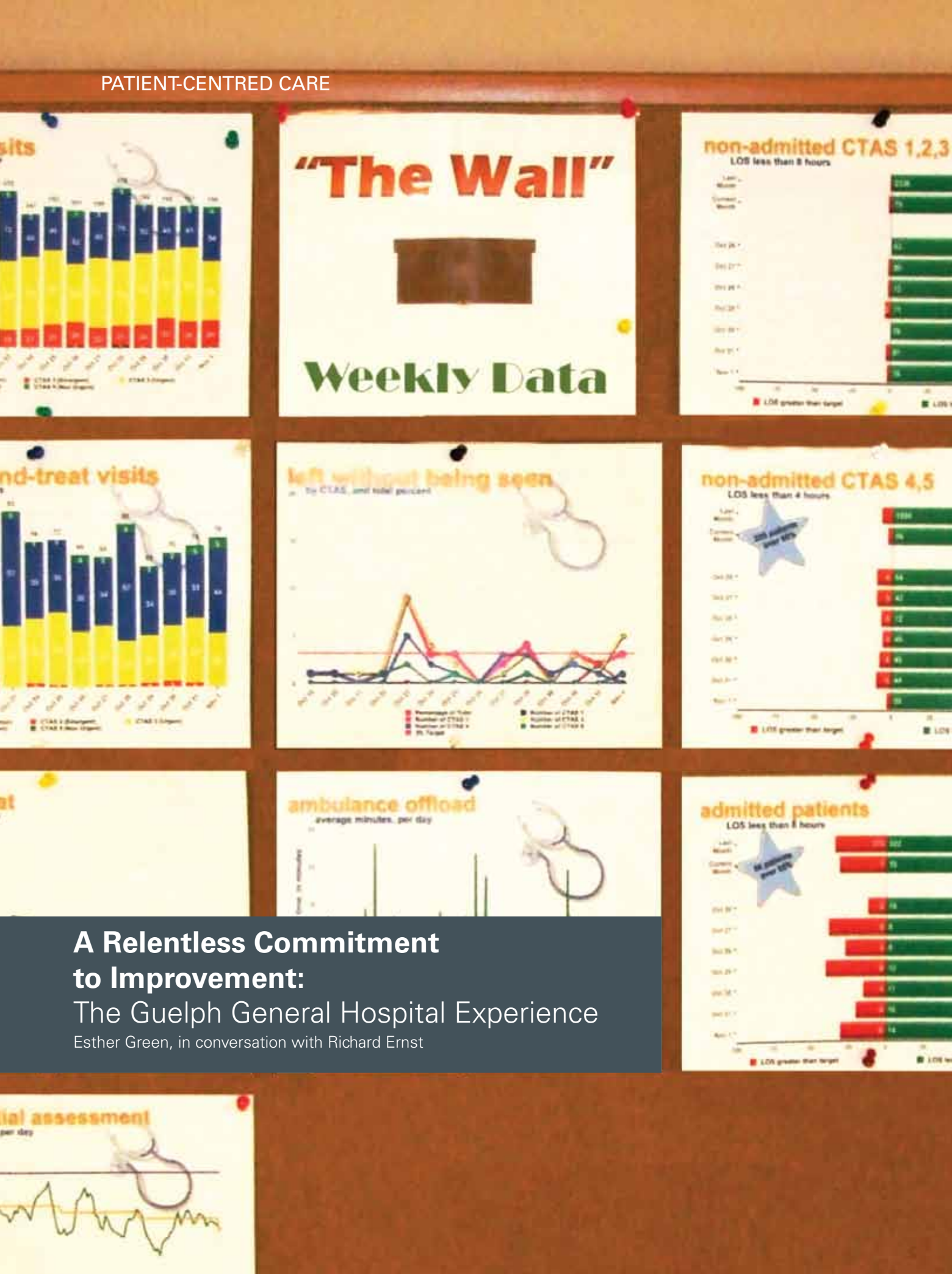

A Relentless Commitment to Improvement:

