Health Sciences North
Horizon Santé-Nord

Excellent Care for All Act.

Quality Improvement Plans (QIP): Progress Report for 2024-2025 QIP

Key:
FY = Fiscal Year
Q1= April, May, June
Q2 = July, Aug, Sept
Q3 = Oct, Nov, Dec
Q4 = Jan, Feb, Mar

Priority Indicator	Performance as stated in the Previous QIP	Performance Goal as stated in the previous QIP	Progress to Date	Was this change idea implemented as intended ? Y/N	*Comments and Lessons Learned*
Indicator **Time to Inpatient Bed** 90th percentile emergency department wait time to inpatient bed **Reporting Period:** Q3 **Data Source:** ExpanseDischargeSummary - Report Viewer	12.2%	13%	This work was on hold due to Expanse launch in June of 2024. Once transitioning from the stabilization phase to the optimization phase occurred, we moved forward with identified steps from action plan.	**N**	**Standardization of discharge planning with EMR** METHOD: Implement discharge workflow in Expanse **DETAILS:** **Progress:** • Multidisciplinary team established, including Patient and Family Advisor and Physician representation • Feedback collected on current "new" current state; discharge barriers post-Expanse go-live • Held an initial team meeting (Jan 14, 2025) to review survey findings and prioritize discharge challenges, focusing on: timely entry of Estimated Dates of Discharge (EDDs), enhancing workflows to reduce physician-related delays, engaged the BPMH (Best Possible Medication History) working group to address overlapping barriers and streamline discharge processes • Software engineering is rebuilding Patient Action Manager (PAM) to pull real-time analytics and enable discharge tracking (rudimentary launch planned for Feb 2025) • Limited engagement from Expanse IT team at other Expanse hospitals regarding discharge optimization **Challenges Encountered:** • All work on hold in anticipation of Expanse launch, then also during the stabilization phase • Data gaps for a few months after Expanse launch • Limited response from Expanse teams from other hospitals on their discharge optimization • Physician engagement/representation

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					• Limited familiarity with Expanse and uncertainty about optimal documentation practices for both staff and physicians, especially with the varying features in Expanse dependent on login access (ie. Physicians have different options than nurses, or allied health etc.) **Next Steps:** • Continue refining EDD entry workflows (establish role and process) • Assess how PAM 2.0 can assist in discharge optimization • Gain more insights into barriers from the physician lens • Liaise with the BPMH on discharge working group to align our efforts • Continuing education for staff and physicians related to optimizing discharge workflows **Lessons Learned:** • Effective collaboration across teams and ongoing IT/DSR support are critical for optimizing workflows and meeting KPIs
				Y	**Implement additional bed capacity** METHOD: Open 31 beds at Amberwood to support transitioning ALC patients to the community **DETAILS:** • Additional 31 beds opened as of mid July 2024 with updated inclusion/exclusion criteria • Helping to ease acute care bed pressures by housing the majority of ALC-LTC designated patients who have longer lengths of stay while awaiting LTC placement • Focus will remain on monitoring the sustained impact of this initiative, identifying best practices, and exploring opportunities to replicate or expand these strategies to further enhance patient flow and optimize acute care resources **Lessons Learned:** • Initial challenges establishing HSN policies and standards due to reliance on agency and Amberwood staff - consistent training and integration are needed • Reliance on external staff highlights the need for a stable, interdisciplinary team to maintain consistent care standards • Ensuring patients remain active and engaged is crucial for preventing deconditioning while awaiting LTC placement – recruitment of OT/PT • Continuous collaboration between HSN, Amberwood, and agency staff is essential to streamline operations and align care expectations.

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Indicator **Experience: Patient-centred** **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?** **Reporting Period:** Jan 2025 **Data Source:** Local Data Collection	72.1% January, 2024	63% by March 31, 2025	69% January, 2025	**Y**	**Discharged patients receive the appropriate information when leaving the hospital** METHOD: Implement Meditech Expanse EMR **DETAILS:** The performance of this indicator has been captured since August 2023 upon the initial distribution of the Canadian Patient Experience Survey - Inpatient Care (CPES-IC). With the transition to the new electronic medical health record, Meditech Expanse, discharge summaries are available to be printed and provided to patients when leaving the hospital. As we turn our focus to system optimization, next steps will involve reporting on the process of providing a printed discharge summary via performance reports that will be available through Meditech Expanse, however we continue to wait for report availability.
Indicator: **Safety** **Medication reconciliation at discharge:**	73% January, 2024	80% by March 31, 2025	80% January, 2025	**Y**	**Improve discharge medication reconciliation performance** **METHOD: Implementation of Meditech Expanse EMR** **DETAILS:** • Standardized medication reconciliation workflows within the EMR system • Improved tracking of medication reconciliation processes to allow for improvement opportunities • Ability to monitor compliance through EMR generated reports.

