Cambridge Memorial Hospital Quality and Safety Plan 2017-19

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Endorsed By:
CMH Board of Directors on November 29, 2017

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Introduction

Cambridge Memorial Hospital (CMH) continues on the transformative journey towards a vision of providing ***exceptional healthcare by exceptional people***. Influential to this journey was the

development of three (3) Quality and Patient Safety Plans (QPSP) initially established in 2011. As we embark on the development of the fourth iteration we are at a point in time where safety is viewed in a broader sense; encompassing the safety of both patients *and staff*. As such, this fourth iteration has been renamed *Cambridge Memorial Hospital Quality and Safety Plan (QSP) 2017-19* and tactics contained herein reflect the name change.

While shorter than previous planning cycles, the two (2) year timing of this QSP aligns to that of the recently approved 2017-19 Strategic Plan. At CMH, provision of exceptional healthcare is defined as the delivery of care that is safe, effective and efficient provided by knowledgeable and caring people. To that end, our four (4) quadrant Quality Framework, first developed in 2011 anchors our discussion.

CMH Quality Framework

The CMH Quality Framework (Figure 1) is based on a balanced scorecard approach with four dimensions: (1) safe, effective and accessible; (2) people and patient focused; (3) integrated and equitable; and (4) efficient. The dimensions are based on attributes of quality, relevant to a community hospital, and consistent with the quality framework adopted by the provincial agency HQO, mandated to set the direction for measuring the quality of healthcare for Ontarians.

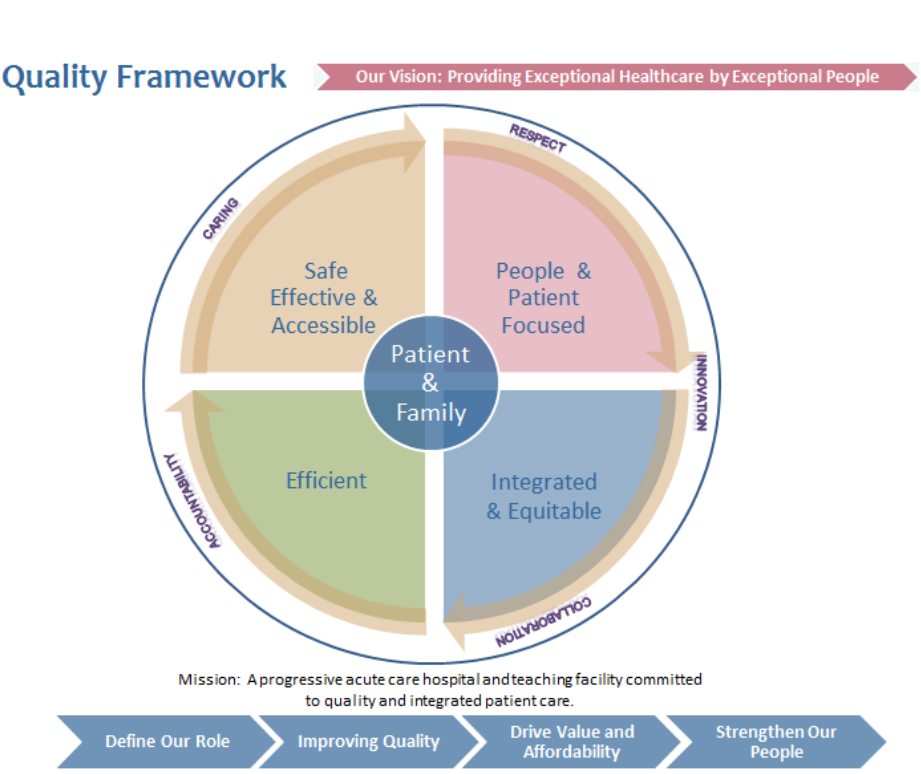

Figure 1: CMH Quality Framework

Safe, effective and accessible

We will endeavor to keep our patients safe. They will not be harmed by preventable errors as a result of care received at CMH. Our patients will receive timely and appropriate healthcare that is based on the best available scientific evidence known to achieve the best possible outcomes.

People and patient focused

Patients at CMH will receive culturally sensitive care that addresses the individual's needs and uniqueness. Patients will be asked for their preference. Health service providers (staff, physicians and volunteers) at CMH will continue to be engaged in a healthy work-environment that supports them as individual practitioners and as members of a unit, cross-unit, and hospital-wide teams, as they endeavor to provide the best possible care to patients and families.

