2023/24 Quality Improvement Plan
"Improvement Targets and Initiatives"

Health Sciences North 41 Ramsey Lake Road, Sudbury , ON, P3E5J1

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 III: Safe and Effective Care	**Patient Centred**	Patient Experience - Did you receive enough information when you left the hospital.	P R I O R I T Y												NRC picker survey method was discontinued by the OHA effective Mar 31, 22. HSN adopted an interim bridge solution utilizing survey monkey. Questions focusing on discharge experience have been asked of discharged medicine and surgical patients and over the last 6 months performance is demonstrating an 80% or higher satisfaction rate. Adoption of a new digital survey solution is expected to launch in 23/24 and HSN will look to integrate measure(s) from this survey into 23/24 quality and patient safety monitoring indicators.
Theme III: Safe and Effective Care	**Effective**	Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged.	P R I O R I T Y	Rate per total number of discharged patients / Discharged patients		959*	Q3 - 72%	75%	Sustain healthy med rec practices and continue to advance progress made to date by increasing our operational target to 75%.	None	**Highest Effort:** Build on the success and improve discharge medication reconciliation performance.	Monthly monitoring and communication of unit level performance.	% discharge med rec completed for all admits to all units /total hospital admits all units	75% by Q4	Excluding patients leaving Against Medical Advice
												Continue and sustain current education practices for prescribers and staff.	% of staff and medical staff who have completed the required education for their role.	90%	
												Support local unit level problem solving with targeted improvement in low performing areas.(i.e. Surgical Program, Critical Care Program and NICU as of Q3 22/23) Local areas will implement action plans to close the gap.	% discharge med rec completed for all admits to all units /total hospital admits all units.	75% by Q4	
											Leverage the new hospital information system to support the process of medication reconciliation	Work collaboratively with internal stakeholders to develop an HSN future state medication reconciliation process map that aligns with Meditech Expanse functionality.	% of applicable staff trained on the new Expanse med rec process	100%	
Theme: Safe and Effective Care	**Safety**	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.	C U S T O M	% / Worker	Internal / 2021-2022 Actuals 2022-2023 Forecast	959*	15.98% 16.25% Forecast	15.00%	Having appropriate and sustained health human resources to meet our current needs is one of HSN's top enterprise risks. HSN's turnover rate has increased significantly from fiscal years 2019/20 (6.6%) and 2020/21 (7.0%) to 2021/22 (15.98%) and 2022/23 (10.83% at Nov 2022; forecast 16.25%). Taking into consideration internal data and OHA benchmarking data for all hospitals in 2021/22 (10.3%) and OHA pulse survey data (14.66% at Sep 2022), a target to contain turnover to 15.00% in 2023/24 is expected to be realistic, given provincial context for staffing and local context for ongoing pandemic response and recovery, and achievable within the fiscal year.	None	DATA - Monitor performance against targets and benchmarks	Define HHR metrics (inclusive of targets) and implement dashboard to enhance visibility and monitoring of results. Include benchmarking comparables where possible.	Implement HHR Dashboard	Data needs defined by April 30th. HHR dashboard implemented by end Q1.	
											Highest Effort: ENGAGEMENT - Define and identify countermeasures to address root causes for attrition	1) Expand Stay interview methodology to Allied Health and Support Services, continue Stay interviews with Nursing 2) Improve participation in Exit Interviews 3) Implement new QWL survey with pulse surveys focusing on organizational priorities. 4) Implement "entry survey" with new recruits 1-3 months after start date	1) Complete 30 exit interviews with Support Services and Allied Health staff, 5 exit interviews with Nursing to expand upon stay interviews completed in 2022/23. 2) Increase participation in exit interviews by 10% 3) Implement new QWL survey tool with pulse surveys focused on organization priorities 4) "Entry surveys" with 85% of new recruits within 3 months of start date.	1) Support Services interviews completed by end of Q1 and subsequent analysis done within 6 weeks of completion. Allied Health interviews completed by end of Q2 with subsequent analysis done within 6 weeks of completion. 5 exit interviews and analysis per quarter with Nursing. 2) Increase participation by 10% participation by end Q4 3) Q3 4) Implement by end of Q1	