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Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged. **Reporting Period:** Average from Apr 2024 to Feb 2025 **Data Source:** - Apr-May 2024 Manual Data Capture - Jun-Feb Decision Support pulled data from Meditech using reports developed a the founding sites				**Y**	**Improve capturing medication reconciliation on admission (BPMH) will improve the quality of medication reconciliation at discharge** METHOD: Implementation of dedicated BPMH collection staff in the ED **DETAILS:** • Helps to improve the quality of BPMHs which should improve accuracy and ease of discharge reconciliation. • Ability to certify and audit dedicated staff within the ED • Enhance inter-professional collaboration between pharmacy technicians, pharmacists, nurses and physicians. METHOD: Implementation of Meditech Expanse EMR **DETAILS:** • Integration of BPMH carry over from visit to visit helps improve turn around time for BPMH creation • Standardizing BPMH creation using available dictionaries reduces the number of transcription errors
Indicator: **Experience:** **Staff Turnover Rate** **Patient-centred**	12.2% December 2023	Contain Turnover to 13% by March 31, 2025	9.4% December 2024	**Y**	**Recruitment** **Targeted recruitment efforts** METHOD: A minimum of 4 action plans implemented for high need recruitment areas (Nursing, PT, OT, Radiation Therapy) **DETAILS:**

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The year-to-date turnover rate of HSN staff in aggregate, calculated by dividing the sum of resignations, retirements, and involuntary terminations by average headcount and multiplying by 100. **Reporting Period:** Apr 2024-Dec 2024 **Data Source:** MyHSN					• Action plans have been developed for Nursing, Radiation Therapists, Respiratory Therapists, and OT/PT. Actions have been planned over the fiscal year with full engagement of the hiring areas/managers. • List of 10 "high risk, hard to recruit" roles identified where there is not a local educational institution to predict future graduates and likely recruitment. • Recruitment incentives policy developed and implemented. **Time to Fill** METHOD: Reduce time to fill external nursing positions from date of first contact to first verbal/conditional offer. **DETAILS:** • Tracking has started for the RPN classification. Data from August 2024 to present tracked 12 external RPNs hire through the pool. 1) metric of candidate application to initial contact made by HSN within 48 hours was achieved 100% of the time. 2) metric of screening the candidate's initial response and which area of the organization they'd like to work in to when they are interviewed is within 7 days; this was achieved 100% of the time. 3) metric of the interview being reviewed by HR and passed along to the hiring manager to when the verbal offer is made is 5 days. This metrics is achieved 90% of the time. The reason for the delay in process is due to the manager's response time and therefore being passed along to another manager for consideration, or the candidate changes their mind to which unit they'd like to be considered for. • The recruitment team continues to maximize all recruitment incentive initiatives available through the Ministry of Health, including the Nursing Graduate Guarantee (NGG), Enhanced Extern, and Supervised Professional Experience (SPEP) programs, and the Community Commitment Program for Nurses. To date, these incentives have supported 803 successful recruitments to HSN: • NGG 2023-2024: 40; NGG 2024-2025 YTD: 48 • Extern (program started in 2021): 469 total hired (190 are currently active and 112 were hired following graduation) • SPEP (program started in 2022): 9 in total were hired • CCPN (program started in 2022): 237 offers for CCPN made **Exit interviews** METHOD: Increase participation; develop process to regularly share information with units to implement improvements

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					DETAILS: • Policy has been finalized and monthly data collection and distribution, as required, has been implemented. Completion rate for Q1 was 14%; Q2 was 16%. Will be reviewed quarterly.
				Y	**Engagement: Enhance culture of well-being** **Implement 2023-24 Stay interview recommendations** METHOD: % of stay interview recommendations implemented in Nursing, Allied Health and Support Services (2 recommendations/group) **DETAILS:** • The Stay Interviews committee has met 3 times YTD. The initial meeting focused on onboarding and orientation, while the second session centered on aligning efforts to determine which recommendations to prioritize. We remain on track with the established work plan. • The final recommendations will be confirmed and action plans will be developed and assigned to committee members for implementation. Once the action plans are finalized, they will be submitted to Senior Leadership for endorsement shortly thereafter. **Organizational focus on HCW satisfaction** METHOD: % of program level targets/plan to improve upon HCW satisfaction. **DETAILS:** • This initiative has been modified to align with the implementation of quality improvement tools. 2023 Quality of Worklife (QWL) survey results and subsequent 2024 QWL Pulse survey results were shared broadly across the organization. Action planning against the QWL results to be supported through leadership with rounding, daily huddle boards and monthly 1:1 meetings. QWL and action planning also the focus of a Leadership Summit in February 2025. **Enhance shared learning opportunities** METHOD: # of quarterly organizational report outs