Integrated and equitable

Patients and families of our region will receive quality care regardless of whom they are and where they live. Health service providers at CMH will continue to collaborate with our Waterloo Wellington regional partners, stakeholders, suppliers and funders to be organized, connected and working with one another aiming to provide high quality care for the region that is integrated throughout the continuum of care. We will continue to collaborate with tertiary and quaternary care providers and other services not available within our region and needed by patients in the region.

Efficient

Staff, physicians and volunteers will strive to achieve the best value of health service for the community's healthcare care needs. Health service providers will continually look for ways to reduce waste, including waste of supplies, equipment, and time from the perspective of the patient. They will respectfully gather ideas and information with the aim of providing appropriately resourced care within the fiscal capacity of CMH.

Monitoring Quality at CMH

At CMH, quality is monitored at multiple levels in the organization from the Board of Directors to the bedside. We conceptualize quality care and service delivery within the context of an acute community hospital providing medical, surgical, critical care, mental health, obstetrical, pediatric, rehabilitation, emergency and ambulatory services. As an adjunct to these services we deliver a suite of diagnostic options from imaging to laboratory and pathology.

Key Relationships and Interdependencies

Healthcare as a sector is a complex adaptive system and as such, CMH is both a system onto itself and a component of a much larger system. Figure 2 provides a schematic highlighting the internal systems or frameworks built to support the delivery of ***exceptional healthcare by exceptional people***. The green ovals in Figure 2 represent external relationships and interdependencies that have the potential to influence CMH on our quality journey.

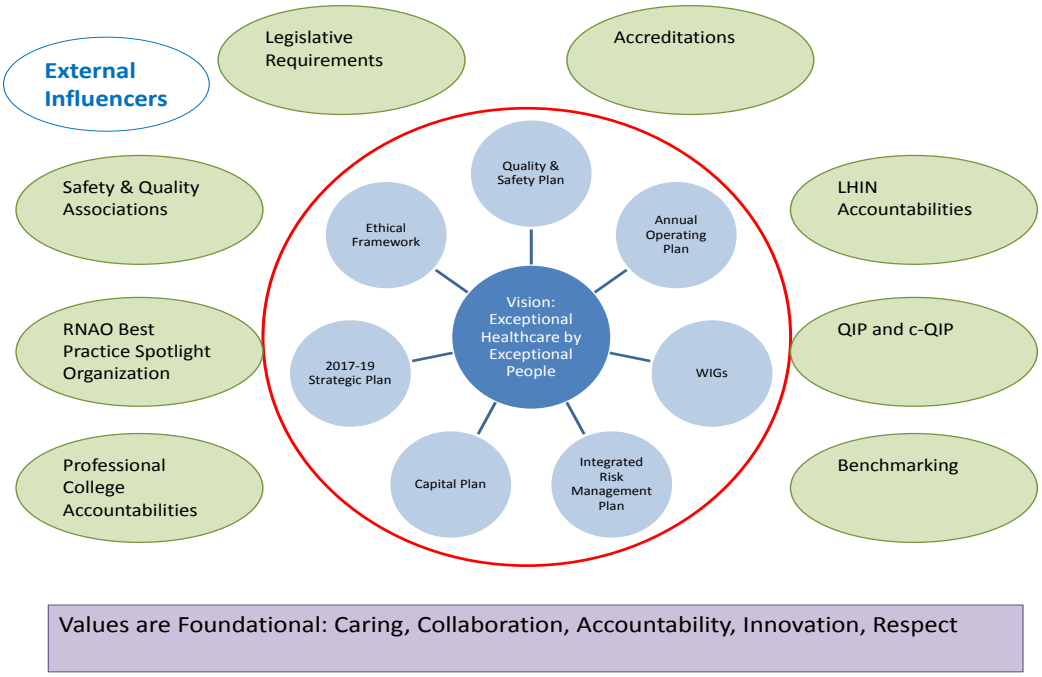

Figure 2: External Influencers and Internal Systems Enabling Quality at CMH

Internal Quality Monitoring Systems

A balanced scorecard approach of monitoring key performance metrics in each of the four (4) quadrants of the Quality Framework has been developed for the Board of Directors, Quality Committee of the Board, Resources Committee of the Board, and Senior Executive. Decisions related to Quality at all levels of the organization should be driven by process and outcome data. As such, data in the form of unit and program level scorecards will be rolled out to programs in fiscal year 2017-18.

Accountability for quality and safety at CMH is monitored at multiple levels of the organization from the Board of Directors to unit level Huddles. Huddle boards provide the opportunity for managers to regularly connect with staff to report on current performance, reinforce alignment of unit level work to corporate work, and to celebrate successes. Figure 3 illustrates the internal structures at the Governance, Leadership and Program levels that monitor quality.

