Thunder Bay Regional Health Sciences Centre

2020-2021 Quality Improvement Plan Narrative

Overview

Thunder Bay Regional Health Sciences Centre (TBRHSC) has a mission to deliver quality patient experience in an academic acute care environment that is responsive to the needs of the population of Northwestern Ontario. Our hospital, with 375 beds, serves the people of Northwestern Ontario. Our region has a population of over 250,000 residents scattered over a geographical area the size of France. We offer a broad range of specialized acute care services. As a teaching Hospital, we are proudly affiliated with Lakehead University and Confederation College and are a host training facility for medical students and residents from the Northern Ontario School of Medicine, as well as other Medical Schools. We are the largest employer in Northwestern Ontario.

Quality remains a central priority of TBRHSC. 2020/21 was a different year for TBRHSC as with all organizations due to the COVID-19 pandemic. TBRHSC worked to maintain service availability wherever possible and to address initial backlogs in elective surgery cases and diagnostic imaging has been working at up to 120% regular volumes for a number of months.

While resources and focused planning were required to support the safe delivery of care to patients in Northwestern Ontario with ongoing challenges of, global Personal Protective Equipment shortages, redeployment of staff and shifting of priorities, TBRHSC continued to advance a number of quality improvement initiatives. Three of these programs are highlighted below.

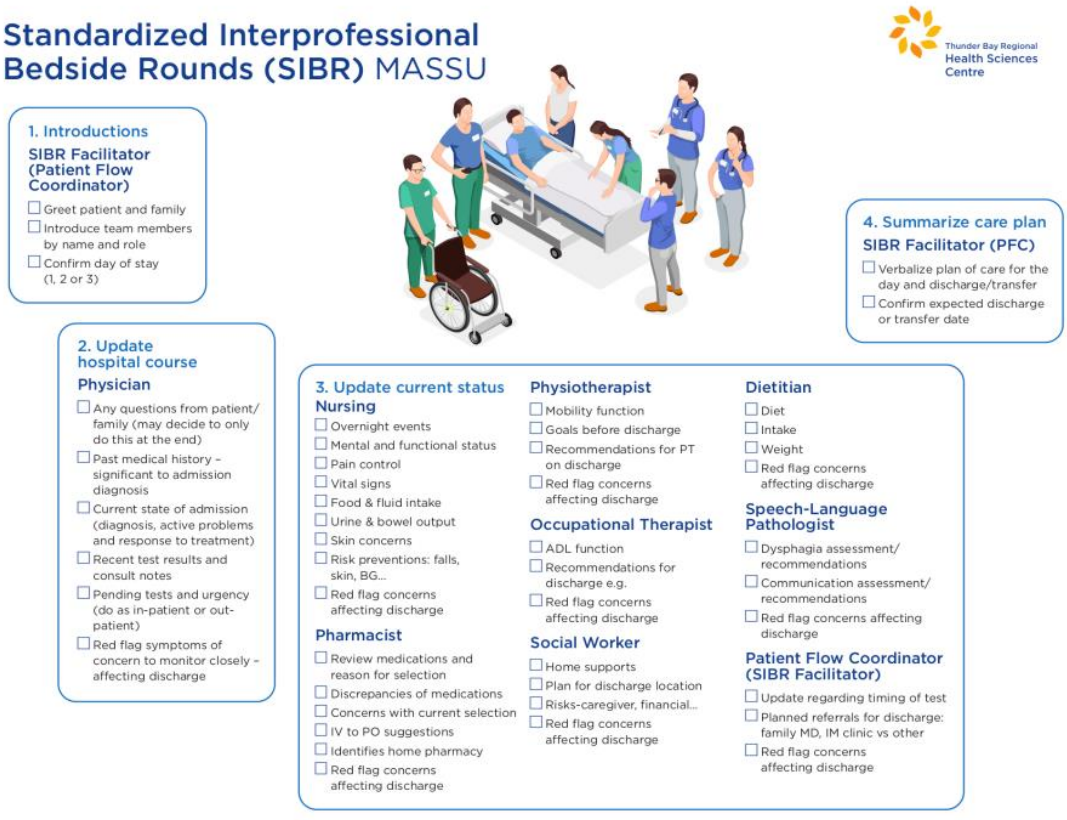
Remote Patient Monitoring: This exciting new initiative was launched for patients undergoing surgery. Remote Patient Monitoring is a new service that keeps our patients connected via an app throughout the course of their surgical journey. The tool provides an interactive, step-by-step guide to help patients prepare for their procedure and recover faster afterwards. The patient or their caregiver can access the tool on any wi-fi connected smartphone, tablet or computer. Engaging and monitoring patients remotely allows the care team to deliver safer perioperative care during the COVID-19 pandemic regardless of where patients live. It enables the safe discharge of patients earlier and minimizes in-person home care services by guiding patients from pre-op preparation through post-surgery recovery with personalized education, progress-tracking and remote monitoring.

