2020/21 Quality Improvement Plan
"Improvement Targets and Initiatives"

North York General Hospital 4001 Leslie Street, Toronto , ON, M2K1E1

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**
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) C = custom (add any other indicators you are working on)															
Theme I: Timely and Efficient Transitions	**Timely**	Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital.	P	% / Discharged patients	Hospital collected data / Most recent 3 month period	632*									Currently NYGH does not measure this indicator and following our selection criteria, it will be assessed to potentially be measured on the corporate quality scorecard first, to determine our current performance and optimize data quality as required.
		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, CCO / Oct 2019– Dec 2019	632*	18.92	18	5% improvement over current performance.		Corporate: Streamline process from ED admission to patient occupying bed on Inpatient unit.	Conduct a process improvement of flow processes to identify gaps and associated opportunities to improve care transitions between the ED and Inpatient units, including a focus on overnight transfers and better matching available resources to demand.	% of change ideas implemented.	100% implementation of change ideas.	
											Patient Flow: Enable better transition planning by improving communication of "Expected Date of Discharge (EDD)" 24 – 48 hours prior to discharge.	1. Conduct a workflow analysis of process (identification, update and communication of EDD). 2. Test with intent to spread the implementation of a communication vechicle to improve information visibility of patients who are likely to be discharged 24-48 hours.	% of change ideas implemented.	100% implementation of change ideas.	
											ED Diversion Project: Identify activities that increase use of outpatient clinic follow-ups for ED diversion and inpatient discharges.	Review of current referral process and the availability of clinic capacity to absorb a greater number of referrals.	1. Number of referrals from ED to OP clinics. 2. Wait time to be seen from OP referral to appointment date.	Increase from baseline.	
	Efficient	Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	P	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / October 2018 - September 2019	53422*	19.19	18.2	Remain below provincial average and meet or exceed absolute target set by the home in previous years.		SBAR education will be provided by a Nurse Practitioner to all registered staff in order to improve information sharing based on resident health assessment.	1:1 and/or group sessions.	1. Number of ED transfers reviewed and analyzed on a monthly basis by the Nurse Practitioner at the "Nursing Practice Meetings". 2. Review of analyzed ED transfers of "Resident Safety Meetings".	100% of Full and Part-Time registered staff will received SBAR education from nurse practitioner.	Physicians and nurse practitioners will report satisfactory outcomes with regards to improved information sharing related to registered staff having received SBAR education.
											Education will be provided to registered staff by Nurse Practitioner on body systems assessment at monthly Nursing Practice Meeting.	1:1 and group sessions.	1.The number of registered staff who receive education. 2.The number of ED transfers reviewed per month by the nurse practitioner at Nursing Practice and Resident Safety meetings.	100% of Full and Part-Time registered staff will receive education from nurse practitioner on body assessments.	Education on body systems assessment is associated with the decreased number of ED transfers.
											Re-education on resident health wishes assessment.	1:1 and group sessions.	Number of ED transfers that were diverted as a result of referencing back to this assessment tool.	100% of Full and Part-Time registered staff will receive education on Resident Health Wishes Assessment.	All residents will have completed health wishes assessment on admission, annually and with any significant changes.
		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 / Jul 2019 - Sep 2019	632*	16.89								This indicator was retired from the 2018-19 QIP. For the past two years NYGH has been monitoring this indicator monthly on the corporate quality scorecard where performance has been sustained against target. We continue to focus on ALC as a priority everyday in order to create space for our community to access as required.
		Unconventional spaces	P	Count / All inpatients	Daily BCS / TBD	632*									NYGH has completed an inventory of conventional and unconventional space in the ED and all inpatient areas in the hospital. Once the Minitsry of Health provides further guidance on this indicator and finalizes the technical specifications we can begin to use the information on a daily basis to support better utilization, optimize performance and improve experience.
Theme II: Service Excellence	**Patient-centred**	Percentage of complaints acknowledged to the individual who made a complaint within five business days.	P	% / All patients	Local data collection / Most recent 12 month period	632*									NYGH monitors this indicator and reports it bi-annually at Board of Quality. We are consistently acknowledging the complaint within 5 business days for 99-100% patients.
		Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"	P	% / LTC home residents	In house data, NHCAHPS survey / April 2019 – March 2020	53422*									This indicator will not be acknowledged as we are aligning with Sienna's key performance indicator for willingness to recommend.
		Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	P	% / LTC home residents	In house data, interRAI survey / April 2019 - March 2020	53422*									This indicator will not be acknowledged as we are aligning with Sienna's key performance indicator for willingness to recommend.
		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?	P	% / Survey respondents	CIHI CPES / Most recent 12 months	632*	53%	58%	Achieve provincial average of 58.1%.		Surgery: Implement all-electronic discharge documentation process with patient education on Surgery Units.	Continuation of Project from Medicine Units (continuation of initiative from FY2019/2020).	1. % of physicians on board with implementation. 2. % provider satisfaction.	Sustain levels from Medicine program implementation.	

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											Corporate: Improve patient experience data collection methods across the organization.	Develop in partnership with patients, a process to increase sample size and real-time patient experience surveying.	1. Completion of process. 2. Reduce margin of error (survey samples). 3. Increase of survey sample size.	Process Completed (Y/N).	
											Inpatients: Conduct a current state assessment of NYGH discharge processes related to the newly released Ontario Health (Quality) Care Transitions Standard with the goal of co-designing with patients and families to improve care transitions.	In partnership with patients, providers and community stakeholders, review standard, evaluate implentation and effectiveness.	Completion of process.	Assessment Completd? (Y/N).	
		Overall how would you rate the quality of services provided by the home	C	% / Residents	In-house survey / January - December 2019	53422*	77%	85%	The home will address areas of low performance on the resident satisfaction survey in order to increase overall satisfaction.		Address staffing and shortages.	1. Create contingency plans for staff shortages, to work within complement. 2. Quarterly audits to address effectiveness. 3. Work with recruiters to fill all vacancies, as well as conduct interviews for why staff leave.	1. Quarterly audits to measure the effectiveness of contingency plans in the case of staff shortages. 2. All vacancies will be addressed. 3. Exit interviews to be offered to all employees who choose to end their employment.	1. Quarterly audits target 90% effectiveness for contingency plan follow-through and usage. 2. 95% of vacancies will be addressed. 3. 90% of staff who choose to end their employment will have an exit-interview format offered to them.	In addressing this QIP indicator, overall quality of work-life for employees and resident satisfaction will be increased.
											Enhance the pleasurable dining experience.	Chef "dining room check-ins" will be completed on a consistent basis. A special committee will meet frequently to address standing agenda items such as: dining ambiance, esthetics of the dining space, food and cutlery and taste tests.	1. The number of "check-ins" with residents. 2. Monthly Special Committee meetings, dining room audits.	1. At minimum 4 check-ins (1 per floor,) by the chef with residents each week. 2. At minimum 4 dining room audits to be completed each week, and results shared at monthly special committee meetings.	Enhancing the pleasurable dining experience will result in increased resident satisfaction.
											Enhancement of the move-in process.	"Heads-up" e-mails will be sent out to all members of the interdisciplinary team, which will provide members a background on the resident before admission. A "check-in" phone call to the family post-move in, to answer any questions and assess satisfaction will also be completed	1. The number of e-mails sent to the interdisciplinary team, before resident move-in. 2. The number of phone-calls made to families (post move-in,) to gauge satisfaction and respond to questions.	1. 100% target completion. 2. 100% target completion.	The goal in enhancing the move-in process is to set out initial expectations of care with the interdisciplinary team, resident/family, address any unanswered questions and open dialogue and communication amongst team members.
Theme III: Safe and Effective Care	**Safe**	Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.	M A N D A T O R Y	Count / Worker	Local data collection / Jan - Dec 2019	632*	412	400	Align with 2019-20 performance to sustain results.		Corporate: Education and Awareness Initiatives (continuation of initiative from 2019-2020): 1) Continue spread of Prevention and Management of Aggressive Behaviours (PMAB) training for staff across all risk levels across the organization and 2) Implement physican focused training sessions to boost physiican safety and support.	The education program will follow a Train the Trainer model and will have organization-wide roll out to frontline staff provided by our "NYGH PMAB trainers". Code White Response team, Emergency and Mental Health teams will be trained in a specialized high risk cirruculum.	1. Number of staff trained. 2. Number of physicans trained.	1. Sustain the number of staff being trained from FY 2019/2020. 2. Baseline number of physician trainees.	
