

Let's Make Healthy  
Change Happen.



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

**April 1, 2016**



**Niagara Health System**  
Système De Santé De Niagara

[ontario.ca/excellentcare](http://ontario.ca/excellentcare)

## Overview

The Niagara Health System (NHS) is “*looking forward*”, charting its future to deliver high quality and safe care through the:

- development of a *strategic plan* with a renewed purpose, vision, and values; and
- submission of a capital plan for a new South Niagara hospital and Urgent Care Centre.

To support organizational focus until the new strategic plan is launched in June 2016, **three (3) organizational goals and priorities** have been developed as a rallying point to deliver on our promise of a high-quality and safe system, one that is patient focused and sustainable. These system-wide priorities are:

- Quality and Safety
- Access and Flow
- Vision and Engagement

These priorities serve as a focal point for the organization through regular huddles as well as team and personal goal setting.

Identification of Quality Improvement Plan (QIP) priorities for 2016/17 was informed by the following *principles*:

- Identify improvement opportunities from the incident reporting system, patient compliments/complaints, and any learning from morbidity and mortality reviews.
- Create focus on a select number of indicators year over year in order to drive, sustain and scale improvement as part of a continuing quality and safety journey.
- Incorporate identified risk factors from the Health Insurance Reciprocal of Canada (HIROC) Risk Assessment Checklist process.
- Implement quality and safety best practices aligned with Accreditation Canada standards.
- Exclude Health Quality Ontario (HQO) priority indicators if:
  - the indicators are captured as part of the NHS’ Hospital Services Agreement Accountability or other Local Health Integration Network/provincial agreements (e.g., Alternate Level of Care days) or form part of program-specific quality and safety scorecards (e.g., Surgical Safety Checklist);
  - where the NHS is performing better than target.

For 2016/17, the NHS continues to commit to the following areas of improvement:

Organizational Goals & Priorities	HQO Quality Dimension	2016/2017 Goal
Quality & Safety	Safe	We will improve the safety of care we provide by increasing the proportion of patients who have their <b>medications reconciled*</b> on admission from 12.6% to 43.4%, at 90% compliance.
		We will improve the safety of care we provide by reducing the <b>hospital acquired C. Difficile infection*</b> rate by 10%.
		We will reduce the number of <b>harmful falls</b> for our acute inpatients by 5%.
		We will reduce the number of <b>falls</b> for our Complex Care patients from 12.1% to 10%.
Access & Flow	Timely	We will improve timely access to our services by <b>reducing emergency department wait times*</b> for admitted patients from 41.0 hours to 28 hours.

\*HQO priority indicators

**Patient Experience.** Improving patient satisfaction and experience is an important priority for the NHS. For 2016/17, we will focus on obtaining real-time patient satisfaction information that will assist in making timely improvements. This indicator will *not* be included in the QIP as we will be confirming our approach and collecting new baseline data for the year.

**Reducing Readmissions – Congestive Heart Failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD).** In April 2016, the NHS will begin participating in the Integrated Comprehensive Care (ICC) Program, with a focus on hospitalized patients with a diagnosis of COPD and CHF who are discharged home and require home support. The ICC program is focused on testing innovative approaches to integrate funding for CHF and COPD patients over their episode of care while improving continuity of care and reducing readmissions through a bundled funding model. This indicator is *not* included in the QIP but will be monitored through the Hamilton Niagara Haldimand Brant Local Health Integration Network (HNHB LHIN) ICC project.

## QI Achievements From the Past Year

Key quality and safety achievements from the past year include:

- **Accreditation Canada Award.** Aligned with our organizational commitment to quality and safety, the Niagara Health System was recently Accredited with Exemplary Standing.
- **Launch of the Critical Care Response Team (CCRT).** Critical Care Response Teams (CCRTs) have shown to increase patient safety and prevent death by identifying vulnerable and sometimes declining patients in the hospital who, without intervention, could end up in the Intensive Care Unit (ICU). To directly support patient safety and quality improvement, the (CCRT) was launched at the St. Catharines Site, available 24 hours a day, seven days a week.

