Ontario Health

Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

June 13, 2022

STEVENSON MEMORIAL HOSPITAL

OVERVIEW

Stevenson Memorial Hospital (SMH) is a progressive, acute care, community-based hospital located in the Town of New Tecumseth that services south Simcoe and surrounding communities.
SMH offers 38 inpatient beds and a range of outpatient diagnostic and treatment services, including cataract, general surgery, fracture clinic, diagnostic imaging, maternal childcare and dialysis, as well as an Emergency Department with 24/7 coverage.

Developed in 2018, our Vision and Mission are as follows:

VISION: Setting a New Standard for Community Hospital Care
MISSION: Promising Progress, Pursuing Perfection

Every day we deliver safe, high quality health care driven by our values: Integrity, compassion,
accountability, respect, and excellence.

There are a number of quality improvement initiatives that have been completed over the last two years including the opening of our High Acuity Unit (Level 2 ICU) and the implementation of several new information technology and health informatics initiatives.

Planning has also been moving forward on the redevelopment of the hospital, in particular a 100,000 square foot wrap-around addition that will revitalize the hospital and significantly expand our Emergency Department. We recently received an approval on our Stage 2 proposal for a redeveloped hospital from the Ministry of Health and approval to move to the Stage 3 Design phase.

SMH has continued to work closely with a number of community partners with the South Simcoe OHT initiative currently in Development.

Lastly, In November 2021, SMH participated in an accreditation process with Accreditation Canada and was awarded Exemplary Standing. This is the highest standing that is awarded by Accreditation Canada which SMH also received in 2016. Their final report included that SMH had met 98.5% per cent of the criteria evaluated, which is an increase from 96.3% of criteria met in 2016.

SMH was noted to have excelled in the areas of COVID-19 pandemic management, implementation of the Health Information System (HIS – SHINE project), health information – Patient Connect portal, redevelopment progress, growth in staffing/leadership roles and overall caring committed staff, physicians and leaders.

REFLECTIONS SINCE YOUR LAST QIP SUBMISSION

Over the past two years, SMH has been working to ensure that the hospital remains as safe as possible during the COVID-19 pandemic. It has been one of the most challenging times in health care history and we are proud of how our staff persevered and continued to provide high quality health care services in very stressful and uncertain times.

As a community hospital with aged infrastructure and limited

amount of single occupant/isolation rooms, we were challenged but succeeded at managing COVID-19 suspect or positive patients. SMH created an Overflow Unit, an 8-bed unit as an extension of the Medical/Surgical impatient unit with each room designated as isolation rooms. We will continue to utilize these additional beds as the pandemic progresses to optimize the use of these single occupancy rooms for the purposes of infection prevention and control (IPAC).

Hand hygiene audits, PPE audits as well as room capacity audits were completed throughout the pandemic and we will continue to complete these as an organization to follow best practices in IPAC. Additional cleaning and disinfection was also introduced, including staff with specific roles regarding high touch cleaning. Increased reporting was also conducted, with daily to weekly Emergency Operations Committee meetings to discuss policies, procedures and protocols related to the pandemic, as well as local outbreaks, health human resources, PPE supply and COVID-19 patients in-hospital.

SMH also supported local long-term care and congregate settings throughout the pandemic with IPAC assessments, education, COVID-19 testing and surveillance. In addition, SMH extended its support to Honda Canada Manufacturing Inc with the reopening of their facilities in the spring of 2020 and provided a guided site visit of SMH's COVID-19 Assessment Centre. SMH will continue to support local organizations and businesses as needed.

Upgrading and introducing new technology has also been a focus over the last two years. In 2021, SMH made significant investments in updating IT infrastructure and implemented 22 new software platforms. This includes Novari ATC surgical booking, Savience, our Self-Check in application and OMNI, our new policy and procedure database. One million dollars in capital was invested, and SMH has invested $3.5 million to date towards the Meditech Expanse update, which is now in Phase 2. (The new Health Information System as launched through the SHINE project with Southlake Regional Health Centre and Markham Stouffville Hospital – now Oak Valley Health - in 2018).

