Access and Flow | Efficient | Custom Indicator

Indicator #4

Percent of patients discharged that had a discharge summary dictated within 48 hours of discharge and delivered to the primary care provider (North Shore Health Network)

Last Year		This Year	
75	**85**	**82.60**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

There is a current improvement strategy in place that has resulted in an improvement over the past 12 months. Barriers to timely completion have been addressed. Physicians have been provided with the overall performance and received individual "report cards" on their own performance. This has brought attention to where the outliers are that are impacting the overall metric. A new EMR is anticipated to go live in March 2024. The new EMR will facilitate a streamlined and more effective workflow to improve the discharge dictation process.

Process measure

- Percentage of patients that have had a discharge summary dictated within 48 hours of discharge and delivered to the primary care provider

Target for process measure

- 85% of charts will have a completed discharge summary within 48 hours of discharge

Lessons Learned

providing feedback to each provider has been effective in improving performance
The Hospitalist program workload has increased. With the implementation of the Geriatric service and use of best practice strategies to improve senior friendly care to reduce ALC days, there are more discharges. With a barely manageable census for one Hospitalist, this can impact ability to dictate the discharge summary within 48 hours. The data does show, however, there is improvement overall in completion of discharge summary times.

Indicator #6

Percentage of Alternate Level of Care Days in inpatient acute and complex continuing care (North Shore Health Network)

Last Year		This Year	
47	**30**	**24.40**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

NSHN Geriatric team will participate in the Regional Geriatric Care training modules to enhance knowledge and participate in job shadowing in urban centres to learn how to apply the knowledge to practice for GEM and Geriatric Assessor roles

Process measure

- Job shadowing completed by end of April, 2023

Target for process measure

- Both nurses completed job shadowing.

Lessons Learned

no challenges. Staff who had the opportunity to shadow found the experience very beneficial

Change Idea #2 ☑ Implemented ☐ Not Implemented

The Geriatric Team will develop the assessment and documentation tools to carry out the comprehensive patient reviews necessary to develop the person centred goals of care

Process measure

- samples from hospitals in the NE received and reviewed by the team

Target for process measure

- assessment and documentation tools developed and implemented by April 30, 2023

Lessons Learned

It takes several iterations of a process to get to a point of moving from a trial to a point of deciding to accept the process and tools for a longer period of time

Change Idea #3 ☑ Implemented ☐ Not Implemented

Introduce the 5Ms of Geriatric assessment and care (Mobility, medication, mentation, multi complexity, what matters most) into care planning

Process measure

- Team is provided with the written information on the 5Ms of Geriatric Care The template used to guide interprofessional/interagency rounds is modified to align with the 5 Ms. Goals are set based on the reports provided by the disciplines attending rounds

Target for process measure

- 100% of the patients reviewed at rounds have the 5Ms of geriatric care discussed 100% of the patient reviewed at rounds have set goals/new orders identified and carried forward to the care plan

Lessons Learned

implemented with some adjustments related to time constraints. Goals are set. The most impactful change is the focus on "what matters most" to the patient. This is an essential component of providing patient centred care

Change Idea #4 ☑ Implemented ☐ Not Implemented

Review Bill 7 with the care team to understand the ramifications and impact of the new bill for patients and families who will need to consider a nursing home that may not be their first choice. The majority of patients who become ALC waiting placement in a Nursing Home choose the NSHN Nursing home. New policies and procedures and a communication strategy is needed

Process measure

- Policies and procedures developed and shared with the team (completed) Template letters with NSHN logo developed and in place (completed)

Target for process measure

- 100% of residents/caregivers will be educated on Bill 7 when a decision is made to be discharged from hospital to a LTC facility 1005 of residents will receive the relevant letters explaining the process and decisions

Lessons Learned

Advising a patient/family about the Bill 7 regulations is not an easy task for the staff. The Social Worker is identified as the primary person to have these difficult discussions.

Change Idea #5 ☑ Implemented ☐ Not Implemented

the inpatient unit will adopt a restorative care model of care. The Restorative care model focuses on improving physical and cognitive functioning to the person's maximum potential with the goal of receiving care in the community if at all possible utilizing the available services to support a healthy and safe quality of life. The goal is to include the patient and caregivers in every aspect of the journey towards their personal "what matters most" destination.

