Health Sciences North
Horizon Santé-Nord

Excellent Care for All Act.

Quality Improvement Plans (QIP): Progress Report for 2022-2023 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 number of surgeries performed at Health Sciences North on the last calendar day of the month. **Reporting Period:** April 1, 2022 – March 31, 2023 **Data Source:** Internal	15,212 3-yr average (2018/19 – 2020/21)	16,500	11,292 YTD Dec 2022	**Y** **Ongoing** **N** **Y**	**Phase 1: Secure Necessary Resources to Support Increased Surgical Capacity** • Schedule additional surgical blocks required to support increase volumes: ○ 50 Blocks were added to the 2022/23 Operating Room (O.R.) block schedule, bringing total planned blocks for 2022/23 to 3132. Staffing and capacity challenges have limited the number of blocks utilized. Forecast is currently at approximately 2850 blocks by March 31, 2023. • Recruit Health Human Resources (HHR) required to support increase surgical volumes: ○ Challenges with HHRs persist. The O.R. has progressed quite well with recruitment and orientation, and is planning to run 13-14 blocks per day in 2023/24. Orientation of several OR nurses continues in Q4 and the O.R. can only run 12 blocks per day. Anesthesia capacity will also be maxed with 13 blocks running each day. • Develop and monitor plan to designate the required number of surgical beds to support increased surgical volumes: ○ Working group formed, bed mapping data reviewed in Fall 2022. Awaiting tabletop exercise to determine impact of designating a set number of surgical beds. • Confirm internal and external resources to support increased surgical volumes: ○ 2022/23 funding confirmed.

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				Ongoing	○ System wide capacity challenges are impacting ability to operate inpatient volumes at maximum capacity. Some surgical cancellations have occurred due to bed capacity and staffing constraints. Mid-Cycle Review Additions: • Train Anaesthesia Assistant (A.A.): ○ Target is to have 4 A.A.s trained. Currently have 3 trained and work underway to hire/train another. • Model throughput needed to match the target volumes considering geography, factors such as isolation, etc. and matching utilization with demand by patient group to ensure the current resources are sufficient to meet the target volumes without negatively impacting flow outside of the surgical program: ○ As described above, table top exercise to determine right size for surgical inpatient capacity (bed mapping). ○ Ongoing collaboration with Decision Support and Reporting and Finance to check and adjust volumes based on actuals/forecasted volumes. • Identify contributors to cancelled surgeries to aid in developing mitigation measures: ○ Target is to determine top 3 reasons for cancellations, including same day. ○ A review of data and the process for how reason for cancellation is documented is required.
				N	
				Y	Phase 2: Implement and Monitor Surgical Ramp-Up • Monitor the number of added surgical blocks and cases within those blocks: ○ 50 O.R. blocks were added to the block calendar in 2022/23. HHR and inpatient capacity constraints has limited our ability to open blocks as planned. However, block utilization is monitored on a weekly basis to ensure available O.R. time is maximized by each service. ○ The surgical wait list was 5253 patients in April 2022 and has improved to 4921 in February 2023.

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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	26.1	26.0	36.4 YTD Dec 2022 (from ERNI) 	**Y**	Adoption of Alternative Level of Care (ALC) leading practices (supported by HSN'S self-assessment completed in 2021): • HSN improved how we identify "at risk (for protracted hospital stays)" patients presenting to the ED. With the implementation, we are now able to flag "at risk" patients when they are admitted in the ED and when the patient is transferred to the unit, staff can prioritize additional assessments to address barriers to discharge. This change idea required modifications to our electronic patient record and internal electronic communication systems • We also improved the mobility of our "at risk" patients in the ED by utilizing our mobility team. We did this by increasing the hours this service was being provided to ensure coverage 7 days a week. We saw a shorter length of stay for those patients who were mobilized by the care transitions team. • HSN's patients receive a written transition plan at the time of discharge 96% of the time, which is well above the target of 80%. Ensuring patients were receiving that plan 48hrs before discharge is a goal we are still working towards in Q4. Lessons learned were to engage unit level teams as early as possible to ensure ability to participate in improvement work.
				Y	Improve response times with Clinical Support Services: • We achieved our goal of transporting 90% of patients within 20min of a request with an average of 97.6% (range 96.5%-98.3%). Because both processes utilize the same human resources, we learned to monitor other metrics, such as time to clean an empty bed, to ensure we were not causing negative system impacts. This change idea did not impact the overall performance significantly, as we consistently met the goal with little changes to activity. Data collection for this change idea was primarily manual at HSN; we would advise others to consider automating data collection, if possible.

