Integrated Quality Improvement & Risk Management Plan **2019-2020**

Quality Vision:

NBRHC subscribes to the Embracing Health Quality vision of Health Quality Ontario (Appendix 1) that promotes a culture of relentless improvement which enables our health care teams to provide care that is evidence based, safe, effective, patient centered, efficient, timely and equitable.

We have undergone a continuous quality transformation in the past five years that has resulted in an embedded quality coordinator team within each portfolio, managers and directors and physician versed in advanced quality principles and training, a widespread adoption of quality tools and strategies (a strategy communication "war" room, regular huddle boards in all hospital departments, advanced problem solving (sigma six and Lean), and vertically cascading scorecards that respect but also link department priorities to board ones. Physicians and front-line providers are active participants if not leaders in quality issues that matter to them. We actively engage all key stakeholders in problem solving, commonly tackle complex issues using more sophisticated quality tools (value stream mapping, Simplexity etc), that are led by physicians or managers, and remain open to novel or unique strategies to engage stakeholders (e.g. crowd sourcing, etc.).

At NBRHC, we believe that the quality system itself should be committed and open to self-improvement. We continually survey the landscape to ensure we comply with changes in legislation, accreditation standards and risk management obligations. We encourage opportunities to link and network with other hospital quality teams and incorporate insights from their experience when applicable. And we refine or realign our structure as needed to in order to better improve systems of care.

Quality Structure/Processes:

The Quality Committee of the Board provides oversight of the entire quality system (Appendix 2). The Chief of Staff/VP Quality leads the team at the senior administration level. We have an embedded quality team in the form of two dedicated quality coordinators assigned to each major portfolio (clinical, mental health and corporate) as well as a quality coordinator serving the physicians and the senior physician leadership team. These coordinators facilitate and support ongoing quality initiatives at all levels of the portfolio and report directly to the respective VP or Chief of Staff.

A quality council (consisting of all coordinators, a corporate risk manager and a clinical risk manager, all VPs, COS, and CEO) meets monthly to review and coordinate quality activities that necessarily involve all portfolios. One or more members of the council serves as lead resource(s) for key organizational-wide quality functions: quality system development, critical incident management, risk management, accreditation, hospital scorecards/metrics and patient involvement. These functions are reviewed at

quality council whose task is to ensure a uniform and consistent organizational approach across portfolios.

Within their own portfolios, quality coordinators meet regularly with their VPs and programs to review quality initiatives and serve as both experts and teachers of quality tools and more sophisticated approaches to problem solving. They also lead more formal education and certification of front line managers and staff in quality methodology (lean, Simplexity, etc). Each VP leads regular discussions of quality and operational priorities in the strategy room supported by the quality coordinators.

Critical incidents trending and reports are overseen by a quality of care committee which in turn reports to the MAC and the Quality Committee of the Board. The status of key quality functions and activities are reported to the Quality Committee of the Board.

Physician involvement and leadership in quality is facilitated by a dedicated coordinator who has regular meetings with all department heads and directors, facilitates their quality projects, manages and supports scorecards for the COS, physician department and medical affairs team, and reports regularly to the COS and MAC on physician led quality.

Quality Goals for 2019-2020:

As with our vision, our hospital priorities aligned well with the directions set forth by HQO in their mandatory and required QIP metrics. In addition, we continue to advance our CQI culture. Two new positions (Manager, Corporate Risk, Patient Experience and Accreditation and a manager, Clinical Quality and Risk) have been added to further develop and refine our quality system to achieve a greater integration of risk management and patient experience into all levels of the organization and promote a true just culture workplace. We are also preparing for a monumental HIS transformation to Meditech Expanse that will lead to a safer system of care delivery and a world of CQI informed by real time data.

HQO's mandatory metric on reducing workplace violence meets our own top priority of providing the safest workplace for our staff. Following internal consultations and ongoing meetings with union leadership locally and provincially has resulted in evidence based best practice initiatives led by a workplace safety council.

The adoption of an integrated risk management (IRM) framework will encourage staff at all levels of the organization, including the Board of Directors, to identify risks of not meeting our objectives: providing safe patient care; ensuring staff are safe; working with our partners and staying within our budget. Once risks are identified, we can then assess them to determine which ones are the most urgent to control.

