Let's Make Healthy Change Happen.

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

HDH

3/29/2019

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

Hanover and District Hospital (HDH) continues to work with its partners to provide a full range of primary acute care hospital services and selected secondary services to meet the needs of the population of Hanover and the surrounding rural townships. Our Mission is to collaborate with our partners to ensure that the residents of our region receive the highest quality accessible care possible. Our Vision is to be an "Innovative Health Care Network" living our Values: Integrity, Compassion and Collaboration. The HDH Board of Governors, staff, and physicians have maintained an unyielding focus on five pillars of strategic direction: Sustainability and Growth, People and Teams, Partnerships and Communication, Needs Based Service and Quality and Safety.

The Board of Governors, staff, physicians and community partners work together to accomplish seamless care that provides core rural health services close to home and formalizes clear pathways for referrals to additional services. Thus, the overall objective is to strive for integration and continuity of care across the healthcare sector. HDH partners with peer acute hospitals; community agencies, such as Home and Community Care SWLHIN (formerly CCAC); long term care homes; Mental Health and Addictions and social service providers to provide, or refer and connect residents of the region to ensure they receive optimal care.

We provide local residents access to the care they need through the 24/7/365 Emergency Department, Acute Care Unit (inclusive of medical surgical beds, multipurpose ICU and restorative care beds), Physiotherapy Program, Cardiac Rehabilitation Program, Surgical Services Department, Family Centered Birthing Unit, Hemodialysis Unit and Palliative Care Services. Access is provided within the organization to Community Mental Health and Addiction Services, Home and Community Support Services, Home and Community Care SWLHIN (CCAC), Victorian Order of Nurses (VON), the Hanover Family Health Team and the Hanover Medical Clinic. HDH's ambulatory clinics include: pediatrics, dermatology, urology, orthopedic, endocrinology/diabetes, surgical ophthalmology, obstetrics, PICC placement, and renal dialysis.

HDH has and will continue to maximize opportunities for service integration and coordination between acute, primary care and community care providing selected acute care, surgical and other health care services within our health care "hub". "Accredited with Exemplary Status" two consecutive surveys, reflects that our Board and staff strive to surpass the fundamental requirements of the accreditation program. Accreditation has aligned and assisted the staff of our health care organization to improve our performance, focusing on quality improvement and safety initiatives for the benefit of the patients and the services we provide.

As we planned for and developed the 2019/2020 Quality Improvement Plan (QIP) we considered the three themed dimensions of quality issues: Transition, Service Excellence and Safe & Effective care with the six indicators as provincial priorities including: Efficient, Timely, Patient Centred, Safe, Effective and Equitable.

The QIP continues with the direction of the Board of Governors, staff and physicians for the coming year in the quality dimensions through the 2019/20 initiatives. This includes an improved communication strategy and plan between staff, physicians and Board Governors, with a patient centered care model inclusive of the Patient and Family Advisory Committee, and increasing collaborative partnerships/ integration projects to complement services both regionally and locally within the HDH Healthcare Hub. This year, the 2019/20 measurable outcomes will be achieved through Hospital peer reviews; integration; partnerships; clinical outcome review; process audits; variance analysis; patient, staff and physician satisfaction surveys; staff education and training; and other appropriate quality improvement techniques. In doing so, the QIP will specifically focus on measurable indicators, changes and ideas under of the chosen quality dimensions:

Theme I: Timely and Efficient Transitions
Dimension :Efficient
Indicator name: Alternative level of care (ALC) rate
This indicator measures the total number of alternative level of care (ALC) days contributed by ALC patients within the specific reporting month/quarter using near-real time acute and post-acute ALC information and monthly bed census data. This indicator parallels the Hospital Service Accountability Agreement performance measure that is 11-12.7%.

Dimension: Timely ~ New Mandatory Hospital Indicator
Indicator name: Emergency Department wait time for inpatient bed
This indicator is measured in hours using the 90th percentile, which represents the maximum length of time that 90% of patients admitted from the ED wait for an inpatient bed or an operating room as a balancing measure to Care in Unconventional spaces indicator (not a stretch target for HDH). The wait-time goal from the Emergency Department to an inpatient bed will be 1.25-1.5 hours.