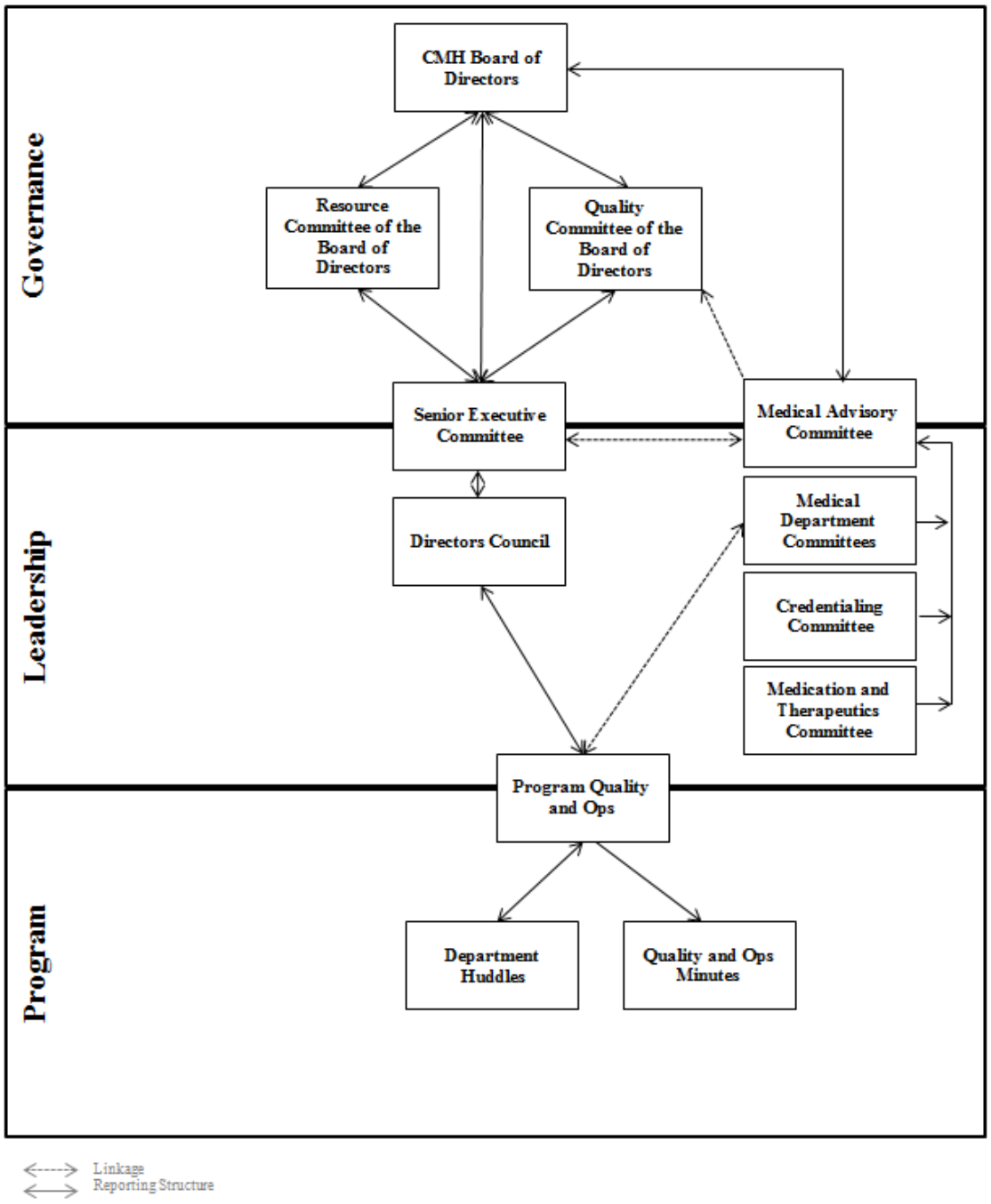

Figure 3: Internal Quality Reporting Structures at CMH

External Quality Monitoring Systems

Accreditation Canada

There is philosophical endorsement at the Senior Executive and Board level that accreditation preparation is continual, not a check-box event once every four (4) years. In 2015 CMH met the criteria for 2169 of 2183 applicable standards and achieved an 'Accredited' standing by Accreditation Canada.

Glancing toward our next scheduled onsite visit in 2019 CMH will be focusing our efforts on medication reconciliation at all points of transfer, and the degree to which patients are engaged in all process/service re-design efforts and individualized care plan design.

