara Hall, VP Person-Centred Health and David Anderson, chief and head of the Department of Medicine, have convened an action team to tackle this challenging measure. The team will develop an action plan and timeline by June 30, 2013. Three major actions for achievement of this 2015/16 goal are:

1. Chronic disease data source identification, evaluation, and implementation of CDM Health System Model
2. Development and implementation of engagement Strategy: Citizens; District Specialists and Family Physicians
3. Leverage ongoing District Chronic Disease Management Work

The expansion of the Diabetes Management Center to a Chronic Disease Management Center, as part of the West Hants Community Primary Health Care Model, supports a commitment to this goal.

[Last updated: April 2014]





## 1.26 Improve Quality of Care in Transitions

**Strategy:** Transforming Person-Centred Health Care Experience

**Goal:** Care teams will improve achievement in meeting established standards in the quality of care at key transition points substantially over 2012 baseline levels.

**Measure:** 50 per cent compliance in documenting patient instructions on the discharge summary.

### What is being measured?

One thousand discharge summary reports were audited to determine compliance on five mandatory key quality elements required to be included in the report: final diagnosis, outcome of care, arrangements for follow-up, medications and patient instructions/education.

The results for the first four elements are considerably higher than the last. Compliance on “including patient instructions in the discharge summary report” is low at just 22.5 per cent. It is also an area highlighted in Capital Health’s patient experience survey results as requiring focus.

The goal is to more than double this result in three years, bringing it up to a 50% compliance rate. This will require a substantial change in practice and culture. We’re already making some progress and are undertaking a lot of work in this area. For example, we’re making these items required computer entry fields when completing a discharge.

### Why is it important?

Transitions are a major challenge for health care systems everywhere, and Capital Health is no exception. Everyone wants their loved one to receive the best possible care, including seamless, complete “hand-offs” between departments and care facilities.

Transitions are a “big dot” indicator of the performance of the system in terms of patient safety and quality – many experts

across the country believe it is one of the most important, and it is covered in an Accreditation Required Organizational Practice.

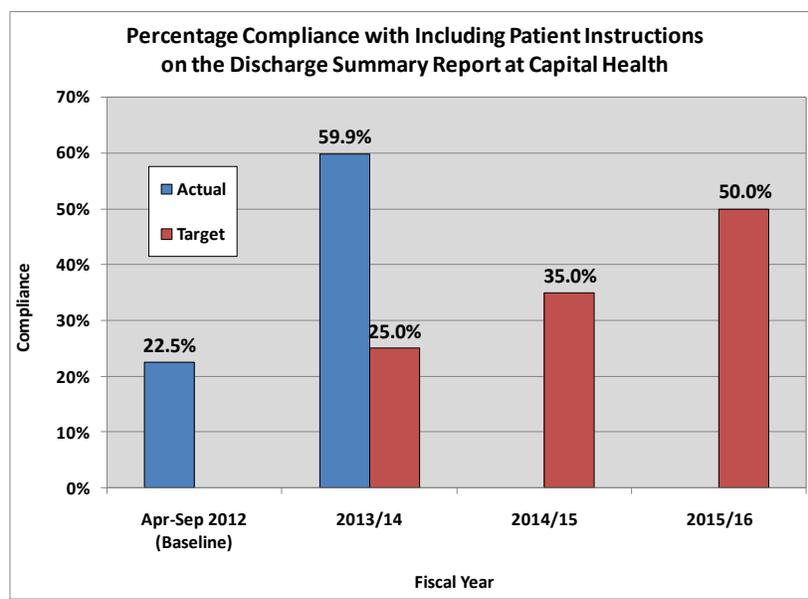
### How are we doing?

A baseline audit of 1000 discharge summary reports from April to September 2012, by site and service, was performed. Results for compliance on the patient instructions/education included in the discharge summary reports for the QEII and DGH were 22.5%. Year 1 audit of 1000 discharge summaries was performed examining records from January 2014 – March 2014. The result was a marked increase in compliance with inclusion of patient instructions/education. Year 1 results were 59.9% exceeding our three year target of 50%.

### What are we doing about this?

Catherine Gaulton, VP of Performance Excellence, and Dr. Steven Soroka, VP of Medicine, are leading a newly formed steering committee to co-ordinate and guide the work already in progress. Its focus is on three initiatives: Safe Patient Information Transfer focusing on education and processes; implementation of an on-line eDischarge Report; and working with the IWK to improve transitions of care from the child-based to the adult-based health care system for individuals with chronic conditions. The group will continue its efforts to provide transition education and further implement of the eDischarge tool.

[last updated June 2014]



Graph Update Frequency: Yearly

Graphs Last Updated: July 2014

Next Update Expected: Summer 2015



## 1.27 Build a Culture of Customer Service

**Strategy:** Transforming Person-Centred Health Care Experience

**Goal:** Patients, families and communities report customer service interactions with Capital Health employees and physicians meet or exceed their expectations.

**Measure:** 20 point increase in the percentage of patients responding most favourably on customer service related survey questions.

### What is being measured?

We currently collect data on patients’ assessment of customer service through our patient experience survey. We started with an item on the survey that most closely relates to customer service—whether patients feel they have been treated with courtesy and respect. We then did a correlation analysis to find other items that most closely link to it, and ended up with a cluster of customer service related items on which we already collect data.

We have chosen to focus on patient responses at the top of the positive scale, in other words “strongly agree” or “4 out of 4.” Research in other industries has shown that the difference in customer loyalty between those responding at the top of the customer service scale and those responding one step down can be as much as six times difference.

The issues and results are quite different between the inpatient setting and ambulatory care. For example, in ambulatory care, key issues are the availability of parking and ease of registration. The inpatient setting is far more complex, involving everything from cleanliness to whether the care provider voices complaints about working conditions. Overall, our goal is to ensure everyone experiences better customer service at Capital Health. Our target of 20% is essentially a proxy for that. It’s a challenging and achievable goal, which will require focused attention on the various issues.

### Why is it important?

This goal really speaks to our commitment to the “relentless pursuit of excellence in care and service.” Excellent customer service is founded on being treated with dignity and respect.

### How are we doing?

Current baseline results: The Patient Experience Survey is conducted three times a year. Inpatients and Ambulatory Care patients are surveyed separately. In 2012, we received 4,576 responses. On inpatient surveys, 31% of respondents responded most favourably and on Ambulatory Care surveys, 66% of respondents answered most favourably.

### What are we doing about this?

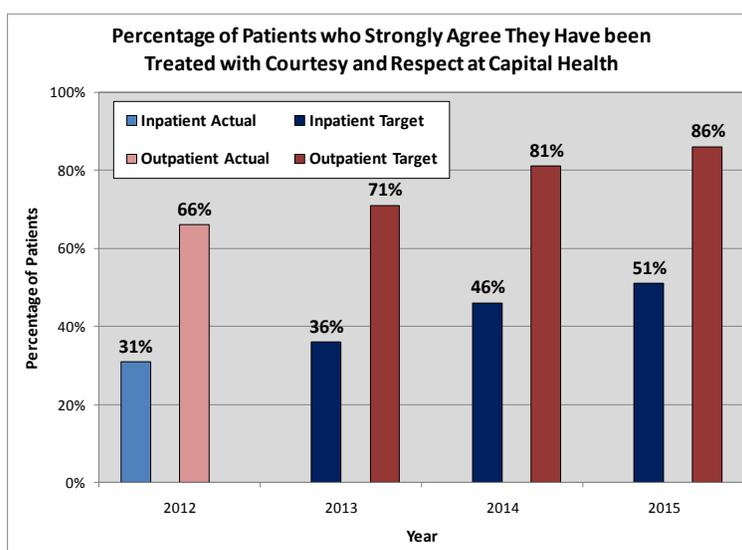
Kathy MacNeil, Vice-President, People, has convened an action team to develop an action plan. Three major actions for achievement of this 2016 goal are:

1. Customer service training for employees & physicians
2. Care experience redesign from a quality and patient safety perspective
3. Infrastructure plan for sustainability

Both Pharmacy and Outpatient Nephrology signed up to be the pilot areas for the customer service training. All formal leaders from both areas have attended the training sessions, including Dr. Ken West. The remainder is in the process of taking the course. Already in outpatient nephrology, the staff members have done some targeted work with some patients in being deliberate in actively involving them in developing goals and plan of care.

All staff members at the Dartmouth General are moving forward with customer service training.

[Last updated April 2014]



## 2 Citizen and Stakeholder Engagement and Accountability



### 2.1 Partner with the Public so Individuals and Communities can Play a Key Role in Managing Their Own Health

**Strategy:** Citizen and Stakeholder Engagement and Accountability

**Goal:** Significant increase in number of individuals reporting that Capital Health has supported them in playing a key role in managing their own health.

**Measure:** 10 point increase in percentage of residents who say they have received support in managing their own health.

#### What is being measured?

In 2013, we carried out a telephone survey of Capital District residents. The survey provided data for the “Managing own health” baseline and also the “Appropriateness of care” baseline.

We spent a lot of time considering how to get at what the public understands, rather than what health care providers understand.

We decided that the key question was “In the past 12 months have you received any support related to managing your own health?”

We’d like to see the percentage of respondents who say they have received support in managing their own health rise by 10 points. That would be a significant shift in our citizens’ experience of being supported in health and with illness.

#### Why is it important?

This is about empowering people to take ownership of their own health, including prevention of illness and maintenance of well-being. We can help by providing them with direct support, and by supporting others who provide support, such as providers and family members.

We need to educate those we serve about what care is available to them in their own community.

#### How are we doing?

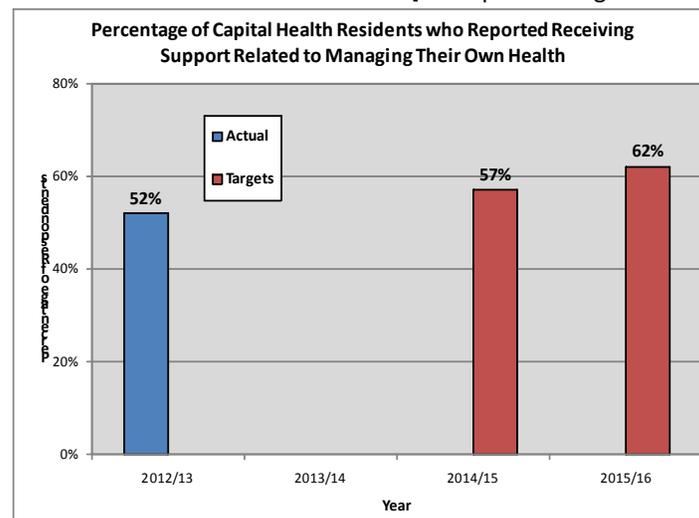
Current baseline results: In 2013, Thinkwell Research conducted a field survey in which 52% of 655 respondents indicated they had received support related to managing their own health.

#### What are we doing about this?

Barbara Hall, Vice-President, Person-Centred Health and Gaynor Watson-Creed, Medical Officer of Health, have convened an action team to develop an action plan. Three major actions for achievement of this 2016 goal are:

- Explore the needs of family physicians for resources to support them in information/community access role
- Explore the use of social media & other tools as a way of engaging with residents to learn what being/feeling healthy means to individuals, sharing perspectives & stories. Utilize tools to enable online access to reliable, brief, clear messages & links to accurate resources
- Identify and promote/communication what is available in communities for a diverse community of individuals at different stages of life

[Last updated August 2013]





## 2.2 Involve Patients Directly in Their Care

**Strategy:** Citizen and Stakeholder Engagement and Accountability

**Goal:** Patients or their surrogates report that their involvement in decision-making related to their care met or exceeded their expectations.

**Measure:** 10 point increase in the percentage of patients responding positively to a survey question about being consulted in decision-making about their care.

### What is being measured?

We currently collect data on patients' assessment of their involvement in decision-making through our patient experience survey.

Our baseline results, including all positive responses, are just under 80% favourable. Our target is to increase this by 10 percentage points, to just under 90% favourable.

