Examining QUALITY HEALTH CARE in Ontario

As CEO of the Ontario Health Quality Council (OHQC), **Ben Chan** is responsible for monitoring our health-care system and reporting back to government and the public on how well it is performing. He's assessed the effectiveness of long-term care and resident satisfaction (2008) and home health care (2009). The role of OHQC has changed with the introduction of *The Excellent Care for All Act* (passed in the legislature June 8, 2010). Chan recently took time out of his busy schedule to talk to RNJ about the new legislation, and OHQC's work with nurses.

Registered Nurse Journal (RNJ): Some of our members may not be aware of the OHQC and especially of its expanded mandate under *The Excellent Care for All Act*. Can you explain what this expansion means, and your vision for OHQC's future focus?
Ben Chan (BC): I think *The Excellent Care for All Act* is one of the most significant pieces of legislation passed in the last decade. It certainly puts the lens on quality in Ontario in a way that we've never seen before. There are three parts of the *Act* that are particularly exciting. One is the emphasis on promoting and ensuring the uptake of evidence-based practices. One of the new responsibilities of the Council will be to provide recommendations on the best clinical evidence, but also to think about what practical tools can be used throughout the system by front-line health-care practitioners to help them adopt the best evidence.

The second piece of the *Act* relates to recommendations about the funding of health-care services. It's important that when health-care providers go about doing their jobs that funding mechanisms, resource-allocation mechanisms and incentives are all aligned to encourage the best possible quality of care.

The third point is the emphasis on accountability for quality. (Hospital) boards are now legislated to pay attention to quality. They have to have quality committees; a portion of executive pay depends on the quality results that an organization is achieving. We hope that the significance of this is that it will now become part of the leadership culture, that the most important thing that we have to pay attention to is quality.

RNJ: The OHQC recently released its 2010 annual report. Can you provide a snapshot of your findings for our readers?
BC: We know that we have difficulty getting frail individuals placed into long-term care in a timely fashion. That, in turn, creates problems for getting people discharged out of hospital who might need a long-term care home, which, in turn, results in a high percentage of beds that are considered Alternate Level of Care (ALC). One-sixth of beds in Ontario are ALC and the problem isn't improving. That, in turn, makes it difficult for us to clear the emergency departments quickly and we also suspect that it makes it difficult for us to get urgent cancer surgeries done within the recommended timeframe. This demonstrates how tightly interconnected the whole health-care system is. When you have a problem in one part of the system there's a ripple effect that takes place throughout other parts. One of the things that we're really going to have to grapple with in the near future is how to meet the needs of the frail elderly who are living in the community.

In other areas of the report we identified where the uptake of evidence-based practices continues to be slow. That includes everything from whether or not patients with diabetes get the right tests or people with heart disease are on the right medications. Often we as health-care practitioners read about the best practice guidelines and want to do everything we can for our patients, but when you're feeling incredibly busy, stressed and run off your feet; it's often difficult to remember all the things you are supposed to do.

RNJ: Can you offer up a specific example of a quality improvement project or initiative you've participated in alongside nurses, and perhaps expand on some of the ways individual nurses can play a role in improving the quality of care in our system?
BC: Recently the OHQC worked with RNAO, the Ministry of Health and the Canadian Association for Wound Care to support the adoption of best practices for prevention of pressure ulcers. We all know that to prevent pressure ulcers we have to make sure immobile patients are turned regularly, to be careful about how we transfer patients so to not tear their skin, to do appropriate risk scoring and to provide padded devices for those at greatest risk. Often we find things like staff turnover or variations in processes between what the day shift and the night shift does can lead to problems. But by empowering nurses to troubleshoot and fix these problems, we can make tremendous progress.

RNJ: How do you see your partnership with RNAO evolving under the OHQC's new mandate?
BC: The RNAO has done tremendously valuable work in the development of best practice guidelines (BPG) for nursing. It will be critically important for the OHQC to work closely with RNAO in ensuring consistent adoption of best practices across the system. A number of best practices in the future will involve a well-coordin-