Laboratory Accreditation

IQMH (Institute for Quality Management in Healthcare) conducts lab accreditation that includes an on-site assessment completed every four (4) years and a comprehensive self-assessment of all requirements at the two (2) year mid-point. Our last full on-site assessment was in September 2017 and CMH maintained the highest possible standard of accreditation resulting in ISO 15189 Plus which only a few laboratories in Ontario hold.

Ontario College of Pharmacy (OCP) Accreditation

The OCP inspects and licenses hospital pharmacies annually under newly created legislation. All areas of the hospital that have mediation storage, preparation and administration are included in the standards for inspection. As this is a new and evolving accreditation, much work is being done at CMH and hospital pharmacies across the province to interpret the standards, align resources and implement strategies particularly in the areas of chemo drug preparation and narcotic handling.

2017-19 QSP Goals

Figure 5 at the end of this section is a summary infographic of the goals for the 2017-19 QSP. The goals outlined in Figure 5 represent those that will require significant effort, resources, or both and are anticipated to substantially move the quality needle at CMH over the next two (2) years.

Excluding monitoring/watch indicators from this plan should not minimize the importance of continued effort to sustain them; but rather highlight the major areas of change for the next two (2) years.

The themes described below provide context to the intersection between the 2017-19 CMH Strategic Plan and the 2017-19 Quality Safety Plan. The numbered goals referenced under theme section below can be found in Figure 5.

Medication Safety

Medication errors remain the largest contributor to potential and actual patient safety events in healthcare. As such, through our newly adopted Integrated Risk Management (IRM) framework Medication Safety was identified as one (1) of four (4) top organization risks and a Medication Safety Plan to systematically mitigate the risk was developed in 2016. Areas of focus for the

next two (2) years include: implementation of automated medication transportation carts, implementation of narcotic diversion software and medication reconciliation at all transfer points. These represent stepping stones on the path towards the medication safety gold standard and ultimate long-term goal of Computerized Physician Order Entry (CPOE).

Goal #1: Implement (November 2017) and evaluate (June 2018) an automated medication transfer cart

Goal #2: Implement (February 2018) and evaluate (September 2018) narcotic diversion software

Goal #3: Implement medication reconciliation at all points of transfer by November 2019

Care Delivery & System Collaboration

A strategic tactic for CMH is to implement new models of delivering care both internally and as a partner in a larger system. Pivotal to this is meeting established Post Construction Operating Plan (PCOP) growth targets.

In 2017-18 CMH has participated in two (2) pilot collaborative QIPs (c-QIPs). The c-QIP is intended to formalize the collaborative efforts between/across organizations and sectors to ultimately impact system level change and improvements.

Intentionally seeking out strategies to enhance system collaboration will be a focus of improving Quality for CMH over the next two (2) years.

Goal #4: Decrease 90th percentile ED LOS from 20.8 (August 2017 coded YTD data) to 14.75 hours by December 2019

Goal #9: Meet established Post Construction Operating Plan (PCOP) growth targets in Year 1 and Year 2 after moving into Wing A

Goal #10: Decrease 30 day all cause readmissions form CHF patients from 20.0% to 14.0% by March 2019

Goal #11: Decrease wait list time for non-urgent outpatient mental health appointments from 16 weeks to 4 weeks by March 2019

Goal #12: Implement new models of care delivery for Medicine and ICU to coordinate with the move into Wing A. Evaluate 6 months post implementation.

Patient Centred Care Philosophy

Legislatively there has been a shift towards expanded inclusion of the patient voice at the planning, development and review tables. This has been echoed by substantial enhancement of requirements by accrediting bodies such as Accreditation Canada. In addition, there is emerging research supporting this shift beyond the moral *right thing to do* in terms of improved clinical outcomes and decreased risk of medical litigation. At CMH, there is a philosophical commitment, yet this remains a journey and as such will be a heightened focus over the next two (2) years.

Goal # 8 – Increase % positive responses to 'would you recommend CMH to family and friends?' from 52% to 65% by December 2019

Staff Engagement

Meeting a legislative requirement under the *Excellent Care for All Act (*ECFAA), CMH administers staff and physician satisfaction surveys bi-annually. At a corporate level Figure 4 illustrates the staff results from 2015 compared to 2017. While there has been a modest improvement there is increased recognition that improving the patient experience must start with improving the working environment for staff. Therefore, the development and execution of staff engagement plans is a strategic focus for the next two (2) years.

