Health Sciences North
Horizon Santé-Nord

Excellent Care for All Act

Quality Improvement Plans (QIP): Progress Report for 2021-2022 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
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 Reporting Period: Dec 2019 Data Source: WTIS, CCO, BCS, MOHLTC	25	25	26.1 YTD Dec 2021 (from ERNI) 	Y	The 20 additional beds in the Reactivation Care Unit (RCU) were successfully implemented in April 2021. The occupancy rate steadily increased over the year and in Dec 2021 was at 95.6%, slightly down from our peak in Nov at 98.4%. The team has developed care pathways for older adults to help with the flow of patients, in particular those being admitted from the ED. The % of patients admitted through the ED fluctuates each month and is highly dependent on the flagging of appropriate patients: Nov 56% and Dec 31%. In order to ensure the team was well supported, interprofessional team capacity building was done with 71% of the staff – increasing their capacity in the domains of comprehensive geriatric assessment. We were not able to build capacity with functional decline due to time constraints, but plan on pursuing this education in the near future. The team has begun the work of implementing a "warm handover" with the next appropriate level of care for patients, but has not reached the set target of 80% - work will continue on this in the next quarter.
				Y	Twenty additional beds in the Addictions Medical Unit (AMU) were implemented in March 2021. The AMU's unit outcome goal was to achieve 75% occupancy. This goal has been achieved and sustained since July 2021. Initial unit pilots and various PDCA's contributed to successful implementation and ongoing problem solving to improve processes and standards, contributing to increasing trend towards and above target. A critical success in achieving these results included engaging patients and front-line staff in the PDCA cycle to adapt unit processes, standards, and pathways. These initiatives contributed to improved patient satisfaction, improved consultation and treatment, and increased occupancy.
				Y	A standardized Bullet Rounds has been successfully developed and implemented across 10/11 select inpatient units. The majority of units are demonstrating a high level of interprofessional team work and are using the Patient Action Manager (PAM) to track estimated date of discharge (EDD) and barriers to discharge/action items. In Dec 2021, the 10 units who implemented Standardized Bullet Rounds, had 85% of their patients with an EDD in PAM and 46% of those patients left on or before their EDD (target was 85%). Work continues to identify barriers to discharge and problem solve; with specific patient

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					populations, regional service constraints and COVID pressures, 85% is not an achievable target at this time. Teams continue to work toward processes to communicate EDDs to patients, with many units printing them and posting them at the patient's bedside.
				Y	A large, cross-sectional team completed the Ontario Health "Hospital Self-Assessment Tool: Alternative Level of Care (ALC) Leading Practices". This took longer than planned due to COVID pressures but was completed by mid-June. Two "unmet" practices were identified and teams put together to facilitate improvement work. A team from the ED is looking to implement a validated tool that would be able to flag patients at point of entry of "at risk" for an extended LOS. If the ED is unable to divert the admission before it occurs, then "at risk" flag would follow the patient to the inpatient unit in order to facilitate an earlier discharge. This work is in progress throughout Q4 and will carry over into 2022-2023. A team from a medicine unit looked deeper into information given to patients at the time of discharge. Data gathered demonstrated that 85% of medicine patients have received the standardized information via the discharge tool. The gap of giving that information to patients 48 hours before they are discharged existed for 100% of those patients and so HSN remains "unmet" for this leading practice. The team recognized that working towards improving this would require a team of physicians, Home and community workers as well as unit nursing/allied staff. This will be explored in 2022-2023.
The number of workplace violence incidents reported by hospital workers (as defined by OHSA) where there was an exercise of physical force. **Reporting Period:** **April 2021 - December 2021** **Data Source: Local data collection**	10/month (90) Events reported (327)	< 10/month	12/month (108) Events reported (335) 		April 2021, The Workplace Violence (WPV) Prevention Committee established its data and reporting routines on a monthly and quarterly basis to include education compliance, annual risk assessments, safety and quality indicators, change management concepts and surveillance of proportion of events with exercise of physical force in relation to the number of incidents reported. In 2021, from April to December, the number of reported incidents increased by 2.4% with proportion of physical force increasing by 4.7%. In August 2021, HSN promoted importance of reporting workplace violence incidents and workplace violence prevention in tandem with initiating plans for Behavioural Escalation Support Team (BEST). Two pilot areas (Emergency Department and Medical Oncology and Palliative Unit) were chosen and an improvement team was formed to support BEST. Pilot launch occurred October 4th 2021. Processes and outcomes were measured regularly. Critical event report out process was designed with Occupational Health and Safety Department. Events are investigated and countermeasures identified. Medical and

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					administrative directors report out on defined critical events occurring in their areas. First report out occurred in October and monthly report outs continue.
				Y	**The Workplace Violence Prevention Committee will guide the implementation of the Behavioural Escalation Support Team (BEST). This included the following planned improvement initiatives, activities and targets:** a) **BEST lead assigned and team structure identified by May 31, 2021:** Resource and launch of full BEST team delayed due to candidate selection and human resourcing logistics. By October, a critical shortage of BEST resources to support work necessitated shortening BEST coverage hours. **Next Steps**: On-going hiring process.
				Y	b) **BEST members trained in all education requirement by June 30, 2021:** As recruitment continued existing BEST members upskilled, and obtained Non-Violent Crisis Intervention instructor credential along with developing materials related to orientation, standards of work, toolkits **Next Steps:** Training for new hires.
				Y N	c) **BEST pilot - 2 high risk areas will test the BEST referral process for assistance in the development of a comfort plan for patients with high risk behaviours** - **80% of BEST referrals will have a risk assessment completed by October 31, 2021** - **80% of individuals assessed as high risk will have a documented comfort plan by October 31, 2021** Best risk assessment referrals exceeded 80% target with 88% in the Emergency Department and 91% on the Palliative Oncology Floor. **Next Steps:** Improvement team will establish process to look at how high risk individuals are identified prior to de-escalation (e.g., Violence Assessment Tool at Emergency Department triage with alert system)
				N	d) **Action plan for organizational spread will be complete by October 31, 2021.** **Next Steps:** BEST organizational spread will be assessed and planned through Q4 2021/2022 with implementation in next fiscal due to pandemic response and other competing priorities (i.e., IT support, changing platforms to Meditech Expanse).

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				N	**The Workplace Violence Prevention Committee will guide the continuous improvement of policies and procedures in the Postvention of workplace violence incidents** **a) 90% of Code White events have a hot wash debrief immediately following the event by April 1, 2021** Verbal debrief process already occurring with Acute Inpatient Psychiatry managers post Code White event. New debrief tool launched in pilot areas but barriers preventing process from occurring including location for debrief, staff time post event and easy access to debrief tool. **Next Steps**: work with improvement team to overcome barriers
				Y	**The Workplace Violence Prevention Committee will guide the escalation, prioritization, activation of system level countermeasures to prevent workplace violence incidents resulting in the exercise of physical force.** **a) 80% of Critical Events will be reported out at the Workplace Violence Prevention Committee within 60 days of the event.** Report out document created to facilitate the conversation with Committee members. To date, five events have been reported out to Committee within 60 days of the event. Additionally, a process has been created to escalate non critical event system level recommendations. **Next Steps**: Enhanced communication and consolidation of trends and system-level risks with recommended countermeasures.