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					DETAILS: • Program level report outs embedded into the Performance Leadership Committee (monthly). Kudos/good news are standing agenda items at Management Townhall. More than 10 good news stories/kudos shared at October 2024 Leadership Summit. **Enhance recognition program** METHOD: HCW President's Awards implemented **DETAILS:** • The inaugural Excellence in Action Awards recognized HSN's commitment to improvement and engagement, with over 220 nominations. All nominees received certificates signed by the CEO. The event on September 27th at the Science North Cavern, with 150+ attendees, honored achievements in 12 categories. 14 winners – including two teams- received trophies and were celebrated in the Wellness Newsletter, Hub posts and social media, inspiring pride and motivating staff to pursue excellence and support HSN's mission. **Organizational Wellness Strategy** METHOD: Implement annual Wellness action plan **DETAILS:** • Under the guidance of the Wellness and Engagement Steering committee, the Wellness Champions Committee held its first meeting in October 2024, and has formed working groups to drive initiatives. A new wellness space, featuring updated décor, resources, and furniture (arriving by January), will open soon, with outdoor enhancements planned for spring. • In addition, work is well underway to achieve the *Excellence Canada, Healthy Workplace Certification* by April 2025. Focus groups with Senior Leadership, medical staff, employee groups, volunteers & learners and Wellness champions were scheduled for February 3rd -5th. An overall report is anticipated to accompany the results, providing the organization with our strengths and opportunities to build a healthy workplace • Wellness resources and updates are communicated to the organization via a monthly wellness newsletter. The newsletter has increase views month over month since its launch and continues to be a source of wellness resources, information and activities.

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					• Increase in Newsletter views month over month Sept: 355 Oct: 368 Nov. 423 • Employee and Family Assistance Program utilization is fluctuating Sept: 152 Oct: 91 Nov: 61 • Wellness Room is slated to be opened by end of January. Room will be painted this month - one month behind schedule
				Y	**Develop our People** **Optimize professional development opportunities with a focus on leadership and skills development** METHOD: # of development opportunities **DETAILS:** Leadership Development Program Overview Total Participants (2019–2024): • 409 participants have completed the Leadership Development Program (LDP) Master Class. Cohort Updates • Cohort 7: ○ 21 Emerging Leaders and 33 Existing Leaders will graduate in April 2025. ○ The program remains a required part of new leader training, with two sessions scheduled this fiscal year to meet demand. Upcoming Needs • As of March 31, 2025, 65 existing leaders still need to complete the program and will be invited in 2025–2026. Emerging Leaders (Current Participation) • Self-Study Series: ○ 77 Emerging Leaders on the waitlist are currently participating in the Self-Study Series. Investment Overview (2019–2024) ○ Frontline to Leadership Promotions: ○ 97 employees were promoted from frontline to leadership positions since 2019. ○ 2 new promotions since the last report. ○ 18 employees were promoted from frontline to management in 2024, including 5 Master Class graduates. • Existing Leaders: ○ 23 existing leaders received promotions or permanent roles, 8 of whom were LDP graduates.

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					• In October 2024, a Leadership Summit was held after the success of our two summits prior to EMR launch. Topics covered included Organizational Excellence framework, HSN capital planning, Strategy Deployment tools and the recognition toolkit. • The next Leadership Summit is scheduled for February 26, 2025.
				Y	**Safety: Reduce number of safety events resulting in Lost Time by 10%** **Improve reporting and data accuracy** METHOD: % supervisor incident report are completed by month end **DETAILS:** • Data completion and accuracy is at 91% from initial benchmark of 57% **Pro-active approach to top 3 areas of hazard risks** METHOD: Organizational level action plans **DETAILS:** • Action plans developed, implemented and monitored monthly for Workplace Violence (WPV), Patient Handling and Slips/Trips/Falls • Workplace Violence action plan, policies and incidents are monitored through monthly WPV Committee • Occupational Health and Safety monthly report shared across the organization **Enhance critical event processes** METHOD: % of staff critical event investigations complete within 30 days. **DETAILS:** • 9 of 14 (64%) Staff Critical Events completed within 30 days **Enhance internal responsibility system (IRS)** METHOD:

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					• % of active management completed Supervisor Safety Training; • % of new hires receive training through general orientation • % of Board of Directors complete their training. **DETAILS:** • Board of Directors training completed in November 2024 • 46% of new hires have received training through General Orientation as of Dec 2024 • 50% of active management have completed Supervisor Safety Training as of December 2024
				Y	**Improved organizational health and safety engagement** METHOD: OHSW safety rounding **DETAILS:** • OHS staff rounding on minimum 2 units per week • Rounding information linked back to OHS daily huddle board • Enhanced rounding in areas when/where safety risk levels increase