Goal #6: Decrease the number of lost time days from workplace violence incidents by 25% by December 2019

Goal #7: Increase the % of staff responding positively to the question 'Overall how would you rate your organization as a place to work' on the Worklife Pulse survey from 36% to 53% by December 2019

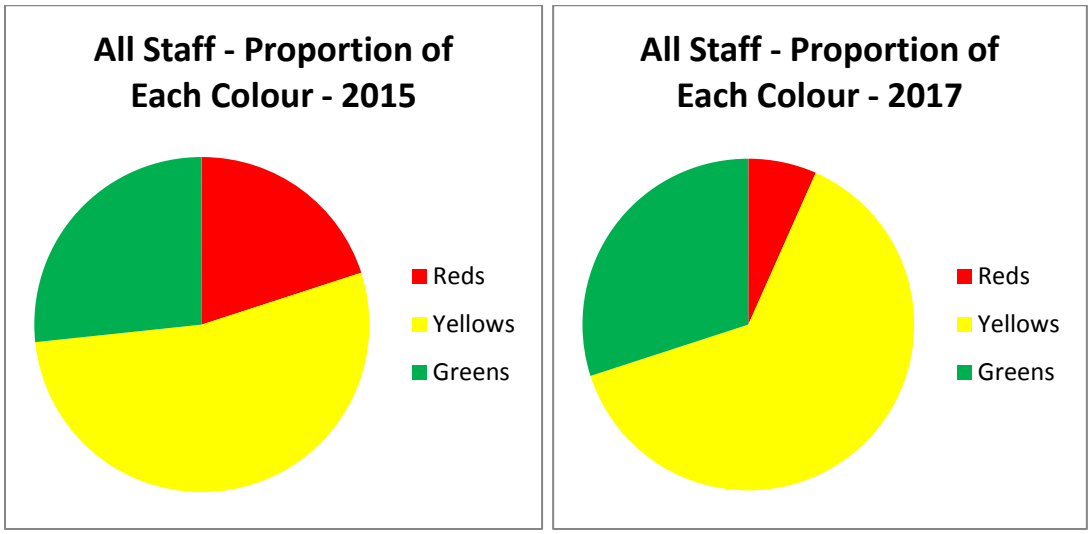

Figure 4: All Staff - Proportion of Each Colour – 2015 vs. 2017

Quality Improvement Culture

As we embark on this QSP journey part of the *gear* we will pack is a standardized methodology for analyzing processes and opportunities. CMH has adopted the Institute for Healthcare Improvement's (IHI) Plan, Do, Study, Act (PDSA) framework for quality improvement. The PDSA framework combined with lean tools provide leaders with a 'tool box' to systematically tackle and track quality challenges. Educating (leaders and staff) and coaching to achieve a quality improvement culture remains a strategic focus for the next two (2) years.

Goal #8: Increase the % of leaders, staff and physicians who have received Quality Improvement education from 7% to 17% by December 2019