We're expecting that one of the actions we'll take to reach this target is to make greater use of shared decision-making tools in the clinical setting. This already occurs in Surgery.

### Why is it important?

This goal is about culture shift. Patients need to know that we want them to be involved in key decisions related to their care. Staff need to understand we are encouraging patients to ask to be included in their own care.

Communications and customer service will be the key to success. Listening well to patients has been shown to improve care quality and patient perceptions of quality.

### How are we doing?

Current baseline results: In the 2012 survey, 78% of respondents responded "agree" or "strongly agree" to the survey item: "Healthcare professionals consulted me or my family or caregiver in making decisions about my care."

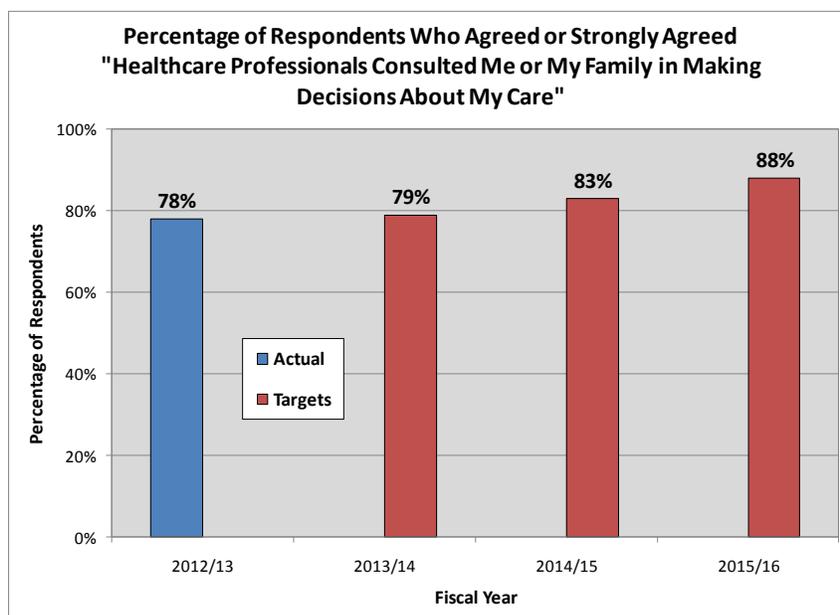
### What are we doing about this?

Paula Bond, Vice-President, Person-Centred Health, Acute Care, and David Kirkpatrick, interim head/chief, Department of Surgery, have convened an action team to develop a plan. Three major actions for achievement of this 2016 goal are:

- Develop and implement care plans for all inpatients outlining immediate, medium and long terms goals with clear protocols related to care plan review for patients with LOS <3days and >3days
- Identify and adopt district-wide criteria for involving patients/families in their care and imbed in operation clinical polices and practice to encourage and support patient/surrogate participation in health care decision-making across all service areas
- Enhance education and communication for patients (or their surrogates), families and clinical teams related to the patient's responsibility as an active participant in health care decision-making.

To engage patients and families in their care and to create efficiencies at the Dartmouth General, white boards have been placed at patient bedsides and a patient booklet with goals of care have been developed. A discharge checklist and readmission risk assessment tools are also under development. The health passport is being updated for the surgical population.

[Last updated April 2014]





## 2.3 Lead Dialogue with the Public Addressing Appropriateness of Care

**Strategy:** Citizen and Stakeholder Engagement and Accountability

**Goal:** Improve public awareness of quality of life issues related to appropriateness of care.

**Measure:** 20 percentage point increase in the percentage of Capital District residents surveyed who report a high degree of familiarity with the concept of appropriateness of care.

### What is being measured?

In 2013, we carried out a public opinion survey that included questions designed to establish a benchmark for the “managing own health” goal and the “appropriateness of care” goal. A total of 655 citizens responded.

Awareness of the concept of “appropriateness of care” is much more important than awareness of the healthcare jargon we use to label it. One in five of those surveyed responded that they are “very familiar” with the concept of appropriateness of care, once it was described to them.

As a challenging and achievable target, we want to double the percentage of residents who are “very familiar” with the concept of appropriate of care, anticipating that this will pull the whole curve of respondents upward.

### Why is it important?

Appropriateness of care refers to care that is right for the individual being treated, taking into consideration their expectations and who they are as a whole person.

Conversations about appropriateness of care have been taking place behind closed doors for years. We need to educate people so we can have these conversations out in

the open, and well in advance of the point of care, so we are enabling informed decision-making on issues related to quality of life.

### How are we doing?

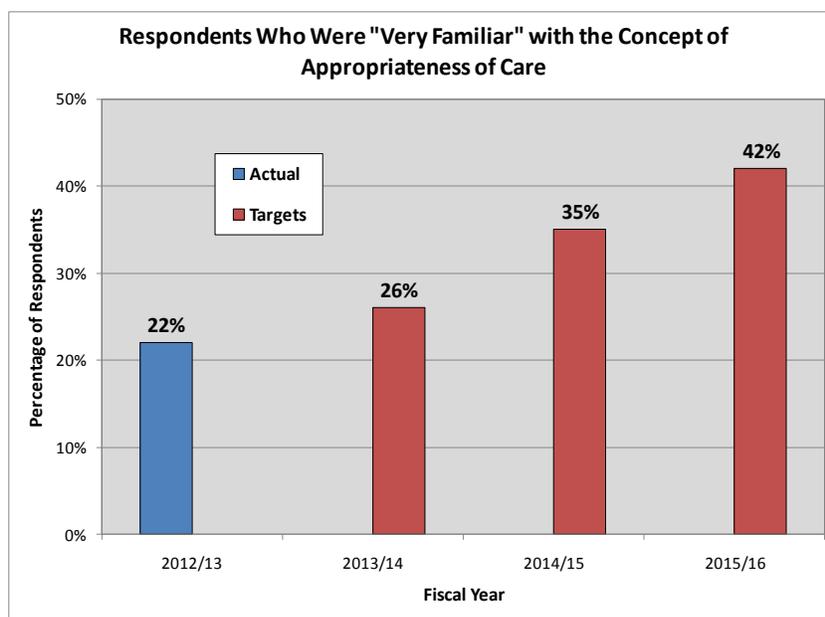
Current baseline results: In 2012, 22% of 655 respondents indicated they were “very familiar” with the concept of appropriateness of care.

### What are we doing about this?

Chris Power, President & CEO, and Nick Delva, District Medical Advisory Committee Chair, have convened an action team to develop a plan. Three major actions for achievement of this 2016 goal are:

- Influence patient and provider conversations: strategy, supports and tools
- Action and advocacy on system issues related to providing appropriate care
- A comprehensive and integrated engagement and communication/marketing campaign to support appropriateness of care conversations

[last updated August 2013]



# 3 Transformational Leadership

## 3.1 Absenteeism

### What is being measured?

This indicator is the average amount of employee paid ill time away from work per month. Employee ill time is an illness of the employee and covered under general illness, sick banks, and short term illness. It is not time away for family illness or preventative appointment time. It includes paid sick time (NSNU employees), paid general illness (all other employees), short term illness, and grandfather illness long term disability at 100%.

### Why is it important?

Employees who are not at work due to illness affect a team's workload and patient care. Absenteeism results in managers paying overtime which results in increased expenses as well as employee burnout, which can impact patient care.

### How are we doing?

A graph of the average sick hours per eligible employee per month at CDHA is shown below. The target is to have 6.15 or fewer hours per month. For the complete 2013/14 fiscal year, the average monthly sick hours was above target at 6.82 (unfavourable), but was an improvement over the previous year. The average for the first three months of 2014/15 shows an increase over the 2013/14 average.

The organization is currently experiencing a high rate of absenteeism. This is during a time in which there are hiring challenges for nursing positions throughout the organization. These challenges result in more staff having to work even more overtime.

### What are we doing about this?

Employee Health has Rehabilitation Consultants working with employees who are off ill greater than five days of absence.

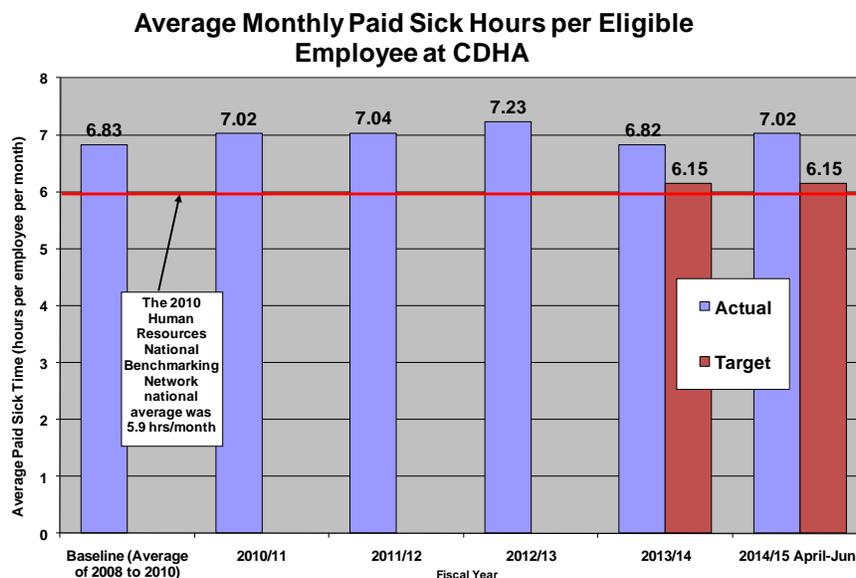
People Services is working to fill vacancies and most recently completed a mass hiring of graduate nurses. While these nurses fill the FTE they are, still junior in experience and will require mentoring to build skills and knowledge. The impact of these staff on the units will be more evident in the coming years.

Healthy Workplace along with Wellness and Safety services have combined forces to provide educational programs for frontline managers to enable them to recognize signs of workplace fatigue attributed to stress. An October 2011 workshop on mental health at work was scheduled as education for senior leaders. In the fall of 2012, communications were sent to employees in the Patient Centred Care Portfolios thanking them for their attendance, while ensuring accountability around sick time usage.

People Services has also teamed up with Wellness and Safety to help deliver education opportunities to assist managers with the utilization of employment contracts around culpable sick time, improving accessibility by means of identification/promotion of services. Relevant quality operational indicators are being identified and will be used to determine the best services available to meet these goals. Measures have been put in place to make pre-hire OH screening mandatory prior to hiring to ensure the new hire is a fit for the position.

The Heart Health Program/Ambulatory Care at the Halifax Infirmary has 28 staff members on Attendance Management Program.

[Last updated April 2014].



Graph Update Frequency: Monthly

Graph Last Updated: Aug. 2014

Next Graph Update Expected: Sep. 2014

## 3.2 Overtime

### What is being measured?

This indicator is total hours worked overtime divided by the total hours worked, multiplied by 100.

### Why is it important?

The amount of OT incurred by a unit and the organization at large is costly from a few points of view. There is a higher financial cost to the organization and the entire health care system, employee have a decreased work life balance and time to recharge from working, potential risks to patient care due to employee fatigue.

### How are we doing?

The graph below shows the percentage of overtime worked at CDHA. In 2013/14, the percentage of overtime hours worked was 1.36%. This is better than the previous year and is better than the target of 1.89%. For April–June 2014, the rate increased to 1.44%, but this is still below target.

There was an increase challenge in hiring staff in 2013/14 year leaving many positions vacant for longer periods and at higher frequencies.

