

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

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**2/23/2017**

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.

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# Overview

# The objective of Geraldton District Hospital’s (Hospital) Quality Improvement Plan (QIP) is to provide safe, effective, patient-centered care to our community that is easily accessible and is integrated with our community partners. This is achieved through the QIP and through the Hospital's quality improvement process, which has been in place for the past thirteen years and continues to evolve. The process starts at the grass roots level where all staff are encouraged to bring forward quality improvement initiatives to our Quality, Risk & Safety (QRS) Committee to be tested and monitored. The QRS committee meets every two (2) months and is comprised of leadership and front line staff from various departments. The Committee's goals align with that of the Hospital, as they are involved in developing new initiatives that improve the overall quality of care and monitoring indicators with respect to patient safety. The QRS committee reports to the Quality Improvement Committee (QIC). The QIC is comprised of senior leadership, board members and clinical care staff.

# The QIC is responsible for monitoring all indicators on a monthly basis to determine if our improvement measures for the indicators are obtaining the desired results and to develop solutions for identified challenges to assist our facility in meeting our set targets. The QIC submits minutes and score cards to the Board of Directors on a monthly basis. In the 2016/17 fiscal year, we worked to restructure our quality improvement program, and with the development of the QRS and its relationship with the QIC, it will be efficient and collaborative with our community partners. We are currently moving towards a Patient and Family Centered Care model and will be looking into how we may incorporate patients and their families into the structure of our new quality improvement program.

# This year, the Hospital is linking the QIP with the directives and goals of our Strategic Plan. The Strategic Plan looks to collaborate with regional and community partners to provide seamless continuity of care and availability of programs and services. Throughout our QIP planning, we included community partners in discussions on how we may coordinate our services to provide better care for our patients. In the 2017/2018 fiscal year, the Hospital will look to integrate with regional partners through Health Links. This will be an area of focus for the Hospital as we look to construct partnerships and increase the overall level of care within our region.

# The Hospital continues to elevate our quality improvement goals and has achieved Accreditation with Commendation in the Hospital’s June 2014 Accreditation survey. The Hospital was able to meet all Required Organizational Practices in relation to medication reconciliation at care transitions in our Emergency Department and Acute Care unit. In anticipation of our 2018 Accreditation Survey, our goal is to achieve a better transition of care for our patients following discharge, to decrease the possibility of them being readmitted for the same condition.

# In the 2017/2018 fiscal year, the Hospital will be working on improving patient and family involvement in care settings through the Patient and Family Centered Care model. This model redefines the relationship between health care providers, patients and families through a mutually beneficial partnership that promotes participation of the patient and family in their own health care. This model will be a focus for the Hospital in upcoming years, as is reflected in our change ideas for our Workplan, which heavily involves providing patients and families with the resources that are available to self-manage and be responsible for their health.

# This year’s QIP followed closely with what was outlined in the 2016/2017 QIP, as it is a community health based effort that involved many community partners. Our areas of focus continue to be COPD, Diabetes and medication reconciliation on discharge. Quality-Based Procedures were not included in this year’s QIP, as they are not applicable to the Hospital at this time. However, we do ensure that we stay current with any of the best practices that are developed in preparation for when they may be applicable to us.

# With the focus of the 2016/2017 QIP being centered on patient engagement and care, we are making progress at including patients and their families in planning and decision-making regarding the QIP. We held community engagement sessions in multiple locations around our region for patients and their families to attend so that they may provide their input on the indicators selected and how we are planning to improve them. With input from our patients and cooperation with our community partners, the Hospital looks to improve the overall quality of care that we provide in the region.

# QI Achievements from the Past Year

As much as the Hospital is always focused on making strides in improvement, there should always be time taken to celebrate success when it has occurred. Over the course of the last fiscal year, we have made positive changes within the Hospital and the community and are looking to continue to do so in the future.

The greatest improvement took place in the Long-Term Care Home where the volume and rate of falls decreased significantly. The number of falls went from over 90 in 2015/2016 to under 70 in 2016/2017, while the percent of residents who experienced a fall decreased from 18.7% in 2015/2016 to 15.6% in 2016/2017. This was made possible through the hard work of all staff, as well the implementation of the improvement initiatives in the 2016/2017 QIP. These initiatives included: adjusting staffing schedule to better reflect time where residents fell most, purchasing new equipment, educating staff on current/new falls prevention equipment, coordinating with the rehabilitation staff to develop a nursing restorative program and working with our community partners to bring activities, such as Tai Chi and music to the resident's home. With this success, falls will no longer be a priority indicator on the 2017/2018 QIP, but will continue to be monitored by the QRS committee.

