2022/23 Quality Improvement Plan
"Improvement Targets and Initiatives"

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AIM		Measure									Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process/Outcome measures	Target for process/Outcome measure	Comments
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) C = custom (add any other indicators you are working on)															
Theme I: Timely and Efficient Transitions	**Timely**	The number of surgeries performed at Health Sciences North on the last calendar day of the month.	C U S T O M	Number surgeries performed	Internal	959*	15, 212 3-yr average (2018/19 – 2020/21)	16, 500	Waitlist growth over the past 9 months has been in excess of 1100 cases. HSN has not yet been able to resume pre-pandemic activity due to COVID impacts and because of this, the focus of this year's surgical indicator will be on re-establishment of pre-pandemic surgical activity volumes.		Highest Effort Phase 1: Secure Necessary Resources to Support Increased Surgical Capacity	Schedule additional surgical blocks required to support increase volumes	# additional surgical blocks scheduled	50 additional blocks reflected on the 2022/23 OR block schedule by February 28, 2022	planned baseline 2021/22 blocks 3082
												Recruit Health Human Resources required to support increase surgical volumes	% additional OR staff (nursing, anesthesia, ward clerk, OR attendant) recruited	100 % additional staff started by May 1st, 2022	assumes 4 month nursing orientation
													% additional surgical program staff recruited	100 % additional surgical program staff started by by June 30, 2022	timeline needs to be identified by non-surgical programs
													% additional non-surgical staff recruited	100 % additional non-surgical program staff started by by June 30, 2022	
												HSN to develop and monitor plan to designate the required number of surgical beds to support increased surgical volumes	HSN to produce a finalized plan	Plan finalized by June 30, 2022	who/what/when required
													# of surgical patients in surgical unit beds	90 beds available for surgical patient placement on surgical inpatient units by June 30, 2022	
												Confirm internal and external resources to support increased surgical volumes	Financial resources secured	Receive adequate funding	senior management input required
														Receive adequate funding	could use $6500/ block x 50 blocks for OR costs; revenues can be estimated
											Phase 2: Implement and Monitor Surgical Ramp-Up	Monitor the number of added surgical blocks and cases within those blocks	# of added blocks and # cases within those blocks	50 added blocks by March 31, 2023 200 added cases by March 31, 2023	
													% total blocks and % total cases per month	100% of scheduled total blocks /month 100% of total cases/month	
Theme I: Timely and Efficient Transitions	**Timely**	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.	M A N D A T O R Y	Hours / All patients	ERNI YTD / Dec 31, 2021	959*	26.1	26	The 26 hour target was selected as it is closely aligned with pre-pandemic provincial performance and remains significantly below HSN performance pre-pandemic. Additionally, achievement will be balanced with efforts to increase surgical capacity and volume, which impact bed utilization.		**Highest Effort** **Adopt Alternative Level of Care Leading practices (supported by Self-Assessment completed in 2021)**	Implement early identification of "at risk (for protracted hospital stays)" patients presenting to the ED	% of tool completed for ED patients over the age of 65 at time of triage	90%	
												Improve mobilization of patients in the ED by the mobility team	% of "at risk" patients mobilized within 4 hours of admission	Q1 - 60% Q2 - 75% Q3 - 90%	Promote nurses and physicians in early mobilization i.e. to diagnostics etc.
												Ensure discharged patients receive a written transition plan, developed and agreed upon in partnership with the patient and their designated care giver, the hospital team, primary care and home and community care providers, 2 days prior to leaving the hospital	1. % patients with written plans given 2. % patients given written plan 48 hrs before discharge	1. 80% (*current rate is 85% in the Medicine Program, but will need to get current state in all other programs as the first step*) 2. 50% (*current rate is 0%*)	Implement across all inpatient units in the: • Medicine Program (excluding CMU) - 8N, 4N, 5S,6S • Surgical Program - 4S, 7N • Mental Health & Addictions Program - 6N (including PICU and SDU), Kirkwood Site, CAMHP • Rehabilitation Program - IRU • RCU and AMU
											Improve response times with Clinical Support Services	Decrease wait times for internal patient transportation requests	% of patients transported within 20 min (received request to transportation complete. Patient transportation is organizational wide.)	90%	
												Improve medical imaging wait times for CT, x-ray and U/S tests ordered in the ED	% of ED patients with turnaround times meeting proposed targets for CT, X-ray and U/S	95% CT 90% X-Ray 90% Ultrasound	target times: CT within 60 min; x-ray within 30 min; U/S within 65 min
											Improve lengths of stay	Standardize use of Patient Action Manager to identify responsibilities and expected outcomes to meet Estimated date of discharge (EDD)	% of patients discharged who have barriers to discharge documented in Patient action manager (PAM)	Q2 - 65% of patients have barriers to discharge identified on PAM within 48 hrs of EDD Q3 - 80% of patients have barriers to discharge identified on PAM within 48 hrs of EDD (no barriers will be identified as such)	Includes all the inpatients units: • Medicine Program (excluding CMU) - 8N, 4N, 5S,6S • Surgical Program - 4S, 7N • Mental Health & Addictions Program - 6N (including PICU and SDU), Kirkwood Site, CAMHP • IRU, AMU and RCU This improvement will lead to continued work with data that will support what the barriers to discharge are so we can begin to have focused work on those barriers in the 23/24 QIP.
