Ontario Health
Quality

## Quality Improvement Plan (QIP)

# Narrative for Health Care Organizations in Ontario

April 30, 2020

LAKE OF THE WOODS
DISTRICT HOSPITAL

## OVERVIEW

Lake of the Woods District Hospital (LWDH) is committed to delivering high quality, integrated care for the patient and families that we serve, a principle directed in the Excellent Care for All Act (ECFAA). The goal of the organization is to ensure that every patient experience is a positive one, and that our patients are provided with the highest quality and safest care possible.

The 2020-2021 LWDH Quality Improvement Plan will be the guide used to drive quality improvement in the organization. The engagement of patients, clinicians, and community partners in its development is essential for the results to be relevant and meaningful. In addition, we are directed by numerous evidence-based best practice resources that define high quality performance such as Accreditation Canada, Safer Heath Care Now, Canadian Patient Safety Institute, and Health Quality Ontario.

For the 2020-21 Quality Improvement Plan, LWDH has identified key drivers for quality planning and are also aligned with:
1. LWDH's Board Vision, Mission and Value Statement
2. LWDH's Interim Strategic Plan
3. North West Local Health Integration Network's (LHIN) Blueprint and Integrated Services Plan
4. Health System Funding Reform (HSFR)
5. Hospital Service Accountability Agreement (H-SAA)
6. Ministry of Health and Long-term Care Plan (MOHLTC)
7. Health Quality Ontario's (HQO)Strategic Plan
8. Public Reporting of Hospital Performance
9. Accreditation Canada's Required Organizational Practices (ROPs)
10. Safer Health Care Now and the Canadian Patient Safety Institute
11. HIROC Risk Assessment Checklist (RAC)and the Integrated Risk Management (IRM) Program which results in subsequent QI initiatives.

In addition, the Quality Improvement Plan commands active consultation and participation with our dedicated health care partners to achieve the plan's objectives. Key internal partners are LWDH staff and credentialed professional staff. Key external partners include MOHLTC, LHIN 14, LHIN Home and Community Care, the Northwestern Health Unit, the Sunset Country Family Health Team, Kenora District Services Board, Pinecrest District Home for the Aged and Birchwood Terrace Nursing Home, the Ontario Provincial Police, and Ambulance Services, Kenora Chiefs Advisory, Firefly, CMHA Kenora, WNHAC plus many more.

While we are confident our QIP will provide the necessary framework and road map to guide us on this journey towards relentless quality improvement, we understand that patients, their families, and our staff play an integral role in the provision of excellent care for all.

The indicators for this year's QIP include:

1. Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of the patient's discharge from hospital.
2. The time interval between the Disposition Date/time (as determined by the main service provider) and the Date/Time Patient left the Emergency Department for admission to an inpatient bed or operating room.

3. 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 hospital
4. Medication reconciliation at discharge; Total number of discharged patients for whom a Best Possible Medication Discharge plan was created as a proportion of all discharged patients.
5. Proportion of hospitalizations where patients with a progressive life threatening illness have their palliative care needs identified early through a comprehensive holistic assessment.
6. Percent of unscheduled repeat emergency visits following an emergency visit for a mental health condition.
7. Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.
8. Number of patients who receive a follow up phone call over the number of patients who consent to receiving a follow up phone call.
9. Percentage of patients who experience a care transition for whom a standardized SBAR (Situation, Background, Assessment, Recommendation) transfer of care tool is completed, over the total number of care transitions.

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

In 2019, a full time Medication Reconciliation Registered Pharmacy Technician was hired, as a pilot project, to address deficiencies and improve compliance with the Medication Reconciliation Accreditation Canada Required Organizational Practice.

The position was filled in July. Subsequent Medication Reconciliation Audits have shown significant improvements in compliance. We exceeded our medication reconciliation target for the 2019/2020 Quality Improvement Plan. We were also compliant with all Accreditation Canada ROPs pertaining to Medication Reconciliation, from our recent Accreditation in October of 2019.