PATIENT/CLIENT/RESIDENT PARTNERING AND RELATIONS

Over the past year we have made a multitude of changes to adapt to the ever-changing environment. Ensuring that concerns are addressed in a sufficient and timely manner ensures the competence and confidence from the patients/families. We are continuously improving our service recovery by ensuring the concerns and issues are addressed with confidence and skills to ease patient and family's minds. We offer virtual support for those who cannot come in to visit. This is done via iPads through our Patient Experience Department. We are constantly reviewing our Visitor Policy to ensure that patients, families and staff are safe to the best of our ability.

With the continuous changing aspects of COVID-19, we regularly involve and engage our staff with constant education and ways to improve our facility. The Patient and Family Advisory Council (PFAC) has been and continues to be an integral part of our organization. The PFAC are represented on most internal committees both at an operational and governance level, where they regularly engage in conversations around quality improvement initiatives providing feedback and advice.

PROVIDER EXPERIENCE

Our staff had to adapt to many new policies and initiatives throughout the pandemic to ensure we remained safe, but also provide health care services needed to our community, including COVID-19 testing and assessment.

In early March, 2020 SMH introduced a screening policy that all individuals will be required to undergo before entering the hospital. Staff were also screened including temperature check at the staff entrance and a universal scrub program was implemented to help stop the spread and transmission of COVID-19 in hospital and at home.

The following week in March, 2020 SMH opened a COVID-19 Assessment Centre in the lower parking lot of the hospital, staffed by SMH physicians, nurses, management and administrative staff. Since then, over 35,000 tests have been completed to date.
All non-urgent and elective surgeries were cancelled at various stages throughout the pandemic and diagnostic imaging was also ramped down in first Wave. Peri-operative and diagnostic imaging staff were redeployed across the hospital, supporting the COVID-19 Assessment Centre, Emergency Department, Medical/Surgical units as well as the Screening station. Security was increased in the hospital at both the COVID-19 Assessment Centre and Screening station.

Over the course of the pandemic, SMH has had over 100 COVID-positive inpatients in the hospital. To ensure staff safety, regularly reviewing donning and doffing procedures and proper PPE protocols were part of the weekly COVID-19 staff information updates. Our IPAC lead worked closely with staff, providing education and training on site to help support staff with these protocols and procedures.

An additional safety measure was the implementation of a mandatory vaccination policy for staff. Education was provided on the importance of vaccination for safety purposes. A vaccination policy was also implemented for visitors, as all individuals are required to show proof of vaccination upon entry unless there are extenuating circumstances. Our Visitor Policy has been restricted in line with COVID positivity rates and transmission in our local community to help keep our facility safe.

In February, 2022 SMH opened a COVID-19, Cold & Flu Clinic in partnership with community physicians. The Clinic is available for anyone who is experiencing mild to moderate or worsening symptoms of COVID-19 or flu who would like to receive in-person care, reducing pressure on our hospital's Emergency Department.

SMH offers patients and the community ambulatory care services, with a variety of health clinics available. One such service run by our Nurse Practitioner, The Well Women 's Clinic, continues to provide physical exams, routine screening, sexual health education and support, as well as prenatal care to women in need of health care.

To help boost morale and celebrate the incredible work of our staff during this challenging time, many staff appreciation initiatives were put into place, such as wellness carts, free meals, prize raffles, massage therapy sessions, staff appreciation BBQs and our Caught You Caring program. The Caught You Caring program provides an opportunity for staff to recognize a colleague for their outstanding work, or for a patient, family/community member to recognize staff. Feel Good Friday emails are sent every week with positive messages from the community or uplifting content for staff. In 2021 we also created the SMH Award of Excellence in Nursing and awarded our first recipient, a longstanding SMH RN.

EXECUTIVE COMPENSATION

Performance-based executive compensation is linked to the priorities in the QIP allowing us to:

- Drive performance and improve quality of care.
- Establish clear performance expectations and expected outcomes.
- Ensure consistency in application of the performance incentive, accountability, and transparency.
- Enable team work and a shared purpose.

