Health Sciences North
Horizon Santé-Nord

# Excellent Care for All Act.

## Quality Improvement Plans (QIP): Progress Report for 2018-2019 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* |
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| **Number of Patients identified with multiple conditions and complex needs (Health Links criteria) who are offered access to Health Links approach and have a coordinated care plan**<br><br>**Reporting Period:**<br>**April 2018-December 2018**<br>**Data Source:**<br>**Internal Data** | 50 | 125 | 5 total coordinated care plans April - Dec. 2018  | **N** | *HSN experienced significant challenges in identification of appropriate patients for Health Links. This was due to loss of funding for two Health Link Care Planners as of April 1st, 2018. At the same time there was a shift in governance of Health Links from CMHA to the NELHIN. During this time of transition, HSN was waiting for direction related to redeveloped and re-launched strategies to increase referral to Health Links. This is still pending and therefore no activity has taken place in 2018 2019.*<br><br>**1. Sustainment of START hubs (Seniors Triage Assessment Rehabilitation and Treatment) in ED, inpatient and outpatient units. Reinforcement of standards of work developed in the previous year to stabilize and sustain.**<br><br>At the start of 2018-2019 HSN had both inpatient and outpatient Senior Triage Assessment Rehabilitation and Treatment Teams (START).<br>• The inpatient START Hub was discontinued in the fall of 2018 due to budgetary challenges and associated staffing changes. Achieving the identified target and plan was limited without the early identification by the inpatient START team.<br>• In the planning phases it was identified that the comprehensive geriatric assessment and treatment plans provided by the North East Specialized Geriatric centre (NESGC) was similar to the assessments as part of the Health links. The outpatient START team provides the link for frail older adult patients to the geriatric programs and undergo a comprehensive geriatric assessment and treatment plan |

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| | | | | | development, and when appropriate, collaboration with community services and partners to create collaborative care plans. Although this work was not done through Health Links it provided the same coordination of services and repeating these assessments and plans through health links was seen as duplicate work for staff. HSN felt the services of the NESGC provide well-coordinated service and plans for our frail seniors. |
| | | | | | **2. Sustainment of work by the Urgent Mental Health Addictions Team (UMAT) in identification of Mental Health Patients for Health Links. Reinforcement of standards of work developed in the previous year to stabilize and sustain.**<br>• Similar to the work identified with the NESGC, there are currently strong community connections through the Urgent Mental Health Addictions Teams (UMAT) and referrals to Community RMT (Rapid Mobilization Table), Outpatient Mental Health Services and/or Partial Hospitalization Program. These teams provide case management and are connected with community based programs to ensure co-ordination of care planning and decrease in utilization of hospital services. In the absence of a structured approach to health links within the region, HSN felt these services provided the same coordination and planning that was embedded in health links thinking, although formal coordinated plans were not created with health links the patients received the same service and support.<br>• To further develop this work, a planning committee is now in place with the NELHIN to review high ED/hospital service users and to explore options on how we manage complex patients in all NE Schedule 1 hospitals. This work is to begin in February 2019. |

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| **Total number of alternate level of care (ALC) days contributed by ALC patients within the specific reporting monthly/quarter using near-real time acute and post-acute ALC information and monthly bed status**<br><br>**Reporting Period:**<br>**Dec 2018**<br>**Data Source:**<br>**WTIS, CCO, BCS, MOHLTC** | 21.87% | 21% | 18.4%<br>Dec 2018 | Y | *HSN was able to exceed its target on this indicator despite the ongoing challenges with the number of our Alternate Level of Care (ALC) patients within the organization as well as continuously being over 100% occupancy.*<br><br>**HSN will implement the foundational strategies and leading practices related to ALC prevention by sustaining and implementing components of the Alternate Level of Care (ALC) Prevention Framework such as: a) Assessment Urgency Algorithm (AUA) screening for 50% of seniors 70+ in the Emergency Department; b) 80% compliance with Home First contract on admission; c) 80% compliance with the Estimated Discharge Date (EDD) within 48 hours; d) 90% compliance with Standard of Work (SOW) for Bullet Rounds, Alternate Level of Care (ALC) rounds and Escalation Process**<br><br>The following lessons learned cover all three outcomes in this indicator as they are all jointly focused on reducing ALC days.<br><br>• Change was easily adopted because through the development of each strategy there was significant engagement and an ability to provide feedback. This feedback allowed those leading to make changes and staff felt that the plans reflected their work reality.<br>• Some strategies were completed and are in sustainability phase, while others will be rolled out in the final quarter. This staggered approach has allowed for focused attention on one or two changes and ensured successful implementation and time for re-evaluation.<br>• Some activities were deferred to next fiscal or dropped once it was determined that they would or wouldn't have a direct impact to the ALC days outcomes. The time to review process outcomes allowed for timely decision making as to which activities should be sustained, which should be slow in pace and which should stop. |

