Let's Make Healthy Change Happen.

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

MUSKOKA ALGONQUIN HEALTHCARE

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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 have 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

Muskoka Algonquin Healthcare (MAHC) proudly serves Muskoka and East Parry Sound by providing safe, quality, patient- and family-centred care at its two sites located in Bracebridge and Huntsville. MAHC is a rural teaching hospital and is affiliated with several academic institutions, including the Northern Ontario School of Medicine (NOSM) and more than two dozen colleges and universities.

Mission: Working together to provide outstanding integrated health care to our communities, delivering best patient outcomes with exemplary standards and compassion.

Vision: As a trusted partner, we strive to improve the delivery of health care to our communities and to be known as an outstanding place to work, learn, live and be cared for.

Values: Our primary aim is to ensure the individuals we serve are provided with exceptional care and the best experience possible. Our values of accountability, respect, optimism, leadership, and engagement underpin our commitment to this aim.

Quality and safety is MAHC's promise to our people and patients. Taking care of people (staff, physicians and volunteers) results in patients and their families receiving the care they expect and deserve. MAHC is committed to using best practices ensuring optimal patient outcomes. To assist us in fulfilling this commitment, MAHC has adopted the Health Quality Ontario's (HQO) definition of a high-quality health system.

Our 2020-2021 Quality Improvement Plan (QIP) reflects the fifth year that MAHC, North Simcoe Muskoka Home and Community Care, Muskoka Health Links, the Cottage Country Family Health Team, the Algonquin Family Health Team, and Community Mental Health Association have worked collaboratively to improve the quality of care for the people of Muskoka and have a history of some shared QIP initiatives. As a collaborative, we are working to improve safe, integrated, effective, patient-centred access to care throughout the entire continuum of health care.

Ontario Health Team: The Muskoka and Area Ontario Health Team (MAOHT), of which MAHC is a key partner, is one of the first 24 teams to implement a new model of organizing and delivering health care that better connects patients and providers in their communities to improve patient outcomes. Working together as partners, the MAOHT will build a quality-focused, equity-driven and outcomes-based system of care provision and services. For year one, the MAOHT will focus on adults over 65 who are experiencing transitions in the health care system and are receiving care from two or more providers. The MAOHT will begin implementing some of their proposed programs and services in 2020. As part of the delivery of those services, how performance will be measured will be determined. As such, MAHC expects to take an important role in the development of these quality/safety performance indicators. Our 2020-2021 QIP is designed to leverage the forward momentum of our overarching quality and safety culture by ensuring we are proactive in anticipating and responding to patient and staff needs, and by improving care transitions from our hospital to the community in collaboration with the MAOHT. Our ongoing quality improvement journey continues to be informed by our patients and their families, our staff, physicians, Board of Directors and health care partners. Our collaborative work in developing our QIP helps to ensure our patients receive the right care, in the right place, at the right time. This year's QIP includes a number of quality initiatives. As well, each of our departments and clinical areas has also identified at least one quality initiative and performance indicator in addition to the QIP performance indicators, which forms part of MAHC's Balanced Scorecard.

Each selected quality improvement priority and its associated improvement indicator is supported by several underlying initiatives to improve quality of care for the Muskoka community. By working together with our community partners, we continue to strive toward enhancing care through the following focused strategies:

(i) Time to Inpatient Bed:

Timely access to an inpatient bed from the Emergency Department for admission to an inpatient bed or the operating room is crucial to the effectiveness and outcome of patient care. Many factors will influence this indicator's result, such as the availability of inpatient beds, the percentage of Alternate Level of Care (ALC) patients, the overall patient population and hospital resources.

(ii) Workplace Violence:

MAHC is committed to ensuring a safe workplace for our people and patients. Last year's QIP focused on ensuring we were capturing all workplace violence incidents. As MAHC is confident our organization's reporting culture is well developed, our QIP target this fiscal will be to reduce the number of workplace violence incidents. The Workplace Violence Working Group will use the collected data of workplace violence incidents (as defined by the Occupational Health and Safety Act) to identify improvement initiatives and will develop and implement these initiatives to reduce workplace violent incidents.

(iii) Patient Ultilization and Patient Flow

Availability of acute care beds to accommodate new admissions is imperative. With the support of our partners, we are committed to ensuring patients who no longer require the services of our hospital are discharged in a timely manner. MAHC will continue to foster strong partnerships with Home and Community Care (HCC), long-term care facilities, retirement homes, and other community partners. MAHC will work with our partners to transition patients from the hospital to the most appropriate care setting to reduce time waiting in the hospital when their acute care phase of hospital care is complete. This indicator will monitor acute care occupancy levels.