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 10, 2022**

DocuSigned by:
John Murray
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John Murray, Board Chair

DocuSigned by:
Alison Howard
C4197C3CB3024D5...
Alison Howard, Board Quality Committee Chair

DocuSigned by:
Jody Levac
47ED47D9B71F48D...
Jody Levec, Chief Executive Officer

DocuSigned by:
Julia Sek
8AFC9D501A2247F...
Julia Sek, Other leadership as appropriate

Theme I: Timely and Efficient Transitions

Measure

Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
The time interval between the Disposition Date/Time (as determined by the main service provider) and the Date/Time Patient Left Emergency Department (ED) for admission to an inpatient bed or operating room.	C	Hours / All inpatients	CIHI NACRS, CCO / Q3	4.80	6.50	Baseline remains from previous year due to pandemic related instability in bed availability.	

Change Ideas

Change Idea #1 Optimize standardized admission process through collaboration with Clinical Coordinators and the Admission Discharge Transfer Nurse.

Methods	Process measures	Target for process measure	Comments
1. Roll model and monitor completion and accuracy of standardized admission process. Build a report to audit this process. 2. Implement and review 'Transfer of Accountability' intervention and process that includes admission timer on the medicine public board. 3. Build and implement a learning module as part of clinical orientation.	1&2. Run audits on transfer of accountability including written order, transfer completion, and completion of admission order indicating transfer is complete. 3. Implementation of module in clinical orientation agenda.	1&2. Quarter two 3. Quarter two	

Change Idea #2 We will track system flow through the use of our daily monitoring tool (DART) in unit-level performance huddles, discharge rounds, and daily bed meetings. This will increase data review at both program and leadership levels.

Methods	Process measures	Target for process measure	Comments
Engage front-line staff in the Emergency and Medical/Surgical quality meetings. Identify and address barriers and challenges to patient flow. Daily monitoring of patient flow metrics in relation to targets.	1. Data update on huddle boards regularly. 2. Minutes reported to board from unit quality meetings (Emergency and Medical/Surgical) 3. Key barriers and challenges identified and action plan developed accordingly.	1. Ongoing 2. Ongoing 3. Ongoing	

Measure

Dimension: Timely

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital.	P	% / Discharged patients	Hospital collected data / Most recent 3 month period	86.00	85.00	Organization is taking the opportunity to hold the target due to change over in staffing and onboarding of new employees. Will continue to have a focus on staff training and onboarding.	

Change Ideas

Change Idea #1 1. Increase awareness of requirements, educational opportunities and available tools to complete discharge summaries efficiently.

Methods	Process measures	Target for process measure	Comments
1. Clinical Informatics to attend the 'Meditech Physician Meeting' held bi-monthly. 2. Outline Meditech concerns and notify CFIO for escalation. 3. Physician training on Meditech functionality (Seasoned and New physicians to the organization): one on one rounding, available resources, and quick reference sheets with examples.	1. Bi-monthly attendance by Clinical Informatics at the 'Meditech Physician Meeting'. 2. As required. 3. Distribution of Meditech Reference Sheets for Physicians.	1. Bi-Monthly 2. Ongoing 3. Ongoing	

Theme II: Service Excellence

Measure

Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of respondents who responded “completely” 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 the hospital?	P	% / Survey respondents	CIHI CPES / Most recent 12 mos	67.33	60.00	Goal to maintain current performance.	

Change Ideas

Change Idea #1 Standardize the discharge process of in-patients on all units throughout the hospital.

Methods	Process measures	Target for process measure	Comments
1. Optimized and implement any required changes to the standardized discharge process. 2. Printable discharge form to be optimized, approved and created in Meditech and available in appropriate format for patient use. 3. Patient education forms cenralized in document management program (OMNI) and accessible to all staff supporting patients.	1.Number of staff trained on standardized discharge process (clinical orientation). 2. Discharge form received by all discharged patients and available within Meditech in a usable format. 3. All forms uploaded to OMNI	1. 100% of clinical staff. 2. Q2 form available 3. Q1	Data source for this indicator will change throughout this QIP cycle. Potential instability in data source identified as a potential barrier to meeting the identified target and managing identified improvements. New indicator wording will be as follows: Did patients feel they received adequate information about their health and their care at discharge?