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| | | | | | • Continue to create a solid action plan/timeline to ensure we move forward as anticipated both for new activities and sustainment. Develop reporting tools to measure success.<br>• Continue to promote the value of each project to both staff involved but also leaders whom are needed to support the work planning and implementation.<br>• Ensure continued socializing of the positive solution with end users and constantly being cognisant of how we are affecting the current work practices.<br>• In order for the solution to be viable and successful we needed to have buy-in/adoption from every level of "the customer".<br>• Advice: recognize the value that lies with the client and aligning the design with those values. |
| **Number of workplace violence incidents reported by the hospital workers (as defined by OHSA) within a 12 month period**<br><br>**Reporting Period:**<br>**Jan 2018-December 2018**<br>**Data Source:**<br>**Internal Data** | 109 | 164 | 303<br>Jan - Dec. 2018 | **Y** | *Creating a culture of support for the reporting of violence in the workplace events will provide HSN with a better dataset to understand our top issues to target improvement*<br><br>**1. Complete Root Cause Analysis (RCA) on reported workplace violence events and report recommended actions/improvements back to the team members**<br><br>During 2018 we demonstrated increased Workplace Violence (WV) reporting attributed to the specific action of consistent response to reported incidents by the Occupational Health and Safety resources and the Critical Event Resource Team (CERT). In developing our Critical Event process and taking note of the learnings, we identified a need to increase our response to WV events causing harm to get a deeper understanding of the direct and root causes and help form our prevention strategies. Timely response to workplace WV events achieved or exceeded organizational targets for immediate response (1 hour of team activation) to all Critical Events via Critical Event Response Team (CERT), inclusive of a Senior Leader and non-critical WV events addressed by Occupational Health and safety within 48 hours.<br><br>2018 data told us that 116 of WV incidents involved physical harm to staff. Knowing this is our biggest problem, going forward HSN needs to develop a plan to decrease physical harm to our staff. We will need to do a deeper dive into this data to better understand |

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| | | | | | these events and engage frontline workers in designing prevention measures. |
| | | | | **N** | **2. Safety training/education to promote a just culture**<br><br>Work identified under with this change idea was put on hold due to capacity issues within the organization to take on any additional work through this fiscal period. |
| | | | | **Y** | **3. Identify the top 3 causes of workplace violence**<br><br>The identified top 3 causes of workplace violence events were flagged as follows:<br>Q1 (July 2018):<br>1) seclusion room unavailable<br>2) lack of staff training<br>3) unexpected action by patient<br>Q2 (October 2018):<br>1) Patient Cognitive Impairment (mental health/dementia)<br>2) Patient Cognitive Impairment (drug/alcohol)<br>3) Patient attempting to leave against orders/advice<br>Q3 (January 2019):<br>1) Patient Cognitive Impairment (mental health/dementia)<br>2) Patient/visitor behavior<br>3) Patient Cognitive Impairment (drug/alcohol)<br><br>We had a great start with the development of the departmental Hazard Assessment and Control (HAxC), and corresponding Workplace Violence Risk Assessments/Re-assessments to bring awareness to this hazard but fell short to achieving the identified targets in by end of Q3 as planned. During Q4, Occupational Health and Safety is continuing to work with management on moving towards the targets of i) completion of Workplace Violence Risk Assessments/Re-assessments and ii) updating the HAxC through check and adjust cycles. The outcome is to ensure that adequate prevention measures are in place especially in our primary areas for WV events. |

