2019/20 Quality Improvement Plan
"Improvement Targets and Initiatives"

Health Sciences North 41 Ramsey Lake Road

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 measures	Target for process measure	Comments
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Theme III: Safe and Effective Care	Effective	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	MANDATORY	Hours / All patients	CIHI NACRS / October 2018 – December 2018	959*	39.4	30 hours	The target is based on the current rolling 12 month average which is 33 hours. A 10% reduction is 30 hours.	Home and Community Care (HCC), LHIN	Refresh Home First initiatives in partnership with Home and Community Care	Formal review of patients made ALC within 48 hrs of admission lead by social work team and in collaboration with HCC	% of patients made ALC within 48 hrs of admission seen by social work team	100% by end of Q4	
											Develop and execute 4 strategies identified in a 2018-2019 value stream mapping exercise to enhance patient flow	Utilize the 33 identified opportunities from the value stream mapping and prioritize/implement 4 activities	# of activities initiated by end of Q2 and by end of Q4	2 initiated activities by end of Q2 and 2 initiated activities by end of Q4	
											Communicate to patients in writing the Estimated Date of Discharge (EDD) within 48hrs of admission (excluding pediatric admissions)	Develop processes for: a) updating unit and patient whiteboards b) addressing longer than expected EDDs c) an integrated discharge planning model d) identify 1 pt population with conservable days (CD) and develop strategies to decrease CD	% of appropriate patients will have EDD communicated in writing within 48hrs of admission (excluding pediatric admissions)	100% by end of Q4	
											Develop a 24/7 consult team to see 100% of Mental Health (MH) and Addictions patients in the ED	Development and implementation of 24/7 consult team to see MH and Addictions patients within 2 hours; implement RAI brief emergency screening tool to assess and triage patients that present as low acuity and divert appropriately to community services	Time to inpatient bed for MH and Addictions patients	Reduce time to inpatient bed for MH and Addictions patients in the ED by 10%	

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Theme III: Safe and Effective Care	Effective	Total number of alternate level of care (ALC) days contributed by ALC patients within the specific reporting month/quarter using near-real time acute and post-acute ALC information and monthly bed census data	P	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July - September 2018	959*	17.56	17%	Through the implementation and reinforcement of the leading practices for ALC prevention, HSN will reduce its ALC rate	Extendicare York, St Joseph's Complex Continuing Care, Home and Community Care, LHIN	Sustain and implement foundational ALC Prevention Strategies	a) Spread electronic whiteboards to all inpatient units	a) % of inpatient units with electronic whiteboards	a) 100% by end of Q4	
												b) Re-align ALC rounds to increase focus on patients at risk of returning to hospital and becoming ALC	b) % of patients discussed at ALC rounds who are at high risk of becoming ALC, prior to ALC designation	b) 50% by end of pilot (Aug.2019)	
												c) Redevelop and apply escalation process to all patients designated ALC-LTC	c) % of patients made ALC-LTC that have been through the escalation process	c) 80% by end of Q4	
											Implement the acute care mobilization pilot program to identify patients at risk of returning to hospital and becoming ALC	Pilot model and roll out tools (AUA/mobility plan/Barthel) to support Assess & Restore model	% of pilot patients with AUA score of 5 or 6 that have mobility plans in place	75% by end of Q4	
											Implement a comprehensive surge plan between HSN and community partners	Convene stakeholders and develop coordinated surge plan based on current learnings	# completed surge plans	1 by end of Q3	
											Implement a standardized inpatient rehabilitation bedded-level of care framework with community partners (SJCC, EY)	Adopt and implement Rehab Care Alliance (RCA) definitions for all 3 inpatient rehab providers	% of patients admitted to rehab beds that meet RCA definitions	80% by end of Q4	

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: **Theme III: Safe and Effective Care**	Safe	Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.	MANDATORY	Count / Worker 3015 FTEs	Local data collection / January - December 2018	959*	303	300	During 2018 we demonstrated an increase in WPV reporting attributed to the specific action of consistent response to reported incidents. During 2019 we need continual focus at a minimum to maintain WPV reporting numbers, while additionally initiating focused work aimed at decreasing WPV incidents where there has been Exercise of Physical force from patients.		Reduce the number of WPV incidents against hospital workers where there was exercise of physical force from patients.	1.) Establish and activate a framework for WPV prevention inclusive of a working group of experts and stakeholders from high violence areas to assist and provide best practice advice. 2.) Increase response to WPV incidents against hospital workers where there was an exercise of physical force from patients by expanding the WPV critical event definition and involving all levels of leadership.	# of WPV incidents against hospital workers where there was Exercise of Physical force from patients	10% reduction, 104 reported events	Exercise of physical force from patients against workers is the most common and most 'severe' type of WPV incident. A reduction of 10% was chosen considering the complexity of the problem and the timeframe available to better understand cause and test/implement countermeasures.

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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	Rate per total number of discharged patients / Discharged patients	Hospital collected data / October - December (Q3) 2018	959*	Baseline to be assessed	50%	Rate justified by expanded availability of admission BPMH and medication reconciliation. Information will be leveraged to support creation of Best Possible Medication Discharge Plan.		Spread and sustain prospective med rec for all patients admitted to HSN	(Q1) • Design/develop monitoring processes to track output of expanded Interprofessional capture • Provide performance by unit to support increased awareness and problem solve gaps	% med rec completed for all admits to all units /total hospital admits all units	Q1 - 55% of all admitted patients will receive med rec on admission	
												(Q2) • Improvement work will focus on direct admits—Work with regional and referring partners to leverage sending facility BPMH and Med Rec info to support	% med rec completed for all admits to all units /total hospital admits all units .	Q2 - 60% of all admitted patients will receive med rec on admission	
												(Q3 & Q4) • Continue spread and stabilize initiatives within all clinical units expanding capture	% med rec completed for all admits to all units /total hospital admits all units .	Q4 - 70% of all admitted patients will receive med rec on admission	
											Design, test and assess best possible medication discharge plan and use findings to inform planning for spread within select areas in a sequenced approach	(Q1) • Design and test BPMH-D, assess results and adjust plan as needed	% discharge med rec completed from all units / total hospital discharges all units	Q1 - establish baseline	
												(Q2) Spread BPMH-D practice to surgical units and family and child units	% discharge med rec completed from all units / total hospital discharges all units	Q2 - 20% of all discharged patients will have Best Possible Medication Discharge Plan	
												(Q3) • Spread BPMH-D practice to medicine—initiate work with one focus area/one discipline	% discharge med rec completed from all units / total hospital discharges all units	Q3 - 35% of all discharged patients will have Best Possible Medication Discharge Plan	
												(Q4) • Spread BPMH-D practice to remaining clinical areas while sustaining current capture	% discharge med rec completed from all units / total hospital discharges all units	Q4 - 50% of all discharged patients will have Best Possible Medication Discharge Plan	