Process measure

- Positions are filled (June 2023 or sooner) Consideration of new graduates is a strong possibility as experienced practitioners are in short supply Manager of the Inpatient Unit educates the nursing staff on the theory of restorative care and the roles and responsibilities of each member of the care team in applying the principles and strategies into practice

Target for process measure

- 1 physiotherapist will be hired by end of April 2023 100% of inpatient nursing staff will receive education on restorative care model and practice by June 30, 2023

Lessons Learned

The model is implemented. The biggest barrier and challenge is with the lack of Home and community care Service resources available to our rural area. The Geriatric team works collaboratively with other partners to bridge the gap by supplementing care in the community when the service providers of home care services are unable to meet the needs of their clients

Access and Flow | Efficient | Custom Indicator

	Last Year		This Year	
Indicator #2 Number of Patient and Resident External Transfer Delays (North Shore Health Network - ELDCAP Unit)	**CB** **Performance (2023/24)**	**CB** **Target (2023/24)**	**9** **Performance (2024/25)**	**NA** **Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Develop an occurrence report that will be entered into the SURGE QRM system

Process measure

- QRM report is operational

Target for process measure

- number of QRM reports entered

Lessons Learned

Time consuming to use this method of collecting data. The analysis shows that these are system issues that cannot be addressed by NSHN. Issues for the EMS is increased volumes, short staffed

Change Idea #2 ☑ Implemented ☐ Not Implemented

Review the data at the monthly QRM meeting to identify the internal barriers that NSHN has control over and develop action plans to address. Identify the external barriers and develop a plan to meet with system partners e.g Algoma OHT or individual agencies e.g EMS to engage and deliberate on what system changes can be made by working collaboratively with a patient focus lens to improve access to services in a more timely, safe, and efficient way.

Process measure

- QRM report is developed and operational in SURGE by April 30, 2023 QRM committee agenda includes as a standing agenda item the review of the QRM reports by May 30, 2023

Target for process measure

- #QRMs launched #action plans developed

Lessons Learned

as above

Experience | Patient-centred | Priority Indicator

Indicator #9	Last Year Performance (2023/24)	Last Year Target (2023/24)	This Year Performance (2024/25)	This Year Target (2024/25)
Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (North Shore Health Network - ELDCAP Unit)	82.35	88	95	NA

Change Idea #1 ☑ Implemented ☐ Not Implemented

Involve Resident and Family Councils in identifying the issues and the development of an improvement plan

Process measure

- Manager of LTC and Quality Lead to develop the PDSA cycle of improvement Develop a mid year mini survey to determine if improvement is made. Bring results back to councils for review and action. (August 2023)

Target for process measure

- % of residents who completed the survey question with a rating of 10/10

Lessons Learned

Did a mini survey of the Resident family members as a comparison to residents responses. The families response was 83.8% vs the resident response of 95%. This data will be used to measure the Caregiver ID impact in improving this rating of family members

	Last Year		This Year	
Indicator #10 Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (North Shore Health Network - ELDCAP Unit)	**100** Performance (2023/24)	**100** Target (2023/24)	**80.95** Performance (2024/25)	**85** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Involve Resident and Family Councils in identifying the issues/concerns/ and ideas about how to sustain and/or improve how residents/families feel about how staff/providers communicate.

Process measure

- Develop the PDSA cycle Develop a mini survey Conduct the mini survey

Target for process measure

- PDSA cycle by May 2023 including mini survey developed mini survey conducted late August 2023 % of residents who responded "completely"

Lessons Learned

Because only 48% on average of the residents are cognitive enough to participate in the survey and recognizing that families are the voice of their family member, the team conducted a mini survey with Resident Families to be able to capture more information about satisfaction with care. The results were much more positive at 90.32 % vs the resident response at 80.95%.

