Let's Make Healthy Change Happen.

Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

3/28/2024

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a Quality Improvement Plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein.

Overview

Bruyère is a multi-site academic health care organization, providing a wide range of services within our hospital campuses, our long-term care homes, and in supportive and independent living for older adults and vulnerable populations.

Our post-acute care hospitals focus on helping patients restore their independence and function, providing them with a bridge back to their homes, or help accommodate the loss of independence to help them along their health care journey. With over 1000 beds in four campuses across the city, we deliver a wide variety of services in aging and rehabilitation, brain health, medically complex, palliative, residential and primary care.

The innovative work of our investigators at the Bruyère Research Institute contributes to a better, more responsive health care system and is enhanced by our Foundation that raises funds with the support of our generous community.

Our Academic Family Health Team is affiliated with the University of Ottawa and provides comprehensive primary health care to 18,000 patients from the Ottawa area at two locations.

Our Vision: TOGETHER. Making each life better.

Access and Flow

In June of 2023, the Palliative Care Program, including the William and Maureen Shenkman Palliative Care Unit, made the much-anticipated move from Élisabeth Bruyère Hospital to the newly renovated 5 South unit at Saint-Vincent Hospital. This move was necessary to support the creation of a new model of care, integrating both palliative and complex care in one building.

In November 2023, a transitional care unit opened on level five at Élisabeth Bruyère Hospital (EB5). Over the course of two phases, a total of 36 beds plus some surge capacity will reopen to accept patients on the unit. Until the second phase is complete, 12 beds opened, on a temporary basis, at the Greystone Transitional Care Unit. The unit will care for Alternate Level of Care (ALC) patients that are internal transfers, and internal referrals from rehabilitation programs. The goal is to create capacity in these programs, improving the experience of those we care for, and ensuring that more people are able to get the right level of care, at the right time, in the right place. Along with creating more capacity in the region, the reopening of these beds moves Bruyère towards Ontario Health's goal for all hospitals to operate at 95% occupancy.

Equity and Indigenous Health

Bruyère is committed to equity, diversity, inclusion, and indigeneity (EDII) for our staff, patients and residents. We have a full time EDII Specialist since 2022 and we have an active EDII committee that meets regularly to review issues and concerns and provides feedback to support equitable change within the organization. Our EDII committee is starting an indigenous employee resource group (ERG) that will focus on implementing equitable practices for indigenous staff and patients to provide a more inclusive environment.

We are collaborating with regional partners/organizations regarding how we can provide more equitable services and practices for indigenous people who are seeking access to health care. In addition, we are looking at building partnerships with indigenous peoples and organizations.

Some of the highlights related to Indigenous health this year have been:

- Hired an Indigenous Consultant, The Indigenous Reconciliation Group (IRG)

- Delivered a Leadership Development Institute session on the topic of reconciliation by Rose LeMay (IRG)
- Offered the Indigenous Cultural Competence & Humility training to our staff
- Created an Indigenous resource page on our internal website
- Invested in Access to knowledge repository through CCDI
- Events and educational sessions were organized on the topic of smudging offered by the EDII committee
- Smudging policy was put in place in 2018
- Created a one pager on resources for working with Inuit patients

Patient/client/resident experience

Bruyère's Service Excellence program is fundamental to ensuring success, developing our valued teams, and engaging our teams in how they can best provide care to those we serve and their loved ones. This is a multi-year journey in collaboration with Huron Group who was chosen as our partner because of their track record in implementing evidence-based solutions and getting results.

The program is rolled out through a series of meetings called Leadership Development Institutes (LDIs) where:

- New practices and tools are taught;
- Methods for implementing these practices with the teams are shared; and
- Standards for rolling out the practices along with supportive tools are introduced.

Some of the evidence-based practices include weekly leader-patient rounding, AIDET, and the 90 day plans. By hardwiring these tools and processes, we will improve our service provision and the patient/client/resident experience.

The Long-Term Care team put in place many initiatives to enhance the resident experience, notably around the topic of "meaningful activities" given its prominence in, both, last year's survey, as well as ongoing comments and recommendations for improvement. The team undertook this matter as a priority quality indicator on the QIP in addition to formulating a designated project charter through the Seniors Quality Leap Initiative group to focus on this area of resident experience.

