Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

April 20, 2023

Ontario Health

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 2023-2024 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 result 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 Health Care Now, Canadian Patient Safety Institute, and Health Quality Ontario.

For the 2023-24 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. Home and Community Care Support Services' Annual Business Plan
4. Health System Funding Reform (HSFR)
5. Hospital Service Accountability Agreement (H-SAA)
6. Health Quality Ontario's (HQO) Strategic Plan
7. Public Reporting of Hospital Performance
8. Accreditation Canada's Required Organizational Practices (ROPs)
9. Safer Health Care Now and the Canadian Patient Safety Institute
10. 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 MOH, Home and Community Care Support Services, the Northwestern Health Unit, the Sunset Country Family Health Team, Kenora District Services Board, Pinecrest District Home for the Aged and Wiigwas Elder and Senior Care, the Ontario Provincial Police, Treaty #3 Police Services, Ambulance Services, Kenora Chiefs Advisory, Firefly, CMHA Kenora, KACL, 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. Wait times in days for CT scans, scopes, total knee replacements, hip replacements and cataracts.
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 staff who have completed the cultural awareness program.
9. Number of complaints received which relate to diversity, equity, and inclusion.

PATIENT/CLIENT/RESIDENT ENGAGEMENT AND PARTNERING

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 Patient Relations process, annual Patient Experience Surveys, feedback obtained from the post discharge follow-up questionnaire, and the review of reported adverse incidents and complaints. We always encourage open and honest communication with patients and their families. 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 Indigenous patients in problem solving and navigating the discharge process. This is another source of feedback from our Indigenous patients.

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.

PROVIDER EXPERIENCE

Lake of the Woods District Hospital recognizes the increased pressures on staff and healthcare providers within our organization and the resulting impacts on burnout as with the increased pressures in health care. In an effort to help support staff through the current challenges in health care, reduce staff burnout, and enhance quality of care, LWDH has and continues to strive for a collaborative approach to address staffing shortages and provide resources to staff to support their wellbeing.

LWDH offers many staff wellness initiatives offered through the organization's active Wellness Committee & Sunshine Club. These committees plan regular activities and provide resources for staff to help promote all facets of wellness. Additionally, the organization has an on-site staff physiotherapist that is dedicated to staff wellness, ergonomics, and rehabilitation. The organization offers EAP assistance to all staff as well as free access to local mental health services.

It is important to us to recognize the hard work of our staff and show gratitude. LWDH offers service recognition awards to celebrate and appreciate staff for their years of service and hard work. We have endeavored to express our thanks and support of staff during this challenging time by offering additional supports for staff such as free parking and accommodating work-from-home arrangements when possible, to assist with child care needs.

We recognize that the needs of our staff may change in congruence

to the demands on the healthcare system and workload. It is important to us to hear from staff regularly to tailor initiatives to their needs. LWDH utilizes the Worklife Pulse Tool to better understand our teams' overall experience working in our hospital. The Worklife Pulse Tool is currently completed by staff every four years as part of the Accreditation Canada survey, however we have identified a need to utilize this tool on annual basis to ensure staff have more frequent opportunities to identify areas of improvement to support work-life balance.

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 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;
4. Patients are routinely screened for violence and delirium on admission and protocols are developed to address levels of risk;
5. Enhanced lighting in the parking lot with LED lighting;
6. Use of surveillance cameras in strategic locations within the building;
7. 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;
8. Code White drills are reviewed on an annual basis;
9. Pinel restraints and a humane restraint chair have been purchased. Staff are now trained on their use.
10. Vocera Smartbadge devices, equipped with a panic button, are carried by staff who work in the hospital;
11. Screamers are carried by staff who work at the Morningstar Detox Centre;
12. All departments have developed, and update annually, a safety plan for their department;
13. The hospital is staffed with security 24/7, with an additional security guard stationed in the Emergency Department from 19:00 to 07:00;
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. The Morningstar Detox Centre has a security on site Monday - Friday from 19:00 - 07:00 and 24 hours on weekends.
18. Funds have been secured to renovate the Emergency Room and create a 'safe room' for patients at risk of harm to themselves or others.
19. 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 Quality and Risk Specialist reports safety and security data to the Hospital Board on a quarterly basis.