- **Huddle boards - Improving the effectiveness of communication to improve quality and safety.** Implementation of focused huddles on all NHS units and departments is one way that we have focused our efforts to improve the effectiveness of communication among caregivers/team members. Huddles are a communication method that enable teams to conduct frequent but short briefings so that all team members can stay informed, review, plan and move ahead within a rapid quality improvement framework. As an example, a daily review of the number of patient falls by unit and opportunities to reduce or eliminate falls has been a focus of the huddle boards.
- **Focus on Improving Patient Flow.** Achieving our organizational goal of 28 hours for the Emergency Department (ED) Length of Stay requires a collaborative team-based approach. To support improved patient flow, quality improvement strategies include:

- **Daily Management of Flow.** Daily huddles, bullet rounds and twice daily patient flow meetings occur at all sites in addition to weekly system-level rhythm rounds that facilitate rapid identification and resolution of patient flow issues.

- **Partnering to Reduce the Number of Alternate Level of Care (ALC) Patients.** Reducing the number of patients waiting in hospital for another level of care helps build capacity on our inpatient units to improve patient flow. Working with our colleagues at Community Care Access Centre (CCAC) as well as community partners (e.g., long-term care and retirement homes), we have made progress with reducing the average number of ALC patients per day. This has been achieved by the implementation of daily “ALC Rapid Rounds” and focused sustainability on the Home First Strategy which includes the interdisciplinary team preparing patients for discharge and support during care transitions.

- **Managing Expectations and Increasing Transparency in ED Wait Times.** Current ED and Urgent Care Centres (UCC) wait times are now available on NHS’s website as part of our ongoing efforts to improve the patient experience and access to care. Four key pieces of information are now available 24/7 to the public:

- wait times to see a physician or nurse practitioner in our EDs and UCCs;
- the number of people currently registered and waiting;
- the number of people currently being treated;
- when the ED/UCC is busiest over the next six hours based on the previous 30 days.

Monitors in the ED and UCC waiting rooms display site specific wait times, while the NHS website includes wait times information for all of our ED and UCC.

- **Patient story boards “My Space”.** As part of our commitment to patient safety and experience, “My Space” boards are now displayed in every patient room across all of our sites. The My Space boards identify who is involved in a patient’s care, describe important actions that healthcare providers take to keep our patients and families safe, and include a space for patients and families to share what’s important to them regarding their goals for care.

- **We Check ID Campaign.** The We Check ID initiative is an important quality improvement and awareness campaign that reinforces the importance of proper patient identification, critical for safe care. As part of this campaign, a number of educational resources were developed which included a One-page tip sheet, a video (We Check ID. Every patient. Two times. Every time.), poster and Audit tool.
- **Ethics Framework.** A renewed Ethics framework was developed by a group of NHS staff and provides a step-by step process to help guide any member of the NHS team in working through ethical issues. The framework is based on the SBAR communication model and follows a predictable pattern: **S**ituation, **B**ackground, **A**ssessment, **R**ecommendation.
- **Safety Council.** In 2015, the Safety Council was launched, with the aim to bring together in a single forum all safety sensitive portfolios within the NHS in order to establish strategic alignment of the safety & quality initiatives across the organization.
- **Engagement in Quality and Safety: “Route NHS” and “Bridge to Extraordinary”.** The “Route NHS” roadmap was created to highlight quality and safety across the NHS, engage frontline staff in preparation for Accreditation as well as recognize milestones as we work towards our organizational goals. Teams across the organization travelled the Route, reviewing themed Accreditation Canada Required Organizational Practices each month and pausing for monthly organizational check-points along the six-month journey. Route NHS has proven to be transformational in terms of staff and leadership engagement and accountability, knowledge transfer, innovation, communications and readiness regarding NHS’s accreditation.

The “Bridge to Extraordinary” has been developed to serve as a bridge between Route NHS and the launch of our new strategic plan in June 2016. Bridge to Extraordinary builds on the Route NHS communications initiative, using visual cues, gamification and two-way symmetrical dialogue at all levels focused on how all staff and physicians contribute to achieving our quality and safety goals aligned with the QIP.

- **Medication Reconciliation.** The NHS is committed to achieving full medication reconciliation (MedRec) at all transitions of care across all programs by June 2018. There has been a significant financial investment for a lead Medication Reconciliation pharmacist and associated supports (e.g., Pharmacy Technicians). An interdisciplinary MedRec Steering Committee has been key in providing leadership and to facilitate the development, implementation, monitoring and evaluation of the MedRec process to ensure patient safety and quality patient care. A key learning from the Mental Health program’s full implementation of MedRec has been the identification of a MedRec program champion who was a key resource in supporting education and monitoring compliance through quality audits as part of the roll-out.
- **Unit Based Teams (UBT).** Unit-based quality teams have been introduced to allow protected time for interdisciplinary members to work on quality improvement ideas and enhance sustainability of quality and safety improvement activities at the unit level, fostering front-line ownership.