(iv) Transition from Hospital to Home- Patient Experience: Did you receive enough information when you left hospital?

Our patients have advised us (via patient satisfaction survey results) that there is a need to improve their support on discharge and provide them with the information they require. Transitioning home after being a patient in a hospital can be challenging. It can be a time of stress for the patient, their family, and health care providers too. Poor transitions also increase the risk of complications and can put a strain on the system (readmissions, visits to the ED etc.).

(v) Continuing the Journey Toward Patient-Centred Care and Patient- and Family-Centred Care Culture

The Patient- and Family-Centred Care Committee has determined that its next initiative is to introduce and enhance the patient's voice at MAHC by introducing 'Patient Partners'. Toward this goal, strategies will be developed and implemented to train and deploy 'Patient Partners'.

(vi) Healthcare-Acquired Pressure Injury

Bedsores, also known as pressure injury, cause problems for many patients with limited mobility. They increase the risk of death and hospitalization and decrease the quality of life. The unrelieved pressure causes bedsores when bones under the skin meet support surfaces (like mattresses) and blood flow in that area is reduced. We will track and review hospital-acquired pressure injury metrics and implement formal strategies to help ensure consistent adherence to the pressure injury assessment and management protocols.

Associated with all of the QIP objectives above are targeted change ideas that will drive and achieve improvements within the quality dimensions of safe, effective, patient centred, efficient, timely and equitable.

MAHC's culture supports and encourages high quality integrated care in every patient/family/provider interaction. We believe that together we can build healthy communities that are aligned with regional and provincial priorities.

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

Quality & Patient Safety: In 2019/20 MAHC developed a comprehensive Quality, Risk and Safety program.

Transitions from Hospital to Home: Our patients advised us (via the patient satisfaction survey results) there was a need to improve supporting them on discharge and providing them with the information they require. Transitioning home after being a patient in a hospital can be challenging. It can be a time of stress for the patient, their family, and health care providers. In response, MAHC brought together a collaborative of representatives from the Home and Community Care, the Cottage Country Family Health Team, the Algonquin Family Health Team, Muskoka Health Links on an improvement opportunity of implementing a Patient-Oriented Discharge Summary (PODS). PODS is recognized as an effective tool to support transitions from hospital to home. Our team continues this work in 2020/21.

Other: By working together with our partners, we met with success by:

- Reviewing and revising our Code Orange response
- Conducting a mock Code Orange at the SMMH Site
- Continuing to enhance the support of our complex patients through hospital-community based initiatives such as Health Links and Telehomecare (connecting patients with care through technology).
- Educating staff and physicians on strategies that support the care transitions of the elderly with complex behaviours.
- Integrating Behavioural Success Agents to assist with developing care plans for patients with dementia-related behaviours.
- Maintaining the successful integration of Home and Community Care employees onsite at MAHC in the role of Care Coordinators who assist in a timely and seamless discharge planning for patients requiring additional support in the community.
- Identifying immunization status (pneumovax, influenza) for all admitted patients who met eligibility requirements for immunization in collaboration with the Family Health Teams. This ensured that patients who may require immunization were identified and appropriately immunized.
- Maintaining hand hygiene compliance rates.
- Focusing on workplace violence at MAHC. In addition to improved reporting and tracking, MAHC has implemented numerous process and policy changes, enhanced security, and constructed safe rooms in the Emergency Departments. An overarching framework for violence prevention and mitigation continues to be developed. Much of the work has been accomplished through the ongoing collaboration with interdisciplinary staff, physicians, community partners, patients and families.
- In December 2018, MAHC was proud to receive a four-year Accreditation with Exemplary Status from Accreditation Canada.

Patient/client/resident partnering and relations

MAHC has been very purposeful in elevating the patient voice in 2019-2020. MAHC launched its Patient and Family Advisory Committee (PFAC) in January 2017, and continuing work has enabled the transcendence of the patient voice with MAHC initiatives. MAHC recruited 10 patient and family advisors who represent all regions of Muskoka. The Advisory Committee reviews the QIP for input and support. Since this time, patient and family representatives have participated in the secure room proejct, the Endovascular Access workgroup, Capital Plan

Development Task Force and have become regular members on the Ethics, Family Practice, Obstetrics and Emergency Department committees. It is anticipated that patient partners will be recruited, educated and available to the remaining clinical care teams by December 2020.

