

Quality Improvement Plan (QIP)

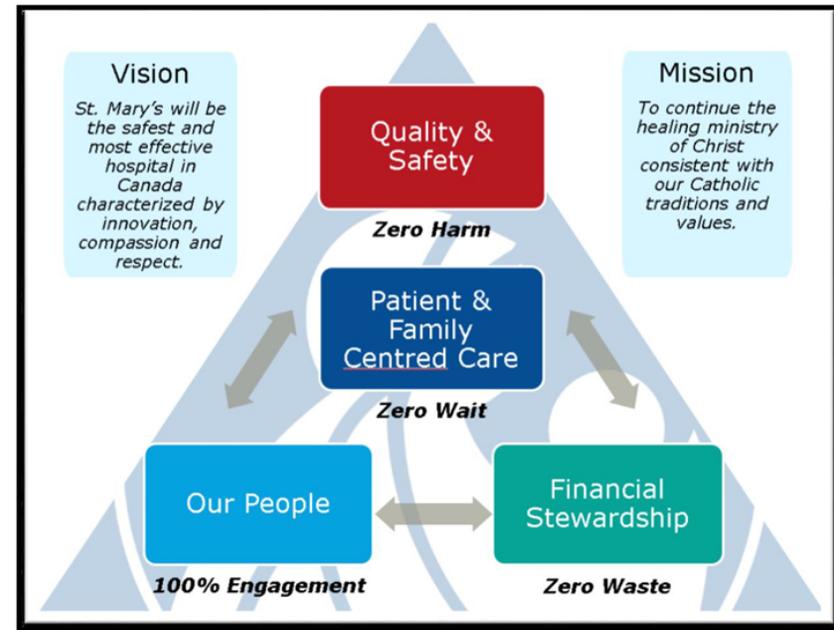
Narrative for Health Care Organizations in Ontario

August 26, 2020

OVERVIEW

The vision for St. Mary's General Hospital (SMGH) is "to be the safest and most effective Hospital in Canada characterized by innovation, compassion and respect." To achieve our vision, we are committed to developing a "culture of problem solvers" through our LEAN Management System to drive quality within the organization. Our four True North Pillars of Quality & Safety, Patient and Family Centered Care, our People and Financial Stewardship ensure that we stay focused on our goals of Zero Harm, Zero Wait, 100% Engagement of our People and Zero Waste. "Our staff have 2 jobs – the first is to do their job to the best of their abilities, the second is to figure out how to do it better" J. Toussant.

Our Quality Framework, Quality Improvement Plan and our Hospital's 2019-20 True North goals and initiatives drive quality through work plans that incorporate a detailed root cause analysis, top contributors and counter measures, aligned with our True North Goals. Through our LMS, front line staff huddle and report out regularly on our outcome, process and balance metrics. This year we have also been experimenting with a "Leadership Dashboard", which further supports our quality infrastructure which includes the cascading of the current status of our progress on achieving our metrics, departmental quality reports which include a patient and family experience story; corporate quality & risk reports; accreditation compliance reports; patient engagement & satisfaction metrics; and quality of care review outcomes.



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

Once again, SMGH has been recognized as one of the safest hospitals in Canada, achieving the eighth best score for Hospital Standardized Mortality Ratio (HSMR), a key indicator of hospital safety. This achievement was recognized with the November 2017 release by the Canadian Institute for Health Information (CIHI) of performance indicators for 2017-18. HSMR measures expected deaths versus actual deaths in acute care hospitals, with a ratio lower than 100 indicating fewer than expected deaths. St. Mary's score was 74, compared to a national average of 89. This excellent result confirms the commitment by staff, physicians and volunteers to St. Mary's vision to be the safest and most effective hospital in Canada.

St. Mary's General Hospital, in partnership with the Waterloo Wellington Local Health Integration Network (WWLHIN), has developed a Waterloo Wellington Regional Cardiac Strategic Plan for 2018-2022 to meet the growing needs for cardiac care in Waterloo Wellington. Among the objectives in the plan, which was endorsed by WWLHIN board, is expanding services within SMGH Regional Cardiac Care Centre, and into the wider community so Waterloo Wellington residents have more equitable access to highly specialized cardiac care. Five working groups (Cardiovascular prevention & Rehabilitation, Congestive Heart Failure, Cardio Diagnostics and testing, Cardiology Services and Patient Education) and 2 advisory groups (Patient Engagement and Digital Health) have been formed to implement the various initiatives in the strategic plan.

The past few years have proven challenging for the Diagnostic Imaging Department in trying to reduce wait times for patients awaiting CT procedures. By offering evening hours, the CT team has been able to successfully reduce wait times to well below the provincial average. Additionally, priority 4 cases (elective outpatient) have been below the 28 day target since August 2018 due to a change in booking contrast and non-contrast patients.

A new service to in-patient departments, the Nurse Led Critical Care Response Team (CCRT) was launched in December 2018. The vision of this team is to bring critical care services beyond the walls of ICU to improve patient outcomes and provide early identification/intervention to patients who may require critical care services. A CCRT nurse follows all MSICU patients 48 hours post-discharge from ICU to lower level acuity beds to ensure continuity of care during the transition to the floor. A CCRT nurse also

responds to calls from staff in in-patient areas when they are concerned about a patient. They respond and assess the patient, working from medical directives, to help improve patient outcomes. The patient may be medically managed by our nurse on the floor in collaboration with their MRP/Intensivist or may require an admission to ICU. Since implementation on Dec 1st, 2018 the hospital has seen a reduction in Code Blues calls in in-patient areas. In addition, the team has been able to help prevent ICU admissions by providing the care the patient required early. An example of this is providing temporary Bi-level positive airway pressure (BiPAP) in addition to administering medications to help improve the patients breathing.