2019/20 current medication reconciliation on discharge performance is 85%.
2018/19 medication reconciliation on discharge performance=71%
2017/18 medication reconciliation on discharge performance=76%
2016/17 medication reconciliation on discharge performance=68%

In addition to improving medication reconciliation compliance, this position has also led to additional quality improvements including:
-Improved auditing: audits are now completed live in a timely manner. This creates an opportunity to identify trends and educate staff as issues with medication reconciliation arise.
-Improved patient safety: Medication discrepancies are captured and corrected as they are discovered, prior to patient discharge. Also, the variability in Medication Reconciliation completion is considerably less, as most medication reconciliations are being done by the Technicians, not multiple different staff. Pharmacy Technicians receive special training during their education to acquire Best Possible Medication Histories (BPMH), and have dedicated, uninterrupted time to complete each history. RN's and RPN's are often multitasking and interrupted while completing the BPMH, leading to increased risk of error. An audit was conducted to determine the accuracy of the BPMH when completed by a registered pharmacy technician, compared to other hospital staff. In the months of December, 2019, and January 2020, it was found that:
-90% of the BPMH's completed by the med rec pharmacy technician were correct with zero discrepancies

-10% of the BPMH's completed by the med rec pharmacy technician were found to have one or more discrepancies (corrected prior to discharge)

-32% of the BPMH's completed by other staff were correct with zero discrepancies

-68% of the BPMH's completed by other staff were found to have one or more discrepancies (corrected prior to discharge)

-Improved workflow on patient wards and in the Pharmacy: Dedicating a Technician to this position has reduced the requirements of nursing to complete medication reconciliation, which has a direct impact on discharge time. Also, Pharmacist time usage has been improved, as they are now able to focus on medication teaching in those patients with complex medication regimens, rather than having to complete the medication reconciliation portion as well.

## COLLABORATION AND INTEGRATION

We are at a historic juncture for Indigenous and Canadian relations in the Kenora area with all communities taking positive steps towards true partnership and "Reconciliation Through Health". The Kenora Chiefs Advisory (KCA), Grand Council Treaty 3, the Kenora Metis Council, Iskatewizaagegan No. 39 Independent First Nation, Animakee Wa Zhing #37 First Nation, the City of Kenora and the Township of Sioux Narrows-Nestor Falls have all agreed to the following resolution signed and witnessed in ceremony "That all parties agree to work together in partnership in the development of an All Nations Health Care System including the construction of an All Nations Hospital and Campus with the express purpose of improving health outcomes for all people of the region it serves" .

Working towards accessible and culturally safe health care across all sectors/services and for the new All Nations hospital will mean aligning planning within the context of Truth and Reconciliation. This will be one of the first large developments in the Kenora area that will embark on a Reconciliation process and true partnership with our surrounding First Nations communities and the Indigenous population in general. To this end, the organization has introduced cultural sensitivity and humility training. This training will be available for all staff and has been developed in partnership with Seven Generations, a local post secondary institution.

Lake of the Woods is an active member of the All Nations Health Partners and the All Nations Health Partners Ontario Health Team (ANHP OHT).

Within the ANHP catchment area, the population requiring and accessing mental health services and specifically crisis intervention has been identified as the priority population for year one of the ANHP OHT. Crisis intervention services are the most important performance improvement opportunity given the high needs and risk factors affecting the ANHP population across all age groups. The lack of appropriate and coordinated crisis services does affect the number of avoidable emergency visits, frequency of emergency visits, and extended hospital stays.

Much of the initial planning work has taken place and efforts are

on-going to develop a central support access line and build an integrated and responsive network of services that will support children, adolescents, and adults in crisis. Several partners are engaged and committed to developing and implementing an integrated model for crisis services. The scope of work includes the development of appropriate indicators to measure, assess, and enhance the impact of the services. Addressing addictions is also within scope of the services being developed and offered to this priority population. An example of the incorporation of addictions services would be through the planning and implementation of a mobile Rapid Access Addictions Medicine (RAAM) Clinic as well as completely redesigning services and programs to support other types, groups, and illness sub-groups within the catchment area.

Primary care will also play an important role overall through early identification of risk factors linked to mental health as well as supporting post-crisis strategies to achieve and maintain healthy communities/patient population. The focus of year one will also include reviewing and identifying data gaps and solutions to align with ANHP priorities and reflect the unique geographic area and access to services.

Key partnerships involving the LWDH relevant to the year one population include:
- Kenora Rainy River Mental Health and Addictions Network
- OPP Situation Table- Rapid Intervention Services Kenora
- Kenora Substance Abuse Task Force
- Inter-agency Services Committee
- Fetal Alcohol Spectrum Disorder Committee
- Social Service Worker Program Advisory Committee
- Healthcare Leadership Advisory Committee - Con College
- Ontario Network of Residential Withdrawal Management Centers
- Ontario Quality Standards for Schizophrenia Treatment Partnership
- Regional Training Leader for the Global Assessment of Individual Needs - Quick 3 (GAIN-Q3)
- District Training Leader for the Columbia Suicide Risk Assessment and Safe-T Protocol
- Northwest Ontario Eating Disorder Network
- Northern Ontario Wellness (NOW) Gambling Prevention and Treatment Partnership
- Mental Crisis Response contingency plan (LWDH MHAP provides all assessment and disposition planning which is a gateway to hospital admission or a gateway to community services, i.e. CMHAK Safebeds)
- OPP / T3P Transfer of Care Agreement
- Northwest Regional Schedule 1 Committee
- Needle Exchange Program partnership with Northwestern Health Unit / Morning star Center
- Youth Addictions service provision partner in Kenora Youth Hub

