Let's Make Healthy Change Happen.

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

Tillsonburg District Memorial Hospital
Partnering to keep healthcare close to home.

2/15/2023

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

Tillsonburg District Memorial Hospital (TDMH) is an accredited 45-bed hospital serving a tri-county community since 1925 with a population catchment area of 45,000. We are committed to supporting the health of our communities with excellent patient care and accessible specialized services close to home. Our services include 24/7 Emergency Department, Acute Care, Complex Continuing Care, Surgical and Orthopaedic Program, Diagnostic Services, Occupational and Physiotherapy Services, Ambulatory Clinics as well as Satellite Dialysis Services. We take great pride in providing the very best care to the communities we serve and promoting health and wellness through collaboration with our health care partners.

We are most proud of the very positive feedback received from our patients and their families during our recent Accreditation Canada survey held in January 2023 at our hospital. We look forward to continuously improving in the care we can provide our patients and the support we can offer our team members in partnership with the Alexandra Hospital, Ingersoll (AHI) and other care providers within Oxford County and the Southwest Ontario region.

Patient/client/resident engagement and partnering

Engagement and feedback from patients and families is critical to the success of quality improvement work. Our goal is to strengthen our patient and family experience surveys, response rates and restructure the process in which surveys are completed. We are also working on ensuring there are tangible action plans based on the results of the surveys.

We will be adding the priority indicator to our F22-23 Quality Improvement Plan (QIP) that asks our patients specifically "*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?".* In using this question, we hope to gain more insight into how well our teams are providing enough information to our patients at discharge.

We have a dedicated Patient and Family Centered Care Committee (PFCCC) and continue to actively recruit new Patient Advisors. Each advisor brings a valuable patient and family perspective to the hospital. Our advisors are active members participating at a number of committees including our Joint Board Quality, Risk and Patient Safety Committee, as well as the Ethics Committee. Our goal is to add patient advisor membership to additional committees where advisors currently do not attend.

An example of work Patient Advisors were recently engaged in was a review of signage and wayfinding within the hospital. There are ongoing efforts to standardize and simplify signage for ease of patient navigation, as well as ensure inclusive language. Three patient advisors recently participated in an onsite review, coming onsite multiple times to complete a walkthrough with leadership. Recommendations were received from the patient advisors and taken into consideration. These recommendations were quickly put into action and advisors are being re-engaged and invited for another walkthrough to review the work completed and determine where additional opportunities lie. This work is part of our efforts to ensure spaces

are easy to find, welcoming and include information patients and families need and can access easily. This is part of our commitment to providing patient-centered care and spaces.

Our PFCCC have also recently revised our PFCCC application and interview tool, taking into account feedback from our recent Accreditation Canada survey and the patient surveyor. This application and tool have been co-designed by patient advisors and administrative leadership.

Our PFCCC will also be reviewing our Patient Satisfaction Survey in Q1 of 2023 and co-designing a new patient satisfaction survey tool with our administration leadership, and also exploring new ways of administering the survey with more involvement of patient advisors as part of that process.

Provider experience

Our Wellness Committee began meeting again this past Fall, with members across TDMH and AHI. This committee has hosted several events over the past months focusing on staff wellness. They kicked off their refreshed approach to wellness with an activity in October called “Walk-tober” where small groups of 4-5 staff/leaders encouraged walking/tracking of steps. Steps were tallied and highest achievers won prizes throughout the month. In November, staff and leaders were encouraged to send Kudos messages to others; with this they were entered into draws for prizes. In December, a dedicated wellness space was created within the hospital; with a “grand opening” event. In January, roaming stretch breaks were provided throughout the hospital. Looking forward, the Wellness Committee is focusing on Heart and Stroke for the month of February with highlights of events posted on the internet (called the HUB). In March, there will be a focus on employee appreciation featuring employee profiles as well as promoting use of wellness rooms with reading material/podcasts available.

To support our health care providers in their preparations for our 2023 Accreditation Canada survey, our Accreditation leads regularly attended the Medical Advisory Committee in the lead up to the survey. During these meetings we would review resources available for physicians, preparation for priority process sessions they were invited to attend, and also share recent communication and education materials such as our Required Organizational Practice (ROP) of the Week Communication, and relevant ROPs and standards that physicians would have accountability for, or participate in.