Dimension : Timely
Indicator name: Discharge summaries sent from hospital to community care provider within 2 business days of discharge
This indicator measures the percent discharge summaries sent from hospital to community care provider within 2 business days of discharge. The target goal will be 100% of summaries transcribed, signed and sent within 2 business days of patient's discharge from hospital for the time period.

Theme II: Service Excellence
Dimension: Patient-Centred
Indicator name: Patient Experience: Did you receive enough information when you left the hospital? This indicator will measure the percentage of respondents who responded positively to the question, "Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?" Counting number of respondents who registered any response to this question, but not inclusive of non-respondents. The goal percentage of positive respondents 95-100%.

Theme III: Safe and Effective Care
Dimension: Safe~ Mandatory Hospital Indicator
Indicator name: Workplace Violence: Number of workplace violence incidents (overall).
This indicator measures the number of reported workplace violence incidents by hospital workers (as defined by OHSA) within a 12-month period including physicians and those who are contracted by other employers (e.g., food services, security, etc.) as defined by the Occupational Health and Safety Act. 2018/19. A baseline for data was initiated in 2018.

Equitable: Throughout all chosen indicators we will be engaging community members/patients through surveys and Patient and Family Advisory Committee (PFAC), for purposes of improving quality; integration and coordination, to ensure the delivery of appropriate, high quality co-ordinated care. Lastly, Quality and Funding, as a small facility we continue to monitor the Quality Based Procedures (QBPs) following their processes and aligning our services to meet the best practices established. The QIP is aligned with our strategic plan, operational plan, service accountability agreements and hospital goals and objectives as well as the provincial priorities and LHIN initiatives through being innovative, collaborative and accountable.

The suggested indicators that HDH chose not to include as priority indicators in the QIP as they are either not within our realm of control, not applicable to our organization or are not stretch targets include;

- •Transition, Efficient: Number of inpatients receiving care in unconventional spaces. This is not a stretch target for HDH, we do not place patients in hallways. Patients have access to nurse call-bells, washrooms and suction/oxygen.
- •Service Excellence, Patient-centred: Percentage of complaints acknowledged to the individual who made a complaint within five business days. This is not a stretch target for HDH. Complaints are acknowledged with within 48 hours.
- •Readmission within 30 days for mental health and addiction. This indicator is not applicable as HDH does not have Mental Health beds. However treating mental health and addictions issues is a growing problem for small hospital emergency departments throughout the province.
- •Medication Reconciliation at discharge. This is not a stretch target for HDH. Past performance 99-100%
- •Documentation assessment of needs for palliative care patients. This indicator is not applicable as data collection is not yet mature enough to validate accurate picture of results. Need to educate physicians and health records staff regarding metrics and coding.

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

Last year's QIP was instrumental in achieving stretch targets to enhance care provisions for the patients and educating the staff with regard to using data to drive improvement when identifying gaps in care with the exception of ALC inpatient days.

Our organization's greatest QI achievement from the past year would be seeing the link and transition of the indicators creating the bigger picture of patient care. Post discharge phone calls and surveys would under Patient experience ask "Did you receive enough information when you left the hospital?"
With information gleaned they learned of missed appointments, misunderstanding of follow-up treatments and thus created future plans to ensure continuum in care. Discharge summaries too completed within 48 hours of discharge sent from hospital to community care provider created strong partnerships in the community with "current" information in the continuum and coordination of care.

With the increasing number of Mental Health and Addictions patients attending the emergency department Workplace Violence had been a growing and critical concern. This past year tracking the number of workplace violence incidents (overall) within a 12-month period including physicians and those who are contracted by other employers (e.g., food services, security, etc.) establish a baseline for data. Staff was able to understand the need for ongoing violence in the workplace education and training. The Board of Governors too were better able to understand the need for added costs of hiring a security firm to assist with managing the increasing number of mental health and addiction cases at the hospital, particularly in the emergency room, including assistance with patients and staff safety issues.