## PATIENT/CLIENT/RESIDENT PARTNERING AND RELATIONS

As per the Excellent Care for All Act (ECFAA, 2010), and Accreditation Canada standards, Lake of the Woods District Hospital consistently incorporates patient partnering and relations within its QIP. This year, the Patient and Family Advisory Committee was actively involved in the development of the QIP. To ensure the QIP information reflects the perspectives of patients, we have actively engaged with them to hear their insights, reflective of their experiences.

LWDH also gives power to the patient's voice through its annual Patient Experience Survey, feedback obtained from the post follow-discharge questionnaire and by the review of reported adverse incidents and complaints. This information is considered in the selection of the annual QIP indicators. LWDH believes that patient engagement positively shapes the quality of our services. The organization understands that the LWDH Patient & Family Advisory Committee will guide our quality work even further.

In partnership with the Kenora Chief's Advisory we have added a Client Navigator to our team. As an employee of KCA, the Client Navigator works with Aboriginal patients in problem solving and Navigating the discharge process. This is another source of feedback from our Aboriginal clients.

The organization has a process to effectively manage feedback, reporting, and communication of patient concerns and complaints. The hospital Board and the organization's expectation is that all reported patient complaints are managed and resolved within one (1) month. The Quality Committee of the Board reviews complaints quarterly, to identify trends and areas to improve. The organization believes that all concerns and complaints provide opportunities for quality and service improvement within the health care system.

The LWDH Board has expanded its membership from 9 to 12 community members and has established cross-representation between the Board and the Patient and Family Advisory Committee to strengthen connections and improve communication between the Board and the patients and families of LWDH. The Board has approved their standing committee terms of reference to include community representation on their Quality Committee and Audit and Finance Committee. Patient engagement is a current focus of the Board and Patient and Family Advisory Committee. The organization is working toward expanding the role of the Patient and Family Advisory Committee, recruiting more members, and integrating the voice of the patient into future quality improvement projects.

## WORKPLACE VIOLENCE PREVENTION

Workplace violence prevention has been a hospital priority for the past several years and has been incorporated into the current strategic plan. Significant investments in security and safety have been made over the past four years. In 2016 a violence prevention task force was created to work with the JOHSC to identify safety and security gaps and develop strategies to mitigate those gaps. Examples of some of these initiatives include:

1. The hospital and most areas are locked down after hours and can only be accessed using pass cards attached to staff ID badges. Access to specific areas is restricted to specific individuals;
2. All employees (paid and unpaid) and medical staff, must wear their ID badges in order to get into the building. Contractors must also be issued and wear ID badges to access the building;
3. All staff accessing the building after hours must sign in at switchboard;
4. All patients who are at risk of violence are flagged and the flags are entered in MediTech and/or a shared folder so LWDH staff, internal and external, are alerted for subsequent visits;
5. Patients are routinely screened for violence and delirium on admission and protocols are developed to address levels of risk;
6. Enhanced lighting in the parking lot with LED lighting;
7. Use of surveillance cameras in strategic locations within the

building;
8. Code silver has been developed and a 'lockdown' button has been installed to immediately lock down the facility. Code silver is reviewed on an annual basis in partnership with the OPP;
9. Code White drills are reviewed on an annual basis;
10. Pinel restraints and a humane restraint chair have been purchased. Staff are now trained on their use.
11. Screamers are carried by staff who work alone or in secluded areas;
12. All departments have developed, and update annually, a safety plan for their department;
13. A security firm was hired in August of 2019 and is providing 24hours a day security service to LWDH;
14 Staff in key areas (ER, Admitting, Schedule 1, Morningstar Detox, Maintenance) are required to have CPI training every 2 years.
15. Comprehensive Violence Risk assessments, from the Public Services Health and Safety Association, are being completed in high risk areas.
16. Renovations to the Morning Star registration area have improved staff safety.
17. Funds have been secured to renovate the Emergency Room and create a 'safe room' for patients at risk of harm to themselves or others.
18. Communication processes have been established whereby care partners, such as the EMS and police communicate with the hospital to inform us if they are bringing a patient who is exhibiting violent behaviors.

