# 2022 - 2023 NORTH SHORE HEALTH NETWORK (NSHN) QUALITY IMPROVEMENT PLAN (QIP)

## PAY FOR PERFORMANCE

### Theme 1: Timely and Effective Transitions

| Indicator | Performance | Target Performance | Q1 | Q2 | Q3 | Q4 | Annual | Alignment | Source | Activities & Comments |
|---|---|---|---|---|---|---|---|---|---|---|
| **Pharmacy:**<br>**1. Percentage of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion of the total number of patients discharged.** | 2021-22: 100% Blind River ACU (Thessalon site not providing inpatient care) | G=93-100%<br>Y= 75-92%<br>R= 0-74% | | | | | | HQO Priority Indicator | Total number of discharged patients for whom a best possible medication discharge plan was created as a proportion of the total number of patients discharged. | Medication reconciliation is the process of comparing a patient's medication orders to all of the medications that the patient has been taking. This reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions. |

### Theme 11: Service Excellence

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| **Quality:**<br>**2. Percentage of complaints acknowledged to the individual who made the complaint within 5 business days.** | Combined sites<br>2021-22: 100% | G =90-100%<br>Y =70-89%<br>R = 0-69% | | | | | | HQO Indicator | Clinical Manager Reporting/CNE QRM, Manual tracking | 1.Review QS-003 Patient, Client or Public Concern Policy<br>2.QRM will provide better tracking of concerns and improvement opportunities. |
| **Long-Term Care/Nutrition Services:**<br>**3. Percent compliance to Ministry of Long-Term Care guidelines using MOLTC tool for menu review.** | 2020-21 64% 14/22<br>2021-22: 82% (18/22) | MOLTC target: 100% (22/22) | | | | | | Internal Indicator<br><br>Ministry of LTC (MOLTC) | 1. Dietary Manager update menu analysis with available Software<br>2. RD complete review of nutritional analysis.<br>3.Review/revision of therapeutic diets & monthly portion audit | |

| Theme 1: Timely and Effective Transitions | | | | | | | | | | |
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| **Indicator** | **Performance** | **Target Performance** | **Q1** | **Q2** | **Q3** | **Q4** | **Annual** | **Alignment** | **Source** | **Activities & Comments** |
| **Emergency Department/Acute Care Unit:**<br>**4. Emergency Department wait time for inpatient bed.** | 2021-22: 1.5 hrs | G = ≤ 8 hrs<br>Y =8.1 – 10 hrs<br>R = ≥ 10.1 hrs | | | | | | HQO Mandatory Indicator | Indicator measured in hours using the 90th percentile, and represents maximum length of time that 90% of patients admitted from the Emergency Department (ED) wait for an inpatient bed.<br>*Inclusions:*<br>Admitted unscheduled emergency visits ED visits with a valid and known Disposition Date/Time and a valid and known date/time the patient left the ED.<br>*Exclusions:* Scheduled emergency visits Non-admitted unscheduled emergency visits, visits with unknown/invalid Disposition Date/Time OR unknown/invalid date/time the patient left the ED | Time is crucial to the effectiveness and outcome of patient care, especially for emergency patients. In conjunction with other indicators, this can be used to monitor the inpatient bed turnover rate and the total length of time admitted patients spend in the ED in an effort to improve the efficiency and, ultimately, the outcome of patient care. Many factors can influence the indicator results, including the availability of inpatient beds, the percentage of alternate level of care (ALC) patients, the overall patient population and hospital resources. |
| **Acute Care Unit:**<br>**5. Percent of inpatients days that beds were occupied by patients who could have been receiving care elsewhere.** | 2020-21: 28.15%<br>2021-22: 17.08% | G= <30%<br>Y= 31-49%<br>R= >50% | | | | | | **NEW**<br>HQO Priority Indicator | Tableau report from DAD<br>Total number of inpatient days designated as alternative level of care (ALC) in a given time period (numerator) / total number of inpatient days in a quarter (denominator) | Review ALC framework for opportunities going forward<br>Working with providers to support admissions that are relevant to acute care services |
| **Acute Care Unit:**<br>**6. Percent of hospitalizations where patients with a progressive, life-limiting illness, are identified to benefit from palliative care have palliative care needs assessed using a comprehensive and holistic assessment.** | 2021-22: 31% | G= 80-100%<br>Y= 60-79%<br>R= 0-59% | | | | | | HQO Priority Indicator | Meditech report to be developed /Local data collection | Patients admitted with a progressive life-threatening illness / palliative care will be identified and assessed using the Palliative Performance Scale (PPS) at admission. |