The Guelph General Hospital Experience

Esther Green, in conversation with Richard Ernst

Patient experience is now accepted as a key element of quality care. In one of two interviews that touch on the patient experience with Esther Green (EG), Richard Ernst (RE) – the CEO of Guelph General Hospital – talks about the full range of efforts that his organization has used to achieve and sustain excellent patient experience ratings. The interview underlies the importance of an organization-wide approach to improvement that touches on processes, human resources, and culture as well as a relentless commitment to improvement that is manifested through regular meetings that track progress.

EG: Guelph General Hospital has seen some positive results with respect to improving the patients' experience. Could you tell me, Richard, what you think are the key factors that have really contributed to the change?

RE: I'll start by mentioning that we've been tracking patient satisfaction indicators on a dashboard since 2007. Prior to that, we were certainly reporting the information that came out of the hospital report on a regular basis. A key factor was not just tracking the outcomes but also focusing on opportunities for improvement that are routinely identified through these reports.

The organization itself has made a commitment to improving our patient experience, and I think one of the best examples is what's transpired in our Emergency Department over the past couple of years. Emergency, as you know, is an entry point to the hospital. Ninety percent of medical patients admitted to our hospital come through our Emergency Department. That's 55,000 ED patients each year, and it's an area of significance to us relative to patient satisfaction.

Starting in about February 2009, Guelph General Hospital became involved in a program of process improvement launched by the Ministry of Health and Long-Term Care. The ministry invested resources in providing consultants to help hospitals in the Waterloo–Wellington LHIN try to move the bar on some of the metrics in the Emergency Departments. In our hospital, we introduced a concept of Lean methodology – value-stream mapping. Using front-line staff, we were able to start to make some changes. For example, when we looked at value-stream mapping, one of the key elements is, you don't do things that don't add value to either care providers or care receivers. If you're not doing things that add no value to patients, you are, by default, improving the patient experience.

Throughout that time, we had great physician leadership, and we had nurses from the Emergency Department shadowing nurses up in the Medical Unit and vice versa, so they could walk a mile in someone else's shoes. This led to an acknowledgement that patients who come to the hospital aren't Emergency Department patients and they're not Medical Unit patients – they are our patients. And it wasn't just those two nursing areas either; it was the diagnostic areas, environmental services, and bed allocation. Everybody who's involved in the process that affects patients recognizes we have to look after these people as they come into the organization.

Some outcomes from that realization were really quite remarkable. In the past, patients may have waited a bit longer in the Emergency Department before they got a bed up in the Medical Unit. But recognizing the concept of these being our patients led to the medical floors phoning the Emergency Department to ask, "Have you got any patients we could bring upstairs?"

EG: Wow, that's a difference.

RE: Absolutely. From the old days when the Medical Unit didn't tell Emergency that they had an empty room, it was as if they were pulling patients to the floors. We changed the way we handled some of our lower acuity patients by setting up a "see and treat" model in the Emergency Department. We had patients complaining that they didn't have time to drink their coffee before they were in and out the door.

EG: As opposed to before?

RE: Yes. Again, the most patient complaints related to emergency services are going to be from low acuity patients who tend to get bumped along the way and wait for long periods. We've been able to cut wait times for those patients by a couple of hours. I think the average wait time for Triage Level Four and Five patients is around 2.2 hours. Under provincial targets, 90% of them would be seen within four hours, and we're well under that.

EG: Amazing.

RE: Yes. We've had about 30 hospitals come to see what we're dong here, so obviously we've been successful in that regard, but it's not just about the Emergency Department.

