Let's Make Healthy Change Happen.

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

2017/18

HORNEPAYNE COMMUNITY HOSPITAL

ACUTE/LONG-TERM CARE

2/8/2017

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.

Overview

The Hornepayne Community Hospital is a unique health care setting where a variety of health care services are incorporated under one roof, including an Acute Care Department, Long-Term Care Department, Emergency Department, Family Medicine Clinic, Telemedicine Suite, Lab and Diagnostic Imaging Department and Physiotherapy Department. All sectors housed within the facility continue to work together in a collaborative working relationship to maintain continuity of care for patients across the system. Completion of the 2017/2018 QIP was a collaborative team accomplishment utilizing input from employees at both the direct care and management level. This process highlights our facility's emphasis on the importance of LEAN processes to utilize the skill sets of our valued employees by engaging everyone employed at our facility to work collaboratively to provide the best services possible to our residents, patients and community as a whole. It has been a year of many changes at Hornepayne Community Hospital with three of our four management team retiring, and three new leaders guiding the way to health care excellence. Our management team and staff have been working tirelessly to update our policies and procedures, charting systems, infrastructure, and education to meet MoHLTC standards and meet, or in many instances, improve our target performance. Thorough auditing and analyzing of internal patient satisfaction surveys, LTC resident/family satisfaction surveys, and emergency department satisfaction surveys, and various work processes have provided a platform for all staff to discuss possible interventions to implement to improve the services we provide, thereby increasing our satisfaction and performance seen in many areas on this years QIP.

Over the past year, we have continued to work collaboratively, with both internal and external resources and agencies to improve the services we are able to offer through our facility. This coordination and integration of services has enabled our organization to offer more supportive services, support the well-being of our patients, and encourage all involved to be an active participant in the health care available within our community. A strong cohesive team, committed to meeting the requirements outlined by the MoHLTC and Accreditation Standards, has resulted in improvement of our facility in an ever changing, challenging health care environment. We remain committed to our vision to become a Healthcare team that collaborates with our partners, shares our successes, and learns from our experiences as we evolve to provide the best care possible to our community.

QI Achievements From the Past Year

Our greatest achievement in the 2016-2017 QIP was in the person experience quality dimension, specifically with respect to the statement "I can express my opinions without fear of consequences". Our facility saw a dramatic increase, from 54.4% to 100% in our resident population responding positively to this statement. We believe this positive increase is attributed to a multitude of factors including our commitment to providing a safe, transparent, open communication environment to our residents, their families, and the interdisciplinary health care team. Open communication with residents and their families, utilizing a bulletin board and information binder, that is always available, showcasing literature on the Residents Bill of Rights under the LTC Homes Act 2007, the MoHLTC Resident Quality Inspection Reports and Compliance Orders, the options available, procedures to follow to make a complaint, our policies and procedures regarding abuse and neglect, whistle blowing protection, least restraints, and information regarding family council provides a platform for transparency. Through analysis during daily reports, monthly nursing meetings, daily management meetings, and monthly board meetings, to determine root meanings of expressed opinions with viable potential solutions, which are communicated to residents and their families, are utilized to foster our vision. In addition to this, our facility has adopted the concept of LEAN Healthcare on our journey of continuous improvement, and is in the process of implementing various ideas, strategies, and changes through Huddle Board processes to ensure transparency in the decision making processes within the facility, which includes addressing resident concerns. Additionally, utilization of technology, including the SURGE learning application, allowed our team to reach every resident/family member/SDM, and clear communication of the meaning of the statement also reflected in our increased patient satisfaction.

Collaboration with partners including the Community Care Access Centre (CCAC), HKS Counseling Services, Ontario Telehealth Network, Nordaski Diabetic Clinic, Behavioural Supports Ontario, Telepharmacy, and Motion Specialties, have allowed us to coordinate the services we are able to provide to our acute and long-term care residents. With these partnerships, we are able to offer services in mental health, palliative care support, geriatric care, diabetes management, and chronic illness management. We have, also, implemented newer charting systems, including Patient Care System (PCS) for our acute care patient population, and Point of Care (POC) and Point Click Care (PCC) for our long-term care patient population, which enable information sharing to be completed in a more streamlined process, thereby improving communication between interdisciplinary team members and community partners, further enhancing the safe, competent care we provide to our patients and community.