| Indicator | Performance | Target Performance | Q1 | Q2 | Q3 | Q4 | Annual | Alignment | Source | Activities & Comments |
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| **Acute Care Unit:**<br>**7. Percent of patients discharged that have had discharge summaries dictated within 48 hours and delivered to primary care providers.** | Combined sites<br>2021-22: 65.4% | G =65-100%<br>Y =40-65%<br>R = 0-39% | | | | | | HQO Priority Indicator | Health Records Tableau report | NSHN-MAC CPSO Quality Partnership indicator. HIS Department & MAC improvement initiatives |
| **Theme 1: Timely and Effective Transitions Internal Indicator / Underdevelopment** | | | | | | | | | | |
| **Indicator** | **Performance** | **Target Performance** | **Q1** | **Q2** | **Q3** | **Q4** | **Annual** | **Alignment** | **Source** | **Activities & Comments** |
| **Community Support Services:**<br>**8. Length of time from Service Assessment to Implementation of Change in client's Care Plan.** | 2021-22: 3-5 business days | G=1-2 business days<br>Y= 3-4 business days<br>R=5+ business days | | | | | | **NEW** Internal Indicator 2022/23 | InterRAI CHA dates; Care Plan dates; schedule dates; pull report from AlayaCare | Currently, takes 3-5 business days to implement change after client's assessment is completed due to high volume of documentation updates required. With implementation of AlayaCare, we anticipate 1-3 business days to accomplish. |
| **Outpatient Physiotherapy:**<br>**9. Percent of patients receiving physiotherapy services that live in the Western half of NSHN's catchment area.** | 22021-22: 13.1% | | | | | | | Internal Indicator 2021/22 | Meditech Tableau | Establish baseline for need of physiotherapy services in Thessalon to determine need for outpatient ambulatory care clinic space to develop business case |
| **Theme 11: Service Excellence** | | | | | | | | | | |
| **Indicator** | **Performance** | **Target Performance** | **Q1** | **Q2** | **Q3** | **Q4** | **Annual** | **Alignment** | **Source** | **Activities & Comments** |
| **Acute Care Unit:**<br>**10. Percent of respondents who responded "Completely" to the question "Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?".** | Blind River Acute Care only. Thessalon Acute Care is non-operational.<br>2021-22: 79% | G =80-100%<br>Y =50-79%<br>R = 0-49% | | | | | | HQO Priority Indicator | QRM: Inpatient Manager Discharge Follow-Up Calls<br>Canadian Patient Experiences Survey-Inpatient Care (CPES-IC) | Discharge follow up calls to be tracked in QRM to facilitate documentation of suggestions for improvement and dissemination of positive comments to front line care providers. |

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| **Acute Care Unit:**<br>**11. Percent of respondents who responded "Definitely Yes" to the question "Would you recommend this hospital to family and friends?".** | Blind River Acute Care only. Thessalon Acute Care is non-operational.<br>2021-22: 94% | G =85-100%<br>Y =50-84%<br>R = 0-49% | | | | | | HQO Indicator | QRM: Inpatient Manager Discharge Follow-Up Calls<br>Canadian Patient Experiences Survey-Inpatient Care (CPES-IC) | Discharge follow up calls to be tracked in QRM to facilitate documentation of suggestions for improvement and dissemination of positive comments to front line care providers. |
| **Long-Term Care:**<br>**12. Percent of residents responding positively to the question "Do the staff listen to you?".** | 2021-22: 80.0% | 82% | | | | | | HQO Priority Indicator | Resident Experience: LTC Manager Annual Survey | Question wording changed as of 2021-22 will continue for this QIP cycle to develop new baseline of responses. |
| **Long-Term Care:**<br>**13. Percent of residents responded positively to the question "Are you comfortable sharing your concerns or complaints?"** | 2021-22: 80.0% | 85% | | | | | | HQO Priority Indicator | Resident Experience: LTC Manager Annual Survey | Question wording changed as of 2021-22 will continue for this QIP cycle to develop new baseline of responses. |

