2024-25 Quality Improvement Plan

Measures						2024-25 Improvement Initiatives				
Priority Issue	**Indicator**	Unit / Population	Source	**2024-25 YE Target**	**Target Justification/ Rationale**	**Planned Improvement Initiatives** *("titles" of Change Ideas)*	**Methods** *(describe actions and how we will measure, monitor and report)*	**Process Measures** *(how will we demonstrate that we are doing the work that we said we would do)*	**Targets for Process Measures** *(what work will we accomplish by when?)*	**Initiative Leads**
Access & Flow	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	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC	**7.2%**	Provincial target was set as 10% reduction from previous year; given that current JBH performance is favourable to provincial average, JBH will target a 10% reduction from the JBH 2023-24 target.	(1) Proactive assessment and response to discharge risks. (2) Implementation of standardized order set, care pathway, and patient/family education for patients admitted with delirium/dementia.	(1) Implementation of discharge planning risk assessment (Blaylock Tool) to support discharge planning. (2) Via dementia/delirium working groups, creation and implementation of standardized order set, care pathway, and patient/family education tool.	(1) Blaylock scores will be reported at discharge rounds for medicine patients admitted from ED. (2) Process auditing to confirm consistent implementation and sustainment.	(1) Full implementation of Proactive assessment and response to discharge risks by September 2024. (2) Full implementation of standardized order set, care pathway, and patient/family education tool by March 2025. **NOTE: Exec Comp Linked to Achievement of Process Measure Target**	Director - Medicine, Post Acute

Measures						2024-25 Improvement Initiatives				
Priority Issue	**Indicator**	Unit / Population	Source	**2024-25 YE Target**	**Target Justification/ Rationale**	**Planned Improvement Initiatives** *("titles" of Change Ideas)*	**Methods** *(describe actions and how we will measure, monitor and report)*	**Process Measures** *(how will we demonstrate that we are doing the work that we said we would do)*	**Targets for Process Measures** *(what work will we accomplish by when?)*	**Initiative Leads**
Equity	% of Staff completing Anti-Racism Learning Module	% of FT Employees	HRIS	**75%**	Target is based upon expectation that a new policy & procedure that includes a progressive response for non-completion of mandatory learning requirements will significantly impact the completion rate by FT employees in its first year of implementation.	Implementation of Mandatory E-Learning & Core Curriculum Policy to reinforce uptake of "Call It Out: Racism, Racial Discrimination and Human Rights learning module.	Roll out and reinforcement of Mandatory E-Learning & Core Curriculum Policy module "Call It Out: Racism, Racial Discrimination and Human Rights to increase staff awareness.	Staff completion of the online staff training module Call It Out: Racism, Racial Discrimination and Human Rights.	Call It Out: Racism, Racial Discrimination and Human Rights learning module completed by not less than 75% of FT/Employees by YE 2024-25.	Director - People Services; Chief Human Resources Officer

Measures						2024-25 Improvement Initiatives				
Priority Issue	**Indicator**	Unit / Population	Source	**2024-25 YE Target**	**Target Justification/ Rationale**	**Planned Improvement Initiatives** *("titles" of Change Ideas)*	**Methods** *(describe actions and how we will measure, monitor and report)*	**Process Measures** *(how will we demonstrate that we are doing the work that we said we would do)*	**Targets for Process Measures** *(what work will we accomplish by when?)*	**Initiative Leads**
Experience	Percentage of respondents who responded with "top box" positive score 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?*	Percentage	Patient experience surveying of discharged acute medicine and surgical inpatients.	**60.0%**	Continue with target set for 2021-22 according to previous JBH years' progress and 2021-22 HNHB LHIN (59.4%) and ON community hospital (57.6%) benchmarks.	Patient group-specific sets of discharge instructions. (i.e., Dementia/Delirium, CHF).	Development, testing and implementation of patient group-specific sets of discharge instructions.	Number of patient group-specific sets of discharge instructions have been implemented.	At least two patient group-specific sets of discharge instructions implemented in all relevant areas. **NOTE: Exec Comp Linked to Achievement of Process Measure Target**	Director - Medicine Chief of Medicine; Director - Surgery; Chief of Surgery Director - Patient Experience

Measures						2024-25 Improvement Initiatives				
Priority Issue	**Indicator**	Unit / Population	Source	**2024-25 YE Target**	**Target Justification/ Rationale**	**Planned Improvement Initiatives** *("titles" of Change Ideas)*	**Methods** *(describe actions and how we will measure, monitor and report)*	**Process Measures** *(how will we demonstrate that we are doing the work that we said we would do)*	**Targets for Process Measures** *(what work will we accomplish by when?)*	**Initiative Leads**
Safety	Patient falls with harm level of Moderate or worse per 1000 inpatient days	Rate per 1000 inpatient days	JBH Incident Reporting System (IRS)	**0.12**	After favourable results in Q1 and Q2 of 2023-24, unfavourable results in Q3 brought YTD Q3 2023-24 results to slightly unfavourable; continue with 2023-24 target in 2024-25 to regain and sustain previous results. There are no external (provincial, federal) benchmarks specific to this indicator.	(1) Purposeful Rounding refresh. (2) Reinforce consistent implementation of Falls Prevention Strategy.	(1) Re-education and branding of purposeful rounding; compliance with Purposeful Rounding will be audited for compliance. (2) Compliance with implementation of Falls Prevention Strategy is audited and results are reviewed and reported.	(1) Relevant units receive re-education and audited for compliance; tracking and analysis of unwitnessed falls at night. (2) Relevant units audited; frequency of audits; frequency of reviews and reports.	(1) By March 2025, relevant units have received re-education and have been audited for compliance; unwitnessed falls at night data has been analysed and reviewed by Falls Prevention Committee. (2) By March 2025, relevant units are being audited; results are being reviewed and reported monthly at unit, program, and corporate levels. **NOTE: Exec Comp Linked to Achievement of Process Measure Target**	Director - Medicine, Post Acute

