Access and Flow

Measure - Dimension: Timely

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% of patients who visited the Emergency Department and left without being seen by a provider	C	% / ED patients	In house data collection / January - December 2024	3.28	3.28	We will target to maintain performance	

Change Ideas

Change Idea #1 Emergency Department Committee to review the current performance by site to determine root cause

Methods	Process measures	Target for process measure	Comments
At the ER committee the data will be be reviewed and analyzed	# of patients who left without being seen / by total registrations x 100	Each month, 90% of triage 2 & 3 patients who left without being seen will be contacted to inquire regarding the reasons for leaving by December 31, 2024	Need to account for the lack of follow up if hospital staff leave message for a patient and they do not respond

Change Idea #2 Once data is obtained from follow up calls, the ER committee will analyze the data and develop an action plan to improve the conditions which caused triage level 2 & 3 patients to leave with out being seen

Methods	Process measures	Target for process measure	Comments
ER Managers & staff will develop a telephone survey to use when contacting patients, develop a process to record the data, report to the ER committee the findings to analyze the data. Develop an action plan to address the issues identified, if possible	# of patients who left with out being seen that are contacted each month	90% of patients will be contacted each month	

Measure - Dimension: Timely

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
ALC - LTC throughput ratio	C	Rate / ALC patients	In house data collection / April to December 2024	2.50	1.00	We feel this is an an attainable target	

Change Ideas

Change Idea #1 Continue to implement Reducing ALC strategies as per the funding agreement

Methods	Process measures	Target for process measure	Comments
Screen all patients over the age of 60 years using the internal mini Geriatric screen to identify those at risk. If at risk, complete a comprehensive Geriatric Assessment and work with the Restorative Care Team to develop individualized care plans	Number of patients admitted who are 60 years and older who receive a Mini Geriatric Screen	100% of patients 60 years of age and older receive a mini Geriatric assessment	

Change Idea #2 All patients 60 years of age and older, who identify at risk from the Mini Geriatric Screen will have a comprehensive Geriatric assessment completed

Methods	Process measures	Target for process measure	Comments
Geriatric Assessors will complete the assessments on at risk patients	the Number of Geriatric Assessments completed on patients 60 years and older	100% of the patients 60 years of age and older will have a geriatric assessment completed within 3 business days of admission	

Change Idea #3 Patients identified as at risk from the Geriatric Assessment receive restorative care with the goal of ALC LTC avoidance

Methods	Process measures	Target for process measure	Comments
The Geriatric Team review data collected on discharges to assess if the restorative care was able to avoid ALC LTC designation	total % of patients discharged from the Geriatric program who were identified at risk and were discharged and avoided ALC LTC placement	target 70% of patients who are in restorative care avoid an ALC LTC admission	There will be patients that will not benefit regardless of intensive restorative care due to their complex medical comorbidities. The goal is to provide restorative care to those at risk to optimize their functioning - to be the best they can be even if they go to LTC

Equity

Measure - Dimension: Equitable

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% of the leadership team who have completed relevant equity, diversity, inclusion and anti-racism education (focus on Indigenous Cultural Awareness)	C	% / Staff	In house data collection / April to December 2024	CB	100.00	We feel that the 26 members of the Leadership Team are able to dedicate time to the education	

Change Ideas

Change Idea #1 Increase the Leadership Teams knowledge and Indigenous cultural awareness and evaluate two education options for appropriateness to be assigned to all NSHN staff

Methods	Process measures	Target for process measure	Comments
In Surge Learning assign the Cultural Competence and Indigenous Cultural Safety series (4 parts)	# of Leadership Team members who have completed the education / the number of Leadership Team members assigned the education	100 % of the Leadership Team will have completed the education by December 31, 2024	

Change Idea #2 Increase the Leadership Teams knowledge and Indigenous cultural awareness and evaluate two education options for appropriateness to be assigned to all NSHN staff

Methods	Process measures	Target for process measure	Comments
Through Ontario Health E-Learning, provide the Leadership Team members the link to the website to register for the Indigenous Relationship and Cultural Awareness Course entitled " Cultural Competence in Health Care."	# of Leadership Team members who have completed the education / the number of Leadership Team members assigned the education	100 % of the Leadership Team will have completed the education by December 31, 2024	

Experience

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (North Shore Health Network - ELDCAP Unit)	O	% / LTC home residents	In house data, interRAI survey / Most recent consecutive 12-month period	80.95	85.00	we feel this is an attainable improvement	