Optimizing patient flow remains a vital need for all hospitals but especially in North Bay where an unexpected closure of a long term care facility has led to a dramatic rise

in Alternate Level of Care (ALC) that challenges our acute bed availability daily. A tremendous amount of work has gone into exploring our current ALC levels and identifying opportunities for improvement, including our quality-led Estimated Length of Stay (ELOS) initiative that enable all clinicians to be aware or refine ELOS at every step of the patient stay from admission to discharge on inpatient medical and surgical units. The organization is also embarking on a journey of discovery and innovative problem solving to address HQO's mandatory indicator on ED wait time for inpatient bed indicator.

We are committed to patient involvement in all quality initiatives. Patients/family members with recent, relevant experience are invited to actively participate in quality and process improvement projects and initiatives. Former or current patients or family members are called upon to represent the perspective of patients in hospital planning, key decision making and various quality improvement initiatives.

We have developed and implemented a standardized patient safety incident and critical incident review process that promotes a Just Culture workplace where incidents are viewed as opportunities for system improvement. The development of a decision tree for patient safety incidents, process map and standard checklist will assist leaders in determining the level of review required, the disclosure requirements and the need for formal quality reviews, leading to formal recommendations to improve the system and reduce the risk of event occurrence and reoccurrence leading to patient harm. The critical incident review process will increase knowledge, build capacity and foster strong inter collaboration at all levels of the organizational, across disciplines, care units and support service departments. We are also building better partnerships between the obligations of corporate risk with clinical risk/professional practice that also remains responsive to new legislation, risk management obligations and professional standards of practice, advances further IRM principles that places risk management at all levels of the organization, but does so while still promoting a CQI/Just Culture environment.

We continue to track and meet accreditation requirements and standards in anticipation of the accreditation review scheduled for 2020. And we continually review, refine, and improve patient safety initiatives (Appendix 3) ensuring they remain aligned with best practice and the needs and priorities of frontline physicians and staff.

Finally, the hospital is committed to the regional Hospital Information System project (ONE) which seeks to implement the Meditech Expanse platform on October 29, 2019. The undertaking will require the commitment of all staff and units to transform their practice into a paperless one. We are well underway meeting the change management challenge this entails. But at the end, new HIS will bring it true system improvement to the hospital (evidence based practice in the form of CPOE, technology enabled hospital processes that protect against error, and real time data that can be used to manage, track and optimize performance.

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Celebrating Success

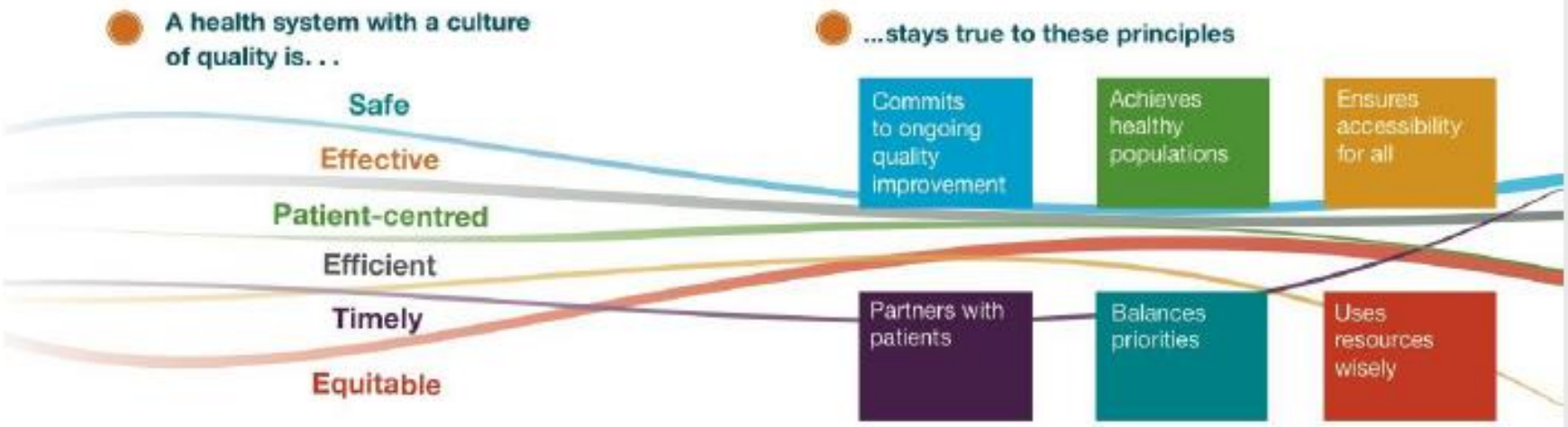
- We recognize those who live by our core values through "Our People Achieving their Best" peer spotlight recognition opportunities. ie. Mainstreet Blog, Report Out
- We recognize staff, physicians, patients, families and community partners for their involvement in initiatives to improve patient care and safety through the *celebration* section on our huddle boards, report outs, blog posts, presentations to the Board of Directors and our annual report.
- We provide our patients and families the opportunity to recognize excellence in safe care provision through the Golden Heart Award.