Another success of the past year was the development of relationships and the collaboration with our community partners to address COPD and Diabetes within our region. Our indicators and change ideas in the 2016/2017 QIP made a focus on both of these issues and there were positive outcomes that showed the success of these efforts. In our 2017/2018 QIP, this will remain a focal point of our work, as we believe that further work and collaboration can be done to address these issues as a community.

The Hospital also focused on providing a safe environment to patients and staff in the 2016/2017 fiscal year, and with our improvement initiatives in place, has succeeded. Hand hygiene compliance throughout the hospital was excellent again this year and is well above provincial average, which is a great success for a Hospital with an Acute Care and Long-Term Care facility. This result, especially when compared to the rates among Ontario hospitals for the last year, shows how much work staff is putting in to maintain a safe working environment. Hand hygiene compliance also ties in with Hospital acquired infections. In the 2016/2017 fiscal year, the rate of hospital-acquired CDI was maintained and continues to be at zero (0).

It takes the effort of the entire Hospital to make positive change and with the commitment of leadership and staff to safety and quality improvement, the Hospital looks to continue to make changes that improve the quality of care given within our facility.

# Population Health

In general, the North West LHIN (NW LHIN) has a very diverse population than the rest of the province and faces many unique challenges pertaining to the health of the population. However, with the geographic area of the NW LHIN being so large and the communities being so rural/remote, different regions within the NW LHIN have even more unique health populations. In the Greenstone region, we have a much higher rate of Diabetes, obesity, COPD and smoking than the provincial average. These have been addressed as areas of concern for our region, and as such, they have become focal points in the creation of this year's and last year's QIP.

Our goal as an organization was to develop a QIP that focused on these issues and how different organizations in the region could work together to achieve better results. With the inclusion of the Greenstone Family Health Team (GFHT) and the NorWest Community Health Centres (NWCHC) - Longlac Site in our QIP planning, we feel that we are on our way to achieving a collaborative approach to addressing these population health concerns.

# Equity

Due to the large geographic and catchment area that we serve, as well as the unique demographics, the Hospital always strives to provide services that are accessible and culturally competent to the entire population. Greenstone is a municipality that spans hundreds of kilometers and includes six (6) small towns and four (4) First Nations reservations. Therefore, transportation and accessibility have always been a concern. We are looking to address this issue for complex patients through Health Links. We believe that a more connected and collaborative approach to complex patients' care will help make health care journey more accessible.

The Greenstone area also has a high population of Francophone and First Nations people. To reflect this, we have many French speaking staff and we have French translation services available, upon request. We make great efforts in respecting the patients preferred language throughout their visit to the Hospital. In addition to this, we have a spiritual room, with capabilities to perform smudging ceremonies, that is accessible to any patients that would like to make use of it during their hospital stay. As a general practice, all of our staff undergoes Cultural Awareness Training to ensure that they recognize and respect the different cultures of the people who may visit our Hospital.

# Integration & Continuity of Care

The planning process for our QIP was coordinated with participation and input from our community partners. With input from the Greenstone Family Health Team and the NorWest Community Health Centres – Longlac Site, the Hospital was able to determine our areas of focus. Discussions with these community partners provided invaluable insight into how we may work together to integrate our services to provide better continuity of care for our patients. In 2017/2018, the Hospital is looking to expand on the cooperation with our community partners to make changes and improve upon all of our chosen indicators. Through sharing of services and improving upon our referral process, the Hospital looks to improve the community's health through managing Diabetes and COPD.

Over the course of the last fiscal year, much effort was made in improving the discharge planning process for patients to community partners. This will continue to be a focus for the organization in the 2017/2018 QIP and improved upon in the coming year, as it is essential in communication of medication changes at care transitions. The Chief Nursing Officer at the Hospital is also the chair of the Healthier Community Advisory Committee and will continue to work towards making positive changes to the continuity of care for patients within the community.

One of the Hospital's largest area of improvement of the last two years, that sprung from cooperation with our community partners, was the decrease in Emergency Department visits for CTAS 4 & 5 patients. These patients are those who do not require immediate medical care and are better served by a visit to a nurse practitioner or a family physician’s office. Unfortunately, our community has not had a full complement of physicians for the past few years, making it very difficult to get an appointment with a family physician during their limited office hours. The Greenstone Family Health Team was able to alleviate the stress caused by the limited resources of physicians in the community by hosting a walk-in clinic on the day that was historically the busiest for the Emergency Department. The NorWest Community Health Centres – Longlac Site has continued their evening walk-in clinic as well, which will continue to help provide patients with the care they need in a timely manner.

Integration, not only among community partners, but also among regional partners, will be a focus for the upcoming year. The Hospital is looking to become more involved in the North West LHIN's Health Links and to become a leading partner in the region. We are currently working with our regional partners to develop Health Links in the region and as such, will be including a Health Links indicator in our Workplan. The Hospital is also involved with the Centre for Effective Practice, the North West Health Alliance and ten (10) other small rural hospitals in the region to construct a North West Quality Improvement Scorecard that will be used within the region to share and compare data on priority indicators that focus on the dimensions of safety, care transitions and timely access to specialized care. This will allow for better understanding and monitoring of the quality of care being improved upon in the region.