PATIENT SAFETY

At LWDH, patient safety is paramount. We strive to not only prevent risk of harm and harm to patients, but also to continuously learn from patient safety incidents in order to improve the quality of care we provide. To support this commitment, we have established robust systems and processes to identify, report, and analyze patient safety incidents.

When an incident occurs, it is immediately reported to the Quality and Risk program through the RL Incident Reporting System. A thorough investigation to determine the root cause and contributing factors is conducted by the manager of the department, with assistance from Quality and Risk when necessary. All follow-up is documented in the system, as well as the resolution.

When a significant incident or near miss occurs, information is then shared with applicable staff and leadership to identify opportunities for improvement and implement corrective actions. For example, through the Medical Quality Assurance Committee, QCIPA Review, etc. LWDH utilizes Grand Rounds to help educate hospital and professional staff on patient safety items identified during incident investigations. Grand Rounds are held almost weekly at our organization and all staff are invited to attend. We also share important patient safety information through our internal staff newsletter.

All reported complaints are reviewed on a quarterly basis by the LWDH Quality, Patient Safety, and Risk Management Committee of the Board to help identify trends and areas for improvement. This committee also receives data around incident reporting including number of incidents reported, type of incidents reported, and severity levels. This committee has representation from the community, the Patient and Family Advisory Committee, and the Board of Directors to ensure knowledge and information sharing.

Beyond the investigation of individual incidents, we also conduct regular safety audits and engage in ongoing staff education and training to promote a culture of safety throughout the hospital. Our goal is to create and environment where everyone is empowered to speak up about potential safety concerns and actively participate in the continuous improvement of our patient care process.

HEALTH EQUITY

At Lake of the Woods District Hospital, we are committed to promoting diversity, equity, and inclusion (DEI) in all aspects of our organization to cultivate an environment where everyone feels accepted, valued, and respected. We recognize that individuals from diverse backgrounds face unique challenges when it comes to their healthcare, and we strive to reduce the disparities of health outcomes, access, and experiences that occur within our healthcare system.

We believe that healthcare is a fundamental human right, and we are dedicated to providing quality care to all members of our community. We value the contributions of each individual, and we

are committed to promoting equity by striving to ensure that everyone has access to the same opportunities and resources within the hospital, regardless of their race, gender, sexual orientation, religion or ability. We believe that achieving equity in healthcare requires both acknowledging and addressing systemic biases that occur within the industry.

To achieve our goals, we continuously work with our community partners, Patient Family Advisory, Accessibility, DEI, and 2SLGBTQIA + Committees to evaluate our policies, practices, and programs to ensure that they are equitable and inclusive. We work to eliminate systemic barriers that prevent individuals from accessing the care they need, and we actively seek out ways to engage with diverse communities to better understand their unique healthcare needs. Our unique geographical location positions us to meet the immediate healthcare needs of residents of the City of Kenora, as well as a large surrounding area, including several First Nations Communities. The work of our Current Operations Innovation Working Group, Indigenous Advisory Council, and All Nations Health Partnership strives to address systemic barriers and inform the provision of culturally safe care to our First Nations communities, both within and outside of our hospital.

We recognize that non-medical social needs can play a significant role in determining health outcomes. For example, cultural barriers, income inequality, food insecurity, and inadequate housing can all have a detrimental effect on health. Therefore, we have implemented several strategies to address these issues. For instance, our various Mental Health and Addictions programs along with partnerships with community organizations facilitate client connection to housing resources, income maintenance, supported employment, meaningful community/cultural activity, and other social services.

Through our ongoing efforts, we strive to create a healthcare environment that is accessible, respectful, and responsive to the diverse needs of our patients, families, and community. We hold ourselves accountable to these values and welcome open dialogue and ongoing feedback from our patients, employees, and community members to continue to improve our diversity, equity, and inclusion efforts.

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 of 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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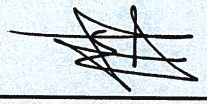
SIGN-OFF

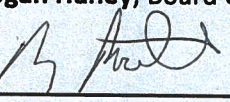
It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan on **April 20, 2023**

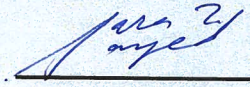


Brent Lundy, Board Chair

Logan Haney, Board Quality Committee Chair



Ray Racette, Chief Executive Officer



Sara Sayed, Other leadership as appropriate