Measures						2024-25 Improvement Initiatives				
Priority Issue	**Indicator**	Unit / Population	Source	**2024-25 YE Target**	**Target Justification/ Rationale**	**Planned Improvement Initiatives** *("titles" of Change Ideas)*	**Methods** *(describe actions and how we will measure, monitor and report)*	**Process Measures** *(how will we demonstrate that we are doing the work that we said we would do)*	**Targets for Process Measures** *(what work will we accomplish by when?)*	**Initiative Leads**
Safety	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	Count / Worker	Local data collection (Incident Reporting System)	**85%**	There is no established national or provincial benchmark, though theoretical target for compliance with a patient safety best practice is zero. This target was set for 2023-24 based upon consultation with Accreditation Canada regarding On-Site Survey expectations for this ROP. JBH not achieve target in 2023-24 (83.7-84.3% in Q1-3) but expects to achieve target with the implementation of the physician escalation approach. Further progress is expected to be made when this process is supported by an electronic medical record.	Refinement of data by Decision Support (prior to Q1 2024-25); Implementation of a progressive escalation process to reinforce completion of Medication Reconciliation in Q1 2024-25; Review build in EPIC to support medication reconciliation compliance and best possible medication histories (Q3-4 2024-25).	Continue to monitor the number of reconciliations in MedsTracker against admission and discharge data from Meditech by Clinical Program and by Provider; Hospital wide compliance dashboard - accessible on the intranet for all users and compliance reports emailed to all Chiefs and Program Directors on a monthly basis by Decision Support. Quality auditing of the Best Possible Medication History continues within Pharmacy Services and is shared at both Pharmacy & Therapeutics Committee and the Medication Reconciliation Advisory Committee. Compliance will also be monitored by the Medication Reconciliation Advisory Committee and by the JBH Corporate Quality Committee. Exclusion: Ambulatory Care Area compliance data will be evaluated manually due to the limitations with MedsTracker.	Hospital wide: Medication Reconciliation Advisory Committee will review the data monthly; Program Quality Committees will monitor their compliance monthly; The Medication Reconciliation Advisory Committee will request programs that are below the compliance target to provide an action plan. Provider-specific: The progressive escalation approach to be implemented in Q1 with oversight by Medical Advisory Committee.	Q1 - Implement Physician Escalation Process; Q2 - All providers below 50% compliance will be addressed; Tests of Compliance for Accreditation Canada Required Organizational Practices Medication Reconciliation as a Strategic Priority and Medication Reconciliation at Care Transitions to ensure standards continue to be met as in 2023. **NOTE: Exec Comp Linked to Achievement of Process Measure Target**	Director - Pharmacy; Chief Medical Information Officer

Measures						2024-25 Improvement Initiatives				
Priority Issue	**Indicator**	Unit / Population	Source	**2024-25 YE Target**	**Target Justification/ Rationale**	**Planned Improvement Initiatives** *("titles" of Change Ideas)*	**Methods** *(describe actions and how we will measure, monitor and report)*	**Process Measures** *(how will we demonstrate that we are doing the work that we said we would do)*	**Targets for Process Measures** *(what work will we accomplish by when?)*	**Initiative Leads**
Safety	Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period	Count / Worker	Local data collection (Incident Reporting System)	**75**	Target was determined according to a 2022 scan of the targets and results shown in the QIPs of other hospitals. It is an approximation of a baseline rate for a hospital comparable to JBH that has achieved fulsome WPV incident reporting.	JBH will act upon the results of its Workplace Violence Prevention (WPVP) gap analysis to advance the work plan and implementation of best practices through the Joint Health and Safety Committee (JHSC) subgroup for WPVP. Improvements to JBH stakeholder awareness, and the consistency of WPVP incident reporting, are expected to result in increased awareness and confidence in reporting.	Formalize the process for identifying and responding to/mitigating areas of concern. Scorecard, progress and results will be monitored by the WPVP subgroup and reported to the JHSC.	Update of the WPVP Committee annual work plan. Implement communication and awareness campaign. Encourage completion of the online staff training module. Develop an incident investigation framework that will better support more robust incident investigation and support more proactive prevention control strategies.	WPVP Committee annual work plan updated by Dec 2024 for FY 2025-26. Communication and awareness campaign completed by YE 2024-25. Develop and roll out a Workplace Violence Incident Investigation Framework by YE 2024-25.	Director - People Services; Chief Human Resources Officer