Health Sciences North
Horizon Santé-Nord

Excellent Care for All Act.

Quality Improvement Plans (QIP): Progress Report for 2023-2024 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: The turnover rate of HSN staff in aggregate. Formula: The sum of resignations, retirements, and involuntary terminations divided by the average headcount and multiplied by 100. **Reporting Period:** April 2023 – December 2023 **Data Source:** MyHSN	N/A	15.00%	12.2% YTD Dec 2023	**N**	**DATA - Monitor performance against targets and benchmarks** • Decision support continued to work on the data dashboard in the month of November 2023 and a PDF version was shared with SLC in December 2023. The dashboard has been uploaded to the Hub as of November 2023 and Decision Support is targeting to have the Q3 dashboard with drill down data available on the hub by the end of February 2024.
				Y	**ENGAGEMENT - Define and identify countermeasures to address root causes for attrition** • 57 Allied Health were interviewed in total and data has been compiled. Recommendations have been created we will begin sharing with stakeholders in January 2024 (Senior Leadership, HR, Clinical Managers, Inter Professional Practice). • Action plan has been developed. Discussion between compensation and recruitment on June 1, 2023. • Work area visits to determine ways to get the exit interview sent earlier (prior to last day when possible). On average for the past two years, completion rate was at 20%. • This action item is behind target due to competing priorities and staffing changes. In December 2023 the new exit interview was launched via survey monkey, as well as the process to issue exit interviews was updated to include a QR code for easier access to completing once individuals have left HSN. • Quality of Work Life Survey Closed and results expected January 25, 2024. • The third one-month entry survey was sent to all June new hires in September 2023. Results are being collated for review. Three months of data is now available and we will review to identify trends and compare to stay interviews. Will be pausing introduction of three month survey. Immediate feedback received from July 2023 survey shared with responsible director to improve orientation; changes confirmed to be made.

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				Y	**WORKFORCE - Securing and sustaining appropriate health human resources** • 39 New Graduate Guarantee (NGG) positions hired/ position has been offered. Between April 1 - December 31, 2023. 33 NGGs transitioned (84.6%), 1 is waiting to transition (2.6%) and 5 resigned (12.8%). Will continue to update/monitor monthly. • As of January 10, 2024, 41 externs eligible to transition to front-line nursing roles. 34 (82.9%) transitioned roles, 3 (7.3%) pending but offers extended, (4 9.8%) resigned. Will continue to update monthly as the pending hires obtain license and transfer to front line roles. Note - a review occurred of extern data the total number has changed from 43 to 41 due to miscalculation. • Assessment of temporary job postings for feasibility for permanency work has been paused. • As of December 31, 2023, all Education Funds have been allocated. A wait list has begun for any cancellations that may arise. • The Wellness Strategy draft has begun, with new Wellness initiatives planned for the next 3 quarters. Healthy Workplace Guide has been approved by steering committee as a framework for the new Wellness Strategy. Physical and Mental Health challenges have begun to help improve wellness at HSN, with the Medical Lead and Wellness coordinator. • Years of Service pins rolled out November 2023 with pins sent to all employees who reached a 5, 10, 15, 20 year milestone as of December 31, 2022. Plans are beginning for the All-Staff awards, scheduled for September 2024.

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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:** April 2022 - December 2022 **Data Source:** WTIS, CCO, BCS, MOHLTC	36.4	29	40.9 TTIB YTD Dec 2023 	**Y**	Standardization of HSN patient flow practices and processes to support on time discharges: • HSN brought a multi-disciplinary team together to redesign and implement standardized discharge processes for medicine inpatient units – building on the culture of on time discharge. • Throughout the year, we maintained consistent organizational discharges, with an average of 28.6% of patients being discharged before 1100 and 73.6% before 1400 • We were able to revamp existing reports e.g. Utilization and Morning reports and facilitated distribution to appropriate clinical leaders to inform decision making to support on-time discharge; we added Patient Flow Supervisor resources to assist in discharge related processes, including inputting EDDs – with an average of 32% of patients having an EDD 5hrs from transfer on to a unit • Currently this work has been designed around the use of the Patient Action Monitor both from an inputting and data pull perspective. In order to continue with this work, focused effort will need to be put in place to ensure expanse can support this improvement work.
				Y	Open a new 52 bed west wing unit: • HSN was successful at opening a 52 bed unit to build more stable capacity across HSN; 26 of those beds were in operation as of December 31, 2023 and the additional 26 will open through until March 2024 with the hiring of the additional staff needed.
				Y	ALC reduction strategy to meet annual target of 95: • HSN continued to implement 6 ALC reduction strategy projects aimed at supporting the transition of ALC patients across HSN; HSN fell short of reaching the ALC target set (95), finishing December 2023 with an average of 127 ALC patients – this metric is a complex metric that relies not only on internal processes but processes with our community and system partners; HSN remains committed to continually work to improve this metric. • Successful strategies in reducing ALC patients at HSN were a direct result of the Home to Rehab program which had over 300 patients successfully discharged home since March 2023 to January 2024, with a readmission rate of less than 8%. • 50% of our ALC patient waiting for long-term care are retirement home appropriate however lack the funds to support retirement living. Work is underway with community partners to look at affordable housing and subsidy.