We have made improvements in several areas of the QIP in the 2016-2017 year, and have exceeded our targets in medication reconciliation at admission and discharge and in our 30 day readmission rates for patients with COPD, CHF, and stroke. Our patient satisfactions scores, in both the LTC and Acute Care sectors are extremely positive with 100% satisfaction seen with most indicators. Notably, 100% of our long-term care and acute care population would recommend our facility to others.

Population Health

The Hornepayne Community Hospital provides care and services for patients with a vast array of disease processes and needs. Approximately ten percent of our community population is over the age of sixty-five, with many of these individuals suffering from chronic illnesses such as diabetes, COPD, CAD, and CHF. Our team has worked closely with Think Research to develop QBP Patient Order Sets for the Emergency, Acute Care, and Long-Term Care Departments to meet the specific needs of these population groups. Our team has worked closely with each department to develop a revised patient discharge record to include a Best Possible Medication History (BPMH), and a discharge teaching section, that is sent to the primary care provider at discharge, to reinforce the care requirements and provide medication reconciliation for these patient population groups. These processes have enabled the patient, their family, and care partners to understand their illness, their medications and care needs, prevent readmission rates, and manage their illness safely in their home environment. Collaboration and streamlined referral processes to the Nord-Aski Diabetes Education Centre, NECCAC, Telehomecare, Telepharmacy, and HKS Counseling Services has allowed our health care team to provide continuous, uninterrupted services across the care continuum. However, due to our remote location and travel requirements for services, as well as our teams personalized knowledge of individual patient needs due to our small population, we will continue in our endeavours to become the Health Hub of the community and employ a Local Care Coordinator to further improve the services provided to our patients and community.

Additionally, we have continued to foster relationships with local organizations including the Algoma EMS, Porcupine Health Unit, Algoma Family Services, Hornepayne First Nations, Community Living Algoma, Children's Aid Society of Algoma, HKS Counseling Services, and Kunuwanimano Child and Family Services, and regional care partners including the NECCAC, Ontario Telehealth Network, Paramed, Red Cross Society, VCC/Criticall Ontario, Cancer Care Ontario/Rainbow Centre Hearst, Vital Aire, Medigas, and Fenlon’s Pharmacy to meet the care needs of patients within our community in a safe, efficient, timely, collaborative manner.

Lastly, we have created partnerships with regional hospitals to provide services to our patients that we are unable to provide in our small community hospital such as labour and delivery care at Notre Dame Hospital, cardiac catheterization at Health Sciences North, acute stroke management at Sault Area Hospital, and CT diagnostic scans at Timmins and District Hospital.

Equity

Our facility prides itself in the individualized patient care that we provide to our patients, their families, and our community. We were able to utilize SURGE technology to reach families who reside a great distance from our facility, allowing them to have a voice in the care their loved ones receive. Utilizing a Patient Oriented Discharge Summary (PODS), with a Best Possible Medication History (BPMH), with thorough health teaching and discharge planning completed by the Registered Nurse at the bedside, with ample time for questions and clarifications, has been especially helpful in providing culturally competent care to our vulnerable population groups. The PODS and BPMH can also be created utilizing the Microsoft Word processor, allowing text size to be increased to enable those with vision difficulties to read their discharge instructions.

Printed materials provided within our facility are available in our two official languages, French and English. Should material not be readily available in French, staff have internet access with links to a variety of resources, and are able to print off information in the French language as required. Our facility also employs six individuals who are available for French translation services. French Language Services, located in Kapuskasing, is utilized to translate English instruction sheets, pamphlets, and other various communication into the French language. For our indigenous population group, Kunuwanimano Family Services and Hornepayne First Nations offer services to ensure care needs and information is being communicated accurately. Lastly, our senior management team recently attended the Ontario Health Achieve convention in Toronto, and are currently researching options for telephone translation services through Access Alliance Language Services for translation services in over one hundred and seventy different languages to meet the needs of additional population groups.

