2017/18 Quality Improvement Plan
"Improvement Targets and Initiatives"

JOSEPH BRANT HOSPITAL

Joseph Brant Hospital 1230 North Shore Boulevard

AIM		Measure							Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Org ID	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Effective	Effective transitions	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?	% / Survey respondents	CIHI CPES / April - June 2016 (Q1 FY 2016/17)	718*	45.6	47.90	5% improvement on current performance	1)Pilot discharge follow-up phone calls for discharged patients to ensure that patients fully understand instructions provided at discharge.	Feedback collected through discharge follow-up phone calls will inform improvements to communication between clinicians and patients preparing for discharge.	Number of discharge follow-up phone calls completed for discharged JBH inpatients.	Establish standardized process for completion of post-discharge calls from inpatient care. 50 discharge follow-up phone calls completed per year for discharged JBH inpatients.	Indicator and Workplan Lead: Director - Collaborative Practice
		Risk-adjusted 30-day all-cause readmission rate for patients with CHF (QBP cohort)	Rate / CHF QBP Cohort	CIHI DAD / January 2015 - December 2015	718*	18.54	19.10	Maintain at or better than current JBH performance Note: Ontario's current performance is at 22.8	1)Increase General Internal Medicine Rapid Assessment Clinic (GIMRAC) and Heart Function Clinic (HFC) Activity and Impact to promote admission (and re-admission) avoidance reduced ED length of stay.	GIMRAC and HFC Appropriate patients will be referred from ED for timely follow up.	GIMRAC and HFC Number of CHF patients who are referred to GIMRAC and HFC	Completion of a comparative review of the outcomes of CHF patients referred to GIMRAC, Heart Function Clinic and/or ICC to inform refinement of CHF care processes.	Indicator and Workplan Lead: Director - ED
									2)Increase Integrated Comprehensive Care (ICC) Program Activity and Impact - onsite integrated care coordinators support transition and monitoring in community for 60 days post discharge.	ICC Program Appropriate patients will be screened for eligibility; Onsite ICC coordinators Mon-Fri to support transition and monitoring in community for 60 days post discharge.	ICC Program Number of CHF patients screened and enrolled in ICC. Percent of CHFpatients enrolled with a 30 day readmission.	Completion of a comparative review of the outcomes of CHF patients referred to GIMRAC, Heart Function Clinic and/or ICC to inform refinement of CHF care processes.	Indicator and Workplan Lead: Director - ED
Efficient	Access to right level of care	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 / July – September 2016 (Q2 FY 2016/17 report)	718*	10.64	12.70	Maintain at or better than Provincial Target	1)Early Engagement Process Improvement Initiative	Early engagement with CCAC for complex discharge planning in Medicine.	1. % of medicine patients and families engaged in discharge planning discussion by CCAC and/or hospital within 48 hours of admission	1. 70% of medicine patients and families with complex discharge planning needs are engaged in discharge planning discussion by CCAC and/or JBH within 48 hours of admission during March, 2018.	Indicator and Workplan Lead: Director - Collaborative Practice
Patient-centred	Palliative care	Percent of palliative care patients discharged from hospital with the discharge status "Home with Support".	% / Palliative patients	CIHI DAD / April 2015 – March 2016	718*	87.65	87.80	Maintain at or better than current JBH performance	1)Burlington Community Palliative Care Visioning Initiative	JBH is participating in a stakeholder group to develop vision for palliative care in the Burlington community that will inform improvement methods.	Establishment of roadmap to realize the vision for palliative care in Burlington community.	Vision and roadmap provide improved access to supports for discharged JBH palliative patients.	Indicator and Workplan Lead: Director - Medicine
	Person experience	"Would you recommend this emergency department to your friends and family?"	% / Survey respondents	EDPEC / April - June 2016 (Q1 FY 2016/17)	718*	43.6	45.80	5% improvement on current performance.	1)Pilot ED visit follow-up phone calls to identify and respond to service recovery opportunities for non-admitted patients.	Feedback collected through ED visit follow-up phone calls and real time iPad surveys will inform improvements to ED patient care and patient experience.	Number of ED visit follow-up phone calls completed for non-admitted ED patients. Number of real time ED patient and family experience surveys using iPads. Number of service recoveries and ED care and service improvements completed.	Establish standardized process for completion of post-discharge calls from inpatient care 50 ED visit follow-up phone calls completed per year for non-admitted ED patients. 30 real time ED patient and family experience surveys conducted per month using iPads. Three service recoveries and ED care and service improvements completed per year.	Indicator and Workplan Lead: Director - Collaborative Practice
