Let's Make Healthy Change Happen.

Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

North Bay Regional Health Centre
Centre régional de santé de North Bay

3/28/2018

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a Quality Improvement Plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein.

Overview

Mission
Partnering in care, we restore and maintain health for mind and body.

Vision
Working with you to be the best in health care.

The North Bay Regional Health Centre (NBRHC) is a unique healthcare organization with three primary roles. It provides acute care services to North Bay and its surrounding communities, it is the district referral centre providing specialist services for smaller communities in the area, and it is the specialized mental health service provider serving all of northeastern Ontario. NBRHC employs 1465 number of FTEs.

In 2016, the NBRHC developed a new Strategic Plan for 2017-19. In 2017 the Board revisited the strategic plan as part of their commitment to ensure it stays current from year to year. From their review came a refinement of their objectives allowing them to focus on key priorities for 2018-19. This then allowed the Board to consider the Quality Improvement indicators for the next fiscal year ensuring that it lines up with the strategic objectives. For 2018-19, NBRHC's objectives will focus on finding solutions to our growing Alternate Level of Care problem, staff safety, patient involvement as well as patient transitions.

Over the next 15 months, we will be embarking on the Hospital Information System implementation with our region, which is a major project for our organization, occupying much of our resources. We anticipate that it will allow us to improve on many of the QIP metrics because a number of process improvements will occur in tandem, and so we want to keep our focus on this initiative. For these reasons, we are choosing to keep our QIP metrics simple, targeting our very top priorities. The 2018-2019 QIP indicators are as follows:

Quality Dimension	Indicator
Efficient	ALC Acute and Post-Acute ALC Mental Health
Effective	Percentage of patients discharged from hospital for which the discharge summaries are dictated within 48 hours of patient's discharge from hospital
Safety	Number of workplace violence incidents reported by hospital workers (baseline collection for this year) **Balancing Metric:** Number of workplace violence incidents which resulted in moderate to severe injury
Patient-Centred	Patients/Family involved in projects

Describe your organization's greatest QI achievements from the past year

We are very proud to have received the HQO Excellence in Quality Improvement Implementation Award for our Department of Surgery and PACU. One example of excellent quality improvement implementation in these services is the work done implementing the surgical site infection bundles. The success of this implementation was as a result of significant stakeholder engagement at all levels. Our physician champion devoted many hours communicating with her colleagues: physicians, nurses, and Directors to gain buy-in for this initiative and help troubleshooting every step of the way. Implementation took place over a number of months and audit results are demonstrating success. We are very encouraged that NSQIP results are starting to show a drop in our SSI rates.

Our Clinical and Mental Health portfolios continue to focus on quality in all that they do. In 2017-18 the Clinical portfolio has been working hard at improving its Estimated Date of Discharge processes (EDD). As part of this initiative the language will be shifted to Estimated Length of Stay (ELOS) allowing teams to have discussions focused on the length of stay for each patient. The Bullet Rounds process has been improved over the last year and continues to be adjusted as we work towards better identification of ELOS with the goal of communicating it to patients and families from the beginning of their stay with us. In Mental Health the teams have been working towards reducing the 30 day readmission rate in Mental Health. Quality initiatives have assisted with reducing readmission rates but this remains a challenge for our organization. Our teams continue to build on community partnerships in order to find solutions to the barriers that contribute to patients being readmitted within 30 days.

Resident, Patient, Client Engagement and relations

When developing our Quality Improvement Plan, NBRHC held a focus group with six patient and family representatives. At this session we presented and educated them on each indicator proposed by HQO and presented to them what we've done in the past to meet these indicators and provided rationale for those indicators we are choosing for this year. One of our focus group members attended the Quality Committee of the Board to provide their input on our QIP. She specifically stated that for the focus group one of their greatest ah ha moments was the background they received regarding those patients designated as ALC and the impact that this issue is having both on our community and our hospital. The focus group was very supportive of our hospital in continuing our work on finding solutions to this ever growing problem.