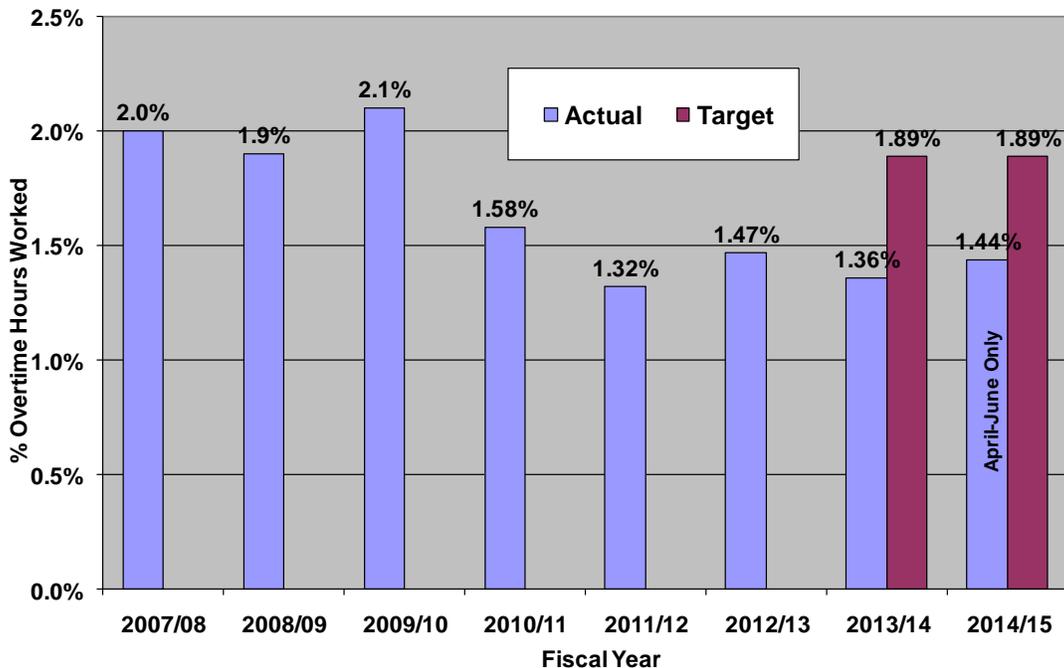
### What are we doing about this?

There are many different overtime initiatives across the organization to help reduce the amount of time used. Some examples are:

- Manager scrutiny of budget reports
- Newly developed Nursing Resource Team, this will take a couple of years to fully establish positive impacts on overtime.
- Central Staffing Office at the QEII site
- Rollout of Kronos Staff scheduling system at the QEII site for the central staffing office.
- Review of Models of Care to ensure we have the right resources doing the right jobs at the right time.
- Managers review a newly developed monthly overtime report to monitor overtime in a more timely fashion.

[Last updated August 2014]

**Percentage of Overtime Hours Worked at CDHA**



Graph Update Frequency: Monthly

Graph Last Updated: Aug. 2014

Next Update Expected: Sep. 2014

## 3.3 Employee Survey

### What is being measured?

This indicator is the percentage of favorable, neutral, and unfavorable responses in various sections of the employee surveys conducted in 2009 and 2011.

### Why is it important?

At Capital Health, we have made a promise to be a world-leading haven for people-centred health, healing, and learning. We can only achieve Our Promise if each of us experiences Capital Health as a rewarding, satisfying, and healthy place to work. That's why every two years, an employee survey is conducted. The survey allows the measurement of progress and the answers the following questions: How are we doing? Where could we be doing better? What will we celebrate?

### How are we doing?

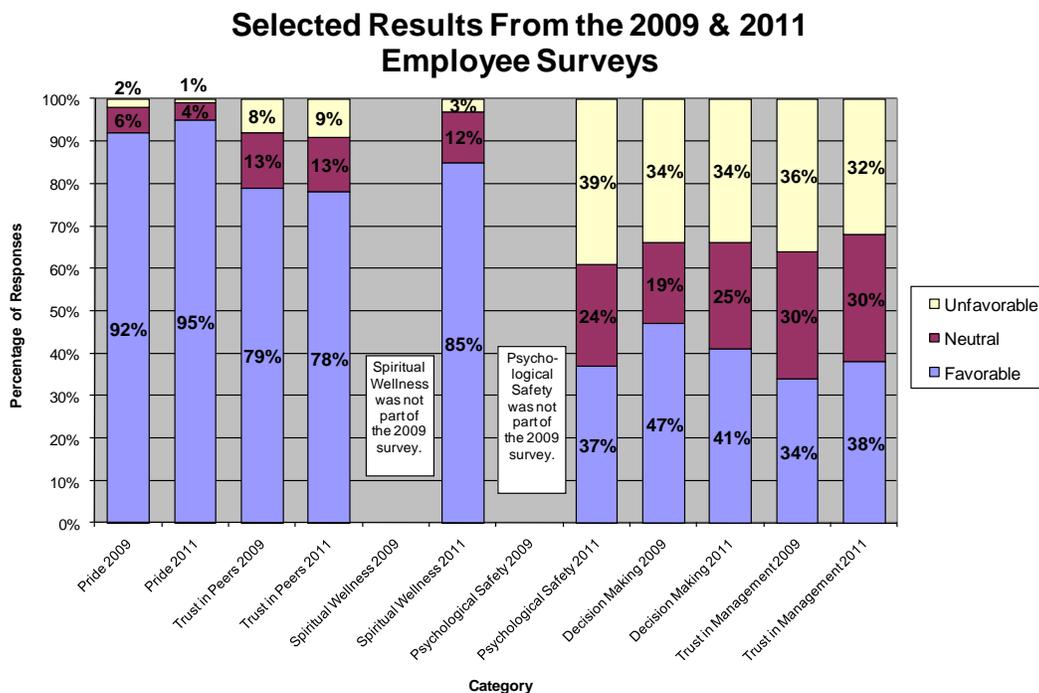
The graph below shows a selection of the results of the 2009 and 2011 Capital Health Employee Surveys. The selection of results presented in this report are meant to highlight a sample of areas to be celebrated and areas where improvements could be made.

From the graph it can be seen that both pride and trust in peers had very high percentages of favorable

responses in both 2009 and 2011. Spiritual wellness was not part of the 2009 survey, but had a very high percentage of favorable responses in 2011. Some of the areas for improvement include psychological safety, involvement in decision making, and trust in management.

### What are we doing about this?

Teams throughout Capital Health will receive team reports in June 2011, have conversations, and implement action on ways to improve their workplace. This process is the most meaningful for staff as each unit or department is unique and will have unique interests and ideas that the organizational response to survey results may not address. The 2011 survey team will make one to two recommendations based on analysis of the organizational survey results—looking at statistical and practical significance of the results and the relationships among the survey measures. The team will look for leverage opportunities based on this analysis and the prospect of alignment with existing or planned strategies within Capital Health and our larger community.



Frequency Tracked: Approx. every two years

Last Updated: June 2011

Next Update Expected: 2014

## 3.4 Employee Survey – Accreditation Canada Worklife Pulse

### What is being measured?

The Worklife Pulse Tool helps organizations identify strengths and opportunities for improvement in their work environments, plan appropriate interventions to improve the quality of worklife, and develop a clearer understanding of how quality of worklife influences the capacity of an organization to meet its strategic goals. The survey takes the “pulse” of quality of worklife, providing a quick and high-level snap shot. The survey is intended to complement the organization’s full-scale employee survey.

### Why is it important?

It is widely recognized that the health care environment is one of the most challenging within which to work due to the physical and emotional nature of work, the high risk of work-related injury, heavy workloads and work schedules, and the high rate of change in the work environment. For this reason, the concept of quality of worklife is central to the Accreditation Canada Qmentum program. Worklife is one of the quality dimensions of Qmentum, with content throughout the core standards, Required Organizational Practices (ROPs), and the Worklife Pulse Tool.

### How are we doing?

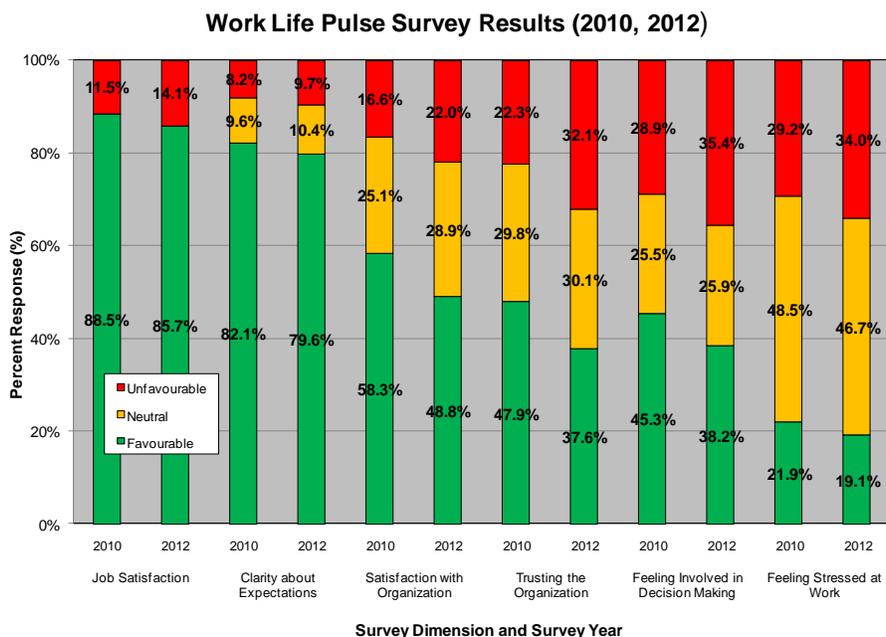
Employee ratings of ‘job satisfaction’ and ‘clarity about expectations’ remained high for 2012. However, there were slight increases in the number of ‘unfavourable’ responses in almost all dimensions – see graph below.

### What are we doing about it?

Analysis of the 2012 results led to a number of actions at the organizational level. Leadership intentionally engaged employees in the process of renewing the strategic plan including identifying organizational priorities for 2013-2016. In order to provide clarity and more succinct direction, the numbers of areas of focus in the new strategic plan were narrowed from 35 to 14.

Results of analysis also showed that engagement of employees for sustainable change required action at the interdisciplinary team level. In order to support improved employee satisfaction at the “front-line” of care and service provision, a toolkit with individualized data was created, and facilitation was provided to teams for action planning based on these more specific results. As of June 1, all Quality and Patient Safety Teams had identified two- to three-item key areas for improvement based on their individual Worklife Pulse results.

[Last updated September 2013]



Frequency Tracked: Every two years

Last Updated: Sept. 2013

Next Update Expected: 2014

# 3.5 Physician Survey

## What is being measured?

This section presents the percentage of favorable, neutral, and unfavorable responses in selected sections of the physician survey. The 2011 Capital Health Physician Survey was created by Physician Services in consultation with several department chiefs, and the presidents of both DMSA and DMAC. In January and February 2011, physicians from all medical staff categories (active, resident, fellow, associate, consulting, courtesy, clinical associate, clinical trainee, and locum tenens) were invited to complete a survey. The survey data were collected through ClearPicture, an independent survey firm. The response rate was 54%.

## Why is it important?

The information uncovered through this survey process will assist Capital Health in further developing and strengthening relationships with physicians for the sake of improved patient centered care.