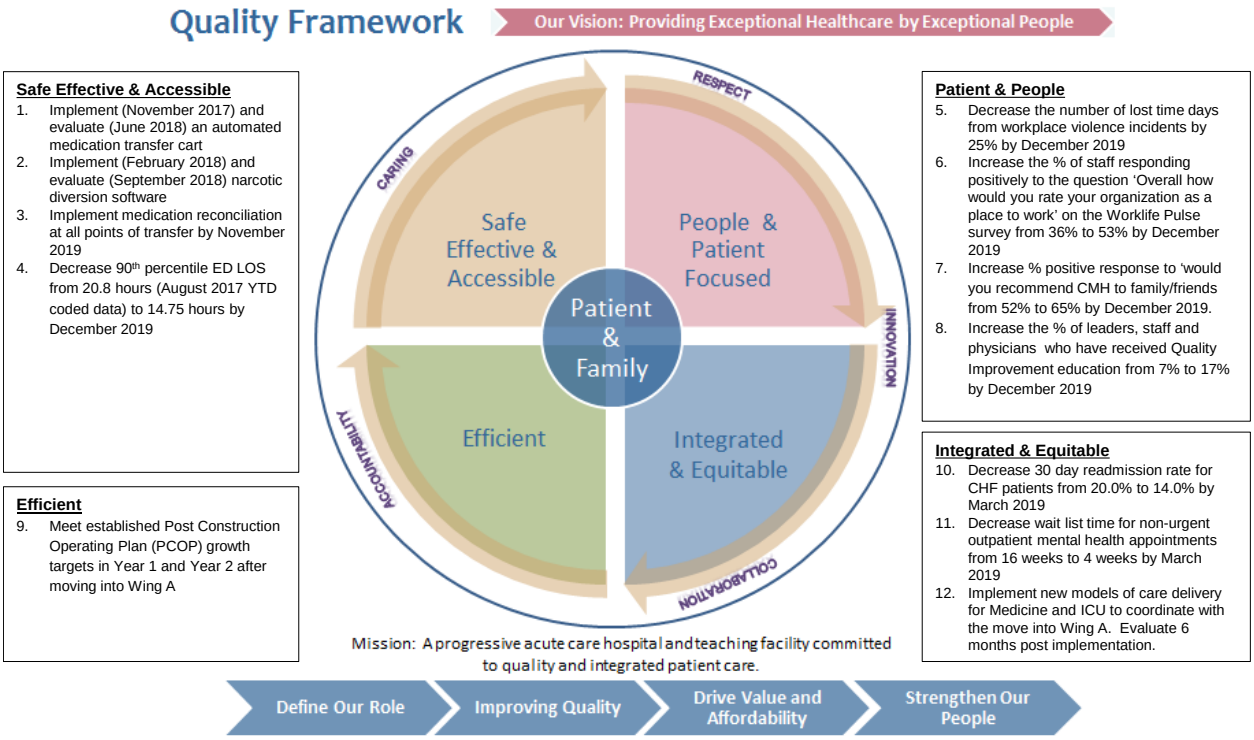

Figure 5: 2017-19 QSP Goal Summary Infographic

Alignment of the 2017-19 Quality & Safety Plan

At a broad level the 2017-19 QSP is nested beneath the 2017-19 Strategic Plan direction of Improving Quality.

CMH Strategic Plan 2017-19

In June 2017, the CMH board approved the 2017-19 Strategic Plan. Figure 6 provides an infographic overview of the entire 2017-19 Strategic Plan. The four (4) strategic directions are:

- Define Our Role
- Improve Quality
- Drive Value and Affordability
- Strengthen Our People