The PFAC has identified several areas for improvement and would like increased involvement with patient satisfaction initiatives in the coming year, implementing the patient partners program at MAHC. This is all part of the continuing journey towards person-centred care.

Workplace Violence Prevention

MAHC has policies and procedures with respect to reducing the risk of violence, reporting of workplace violence, and for summoning immediate assistance. In order to test our policies, we conduct mock Code Whites (aggressive/violent person code). To support our staff when there are incidents of violence in the workplace, formal debriefs are conducted as needed. From a training perspective, we currently provide a training program to de-escalate confrontational and violent situations. Our training program moved from Non-Violent Crisis Intervention (NVCI) to the MANDT training program, which is mandatory for all MAHC staff to complete.

To support the policies and procedures, training and support within MAHC, there is infrastructure in place to help keep people safe. This includes:

- The ability to summon support and assistance with the use of panic buttons in the Emergency Department and switchboard (i.e. dispatch to the OPP).
- Practices to ensure safety when working with potentially aggressive patients.
- Enhanced security coverage, particularly during high-volume seasons.
- Ongoing education.
- Formal debriefs to ensure practice changes occur as identified by trend analysis.
- Review and analyzing incident-reporting data.
- Construction of secure rooms within the Emergency Departments for potentially aggressive patients, equipped with cameras for monitoring patients.
- Patient flow processes to assist in getting patients to the right bed in the most efficient manner.
- Development of Behavioural Support Agents to create care plans for inpatients exhibiting aggressive behavior related to dementia.
- Development of Patient Order Sets for aggressive mental health and addictions patients.

Overall, the security officer presence at MAHC has been increased to include additional hours of coverage across the organization at our two sites to support peak times of aggression and violent behavior that may sometimes occur.

To support the care of our patients and ensure the safety of our staff, a Mental Health Working Group was established and recommendations for change continue to be implemented. The working group became an implementation committee that worked toward the implementation of the recommendations, which have included:

- Purchase of pineal restraints and safety pajamas
- Implementing order sets for mental health patients in the Emergency Department
- Creating a locked, secure Emergency Department
- Developing a Code Silver policy and procedure with plans for a mock event with our OPP partners
- Focus on shortening time to see a physician in the Emergency Department for mental health patients
- Collaboration with the Canadian Mental Health Association (CMHA) to provide onsite support.

- Working closely with neighbouring Schedule 1 facilities to ensure standardized approaches to care to support transitions
- Construction of two monitored secure rooms in May 2019 at each of our sites
- Working with our partners to improve timely transfers of patients to a Schedule 1 facility

The Joint Health and Safety Committee struck a Workplace Violence Working Group. This group has continued to develop additional strategies for workplace safety. A workplace violence framework was developed to support MAHC through the continued implementation of programs to reduce the risk of violence in the workplace. The overall safety and security of our people at MAHC is of great importance and is on a path of consistent quality improvement as we learn from both violent incidents and near misses.

Engagement of staff, physicians and leadership in the development of the MAHC QIP has been broad. Board members, the Leadership Team, front-line clinicians and staff, and physician representatives have collaborated in the development of our QIP. MAHC staff in all departments are involved in quality improvement initiative methodologies such as continuous quality improvement, Plan-Do-Study Act (PDSA), LEAN, etc. that continuously enhance the quality of care to our patients. As well, all taff are strongly encouraged to identify and participate in implementing quality improvement strategies throughout the year.

Leadership and front-line staff participate in regular huddles to identify current safety issues and to discuss urgent and/or emerging issues. Our Senior Leadership Team and clinical leaders round on both patients and staff creating a visible presence to patients and staff, providing an opportunity to compliment and recognize staff on excellent work and address concerns.

Executive Compensation

The Ontario government passed the Excellent Care For All Act (ECFAA) and Bill 16 in 2010, which required Hospital Boards to establish an “at risk” component of executive compensation and achieve targets, tied to the QIP. At MAHC, each senior leader develops goals that create synergy with the Strategic Plan and the QIP and that align with responsibilities within their portfolio and in accordance with our Executive Compensation Policy. Executive compensation is linked to performance in three performance assessment categories: Quality, Financial and Strategic. Performance assessment categories are rated on the following scale:

- Quality = 50%
- Financial = 30%
- Strategic = 20%

Each year, all executives at MAHC have 3% of their compensation “at risk”. This portion of the compensation is held back and measured against the achievement of goals and objectives.