The Manager of Quality and Risk reports safety and security data to the Hospital Board on a quarterly basis.

## VIRTUAL CARE

LWDH utilizes virtual care to improve health care service access to our patients. The Telemedicine department schedules patient consults on site with specialists located throughout Ontario, as well as Manitoba. This allows patients to access specialty care in their home community. On site physicians also utilize the Telemedicine program to see patients from the region. The Telemedicine department also offers programs, such as cardiac rehabilitation, through Thunder Bay Health Sciences Center (TBRHSC), which creates opportunity for local patients to participate in regional programing.

Telemedicine virtual care is also utilized to participate in TBRHSC ICU rounds, allowing local physicians an opportunity to consult with ICU physicians and share in decision making regarding critical care.

Telemedicine also plays an integral role in stroke care provided throughout the hospital where a patient can be seen by a neurologist very quickly, through telemedicine, upon presenting with stroke symptoms.
Locally TBRHSC Telemedicine is working on improving and increasing usage of their tele-homecare visits where certain cohorts of patients with chronic disease are supported by multidisciplinary visits in their homes on personal devices.

## EXECUTIVE COMPENSATION

Our Executives' compensation is linked to performance in the following ways:

Senior Managers % compensation linked to achievement of targets:

President & Chief Executive Officer - 2.5%
Chief of Staff - 1%
VP Patient Care & Chief Nursing Officer - 1%
VP Corporate Services & Chief Financial Officer - 1%

Performance is linked to nine (9) quality indicators, which are outlined in our Quality Improvement Plan (QIP).

• If legislation permits, achievement of targets beyond a five (5) out of nine (9) will result in eligibility for a pay for performance.

• For example if eight (8) out of nine (9) targets are achieved, the CEO would be eligible for a 3/4 X 2.5% incentive.

• Given that the CEO and Senior Management position salaries have been frozen, and with no end in sight to this situation, the Board finds it unconscionable to put any base salary at risk. The Board recognizes that current legislation does not allow for any salary bonus or claw-back.

Compensation will be pro-rated and based on the following achievement proportions:

| #Outcomes Met: | Total # Indicators | % Compensation 1-5% as indicated above) |
|---|---|---|
| 9 | Out of 9 | Full |
| 8 | Out of 9 | + 3/4 X % at risk |
| 7 | Out of 9 | + 1/2 X % at risk |
| 6 | Out of 9 | + 1/4 X % at risk |
| 5 or less | = no bonus | |

## CONTACT INFORMATION

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## OTHER

This year, the Quality Improvement Plan has been developed to reflect and monitor the recommendations received from Accreditation Canada, in the October 2019 Accreditation Survey. The survey identified that transfers in care were a focus area of improvement for the organization. To address this, LWDH has introduced Patient Orientated Discharge Summaries (PODS). The patient follow up phone call program has also been enhanced, and the Patient Orientated Discharge Summaries (PODS) are utilized as a guide to conduct these calls. Quality improvements will be identified by tracking data and trends from the follow up phone calls. Lastly, the SBAR transfer of care tool is now a permanent part of the patients chart, and the organization will move to an electronic MEDITECH SBAR in the EMR in Q1.

These quality improvements have introduced significant practice changes in the organization. Monitoring SBAR and follow up phone call compliance (this indicator monitors PODS completion as well), through the Quality Improvement Plan, will ensure that that these practice changes are implemented fully and sustained throughout

the year.

Another quality improvement that will be occurring in 2020 is development of a new Professional Staff structure. This action has been taken to address recommendations from an Operational Review that occurred in 2018. These changes will expand the number of Service Lead positions and the size of the Medical Advisory Committee for oversight purposes; establish role clarity for the Service Leads as well as the Chief of Staff positions; and provide investment for Professional Staff leadership training. Establishing Professional Staff Service Leads will support quality improvement throughout the organization, as the Service Leads will be engaged in quality improvement activities affecting their service areas. The new Professorial Staff Structure has been developed and approved by the Professional Staff Committee, Medical Advisory Committee and Board of Directors. Implementation will begin during the summer of 2020.

## 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 **April 30, 2020**

**Wendy Cuthbert**, Board Chair

**Wendy Peterson**, Board Quality Committee Chair

**Ray Racette**, Chief Executive Officer

**Erin Mudry**, Other leadership as appropriate