Our Enhanced Recovery After Surgery Video Assisted Thoroscopic Surgery (ERAS VATS) program has been successful. The length of stay data suggests the gains from the launch continue to be improved over the last two years. Primarily next day discharge and some same day discharges continue to occur. Patients are heavily supported by ICC after discharge. If assessments are required by the thoracic surgery team, these are done as outpatient visits in the airway clinic not ER visits or re-admissions.

PATIENT/CLIENT/RESIDENT PARTNERING AND RELATIONS

At SMGH, patients and families are invited to be active contributors to our lean-guided culture of problem-solvers by participating in Accreditation and quality improvement opportunities, enabled by our Lean Management System (LMS). To encourage their participation, SMGH priorities for fiscal year 2018-19 included the engagement of patients and families in generating improvement ideas. Through our Patient and Family Advisory Committee (PFAC),

and utilizing our LMS we move suggestions and ideas from patients and families for evaluation and possible implementation.

Not only does our PFAC have input and evaluation of our hospital priorities and the development of our QIP, but in the fall of 2018 SMGH had a "Lobby Day" to create awareness of our QIP and request suggestions for improvement and change ideas for our QIP. This allowed us to reach a broader range of patients and community members in the development of our QIP. We will continue to seek out opportunities to engage patients and families in the improvement of quality of our service delivery.

SMGH Patient Experience and our PFAC took part in the WWLHIN wide forum which brought together many different healthcare organizations to provide input in revising the regional Patient Declaration of Values. Members of SMGH Patient Experience and PFAC participated in the discussion and approval of a new WWLHIN adopted declaration.

SMGH Patient feedback including complaints and compliments are received by the Patient Experience Office through many mediums, including paper based surveys; web-based surveys; patient rounding/bedside surveying; and care teams. We continue to meet our target of responding to all complaints within 48 hours and resolving within 5 days. Patient/family feedback is reported regularly to the Board Quality Committee. In addition, the Quality and Operations Committees continue to monitor feedback collected through the Patient Experience Office. The Senior Leadership Team also rounds with patients, monthly and collects patient and family improvement ideas, forwards to the appropriate area for review and is monitoring responses.

WORKPLACE VIOLENCE PREVENTION

Workplace violence prevention continues to be a priority for SMGH.

We are committed to a culture of safety. Last fiscal year we established a goal to reduce the number of incidents causing injury by 10% and increase the number of reported incidents by 10%. As this fiscal year is coming to an end, we are realizing success in initiatives implemented.

A Workplace Violence Prevention Task Force has been in place at SMGH since 2008. The Workplace Violence Prevention Task Force is a sub-committee of the Joint Occupational Health & Safety Committee. The team's work is guided by a Strategic A3 which has recently been updated to include new countermeasures including standardization of flagging across the hospital and initiation of safety talks on de-escalation techniques. Patients and families will also be engaged in behavior plans that identify triggers to provide support for patients with known aggressive behavior.

These key indicators are on our Corporate Scorecard and QIP, which are reported to our Board of Trustees. In FY17/18, staff reported 38 incidents, 20 of which resulted in staff injury. Since April of 2018 (FY18/19) there has been 42 reported violent/aggressive incident, 15 of which resulted in staff injury. In September of 2018, 2 new categories which may lead to Workplace Violence were added to our incident reporting system, Disrespectful Behaviour and Harassment/Bullying which are measured to prevent these types of incidents from escalating.

In 2019-20, "Ensuring a safe, healthy and respectful workplace" will be taking center stage, by establishing this as one of our four True

North Priorities. One of the initiatives that will be implemented to achieve this goal will be to investigate, respond and close all disrespectful behavior complaints reported through our incident management reporting system, within 10 days. Supporting a respectful workplace, free from incivility, will mitigate the risk of behavioral violence escalating to bullying and harassment and ensure the continued engagement of our people. We will also be focused on reducing the number of incidents that impact staff including a reduction in Blood and Body Fluid (BBF) incidents, Muscularskeletal Disorder (MSD) injuries, mental health short term and long term disability claims and the reduction of employees who resign within one year.

EXECUTIVE COMPENSATION

The Quality Committee of the Board has recommended that the following key performance indicators of quality are tied to the Senior Leadership Team's executive pay for performance component of total compensation.

- Quality and Safety – evidence of A3 and actions taken to address patient safety needs, with regular reports to the Board;
- Patient and Family Centred Care – evidence of A3 and actions being taken to address patient flow and access to care requirements, with regular reports to the Board; and
- Our People – evidence of A3 and actions taken to improve engagement by addressing total incidents that impact staff, with regular reports to the Board.

It is noteworthy that at SMGH Executive Compensation does not include a pay for performance "bonus". Instead, a portion of their base salary (5% President & Chief of Staff & 3% for Vice Presidents) is "at risk" and clawed back if the expectations set by the board are not met.

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 **March 29, 2019**

Tom Motz, Board Chair

Marion Thomson Howell, Board Quality Committee Chair

Andrew Falconer, Chief Executive Officer

Other leadership as appropriate