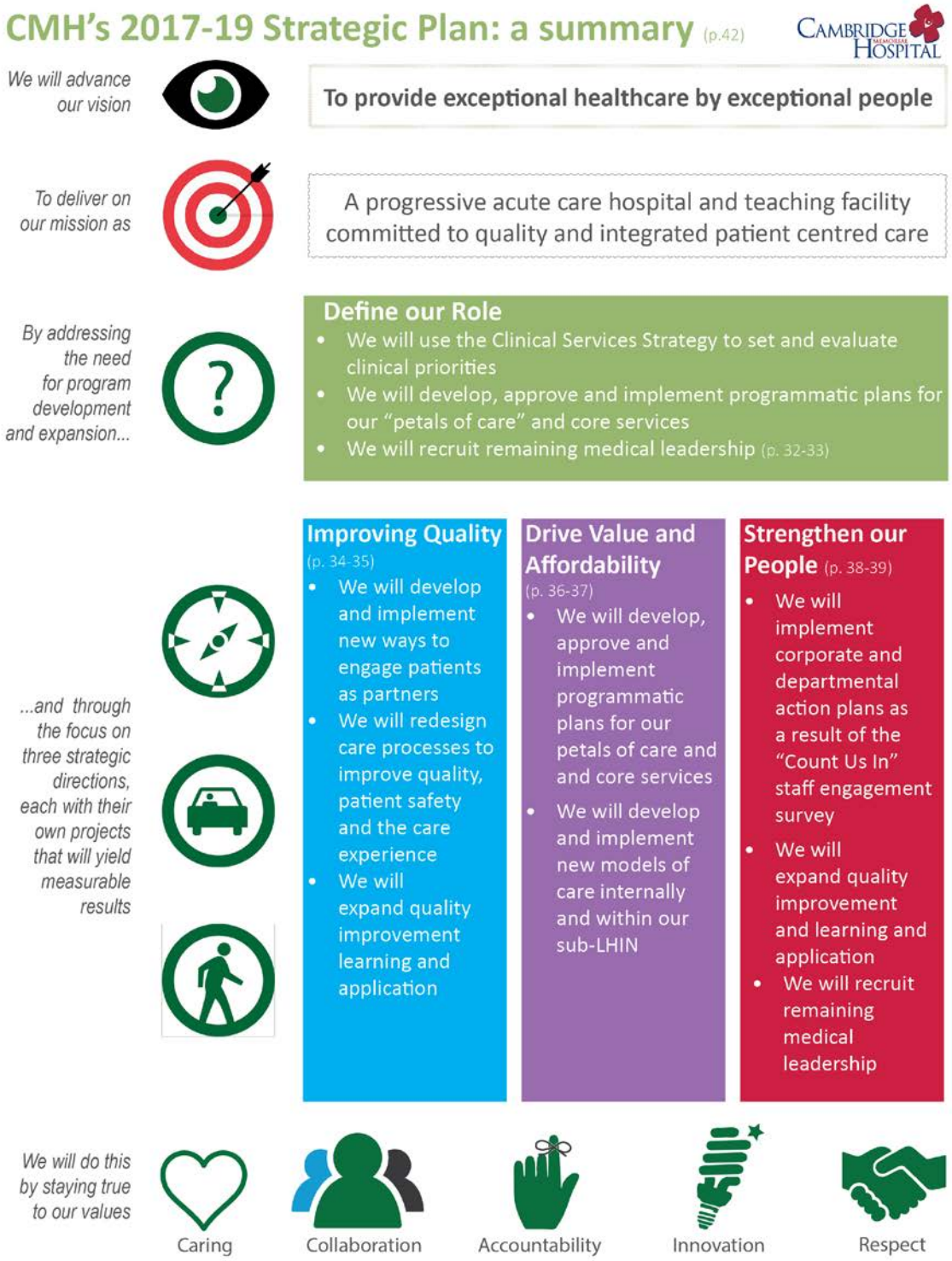

Figure 6: CMH Strategic Plan 2017-19 Infographic

As part of our annual and multi-year planning, this QSP should serve to inform, and be informed by, the following:

- Quality Improvement Plan (QIP) and Collaborative Quality Improvement Plans (c-QIPs)
- Wildly Important Goals (WIGs)
- Integrated Risk Management (IRM) Framework

Annual QIP and c-QIPs

Now eight (8) years since inception under the Excellent Care for All Act (ECFAA), QIPs as a legislated requirement were intended to drive system-level change by encouraging hospitals, long term care homes, primary care and community based care to be working on the same priorities and essentially 'rowing in the same direction'.

New to the Waterloo Wellington LHIN (WWLHIN) in 2017-18 was the pilot of multiple collaborative QIPs (c-QIPs). The c-QIP is intended to formalize the collaborative efforts between and across organizations and sectors to ultimately impact system level change and improvements. The c-QIP work started in 2017-18 is anticipated to rollover to fiscal 2018-19.

Legislative changes to ECFAA in 2017 will see the inclusion of Mandatory indicators beginning with the 2017-18 QIPs. An indicator related to workplace violence prevention is predicted to be the first mandatory QIP indicator.

Annual Wildly Important Goals (WIGs)

Each year CMH selects two (2) or three (3) significant operational goals with the overarching intent in doing so, to create organizational focus with cascading levels of accountability for achievement.

Integrated Risk Management (IRM) Framework

In April 2016, CMH began the process of developing a formal IRM strategy to quantify and mitigate risk from the organizational vantage point. Senior leaders identified and rated top risks for impact and likelihood. The top four (4) organizational risks were identified, mitigation plans were developed and regular reporting of the mitigation plans have been regularly presented to the Board and respective Board committees. The Audit Committee of the Board provides oversight to the IRM process that includes an annual review by senior leaders to re-evaluate current risks, updating mitigation plans, and adding new risks.

Capital Redevelopment Plan (CRP)

Exciting times are imminently upon us as occupancy of the newly constructed Wing A is anticipated to take place in early 2018. Following occupancy an extensive renovation to existing Wing B will take place with the net end result being additional beds, significantly expanded emergency room space, additional operating rooms, and expanded diagnostic capabilities.

Through the planning and implementation of each phase quality and safety are being carefully considered and monitored. Each clinical program has selected key quality and safety metrics

indicative of the new physical space and service re-designs. Regular updates related to quality and safety are provided to Quality Committee of the Board and the CRP Steering Committee.

Emerging Quality Literature

A High Reliable Organization (HRO) is described as an organization (or sector) that provides or performs high risk work rarely experiencing catastrophic events. Sectors such as aviation, nuclear power and astronomy have spent decades preoccupied with failure to build preventative systems to prevent harm. The services provided in healthcare are high risk yet, healthcare as a sector has not made the same quantum gains in ultimately moving towards improving patient safety. Accelerated with the release of *To Err is Human: Building a Safer Health System* in 1999 Patient Safety as a subset of Quality has garnered a tremendous amount of research attention over the past 18 years. A refined focus at CMH on standardization of both delivery processes and the methodology in which analyze errors puts us on the *path* in the *direction* of a HRO.