Other than holding focus groups, our organization takes very creative approaches to engage our patients and families in our process improvements. For some events we call designated patients asking for their input on the process we are improving. We have also visited patients in waiting rooms and patient rooms where appropriate to ask for their feedback on a process that is currently impacting them. In other instances we invite patients and families to our improvement events allowing them to take a more active role in the day as well as the follow-up implementation. We have also incorporated patient stories at all of our Board quality meetings as a reminder to those around the table of why we are here. Engaging our patients in all that we do is so important to our Board and Senior Team, that we have included this as a quality indicator for two consecutive years with the goal of building a culture where the patient's voice is always sought and considered. As such, we have a number of examples where patients have voiced an opinion and we have acted on it; from a waiting room set-up, wait time initiatives, to recreational activities for our mental health patients we listen to our patients.

Collaboration and Integration

Currently our greatest issue is the rapidly increasing amount of alternate level of care patients in our beds. This is partially due to the closure of one of our

community long-term care facilities but also due to a number of other barriers that exist in our system as a whole. We have gathered seniors residence leaders, long-term care leaders, LHIN Home Care (former CCAC), Nurse practitioner offices, public health, and the LHIN to work through this challenge as a community.

NBRHC is also part of the Regional Hospital Information Systems implementation, which represents a major undertaking for our hospital and our region. We have been involved from the beginning and our leading the way as one of the first wave hospitals. This work effort is a collaboration of many regional partners including the Northeast LHIN, e-health Ontario, and 24 partner hospitals in our region. The group meets quarterly with take-away items at every meeting. We are looking forward to having a system that allows for one person, one record, one system, in our region.

Engagement of Clinicians, Leadership & Staff

Input from clinicians, leadership and staff is considered every year as we develop our Quality Improvement Plan to ensure we are focusing on our greatest opportunities. Once selected, the QIP indicators are built into the organizational report card and cascading down to the portfolios and the programs via their huddle boards. These indicators are visible throughout the facility which promotes frontline staff engagement with these improvement initiatives.

Population Health and Equity Considerations

The Northeast Region is a very geographically dispersed catchment with a population who have very complex health needs. Twenty three percent of our population is Francophone and 11% are Aboriginal, First Nation or Metis. Our Seniors' population also continues to grow at a rapid rate.

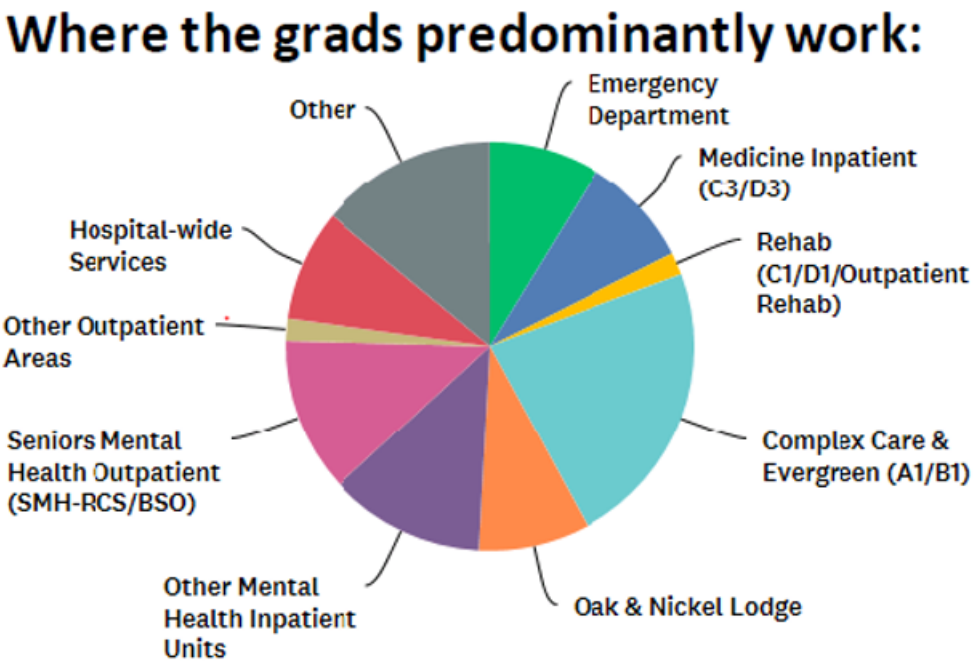
NBRHC has been partially designated as a French Language Service and we maintain a minimum of 25% of staff who speak French ensuring as much as possible that French speaking staff serving the public are on each shift. With respect to First Nations people, NBRHC continues to integrate culture into the care of those patients and families where appropriate. We have a Board member representing this population on our Board who ensures the voice of the First Nation people is represented in our decision making.