									2)Conduct real time ED patient and family experience surveys using iPads	Feedback collected through ED visit follow-up phone calls and real time iPad surveys will inform improvements to ED patient care and patient experience.	Number of ED visit follow-up phone calls completed for non-admitted ED patients. Number of real time ED patient and family experience surveys using iPads. Number of service recoveries and ED care and service improvements completed.	Establish standardized process for completion of post-discharge calls from inpatient care 50 ED visit follow-up phone calls completed per year for non-admitted ED patients. 30 real time ED patient and family experience surveys conducted per month using iPads. Three service recoveries and ED care and service improvements completed per year.	Indicator and Workplan Lead: Director - Collaborative Practice
		"Would you recommend this hospital to your friends and family?" (Inpatient care)	% / Survey respondents	CIHI CPES / April - June 2016 (Q1 FY 2016/17)	718*	46.2	48.50	5% improvement on current performance.	1)Pilot discharge follow-up phone calls to identify and respond to service recovery opportunities for discharged patients.	Feedback collected through discharge follow-up phone calls will inform improvements to patient care and patient experience.	Number of discharge follow-up phone calls completed per month for discharged patients. Number of service recoveries and inpatient care and service improvements completed.	Establish standardized process for completion of post-discharge calls from inpatient care. 50 discharge follow-up phone calls completed per year for discharged patients. Three service recoveries and inpatient care and service improvements completed per year.	Indicator and Workplan Lead: Director - Collaborative Practice
Safe	Medication safety	Medication reconciliation at admission: The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital	Rate per total number of admitted patients / Hospital admitted patients	Hospital collected data / Most recent 3 month period	718*	35.5	70.00	Based upon Accreditation Canada Requirement and based upon targets set by peer hospitals implementing electronic Med Rec solutions	1)Implementation of Medstracker electronic solution.	BPMH will be completed electronically by nursing staff. Physicians will complete medication reconciliation electronically.	Percentage of patients with med rec completed within 24 hours of admission.	70% of patients with med rec completed within 24 hours of admission during March 2018	Indicator and Workplan Lead: Director - Pharmacy
		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.	Rate per total number of discharged patients / Discharged patients	Hospital collected data / Most recent quarter available	718*	0	70.00	Based upon Accreditation Canada Requirement and based upon targets set by peer hospitals implementing electronic Med Rec solutions	1)Implementation of Medstracker electronic solution.	BPMH will be completed electronically by nursing staff. Physicians will complete medication reconciliation electronically.	Percentage of patients with med rec completed upon discharge.	70% of patients with med rec completed upon discharge during March 2018	Indicator and Workplan Lead: Director - Pharmacy
Timely	Timely access to care/services	Total ED length of stay (defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ED) where 9 out of 10 complex patients completed their visits	Hours / Patients with complex conditions	CIHI NACRS / January 2016 – December 2016	718*	16.5	15.10	5% improvement on current performance.	1)ED and Medicine 24/7 Unit Charge RN Role and Standard Work Implementation.	Training and accountability for daily unit-level operations ("Standard Work") including: patient flow and bed management, scheduling and staff assignments, and MRP liaison.	Number of Charge Role processes that have been developed and implemented as Standard Work.	Three Charge Role processes developed and implemented as Standard Work by March 31st, 2018.	Indicator and Workplan Lead: Director - ED
									2)Site-wide Bed Map	Application of predictive simulation modelling to inform changes alignment of bed resources and bed management policies. (Partnership with Centre for Healthcare Engineering at University of Toronto).	Number of scenarios developed tested as virtual PDSA cycles to predict the impact of bed resource allocations and bed management policies on timely patient flow to appropriate inpatient beds.	Bed resource allocations and bed management policies will be in place for opening day of new tower and subsequently evaluated for further improvements.	
									3)Establish and refine flows of patients in the new tower ED.	Application of Lean process improvement activities to support ED staff and physicians in defining, and realizing opportunities to optimize, ED patient flows.	Number of ED patient flows that have been established, evaluated, and refined in the new tower.	All identified ED flows have been evaluated and refined within the new tower by March 31st, 2018.	