Through engagement from various departments such as therapeutic recreation services (TRS), spiritual care and volunteer services, the variety and frequency of activities offered were greatly enhanced. As we continue to adjust to the new reality following the COVID-19 pandemic, the team has returned to offering non-cohorted activities and has created a "modified activities" plan to continue offering small-group activities during an outbreak according to ministry directives and internal IPAC team guidelines. Moreover, staffing was adjusted to offer more evening and weekend activities, additional opportunities were created for meaningful group sessions with the Chaplain, as well as restarting our skills and interest groups and external outings.

Our active family groups at our LTC homes have identified and led initiatives such as having themed photobooths. Other examples of enhancements to the resident experience include creating sub-committees to discuss other themes of resident experience (e.g. food related), and enhancing the communication to residents when one of their co-residents has passed, etc. In addition, to ensure representative data and enhance its collection, the team implemented a new monthly surveying model to obtain resident's feedback throughout the entire year. Nonetheless, many efforts are being deployed to enhance activity offerings by building partnerships with various community partners in addition to increasing the number of active volunteers.

The team has also enhanced previous "Transformation advisory team meetings" into designated quarterly Resident Experience committee meetings where numerous topics such as the Collaborative Living Journey, Meaningful engagement and reducing isolation, Person-centered Language Movement and Resident and Family surveys are discussed.

Bruyère Academic FHT

Patient Engagement Strategic Planning
The FHT Patient Partner Committee continues to review patient complaints, patient safety incidents, and also review of projects that impact patients. We continue to identify engagement opportunities such as ongoing patient partner participation with Quality Improvement Committee, Annual Mental Health Strategic Planning Retreat, and Patient Newsletter. Change ideas continue to emphasize patient education material about safety practices to expect from staff in addition to promotion of increased health literacy and patient self-management tools. 2024-25 priorities for patient experience include an improved phone system and planned implementation of new secure messaging and online appointment booking platform.

FHT Program and Service Highlights

Supporting Chronic Disease Self-Management
Our Chronic Disease Management RN Isabelle LeClerc is a member of Project Echo and, in collaboration with a physiatrist, she has developed a wide body of knowledge and a protocol for assisting our patients with chronic pain. She is sharing her techniques and knowledge with other FHTs in the province. She and our kinesiologist works closely with a specialist in Chronic Pain who consults in our clinics one half day per month. The outcomes of the RN's work are the subject of two research projects, and recent widely disseminated publication. Chronic noncancer pain management. Metasebia Assefa, Isabelle LeClerc, Elizabeth Muggah, Raywat Deonandan, Charles Godbout, Hillel M. Finestone. Canadian Family Physician Mar 2023, 69 (3) e52-e60; DOI: 10.46747/cfp.6903e52

Elder Care
With the establishment of our new Elder Care RN role, we have been able to progress with the Quality Improvement Indicator Priority for Safe and Effective Care: Proportion of primary care patients with a progressive, life-threatening illness who have had their palliative care needs identified early through a comprehensive and holistic assessment. For three years we had not made progress on planned change initiatives to establish baseline data nor progress on indicator despite five separate family medicine resident scholarly projects on the subject between 2017-2021. We leveraged the data from the projects to inform the programming direction for the role. Now not only are the Advanced Care Planning and Goals of Care discussions being initiated but they are being documented as well. Furthermore, the FHT partnered with research project Marche vers le futur to deliver a community wide falls prevention program for Ontario francophones 55+ addressing gap in Ontario. Our Elder Care RN Audrey Lienhard also formed partnership with Compassionate Care Ottawa for patient referrals to their Advanced Care Planning sessions.

Early Childhood Literacy
We are proud to have been selected as a successful site for the Early Words program promoting childhood literacy which includes free children's books for distribution during the two-year pilot. Factors supporting our selection included the number of residents and learners we have, as well as the priority populations we serve including newcomers, St. Mary's and Bethany in particular. Staff and residents

participated in training with a notable commitment and support toward promoting childhood literacy already demonstrated by previous staff initiatives. "Evidence shows that children whose families receive early literacy guidance as part of well-child healthcare visits are 2.5 times as likely to be read to frequently." (Canadian Children's Literacy Foundation.)