**Access to the Right Level of Care – Addressing ALC Issues**

Alternate Level of Care (ALC) occupancy of Acute Care beds continues to be a regional and organizational issue. The Hospital has, and will continue to make strides in improving the transition of ALC patients from Acute Care beds to their destination. In 2016, our Acute Care/Emergency Department Nurse Manager attended an ALC conference where ideas were brainstormed on how to address this issue. Unfortunately, few usable solutions were available to us since our small rural context is vastly different than that of the larger, more urban facilities. For example, with the absence of services, such as Meals-on-Wheels, 24-hour assisted living services, homemaking services or other privatized services, it is very difficult for our ALC patients to live safely in the community.

To address these concerns, our Acute Care unit works closely with the LTC home, the CCAC, as well the patients’ families. During meetings with the patient's family, strategies are put into place on how to fill service gaps in the community. Our LTC is attached to the Hospital and allows us to have vacancies in LTC quickly filled to promote better options for ALC patients within constraints of their list of options.

In 2016, our organization was chosen to be one of eighteen (18) Hospitals from around the world to participate in the Acute Care for the Elderly (ACE) collaborative, which aims to create an elderly friendly environment in the Hospital's Acute Care unit. With our aging population and growing ALC issues, this was identified as a major improvement initiative to be undertaken over the course of the year. To help with the ALC issues in our Hospital, we developed an Identification of Seniors At Risk (ISAR) Emergency Department screening tool. This tool is used on any patient sixty-five (65) years of age and over that present in the Emergency Department and allows them to receive the appropriate level of care based on the screening results. One of the interventions of the screening for high-risk results is for the patient to be referred to CCAC services to ensure that they are receiving any services that they may need in the community to reduce their risk of being admitted to the Hospital or becoming an ALC patient.

ALC continues to be an issue in our community and with the lack of available resources, we have been creative and collaborative in creating solutions.

# Engagement of Leadership, Clinicians and Staff

In the 2016/2017 fiscal year, the Hospital updated its quality improvement team model, which better utilized human resources and the time of our management and staff. Our new committee (the QRS) meets every two (2) months and integrates safety, quality and risk. The QRS still reports to the QIC, which then reports to the board, but replaced the six (6) teams that we had reporting on a monthly basis. This committee brings in members of specific departments to seek their input and in the future, will look to bring in community partners to include them in planning and discussion. These changes will save much time and effort over the course of the year by focusing the Hospital’s resources on more encompassing meetings.

The Hospital continues to include staff members and leadership in the planning processes for determining the change ideas that would be implemented to improve on our chosen indicators. The feedback provided was crucial in determining what solutions would be implemented and what steps would need to be taken in order to address issues within the Hospital and the community. With their knowledge of the inner working of the Hospital, many individual steps were addressed and ideas put forward to improve upon specific aspects of our service. In 2017/2018, staff, clinicians and management will be heavily involved in the implementation of the strategies focusing on Diabetes, COPD and medication reconciliation on discharge.

Throughout the 2017/2018 fiscal year, staff will continue to be provided with education and training on a host of subjects. The focus of this education will centre on the change ideas implemented in this year’s QIP. Through providing staff with education and training involved with COPD and Diabetes, the Hospital will increase the quality of care given to its patients. This education will involve the necessary care of patients with Diabetes and COPD, as well as training with medication used to treat patients with Diabetes and COPD.

# Patient/Resident/Client Engagement

Since the Hospital is located in a small, northern, rural community, we have always been engaging patients and their families to improve quality and care in our facility. Many of our internal committees involve former patients as active members, and not only do our patients and their families sit on our Accessibility Committee, Ethics Committee and Anishnabe Liaison Committee, but they also volunteer at the Hospital to assist in providing quality care to our patients and residents.

Last fiscal year, the QIC decided that input from a community member would enhance the quality improvement program at the Hospital and as such, added a voice to help represent the patients. This was a great asset to the QIC and this practice will continue in the 2017/2018 fiscal year. The Hospital is also looking into incorporating a Patient and Family Centred Care model, which will look to include patient advisors at our Hospital in upcoming years.

Another way the Hospital has always, and will continue to engage patients/residents, is through patient and resident feedback surveys and comment cards. The feedback provided through these tools allows the Hospital to narrow its focus on certain areas of concern. This process provides us with additional information that is necessary to complete the QIP in a manner that reflects the patients' concerns. In the 2016/2017 fiscal year, the Hospital updated its survey system in an attempt to obtain better quality of data. The Hospital’s new survey system involves feedback “blitzes”, which focuses on obtaining feedback from only one department over the course of a month. This improved the number of responses and the quality of data received.