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				Y	Integrated community ALC complex discharge planning: • HSN successfully implemented ALC rounding, including our community partners as well as fully integrated 3 Home First Liaisons, with complex discharge planning responsibilities identified in a Standard of Work. One of the Home First Liaisons is dedicated to presenting clinical pathways to support patients in home prior to designating a patient ALC. This is a new practice and is aligned with how many hospitals designate.

Indicator: 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.
 	
Reporting Period: April 2023 - January 2024
 	
Data Source: Meditech/PHA
	Q3-72	75	73
			YTD Jan 2024
			
				Y	Build on the success and improve discharge medication reconciliation performance.
					• Monthly monitoring and communication of unit level performance is occurring.
					• Supported 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)
					• The surgical program, ICU and NICU were identified as areas of focused effort. They have identified the following barriers:
					  • Onerous process steps for capture (sending med rec for scanning)
					  • Staffing (turnover, vacancies and agency staff)
					  • Transfers to higher level of care

				Y	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. Continue and sustain current education practices for prescribers and staff. • Revised Expanse go-live date has changed the trajectory of this initiate. We are working collaboratively with stakeholders to incorporate functionalities. • Education and training to commence Q4 in preparation for Expanse.
The number of workplace violence incidents reported by hospital workers (as defined by OHSA) involving physical force.	116	104 (10% decrease) One event less each	150 FYTD as of Jan 31,2024 	**Y**	• Workplace violence incidents continue to trend higher than target through Q4, with January 2024 year-to-date actuals reporting 150 incidents, exceeding our annual improvement target of 104 incidents. • This trend has largely been driven by multi-incident single patient events. A plan has been developed for the introduction of a safe room in response to the significant increase incidents within the Child and Adolescent Mental Health Unit over the recent months. All other improvement work remains as planned.

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Reporting Period: April 2023 – January 2024 **Data Source:** Local data collection		month than previous year.			• The coming months will focus efforts on improving emergency code compliance. Currently Code Silver compliance has improved from 57% in November 2023 to 68% in January 2024 and Code White compliance is at 80%. **January 2023 compared to January 2024:** • The total number of overall workplace violence incidents reported by hospital workers increased from 33 to 34. • The number of workplace violence incidents reported involving physical force remains the same with 19 incidents in January 2023 and 19 incidents in 2024. • The proportion of workplace violence incidents reported involving physical force proportionally decreased by 1%. (57% to 56%). • There are 10 total lost time injuries for all WPV incidents (FYTD) =3%of total WPV events.
				Y	Strategic investments in supporting and developing our people in the prevention and response to Workplace Violence. The Proposed budget for 2023/2024 included a $2,239,000 annualized investment in improved safety measure, including human resources and environmental controls. • $400,000 annualized investment in the Behavioural Escalation Support Team (BEST) • $250, 000 for security in the Emergency Department (ED) • $700,000 sustainment investment for in house security • $200,000: 7/7 planned inpatient psychiatry space upgrades completed. • $510,000: Emergency Department registration and triage physical space renovations completed • $179,000 for security enhancements at Kirkwood
				Y	Adopt Workplace Violence Prevention leading practices as recommended by the Public Services Health and Safety Association (PSHSA). HSN continued with the implementation and compliance of the Patient Violence Risk Assessment Process (PVRA). This included: • Increasing education compliance on the new process to 95% by May 2023. • Sustain 95% of patients with a Violence Assessment Tool (VAT) score at time of ED triage. • Increasing compliance in having a VAT score entered in Meditech within 12 hours of patient admission to an inpatient unit to 80% by Q4.