NBRHC also continues to work on its Seniors Friendly Hospital initiatives and we are very proud of our Senior Friendly Care (SFC) Advocate Training Program which has graduated approximately 65 staff from nursing to allied health (refer to pie chart below to see where our graduates predominantly work). The SFC Advocate Program is a tailor made NBRHC on-line educational program that aims to build staff's capacity in providing quality care to older adults. The program runs twice a year, with 3 months provided to complete the program requirements.

Core curriculum focuses on:

- The Senior Friendly Hospital Framework
- Senior Sensitivity
- Clinical Care (e.g. delirium, functional decline & other geriatric giants)

This voluntary program is not only about gaining knowledge and skill, but also about participants applying their learning within their work setting. It encourages staff to identify quality improvements opportunities to positively impact the experience and well-being of older adults at NBRHC.



Access to the Right Level of Care - Addressing ALC

NBRHC is collaborating with the LHIN and other external partners such as long-term care homes, seniors' residences and other community care providers to work on solutions to the ever-growing ALC problem. We continue to work on an ALC avoidance framework with our LHIN. We are currently implementing an Estimated Length of Stay initiative which will allow us to communicate to patients and families their anticipated length of stay from the point of arrival to hospital. Along with this initiative we will be investigating the use of a risk assessment tool to help us identify those at risk for ALC designation sooner with the goal of supporting them more quickly thus enabling them to remain in the community.

Opioid Prescribing for the Treatment of Pain and Opioid Use Disorder

NBRHC is committed to controlling opioid dependency in our district. Our Emergency Department does not prescribe pain medications for non-cancer patients and have signage explaining this to the patients. If they do prescribe opioids they do so in tapered doses to decrease dependency. New in 2017, we have also moved our Withdrawal Management Program from a social detox model to a medical detox model to better support patients with complex treatment issues. Patient satisfaction has improved since we have implemented this change.

Workplace Violence Prevention

In order to ensure that workplace violence prevention remains one of the organization's top priorities, the Board added this to their scorecard. In the summer, a planning session was held to recommend improvement initiatives that would assist with reducing the number of occurrences of violence. The group has also developed a comprehensive project plan which is designed to identify actionable solutions to create better systems for managing workplace violence and for identifying strategies for violence prevention. Included in the plan is a review of our incident management and reporting process. Our team has reviewed our incident results and have found that we do have a culture of reporting, however our database needs to be updated to allow us to pull data more accurately in order to get to the root causes. Once the update is in place, the team will analyze results and target those areas of concern.

Performance Based Compensation

In addition to the President and Chief Executive Officer, Paul Heinrich, direct reports to the CEO are included in the performance incentive plan as follows:

- Silveri, Tiziana, Vice President, Clinical & Chief Nursing Executive
- Nixon, Tanya, Vice President, Mental Health
- Tonks, Sara, Vice-President, Corporate & CFO
- Dr. Fung, Vice-President Quality, Chief of Staff

The performance of each executive is linked to one indicator of the plan. Payouts will occur following verification of the performance targets achieved in 2017-2018:

2018-19 Compensation

Performance Goal (annual patient/family instances)	Indicator weight	Max total incentive	Intermediate performance levels and related payout
30	100%	1%	30 = 1%
29			29 = 0.66%
28			28 = 0.33%

Contact Information

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Sign-off

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan

Board Chair _____ (signature)
Quality Committee Chair _____ (signature)
Chief Executive Officer _____ (signature)
Other leadership as appropriate _____ (signature)