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Philip Matthews
Chair, Board of Directors

Peter Deane
Chair, Quality & Patient Safety Committee

Sign-off

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

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

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

2020/21 Quality Improvement Plan
Improvement Targets and Initiatives

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)															
Timely and Efficient Transitions	Timely	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	Hours / All patients	CIHI NACRS Fiscal 2020/2021	968*	4.1	Provincial Target 8 hours (HQO)	Our target is to be less than or equal to the provincial target performance as MAHC is performing well within the LHIN and when compared to provincial average.		Continue to monitor time to inpatient bed once decision to admit has been made.	1) Continue to utilize Patient Flow Navigators (PFN) for admission avoidance. 2) Continue to review bed utilization at daily bed meetings and ensure timely discharge where appropriate. 3) Continue to monitor ALC days and work with community partners to identify solutions and continue to report rates on a monthly basis to Senior Leadership Team, Quality Council, clinical care committees, Board Quality & Safety Committee and Board of Directors. 4) Ensure adequate support services (ENVS) are available to avoid delay to inpatient bed due to room not being ready. 5) Ensure the Gridlock and Patient Distribution Policy is being consistently adhered to and that when appropriate, patients are transferred to the alternate site. 6) Continue to educate physicians regarding the importance of timely orders once decision to admit has been made. 7) Monitor and adjust inpatient capacity to respond to demand for inpatient beds.	1.1) Document number of admissions avoided by utilization of PFN for admission avoidance. 2.1) Daily bed utilization report will be circulated twice daily to ensure all stakeholders are aware of bed status at each site and plan for gridlock/surge. 2.2) Review, revise and implement additional PDSA cycles for discharge at 1100hrs. and monitor results. 3.1) continue to monitor ALC days with monthly reporting to Senior Leadership Team, Quality Council, clinical Care Teams, Board Quality & Safety Committee and the Board of Directors. 4.1) Continue to improve communication between nursing unit and Support Services to identify time of discharge to room availability, as well as, document date/time when unable to transfer due to lack of room readiness. 5.1) Ongoing education for all staff, team leads and managers regarding the Gridlock and Patient Distribution Policy. 5.2) Complete a process mapping exercise to identify bottlenecks or issues. 5.3) Source out additional information or education on patient flow practices. 6.1) Continue to educate physicians regarding the importance of timely orders once decision to admit has been made using just in time sessions, attending ED rounds and through the ED Committee. 7.1) Monitor seasonal variations and develop staffing strategies to address anticipated volumes. 7.2) Review discharge times to ensure timely availability to beds and efficient patient flow. 7.3) Review of conservable days by the utilization committee and development of strategies as needed by the Family Practice Committee.	Maintain current target for time to inpatient bed once decision to admit has been made.	
Timely and Efficient Transitions	Timely	Patient Flow/Bed Utilization	P	Acute and CCC	Cerner	968*	109% average annual occupancy rate	100% or less average annual occupancy rate	Availability of acute care beds to accommodate new admissions.	Home and Community Care	1) Reduce bed occupancy levels: identify and implement strategies to address occupancy levels by conducting a "barrier to flow" analysis. From this analysis three ideas to reduce occupancy levels will be determined and implemented. (e.g. Implement a discharge pathway with escalation framework to enhance patient flow, including ALC patients).	1) Create a Patient Flow working group to conduct analysis and review barriers to discharge, discharge planning, length of stay, conservable days and one-day admits. 2) Regularly identify the top themes causing discharge delays. 3) Work collaboratively with internal clinicians and clinical teams to implement a standard discharge process 24/7. 4) Send an inter-professional team to the OHA/IHI patient flow training in the spring.	A) 100% of family meetings of patients designated as ALC will be held within 24-48 hours of designation.		
Service Excellence	Patient-centered	Percentage of respondents who responded positively 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?"	P	% / Survey respondents	NRC Picker Most recent consecutive 12-month period	968*	57.1	70%	Ensuring the patient has sufficient information at discharge, including medication reconciliation, decreases the risk of readmission within 30 days and supporting patient focused care.	Home and Community Care Primary Care	1) Finalize PODS and implement and trial the new Patient Oriented Discharge Summary (PODS)on or before April 1, 2020.	1) Finalize PODS by March 31, 2020. 2) Medication Reconciliation on discharge required for all discharges. 3) Monitor sustainability. 4) Monitor NRC patient satisfaction survey results 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?" with Quality Council, clinical care committees and the Board Quality & Safety Committee on a quarterly basis.	PODS continued education provision and compliance monitoring	Percentage of respondents who responded positively to the following question "did you receive enough information from hospital staff at time of discharge?" beginning April 1, 2020.	
