

Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

June 29, 2023

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 1680 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 2019-20, NBRHC's objectives will remain the same with a focus on finding solutions to our growing Alternate Level of Care problem, staff safety, patient involvement as well as patient transitions and our implementation of expense, an upgrade to our electronic documentation system.

Over the next 9 months, we will be continuing our work to

implement a Hospital Information System 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. This is also an accreditation year. For these reasons, we are choosing to keep our QIP metrics very similar to those selected in 2018-2019.

Quality Dimension Indicator

Efficient ALC Acute, Post Acute and Mental Health

Rationale: It allows us to continue the conversation with our partners to support building capacity in the community in an effort to promote effective transitions back into the community.

Timely Time to inpatient bed (from Emergency) - MANDATORY

Rationale: It allows us to track and demonstrate the pressures on our beds and promotes all sectors working together to improve how patients move through the system.

Patient-Centred Patient Experience: Did you receive enough information when you left the hospital?

Rationale: During our consultations with the Board last year, they indicated that effective transitions to home are a priority for them. This indicator would allow us to gather information on how patients perceive and experience their care.

Safety Number of workplace violence incidents overall - MANDATORY

Balancing metric: Number of Staff Injuries resulting in medical aid, severe harm or death as a result of violence.

Rationale: We need to continue our efforts towards reducing the number of workplace violence incidents. Our balancing metric allows us to monitor the number of serious injuries related to violence.

Number of Risk re-assessments completed.

Rationale: Risk assessments must be completed annually. The first series of assessments has been completed but it is important to keep this front and centre for our managers. This indicator will allow us to continue to promote this work effort with our managers.

DESCRIBE YOUR ORGANIZATION'S GREATEST QI ACHIEVEMENT FROM THE PAST YEAR

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

Before July 2018, there was no standardized way that NBRHC delivered messages of Estimated Length of Stay (ELOS) to patients and families at time of admission through discharge. Every patient was given a three day length of stay, no matter what the diagnosis was. Additionally, team members were not always communicating the same discharge plan and there was no process to confidently discuss ELOS. Also, there was no formal or validated tool to identify patients at risk for going "home". The lack of process impacted communication of length of stay (LOS) resulting in inefficiencies to patient flow

High ALC rates, ED bed pressures (No bed admissions). There was a need to improve consistency of messaging to patient and family

throughout stay.

DATA

When looking at our own data, we compared 18 of our top medical and surgical admissions to NBRHC with the province and again with large community hospitals. We discovered that our Length of Stay (LOS) is below or the same as our comparators. So we proposed that we communicate our own actual lengths of stay from a 3 year historical and last fiscal year's lengths, to our patients when they are admitted for elective or unexpected admissions.

See uploaded image.

This was a large project with a large scope on our medical and surgical units, which began in Nov 2017. We conducted a Value Stream Mapping exercise. We then established 5 working groups involving many stakeholders to complete the work and implementation of a standard process to communicating ELOS to patients and families. The process improvement initiatives were supported by more 50 staff and over 15 patients. The implemented initiatives are as follows:

- 1) Searchable resource database built to allow ELOS identification on admission, based on historical data. Information populated on the order sheet which the physicians verify and correct based patient comorbidities.

2) The BRASS (Blaylock) tool was rolled in those areas and completed on all patients 65 and over to help identify risks to transition to home or other (nursing home). Based on the BRASS score, patients identified as intermediate or high risk receive a Passport to Home to begin the communication of ELOS. The Passport engages and empowers patients in planning their discharge at the beginning of admission.

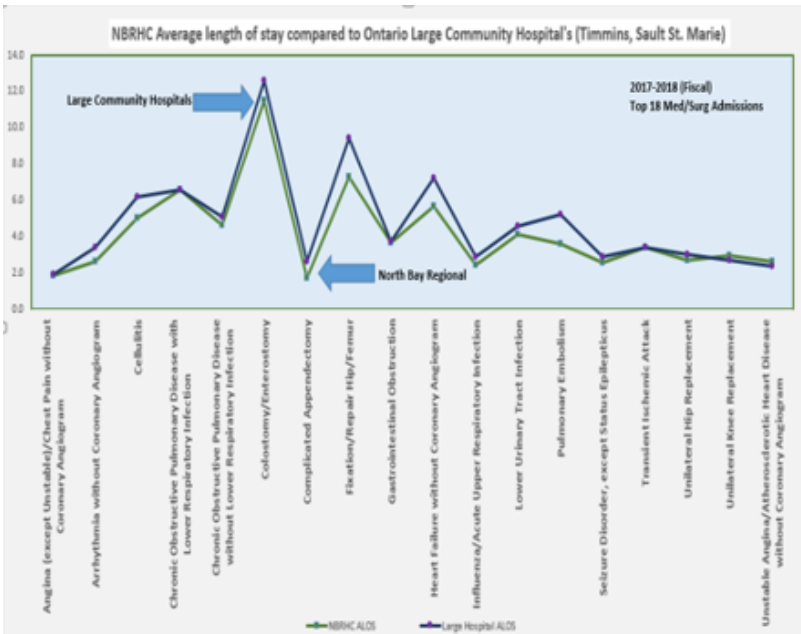
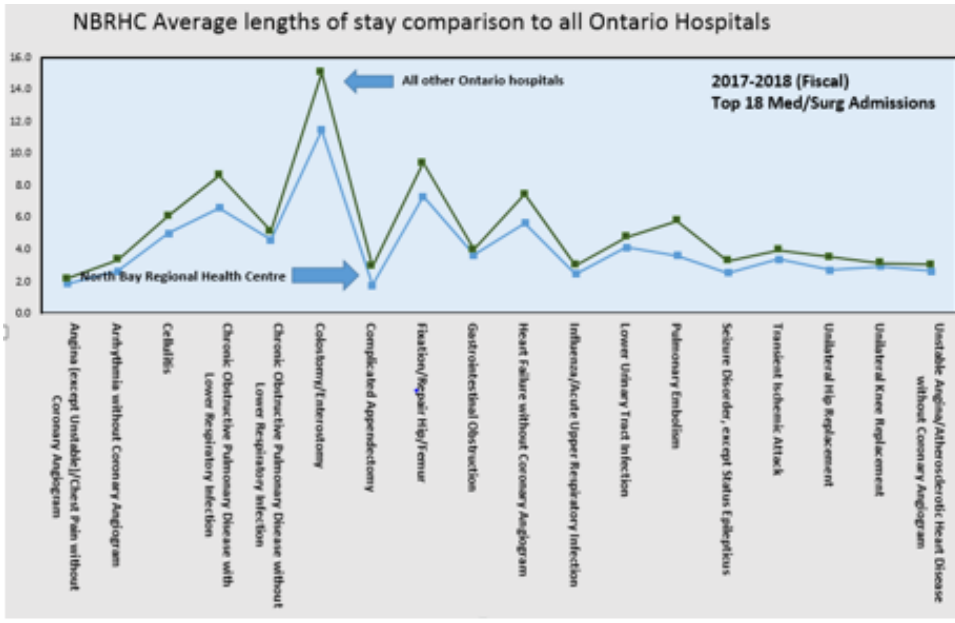
3) Passport developed based on feedback by inpatients, a family member, a recent patient, and the NELHIN Patient and Family Advisory Committee in order infuse the patient experience in the passport.