Much of the work done in the past around quantifying medical errors and risk of harm in healthcare has relied on self-reporting of incidents and near-misses. The Canadian Institute of Healthcare Improvement (CIHI) have begun foundational work on defining and collecting data on a Healthcare Harm Indicator stated as the rate of hospitalizations where at least one (1) harmful event from a list of thirty-one (31) has occurred. Baseline data from 2014-15 obtained from coded data indicate a rate of one (1) potentially harmful event in every eighteen (18) hospitalizations. While high level and longitudinal in nature, the benefit to an indicator such as this is the ability to access coded medical record data versus self-reports thus allowing cross-organizational comparisons and the development of best practices.

There has been a shift recently to include patient experience in the definition of Quality due to the correlation between experience and improved clinical outcomes including measures of utilization and efficiency such as re-admissions. Enhancing patient experience, improving population health and reducing costs remain cornerstones to improving population health, however, more recently literature is supporting the move from the *triple to the quadruple aim;* that is, acknowledging the vital role that healthcare providers play in achieving this. The burnout being experienced by staff and physicians alike needs to be addressed if we are to successfully improve population health.

Legislative Landscape in Ontario

Below is a list of the most relevant pieces of Ontario legislation governing the provision of quality healthcare in Ontario and recent changes.

Excellent Care for All Act (2010)

Established in 2010 the Excellent Care for All Act (ECFAA) laid the foundation for the standardized formation of Quality Committee of the Boards, annual development and public posting of an organizational Quality Improvement Plan (QIP), and bi-annual surveying of staff for satisfaction.

A revision to ECFAA in September 2015 legislated the requirement to include the patient voice in the development of the annual QIP. Amendments to ECFAA in July 2017 provided legislative authority of the Minister of Health to declare mandatory inclusion of specific indicators to the QIPs under the advisement of Health Quality Ontario (HQO).

Quality of Care Information Protection Act (2016)

Changes in July 2017 that included re-writing the entire piece of legislation as a foundational step toward the adoption of the QCIPA Review Committee Recommendations submitted to the Minister of Health in December 2014. Major components include the inclusion of the patient voice (either directly or via a patient relations role) into the review of all critical incidents and legislating a full review of this legislation every five (5) years.

Risks and Mitigation Strategies

This is an aggressive QSP and will require a clear plan to meet each individual goal with identified targets. The table below outlines risks and associated mitigation strategies to address.

Risks to Success	Mitigation Strategies
System level (LHIN, Provincial) changes – timing and level of impact	Regional and provincial connectivity tables for updates, modify plan and targets as required
Capacity of leaders and staff to deliver the goals of this aggressive plan	Focused priorities, goal ownership
CRP delivery date is a moving target	Some goals are tied to the Wing A move in date. Alterations to the target date may need to be made.

Monitoring Progress

An update on the QSP will be reported quarterly to the Quality Committee of the Board and CMH leaders. Scorecards are already in place for the Board Sub-Committees and Senior Management Committee and will be rolled out to all clinical programs in fiscal 2017-18. Additionally, all major clinical and support programs report their performance to the Quality Committee on an annual basis.

References

Bodenheimer, T., & Sinsky, C. (2014). From triple to quadruple aim: care of the patient requires care of the provider. *The Annals of Family Medicine*, *12*(6), 573-576.

Boulding, W., Glickman, S., Manary, M., Schulman, K., & Staelin, R. (2011). Relationship between patient satisfaction with inpatient care and hospital readmission within 30 days. *The American journal of managed care*, *17*(1), 41-48.

Canadian Institute for Health Information, Canadian Patient Safety Institute. (2016). *Measuring Patient Harm in Canadian Hospitals.*

Doyle, C., Lennox, L., & Bell, D. (2013). A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. *BMJ open*, *3*(1),

Excellent Care for all Act (2010)

Korn, L., Corrigan, J., & Donaldson, M. (1999). To err is human: building a safer health system. Washington: Institute of Medicine.

McChesney, C., Covey, S., & Huling, J. (2012). *The 4 disciplines of execution: Achieving your wildly important goals*. Simon and Schuster.

Meliones, J. (2000). Saving money, saving lives. *Harvard business review*, *78*(6), 57-65.

National Patient Safety Foundation. (2015). *Free from harm: Accelerating patient safety improvement fifteen years after To Err is Human Executive Summary.*

Press, I. (2002). *Patient satisfaction: Defining, measuring, and improving the experience of care*. Annapolis, MD: Health Administration Press.

Quality of Care Information Protection Act (2016).

QCIPA Review Committee Recommendations (2014).

Stelfox, H., Gandhi, T., Orav, E., & Gustafson, M. (2005). The relation of patient satisfaction with complaints against physicians and malpractice lawsuits. *The American journal of medicine*, *118*(10), 1126-1133.