Safe and Effective Care	Safe	Healthcare-Acquired Pressure Injury	P	Acute and CCC patients	Cerner April to September 2019	*968	216 (forecasted estimate for 2019/20)	20% of forecasted case reduction (43 cases).	Hospital-acquired pressure injury are avoidable and the work that will be accomplished will specifically target prevention. As baseline work needs to be accomplished, a 20% reduction is determined to be an achievable goal.		Re-casting the MAHC pressure injury prevention program.	1) Form a working group. 2) Recruit a clinical lead. 3) Re-work the policy and program. 4) Re-institute the champion model, including intensive education. 5) Implement consultation team. 6) Institute MAHC-wide prevention strategies.	Q1: Work group will be formed. Q2: Policy and program will be finalized, champion model determined and education completed and prevention strategies implemented. Q3: Monitor effectiveness.	Q1 completion by June 30, 2020 Q2 completion by September 30, 2020 Q4 completion by December 31, 2020	
Patient-centered	Patient-centered	Continuing the journey towards a Patient-Centered Care culture: The Patient- and Family-Centered Care Committee has determined that the next IceIInitiative they wish to introduce and implement to enhance the patient's voice at MAHC is introduction of Patient Partners. Patient Partners will act as the patient's voice when new initiates, polices, and advice is needed throughout the organization.	P	Organization		*968	0 Patient Advisors	Six (6) 'Patient Partners' recruited and trained	Determined that six 'Patient Partners' are required		Align our internal philosophy to support Patient- and Family-Centered Care (PFCC) and build a stronger mechanism for patient/family engagement	1) Implement strategies to train and deploy 'Patient Partners'. 2) To determine the methods used to develop a new internal committee and 'Patient Partner' panel with a shared work plan to mutually support the implementation of a patient partner program.	# of 'Patient Partners' trained and deployed	Six (6) 'Patient Partners' deployed by Q3	
Safe and Effective Care	Safe	Reduction of the number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12-month period.	M	# of incidents	Local data collection / April 1 to March 31 2019	968*	62 forecasted incidents of workplace violence	55 or less (10% reduction)	The Incident Management System has been implemented for well over a year, and MAHC is confident we are capturing all incidents of workplace violence. The newly formed Workplace Violence Working Group is actively working at implementing initiatives to reduce incidents of workplace violence, using the provincial roundtable recommendation as guidance.		1) Education and training for all staff, including mandatory MANDT training and recertification.	Workplace Violence Working Group continued work toward understanding the root causes for each reported incident and provide recommendations. This report will also be provided quarterly to Quality Council, Board Quality & Safety Committee as well as clinical care teams.	1.1) The Workplace Violence Working Group will further develop the framework for reporting and addressing workplace violence based on the PHSA and OHA toolkits and frameworks.		
											2) Continue to work with staff to promote reporting of all incidents.	1) The working group will review all incident reports, which contain data regarding "the exercise of physical force by a person against a worker, in a workplace, that causes or could cause physical injury to the worker to identify rates per 100 workers, trends and to identify areas for improvement. 2) The working group will share results with the Joint Health & Safety Committee, Senior Leadership Team and all clinical care committees to assist in the identification of strategies to reduce violent incidents at MAHC	1.1) The working group will review all incident reports which contain data regarding workplace violence and conduct a root cause for identified themes. 2.1) The Workplace Violence Working Group will provide quarterly data to the Joint Occupational Health & Safety Committee, Senior Leadership Team and all care committees to assist in the identification of strategies to reduce violent incidents at MAHC and to monitor reporting trends.		
											3) Formation of the Workplace Violence Working Group to monitor rates and provide recommendations from trends.	1) Identification of two strategies to reduce violent incidents at MAHC utilizing OHA Toolkit "Preventing Workplace Violence in the Healthcare Sector" in consultation with the Workplace Violence Working Group to ensure best practices. 2) Development of a Violence Prevention Framework to guide a comprehensive approach to prevention, mitigation and response.	1.1) Workplace Violence Working Group will present recommendations for two priority strategies to reduce violent incidents at MAHC by March 31, 2021.		