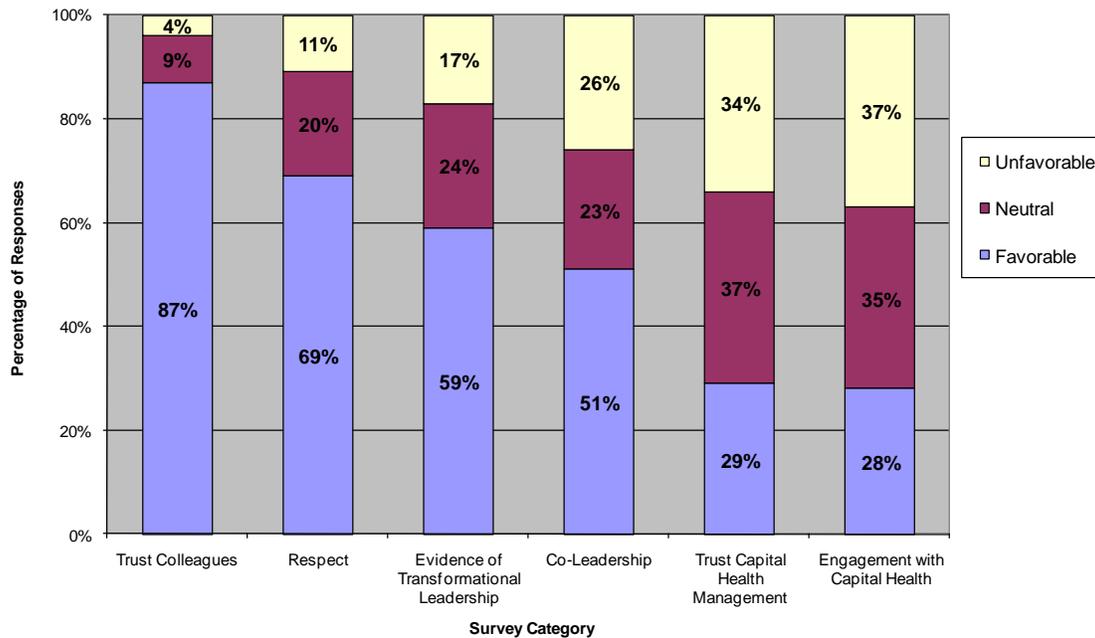
## How are we doing?

The graph below shows the results for six selected sections of the physician survey. Of the six shown, trust in colleagues and respect had the highest percentages of favorable responses, while trust in Capital Health management and engagement with Capital Health had the lowest percentages of favorable responses. Transformational leadership and co-leadership fell in between.

## What are we doing about this?

Initiatives such as Co-Leadership have been established to increase physician involvement in leadership at Capital Health. Co-Leadership work focuses on improving relationships for the sake of improved performance. Novel development work was recently presented at the Canadian Association for Health Services and Policy Research Annual Conference. The Fully at the Table program is still offered and is the focus of a national research investigation exploring ways to advance leadership for the sake of improving health care.

**Selected Results from the 2011 Capital Health Physician Survey**



Frequency Tracked: Every two years

Last Updated: June 2011

Next Update Expected: 2014



## 3.6 Improve Leadership Capacity at all Levels

**Strategy:** Transformational Leadership

**Goal:** Employees and physicians working at Capital Health will meet or exceed expectations of leadership in their work as defined by the Capital Health leadership capabilities.

**Measure:** 20 point increase in the percentage of employees and physicians responding most positively on survey scales related to leadership.

### What is being measured?

In 2012, we conducted a survey of employees and physicians on three dimensions of leadership:

1. Self-reported knowledge of the expectations of each employee/physician to be leaders
2. Assessment by employees and physicians of the leadership of their formal leaders
3. Self-reported assessment of employee's and physician's own leadership.

More than 1000 staff and 50 physicians responded. Our baselines reflect the top of the range – percentages of responses at 4.5 or higher out of 5.0. Focusing on those 4.5 or 5 responses, we target is to achieve a 20 point increase on all three dimensions.

### Why is it important?

We are putting our patients at the centre of all that we do. At the same time, we deliberately use the word “people-centred” in our mission statement. We must continue to invest in those who serve, helping everyone step up in their job to make things better, and providing an environment where employees and physicians embrace and deliver on their responsibilities to our patients.

### How are we doing?

Current baseline results: In the 2012 leadership survey, the following percentages of respondents indicated 4.5 or higher out of 5 in each of the three dimensions:

Clear Expectations: 13%

Transformational Leadership (formal leaders only): 21%

Leading in Own Work: 25%

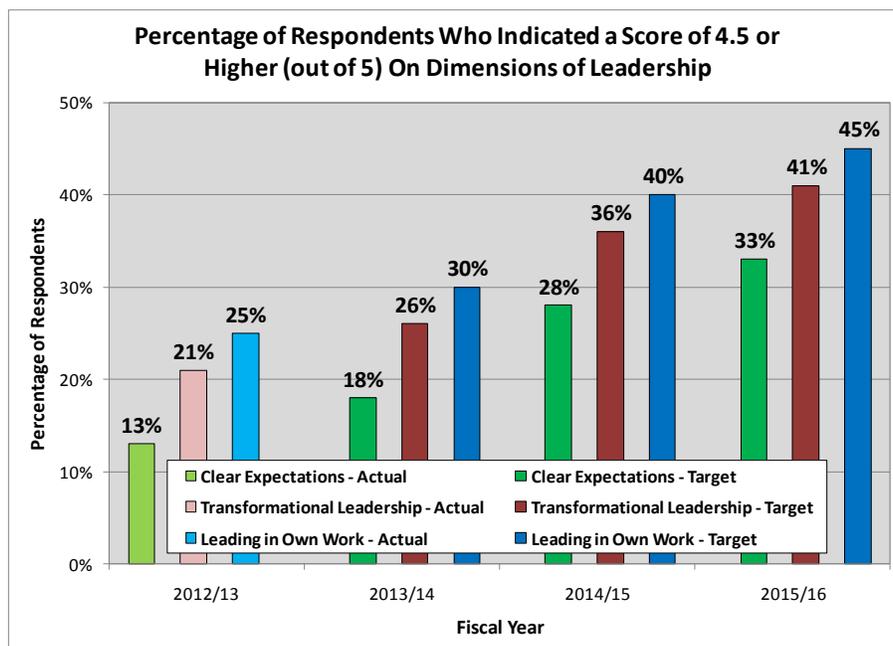
There were no statistically significant differences between physicians and employees.

### What are we doing about this?

Kathy McNeil, Vice President, People, and Steven Soroka, Vice-President, Medicine, have convened an action team to develop an action plan. Two major actions for achievement of the 2016 goal are:

Set clear expectations; provide support and accountabilities for demonstrating the CH leadership capabilities with behaviours and actions on the job  
 Demonstrate leadership capabilities by developing an excellent customer service culture

[Last updated: August 2013]





## 3.7 Strengthen Accountability of Employees and Physicians.

**Strategy:** Transformational Leadership

**Goal:** Staff, management and physicians at all levels report being held accountable for their performance.

**Measure:** 20 point increase in the percentage of staff, management and physicians responding most positively on survey items measuring self reported accountability.

### What is being measured?

As with the leadership measure, we recently conducted a survey of employees and physicians on accountability. The survey included a cluster of items that correlate to form a scale. We asked respondents if they were clear on what is expected of them in their role, if they had received feedback on their work in the past 12 months, and if they feel they are held accountable in their work.

Our baseline reflects the top of the range – percentages of responses at 4.5 or higher out of 5.0 on average for the scale. Again, we are looking to shift the whole curve up – our indicator is at the top end, but we are looking to address this issue across the board.

Thirty-five per cent of respondents answered “most positively” on the survey. Our target is to achieve a 20 point increase on this result.

### Why is it important?

Transformation requires leadership, and accountability is a big part of that. What we heard loud and clear through our strategic engagement process was a call, from staff and the public, for more accountability for action.

At Capital Health, we are building a culture of accountability. Over the past three years we have sown the seeds of leadership through the My Leadership program and Fully at the Table. The next three years will be about nurturing those seeds for real growth.

### How are we doing?

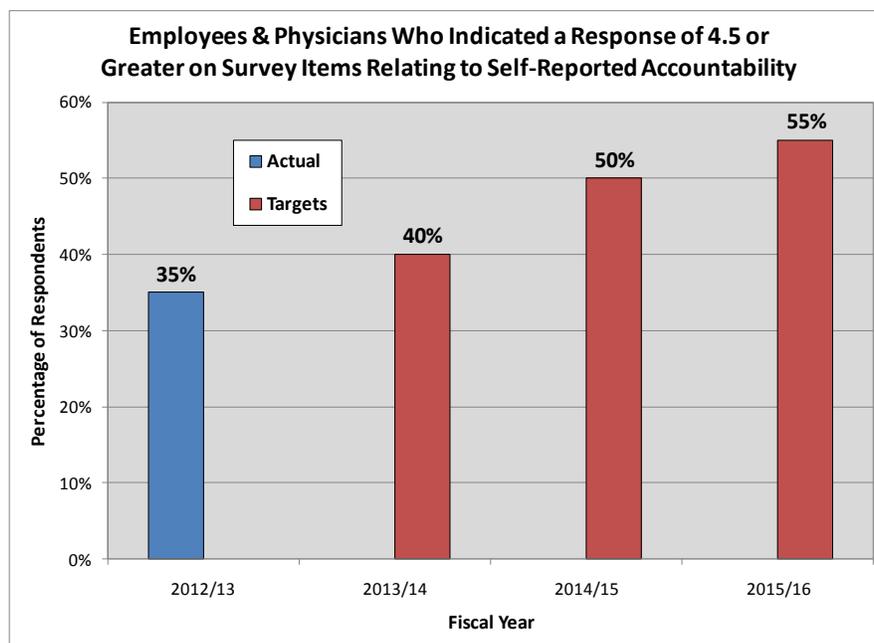
Current baseline results: In the 2012 employee and physician survey, 35% of respondents indicated a response of 4.5 or higher out of 5.0 with regard to accountability. There were no statistically significant differences between physicians and employees.

### What are we doing about this?

Steven Soroka, Vice-President, Medicine, and Kathy McNeil, Vice President, People, have convened an action team to develop an action plan. Three major actions for achievement of this 2016 goal are:

1. Set clear standards and expectations
2. Communication performance feedback/enhance career development
3. Support manager accountability using a competency development process for managers

[last updated August 2013]



## 4 Innovating Health and Learning

### 4.1 Research Funds from Grants & Contracts

#### What is being measured?

This indicator is the total new dollars in grant and contract research funds received during the fiscal year.

#### Why is it important?

Capital Health Research Services manages more than 1072 research accounts (funded projects) supporting 1133 active research projects (funded and unfunded), and is responsible to ensure that all legal, financial and ethical requirements and approvals for research at Capital Health are fulfilled. There are 280 research employees who are integral members of the interdisciplinary healthcare teams providing quality patient-centered care at Capital Health.

#### How are we doing?

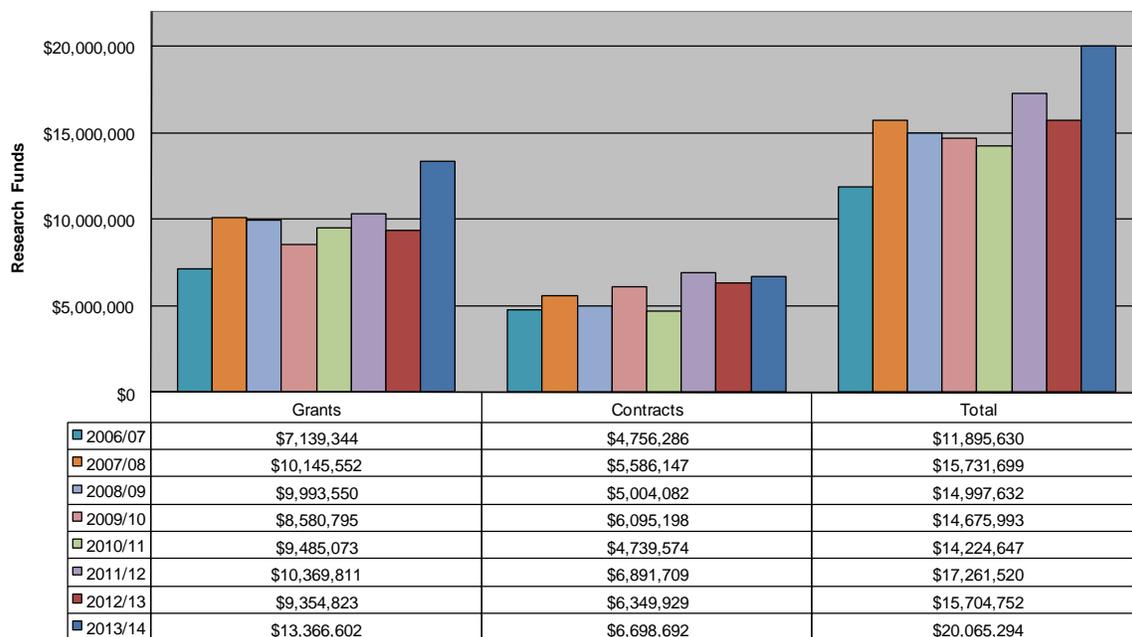
Total research funds broken down into grants and contracts are shown in the graph below. The increase in

grant funding is attributed to several new large investigator-initiated projects one of which is the SPOR initiative funded by Canadian Institutes for Health Research (CIHR), Nova Scotia Health Research Foundation (NSHRF) and Nova Scotia Department of Health and Wellness (NS DHW). See this link for more information: <http://www.cdha.nshealth.ca/discovery-innovation/maritime-spor-support-unit>

#### What are we doing about this?

Capital Health researchers have been the recipients of several large awards. These awards tend to be multidisciplinary in nature and involve a variety of researchers with diverse knowledge and expertise. Additional project management resources have been provided to ensure these projects are successful at every level.