Addressing Interpretation Gaps
One of our nurse practitioners has been providing targeted services to a large group of former refugees from Myanmar who often struggle with health literacy and are often face lower socio-economic status. Due to the minority status of the languages, Burmese and Karen, there has been a number of challenges with availability of in person interpretation for this cohort. In partnership with the Somerset West Community Health Centre Ottawa Language Access Centre, our primary interpretation services provider, we have successfully recruited a new interpreter through clinic posters. We have also been piloting use of video interpretation through tablets which has been a positive experience for patients with instant access to a wide range of languages.

Collaboration and Integration

Support to Key Populations in the Community
Currently in our community there are key populations not adequately connected to primary care where primary care services need to come to them. As a Patient Medical Home, we have historically prioritized bridging this gap through formal outreach relationships with community partners including St. Mary's Home and Bethany Hope Centre (shelter and support services for young parents and their children), the Ottawa Mission (homeless shelter), Unitarian House (retirement residence), Cornerstone – Princeton Women's Housing and Options Bytown Supportive Housing. Many of these patients experience mental health and addictions issues that can make self-management and access to health care challenging. We are facing reduced capacity without additional funds for more primary care providers to continue to roster the unattached patients associated with these community partners.

Provider experience

Bruyère continues to develop a culture that embodies psychological health, safety, and well-being in all aspects of the workplace through inclusivity, collaboration, respect, compassion, accountability, and learning; and by adopting the National Standard for psychological health and safety in the workplace as our framework. The goal is to create an army of transformational leaders, both formal and informal, to spread love, wellness and recognition.
The Bruyère Team Wellness, led by our Wellness Coordinator, has been championing this work and organizing many initiatives aimed at enhancing the resiliency of our staff, reducing stress, destigmatizing mental health and normalizing help seeking. Some of the initiatives included:

- Partnering with Willis College to have staff massages on-site
- Providing Mental Health First Aid to staff
- The Working Mind Training (anti-stigma)
- CMHA Your Health Space came to complete wellness moments for 52 teams and they will return regularly throughout 2024-2025
- Reviewing EFAP providers to ensure optimal services for our teams/staff
- Residence St Louis is paving the way in our psychological health and safety journey. They have been participating in a mental health for LTC coaching program through the CLRI to help them adopt the national standard

The Your Hub / Votre Carrefour project is another effort undertaken to implement a Human Capital Management System to transform our human resources workflows, improve staff experience, and modernize our use of digital technology for all staff (compensated and non-compensated), from hire to retire. The project includes change management, following PROSCI ADKAR, to facilitate the adoption of the new technology and workflows. The system is scheduled to go live in summer, 2024.

Safety

Workplace Safety:

Bruyere remains focused on preventing injuries to staff to ensure a safe environment for all who live, work and learn at our locations. The most common injuries to healthcare workers are musculoskeletal injuries that occur when lifting, transferring or repositioning those we care for. Over the past year Bruyere has continued to invest in new equipment to support our workers. Bruyere also entered into a partnership with Able Innovations to support their development of a new platform to laterally transfer patients which they call the Alta Bed. This year Bruyere initiated two temporary positions in a role we've titled as Workplace Safety Liaison Leaders. The WSLLs worked with clinical leaders and staff to pinpoint root causes and staff injuries in clinical areas, recommend practice and equipment changes, as well as providing refresher training to staff as required. These positions were successful and planned to be implemented on full time basis.

Patient Safety:

Bruyère is dedicated to patient safety and improving our practices to mitigate and minimize risks to patients.

Our Corporate Falls Committee meets regularly to review practice related to fall prevention. The goal is to decrease our falls rates as well as risk of injury related to falls. Falls information is communicated with leaders on a weekly basis through a leadership safety call where all leaders share safety related issues across the organization.