Upon discharge from the hospital, patients are able to report their pain scores, symptoms, and share wound photos from their own devices, enabling them to be monitored by the care team. The digital tool is currently available for Hip and Knee Replacement surgery, and will be rolling out to surgical programs in Spine, Shoulder, Urology, Colorectal, Bariatrics and Thoracics.

In the first 3 months of implementation, over 210 patients have benefited from using the digital tool, with 93% of those surveyed recommending their experience to others. In addition 96% of patients said the program helps them feel less anxious before surgery and 86% said it helped them feel less worried at home after surgery. Further, 39% of patients stated the program helped to avoid on or more call to the hospital after surgery, and 12% stated it helped avoid one or more visits to the hospital. Finally, Emergency Department visits decreased by 25%, re-admissions went from 1 to 0 and average length of stay went from 3 to 1.6 for the same time period from 2019/2020.

Standardized Physician Physical & History Documentation: The TBRHSC Emergency Department is a fast-paced environment with increasingly high volumes of patients. As COVID-19 has emerged, patients are being triaged with high acuity levels, increasing the complexity of care they necessitate. Diagnostic errors occur more frequently in the ED than in regular in-patient hospital care and are associated with insufficient assessment, misinterpretation of diagnostics (Hussain, 2019). A wide variation of practice exists within the ED; standardization of practice through implementation of evidence-based clinical pathways is an effective way of reducing errors in emergency systems (Wright, 2007). In addition, there is evidence that up to 30% of tests, treatments, and procedures in Canada are potentially unnecessary (CIHI, 2017). These investigations do not add value for patients, potentially expose patients to harm, lead to more testing to investigate false positives, contributes to unwarranted stress, and consume precious time and resources (CIHI, 2017). Presently in TBRHSC's Emergency Department, no standardized ED Physician assessment/documentation tools exist. This contributes to significant variations in ED physician's ordering practices, documentation, and history and physical assessments. The aim is to improve patient safety through application of best available medical evidence, reduce unnecessary tests, treatments and procedures by embedding Choosing Wisely in standardized assessments and improving documentation of ED physician's physical and history. The scope of the project includes patients who present to the ED with: back pain; chest pain over the age of 50 years; headache; or multi-trauma over the age of 17 years.

Standardized Interprofessional Bedside Rounds (SIBR): During the Medical Assessment Short Stay Unit (MASSU) 13-week pilot, SIBR rounds were implemented with the aim to standardize communication, embed a quality-safety checklist, actively involve patients in their and discharge planning and improve interprofessional communication and collaboration. Patient feedback was collected by 80 patients who participated in the pilot,the majority of patients love the bedside model, they appreciated the opportunity to ask questions to the entire team, they felt their concerns were heard, felt better prepared for discharge as a result. Staff feedback was collected in focus groups with both MASSU interprofessional team including physicians, they found bedside rounds allowed for a common understanding of the plan of care and increased communication and collaboration, which facilitated seamless discharges. One staff said "it was the first time I felt I was truly providing patient centred care." The MASSU pilot has identified frontline champions who are engaged to continue to improve and scale interprofessional bedside rounds through ongoing PDSAs.



Compensation:

The Pay at Risk Compensation of our Executives applies to the following positions:

- President and CEO;
- Executive Vice President, Corporate Services and Operations;
- Executive Vice President, Regional Programs, Clinical Supports, Medical Affairs, and Regional Vice President Cancer Care Ontario;
- Executive Vice President, In-Patient Care Programs;
- Executive Vice President, People, Culture and Strategy;
- Executive Vice President, Regional Transformation & Integration;
- Executive Vice President, Research, Quality, and Academics;
- Chief of Staff.

The following indicator will be linked to compensation in 2021-22:

1. Rate of hand hygiene compliance.

Two percent of the executive salary will be linked to achieving the quality improvement indicator. Following April 1, 2020 team achievements will be assessed against the above quality indicator. The executive will have the opportunity to earn back the reduced salary when the target is achieved.

Each indicator will have the following sub-measures:

- No improvement over the prior year's actual = 0%;
- Improvement above prior year's actual by 75% of target will receive 75% of the maximum for that target; and
- Improvement above prior years actual by 76 to 100% of target will receive a directly proportionate 76-100% of the maximum for that target.

The resulting amount will be paid retroactively to April 1, 2021.