The community, patients, and family members have been involved in sharing their experiences, opinions, and ideas about the health care services we provide and how we can improve the services to them through meetings, presentations, surveys and satisfaction data. We actively seek out the perceptions, understanding and advice of our stakeholders through public engagement sessions, as well as through our Network/healthcare partners for the hospital services. Through engagement sessions and patient feedback we continue to learn and improve how we deliver care over the years. With their feedback, we identify gaps and issues that are important to them and work collaboratively to address issues and develop programs and services within our catchment area. The feedback we receive helps us identify and work on issues to improve the health of our communities as well as shape and develop the content of our QIP.

Patient/client/resident partnering and relations

HDH is always cognisant of striving for the vision of a patient centered model: a system centered on the needs of the demographics, the people's needs and preferences. Knowledgeable and involved patients, informed and investing in their own health care will reflect in the overall improvement of the broader health care system. Patients bring their unique and important perspective about the care and services provided. They know firsthand about the experience they receive at HDH and in other organizations, and on the coordination and cooperation among healthcare partners involved in their care. At HDH we strive to involve patients, their families and other caregivers, and the public in meaningfully engaged care or as partners in its improvement.

Recognizing the importance to focus on the patient, a learning health care facility like HDH is one in which patients and their families are key drivers of the design and operation of the learning process. The Patient and Family Advisory Committee (PFAC) and the Medical Advisory Committee (MAC) are utilized 100% for important feedback. These committees involve physicians, patients, clients, residents, families, other caregivers, and the public, who are full, active participants in care and engaged with the organizational decisions, the overall health experience of care, and the improvement of economic outcomes.

This is important as the ripple effect of discharge planning is placing an increasing burden of care on the family caregiver. Discharge planning is significant for the growing numbers of the older population, or the mental health and addictions population where inadequate practices can be linked to adverse outcomes. There is an increased risk for readmission. The role of discharge planning and transitions in care are important and play a role in bridging the gap between the care provided in hospital and the care needed in the community. The need for a coordinated approach with physicians, patients, clients, residents, families, other caregivers, other services and the public includes clear communication, distribution of information, and active support linking to community

Executive Compensation

The Board agrees the following executives will be linked to the organization's achievement of the targets set out in the annual QIPs:

- President CEO (Administrator)
- Chief of Staff
- Senior Management reporting directly to the President CEO

Each year, QIP targets are reviewed with the Board Governors indicating the degree to which the targets have been met. As indicated in the Hospital Board Policy and QIP, 5% of the President/CEO annual base salary (step increase) is considered to be 'at risk' and is linked to achieving 100% of the targets set out in the QIP. Achievement of all targets would result in 100% payout; partial achievement of targets will result in partial payout, as determined by the Board of Governors.

Summary: Performance based compensation accounts for 5% of each executive's annual compensation.

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 Lorna Eadie Hocking _____ (signature)

Board Quality Committee Co-Chair Tina Shier _____ (signature)

Board Quality Committee Co-Chair Corwin Leifso _____ (signature)

Chief Executive Officer Dana Howes _____ (signature)

services. It is our goal that ensuring positive and strong partnerships and relations with the informed, involved patient and family members will entail positive outcomes, allowing nurses and others involved with the care process to better reconcile the family caregivers' needs and expectations.

Workplace Violence Prevention

Patient and staff safety are of paramount concern. Workplace violence prevention is a strategic priority for our organization with the growing number of mental health patients being police escorted to the emergency department and an increase in overall Acute incidents. Concerns about frequency and severity of workplace violence incidents with Code White alerts are a growing concern of the leadership team, staff, physicians and governors. Leaders realize the importance of identifying tangible steps toward changing attitudes, teaching defensive skills, and providing support for prevention and escalation of violence and harm. As an organization we are focused in making our health care environment safer and being more responsive to occurrences of violence. To assist the staff a security firm was hired with the same training as the staff at the Hanover Hospital. The staff welcomed the needed additional security to manage the increasing number of mental health and addiction cases at the hospital, particularly in the emergency room, including assistance with patient and staff safety issues.