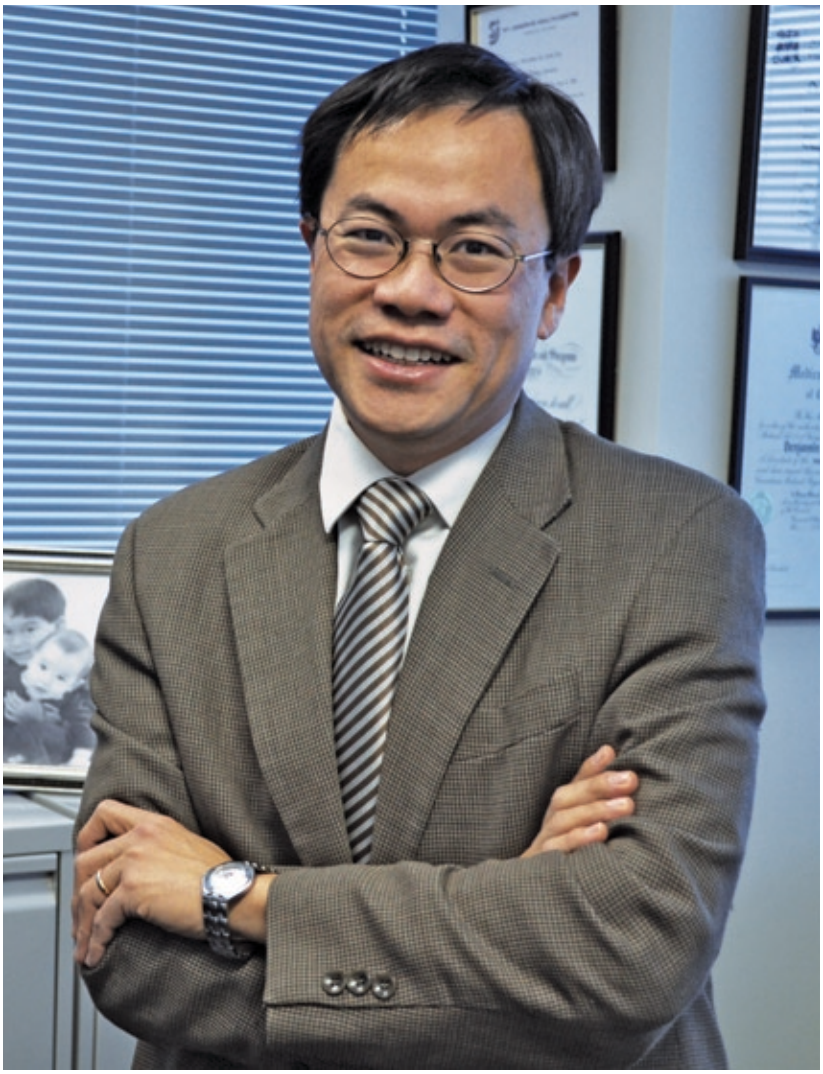

PHOTO: JILL-MARIE BURKE

ated team approach with strong coordination between nurses, physicians, pharmacists and other care providers. We also need to be thinking about how guidelines are contextualized, not just for one profession but for a care team as a whole.

RNJ: You first heard about RNAO's BPG program when you were CEO of the Health Quality Council in Saskatchewan, and advocated having the pressure ulcer BPG implemented in some of that province's long-term care homes. Why?

BC: Six years ago, when we launched the pressure ulcer quality improvement initiative in Saskatchewan, we looked to RNAO to provide us with the best clinical evidence. Those guidelines were adopted provincially and formed the basis of the specific ideas for improvement that quality improvement teams working on that initiative were testing in their local sites. We chose them because they were obviously well-researched, easy to read, and because they were developed in another Canadian province.

RNJ: You often refer to the "quality agenda" when discussing your work with front-line providers, managers and policy makers. What is that agenda, and how does it impact the day-to-day work of nurses?

BC: To me the "quality agenda" is a mindset and culture across an organization and across the entire health-care system that is constantly focused on how to improve quality. Any time there's a problem with quality, there's an instinctual reaction amongst staff and management to recognize the problem, understand the root causes, find the evidence-based ideas to improve, and test it out. It involves looking at an environment as a system, a series of processes that take place, and understanding which processes are broken and need to be redesigned. It's a culture where people are not afraid to report problems, but instead take individual leadership to name the problem and fix it.

RNJ: As a physician who still practises in rural Ontario, you see first-hand what nurses are doing to improve quality of care for patients. How would you describe their unique role?

BC: We know that nurses play a critical role in patient care by providing a wide variety of clinical services. But perhaps what's as important, if not more important, is that nurses, as the eyes and ears of the health-care system, through their frequent contact with the patient and through their regular dialogue with the patient, can understand not only clinical problems and warning signs that relate to their clinical status but also their emotional and psychosocial well-being, which is also critically important to their health. The health-care system couldn't function without them.

RNJ: What aspects of our health system aren't working, and what changes would you like to see?

BC: We still have care delivered in too many different silos. We still lack the kind of tight integration between primary care, hospital care, and community care that we aspire to. We still have too many patients falling through the cracks when they move from one part of the system to the next. A practical example is that we still have a lot of people who are re-admitted to hospital after being discharged, particularly those frail elderly with multiple chronic conditions. I think we have a great opportunity to identify what should be the best practices in those types of situations, and to set forth better expectations for the amount, the accuracy and the timeliness of information about a patient's condition and their treatment plan as they move across the system. **RN**