To reflect our continued commitment to improving our patient engagement process, the Hospital is including an indicator that will track the satisfaction of the new services being implemented in the coming fiscal year. By tracking the satisfaction of patients who made use of our COPD and Diabetes related services, the Hospital will make changes to better reflect the needs of our patients. The data obtained will be two-fold, as it will determine the satisfaction of patients, as well as to determine if the change ideas implemented are having the desired effect.

Following feedback from quality improvement related resources, the Hospital has included a link on our website to the compliment and complaint forms. Rather than having to fill out a form in-person at the Hospital, patients, residents and family members may now fill out the form at home and submit it via mail or e-mail to the Hospital. This process will provide our community with a more accessible option for voicing their opinions on matters related to the Hospital, from which the Hospital may make positive changes. This is also essential for our Hospital, as we are small, rural and serve a very large geographic area. Patients, residents and families may fill out a form at home, rather than making a lengthy trip to the Hospital.

**Staff Safety & Workplace Violence**

The Hospital is committed to providing a safe working environment for all staff members. As such, the organization provides a wide range of training and education that allows staff to be prepared for any potential workplace violence events. This training includes training from the Crisis Prevention Institute (CPI Training) of non-violent crisis intervention for the whole Hospital staff. For the nursing staff, the Hospital provides education on Zero Tolerance, Gentle Persuasive Approach (GPA) and P.I.E.C.E.S (Physical, Intellectual, Emotional, Capabilities, Environment, Social & Cultural).

In addition to the education/training provided, the Hospital’s management is also involved in ensuring that their staff work in a safe environment. Managers are involved in annual risk assessments for their departments, where staff communicate to their managers any area where they feel that safety could be improved. The Hospital also has a Workplace Violence & Harassment Prevention Program that oversees the prevention of violence and harassment in the organization.

# Performance-Based Compensation – Accountability Management

The purpose of Performance-Based Compensation is to drive accountability for the delivery of quality improvement. By linking compensation to the achievement of quality dimension core indicator targets, the Hospital is able to: drive performance, improve quality, establish clear performance expectations and create clarity about expected outcomes. The Hospital is also able to ensure consistency and transparency in the application of performance incentives and drive accountability with respect to the delivery of the QIP.

Performance-based compensation applies to the following positions:

1. Chief Executive Officer (CEO) – Board decided and approved

2. Chief of Staff (COS) – Board decided and approved

3. Chief Nursing Officer (CNO) – CEO decided and approved\*

4. Chief of Clinical Services (CCS) – CEO decided and approved\*

\*(Numbers 3 and 4 are decided upon collaboratively by CEO, CNO, CCS)

Executive Positions – Percent Compensation

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Year  April 1st | CEO | COS | CNO \* | CCS \* |
| 2016/17 | 10% - as per current contract | 1% | 1% | 1% |
| 2017/18 | 2% - Board decision | 1% - Board decision | Internal decision | Internal decision |
| 2018/19  (Recommendation) | 2% - Board decision | 1% - Board decision | Internal decision | Internal decision |

\*Both the CNO and CCS, despite being executive staff, do not reach the current salary expectations of six figures; hence, we will continue to set performance indicators to maintain the highest quality levels. However, once they do reach six figures they will be subject to salary performance based implications.

Manner in Which Compensation is Linked to Performance

The legislation and regulations do not include specific requirements regarding the percentage of salary that should be subject to performance-based compensation, the number of targets that should be tied to executive compensation, weighting of these targets, or what the targets should be. A clear link between QIP indicators and performance-based compensation fulfills the requirements of the ECFAA (Excellent Care for All Act). Performance-based compensation should be something that is led by the individual organization to drive performance and improvement on organization‐designated priorities.

Executive Compensation – Selected Indicators

|  |  |  |  |
| --- | --- | --- | --- |
| Executive Position | Quality Dimension | Indicator | Target |
| CEO | Effectiveness | Total Margin | >0.0 |
| Effectiveness | Current Ratio | >2.0 |
| COS | Access | Reduce Wait Times in ED | <7.8 Hours |
| Patient Safety | Medication Reconciliation on Discharge | >85% |
| CNO | Patient Safety | Reduce Hospital Acquired *C. difficile* | <1.0 |
| CCS | Access/Patient Centred | Ultrasound Appointments/Bookings | <8 days |

The percentage of salary and indicators may be amended from year to year at the discretion of the Board of Directors. Should one or more of the targets not be met because of extenuating circumstances beyond the control of the Executive, then the Board of Directors may amend the percentage of the salary at risk for the respective Executive.

## 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 : James McPherson

Quality Committee Chair: Ralph Humphreys

Chief Executive Officer : Lucy Bonanno