Every Thursday morning, staff from medicine come down to the Emergency Department and chat. We go over our metrics every single week, and it's an opportunity for front-line staff to interact with the Chief Nursing Executive (CNE) or the Chief of Staff. I attend these meetings – not every week but often – and there's problem-solving right there, on the spot, about things they've learned or things they want to try. We've got structured groups working on these things all the time. Three years ago, we were on the verge of a collapse with regard to morale and the feeling of providing really good care in emergency. I think there's lots of literature to support the concept "happy nurses = happy patients." It's been a real change for us.

The other thing is that as an organization, we're focused on quality and patient safety. It was the first strategic goal approved by our board, and it's been in place for some time. The board also approved a quality framework that makes quality at Guelph General Hospital part of everyday life. And our cultural evolution.

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EG: Richard, you mention a quality framework. Is it a specific framework, or is it something that your organization developed?
RE: It's one that we developed. When I say "framework," it's the boxes of what we oversee or how we manage quality, and who's accountable for what. I'm happy to share that if you're interested. It's nothing fancy, but it does lay out roles and accountabilities for the Board, for the Board's Quality Committee, the Medical Advisory Committee, senior management, quality teams, quality council, and the engagement of staff on our quality teams at the front line. Staff see this engagement as part of their work.

When we get our patient satisfaction scores, we share them broadly throughout the organization.

EG: Yes, I would be interested in looking at it. The reason I asked is, everybody is always going to somebody to say, "Well, what is our framework; how can we use it, look at the best processes?" But what I hear you say is that you developed it because it has meaning for you; it's working for you. It has very clear accountabilities; it says who's involved. That's the most important thing, because you've not only made it at home; you make it work at home.
RE: Right. And I think, going back to the accreditation piece and the previous two surveys we had, there's always a good feeling when someone tells you you're doing a great job – that's probably the best part of those processes. But the actual recommendations don't contain anything significantly substantive, aside from maybe a couple of things that we asked the surveyors to put into the report.

EG: If I'm not mistaken, that's often the case.
RE: Yes. I think there might have been four or five recommendations in each of those last two reports.

EG: Richard, I want to confirm something about those weekly meetings, and, by the way, do you have a name for them?
RE: "The wall." We go to a wall in the Emergency Department, where we review all the metrics and have a discussion about our progress on them.

EG: But it's the people who are involved; it's the staff plus the senior leaders, so you're sharing metrics with the staff. Everybody knows exactly what's going on, where things are going well, and where something needs some improvement. Then you do the problem solving on the spot, right?
RE: In some cases. Sometimes, it will just be a discussion of here's where we are. Everybody smiles, gets back to work and that's fine. But at other times, you're looking at things like patients who have left without being seen, or how long it took us to admit patients to the inpatient units. These are daily statistics, so staff may see metrics a week at a time or a few weeks at a time. There are graphs. How long were those Triage Level Four and Five patients waiting to be seen yesterday? Are we meeting our targets? That's key. If we're meeting our targets – whether we set them or the Province set them – there's a positive feeling. You can go back to work and say, "Hey, we're doing a good job here." It's never perfect, but it's going to translate positively into your interactions with individuals, and some of those metrics involve patient satisfaction.

There are other ways that we get those patient satisfaction messages back to our departments, too. Our quality teams focus on this, so there are all kinds of things to move the bar with regard to quality. If the Emergency Department feedback says that wait times are a problem; or in the Family Birthing Unit, pain relief is a problem; or in Critical Care, coordination of care is a problem, we go back and look at those opportunities for improvement and try to make things better for our patients.

EG: I guess the piece that really resonates for me, and I'm putting on a different hat, is that often staff don't know what the results are; they're almost kept in the dark, or the results that they do know about are the negative ones.
RE: When we get our patient satisfaction scores, we share them broadly throughout the organization. E-mails go out hospital-wide; reports go to the Board. We make sure we report them in the open session of our Board meeting, hoping that our media will pick up on them and share them with our public. We share them with the MAC; we attribute the successes that relate specifically to physician questions on those patient satisfaction surveys. We don't just get them and sit on them; we want to let people know that they're doing a good job, but we also include the bullet points, the things we need to work on.