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| | | | | | Exercise of physical force from patients is the most common and most 'severe' incident totalling 116 or 42% of our Workplace Violence events in 2018. We have recognised the complexity of the problem and will extend work on this in the upcoming fiscal year to perform appropriate analysis of the problem by categorizing causes and identifying countermeasures to mitigate reoccurrence and harm. |
| **Frequency of Lost Time Events**<br><br>**Reporting Period: December 2018**<br>**Data Source: Internal Data** | 1,48 | 2.00 | 2.47<br>Dec. 2018 | **Y** | *The number and frequency of reported lost time accidents remains above target. Full implementation of the Hazard Assessment and Control (HAxC) System has not occurred; managers are not consistently reviewing (and updating as required) their HAxC registries after employees report hazards, incidents and accidents. The highest level of compliance year to date has only recently reached 60% after the Supervisor Report of Occupational Hazard/Incident/Accident was updated to provide a question and reminder about the key linkage between reported hazards, incidents accidents and the HAxC. Disability Management has implemented an additional initiative to consistently follow-up with and coach managers when they fail to review their HAxC (or fail to indicate they've updated their HAxC).*<br><br>1. **Prevent harm events with an integrated hazard assessment and control system**<br><br>This exercise has highlighted the importance of reinforcing policy and education through consistent follow-up and coaching to keep key concepts "front of mind" for staff until they become habitual; this applies to all new procedures and practices organization wide. |

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| **Percentage of Critical Events closed within 30 days**<br><br>**Reporting Period:**<br>**June 2018-December 2018**<br>**Data Source:**<br>**Internal Data** | 0% | 75% | 64%<br>Cumulative<br>Dec. 2018 | **Y** | We had valuable learnings during our improvement work, with the goal to close all reported critical events (affecting a patient, staff, and facility) within 30 days, following a consistent approach. Our definition of closed includes the reporting, analysis, identification and implementation of countermeasures and the development of a shared learning plan. The implementation of a newly designed Critical Events Response Team (CERT) was the planned change initiative with the intent to provide support and coaching to teams who experienced the event. A Senior Leader is part of every response, demonstrating the importance of safety to the organization and ensuring support is in place to mitigate barriers to close events. The CERT team was implemented in June of 2018 and have triaged and responded to every reported event. Achievement of our target has fluctuated from month to month; the more complex events with multiple care providers are the most challenging to progress. Also depending on the countermeasures identified, some take longer than the 30 days to implement. The process is stabilizing<br><br>**1. Review of all Critical Events to identify and implement recommendations and share the learnings with appropriate stakeholders**<br><br>There were a number of learnings identified throughout the implementation of the change idea:<br>• The recognition of a critical event is not always straightforward. There are events where it is fairly obvious the process/system failed and resulted in harm. More challenging are situations where there has been a negative outcome and it takes some investigation to determine if there was preventable harm; we are getting better at asking questions while being sensitive to the competing demands on providers.<br>• There is increased awareness at the senior leadership level regarding system issues that lead to harm. For example, we have an improved understanding of the causes of workplace violence incidents and the areas of highest occurrence, and can relate these back to actual events. This will help in building our workplace |

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| | | | | | violence prevention strategy.<br>• Our designed process is inclusive of staff calling the Senior Leader on call (24/7) every time there is an event that met the definition of a critical event for; patients, staff, physicians, visitors, learners, building or workplace violence events, with the intent to support the team in the investigation. This doesn't always happen; we continue to strive to better this part of the process by striving to understand cause and reinforcing messaging around purpose and process.<br>• We targeted to respond to critical events within one hour to support the team in the investigation process. We learned early on that for some of these events it was not beneficial to respond immediately after the harm was discovered, as the event occurred earlier in the care pathway. An alternate pathway has been developed for these scenarios which still results in timely investigation.<br>• Sharing with 'appropriate stakeholders' has been a challenge, especially sharing outside of the area where the event took place. We have planned work to better our organizational approach for sharing, which includes considering our current culture and ensuring we continue to promote a learning culture. |
| **Medication Reconciliation at admission: The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital**<br><br>**Reporting Period: December 2018**<br>**Data Source: Internal Data** | 46.96% | 50% | 50.4% Dec. 2018  | **Y** | Current performance achieved by implementing interdisciplinary approach to BPMH and medication reconciliation. Paper based systems do not include forced functions. Two sources of information for BPMH remains the standard being applied.<br>Shift to BPMH at point of entry (ED, Surgical preadmission) has been instrumental in ensuring accurate BPMH is available for physician led reconciliation as early as possible upon admission.<br>Scanning of reconciled BPMH will improve information availability and support medication reconciliation at transitions and discharge.<br>Next QIP will build on these gains by extending to direct admission areas and implement medication reconciliation at discharge. |