Integration and Continuity of Care

The Hornepayne Community Hospital has worked collaboratively with many local organizations, regional organizations, and partner hospitals in our endeavour to provide continuity of care to our patients, families, and community over the health continuum. Our remoteness, small facility size, and difficulties in retaining qualified staff have led to many challenges in meeting the continuing, ever evolving needs of the populations we serve. We continue in our endeavours to become the Health Hub of the Community, with our plan to integrate and coordinate services with a Local Care Coordinator, who truly understands the needs of our community, on site in the near future.

Our partnerships with HKS Counseling Services has enabled our facility to employ a full-time Mental Health Counsellor, and we have recently developed a partnership with NDH to provide physiotherapy services for homebound patients, have recently utilized LHIN #13 funding to provide physiotherapy services to our long term care residents, and utilize Nord-Aski Diabetes Education Centre to provide diabetes management education to patients in the community on a monthly basis.

Focusing on health teaching, illness prevention, and management of chronic disease processes is believed to be a great asset that our team utilizes in the acute care hospital, long-term care department, and emergency department to meet the needs of those patients frequently seen in our facility. We have utilized funding from LHIN #13 to become deeply involved in the QBP Patient Order Sets (POS) project, spearheaded by Think Research, and have recently implemented six QBP order sets to complement our original POS library. These QBP order sets enable our care providers to provide a more standardized, evidence-based, high quality patient-centered health care service to specific population groups. Additionally, the QBP interventions within the POS meet best practice standards, and provide a foundation for health teaching topics to be discussed with patients along the health continuum to help our patients manage their disease processes safely in their home environment.

Referrals for a variety of health promotion and health maintenance programs through the CCAC are also organized prior to discharge. One great success in the management of COPD has been the use of Telehomecare, greatly reducing the readmission rate experienced by one of our patients. Due to the success of this program, eligible candidates are being referred frequently through our acute care and emergency departments.

Patient Oriented Discharge Summaries (PODS) provided at discharge, with follow up appointments with the patient's family physician within two weeks of discharge has greatly reduced our readmission rates and has been successful in promoting optimum health outcomes by assisting in the management of follow-up care.

LEAN processes, with the use of daily or biweekly huddle board discussions, are providing a platform for departments within the facility to work through processes currently in use within our facility in order to improve workflow and processes to improve the care provided within our facility. This process has helped uncover a variety of barriers to successfully integrating services, has enabled care providers to voice the implications of proposed changes on patient safety and ability to deliver safe, high quality services to patients, and also allowed patients to have a voice in their health care needs.

Our facility has worked closely with LHIN #13 Hospice Suite Implementation Knowledge Exchange Group to construct, and open a Hospice Suite by March 31, 2017 that provides equitable, timely, and quality palliative care. To date, 100% of our direct care and activity staff have attended palliative care education sessions with a goal of two volunteers to be trained by December 31, 2017. We feel this will be an invaluable service we can offer to our community.

Integration and Continuity of Care

Our long-term care and acute care departments have worked very closely to look at the processes in place, resident needs, and barriers to keep residents in their home, and avoid unnecessary transfers to the emergency department when possible. Due to the same staff caring for patients in the long-term care, acute care, and emergency departments, we feel our processes currently in use are attributing to our elevated ED visits in our long-term care patient population group. Utilizing LEAN processes, collaborating with care partners, and communicating patient needs will be instrumental in our change process.

Our laboratory department is part of the Timmins Cluster Laboratory Partnership that provides standardized policies and procedures for the collection, analysis, and reporting of results across the region. Additionally, this partnership provides contracts with other laboratories in the region to send out samples for specialized laboratory testing not completed on site. Products and supplies are also purchased through this partnership, and our Regional Transfusion Medicine policies and procedures are also managed through the partnership. By operating under this partnership, our small laboratory department has the support from regional hospitals and laboratories, and is able to offer the same standardized, accurate, accountable laboratory services that patients receive across the region.

Similarly, the diagnostic imaging department is also in a partnership with Timmins and District Hospital, who provide standardized policies and procedures for both radiology and ultrasound procedures. This partnership provides support from other hospitals within the Timmins partnership, and enables our small imaging department to offer the same standardized, accurate, accountable diagnostic imaging services that patients receive across the region.