Evaluation and Adjust

The hospital is embracing the Ministry's new Ontario Health Team model and "ending hallway medicine" strategic direction. We will build on our strong relationships with primary care providers and community partners and are seeking to become one of the pilot community's chosen to take on this initiative.

Our integrated quality improvement and risk management plan is aligned to the hospital strategic plan, HQO and accreditation obligations, and the Board's commitment to the identification of key risks. The Board selects the five key metrics (representing the five dimensions of our strategic plan: access to the right care, partnerships with purpose, patient experience, People achieving their best, and wise choices). Each key board metric drives one or more quality projects and are reported on monthly to the board. Similarly, meeting obligations of HQO, accreditation, and HIROC are reported to senior team to the Quality Committee of the Board. Finally, the status and management of critical incidents are reported to the Quality of Care committee, the Medical Advisory Committee and the Board of Directors.

Embrace Health Quality



. . . and can only happen when we

Engage patients and the public	Redesign the system to support quality care	Help professionals and caregivers thrive	Ensure technology works for all	Support innovation and spread knowledge	Monitor performance with quality in mind	Build a quality-driven culture

A just, patient-centred health system committed to relentless improvement. Let's make it happen.

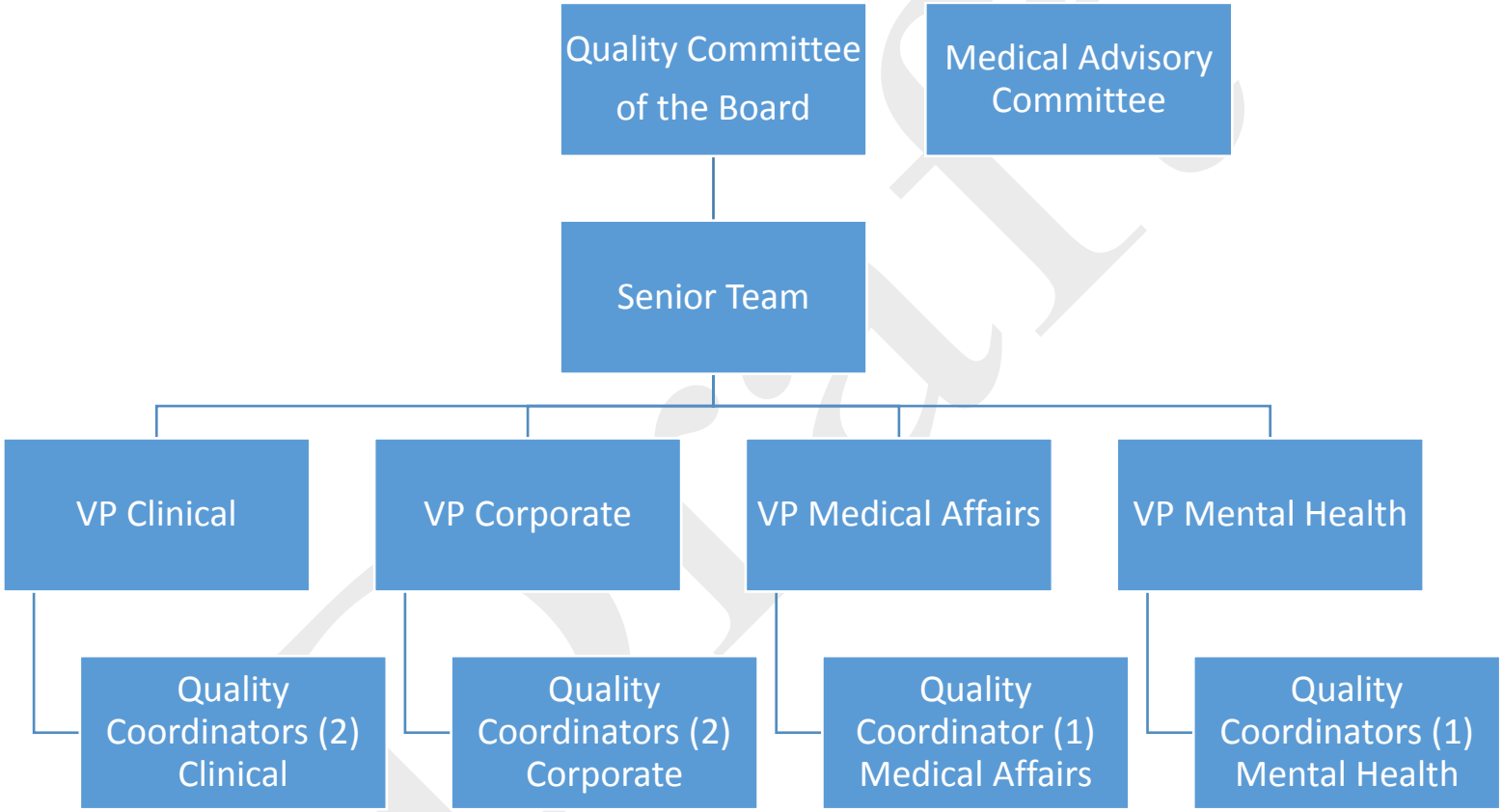
Read our vision for achieving a quality health system
Quality Matters: Realizing Excellent Care For All

www.hqontario.ca

Ontario
Health Quality Ontario

Appendix 2

NBRHC Quality Structure



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Appendix 3

Innovation, Compassion, Accountability, Respect, Excellence
NBRHC's Quality and Patient Safety Plan