## Theme 11: Service Excellence Internal Indicator / Underdevelopment

| Indicator | Performance | Target Performance | Annual | Alignment | Source | Activities & Comments |
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| **Long-Term Care/Nutrition Services:**<br>**14. Percent of residents who responded positively to the question "Do you like how the food tastes?"** | 2021-22: 79.2% | ≥ 80% responses "Always or Often"<br>---<br>0% residents selecting 'never' | | Internal Indicator<br><br>Ministry of Health and LTC guidelines. | Resident Experience: LTC Manager Annual Survey | 1.Audits for: standardized recipes, meal taste, nourishments, temperature<br>2. Quarterly resident taste panel<br>3. Resident & Family Councils for menu review & input |
| **Long-Term Care/Nutrition Services:**<br>**15. Percent of residents who responded positively to the question "Are you happy with the variety of foods provided?"** | 2021-22: 83.3% | ≥ 80% responses "Always or Often"<br>---<br>0% residents selecting 'never' | | Internal Indicator<br><br>Ministry of LTC and FLTCHA 2021 | Resident Experience: LTC Manager Annual Survey | 1.Audits for - use of standardized recipes, meal taste, nourishments, temperature<br>2. Quarterly taste panel for resident input for meals and nourishments<br>3. Meet with Resident & Family Councils for menu review & input |

| Theme 111: Safe and Effective Care | | | | | | | | | | |
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| **Indicator** | **Performance** | **Target Performance** | **Q1** | **Q2** | **Q3** | **Q4** | **Annual** | **Alignment** | **Source** | **Activities & Comments** |
| **Emergency Department:**<br>**16. Percent of unscheduled repeat Emergency Department visits within 30 days following an emergency visit for a mental health condition.** | Combined sites<br>2021-22: 17.0% | G= ≤ 15%<br>Y= 15-25%<br>R= ≥ 26% | | | | | | HQO Priority Indicator | Health Records<br>Tableau Report | Virtual Rural Psychiatry is expected to improve the development of safety plans and medication management to improve this metric. |
| **Long-Term Care:**<br>**17. Percent of long-term care home residents who fell in the last 30 days.** | 2021-22: 17.1% | G=≤16%<br>Y=16.1%-20.3%<br>R= ≥20.4% | | | | | | **NEW**<br>HQO Indicator | interRAI, Canadian Institute for Health Information (CIHI) | LTC home residents in a fiscal quarter who had a fall in the last 30 days (numerator) / # LTC home resident in a fiscal quarter (denominator) x100. |
| **Infection Prevention and Control:**<br>**18. Percent hand hygiene compliance among health care providers *before* and *after* patient or patient environment contact** | Combined sites<br>2019-20 *After*: 97%<br>2021-22 *After*: 96% | G= 90-100%<br>Y= 75-89%<br>R= 0=74% | | | | | | **NEW**<br>HQO Indicator | JHSC/OCC Health Reported. The minimum number of observed opportunities is 50 for any hospital with 25 beds or less (HQO, 2017). | Manual hand hygiene audits are performed. QRM online audit to be launched in 2022 improving data capture. Website reporting under development 2022 for public access. |
| **Theme 111: Safe and Effective Care Internal Indicator / Underdevelopment** | | | | | | | | | | |
| **Indicator** | **Performance** | **Target Performance** | **Q1** | **Q2** | **Q3** | **Q4** | **Annual** | **Alignment** | **Source** | **Activities & Comments** |
| **Pharmacy:**<br>**19. Percent of patients who are receiving vancomycin whom have a signed order set in their chart.** | 2021-22: 84% | ISMP target: 100%<br>G=80-100%<br>Y=50-79%<br>R=0-49% | | | | | | Internal Indicator | Quarterly reported in QRM | |
| **Acute Care Unit:**<br>**20. Percent of vital signs documented by Nursing staff before 10:00 a.m. on admitted acute care patients.** | Blind River Acute Care Only<br>2021-22: 97% | G=80-100%<br>Y=50-79%<br>R=0-49% | | | | | | Internal Indicator | Pulled from Meditech;<br>Report to be developed | Ensuring the interprofessional team have current assessment data for decision-making early in the day is crucial for care organizing and discharge planning. |
| **Indicator** | **Performance** | **Target Performance** | **Q1** | **Q2** | **Q3** | **Q4** | **Annual** | **Alignment** | **Source** | **Activities & Comments** |
| **Emergency Department:**<br>**21. Percent of patients receiving treatment in the Emergency Department that do not require physician assessment.** | Combined sites<br>2021-22: 7.7% | | | | | | | Internal Indicator | Meditech; manually collected data<br>1. Determine CTAS 4 & 5 patient criteria 2. Use coding info cross referenced with daily chart audits by ward clerk<br>3. Tableau | ED patients that required repeat visits for same complaint that could be treated at a home care/physician clinic outside the ED. Determine need for O/P ambulatory care clinic space to develop business case. |