The Quality, Patient Safety and Risk Management team holds reviews at the hospital unit level to foster a just culture to enhance patient safety across the organization. Using the Canadian Patient Safety Culture Survey (CPSCS) tool, incident follow-up was identified as a target domain for improvement. Thus, the Just Culture Exploration (JCE) was developed and added to the existing incident review process and CPSCS based questions were used to measure progress. In addition, feedback to staff who have reported safety incidents is now provided to advise on the actions taken to prevent recurrence.

Our Risk Incident Management System (RIMS) is in the process of being optimized to reduce redundancy and encourage increased reporting. In addition to reporting and reviewing of incidents in RIMS, we have also joined the Never Events provincial reporting initiative.

Moreover, our LTC team has enhanced their interdisciplinary fall reviews by creating two documentation tools to track the discussions and actions items to be taken. At the Saint-Louis Residence (SLR), the interdisciplinary Fall Squad was re-launched which includes various team members such as Behavioral Supports Ontario, Leadership, MDS coordinator, Nurse Practitioner, Occupational Therapist, Pharmacist, Physiotherapist, Quality Coordinator, Registered Dietitian, Recreation team and feedback from nursing staff. The Fall Squad discusses residents who have been falling frequently to put in place interventions to help prevent and mitigate

the risk of falls. In parallel, at SLR, a similar interdisciplinary group was created to discuss residents who have new or worsening pressure injuries or those at high risk, to put in place interventions to help prevent and mitigate risk. This group is called the Wound Squad and includes Leadership, MDS coordinator, Nurse Practitioner, Occupational Therapist, Physiotherapist, Quality Coordinator, Registered Dietitian, Skin Wellness Associate Nurse and feedback from nursing. A charting template to document interdisciplinary wound reviews was also created for both LTC homes.

Population Health Approach

We have implemented the Bruyère@Home program to facilitate sustainable, safe discharges from hospital programs home, for patients and their caregivers. This bundled funding program requires a close partnership with a contracted community agency who provides a range of tailored clinical services and supports for up to 16 weeks, including but not limited to nurses, personal support workers, occupational therapists, physiotherapists, speech therapists, and social workers, and equipment rental. This program can accommodate up to 250 patients per year, and we are now moving to test this approach with older adults at risk of hospitalization, by partnering with organizations serving seniors at risk, including Primary Care Outreach and the Community Paramedicine Programs.

In collaboration with the Champlain Community Support Network, the Dementia Society, and VHA Health & Home Supports, we have created a coordinated access point to community services throughout the region (Access Community Supports). Bruyère provides strategic and operational support to the partnership, which focuses on working with older adults and their natural supports to direct people to the social, health and home support services they need. We receive referrals from hospitals, community services, but can also receive self-referrals: all referrals are made through a digital health e-referral platform, widely in use by all community services (including Home & Community Care), Caredove, enabling ongoing monitoring of the partnership to facilitate identification of gaps, opportunities, and learnings.

Bruyère has prioritized working in collaboration with Ontario Health Teams across our region. This has included ensuring representation at leadership, navigation, and/or digital health committees in each of the five OHTs in the region, identifying opportunities for regional alignment, and providing support and expertise in the development of regional pathways (leveraging our role as the lead in the Champlain Sub-Acute Planning Network).

Executive Compensation

Our executives' compensation, including the percentage of base salary and targets, is linked to performance in the following ways:

• President and Chief Executive Officer: 4% of annual base salary is linked to successful completion of the QIP performance goals.

• Senior Leadership Team*: 4% of annual base salary is linked to successful completion of the QIP performance goals. (*Includes: Vice President Human Resources and Organizational Development; Senior Vice-President Clinical Programs & Chief Nursing Officer and Allied Health; Chief Financial Officer and Vice-President Corporate Services, Planning and Development; Vice President, Strategy, Engagement, Communications, Development and Integration; Interim Vice-President of Infection Prevention and Control; and Chief of Staff.

The pay for performance envelope is spread across the 4 Hospital programs QIP priority indicators for all members of the executive subject to pay for

performance. Partial achievement of objectives will result in partial payout, as determined by the Board of Directors.

Contact Information/Designated Lead

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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

Board Chair _____ (signature)
Board Quality Committee Chair _____ (signature)
Chief Executive Officer _____ (signature)
Other leadership as appropriate _____ (signature)