												Improve lengths of stay for top contributors (Case mix groups)	% reduction of LOS for 2 selected Case mix groups	Q2 - 100% - Leadership Training Q3 - 100% - Top 2 cmg's for review identified by all units Q4 - 100% - Improvement plan developed by all units (ie. applied use of handbooks, choosing wisely, seniors friendly)	

Theme III: Safe and Effective Care	**Safety**	The number of workplace violence incidents reported by hospital workers (as defined by the Occupational Health and Safety Act) involving physical force	C U S T O M	Count / Worker	Local data collection Apr - Dec 2021	959*	12/month (achieved <10 2/9 months)	Pursue zero harm through prevention of workplace violence involving physical force. We will measure progress by the number of months where the number of workplace violence incidents involving physical force was fewer than the prior year	In 2021/22 there were an average of 12 incidents per month. Organizational efforts to address and achieve zero harm continue and the root causes of incidents are still being studied. System improvement and support measures to minimize harm that were initiated in 2021/22 continue with an anticipation of further incident reductions into next fiscal.		**Strategic investments in supporting and developing our people in the prevention and response to Workplace Violence**	The proposed budget for 2022/2023 will include an annualized investment for the Behavioural Escalation Support Team as well as a new investment to support consistent and reliable Security services	$400,000 annualized investment in BEST	$400,000 annualized investment in BEST Strategic investments in supporting and developing our people in the prevention and response to Workplace Violence	The proposed budget for 2022/2023 will include an annualized investment for the Behavioural Escalation Support Team as well as a new investment to support consistent and reliable Security services
											Highest Effort **Determine patient's level of risk for workplace violence**	A) The Behavioural Escalation Support Team and Emergency Department Leadership will guide the implementation/utilization of a violence assessment tool to determine if a patient is low, medium, high or very high risk at first contact	% of patients of identified target population at Emergency Department triage or first contact with their primary care nurse will have a documented violence assessment rating.	80% by Dec. 31, 2022	Violence assessment tool from Public Services Health and Safety Association used for all patients but Mental Health - use Dynamic Appraisal of Situational Aggression
													% of patients on admission to an inpatient unit will have a documented violence assessment rating.	80% by Dec. 31, 2022	Do a current state review of existing assessment tools: Validate the tool on Child and Adolescent Mental Health Program
													% of team members receiving education/training on the new process	95% by December 31, 2022	Behavioural Escalation Support Team for content, Leadership and Learning for education design
												B) Mental Health Program will lead the development of a process to enhance communication and shared decision-making in the determination of a patient's level of risk upon entry to the Emergency Department	Develop and implement a police - hospital transition framework in collaboration with police, Mental Health, and the Emergency Department	Completion by March 31, 2023	
											Manage/mitigate workplace violence risk determined by violence assessment rating	The Behavioural Escalation Support Team will guide the implementation of a process for clear pathways to controls/supports based on level of risk of low, medium, high and very high.	% of incidents involving physical force that did not have controls/supports in place at the time of the event	0% by December 31, 2022	Develop algorithm for low, medium, high, very high risk - when to trigger Behavioural Escalation Support Team, Crisis, Security, etc.
											Provide workplace violence prevention education and training to NEW Health Care workers	Leadership and Learning will provide all new hires with Workplace Violence Prevention de-escalation training (developed by Behavioural Escalation Support Team) as part of General Orientation.	% of all new hires that complete verbal de-escalation training prior to starting work on their units	95% to start at July General Orientation session.	1/2 hr Self -Learning Package to be completed prior to the General Orientation Session. Build off of an existing Self-Learning Package. Anne Sprack to develop.
											Leadership maintains compliance with Workplace Violence Risk Assessments	Senior Leadership Committee will identify completing annual review of Workplace Violence Risk Assessments as one element of People and Safety performance goals for leaders.	% of Workplace Violence Risk Assessments that have been reviewed within 12 months. To be shared with the Workplace Violence Prevention Committee and Senior Leadership Committee	100% compliance reported out quarterly at Workplace Violence Prevention Committee and Senior Leadership Committee	Blitz in February to complete Risk Assessments, will convert to a quarterly rather than annual process
											Implement process to learn from workplace violence incidents	A) Security will facilitate the activation of a standardized debrief process (debrief tool) to gather root causes following a Code White	% of Code Whites that will have a documented root cause that will be shared with the Workplace Violence Prevention Committee monthly	80% by September 1, 2022	Debrief tool has been developed and includes triggers/root cause - Security to implement once resources are in place and upload into Critical Risk Management System
												B) Occupational Health and Safety will assist managers in the investigation of workplace violence incidents involving physical force to gather root causes	% of incidents involving physical force will have a documented root cause/trigger that will be shared with the Workplace Violence Prevention Committee monthly	95% by September 1, 2022	Once MyHSN is in place - will be easier for Occupational Health and Safety to track this (May 2022)
											Standardize approach to supporting health care workers in the defuse process following a Code White	A) Security will provide staff with available resources during the debrief process following a Code White	% of Code Whites that have indication on the debrief form that staff are made aware of potential resources.	80% by September 1, 2022	Security will develop a Code White Response Kit to include debrief form - defuse resources. Create a pamphlet for staff to take home with them.
												B) Behavioural Escalation Support Team will support managers/staff where a Code White occurred to determine if additional resources are required	% of Behavioural Escalation Support Team follow-ups that occur within 48 hours of a Code White	80% by September 1, 2022	Behavioural Escalation Support Team will receive all Critical Risk Management System Code White notifications - automatic trigger via email