**Total Research Funds from Grants and Contracts**  
Capital Health



Frequency Tracked: Annually

Last Updated: August 2014

Next Update Expected: Summer 2015



## 4.2 Focus on Innovation that has Benefits for Patients & Aligns with Our Mission.

**Strategy:** Innovating Health and Learning

**Goal:** New innovations are demonstrably aligned with organizational goals, have clear benefits for patients, and contribute to sustainability.

**Measure:** Implementation of a health technology assessment process for all new major capital equipment expenditures over \$500,000, and all new externally provided diagnostic testing which costs more than \$10,000 annually per type of test.

### What is being measured?

To fulfill this goal, we need to implement a new health technology assessment process. Currently, we don't have such a process in place – in a sense, that's our baseline.

This process will cover all major capital equipment expenditures over \$500,000 and all new types of diagnostic testing provided by an external supplier and projected to cost over \$10,000 annually. Of course, we're in the early stages on this and there is a lot more engagement and input to come from clinical groups on what this process will cover.

### Why is it important?

A Health Technology Assessment is a best practice, evidence-based approach to ensure expenditures are aligned with our strategies, benefit our patients, and realize cost efficiencies. It is a methodological approach to making decisions.

There are two elements to this: first, rigorous evaluation and prioritization to ensure innovations align with our priorities at Capital Health; second, translating innovations into improvements in care and services.

### How are we doing?

Current baseline results are not yet available.

### What are we doing about this?

Catherine Gaulton, Vice-President, Performance Excellence & General Counsel, and Pat McGrath, Integrated Vice-President, Research and Innovation, have convened an action team to develop an action plan. Two major actions for achievement of this 2016 goal are:

1. Implementation of health technology assessment to new capital equipment purchases over \$500,000 and other capital processes as recommended by Capital Funding Committee and approved by LET
2. Implementation of NS-based health technology assessment process to all qualifying diagnostic processes and to other diagnostic processes as recommended by Lab Utilization Committee and approved by LET

[Last updated: August 2013]



## 4.3 Strengthen Partnerships with Learning Institutions

**Strategy:** Innovating Health and Learning

**Goal:** Partners in the academic health learning network report a high degree of quality in their relationship.

**Measure:** 85% positive response by academic partners on survey items related to the quality of the partnership.

### What is being measured?

We sent an online survey to 11 senior leaders at our key partnering academic institutions, asking them about the quality of our partnership with respect to both research and education.

We only received three responses, so the baseline is not concrete. We will look to increase both the response rate and the rate of positive results. Our target is to have 85% positive responses from our partners.

### Why is it important?

Simply, if we are not performing at the highest possible level with regard to education, research and innovation, we won't be improving care at Capital Health.

We are committed to strengthening our ties to learning institutions across the Maritimes – connecting directly to our academic mandate. As an academic health science

network, we have a unique role to play in fostering relationships among learning organizations.

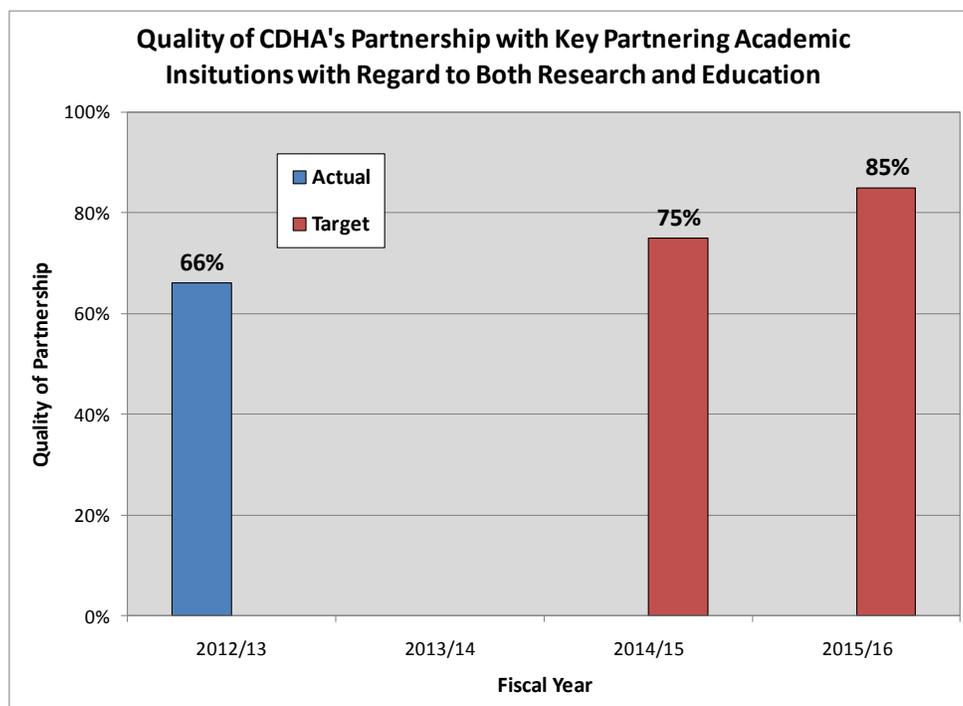
### How are we doing?

Current baseline results: In the partner survey, respondents rated the quality of our partnership with regard to both research and education at 66%.

### What are we doing about this?

Pat McGrath, Integrated Vice-President, Research and Innovation, have convened an action team to develop an action plan. A major action for achievement of this 2016 goal is to further discussions with key researchers at the key educational institutions to gather information and identify barriers to enhance research relationships, ease research approval and facilitate innovation within universities and CH.

[Last updated August 2013]





## 4.4 Build our Capacity for Interprofessional Research and Interprofessional Education

**Strategy:** Innovating Health and Learning

**Goal:** Increase opportunities for interprofessional research and interprofessional education

**Measure:** 50% increase in the percentage of new, Research Ethics Board approved research initiatives that are interprofessional, and in the number of hours of interprofessional education offered annually

### What is being measured?

Although we are measuring increased interprofessional capacity for both research and education in this goal, they are actually quite different areas. We will require two baselines and measures. We feel we can address both initiatives with a common target of a 50% increase in results.

We've chosen number of hours as our measure for interprofessional education, and the percentage of new, Research Ethics Board approved interprofessional initiatives as our measure for research.

### Why is it important?

The Canadian Institute of Health Research and other research funding bodies are moving to make it a requirement that research initiatives be interprofessional – we are falling in line with a national trend.

This goal relates to our efforts to strengthen collaboration – around chronic disease management, for example. It also connects directly to our focus on improving the quality of care in transitions.

Professions tend to focus on what makes them distinct – we need to work hard to focus on what we hold in common, and by doing that we can transform care.

### How are we doing?

Current baseline results: In 2012, 45 of 260, or 17%, newly funded research projects were interprofessional.

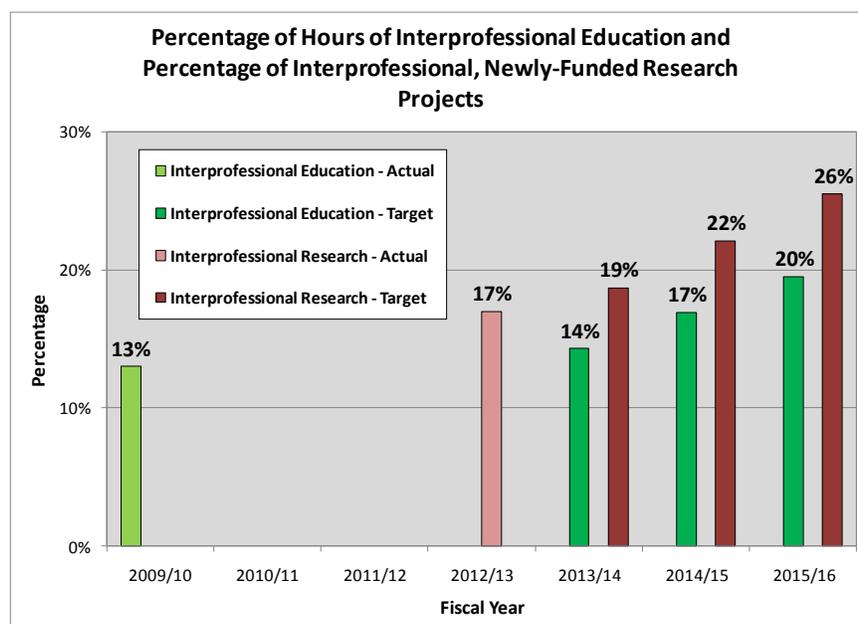
According to the 2009 inventory of corporate and clinical education, 1500 hours of the total, or 13%, were dedicated to interprofessional education.

### What are we doing about this?

Kathy MacNeil, Vice-President, People, and Pat McGrath, Integrated Vice-President, Research and Innovation, have convened an action team to develop an action plan. Three major actions for achievement of this 2016 goal are:

1. Clinical professional development advances acquisition and demonstration of interprofessional competencies. Corporate education facilitates interprofessional and cross sector collaboration at a leadership level
2. Interprofessional student placement experiences occur in every clinical area. Responsibility for interprofessional facilitation seamlessly head by the team
3. Simulation initiatives are maximized for advancement of technical skills and team processes

[Last updated August 2013]



# 5 Sustainability



## 5.1 Innovate Systems and Processes for Greater Efficiency

**Strategy:** Sustainability

**Goal:** Optimize resources to improve organizational (system) performance, quality and efficiency.

**Measure:** 60% of typical cases for identified Case Mix Groups have an ALOS equal to or less than the ELOS

### What is being measured?

This goal is being looked at from the perspective of optimizing the use of clinical resources. As a result, the measure relates to average length of stay (ALOS) and expected length of stay (ELOS). ALOS is measured based on the length of stay for patients at Capital Health with a particular diagnosis. ELOS is the objective or target – how long patients with that diagnosis would be expected to be in hospital, which is derived from national data.

The main focus will be on three case mix groups (CMGs): heart failure without coronary angiogram, chronic obstructive pulmonary disease, and ischemic event of central nervous system (but not to the exclusion of other CMGs). This is also for typical cases only.

### Why is it important?

The focus is on these three groups because of the need for improvement in these areas. If addressed, there will be improvement in the overall results. These 3 areas are in the top 10 CMGs by volume. Results in these areas connect well with other key indicators being tracked.

Finally, and importantly, there is a strong correlation between these areas and Emergency Department flow. Delays in discharging patients in these CMGs affect the whole system – right back to the patient in Emergency waiting for a bed.