The Code White policy is regularly reviewed to ensure optimal patient and staff safety. Proper restraints for code white patients have been purchased, and key staff and security have all been trained. A quasi designated "mental health safe" room within the emergency department was established that has minimal equipment in it for code white patients. Staff receives regular code white training from two in house Crisis Prevention Intervention (CPI) Train the Trainers. With two trained educators, we are able to provide increased training for staff and physicians. Education on how to handle and diffuse a potentially aggressive situation and apply restraints, are very important for the safety of everyone and has been incorporated into our CPI in house training program.

All staff are encouraged to practice personal safety measures when entering or leaving the building after hours; park in the designated staff on call parking spots across from the emergency department doctor's entrance (close to the building) and to use a buddy system when leaving the building after hours. Staff working alone or few in number are provided personal safety alarms. The security firm hired also assists staff with building security, code white scenarios and guarding violent patients. The security team was provided all the training that our hospital staff receives, which includes CPI in-house training.

HDH has a monthly workplace inspection program where all hospital departments are inspected for violence and safety concerns. We annually administer a workplace violence survey to gain feedback and insight from our staff and volunteers. A mandatory annual education fair is held to ensure that all staff, physician and volunteers receive necessary safety education (some of the many elements covered during this fair include; violence and respect in the workplace, organization policies and procedures pertaining to code of conduct, personal alarm use, code white training and response).

As an organization we have implemented enhanced communication strategies pertaining to violent or potentially violent patients which include; 'Blue Stop Sign' posted on the patient doorways for aggressive or potentially aggressive patients, 'System Alerts' that identify patients that have a history of aggressive behaviour, "Dealing with Difficult Patients and Families" reference list that clearly outlines that resources for staff to utilize and a "Zero Tolerance" policy and posters, which are displayed throughout the organization. We continue to work closely with Public Services Health and Safety Association (PSHSA) to review our program and utilize existing toolkits and resources made available to the Acute Care sector.

The Joint Health and Safety Committee (JHSC) in conjunction with the Code White team ensure that annual mock training is provided in order to ensure that staff is well educated and trained to respond to emergency situations.

2019/20 Quality Improvement Plan
"Improvement Targets and Initiatives"

HDH

Hanover And District Hospital 90-7th Avenue

AIM		Measure									Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) C = custom (add any other indicators you are working on)															
Theme I: Timely and Efficient Transitions	**Efficient**	Total number of alternate level of care (ALC) days contributed by ALC patients within the specific reporting month/quarter using near-real time acute and post-acute ALC information and monthly bed census data	P	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July - September 2018	676*	11.47	11.00	Monitor the ALC rate		1)(1) We are changing the process to reflect Provincial approach, therefore expect our results to increase while noting patient volumes should remain consistent. (2) Continue to work with Home and Community Care SW LHIN (formerly CCAC) daily to discharge plans (3) Continue to promote Home First with families, nursing staff and physicians (4) Discuss Home First Stats and ALC rates at Utilization and Medical Advisory Committee meetings (5) Call Home First discharge patients frequently: 48 hours, 7, 14, 21 and 28 days to ensure that services are in place and meeting their needs (6) Set discharge date and plan at admission (7) Early diversion in ED of "Failure to Cope" patients – involved with Home and Community Care SW LHIN from point of assessment in ED (8) Meet with long term care (LTC) and lodges to discuss ALC issues and care coordination	(1) Track ALC, Home First Readmission and LOS rates (2) Monitor rates of patients admitted with "Failure to Cope" as a diagnosis (3) Continue to monitor lab early morning turnaround times (4) Continually inform the SWLHIN when unable to send patients home with support	• ALC Rate • Home First Rate • LOS Rates • Readmit Rates	We are targeting for a percentage corridor of 11-12.7%	The small number of inpatient days for the hospital makes this a variable metric. Further, the ALC metric is a system wide issue; HDH plays a role but cannot control this metric solely. This is also a H-SAA target. Demographics of area reflect a higher population of frail elderly in this Grey Bruce region thus increase number of unstable elderly with a shortage of LTC beds. Huge PSW shortage in community. Difficult to get patients home. Lack of Nursing Home Beds also creates more in hospital days
	Timely	Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital.	P	% / Discharged patients	Hospital collected data / Most recent 3 month period	676*	90	100.00	Increase discharge summaries sent from hospital to community care provider within 2 business days of discharge		1)(1) Physicians need to complete discharge summaries as soon as patient is discharged (2) Monitor and track completion time and time sent to community partners (3) Medical Advisory Committee to review metric (4) Provide staff and physicians feedback when this metric does not meet performance target	(1) Monthly review of performance rolled up and individual tracking	Monthly Reviews	We are targeting to increase the discharge summaries sent from hospital to community care provider within two business days of discharge 100%	Work to migrate toward Dragon dictation. There is no Health Records transcriptionist after 4 pm Friday until Monday at 8 AM
		The time interval between the Disposition Date/Time (as determined by the main service provider) and the Date/Time Patient Left Emergency Department (ED) for admission to an inpatient bed or operating room.	**M A N D A T O R Y**	**Hours / All patients**	**CIHI NACRS / October 2018 – December 2018**	**676***	**2.17**	**1.50**	**Reduce ED wait time for inpatient bed**		**1)(1) Medical Advisory Committee to review metric (2) Provide staff and physicians feedback when this metric does not meet performance target (3) Daily reports to Senior Team when a patient falls outside the expected corridor (4) Review routinely at Acute Care and ED huddles**	**(1) Monthly review of performance rolled up**	**• Daily review of patients that have not met this target**	**We are targeting to reduce the ED wait time for inpatient bed target 1.25 -1.5 hours**	