Measure

Dimension: Patient-centred

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Seeking provincial opportunities to support COVID recovery efforts appropriate for medium size hospitals.	C	Other / All patients	Hospital collected data / January - December 2022	CB	CB	Work within this measure is very specific to the pandemic and the community needs. Further to that they are linked to available funding from the Ministry.	

Change Ideas

Change Idea #1 COVID @ Home Program

Methods	Process measures	Target for process measure	Comments
COVID @ Home program was created to support individuals in the community with COVID-19. This includes a supporting Meditech platform, intake process and supporting resources. Escalation process in place if patient assessed to require higher level of care not obtainable while in community setting. Intake comes from the Alliston Family Health Team/Primary Care providers in community, COVID-19 Cough and Cold Clinic, and Stevenson inpatient and emergency department.	Weekly Active enrollment Total # of patients served Weekly discharges from the program	Total enrollment = 25 approximately	

Change Idea #2 COVID 19 Cough and Cold Clinic

Methods	Process measures	Target for process measure	Comments
Ministry funded community clinic created on hospital grounds and run/staffed by SMH. Meditech platform created to support care/assessments of community members that have a cough or cold like symptom. Clinic runs three times weekly.	Weekly and Daily Clinic #	24 Patients Weekly (12 per clinic)	

Change Idea #3 Surgical Innovation Fund

Methods	Process measures	Target for process measure	Comments
Seeking approval from the Ministry for additional funding to address cases that have been backlogged.	Number of additional surgical days offered and reduction of backlog	Undetermined, waiting on approval funding which will drive target setting.	

Change Idea #4 Overflow Unit - Capacity

Methods	Process measures	Target for process measure	Comments
Operationalizing additional overflow bed capacity and seeking ministry funding to expand beds to support isolation needs of patients within the hospital (current and additional).	Daily unit census versus available beds	>80% unit census Increase bed count on overflow from 8 to 12 beds	

Change Idea #5 MRI/CT wait-times

Methods	Process measures	Target for process measure	Comments
Watching for government 'Blitz Hour Initiatives' that will support additional funded hours to support clearing waitlists accrued over the last two years.	Based on availability of funding, additional supported hours completed.	Total # of hours completed	

Theme III: Safe and Effective Care

Measure

Dimension: Effective

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged.	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / October 2021– December 2021	64.56	72.00	This target remains unchanged. We continue to strive for this target as we feel it is achievable and important to patient care.	

Change Ideas

Change Idea #1 1. Continue to define what patient population will receive medication reconciliation at discharge and optimize current training and documentation practices.

Methods	Process measures	Target for process measure	Comments
Benchmark with other peer facilities to determine what populations are excluded. For example patients with less than 24 hour admission. Continue to insure training is provided for newly on-boarded staff and audit completion of 'GEN Interprofessional Discharge Planning' intervention within Meditech.	1. Benchmark with other like hospitals to determine common practice. 2. Staff training at hire regarding standardized process (Clinical Orientation). 3. Create report to audit completion of 'GEN Interprofessional Discharge Planning' intervention with further detail on med rec completion.	1. Quarter 1 2. Ongoing 3. Quarter 3	

Measure

Dimension: Safe

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.	P	Count / Worker	Local data collection / January - December 2021	10.00	0.00	Baseline collection indicated this past year and will continue into the next cycle due to implementation of a new reporting platform.	

Change Ideas

Change Idea #1 1. Ensure all staff have appropriate training courses and understand the incident reporting requirements of the organization.

Methods	Process measures	Target for process measure	Comments
1. All front facing staff trained in: A)MOAB (Management of Aggressive Behavior) B) Gentle Persuasive Approach (GPA) upon hire and re-certification every year through online learning. 2. Ensure onboarding and yearly mandatory curriculum is completed by all staff. 3. Implementation of new incident reporting system organizational wide.	1. Attendance lists for both courses maintained. 2. Management of completion rates. 3. Completion of implementation and active use organizational wide (demonstrated understanding of system).	1. 100% by Q4 for MOAB; 100% of those requiring GPA by Q4 2. 100% by October 1 (yearly due date). 3. Q2 = fully implemented; Q2 incident reports submitted.	FTE=292