Experience | Patient-centred | Priority Indicator

Indicator #11

Percentage of respondents who responded “completely” to the following 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? (North Shore Health Network)

Last Year		This Year	
74.55	**80**	**97.62**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Acute care leadership to review the discharge processes with the interdisciplinary/interagency team to identify currently how information is communicated to the patient prior to discharge. Focus will be on finding out how we could do a better from the perspective of the patient/caregivers

Process measure

- Review of the current discharge communication processes completed Additional question added to the telephone survey completed Revision of the communication processes completed

Target for process measure

- Review of the current discharge communication process June 2023 Addition of the question April 2023 Revision of the communication process October 2023

Lessons Learned

process in place and good results

Experience | Patient-centred | Custom Indicator

	Last Year		This Year	
Indicator #8 Percentage of patients who felt they were involved in decisions about their care (North Shore Health Network)	**CB** Performance (2023/24)	**CB** Target (2023/24)	**97.60** Performance (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Implement the 5Ms of geriatric assessment and care planning which includes the question "what matters most" to the patient

Process measure

- Revise the weekly patient rounds template to include the question % of patients with an identified goal around what matters most to them

Target for process measure

- 100% of patients will have a documented goal around what matters most to them

Lessons Learned

The strategies have been effective. The new investment in a Geriatric team has provided the resources to educate staff on best practice to provide senior friendly care.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Implement the Caregiver ID program

Process measure

- Implementation plan is developed and implemented #of caregivers who complete the program

Target for process measure

- % of caregivers who complete the program who rate the program as highly beneficial

Lessons Learned

being implemented end of February 2024

Change Idea #3 ☑ Implemented ☐ Not Implemented

Add the question to the post discharge telephone satisfaction survey and ask patient/caregiver how we could have done better.

Process measure

- # of post discharge calls where person agreed to be surveyed/quarter

Target for process measure

- % of patients who answered the question with a completely response.

Lessons Learned

patients appreciate the personal call. There is opportunity to ask the person "what could we have done better"
The information is then reviewed by the staff and at weekly rounds to identify improvements

Change Idea #4 ☑ Implemented ☐ Not Implemented

In collaboration with patient/caregivers, the goals of care will be documented on the patient whiteboard in their room

Process measure

- # of patients with documented goals of care on their whiteboards

Target for process measure

- 100% of patients will have documented goals on their whiteboards

Lessons Learned

It is a challenge to get the goals on the whiteboard on a daily basis. The Manager and the Geriatric Team are monitoring and coaching the staff on the importance of the patient and essential caregiver to know what the priority tasks of the day are

Safety | Safe | Custom Indicator

	Last Year		This Year	
Indicator #13 Rate of medication errors all units (North Shore Health Network)	**3.07** **Performance (2023/24)**	**2.50** **Target (2023/24)**	**2.50** **Performance (2024/25)**	**NA** **Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Managers of care units provide the nurse(s) who are involved in the error with an opportunity to discuss the circumstances of how the error was made, identify process issues, and to reflect on how the error could have had serious consequences

Process measure

- # of medication errors reviewed with nurses

Target for process measure

- 100% of nurses will have a discussion with the manager after an error is made

Lessons Learned

Practice of meeting with nurses to discuss the error are in place across all inpatient units and Emergency Rooms.
Nurses are asked to reflect on why the incident occurred and to identify any process issues and how the nurse can personally address their practice

Change Idea #2 ☑ Implemented ☐ Not Implemented

provide education for nurses on safe medication practices

Process measure

- # nurses attending educational practice sessions/unit

Target for process measure

- % of nurses who attended educational sessions/unit

Lessons Learned

Nurses on the LTC/Eldcap/CCC unit were provided with education sessions.
All Managers "huddle" with staff when a critical or a trend in errors is identified. The Manager coaches and provides support to nurses to ensure that the significance on patient care outcomes can be impacted by the errors.

Indicator #12

Rate of medication errors Acute Inpatient Unit (North Shore Health Network)

Last Year		This Year	
6.03	**5**	**5**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Manager of Acute Care Inpatient will continue meeting with individual nurse(s) to review the medication error. The nurse will be provided with an opportunity to describe the circumstances that may have contributed to making an error, offer suggestions on processes that could be improved, and to reflect on how the error to could have had an adverse effect for the patient.

Process measure

- # nurses who have a meeting with the manager after a medication error is made

Target for process measure

- 100% of nurses will have a meeting with the manager to discuss the incident

Lessons Learned

100% of nurses meet with the Manager to review the medication error. Each nurse is asked to a reflection on why the error was made and to identify a plan to mitigate further errors. The challenge in reducing the errors is due to the multi-step process of transcribing the medication. With the implementation of Computerized Physician order entry which eliminates many of the process issues in the current system it is expected that the errors will be greatly reduced as transcription is the most common type of error

Indicator #1

Current Ratio (North Shore Health Network)

Last Year		This Year	
0.60	**1**	**0.60**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

The NSHN operational review by a third party will provide strategic opportunities and directions for consideration to inform the ongoing operation of the programs and services provided across the three NSHN sites.