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					• We also achieved our medical imaging ordered in the ED goals consistently throughout the year. In the upcoming year, we will continue with overnight CT hours and reinstatement of overnight MRI hours. We will also consider Ultrasound call to assist with overnight turnaround times.
				Y	Improve lengths of stay: • HSN was able to validate how the system has standardized use of our internal tool, the patient action manager (PAM), to document barriers to discharge. We recognized that there was inconsistency across the system in the utilization of the information. Work continues using the care transitions team to standardize pathways and use of escalations to address barriers. • To allow us to improve program lengths of stay, HSN examined the data for the top contributors across the system. In order to get a better sense of top contributors, examining data for each program provided a more relevant data set. In Q4, each program is formalizing an improvement plan for execution in the next fiscal year.
The number of workplace violence incidents reported by hospital workers (as defined by OHSA) involving physical force. **Reporting Period:** January to December 2022 **Data Source:** Local data collection	153 134 (April 2021 – March 2022)	120 (average 10/month) Pursue zero harm through prevention of workplace violence involving physical force. We will measure progress by the number of months where	116 9/12 months the number of incidents with the exercise of physical force was fewer than the previous year		January to December 2022 - the total number of overall workplace violence incidents reported decreased from 424 in the same period in 2021 to 381. The proportion of workplace violence incidents reported involving physical force proportionally decreased by 6%. Furthermore, the number of workplace violence incidents reported by hospital workers involving physical force decreased from 153 in the same period in 2021 to 116 representing a 24% decrease.

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		the number of workplace violence incidents involving physical force was fewer than the prior year			

				Y	Strategic investments in supporting and developing our people in the prevention and response to Workplace Violence. The Proposed budget for 2022/2023 included a $400,000 annualized investment for the Behavioural Escalation Support Team (BEST) as well as a new investment to support consistent and reliable security services.
					• Behavioural Escalation Support Team (BEST)
					  ○ Current staffing model is a team of 4 (3 full-time and 1 part-time). Currently we have 2 full-time (one RN and one social worker) and one part-time (social worker).
					  ○ There has been challenges in filling the full complement of BEST members.
					• New investment to support consistent and reliable security services
					  ○ 25 new security guards were hired and oriented (4 full-time team leads, 16 full time guards, 4 part time guards) and a new Security Emergency Preparedness Advisor.

				Y	Determine patient's level of risk for workplace violence: The BEST and Emergency Department (ED) leadership will guide the implementation and utilization of a violence assessment tool to determine a patient's level of risk of violence at first contact in the ED. **Target:** 80% of patients of identified target population at ED triage will have a documented violence assessment rating, by December 31, 2022. **Launch date:** January 9th, 2023. Compliance, check and adjust on the process will occur January to March 2023

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					• A patient violence risk assessment process has been developed and trialed for the Emergency Department to complete a Violence Assessment Tool (VAT) at ED triage for all patients 8 years of age and older. The assessment takes into account a patient's history of violence and observable behaviours. • The process developed includes visuals of level of risk, comfort planning and transfer of level of risk at care transitions. • Staff education was launched on December 5th and staff has until the launch date of January 9th to complete education on the process. **Lessons Learned:** • More time was required than initially planned to pilot the process, develop education material and engage all stakeholders. • Considerable time was spent with our I.T. department on processes and a plan for data collection
				Y	Determine patient's level of risk for workplace violence: The BEST team will guide the implementation and utilization of a violence assessment tool to determine a patient's level of risk of violence at first contact on the inpatient units. **Target:** 80% of patients on admission to an inpatient unit will have a documented violence assessment rating, by December 31, 2022. **Launch date:** January 9th, 2023. Compliance, check and adjust on the process will occur January to March 2023 • A patient violence risk assessment process has also been developed and piloted on 3 inpatient units to complete upon admission to an inpatient unit for all patients that are 8 years of age and older. • The process developed includes visuals of level of risk, comfort-planning transfer of level of risk at care transitions and a streamlined support referral process. • Staff education was launched on December 5th and staff has until launch date of January 9th to complete education on the process.

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					• A new flagging system will also be implemented across the organization with the launch of the Patient Violence Risk Assessment process. **Lessons Learned:** • It was difficult to build a process that is not organization wide. The process on the outpatient units will begin in the fall of 2023. • The pilot demonstrated that comfort plans include measures that certain units cannot always provide. •
				Y	Determine patient's level of risk for workplace violence – Compliance of team members receiving education/training on the new Patient Violence Risk Assessment (PVRA) process **Target:** 95% of team members receiving education/training on the new process by December 31, 2022 **Current State:** 28% (December 31, 2022) • The Patient Violence Risk Assessment (PVRA) self-learning package, physician summary page and PVRA read and sign for Environmental Services launched with assignment profiles so they were automatically assigned to those who required them. Piloting the education material allowed us to incorporate feedback, make adjustments and know exactly whom the intended audience was. • Compliance remains low and strategies will need to be considered to increase completion of education prior to the launch on January 9th. **Lessons learned:** • Engaging clinical managers/nurse clinicians in a brief review of the intended assignment profile sooner. • Engaging Environmental Services sooner in the development of the education material. •