EG: That gets us to the next question. When you're looking at the results, I think you have a really good understanding of what helps you focus not only on the successes, but also on doing some collaborative – and that's my word, not yours – problem solving on trying to close the gap, to make it more meaningful. You've talked about the patient experience before, so patient satisfaction. Is that the NRC Picker tools or something else?
RE: No, it's NRC Picker.

EG: It's for both Inpatient and Acute?
RE: Right, and it shows results for medicine, surgery, obstetrics and the Emergency Department. When we get results that show we're the leading performer or a tie for leading performer in the Province, the CNE and I will often walk up to the Nursing Units

Geulph General Hospital Quality Comittee: (l-r) Eileen Bain, VP Patient Services and Chief Nursing Executive, Karen Suk-Patrick, Director Organizational Development, Anna Leah Desembrana, Director Maternal/Newborn, Merle Seegmiller, Director Ambulatory Care, Melissa Skinner, Director Quality and Professional Practice, Helen Martini, Quality and Patient Safety Specialist, Jacqueline Malonda, Quality and Patient Safety Specialist, Joyce Rolph, Senior Director, Richard Ernst, President and CEO, Sue MacNeil, Director Food Services and Environmental Support, and Maureen McCafferty, Senior Director and Chair of the Committee.

and say, "Hey guys, this is what you've done." I say often, because we never get there enough, although they've had consistently high results, especially in some of our surgical areas. But if we have a reason to go up and say thanks to the staff, recognizing there's only a fraction there at any one time, it does create an opportunity for recognition. Through our employee surveys and our Healthy Hospital surveys, our staff have indicated that recognition is important to them. It feeds back into patient satisfaction.

EG: That was the next part of the second question. Is there a linkage between those patient satisfaction results and the staff satisfaction survey? You mentioned that staff want recognition from the staff survey results. It seems that as you find out results you purposefully go up and really stimulate that conversation among the staff: "This is great, you're doing great work," and so forth.
RE: Yes.

EG: Is there another piece of the staff survey results that also links back? At the beginning of our conversation, you said that if staff aren't happy, patients won't be, either.
RE: Right. There's been research emerging over the past 10 to 15 years that correlates nurse staffing and nurse engagement with positive patient outcomes – my CNE can quote chapter and verse on this. I use the phrase "happy nurses = happy patients," but I know it's more scientific than that. One of the things that we've been involved with is the RNAO (Registered Nurses' Association of Ontario) best practices; we're now in the third year and we're a Best Practice Spotlight candidate. We expect to complete that and have the designation by April 2012. It provides a structured approach to engage front-line staff and focus organizational leverage on how we affect patient care and improve patient satisfaction, so that's just another of the things we do to raise the level of staff engagement.

EG: What about the other disciplines?
RE: It's funny, that does focus on nursing, but I think people here generally feel they're part of a team. We went through an exercise a number of years ago to develop a new mission, vision and values for the hospital; I've probably done it twice in the last 12 years. Our staff feed into this and the Board basically approves it. Teamwork is a value and accountability is a value; that speaks, I think, to how we want to work together, but also to how we each have distinct roles to play. I don't hear of other disciplines feeling left out, and I know that when we went through our Emergency Department process, everyone – the bed allocator, the housekeeper, the porter, the diagnostic folks from the laboratory and imaging – they all made contributions to changing what we did there to deal with patients. They really felt engaged as part of that team.

EG: You talked previously ago about clinical champions, and I've heard you talk about senior leadership in particular, so you and the CNE or you and the Chief of Staff really are engaged. You go to that point of care, you talk with the staff about what's happening and you commend them. But what about other clinical champions? Have other people in your organization taken up that drive to be a clinical champion and make a difference, along with your senior team?