Process measure

- The operational review and report will be finalized by end of May 2023. The operational and strategic planning related to moving forward on the agreed upon strategies for improvement will be developed.

Target for process measure

- To be developed when strategic directions are determined

Lessons Learned

Increased volumes of patients, increases in employee wages related to Bill 124 settlements, Increased costs due to difficulty recruiting nurses and having to continue to use Agency Nursing Organizations, increased costs associated with stipend for Hospitalists

	Last Year		This Year	
Indicator #5 Percent of residents who fell in the last 30days (North Shore Health Network)	**18.12** **Performance (2023/24)**	**15** **Target (2023/24)**	**16.70** **Performance (2024/25)**	**NA** **Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Implement the RNAO BPG

Process measure

- # of strategies implemented each quarter

Target for process measure

- 75% of strategies implemented by March 31, 2024

Lessons Learned

Challenges include how an outbreak affects the residents who are isolated in their rooms. Physical deconditioning from not being able to participate in exercises and physio has a significant impact on being able to mobilize.
Implemented over the last two months strategies related to looking at the incident reports for time of day and location of the falls.
Significant improvement shown from early data

Change Idea #2 ☑ Implemented ☐ Not Implemented

Reduce the number of days in isolation wherever possible. Prolonged periods of isolation contributes to development of delirium, depression and decreased mobility which then increases falls risk

Process measure

- # of times/ days that caregivers/visitors are not permitted to visit a resident in isolation during an outbreak # of documented incidents of adverse effects on residents due to long period of isolation in the QRM reporting system

Target for process measure

- 100% of residents will have documentation in the chart about effects of isolation on their mental and physical health 100% of residents who suffered an adverse effect from being in isolation will have a QRM occurrence form completed.

Lessons Learned

The Infection Control team uses the up to date directives related to isolation
In process of implementing the Caregiver ID program which will allow identified Essential Caregivers to be included in the care team which permits visiting

Safety | Effective | Custom Indicator

	Last Year		This Year	
Indicator #7 Percentage of LTC, Eldcap, and Complex Continuing Care residents not living with psychosis who were given antipsychotic medications (North Shore Health Network)	**26.27** **Performance (2023/24)**	**15** **Target (2023/24)**	**8.62** **Performance (2024/25)**	**NA** **Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Educate the staff, residents, and caregivers on the risks associated with taking an antipsychotic vs the benefit of using non medical interventions to manage responsive behaviours.

Process measure

- # of educational sessions provided by BSO nurse

Target for process measure

- % of staff who attend educational sessions

Lessons Learned

process is effective. BSO resources a challenge due to staff absences. However, excellent performance which demonstrates the knowledge transfer that has happened through BSO leadership

Change Idea #2 ☑ Implemented ☐ Not Implemented

Review resident medication profiles to identify any resident who is on an antipsychotic without a documented psychosis for the purposes of weaning off the drug. The resident will be added to the antipsychotic reduction program.

Process measure

- # of residents who are on an antipsychotic who are not living with psychosis

Target for process measure

- % of residents not living with psychosis who were given antipsychotic medications will be reduced to 15% by March 31, 2024

Lessons Learned

process is effective as designed

Safety | Safe | Priority Indicator

Indicator #3	Last Year		This Year	
Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period. (North Shore Health Network)	**15** Performance (2023/24)	**15** Target (2023/24)	**15** Performance (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Senior Team to review and revise policies and procedures related to workplace violence. The Joint Health and Safety Committee will review and provide feedback on the policies and procedures The clinical teams will implement a model that focuses on strategies on how to engage patients and families in workplace Violence Prevention

Process measure

- Policies and procedures reviewed, revised, and implemented How to engage patients and Families in Workplace Violence Prevention program implemented

Target for process measure

- 100% of the Policies and Procedures will be reviewed, revised, and implemented by December 31, 2023 The How to Engage Patients and Families in Workplace Violence will be implemented by December 31, 2023

Lessons Learned

Implemented the Caregiver ID program that includes policies and procedures around violence
Staff safety plans have been developed to address situations of risk. No lost employee time as a result of any of the reported workplace violence incidents