The foundation of NBRHC's Quality and Safety Plan lies within our vision; working with you to be the best in health care. We are guided specifically by our strategic plan which puts the PATIENT FIRST.

At NBRHC, patient safety is not a "stand alone" program. Accountability is rooted in our values, practice, implementation of policy and our approach and management of patient safety incidents to ensure continuous quality improvement as well as for the purposes of mitigating risk. All staff, physicians, volunteers, patients and families have a part to play in doing the right thing to ensure the delivery of equitable, ethical and high quality care that always supports our patient-first environment.

We consider many quality indicators of patient safety:

- Safety Reports
- Patient falls
- Pressure injuries
- Transfusion reactions/blood/blood product administration
- Surgical site infections
- Antimicrobial Stewardship
- Use of restraints
- Visitor safety
- Staff safety
- Staff immunization program
- Healthcare-associated infection (HAI) rates
- Venous Thromboembolic Prophylaxis
- Medication Reconciliation
- Safe Surgical Checklist
- Workplace Violence Prevention
- MORE OB
- Hand hygiene compliance
- Readmission rates (mental health program)
- Staff/physician engagement
- Patient satisfaction survey results
- Safewards

We are guided by:

- Accreditation Bodies
- Advisory Bodies
- Evidence-based Practice
- Excellent Care For all Act
- Legislation
- Patients and Families
- Professional Colleges
- Institute for Safe Medication Practices (ISMP)
- Occupational Health & Safety Administration
- Health Quality Ontario
- Registered Nurses Association of Ontario, Best Practice Spotlight Association
- Our Ethics Framework
- Strategic Objectives and Values Statements

We use the following tools to monitor and support our progress:

- Integrated Quality Improvement and Risk Management Plan
- Balanced Scorecard
- Patient Safety Culture Action Plan
- Integrated Risk Management
- Safety Reports and Learning System
- Quality/Quality of Care Information Protection Act Reviews