											WORKFORCE - Securing and sustaining appropriate health human resources *prioritization undertaken leveraging knowledge gathered through engagement actions	1) Optimize recruitment initiatives 2) Proactively identify final year placement students and transition to front-line roles 3) Assess temporary job postings 4) Optimize Professional Development Opportunities 5) Implement Wellness Strategy 6) Enhance Recognition Program	1) 80% NGGs who transition to front-line nursing roles following the 12-week orientation. 2) 80% nursing extern students in their final year who transition to a nursing role at HSN. 3) Review 100% of existing temporary job postings for feasibility for permanency by end of Q1. 4) 100% of Education and development investment is utilized 5) a) Hire Wellness Lead b) Enhance physical and mental health resources for healthcare workers as part of Year 1 Wellness Strategy 6) Implement enhanced years of service recognition program	1) end of Q4 2) end of Q2 3) end of Q1 and ongoing monitoring 4) Monitored quarterly 5) a) end of Q1 b) end of Q3 6) end of Q3	

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.	C U S T O M			959*	36.4 YTD Dec 2022 (from ERNI)	**29**	The 29 hour target is recommended as it represents a significant improvement over 2022-23 performance both at HSN and provincially. As of January 31, 2023 HSN's performance was 37hrs and provincial performance in the same period was 34 hours. It is important to note that whilst this year's target is lower than the prior year of 26 hours target we are using a similar methodology. The reduction in the target is driven by overall decline in provincial performance in 2022-2023.	Transportation Partners HCCSS	**HIGHEST EFFORT:** Standardization of HSN patient flow practices and process to support on time discharge.	***1. Discharge practices across inpatient units*** A multi- disciplinary committee will work together to design and implement standardized discharge process for inpatient units that builds on the culture of on time discharge.	1. Development of clinical communication tools and clinical process to support multidisciplinary discharge planning. 2. Develop a standard of work for multidisciplinary team outlining key roles, daily activities, rounds, patient EDD and operational process including clinical escalation triggers 3. Transportation pathway developed to ensure resources are available for earlier discharge.	**~HSN Standardized Discharge Practice inclusive of communication tools, SOW key roles, daily activities, operational processes** **~Transportation Pathway.** **~Bed Flow Management Policy updated with Clinical Escalation Triggers to support decision making.**	Implementation plan for inpatient units to be designed.
												2. Discharge practices across inpatient units Increase organizational discharges to occur before 11 and 14:00.	Increase % of earlier discharges	1. 30% by 11 and 2. 60% by 1400 (current state 11% by 11 and 37% by 1400)	
										HCCSS		***3. Utilization of clinical information to inform decision making and on time discharge*** . Routinely predict and act on estimated date of discharge (EDD) which includes discharge planning with the patient and their designated care partner and the entire interdisciplinary team in collaboration with external partners.	1. Patients receive an EDD within 5 hours of admission to an inpatient unit and the EDD is made visible to the patient 2. Barriers to discharge are identified in PAM 48 hours in advance of EDD. 3. Patients and DCPs are provided with a written transition plan 48 hours prior to discharge. 4. utilization of white board communication tools to inform patient and [illegible]	1.80% 2.80% 3.70%	
												4. Utilization of clinical information to inform decision making and on time discharge . Utilization committee develop and endorse a HSN wide approach to data driven hospital wide patient flow which support decision making a culture through continuous quality improvement. Ultimately creating a pull patient flow system across clinical areas.	1. Utilization Report. 2. Morning report to directors and managers with the following; no bed admits in the ED, inpatients (unit specific) who are near and who have exceeded the EDD, regional patients waiting for admission and level of priority, patient repatriation status on each inpatient unit. 3. Barriers to discharge report (unit specific) 4. Develop a standard of work for multidisciplinary team outlining key roles, daily activities, rounds, patient EDD and operational process including alert escalation practices.	1. Q1 - 100% Complete 2. Q2 - 100% Complete 3. Q2 - 100% Complete	
											Open New 52 Bed West Wing Unit 2023-24	Utilize Funding to open 52 Beds in west wing to build more stable capacity across HSN.	1. Model of Care for the new unit to be developed. 2. Staff to be hired and onboarded. 3. Construction to be completed on time and on budget 4. PFAC engagement in the development of the 52 Bed Wing Capacity	52 Beds are open and staffed	
										HCCMS	ALC Reduction Strategy to meet Annual Target 95	ALC reduction funding strategies, six projects are initiated and support the transition of ALC patients from HSN	**6 key projects implements with NESGC and Rehab** 1. Geriatric Inpatient Consultation Service Expansion 2. Hospital Elder Life Program 3. Hospital-Based Outpatient Rehabilitative Care 4. Expansion of the Geriatric Transitional Care Team 5. NESGC Geriatric Medicine Urgent Response Team 6. NESGC Coordinated Access	95 ALC patients admitted in hospital	