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| | | | | | 1. **Phase 1: Medication Reconciliation performed on 35% of all current inpatients by end of Q1:**<br>Engagement of interdisciplinary team and associated Physician, Pharmacy and Nursing leadership with management champions from the outset is critical to implement effectively. Focussed project management to ensure that individual departments were engaged and supported. |
| | | | | | 2. **Phase 2: Medication Reconciliation on 40% of all admitted patients by end of Q2**<br>Expanding the population to ages 45+ did not increase capacity to complete the process therefore did not add substantially to results. Other small direct admission areas such as Rehab had limited impact. Interdisciplinary planning for BPMH process helped set the stage for pilots in ED and Surgical preadmission. |
| | | | | | 3. **Phase 3: Medication Reconciliation on 45% of all admitted patients by end of Q3 – Implement prospective in the Emergency Department:**<br>Prospective medication reconciliation in ED was tested with Mental Health patient population however proved difficult to implement in a defined subset of patients. This approach was abandoned. |
| | | | | | 4. **Phase 4: Medication Reconciliation on all admitted patients by end of Q3 – Spread prospective to direct admits only:**<br>Prospective BPMH in surgical preadmission was successful as it could be applied to the entire population, could utilize existing RN resources and had a close connection to the surgical units and physicians for reconciliation. |
| | | | | | 5. **Phase 5: Achieve 50% Medication Reconciliation on all admitted patients by end of Q4:**<br>Achieved 50% target in Q3 due to uptake in Surgical preadmission. Prospective BPMH in ED shifted to all admitted patients based on earlier pilot lessons. Direct admission areas continue to expand. |
| | | | | | 6. **Phase 6: Assess Ambulatory Medication Reconciliation – current state:**<br>Standard developed to support Med Rec population needs assessment in all ambulatory settings. Policy developed and standards of work underway in all |

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| | | | | | ambulatory settings. |
| **CT Turnaround Time (TAT) – Request to Report (inpatient and emergency department)**<br><br>**Reporting Period: December 2018**<br>**Data Source: Internal Data** | 27 hours Inpatient | 12 hours Inpatient | 17.11 hours Dec. 2018  | **Y** | *Inpatient turnaround times were improved significantly from 27 hours to 17.11hours. The source of the improvements were Radiologist after hours remote reporting that on average approached the professional turnaround time target of 4 hours. Further analysis on Inpatient turnaround times revealed that 28% of cases involved planned timing that exceeded the turnaround time target. Removal of these scans from the data (starting December) result in 75% of inpatient scans being completed in 12 hours.*<br>*The turnaround time for ED patients exceeded the target for November primarily due to professional turnaround time improving to greater than 1hr. This was due to after-hours remote reading of ED cases. However with staffing challenges through the month of December we were not able to achieve target.*<br><br>**1. Reduce inpatient professional turnaround time (TAT) from 11.1 hours to 4 hours:** After hours remote reporting had the greatest impact on this measure. |
| | | | | | 2. **Reduce inpatient technical turnaround time (TAT) from 12.05 hours to 8 hours:** 28% of Inpatients had timed scan requests therefore reducing to an 8 hour TAT was not possible including timed scans. Timed scans are from the % within target data from December onwards. |
| | 12 hours Emergency Dept | 2 hours Emergency Dept | 4.2 hours Dec. 2018  | **Y** | **3. Reduce Emergency Department professional turnaround time (TAT) from 13 hours to 1 hour:** After hours remote reporting had the greatest impact on this measure. |
| | | | | | **4. Reduce Emergency Department technical turnaround time (TAT) to 1 hour:** Introducing 24 hr CT staff onsite improved image acquisition time to <1hr. |