### How are we doing?

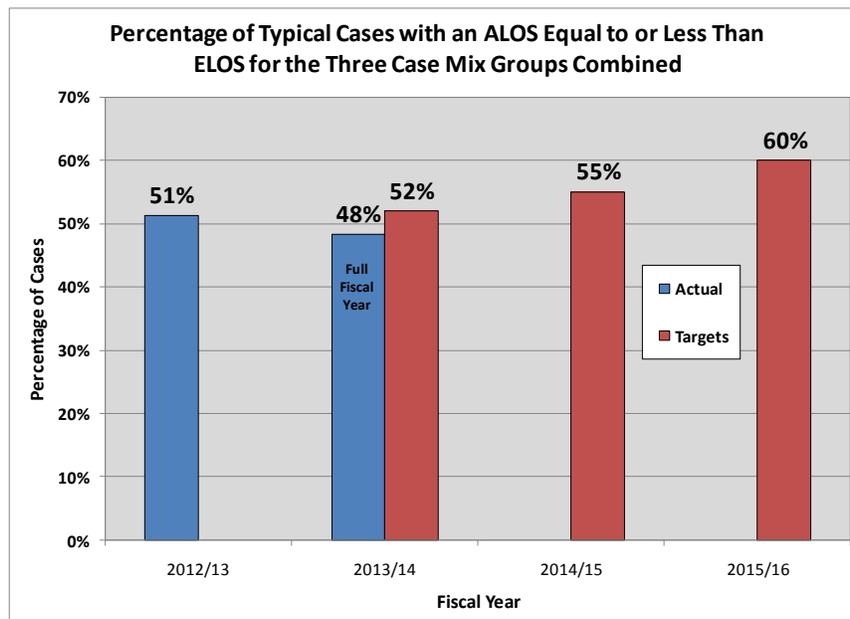
For the complete 2013/14 fiscal year, the percentage of typical cases for the three CMGs with an ALOS equal to or less than the ELOS was 48%. This is a decrease from the baseline of 51% and short of the 2013/14 target of 52%. Individual CMG percentages were:

- Heart failure without Coronary Angiogram: 46%
- Chronic Obstructive Pulmonary Disease: 49%
- Ischemic Event of Central Nervous System: 47%

### What are we doing about this?

- For heart failure patients, a multidisciplinary committee has been formed involving all areas who care for heart failure patients to look at the ALOS vs. ELOS issue.
- A review of data identified the Cardiology Unit (6.2) as the biggest concern related to the LOS for heart failure patients.
- A national scan was done looking for Clinical Pathways for heart failure that have already been implemented in other jurisdictions. Results will be reviewed at an upcoming meeting.
- The multidisciplinary committee will also look at barriers to early discharge for this CMG and devise a plan to overcome these barriers.

[Last updated: April 2014]



Graph Update Frequency: Monthly

Graph Last Updated: June 2014

Next Graph Update Expected: Fall 2014



## 5.2 Develop Funding Models Based on our Priorities

**Strategy:** Sustainability

**Goal:** All 14 areas of focus are transitioned to funding models based on leading practices.

**Measure:** 100% implementation of funding formulas based on our priorities, using leading practice where available.

### What is being measured?

This goal and its measure are important indicators in their own right, ensuring we are making progress on our strategic plan. They will enable our success with regard to the other 13 goals.

This work is fairly straightforward. We just need to get on with the work and put the models and formulas in place. It will take time, of course, and we don't expect we will find many leading practices to adopt - we'll actually be breaking new ground.

### Why is it important?

Unfortunately, we know that in health care, sometimes we embark on initiatives without giving them the necessary resources. This goal is about changing that.

The most significant impact of this goal, and its measure, is that we will have a process in place to help us be intentional about the trade-offs we need to make with our resources.

We cannot do everything, and we need to ensure that our strategic priorities are funded while advancing other key indicators. There are challenging times ahead, and the process we put in place will help us move through them.

### How are we doing?

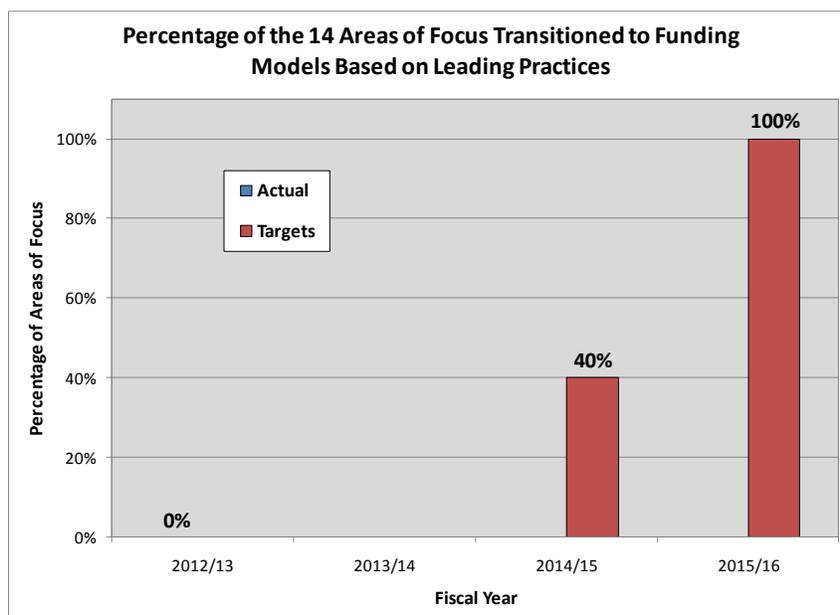
In the baseline year of 2012/13, none of the Areas of Focus had funding models based on leading practices.

### What are we doing about this?

Amanda Whitewood, Vice-President, Sustainability and Chief Financial Officer, has convened an action team to develop an action plan. Three major actions for achievement of this 2016 goal are:

- Review existing budgeting and business planning processes
- Design engagement process for leaders
- Implement funding formulas

[Last updated August 2013]





## 5.3 Be Better Environmental Stewards

**Strategy:** Sustainability

**Goal:** Capital Health is independently recognized as a leader in adopting practices and processes that minimize the impact on the environment.

**Measure:** 15% reduction in total annual electrical power consumption.

### What is being measured?

Originally, we saw the work of developing our measure as finding an independent body to review our practices and processes, and target an improvement in their assessment of our progress.

What we quickly realized in our discussions is that the actual result is what is key. So we have chosen a significant environmental indicator – power use – and established a challenging target.

Over the past two years our power use has been trending upwards. We want to stop that climb, and begin to reverse it, by achieving a 15% real reduction in power consumption in three years.

### Why is it important?

As a major organization in this region, we are accountable to our larger community, and can play an important role in reducing our environmental impact.

We are working closely with Efficiency Nova Scotia, a recognized independent body, to achieve this important goal.

### How are we doing?

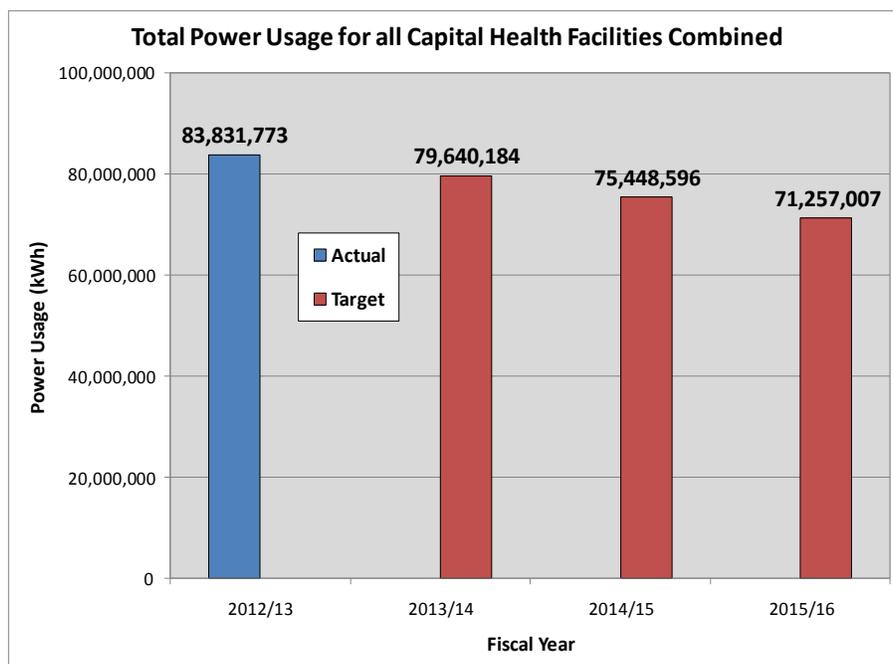
Current baseline results: Our baseline is a total organizational kWh usage, including totals from all facilities. In 2012, our total power usage was 83,831,773 kWh.

### What are we doing about this?

Amanda Whitewood, Vice-President, Sustainability and Chief Financial Officer, has convened an action team to develop an action plan. Three major actions for achievement of this 2016 goal are:

- Implement sustainable sources of internal funding dedicated to efficiency projects
- Establishment of Embedded Energy Advisor position
- Create a list of projects, prioritized and reviewed annually

[Last updated August 2013]





## 5.4 Implementation of the Electronic Health Record

**Strategy:** Sustainability

**Goal:** An electronic health record.

**Measure:** Percentage of the implementation of the Electronic Health Record.

### What is being measured?

A fully integrated electronic health record (EHR) is a real-time, patient-centered record that makes information available instantly and securely to authorized users. EHRs are designed to contain and share information from all providers involved in a patient's care journey. Key EHR components include: electronic clinical documentation; Positive Patient Identification; Computerized Physician Order Entry.

### Why is it important?

Connecting people and their health information electronically is essential to provide real time access to health information. We have heard from patients, and staff, how essential this is to transforming health and health care. Integrated patient information management solutions such as the EHR are critical to supporting a systemic shift in health care, from that of the organizational view of patient health to patient ownership of his/her own health. Implementation of the EHR has been identified as a priority in Capital Health's Business Plans and Strategic Plan, and aligns with the long term goals for provincial clinical services of the Department of Health & Wellness.

### How are we doing?

Capital Health's efforts to implement an EHR have stalled due to the province's desire to have a single

health information solution. The province is commencing with the development of a business case for treasury board to move all clinical system applications to a single solution, from today's three information technology platforms (Capital Health – Best of Breed, IWK – Meditech Magic, All Other Districts –Meditech). Capital Health's E.H.R. initiative (RFP for technology) has been put on hold as a result of this provincial initiative. However, the province has approved Capital Health to launch preparatory work (change management, form consolidation, electronic form development, business process, etc.). We are recruiting a team of new resources to lead this work.

### What are we doing about this?

We realize that implementing a fully electronic health record involves much more than just installing a software system. We are currently undertaking activities that will support the introduction of an electronic records system once it is chosen. Infrastructure such as computer terminals and wireless connects must be in place. Process redesign and change management needs for the front lines and support areas must be explored to ensure we make the most of any system.

[Last updated: July 2014]



## 5.5 Actual Expenditure to Approved Budget

**Strategy:** Sustainability

**Goal:** Be good fiscal stewards

**Measure:** Percentage variance of actual expenditure to approved budget

### What is being measured?

Actual expenditure to approved budget measures our fiscal accountability. Financial reporting is intended to provide clients, stakeholders, citizens, and taxpayers with a general overview of the Capital Health's finances and to demonstrate accountability for the tax funding it receives.

### Why is it important?

Capital Health understands the financial pressures our provincial government and Nova Scotia taxpayers are facing. A new approach is needed. The reality of our finite funds means we must find ways to make the most of the limited human and financial resources with which we are entrusted. Our financial plans reflect a commitment to responsible stewardship of public resources, supporting our citizens to improve overall. Accountability means taking responsibility for our words and actions in open and transparent ways. It encompasses sustainability by changing the way we think about our resources, whether they be people or buildings, dollars and cents, or earth and air.

### How are we doing?

The table below shows total budgeted, actual, and variance for Capital Health revenue and expenses in 2013/14. Actual expenditure showed a variance of 0.44 % over the approved budget.

Budget & Planning coordinates the annual business plan submission to the Department of Health and Wellness. Ongoing 2013/2014 financial reporting & oversight was provided to the sustainability committee of the board, as well to the board on significant financial pressures and risks. The most significant financial pressure for the 2013/2014 fiscal year centered on the utilities budget. Contributing factors included the ongoing natural gas price escalation and the harsh winter climate. Overall the utilities costs exceeded budget by just under \$5M. A balanced budget was achieved through internal mitigation strategies and one-time funding of \$2.2 million from Department of Health & Wellness to help offset utility costs.