										HCCMS	Integrated Community AL-Complex Discharge Planning.	ALC - dedicated complex discharge team with integrated ALC rounding that includes our community partners.	1. Full integration of home first liaisons with robust complex discharge responsibilities identified in sow. 2. ALC discharge rounds early in the week with the interdisciplinary team. 3. Wait times for assessment by HCCSS are made visible with action plans identified to support improvements on response times.	1. Q1 2. Q1 - rounds established 3. Q2 - Plan developed to align at risk referrals to be assigned within 3 days	
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 Jan - Dec 2022	959*	116 (9/12 months had fewer workplace violence incidents than previous year)	104 (1 event less each month than the previous year)	Continue to pursue zero harm through prevention of workplace violence involving physical force. We will continue to measure progress by the number of months where the number of workplace violence incidents involving physical force is fewer than the previous year.		Strategic investments in supporting and developing our people in the prevention and response to Workplace Violence	The proposed budget for 2023/2024 will include : 1) Annualized Investment in the Behavioural Escalation Support Team (BEST) 2) Implement Security +1 in the Emergency Dept 3) Complete inpatient psychiatric space upgrades (remaining 2 of 7 beds) 4) Emergency Department registration and triage safety 5)Security enhancements at Kirkwood	$ 2,239,000 invested in improved safety measures, including human resources and environmental controls.	1) $400,000 annualized investment in BEST 2) $250, 000 for security in the Emergency Department and sustainment of the $700,000 investment for in house security 3)$200,000: 7/7 planned inpatient psychiatry space upgrades completed. 4)$510,000: Emergency Department registration and triage physical space renovations completed 5)$179,000 for security enhancements at Kirkwood	
											Highest Effort: Adopt Workplace Violence Prevention leading practices as recommended by the Public Services Health and Safety Association (PSHSA)	Continue the implementation and compliance of the Patient Violence Risk Assessment Process (completion of a violence assessment tool (VAT), controls and supports, comfort planning and communication)	Education compliance: % of team members that have completed training on utilizing the patient VAT.	April: 80% May: 95% June: Sustainment - content will be added to General Orientation sessions.	
													VAT compliance : 1. % patients with a VAT score at time of ED triage 2. % patients with a VAT score entered in Meditech within 12 hours of admission 3. % of patients assesses as high risk (VAT) with a completed comfort plan. (pilot on 1 inpatient unit)	1. ED - 95% sustainment 2. Inpatient units- 80% by Q4 3. 80% comfort plans completed on 1 inpatient unit.	

													VAT Implementation: % of patients on registration to an outpatient area (Cedar Street) that will have a documented violence assessment rating.	Q3: Complete pre-work Q4: Pilot for outpatient area (Cedar Street)	
											Improve coordination and collaboration between Health Sciences North and Greater Sudbury Police, Ontario Provincial Police to improve outcomes for individuals apprehended under the Mental Health Act.	The Emergency Department and the Mental Health and Addictions Program will lead the implementation of a process to improve the transition of individuals apprehended by GSPS under the Mental Health Act to HSN's Emergency Department for medical clearance, mental health assessment and care.	Implementation of Police/Hospital Transition Framework	1) Signed memorandum of understanding 2) 90% Education completion by September, 2023	Improved outcomes and transitions from police to hospital for individuals apprehended under the Mental Health Act.
											Increase Emergency Code Readiness	Assessment and enhancement of current state readiness for code silver and code white	% of staff that have participated in at least one Code Silver learning opportunity in high risk areas	Q1: Education Development Q2/Q3: 90% education for high risk areas by November 30, 2023	Code Silver learning could include: Completion of self-learning package in MyHSN Simulated table top exercises Manager prep talks at huddle Emergency preparedness in person facilitation
													# Practical application sessions of simulated Code Silver table top exercises	# of participants by March 2024.	Leadership on call and senior leaders 4 higher risk teams and invite senior leaders to the event (include checklist to determine effectiveness)
													% of staff having completed code white SLP within 2 years	90% training for high risk areas by September, 2023	
											Security Presence: Securing adequate and skilled resources	Skill development: a) Implement Use of Force Training for all Security Guards (in-house and contracted) supporting the understanding of level of force used vs. perceived threat. b) Maintain NVCI training for all in-house and contracted Security c) Implement Search and Seizure Training	% of Security staff that have completed the training	a) 100% for use of force training b) 100% for NVCI training c) 100% for Search and Seizure training, by end of Q3	