Theme II: Service Excellence	**Patient-centred**	This indicator measures the percentage of respondents who responded "Yes" to the following question: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?	C	% / ED patients	Local data collection / Q3 (October 2018-December 2018)	676*	98	95.00	Increase the information provided to patients on what to do if they are worried about their condition or treatment after they leave the hospital.		1)• Continue to hand out prepared packages on commonly admitted conditions including COPD, DM, HTN, Angina, Arrhythmia, asthma etc. • Continue to provide Lexicom information regarding medication and medical conditions to patients • Work with the Hanover Family Health Team (HFHT) to ensure that patients receive information about community based patient education programs • Modify patient information with the guidance of the Patient and Family Advisors	• Hand out prepared packages to patients • Orientate nurses to Lexicom annually • Discuss patient education at rounds • Work with HFHT to ensure that patients rostered with them receive information about community based education programs • Review documentation of education charting in CareNet system • Provide every patient, upon admission, with the Welcome Information leaflet on Acute Care	• # of information packages handed out quarterly • # of referrals that HFHT receives from HDH • Audit the education section of the CareNet on patient e-chart	We are targeting to increase the information provided to patient on what to do if they are worried about their condition or treatment after they leave the hospital to 95-100%	Survey responses available are: • Yes • Somewhat • No
Theme III: Safe and Effective Care	**Effective**	Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged.	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / October - December 2018	676*	99.66				1)				This is not a stretch target for HDH. Past performance 99-100%.
	Safe	**Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.**	**MANDATORY**	**Count / Worker**	**Local data collection / January - December 2018**	**676***	**CB**	**CB**	**Collecting Baseline**		**1)(1) Identify causes, challenges, gaps and develop education/safety networks for staff**	**(1) Use the RL6 in-house hospital incident and patient safety reporting systems for determining the number of workplace violence incidents (2) Provide education to staff defining the terminology with respect to violence and harassment (3) Mandatory CPI training for Acute Care and Emergency (4) Staff to complete annual survey regarding violence in the workplace (5) Leadership Development Institute (LDI) to review Violence in the workplace legislation and policies at HDH**	**• Collect data on the number of violent incidents reported by workers, including physicians and those who are contracted by other employers (e.g. food services, security, etc.) as defined by the Occupational Health and Safety Act • Monitor the number of staff with CPI training against those who still need training • Review survey results**	**We are targeting the tracking/collection of numbers to monitor the number of workplace violence incidents. We will target the percentage of trained staff and ongoing education of mandatory departments i.e. ER, Switchboard/registration housekeeping maintenance, Acute care. And others as interested.**	**FTE is 117.5**