### What are we doing about this?

In addition to the provision of fiscal oversight to the sustainability committee & the board, Capital Health provides regular financial updates to the Department of Health & Wellness (DHW). While the demand for health care services continues to grow, we are actively pursuing opportunities to reduce costs through improved scheduling, service delivery and purchasing processes. This work will continue within the organization and in collaboration with other district health authorities and provincial partners.

[last updated July 2014]

Fiscal Year 2013-2014	Budget	Actual	\$ Variance	% Variance
Revenue	\$ 865,822,800	\$ 869,574,109	\$ 3,751,308	0.43 %
Partners for Care (Net Revenue)		\$ 95,445	\$ 95,445	n/a
Expenses	\$ 865,822,800	\$ 869,669,553	(\$ 3,846,753)	<b>(0.44 %)</b>
Net Result	\$0	\$0	\$0	



## 5.6 Focus on Sustainability

**Strategy:** Sustainability

**Goal:** Appropriate level of funding requests for capital equipment

**Measure:** Percentage of funded requests for capital purchases in relation to identified required funding

### What is being measured?

The measure for this goal is the percentage of funded requests for capital purchases in relation to identified required funding.

### Why is it important?

To fulfill this goal, we need to ensure we prioritize our requests for capital funding and provide clear, compelling business cases to ensure funders are aware of the need, risks and impacts for each request.

A new process was introduced to evaluate and prioritize all requests for capital equipment.

We are pursuing a best practice, evidence-based approach to ensure expenditures are aligned with our strategies, benefit our patients, and realize cost efficiencies. It is a methodological approach to making decisions.

### How are we doing?

The graphs below show the progress toward this goal. The first graph shows progress toward obtaining capital funding for identified priority purchases and infrastructure improvements. The second graph shows the percentage of actual funding approval compared to the target.

### What are we doing about this?

**Infrastructure.** Requests are submitted to DHW in categories: funding for design work; repair and renewals(R&R) over \$90,000 and R&R under \$90,000. There is a separate submission for capital projects over \$1Million; clinical capital projects would fall in this as well. In 13/14 we had approved funding from internal and external sources of \$10,355,029 for 4 projects. We currently have business cases submitted for projects for fiscal 14/15; 15/16 e.g.

next phase of the Innovative Care Flexible Facilities Renewal; Purdy Exit.

We have allocated funds for our on-site energy advisor and projects. This is to help us reach our business plan target of reduction in electrical consumption by 15% over 3 years.

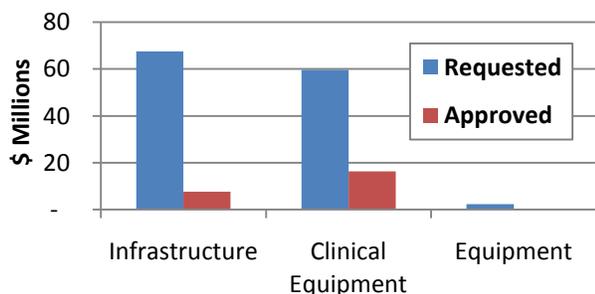
**Clinical Equipment.** Ways to improve our capital funding are continuously being sought. CDHA participated in a DHW consulting project and our primary recommendation was that the funding model for equipment should span more than one year to enable us to access items in a more stable manner and complete projects. Clinical Engineering continues to maximize the usable lifespan of the equipment. In February 2014, DHW requested a business case for the three Linear Accelerators (\$12M) on our list. It was submitted by CDHA in April. This was outside the normal process due to the high cost of items. There is continuous work with Directors and Managers to find any available sources to cover urgent needs. Due to financial constraints, a proactive multi-year asset management plan for equipment replacement is not feasible at this time. With limited funds we rank the urgent needs and purchase what we can within funding sources.

**Equipment (not direct patient care).** A need has been noted in our next Capital Budget (FY14/15) to try to allocate funds for this category and rank them separately. These types of requests previously were ranked with the clinical equipment and would never rank high enough to receive funding. If the equipment is substantial, we can also submit it to DHW, although it is difficult to obtain funding through that process.

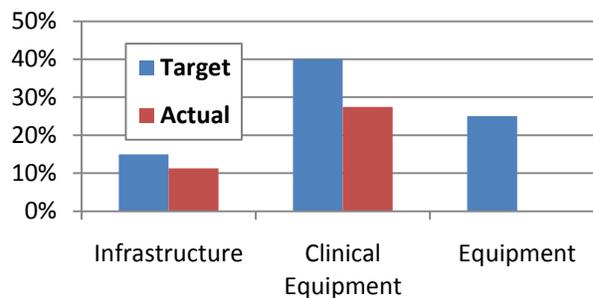
In summary, while we all work to secure capital funding, as a system it is an on-going challenge.

[Last updated June 2014]

**Capital Requests and Approvals  
FY 2013/14**



**Target vs. Actual Approval  
Percentage - FY 2013/14**





## 5.7 Improve Population Health

**Strategy:** Sustainability

**Goal:** Influence change in six major public policies that affect population health

**Measure:** Active participation in and contribution to development of primarily *non-health sectors*

### What is being measured?

Capital Health's active participation in and contribution to development of healthy public policy by primarily non-health sectors (municipality, school board, finance sector, community services sector, etc). Our Promise in Action 2013 – 2016 goal is to influence two major policies per year in each of 2013/14, 2014/15, and 2015/16. At least one policy should be at the municipal government level. A **major** policy is one that actively engages the **senior leadership** of the target sector and that could lead to significant public dialogue. Policies need not be new if CDHA's active involvement continues from one year to the next, as policies sometimes take years to develop.

### Why is it important?

The Pepin and Keon<sup>1</sup> report on Population Health (Senate Sub Committee report on Population Health, 2009) describes that much of what influences health exists in policies and arenas well outside of health care (1). While most authorities agree that a maximum of 25% of health is achieved through health service delivery and related policies, the Pepin/Keon report points out that 10% of health is achieved through creation of policies promoting

healthy built environments, with another 50% being contributed to by social and economic policies. Advocating for and contributing to non-health sector led healthy public policies is therefore the most important strategy we can use to act on the determinants of health and reduce health disparities.

### How are we doing?

In 2013-14 Capital Health actively contributed to the policies noted in the table below. Anticipated policy directions for 2014/15 and 2015/16 are also noted.

### What are we doing about this?

Gaynor Watson-Creed, Medical Officer of Health, and Barbara Hall, Vice-President, Person-Centred Health, are overseeing activities to achieve the 2016 goal.

[last updated July 2014]

<sup>1</sup> Pepin, L, and Keon, W. 2009 A healthy productive Canada: a determinant of health approach. Final Report of Senate Subcommittee on Population Health

Focus of Policy Direction	Year		
	2013/14	2014/15 (anticipated)	2015/16 (anticipated)
<b>Non-Municipal Government</b> Local, i.e., school board, DHA, CHB	<ul style="list-style-type: none"> <li>CDHA Breast Feeding Policy (complete)</li> </ul>		
<b>Municipal Government</b>	<ul style="list-style-type: none"> <li>Municipal Alcohol Strategy, HRM (first draft complete)</li> <li>HRM Regional Municipal Planning Strategy (complete)</li> <li>Mayor's Round Table on Health (HRM) (initiated)</li> <li>Mayor's Round Table on Housing (HRM) (initiated)</li> </ul>	<ul style="list-style-type: none"> <li>Guidelines for the development of prostitution business districts (HRM)</li> <li>Healthy Eating in Recreation Centres (HRM)</li> <li>Finalization of Complete Streets Policy (HRM)</li> <li>Contribution to Municipal Food Strategy (HRM)</li> <li>Contribution to HRM Centre Plan (HRM)</li> </ul>	
<b>Provincial or Federal</b>		<ul style="list-style-type: none"> <li>Guidelines for the development of prostitution business districts (Provincial, led by Dept Community Services and DHW)</li> <li>Healthy Eating in Recreation Centres (HRM) (Provincial, led by DHW)</li> </ul>	

## Appendix A: Patient Safety Scorecards

LEGEND	Not meeting target	Almost meeting target	Meeting target	No established target or data not available
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**Table A1: Scorecard for Quarterly-Trending Indicators**

Area	Indicator	Target	Q1 11/12	Q2 11/12	Q3 11/12	Q4 11/12	Q1 12/13	Q2 12/13	Q3 12/13	Q4 12/13	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14
Hospital Acquired Infections	MRSA Transmission (per 10,000 patient days)	< 12.44	2.9	4.6	3.2	5.3	3.8	6.7	3.5	4.7	4.5	4.6	3.4	3.0
	C. difficile Incidence (per 10,000 patient days)	< 6.0	2.9	3.3	1.4	2.0	2.0	3.1	3.0	3.9	5.0	3.4	2.9	3.9
	VRE Incidence (per 10,000 patient days)	< 8.6	0.0	0.0	7.9	0.7	3.0	0.7	0.3	0.3	1.9	1.4	1.5	0.9
DGH Quick Response Team	DGH Code Blue Count (Average codes per month)	≤ 3	1.3	2.3	1.7	3.3	2.3	0.7	0.7	2.7	3.0	1.0	2.0	1.3

**Table A2: Scorecard for Calendar Year Annually-Trending Indicators**

Area	Indicator	Target	2010	2011	2012	2013	Jan-Mar 2014
Hand Hygiene	Compliance Before Patient Contact	80%	29%	54%	46%	60%	65%
	Compliance After Patient Contact	80%	55%	75%	74%	81%	81%
	Overall Compliance	80%	44%	66%	61%	72%	74%

**Table A3: Scorecard for Fiscal Year Annually-Trending Indicators**

Area	Indicator	Target	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Mortality	Hospital Standardized Mortality Ratio (HSMR)	≤ 100	109	113	105*	99	107	99 (Q1-Q3)
Patient Safety Culture Survey	"Excellent" & "Very Good" Responses				47%		51%	
	"Acceptable" Responses				44%		41%	
	"Poor" and "Failing" Responses				10%		9%	
	Total of "Excellent", "Very Good", and "Acceptable" Responses Combined	90%			91%		92%	
Annual Patient Safety Training	Documentation of Percentage Completion in LMS	100%		33%	51%	45%	58%	58%
Patient Experience Survey – Concern for Safety: Inpatient & Organizational Results	Percentage of "Agree" responses to: Staff consistently washed hands before providing care	90%				90%	89%	89%
	Percentage of "Agree" responses to: Before giving medications, did staff tell you what the medicine was for?	90%				87%	86%	86%
	Percentage of "Agree" responses to: Hospital staff described possible side effects in a way that was understandable	90%				69%	69%	67%
	Percentage of "Yes" responses to: Told what you could do to make sure you were safe in hospital	90%				69%	68%	69%

\* The HSMR score can be listed as greater than 100 and still be meeting the target if the score is NOT reported to be statistically significantly different from the 2009/10 national average of 100.