RE: I think that the contributions from some of our physicians have been unique here. In particular, I think back to the physicians in our Emergency Department and in our Department of Hospital Medicine, even to those in the diagnostic areas, who are part of changes that need to be made to work collaboratively, to do things better for patients. They've bought in because it makes their environment better as well. I think when we had this meltdown a few years ago in our Emergency Department, its genesis was that our halth care providers didn't believe that people were getting the care they were entitled to. We had to change the way we were doing things. Throwing more money at the issue wasn't the solution; doing things better, safer and more effectively was. These physicians dedicated many hours of time to the process of lean methodology, value-stream mapping, being on committees, problem solving, trying things, fine-tuning them and correcting them, so I think the leadership here has been remarkable – from a patient experience viewpoint.

EG: Solution starts at the top, doesn't it, Richard? I think that the work you and your colleagues have done as senior leaders, and frankly as boards, probably has stimulated that. You set the bar and said, "This is where we're going; this is the direction we're going in," which is really great.

RE: Yes, we'll talk about the board in a minute. It's a unique situation, too.

EG: How have patients or family members been engaged in that transformation in your organization?

RE: Our mission statement is that we will provide quality patient-centred care, and, again, that's developed at the grassroots. We have lots of open dialogue with patients and families on the Nursing Units but no formal council. In 2006 we hired our first Patient Relations Coordinator, and this provided a role to deal with patient issues or concerns, and also to build relationships and engage our patients in our community. Last year we invited a survivor, the widower of a woman who died in this hospital, who had shared his story at a social event I attended. I said to him, "You need to come to our long-term service awards dinner and talk to our staff, share your experience." It was remarkable; there was probably not a dry eye in the house, but I think every single person who walked out of that room was proud of what we're doing here at this hospital.

I try to get out to the community every three months or so. I give a presentation at a seniors' group, service club, or what have you, and I try to convey the state of the nation. Here's what's going on at Guelph General Hospital; what are your questions? The questions are wide-ranging, sometimes related to things that go on in the hospital and sometimes not. We're trying to engage the community this way. I think in our community there's a sense of ownership and involvement with the hospital. Our size really helps. We're not a gigantic hospital; our budget is about $135 million. The hospital has been in the community a long time, and it's a close enough environment that people actually feel engaged. We have a fairly open-door policy here at the hospital, if people want to come in and talk to me or to anybody. We try to manage our complaints and concerns in a consistent way with our Patient Relations Coordinator, but if someone wants to talk to me, I'll talk to them. I won't solve their problems, but I'll listen and help to resolve their concerns.

We're just going through our master planning process now and talking about community engagement, and it's sometimes difficult to do. So once your program's set up, I'd be interested in hearing how you go through a process of selection. I find that the most challenging part is, who do you identify as people who can give you objective and meaningful input into how you can improve a patient experience.

EG: Sometimes there are attitude challenges about patient-centred care. Did you encounter that, and, if you did, what were some of the challenges or barriers, and how did you overcome them?

RE: Guelph has roughly 120,000 people. Lots of patients who come in are friends, family and neighbours; they know our staff. Quite a number of long-serving staff here may see repeat patients coming through; staff know too that if they're ill this is the place that they're likely going to come.

I think if you look back at Hospital Report results – and you have to go back a few years, you'll see patient satisfaction scores that are extremely high at a place like SickKids, not so high at other teaching hospitals, middle of the road for many community hospitals, but extremely high in the small rural hospitals.

EG: Exactly. Richard, you've mentioned the Dashboard and the role that the board play in all this. Can you say more about what they have done?

RE: Yes. I did mention our Dashboard, which has been in place for several years. It's on our website and shows issues related to patient safety, patient access and patient satisfaction. There are some financial and volume measurements too, but the point is that patient satisfaction is a metric that is tracked by the Board. We used to have a quality committee at the Board, but we dissolved it about six years ago; we felt that there was a better way for us to deal with quality. Rather than have a quality committee of maybe four or five Board members and some of

our senior staff and quality people, the board decided to deal with quality as an entire board, so the first order of business in either the open or closed session was the quality report. We would present Dashboards, and we would present quality activities at the hospital. In the closed session, we might talk about some of the reviews that were under way or some of the serious issues or critical incidents that needed addressing.