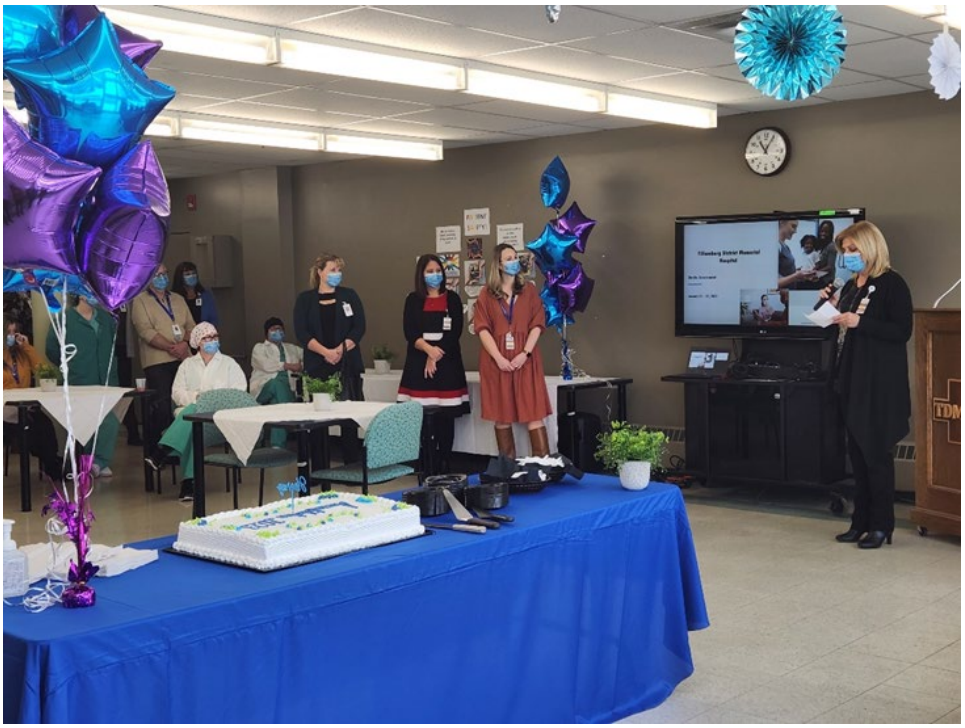
Our organization also provided support to leaders for their own Accreditation preparation. We piloted a new system, OnboardQi, created by Accreditation Canada allowing leaders to review Accreditation Standards and rate their compliance and find opportunities for improvements. Using those opportunities, we created action plans for leaders and assigned tasks to meet the criteria.

To support leaders with this work, our Accreditation leads held “health checks” with each leader monthly, or more frequently, to support their progress and provide dedicated and

focused time for questions. Leaders in turn provided staff with an opportunity to become Accreditation champions and participate in the action plan work, as well as run ROP tracers within their department to help educate peers. These tracers helped to obtain a snapshot of ROP competencies across the organization and allow more focused work on ROP compliance before the survey.

To highlight the achievements of each department, each leader was asked to complete a standardized “one-pager” which our accreditation leads had developed for leaders and staff to encourage a quality improvement mindset. The one-pager provided a brief overview of the unit or program, along with highlights and achievements such as quality improvements, new services or new equipment.

TDMH received the results of our recent Accreditation Survey in late February, and we have been awarded “Accreditation with Commendation”. This is a great achievement for our hospital, indicating that we have surpassed the requirements of the accrediting program. We have been proudly sharing this final award decision with our teams and partners. Over the next several months, we will use the final Accreditation report to guide our focus our improvement efforts on key areas related to the Required Organizational Practices (ROPs).



Staff, physicians, volunteers, and Joint Board Members, attend the 2023 Accreditation Survey Debrief Celebration and listen to remarks from the Joint Board Co-Chair

Workplace Violence Prevention

Workplace Violence Prevention is a priority within our organization, no staff or patient should ever feel unsafe within our walls.

We report on Workplace Violence indicators in our Human Resources: Quarterly Workforce Report and include two Violent Incidents measures, incidents of patient to staff violence, and incidents of patient-to-patient violence. Incident data is shared at our Joint Health and Safety Committee monthly. We are in the midst of creating a work plan to increase reporting by having workplace violence reporting as a Quality Improvement Plan metric for F22-23. Also, we are working on how best to have staff report any staff-to-staff incidents.

The Workplace Violence and Harassment Prevention policy was updated and shared with staff in December 2022. Additionally, a Workplace Violence and Harassment Module was recently launched in our new Talent Learning Management System which all staff must complete.

Recently, Workplace Violence Prevention (WVP) was highlighted in preparation for our 2023 Accreditation Survey and featured as an 'ROP of the Week'. We provided ongoing education with email and intranet communications about what the ROP is, what the tests for compliance are, and how TDMH complies, along with links for staff to explore the policy, learning module, and reporting. Another education activity was an interactive booth focused on awareness of Workplace Violence Prevention efforts held at TDMH in the Fall of 2022. Our Accreditation leads ran the booth and discussed the ROP with staff including how to report a violent incident using our incident reporting system. Materials were provided to staff for review.

A guide to using our Incident Management Reporting System, RL6, was provided to staff, as well as a reminder about our Employee and Family Assistance Program (EFAP). There were also chances for staff to engage in interactive games, designed to increase awareness and reporting.

Workplace Violence Prevention Awareness booth during 2023 Accreditation Survey preparation

Recently, daily communications were shared with all staff to increase awareness of our hospital Emergency Codes. All staff complete mandatory learning on Emergency Codes and this effort was to refresh learning and increase familiarity with recommended actions during a Code. These communications focused on quick bites of information if you are involved in, or near a Code, and included Code Silver, Code White and Code Red.