## Appendix B: Access (Wait Times) Scorecard

<b>Performance LEGEND</b>	<b>Not meeting target</b>	<b>Almost meeting target</b>	<b>Meeting target</b>
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**Table B1: Target and Actual Wait Times for Key Treatments/Procedures at Capital Health**

Treatment / Procedure	Target Wait Time	Average Wait Times for June 2014 (except where noted)	
		Location	Performance
Elective Computed Tomography (CT)	28 days	Capital Health	25 days
Magnetic Resonance Imaging (MRI)	28 days	QEII	220 days
Radiotherapy – Intermediate Cases	14 days	QEII	19 days
Radiotherapy – Urgent Cases	7 days	QEII	6 days
Hip Replacement	100% of cases completed within 26 weeks	Capital Health	58% of cases completed within target (Q1 2014/15)
Knee Replacement	100% of cases completed within 26 weeks	Capital Health	37% of cases completed within target (Q1 2014/15)
Hip Fracture Repair	100% of cases completed within 48 hours	Capital Health	69% of cases completed within target (Q1 2014/15)
Cataract Surgery	100% of cases completed within 16 weeks	Capital Health	74% of cases completed within target (Q1 2014/15)
CABG – Urgent Cases	7 days	QEII	5 days (median wait time)
CABG – Semi-Urgent Cases	21 days	QEII	25 days (median wait time)
CABG – Scheduled Cases	42 days	QEII	33 days (median wait time)
ED – 90 <sup>th</sup> Percentile Wait Time from Triage to Admission	8 hours	QEII	24 hours (90 <sup>th</sup> percentile)
		DGH	25 hours (90 <sup>th</sup> percentile)
ED – Average Wait Time from Triage to Physician: CTAS Level 3 (Urgent)	30 minutes	QEII	154 minutes
		DGH	160 minutes
		CCHC	85 minutes
		HCH	59 minutes

## Appendix C: Strategic Streams

This report has been organized around Capital Health's Five Strategic Streams:

**Person-Centered Health Care** – Person-centered health welcomes the patient as a full-fledged member of the health care team, respects their ownership and rights to their own health, and recognizes that a healthy person needs a healthy community. Capital health will care for the whole person before us with our hearts, as well as our hands and minds.

**Sustainability** - Capital Health is transforming health care today because we want to be here for the people of our communities for a very long time. We are working to ensure our workforce will be sufficient to care for those we serve; buildings will be designed with the needs of patients citizens and the environment in mind; and all of this will happen on a budget that will not break the bank.

**Transformational Leadership** - Capital Health invites every person to share their talents, act with passion and purpose, listen deeply, grow relationships, take risks and embrace tension to co-create a world-leading haven for people-centered health, healing and learning. We will focus on matching peoples' passion, talents and sense of purpose to the work rather than just focusing on the technical aspects of the job. We will create a culture and environment that fosters joy, pride, trust, and respect.

**Citizen Engagement & Accountability** - Capital Health is opening our doors, our minds, and our ears to connect with what communities really need. We are committed to a health system where each of us shares in the accountability for our individual health, the health of our health system and that of our community.

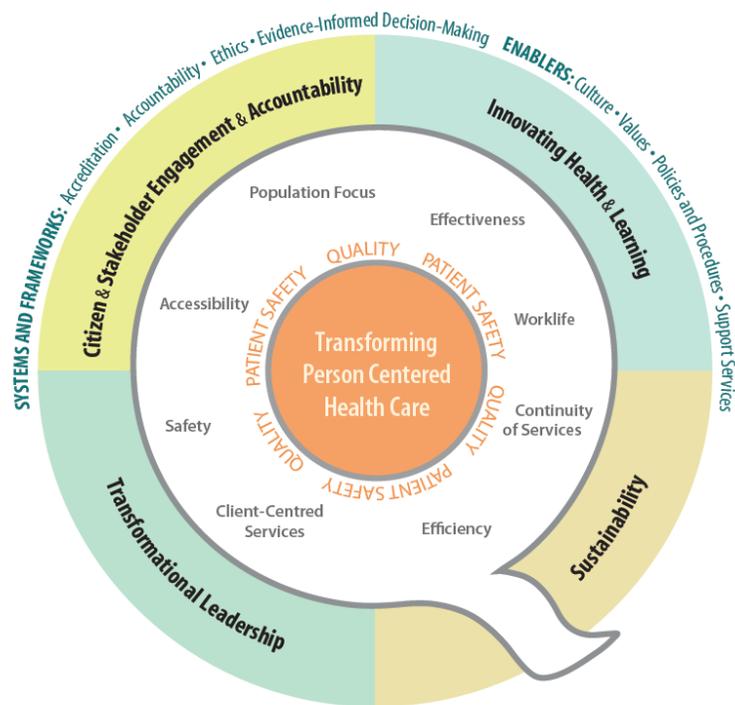
**Innovation & Learning** - Capital Health will contribute to a better tomorrow as lifelong learners, educators of the next generation, and researchers of new frontiers in health and healing. We will keep the spark of curiosity alive, and encourage it in everyone—whether they're at the bedside, in the boardroom, or in the lab. Constantly asking why will help us find a better way.

# Appendix D: Quality and Patient Safety Framework

The Integrated Quality and Patient Safety Framework shown below outlines the quality and patient safety structure, functions, responsibilities and accountabilities at Capital Health. The framework is not a stand alone document – it is supported by Our Promise, Our Declaration of Health, the Patient Safety Plan, our Strategic Indicators Reporting Framework, Capital Health Ethics Framework, Research Ethics Framework, and our foundation as an academic health sciences network. It provides information and guidance to the organization for selection and measurement of our achievements in service quality, care outcomes, and risk mitigation. It is not intended to be a detailed procedure for designing or implementing quality and patient safety initiatives. The framework is reviewed on a regular basis to ensure continued alignment with the vision mission and strategic direction of Capital Health.

This framework was developed in 2010 and first appeared in the October 2010 version of this report— replacing the Framework for Developing and Reporting of Operational Measures.

## Integrated Quality and Patient Safety Framework



**OUR FOUNDATION:** Capital Health is an academic health sciences network providing timely access to advanced patient care, leading edge research and training for the current and the next generation of health care professionals.



In addition, each indicator found within Capital Health's Strategic Indicators Report falls into one of the eight Qmentum quality dimensions outlined by Accreditation Canada (<http://www.accreditation.ca/en/default.aspx>). The quality dimensions are listed below.

Qmentum Quality Dimensions:

**Population Focus** - working with communities to anticipate and meet needs

**Accessibility** - providing timely and equitable services

**Safety** - keeping people safe

**Worklife** - supporting wellness in the work environment

**Client-centred services** – putting clients and families first

**Continuity of Services** – experiencing coordinated and seamless services

**Effectiveness** - doing the right thing to achieve the best possible results

**Efficiency** - making the best use of resources

# Appendix E: Our Promise in Action Poster



**Our Mission** is to be a world-leading haven for people-centred health, healing and learning.

**Our Vision** is for a future with healthy people and healthy communities.

**Our Values** are who we are and how we act. We're grounded in integrity, and courageous, caring, accountable and inquisitive.



## Transforming Person-Centred Health Care Experience

Putting those we serve – patients, families, communities – at the centre of our work. Relentless pursuit of excellence in care and service.

**AREA of FOCUS:** Strengthen community-based care for chronic disease.

**GOAL:** Significant increase over baseline of chronic disease management occurring in the community where appropriate.

**MEASURE:** 5% reduction in the number of return outpatient visits annually at selected clinics in relation to hypertension, heart disease, COPD, and diabetes.

**AREA of FOCUS:** Improve quality of care in transitions.

**GOAL:** Care teams will improve achievement in meeting established standards in the quality of care at key transition points substantially over 2012 baseline levels.

**MEASURE:** 50% overall compliance in documenting patient instructions on the discharge summary.

**AREA of FOCUS:** Build a culture of customer service.

**GOAL:** Patients, families and communities report customer service interactions with Capital Health employees and physicians meet or exceed their expectations.

**MEASURE:** 20 point increase in the percentage of patients responding most favourably on customer service related survey questions.



## Citizen and Stakeholder Engagement and Accountability

With patients, partners and the public, we exchange information, make decisions, act together and share responsibility to improve health and well-being.

**AREA of FOCUS:** Partner with the public so individuals and communities can play a key role in managing their own health.

**GOAL:** Significant increase in number of individuals reporting that Capital Health has supported them in playing a key role in managing their own health.

**MEASURE:** 10 point increase in percentage of residents who say they have received support in managing their own health.

**AREA of FOCUS:** Involve patients directly in their care.

**GOAL:** Patients or their surrogates report that their involvement in decision-making related to their care met or exceeded their expectations.

**MEASURE:** 10 point increase in the percentage of patients responding positively to a survey question about being consulted in decision-making about their care.

**AREA of FOCUS:** Lead dialogue with the public addressing appropriateness of care.

**GOAL:** Improve public awareness of quality of life issues related to appropriateness of care.

**MEASURE:** 20 point increase in the percentage of Capital District residents surveyed who report a high degree of familiarity with the concept of appropriateness of care.



## Transformational Leadership

Everyone is expected to be a leader in their work. Together we are accountable to make things better.

**AREA of FOCUS:** Improve leadership capacity at all levels.

**GOAL:** Employees and physicians working at Capital Health will meet or exceed expectations of leadership in their work as defined by the Capital Health leadership capabilities.

**MEASURE:** 20 point increase in the percentage of employees and physicians responding most positively on survey scales related to leadership.

**AREA of FOCUS:** Strengthen accountability of employees and physicians.

**GOAL:** Staff, management and physicians at all levels report being held accountable for their performance.

**MEASURE:** 20 point increase in the percentage of staff, management and physicians responding most positively on survey items measuring self-reported accountability.



## Innovating Health and Learning

Excellence in education and research. Learning all the time, in everything we do. Embracing new ideas and having the courage to do things differently.

**AREA of FOCUS:** Focus on innovation that has benefits for patients and aligns with our mission.

**GOAL:** New innovations are demonstrably aligned with organizational goals, have clear benefits for patients, and contribute to sustainability.

**MEASURE:** Implementation of a health technology assessment process for all new major capital equipment expenditures over \$500,000, and all new externally provided diagnostic testing which costs more than \$10,000 annually per type of test.

**AREA of FOCUS:** Strengthen partnerships with learning institutions.

**GOAL:** Partners in the academic health learning network report a high degree of quality in their relationship.

**MEASURE:** 85% positive response by academic partners on survey items related to the quality of the partnership.

**AREA of FOCUS:** Build our capacity for interprofessional research and interprofessional education.

**GOAL:** Increase opportunities for interprofessional research and interprofessional education.

**MEASURE:** 50% increase in the percentage of new, Research Ethics Board-approved research initiatives that are interprofessional, and in the number of hours of interprofessional education offered annually.



## Sustainability

Making responsible and wise decisions about our resources now while investing in the future. Transforming the system to ensure it is there when and where needed.

**AREA of FOCUS:** Innovate systems and processes for greater efficiency and quality.

**GOAL:** Optimize resources to improve organizational (system) performance, quality and efficiency.

**MEASURE:** 60% of typical cases for identified Case Mix Groups have an Average Length of Stay (ALOS) equal to or less than the Expected Length of Stay (ELOS).

**AREA of FOCUS:** Develop funding models based on our priorities.

**GOAL:** All 14 areas of focus are transitioned to funding models based on leading practices.

**MEASURE:** 100% implementation of funding formulas based on our priorities, using leading practice where available.

**AREA of FOCUS:** Be better environmental stewards.

**GOAL:** Capital Health is independently recognized as a leader in adopting practices and processes that minimize the impact on the environment.

**MEASURE:** 15% reduction in total annual electrical energy consumption.

## **Appendix F: Summary of the 14 Areas of Focus with Respect to the 2013/14 Targets**

This section will be completed when 2013/14 targets are established and progress measures are available for the 14 Areas of Focus.

## Appendix G: Contributors

Many people contributed to the preparation of this report. In particular:

- Gail Blackmore, Performance Excellence Program
- Mary Bourque, Occupational Health
- Sara Brown, People Services
- Pam Currie, Occupational Health
- Susan Delaney, Diagnostic Imaging
- Lisa Dillman, Finance and Decision Support
- Ruth Harding, Performance Excellence Program
- Denise Hatchette, Finance and Decision Support
- Margaret Ivey, Heart Health & Critical Health
- Amanda Murphy, Finance and Decision Support
- Nancy MacDonald, Finance and Decision Support
- Tammy MacDonald, Infection Control
- Joel Maxwell, Performance Excellence Program
- Lynn Molloy, Department of Surgery
- Kim Ryan, Performance Excellence Program
- Stacey Squires, Perioperative Nursing
- Sarah Teal, People Services
- Jodie Trembley, Cancer Care Program
- David Urquhart, Department of Emergency Medicine

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