As part of the NEON 02 group, we have developed partnerships with Hearst/Kapuskasing/Smooth Rock Falls to utilize a shared coordinator and management of services with respect to our information technology system. We are part of the MASS project for Meditech archiving and scanning, and have developed a close relationship with Notre Dame Hospital, Sensenbrenner Hospital, and Smooth Rock Falls Hospital to mentor our senior management regarding financial reporting and meeting Ministry of Health and Long Term Care and Accreditation standards. This mentorship agreement has been instrumental in our facility's success at meeting, and many times exceeding priority indicators.

Access to the Right Level of Care - Addressing ALC Issues

The Hornepayne Community Hospital continues in our endeavours to become the Health Hub of the community, with plans to employ a Local Care Coordinator within the facility who understands the individual needs of the patients we serve within the community, who truly understands the barriers faced by individuals in the community, and has viable, attainable, safe options available in our unique, remote, small, isolated community to keep patients in their home longer, thereby preventing the need for ALC admissions. ALC is a cross-sector challenge, and we believe that by allowing a Local Care Coordinator to mitigate the supports available to meet individual needs of our patients, we will be able to provide a more individualized approach to the management of chronic disease processes, teach patients how to manage their chronic illnesses safely in their home, and enable patients to remain safely in their home environment instead of occupying hospital beds while awaiting LTC placement.

Our plan is to provide literature to identified individuals in the community at high risk for ALC needs regarding the options for care and support services available in the community. Literature development will be completed by the Local Care Coordinator and monitored by the Chief Nursing Officer.

Another initiative implemented in our facility is the use of Respite Care. Respite care provides patient care in a safe, caring, professional environment to provide caregivers with temporary rest from their caregiving duties. These short term breaks allow caregivers to rest, reduce their stress, renew their energy, and restore a sense of balance to their lives so that they can continue to provide the best care for their loved ones in the future. When respite patients are admitted to hospital, they are invited to attend meals and social events in the Long-Term Care department to enhance their quality of life and well-being while away from their loved ones. This experience also allows these patients to participate in and ask questions regarding LTC living, many times decreasing anxiety about upcoming LTC placement decisions.

Additionally, our facility plans to pilot a senior day program available to high risk individuals in the community to provide important socialization services, with coordinated medical appointment and transportation services. This program will allow our facility to reach out to individuals who may not otherwise have the ability to access required services, and will allow our health care team to help patients manage their chronic illness conditions more closely, preventing hospital admissions, and enabling patients to remain safely in their home longer.

Engagement of Clinicians, Leadership & Staff

Completion of the 2017/2018 QIP was a collaborative team accomplishment utilizing input from employees at both the direct care and management level. By utilizing this inter-collaborative process, we have been able to communicate the indicators, change ideas, and process measures in an open, transparent environment that has served as a platform, in conjunction with LEAN processes, to implement change ideas in our day to day operations. We have made our QIP Narrative, Progress Report, and Work plan available on our shared X-drive, and have encouraged all staff members to leave comments and suggestions to help ensure the work plan is carried out to manage patient care safely and efficiently. Currently, our Quality Committee, consisting of our four department managers and a Board of Directors representative meet monthly to discuss Quality Improvement indicator progress. Managers and the Local Care Coordinator will be tracking the QIP indicators and progress, and will be communicating ongoing performance results to direct care staff members to critically analyze work processes and help ensure the process measures are integrated into day to day operations.

We strongly believe that collaborative teamwork in integrating and carrying out our change ideas will have a positive influence on our ability to improve the quality of care provided by our facility, and foster collaboration and team work with our direct care, physician, and management team.

Resident, Patient, Client Engagement

The Hornepayne Community Hospital believes that patients, residents, family members, and the community as a whole, are an essential part of quality improvement. We utilize in house paper internal patient satisfaction surveys upon discharge to determine acute internal patient satisfaction, both paper and electronic resident satisfaction surveys through the SURGE learning application to determine long term care resident/SDM's satisfaction, and paper emergency department satisfaction surveys to determine emergency patient satisfaction with respect to various aspects of care. The results of these surveys are utilized as a significant source of information to provide insight and ideas to influence change in processes to better meet the needs of the community.