Change Ideas

Change Idea #1 Complete RNAO gap analysis for resident and family centered care and develop action plan to implement RNAO clinical pathway for resident and family centered care

Methods	Process measures	Target for process measure	Comments
Manager of LTC to develop action plan which includes policy development; communication with residents and families via the Resident and Family Council; and collect data through the NQUIRE system for submission to RNAO	The number of residents surveyed	100 % of capable residents will have completed the survey by Dec 31, 2024	Total Surveys Initiated: 21 Total LTCH Beds: 42

Change Idea #2 Develop a standardized approach/ training to asking the survey questions to the ensure that the residents comprehend the questions asked

Methods	Process measures	Target for process measure	Comments
The Clinical Quality Specialist will develop a standardized approach/ script to asking the questions	The number of individuals who are trained on the standardized approach in addition to the Clinical Quality Specialist	100% of the individuals administering the survey will be trained by September 30, 2024	

Change Idea #3 The Clinical Quality Specialist will be familiar with the residents to assist in the survey delivery and resident comfort

Methods	Process measures	Target for process measure	Comments
The Clinical Quality Specialist will attend Resident Council meetings and attend the unit in order to meet the residents	The number of Resident Council meetings the Clinical Quality Specialist attends	Attend 3/7 Resident Council meeting by November 30, 2024	

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% of patients screened at registration who have been asked the question " Do you self-identify as Indigenous?"	C	% / Other	In house data collection / January to December 2024	91.20	93.00	We feel this is an attainable improvement	

Change Ideas

Change Idea #1 Provide education to all staff that register patients across all sites

Methods	Process measures	Target for process measure	Comments
Develop training program which provides staff the knowledge as to why the question is asked, that the question is mandatory and to be confirmed with each visit; develop a script and training for staff on how to ask the questions in an appropriate manner; Continue to monitor and evaluate monthly	# of staff who register patients that have been trained	75% of staff requiring education will have received the education by September 30, 2024 and 90-100% by Dec 31, 2024”	The question is mandatory for hospital staff to ask, not for the patient to respond; Account for staff that are not at work due to mat leave etc.

Measure - Dimension: Patient-centred

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% of respondents who responded " Yes" to the question- " Did you receive enough information about what to do if you were worried about your condition or treatment after you left the hospital".	C	% / Discharged patients	In house data collection / January to December 2024	90.80	92.00	We feel this is an attainable improvement	

Change Ideas

Change Idea #1 Speak with patients post discharge to gather data on if they felt they received enough information about what to do after they left the hospital. As well, as gather data on their suggestions for improvement.

Methods	Process measures	Target for process measure	Comments
The Manager of ACU will place telephone follow up survey calls to all discharged patients. Data to be collected and reported to the ACU committee to inform the development of the discharge planning tool	Number of successful follow up survey calls where the Manager of ACU spoke to a patient	100% of discharges patients will receive a follow up survey telephone call by December 31, 2024	

Change Idea #2 Develop a new discharge planning tool based on patient and PFAC feedback to ensure patients receive adequate information at discharge

Methods	Process measures	Target for process measure	Comments
The ACU committee will develop a new discharge planning tool based o the patient feedback	Development and implementation of the new discharge tool	The discharge planning tool will be developed by September 1, 2024. 100% of ACU discharged patients between September 1 to Dec 31, 2024 will have th enew discharge tool used for their discharge.	

Safety

Measure - Dimension: Safe

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% of residents (LTC/ ELDCAP/ CCC) who fell in the last 30 days leading to their assessment (North Shore Health Network - ELDCAP Unit)	C	% / Other	In house data collection / April to December 2024	16.70	15.00	We feel that with the work being done this is a reasonable target	

Change Ideas

Change Idea #1 Implement the RNAO Falls Prevention Best Practice Guideline

Methods	Process measures	Target for process measure	Comments
The RNAO gap analysis has been completed based on that gap an action plan has been developed to implement best practice for falls prevention (ie: Bed alarms, Chair alarms)	# of residents assessed quarterly with their MDS	“100 % of residents will have been assessed each quarter (Q1/2/3) by Dec 31, 2024”	

Change Idea #2 Use the data in the QRM system to analyze falls data

Methods	Process measures	Target for process measure	Comments
Each quarter data will be collected from QRM prior to the LTC Quality Committee. Data is analyze at the meeting and determine any further change ideas that need to be implemented/ any process changes needed/ do we need to change staffing patterns base don when falls are occurring/	Number of QRM falls reports review at each Quality Committee meeting	100% of the QRM falls reports reviewed at each Quality Committee meeting by December 31, 2024	