Quality Improvement Plan

Quality improvement is a priority at the Pembroke Regional Hospital (PRH). One of the ways in which we demonstrate this is through the development of an annual Quality Improvement Plan (QIP). Our QIP helps us to plan, document and review performance in the areas of safety, effectiveness, access, patient centeredness, and integration of care. It helps us to identify new and better ways of doing things in order to improve care for our patients, increase satisfaction levels and achieve better clinical outcomes.

The *Excellent Care for All Act, 2010* (ECFAA) requires all hospitals to produce a QIP annually, make it available to the public and document progress.

Ontario Health has requested that hospitals select and report on some of the core indicators to support province-wide comparability where possible. Not all indicators apply to all hospitals.

You may find some of the questions and answers below helpful in understanding the QIP process.

How is the QIP developed?

The PRH Board of Directors is responsible for overseeing the development of the QIP. The members of our Board work closely with our management team, various healthcare professionals and patients and families to determine areas for improvement. Once areas for improvement have been identified, targets are set for improvement. Once the plan is finalized, it is then submitted to the Ontario Health.

What timeframe does the QIP cover?

Quality Improvement Plans are developed each fiscal year.

How do we know if progress is being made?

We take quality improvement very seriously and are committed to achieving the targets that we set out in our annual plans.

Measuring progress against our established targets is the primary way in which we hold ourselves accountable to our stakeholders.

Reports on progress are provided to our Board of Directors, Medical Advisory Committee, Quality and Patient Safety Committees, as well as, our Patient and Family Advisory Council throughout the year and a summary report is posted on our website annually.

Where can I find out more information about the *Excellent Care for All Act* and quality improvement plans?

Please visit https://www.health.gov.on.ca/en/pro/programs/ecfa/legislation/act.aspx for more information about the legislation and its requirements.

Ontario Health

Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

June 29, 2022

Hôpital Régional de Pembroke Regional Hospital

OVERVIEW

It has been two years since the previous Quality Improvement Plan (QIP) was developed. Many things have changed during this period. Therefore, prior to developing the 2022/2023 QIP, significant time was spent consulting key stakeholders and reviewing data to help guide the development of this year's hospital drivers. Ultimately, we needed to assess and understand our current needs before we could choose our direction moving forward.

Consultations were completed with the Pembroke Regional Hospital (PRH) management group, Medical Advisory Committee, Patient and Family Advisory Council, Board Quality and Patient Safety Committee, and a Staff Satisfaction and Engagement survey was completed. Furthermore, a variety of data was examined to help support decision making related to change ideas.

Four main drivers were developed as a result of the consultation process including:

- Develop processes to improve communication and care decision involvement for patients and families receiving care.
- Develop plans to ensure Accreditation Canada's standards are met in 2023.
- Establish staffing models that can be implemented in 2023 to stabilize the workforce.
- Improve skills among staff, management, and physicians through training, mentorship, orientation.

REFLECTIONS SINCE YOUR LAST QIP SUBMISSION

The COVID-19 pandemic has impacted hospital operations for over two years. During these challenging times, Pembroke Regional Hospital (PRH), like most healthcare organizations, has dealt with unprecedented challenges and instability. This forced many quality improvement initiatives to be put on hold, especially during peak pandemic periods.

PRH has continued to focus on previous hospital drivers developed in the 2020/2021 QIP and saw good outcomes related to advanced care planning for patients, as well as improved discharge communication. As we begin what we hope is the recovery stage of the pandemic, this year's Quality Improvement Plan focuses on getting back to our commitment of providing patient focused care, with quality and safety prioritized.

PATIENT/CLIENT/RESIDENT PARTNERING AND RELATIONS

Limitations over the past two years on visitors have been challenging for our patients and their loved ones. Frequently changing visitor policies in response to government requirements, and restrictions related to vaccination status have added to the frustrations.

Furthermore, many of the meetings we used to host in-person with patients, families, or community partners were forced to be either cancelled, or moved to virtual platforms. The switch to virtual meeting rooms certainly came with its challenges. This was a learning process for all involved and was an effective method to solve communication barriers experienced during the pandemic.

In preparation for this year's QIP, consultations with our Patient and Family Advisory Council have highlighted the importance of prioritizing communication and involvement of patients and families in care decisions. Providing patient focused care is a pillar of Pembroke Regional Hospital. In this year's QIP, significant focus will be placed on ensuring processes are improved or developed to overcome barriers that inhibit effective communication, and involvement of patients and families in care decision.

PROVIDER EXPERIENCE

Consistent with most health care organizations, Pembroke Regional Hospital is experiencing significant challenges related to staffing. Our health care providers are facing unprecedented challenges. Many of the experienced staff are retiring or choosing different careers, and the availability of new staff to hire is limited leading to vacancies. Over the past two years, there has been significant turnover within our care provider team, management team, and among physicians.

With these challenges in mind, two initiatives specifically focus on improving the provider experience within the PRH QIP; establish staffing models to stabilize the workforce, and focus on skill development among staff, management, and physicians.

Continued frontline staff and physician engagement is imperative as we strengthen and stabilize our workforce.