Long-term care residents, acute and emergency room patients are also invited to our huddle board sessions implemented through LEAN processes. Patient ideas and insights expressed at these sessions are taken into account during the act, plan, do, and check phases in our journey of continuous improvement.

Monthly resident council meetings are conducted as a platform for long-term care patients to freely express their opinions, and offer valuable solutions in a neutral, unbiased, transparent environment. Our health care team continues to encourage the development of a family and friends council to further engage residents and their families in the health care they receive.

By taking a proactive approach to integrate the perspectives of patients, their family, and the community into the change process, it is our hope that our facility will be able to provide the highest standard of care by improving our services, creating better patient experiences, and providing higher quality of care with lower costs and increased satisfaction. This proactive approach meets the work supported by the Patients First Act, 2016.

Staff Safety & Workplace Violence

Our facility has adopted a zero tolerance for workplace abuse, violence, and harassment outlined in our Abuse, Harassment, and Violence in the Workplace Policy, and Abuse, Harassment, and Violence Prevention Program that complies with the Ontario Health and Safety Act, 2010. Our facility reviews this policy and program on an annual basis, and employee reviews of the policy and program are completed during annual employee appraisals. All new employees receive an extensive orientation to our hospital, provided by our Chief Nursing Officer, which includes reading and understanding of our Abuse, Harassment and Violence in the Workplace Policy and Prevention Program. Mandatory SURGE learning, regarding Workplace Violence and Harassment, is completed annually by all staff, which reinforces the most current laws and information to monitor, reduce, and prevent workplace violence.

Our facility conducts a Workplace Risk Assessment every two years, with representatives including the CEO, Health & Safety Committee Chair and Co-chair, a minimum of three staff members representing the CUPE and ONA unionized and non-unionized employees, and one Board Member. This committee analyzes information including health & safety meeting minutes, WSIB form 7 and employee incident reports, unusual occurrence reports, staff risk assessment surveys, and completed risk assessment workplace inspections, adapted and reprinted with the permission of the Canadian Centre for Occupational Health and Safety (CCOHS) as one step in monitoring, reducing, and preventing workplace violence.

Performance Based Compensation

Performance based compensation is utilized within our organization to strive towards performance improvement in every aspect of implementation of planned improvement changes in meeting our performance targets. We utilize this compensation to drive accountability for the delivery of our quality improvement plan by increasing the motivation of all employees within our facility to achieve both long and short term goals. The performance based compensation plan outlined below ensures that improvement is our focus, meeting the Excellent Care for All Act (2010). Our management team's compensation, including percentage of salary at risk and targets the management team is accountable for achieving, is linked to performance in the following way:

Chief Executive Officer- 3% of annual base salary linked to achieving priority target indicators set in our QIP as listed below.
Chief Financial Officer- 3% of annual base salary linked to achieving priority target indicators set in our QIP as listed below.
Chief Nursing Officer- 3% of annual base salary linked to achieving priority target indicators set in our QIP as listed below.

Priority Target Indicators:

Quality Dimension	Indicator
Safety	Medication reconciliation at discharge: 100%
Safety	Percentage of residents who fell: less than 8%
Effective	Receive enough information at discharge: 100%
Person Experience	Patient satisfaction: 100%
Resident Experience	Resident satisfaction: 100%

Terms of compensation plan:
1) The five indicators are equally weighted.
2) Achievement of meeting indicator targets would result in 100% payout.
3) Partial achievement of meeting indicator targets would result in 50% payout.

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Other

The Hornepayne Community Hospital is continually seeking partnerships with local and regional organizations, and advancing technology, to streamline services, improve the quality of care, and utilize innovative options to provide quality health care services to our patients, residents, and community. Our new management team takes pride in our ability to provide high quality service and care across all sectors, and are working extremely hard to collaborate with our partners and resources to find efficiencies in our system to direct resources where they are needed most to meet the needs of our community.

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 _____

Chief Executive Officer _____