											Corporate: Unit audits of the Cerner Behavior Assessment and Safety Alert to ensure patients with the potential to harm have a safety alert in place (implementation of Safety Alerts in Cerner during FY2019-2020)	Unit Compliance by audit	1. Number of audits and incident reviews completed. 2. Number of days lost to Work Place Violence (quarterly). 3. Number of incidents of Work Place Violence reported by staff with no lost days but escalated severity.	1. Sustain the number of audits completed. 2. Establish baseline for the number of days lost to Workplace Violence. 3. Establish baseline for the number of incidents of Workplace Violence reported by staff but no loss of days.	
											Implement Mock Code White simulation in high-risk areas to reduce knowledge gaps with the intent to spread simulation across the organization.	Mock code white simulations for high risk areas.	1. Completed simulation. 2. Number of staff trained.	1. Simulation Completed (Y/N). 2. Establish baseline staff receiving training.	
	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 / Oct 2019– Dec 2019 (Q3 2019/20)	632*									At NYGH, this indicator has been sustained for the past three years and there will not be an opportunity to further improve by 5%-10%. The indicator will continue to be monitored internally on the corporate quality scorecard and by pharmacy program management. Where escalation is required in particular programs or areas, we will do so through our internal committee structure.
		Percent of unscheduled repeat emergency visits following an emergency visit for a mental health condition.	P	% / ED patients	CIHI NACRS / April - June 2019	632*	18.28	Baseline year		Addiction Services York Region	Establish 2nd Rapid Access Addiction Medicine Clinic (RAAM): Expansion to improve access to care for addiction issues, including assessments, counselling, prescriptions for medications and help patients to navigate access to other services.	1. Establish patient experience of RAAM clinic patients. 2. Spread learnings to advance development of similiar service model for the long-term management of mental health. 3. Utilization of RAAM clinic services.	1. Patient experience measures (service barrier/walk-in model/patient-centered). 2. Number of overall RAAM visits (Baseline: FY 2019/20 Q3 & Q4 & Actual: FY 2020/21 Q1 & Q2). 3. Number of repeat RAAM visits (Baseline: FY 2019/20 Q3 & Q4 & Actual: FY 2020/21 Q1 & Q2).	5% improvement from baseline.	
											Ontario Health Team Project: Mental Health and Addictions "Health Desk": Develop a walk-in for people with MHA issues while on a waitlist for service(s).	The Ontario Health Team implementation committee to bring together partners and patients to develop.	% project milestones completed.	100% completion (set-up one clinic).	
										Toronto North Support Services & COTA Health	ED discharge pathway refinements for those patients not referred to a crisis team: Better guide ED MD to better connect patients to hospital and community supports (Peer Navigators; Access to Resources & Community Support (ARCS); RAAM Clinic and Mental Health Urgent Clinic).	Focus on improving discharge planning, enhance awareness and access to improve the utilization of supports (Peer Navigators; Access to Resources & Community Supports (ARCS); RAAM Clinic and Mental Health Urgent Clinic).	Increase number of GEM nurse referrals.	5% increase number GEM referrals.	
		Proportion of hospitalizations where patients with a progressive, life-limiting illness, are identified to benefit from palliative care, and subsequently (within the episode of care) have	P	Proportion / All patients	Local data collection / Most recent 6 month period.	632*									Currently NYGH does not measure this indicator and following our selection criteria, it will be considered for measurement and monitoring on the corporate quality scorecard first, to determine our current performance and optimize data quality.
		The proportion of residents with a progressive, life-limiting illness, that are identified to benefit from palliative care, who subsequently have their palliative care needs assessed using a comprehensive and holistic assessment.	P	Proportion / LTC home residents	Local data collection / Most recent 6 month period.	53422*	100%	100%	Sustain performance.		Utilize Indicator data J5C and CHESS (populated in QIA) to trend and analyze resident scores.	Monthly QIA data entry.	Review the number of residents identified with CHESS scores of 3 or higher and/or with triggered J5C.	100% Indicator Trending in QIA on a monthly basis.	
											Residents will die peacefully at the home.	Information sharing by the Nurse Practitioner at the Nursing Practice Meetings and Resident Safety Meetings on residents who are being identified as palliative.	Review the number of residents deemed palliative and identify how many of them passed away in the home.	1. 91% of resident's will die at home. 2. 95% of residents deemed palliative will die at home.	
											Palliative Care Consultation with Freeman Centre.	Consults e-mailed to representative of Freeman Centre for High Risk Palliative Care Consult.	Number of referrals completed.	100% of High Risk Palliative Care residents will receive a palliative care consultation from the Freeman Team.	
Equity	**Equitable**														