Patient Safety

We have a policy and procedure that guides our patient safety incident process. Depending on the level of the incident, various leaders are notified, e.g., Level 4 or 5 are reported to Chief Executive Officer and Chief Nursing Executive. The policy names the responsibility of all staff, physicians and leaders to report incidents. Our hospitals currently use a system called RL6 for patient safety incident reporting. Staff or leaders will enter a report, which triggers an email to the most responsible leader. The leader then launches an investigation and documents outcomes in the RL6 file. The loop is closed by reporting back to the staff member that reported the incident. Where applicable, disclosure happens with the patient and/or family as per policy. Trends of these reports are added to our quarterly report to the Quality, Risk and Patient Safety subcommittee of the Joint Board. We are working towards reporting these trends at unit-based councils and sharing lessons learned across the organization at Team Forums.

Patient Safety continues to be a critical priority at TDMH. We recently filled new positions with a focus on patient safety at the coordinator and manager levels.

Our organization conducts monthly Leadership Safety Walkabouts. Walkabouts provide an opportunity for members of the leadership team and Board members to purposely connect with front-line staff to listen to and to understand their concerns about safety; identify underlying risk; and, to prevent future harm. They are designed to be informal, and walkabouts are limited to approximately fifteen minutes to help minimize disruption to the department. There are two standardized questions during the walkabout, “Are there any safety issues/concerns that we need to be aware of that effect staff and/or patients?” and “If you had a magic wand, what would you change?” The department's leader summarizes the discussion and shares team member responses and possible resolutions identified during the conversation with the team.

We also share Patient Stories at our Joint Board Quality, Risk and Patient Safety Committee and PFCCC meetings. Follow-up actions of Patient Story are featured.

Our Patient Safety efforts were highlighted before our 2023 Accreditation Survey. We ran a week-long campaign, highlighting Patient Safety through communications internally and in-person events like booths, games and prizes. Patient Safety Education and Training is another ROP we highlighted in October 2022, and featured as an “ROP of the Week” with accompanying communications via email and on our intranet to all staff. Staff participated by providing examples of their departmental contributions to patient safety. These messages were

shared with staff in emails, accompanied by pictures of staff showcasing safety in their roles. These photos feature examples and photos of our commitment to patient safety and are displayed in our TDMH cafeteria for patients and families to also view.

A Patient Safety feature wall in the TDMH cafeteria featuring staff and quotes about how they participate in our safety culture

We will be adding discharge medication reconciliation to our Quality Improvement Plan for F23-24 demonstrating our commitment to improve our compliance with this important patient safety metric. We have created a robust action plan to improve our data quality, educate our health care providers about the importance of medication reconciliation, roles and responsibilities of team members, and accountability to performance. We plan to continue to share the results and progress of this quality improvement work at our Joint Board Quality, Risk and Patient Safety Committee meetings through quarterly reporting.

Health equity

In January 2023, we presented a new learning module to the Patient and Family Centered Care Committee (PFCCC), the Joint Board Quality, Risk and Patient Safety Committee, and the Joint Board. After their review, our organization launched a Cultural Sensitivity Training learning module, focused upon the principles of health equity, cultural competency, diversity, and inclusion. It also highlights the culturally diverse populations within Oxford County, and ways to engage and provide culturally sensitive care to them. The module also references our related policies which include Interpretation and Translation Service and Harassment, Bullying and Discrimination.

The learning module also contains resources to learn more about the populations we serve in a variety of mediums including videos, podcasts and books. The learning module is required for all leaders, and is currently optional for staff, but as we review our broader Health Equity and Inclusion Strategy, that may change.

Leaders will also be participating in a mandatory course on Unconscious Bias & Micro-Aggressions Workshop in April 2023. This course is offered through Homewood Health, our

the impacts they can have on individuals and the workplace, and the benefits of addressing unconscious bias and reducing microaggressions to help create a more inclusive, collaborative and productive workplace. Attendees will also increase their awareness of their own unconscious bias, an important first step to address. Leaders will gain strategies to address unconscious bias and reduce microaggressions in themselves and in the workplace.

As part of our review of our Patient Satisfaction Survey, we intend to explore adding a question that addresses patient experience with culturally safe care.

Executive Compensation

Our executive team compensation is linked to the performance of the quality improvement plan metrics. The Chief Executive Officer has 5% applied as pay for performance, whereas the Chief Nursing Executive/VP Clinical Services, Chief Transformational Officer/VP Human Resources, Chief Operating Officer/VP Finance and Chief of Staff have 2% applied as pay for performance.

Contact Information

For more information about our hospital's quality journey, please contact:
Nadia Facca
CEO/President AHI & TDMH
Nadia.facca@tdmh.on.ca

Other

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 _____ (signature)

Board Quality Committee Chair _____ (signature)

Chief Executive Officer _____ (signature)

Other leadership as appropriate _____ (signature)