When the Excellent Care for All Act came along and said that a board must have a quality committee, our board said, "Well, we've been functioning like that," and it was unanimous that the quality committee of our board would be the entire board. We've carried on with that model, and I think it's stood us very well. We'll still touch on quality issues at regular board meetings, because the quality committee in its terms of reference meets a minimum of four times a year. We put the Dashboard in my report going to a regular board meeting, because we want to get it out there and on our website so that people can see it.

EG: Your board has representatives from your community?
RE: Yes, there are 15 people on the board, four ex-officio members and 11 elected members; I think eight live in the City of Guelph and two are from Wellington County, so some are in the surrounding community.

EG: Potentially, Richard, they or their family members have been in your hospital.
RE: Oh, absolutely.

EG: So you're engaging patients at a board level in some respects too?
RE: Yes, but I'm always conscious that they're insiders, so if I was thinking of the Patient Advisory Council, you might have someone from the board on that, but I don't believe the public would view them as being objective.

EG: No, I hear you. Another concept that some boards and organizations have introduced is to begin the board meeting with a patient story. Do you have opportunities to bring in people to share their story with the board?
RE: No, but I think the very thing you're mentioning, Esther, has been raised. I'm not sure whether it was at the last meeting, but I would say that it's under consideration.

EG: It sounds like your board is really striving for quality, and your point about when ECFA came out and said, "Thou shalt have …," you were already doing it, but were making it an entire Board responsibility.
RE: Correct. I think the only thing we had to really look at that was going to change things a bit for us was performance-based compensation; the rest had been in place for years. We've been doing the staff satisfaction surveys way back into the '90s. Every three or four years you roll out another one and go through your lists. We're practical; you make the changes your staff recommended.

EG: Richard, do you mind if I ask about the percent response rate to the patient satisfaction survey?
RE: I'd say in the 55% to 60% range.

EG: Excellent. That's amazing.
RE: Yes. But our staff satisfaction response rate dropped considerably last time. We're just about to launch our next one. Last time we had about 350 out of 1,200 employees respond – and that was down by almost 200. We're trying to determine whether it was harder for staff to find time to do the survey, or were things fine and they didn't want to complain or make suggestions for improvement. We don't know, but we send out a letter with the survey, telling everyone that their director will give them 15 to 20 minutes during their workday to complete it; they don't have to use their personal time. (Esther – we had 936 employees (80.6%) respond to our 2012 survey and our results continued to improve.)

EG: That's an incentive. We're not asking you to do it outside of work. This is important to us; we want to hear what your thoughts are.
RE: And you can do it online or on paper, whatever you're comfortable with; it's all confidential. We also follow up. Again, if we get information that's troubling, the CNE and I make the rounds talk to departments about concerns. We had a Ministry of Labour review here a couple of years ago. Some of the feedback was that there are circumstances in the hospital where staff feel unsafe or where they get abused or yelled at by patients. We went around and talked to every single department in the hospital. I went with every VP to say, "This is not acceptable. Just because this is the way things are, have been forever, doesn't mean we're not interested in making changes and making things better. We need to hear from you when there's a problem, and we need to address these problems." I think people are starting to actually believe that it's worth their while to come forward and express concerns.

That applies to the patient side of things as well. One of the reports that goes to our board is a summary of all the incidents that occurred in the hospital, whether harm is done or not. There are five different categories. When you see those numbers, it's like, "Gee, we've got a lot of problems here." And we think, "No, our reaction is, the more things that are being reported, the more open people are about identifying mistakes or opportunities for improvement." Our board always asks what's going on if they see a change in that trend line, whether up or down. They're observing and noticing these changes, and they want explanations. **Back to page 15.**