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				Y	Determine patient's level of risk for workplace violence: the Mental Health program will lead the development of a police –hospital transition framework in collaboration with police and the ED to enhance communication and shared decision-making in the determination of a patient's level of risk upon entry to the ED • Timelines to have the police – hospital transition framework in place by March 31, 2023, continues to move forward as planned. • Draft education has been completed and education dates have been set for the last two weeks of February.
				Y	Manage/mitigate workplace violence risk determined by violence assessment rating. The Behavioural Escalation Support Team (BEST) 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. **Target:** 0% of incidents involving physical force that did not have controls/supports in place at time of the incident. **Launch date:** January 9th, 2023. Compliance, check and adjust on the process will occur January to March 2023 • The Behavioural Escalation Support Team (BEST) supported and continues to support the development and pilot of the PVRA process and the development of a streamlined process for support referrals based on patient's level of risk for violence and observable behaviours. **Lessons Learned:** • The pilot demonstrated that controls and supports based on the patient's level of risk can be more clearly defined (i.e. contraband searches)

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				Y	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 as part of General Orientation **Target:** 95% of all new hires that complete verbal de-escalation training prior to starting on their units, to start at July General Orientation session. **Current State:** 75% within 30 days of General Orientation Session (December 31, 2022) • De-escalation training started as a Self-Learning package (SLP) as live sessions of General Orientation were paused during COVID pandemic. Originally, compliance was low. • Live sessions were resumed and the content was taught to new hires in person. Compliance increased significantly. If staff were unable to attend General Orientation, then the SLP was automatically assigned to all new hires to complete within 30 days and Leadership and Learning tracks compliance. • Not only new hires are benefitting from this education: high-risk areas are encouraging existing staff to complete the de-escalation SLP to upskill staff on how to de-escalate potential violent behaviour. **Lessons learned:** • Our compliance goals were unrealistic for new hires to complete the training prior to starting work on the units. The metric was changed to track within 30, 60 and 90 days of hire.
				N	Leadership maintains compliance with Workplace Violence Risk Assessments: Senior Leadership will identify completing annual review of Workplace Violence Risk Assessments as one element of People and Safety Performance goals for leaders. Compliance will be shared with the Workplace Violence Prevention Committee (WPVPC) and Senior Leadership Committee.

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					Target: 100% of workplace violence risk assessment that have been reviewed within 12 months. **Current State:** 57% (December 31, 2022) • Having workplace violence risk assessments as one element of People and Safety performance goals for leaders and reporting out on compliance to the WPVPC was unable to gain traction in increased compliance. • OHSW will develop an alternative plan with stakeholder feedback to reach target. •
				Y	Implement process to learn from workplace violence incidents – security will implement the activation of a standardized debrief tool to gather root causes following a Code White **Target:** a) 80% of code whites will have a documented debrief tool, by September 1, 2022. b) 80% of code whites will have a debrief tool used as part of the root cause analysis for incidents with the exercise of physical force, by September 1, 2022. **Current State:** a) 100% December 31, 2022 b) 100% of critical events where a code white was called, uses the debrief tool as part of the root cause analysis. • Security led the development and implementation of a debrief tool following a Code White. The Code White Incident Commander is leading the debrief process to investigate real time ways to improve staff responses and explore options to prevent similar situations from happening in the future. It is also an opportunity to identify contributing/precipitating factors that may have led to the patient's escalated behaviour. • This information is used to support root cause analysis of these events to determine potential countermeasures to enhance staff and patient safety.

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				Y	Implement process to learn from workplace violence incidents – Occupational Health and Safety will assist managers in the investigation of workplace violence incidents involving physical force to gather root cause(s) **Target:** 95% of incidents will have a documented root cause/trigger that will be shared with WPVPC **Current State:** OHSS is supporting managers in the investigation of workplace violence incidents**.** OHSS is devising a process to categorize root causes and share with the WPVPC (December 31, 2022) • OHSS adopted Root Cause analysis through cause mapping process. Countermeasures were brought to the Workplace Violence Prevention Committee for report out, discussion, recommended follow-up and system level recommendations. OHSS will monitor and evaluate for trends in 2023. **Lessons learned:** • Incorporating additional key stakeholders in critical event analysis has widened conversations on potential countermeasures.
				N	Standardize approach to supporting health care workers in the defuse process following a Code White: security will provide staff with available resources during the debrief process following a Code White • The debrief/defuse process would require additional structure, support and resources to meet the emotional needs of those involved in the event. • This change idea was not implemented as intended. • This improvement initiative will be undertaken by OHSW as part of the wellness program using a peer support model.

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				Y	Standardize approach to supporting health care workers in the defuse process following a Code White: BEST will support managers/staff following a Code White to determine if additional resources are required **Target:** 80% of BEST follow-ups that occur within 48 hours of a Code White, by September 1, 2022 **Current State:** 100% (December 31, 2022) • BEST members attend code whites when on site. If not available to attend, they will review the code whites and follow-up with staff and the patient on next shift. • BEST members will support staff through education on de-escalation techniques and additional resources if needed. They will also support staff in the completion of the patient's level of risk assessment and comfort plan. **Lessons Learned:** • Needed a clear definition of what support BEST would provide • Needed a data collection process Not a 24/7 operation – BEST developed a process to review and follow-up on all Code Whites when not able to attend in person.