EXECUTIVE COMPENSATION

Our Senior Leadership Team is made up of the President & Chief Executive Officer (CEO), the Senior Vice-President Clinical & Support Services, the Vice-President of Clinical & Support Services / Chief Nursing Executive (CNE), the Vice-President of Finance and Corporate Services / Chief Financial Officer (CFO), and the Chief of Staff.

For each of these executives, 5% of their total available compensation is tied to the achievements of targets identified in the annual QIP.

For 2022/2023 each member of the senior team will have 5% of the total available compensation linked to achieving the targets as set out in our 2022/2023 QIP.

The outcome measures or indicators are typically weighted and the achievement of all targets would result in 100% payout, with partial achievement of targets resulting in partial payout as determined by the Board of Directors.

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 June 29, 2022

Board Chair

Board Quality Committee Chair

Chief Executive Officer

Other leadership as appropriate

Theme II: Service Excellence

Measure

Dimension: Patient-centred

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Top two boxes score for questions related to communication on Canadian Patient Experience Survey on Inpatient Care (CPES-IC).	C	% / All patients	CIHI CPES / April 1, 2022 - March 31, 2023	CB	0.00	Through consultation with Patient and Family Advisory Council, Board Quality and Patient Safety Committee, and reviewing complaints submitted, communication was identified as a priority. Root causes of communication gaps and baseline scores will need to be identified prior to setting a numerical target.	

Change Ideas

Change Idea #1 Develop processes to improve communication and care decision involvement for patients and families receiving care.

Methods	Process measures	Target for process measure	Comments
Conduct a Plan, Do, Study, Act to identify areas of improvement related to patient and family communication for care areas. Identify two processes per department to improve communication with patients and families related to care and care decisions.	Q2: Identification of 2 change ideas related to patient and family communication and care involvement per responsible department. Q3: Number of responsible departments with two processes developed to improve communication and care decision involvement for patients and families receiving care. Q4: Total number of processes implemented on responsible units.	Q2: 16 Q3: 8 Q4: 8	

Theme III: Safe and Effective Care

Measure

Dimension: Safe

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Maintaining accreditation from Accreditation Canada.	C	Other / Other	Other / April 1, 2022 - April 1, 2023	1.00	1.00	Successfully meeting the standards of Accreditation Canada, including Required Organizational Practices.	

Change Ideas

Change Idea #1 Assess current performance related to Accreditation Canada's Required Organizational Practices (ROP), and develop plans to ensure Accreditation Standards as part of COVID-19 recovery planning.

Methods	Process measures	Target for process measure	Comments
Establish Accreditation Working Group to review current ROPs and Standards and assign ROPs to responsible departments. Establish Accreditation departmental teams responsible for completion of self-assessment and development of plans, policies, and procedures to address gaps identified through self-assessments. Departmental teams are responsible for implementation of plans, policies and procedures within departments. Accreditation departmental teams develop and implement education plans for staff related to Standards and ROPs in preparation for Accreditation Canada's evaluation.	Q2: Percentage of Accreditation Canada Self-Assessment tools for departments completed. Q3: Percentage of ROPs with developed policies, procedures and audit tools. Q4: Percentage of ROPS across the organization that meet Accreditation Canada Standards. Percentage of departments implementing Accreditation education plans.	Q2: 100% Q3: 80% Q4: 80% Q4: 100%	

Measure

Dimension: Safe

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of shifts that are vacant each week per department.	C	% / Health providers in the entire facility	Hospital collected data / April 1, 2022 - March 31, 2023	CB	CB	Establish benchmark for indicator prior to setting target.	

Change Ideas

Change Idea #1 Establish staffing models that can be implemented in 2023 to stabilize the workforce.

Methods	Process measures	Target for process measure	Comments
Conduct a strategic Plan, Do, Study, Act (PDSA) to determine total vacancies, department needs, potential models, establish roles/responsibilities, and plan implementation	Q2: Percentage of departments with total vacancies identified by profession and baseline operational requirements identified. Percentage of departments in which at least 10 staff, physicians, managers and directors provide feedback to determine needs/gaps related to completion of services. Q3: Percentage of responsible departments with identified staffing model innovations, including roles and responsibilities. Percentage of responsible departments with completed implementation plans related to staffing models. Q4: Selection of 1 department to pilot staffing model. Percentage of new staff to fill roles and responsibilities identified in Q3 for pilot department.	Q2: 100% Q2: 100% Q3: 100% Q4: 1 Q4: 75%	

Measure

Dimension: Safe

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Annual staff and physician satisfaction score related to skill development opportunities.	C	% / Health providers in the entire facility	In-house survey / April 1, 2022 - March 31, 2023	CB	75.00	Skill development needs should be driven by front line staff needs and be directly relatable to their job duties. 75% satisfaction will indicate appropriate types of skill development opportunities are being selected.	

Change Ideas

Change Idea #1 Improve skills among staff, physicians and management through training, mentorship, orientation.

Methods	Process measures	Target for process measure	Comments
Engage management, physicians and staff to determine the needs of each department. Identify training programs/opportunities to meet the needs of staff, physicians, and management, and create skill development plan for each unit based on identified needs.	Q2: Number of departments where front line, physician and management engagement is completed and needs identified. Q3: Number of departments with skill development/training plan completed. Q4: Percentage of planned skill development opportunities provided.	Q2: 11 Q3: 11 Q4: 75%	