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					• Increasing compliance for patients, assessed as high risk (VAT score), with a completed comfort plan (pilot on 1 inpatient unit). • Implementation of the PVRA process to the outpatient setting. Pilot the process in one outpatient area to increase the percentage of patients on registration that have a documented violence assessment rating. A current state assessment of the PVRA process occurred in the spring of 2023 with proposed changes to the process. The changes included a more concentrated approach to those patients identified as high risk – flagging, comfort planning, etc. and re-assessment for risk of violence would only occur with a change in a patient's location or behaviour. • The education self- learning package was revised and a one-pager was developed to highlight the changes to the process. Education compliance is currently at 77% and strategies will continue with the release of the new education material. • The new process also adopted a streamlined approach to the Emergency Department assessment at triage to include 2 screening questions based on the patient's history of violence and current observable behaviours. Compliance continues with 97% of patients having a violence assessment at ED triage that is made visible to all ED staff on their whiteboard. • The indicator measuring VAT scores being entered into Meditech within 12 hours of admission to an inpatient unit, was no longer an accurate measure of the process. Staff would only enter the VAT score into Meditech on admission to an inpatient unit, if the new assessment yielded a change in risk level scoring from a previous assessment (in the ED or another inpatient unit). Having the VAT score in Meditech is a means of communicating the level of risk to the organization (inpatient unit staff, security, environmental services, etc.). A report was developed to ensure that all inpatients have a documented VAT score at any given time. Currently 82% of patients have a score in Meditech and strategies will continue to improve this number further. • Expanding the PVRA process to the outpatient setting was piloted in our psychosocial rehab services. It was determined that the VAT was not appropriate for this patient population and alternative tools are being investigated. • Changes to VAT tool implementation (as requires IT services, form changes, and staff education) on hold for Expanse roll-out.

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				Y	Improve coordination and collaboration between HSN and Greater Sudbury Police (GSPS), Ontario Provincial Police (OPP) to improve outcomes for individuals apprehended under the Mental Health Act. Police TOC update from October to December: • In October, our Transfer of Care (TOC) documentation compliance reached 72%, but it declined notably in November and December. • Data integrity concerns exist due to uncertainty regarding the consistency of scanning the TOC form into patient EMR by the medical records team. • Increased patient volumes and longer wait times during the months of November and December have been identified as factors contributing to the decline in compliance. • Joint assessments by Greater Sudbury Police Service (GSPS) have faced challenges due to difficulties in identifying primary nurses and locating busy nursing staff. • There have been no instances of client abscondment or the need for police intervention post-TOC. Opportunities for improvement: • Requesting quarterly reports from GSPS could provide valuable insights into ED wait times despite lower documentation compliance. • Developing a strategy to adapt reporting and auditing processes to the new Meditech Expanse system may be necessary. • In the process of requesting physical charts from medical records to conduct audits to determine if there are continued gaps in the scanning processes. • January compliance numbers have trended upward, planning ongoing staff education, reminders, and further communication with police partners. • Upcoming meeting with all partners the week of February 19. The Emergency Department and the Mental Health and Addictions Program led the implementation of a process to improve the transition of individuals apprehended by Greater Sudbury Police Services under the Mental Health Act to HSN's ED for medical clearance, mental health assessment and care. Our goal was to have a signed Memorandum of understanding and 90% of staff educated on the new process. The Memorandum of understanding was signed in July 2023 and to date 93% of staff have completed education on the new process.

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					The ED continues to monitor the success of the process. From June to September: • Data demonstrated a decreased amount of time that GSPS had to spend in the Emergency Department awaiting transfer of care. • Only one patient absconded from the ED post transfer of care (*with safe return) • Needed to re-engage with police once to help respond to behaviours • 70% of the time there was a complete documented Transfer of Care Opportunities to continue to improve the process/continual steps towards Excellence: • Frequent touchpoints with police partners • Continue on-going staff education
				Y	Increase Emergency Code Readiness. Increase staff completion of at least one Code Silver/Code White learning opportunity in high-risk areas to 90%. Currently Code Silver compliance is at 68% and Code White compliance is at 80%, an improvement over the last reporting period. Emergency preparedness continues to communicate with high risk areas on the barriers to completing the education. Additional learning opportunities were offered to high-risk areas (i.e. huddle prep talks) and compliance continues to trend upward. A new emergency preparedness advisor is set to start full time in March and engage with management to develop appropriate leader education and to support any mock exercises going forward.
				Y	Enhance Security Skill development for all Security Guards (in-house and contracted). By Q3, 100% of security staff complete training in Use of Force, Non-Violence Crisis Intervention, Search and Seizure training. With consensus from the WPVPC members, the target was changed to 90% education completion within 6 months of hire. Accessibility to training (timing, number of instructors) left a small window of opportunity to train all security guards. • Use of Force: This training initiative kicked off in November with an inaugural group of 12 guards receiving training. Training was provided by an external agency with a certified instructor who focused on the criminal code, effective communications when dealing with an individual in crisis or displaying resistive behaviours and

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					sharp- edged weapons defense. Currently, 41% of security guards have received UoF training within 6 months of hire. This is a new program and additional training is scheduled for March with this external provider. • Non-Violent Crisis Intervention: This training is delivered by HSN staff. The most recent training for security was held in December of 2023. Currently, 78% of full and part time security guards have received NVCI training within 6 months of hire. Additional security guards are scheduled for training in February and March. • Safe Searches: This training was developed by our Emergency Preparedness and Security Services and is delivered by our team with the assistance of our SIM Lab partners. Currently, 96% of full and part time security guards have received NVCI training within 6 months of hire.