Refer to uploaded image

4) Length of Stay added to patient room whiteboard.

5) Daily bullet rounds are held to discuss barriers identified through verbal discussion and BRASS scoring index. The care team discusses each patient daily with a focus barriers to staying on track to their estimated length of stay. Any changes are made by the care team and communicated to patients and families verbally and on the whiteboards in their rooms by staff.

This initiative will remain on our Quality Improvement Plan for 2019/2020. As part of the improvements, an evaluation process will begin.



YOUR PASSPORT TO HOME
ESTIMATED LENGTH OF STAY (ELOS)
A GUIDE FOR PATIENTS AND CAREGIVERS

PATIENT NAME: _____

SEE THE WHITEBOARD IN YOUR ROOM FOR YOUR CURRENT ESTIMATED LENGTH OF STAY

DISPONIBLE EN FRANÇAIS

WHAT YOU NEED TO KNOW BEFORE YOU LEAVE THE HOSPITAL
Knowing your estimated length of stay helps you, and your care team, prepare and plan for your discharge.
At the North Bay Regional Health Centre you are not only at the center of care but also an important member of your care team!

Your Care Team will include Doctors and Nurses. It may also include:

- Patient Flow Navigator
- Pharmacist
- Clinical Nutrition
- NLRIS Home & Community Care
- Speech Language Pathologist
- Social Worker
- Other Community Supports
- Respiratory Therapist
- Recreational Therapist
- Chaplaincy
- Physiotherapist
- Occupational Therapist

Do you have concerns with your **unexpected** admission to hospital?
Concerns or questions about your discharge?

Talk to a member of your health care team!

PATIENT/CLIENT/RESIDENT PARTNERING AND RELATIONS

Patient Partnering and Relations

When developing our Quality Improvement Plan, NBRHC held a small focus group with two 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. Their input on the QIP was presented to the Quality Committee of the Board which also has a patient representative. The focus group was very supportive of our hospital staff and indicated that we were doing the best that we could with the resources available.

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. This was clearly demonstrated during our estimated length of stay initiative describe above in the greatest achievements section. 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 had included this as a quality indicator for two consecutive years to build a culture of patient engagement at all levels of the organization. We are very proud to say that from our kitchen and building services to our inpatient care areas, everyone considers the patient's voice in their improvements. For 2019/2020 our focus will be on continuing to gather patient feedback on their experience and satisfaction with care and using that information to make improvements.

WORKPLACE VIOLENCE PREVENTION

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. A comprehensive workplace violence workplan is at the implementation stage. It includes the annual completion of violence risk assessments throughout the organization. This initiative is a major focus for the organization and so we have added it to our 2019/2020 workplan. Also included is the creation of a Safety Council whose members include the CEO, managers and union representatives to discuss top safety concerns and to drive further improvements. As part this workplan the organization has invested in mandatory training for all of its managers on Health and Safety Competency Training for Leaders to provide leaders with the skills and knowledge related to their responsibilities under the Occupational Health and Safety Act (OHSA). It is anticipated that the training will lead to improved knowledge and compliance with OHSA expectations, which includes workplace violence.

EXECUTIVE COMPENSATION

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 2018-2019:

2019-20 Compensation

Performance Goal

(Percentage of workplace violence risk assessments completed)

Indicator weight Max total incentive Intermediate performance levels and related payout

100% 100% 1% 100% = 1%

95% 95% = 0.66%

90% 90% = 0.33%

CONTACT INFORMATION

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 on **June 10, 2019**

Gary Jodouin, Board Chair

Jennifer Valenti, Board Quality Committee Chair

Paul Heinrich, Chief Executive Officer

Other leadership as appropriate