| Quality Risk Management (QRM) – Safety Reports | | | | | | | | | | |
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| **Indicator** | **Performance** | **Target Performance** | **Q1** | **Q2** | **Q3** | **Q4** | **Annual** | **Alignment** | **Source** | **Activities & Comments** |
| **Occupational Health:**<br>**22. Number of workplace violence incidents reported by workers.** | 2019-20: 58<br>2020-21: 11<br>2021-22: 9 | The direction of improvement is not defined. | | | | | | HQO Mandatory Indicator | JHSC/OCC Health Reported QRM Surge Report | Due to organizational focus to build a reporting culture, QIP target for this indicator is to to increase the number of reported incidents. When organizational reporting culture is already well-developed, our QIP target may be to decrease. Terms "worker" and "workplace violence" as defined under Occupational Health & Safety Act (2016). |
| **Internal Indicator / Underdevelopment** | | | | | | | | | | |
| **Indicator** | **Performance** | **Target Performance** | **Q1** | **Q2** | **Q3** | **Q4** | **Annual** | **Alignment** | **Source** | **Activities & Comments** |
| **Quality:**<br>**23. After training for Quality Risk Management (QRM) Incident Management System has been provided, each non-locum Active Provider will demonstrate the ability to navigate the Surge QRM system, launch and complete an incident report.** | No physicians currently complete safety/incident reports. | Collecting baseline - 100% of non-locum active providers demonstrate ability to access, navigate, launch, & complete QRM Report.<br>G =80-100%<br>Y =50-79%<br>R = 0-49% | | | | | | **NEW** Internal Indicator | Surge Learning – report generation of non-locum active providers accessing training module and completing. | 1. Majority of training will occur during MAC meetings and include the opportunity to perform the demonstration back. 2. Attendance and compliance will be monitored and assigned by COS. 3.Education will be monitored and reported in the QRMC, MAC, and a summary will be forwarded to the Quality Committee of the Board. |
| **Indicator** | **Performance** | **Target Performance** | **Q1** | **Q2** | **Q3** | **Q4** | **Annual** | **Alignment** | **Source** | **Activities & Comments** |
| **Pharmacy:**<br>**24. Rate of medication errors.** | 2021-22: 7.1 | Canadian Rate: 7.5<br>G= ≤ 7.5<br>Y= 7.6-12<br>R= ≥ 13 | | | | | | Internal Indicator | Pharmacy Reported QRM Surge Report | |
| **Pharmacy:**<br>**25. Percent of reported Medication Incidents completed fully within the QRM Surge system within 14 days of initial report/Total medication errors.** | | Collecting baseline - 100% of Medication Error QRMs will be monitored.<br>G= 80-100%<br>Y= 50-79%<br>R= 0- 49% | | | | | | Internal Indicator | Pharmacist, Surge QRM Report | New QRM going live April 2022 to improve data capture, collection, and reporting. |

| Indicator | Performance | Target Performance | Q1 | Q2 | Q3 | Q4 | Annual | Alignment | Source | Activities & Comments |
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| **Quality:**<br>**26. Rate of reported Laboratory Non-Compliance Reports completed fully within the QRM Surge system within 14 days of initial report/Total Non-Compliance Reports.** | | Collecting baseline - 100% of Laboratory Non-Compliance QRMs will be monitored.<br>G= 80-100%<br>Y= 50-79%<br>R= 0- 49% | | | | | | Internal Indicator | Surge QRM Report/trend data | Providing education to clinical areas to increase compliance with reporting. |

*End*