- **Crucial Conversations and Crucial Accountability Training.** Training is underway for Leaders and some staff on *Crucial Conversations* and *Crucial Accountability* that will provide added tools/skills to engage in high risk conversations which may improve safety.
- **External Reviews.** A number of program-level external reviews have taken place to identify quality and safety improvement opportunities.

## Integration & Continuity of Care

The NHS continues to promote the development of collaborative partnerships. Examples include:

**Winter Planning.** As part of our “Know your Options” campaign, a Niagara Region Winter Planning Command Centre was mobilized to ensure access to care. Teleconferences are held twice a week with all of our partners including Niagara Emergency Medical Services (NEMS), Niagara Region, Long-Term Care facilities, Community Care Access Centre (CCAC) and the Local Health Integration Network (LHIN). The Command Centre provides a framework to identify the critical pressure points, identify staffing issues that will affect daily operations and take action to help reduce the flow challenges. A significant amount of planning and preparation took place prior to the holidays to support the increased demands and pressures on patient flow throughout the holiday season.

**Partnering to Reduce the Number of Alternate Level of Care (ALC) Patients.** As outlined above, the NHS continues to collaborate with CCAC and other community partners to focus on improving care transitions and reducing the average number of ALC patients per day.

**Health Links.** The NHS is working with its partners both internally and externally using a quality improvement approach to foster real-time identification of Health Links patients to facilitate more timely access to coordinated care plans and community supports.

**I-EQUIP (Interprofessional Education for Quality Improvement Program).** The NHS continues to leverage its academic partnerships with a focus on quality improvement, working collaboratively with McMaster University's Michael G. DeGroote School of Medicine - Niagara Regional Campus and Brock University. I-EQUIP is a collaborative educational and applied experience in quality improvement, change, and leadership working within an interprofessional model with medical students, undergraduate health science students and NHS staff and physicians.

## Engagement of Leadership, Clinicians and Staff

The NHS has hosted twenty-nine *visioning day* engagement sessions in the past year, with a combination of in-person and on-line opportunities for staff, physicians, volunteers, community/academic partners and the public. Feedback from those engagement sessions have informed and reinforced the areas of focus for the QIP, particularly related to access to safe and timely care.

## Patient/Resident/Client Engagement

The NHS' Community Advisory Committee (CAC) provided valuable input on key QIP initiatives, including:

- patient experience,
- medication reconciliation, specifically strategies to increase patients/families presenting to hospital with a best possible medication history,
- opportunities to increase patient/family hand hygiene compliance.

In addition, a number of NHS's clinical programs are engaging patients and their families by developing opportunities for experience-based co-design, aimed at improving the patient experience.

## Performance Based Compensation [part of Accountability Management]

The NHS's Executive Compensation Program provides for base salary, performance-based (pay at risk) and a pension/benefits package. The Performance-Based Compensation Plan is designed to align executive compensation with objectives in the Hospital's QIP. The Plan does not provide for a bonus on top of base salary, but it is an amount clawed back from an executive's base salary, and may be re-earned every year if the NHS and the executive achieve targets set out in the Hospital's QIP, as well as group/program and individual measures. At the beginning of each fiscal year, the Board approves the key measures and targets to be achieved as part of the Plan, and results are evaluated at the end of the fiscal year.

The amount of compensation clawed back is based on the following:

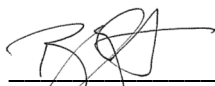
- President: 7.5% of base salary
- Chief of Staff/EVP Medical: 10% of base salary
- Executive Vice President: 5% of base salary
- Vice President; Physician Chiefs: 3% of base salary.

The structure of the Performance-Based Compensation Plan consists of three (3) elements:

1. Attainment of QIP Core Priority Objectives: 60% weighting
2. Attainment of Group/Program Objectives: 30% weighting
3. Attainment of Individual-specific Objectives: 10% weighting

## Sign-off

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



Barry Wright  
Board Chair



Bunny Alexander  
Quality Committee Chair



Suzanne Johnston  
President