2023-24 JBH Quality Improvement Plan – Work Plan

	Measures		2023-24 Improvement Initiatives				
Dimension	**Indicator**	**YTD Q3 2023-24 Target**	**Planned Improvement Initiatives** *(Change Ideas)*	**Methods** *(how will we measure, monitor and report)*	**Process Measures** *(how will we demonstrate that we are doing what we said we would do)*	**Targets for Process Measures** *(what will we accomplish by when? did we keep our foot on the gas pedal?)*	**Initiative Leads**
Safety	**Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.**	**75**	JBH will complete and act upon the results of its Workplace Violence Prevention (WPVP) gap analysis to advance the development of a multi year 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.	Introduction of WPVP scorecard for monitoring, and formal process for identifying and responding to/mitigating areas of concern. Progress and results will be monitored by the WPVP subgroup and reported to the JHSC.	Develop and introduce WPVP scorecard. % of programs and departments for which WPVP risk assessments have been conducted. Completion of WPVP Committee annual work plan. Implement WPV reporting communication and awareness campaign. Introduce an online staff training module on Workplace Violence Prevention	WPVP risk assessments have been conducted for not less than 50% of programs and departments by YE 2023-24. WPVP Committee annual workplan completed by YE 2023-24. Communication and awareness campaign completed by YE 2023-24 Online staff training module developed and launched by YE 2023-24.	Chief Human Resources Officer
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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.**	**85.0%**	Regular distribution of compliance reports analyzed at the unit/service/provider level. Medication Reconciliation Advisory Committee re-launched to continue to develop strategies to improve Medication Reconciliation at Admission and at Discharge. Leverage Accreditation processes to increase awareness and reinforce compliance across all relevant areas of JBH.	Compliance data is collected electronically and analyzed monthly at the unit /service/provider level. Compliance reports are reviewed and opportunities for improvement are discussed at Program Quality Committee meetings led by Director/Chief Dyads, and at Physician Service meetings. Beginning Q1 2023-24, compliance reports will include Medication Reconciliation at Admission, as well as, at Discharge. 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, Accreditation Steering Committee, and by the JBH Corporate Quality Committee.	Percentage of relevant units and Physician Services receiving and reviewing compliance reports on a monthly basis. Success in meeting Tests of Compliance for Accreditation Canada Required Organizational Practices: Medication Reconciliation as a Strategic Priority, and Medication Reconciliation at Care Transitions.	100% of relevant units and Physician Services received and reviewed compliance reports on a monthly basis during 2023-24. 100% of Tests of Compliance for Accreditation Canada Required Organizational Practices for Medication Reconciliation are met.	Director - Pharmacy Chief Medical Information Officer
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Patient-Centered	**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?**	**60.0%**	Implementation of communication materials such as the "JBH Patient and Family Guide" information handbook that includes education content related to discharge and safety. A Discharge Information Sheet will be developed and tested to provide key messages and information for those preparing to transition home from inpatient care.	Impacts of the Discharge Information Sheet will be studied to inform Plan-Do-Study-Act (PDSA) improvement cycles. Feedback will be collected from patients, families and JBH staff and Physicians to inform improvements to the "JBH Patient and Family Guide" implementation and content. Initiative Leads will report on progress to the JBH Corporate Quality Committee.	Availability of the "JBH Patient and Family Guide" to Medicine and Surgical inpatients. Implementation of Discharge Information Sheet.	The "JBH Patient and Family Guide" made available to all Medicine and Surgical inpatients by Q1 2023-24, and will undergo a complete PDSA cycle in 2023-24. The Discharge Information Sheet will undergo a complete PDSA cycle in 2023-24.	Director - Acute Medicine, Post Acute, & Patient Flow; Chief of Medicine; Director - Surgery; Chief of Surgery Director - Patient Experience
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Safety	**Patient falls with harm level of Moderate or worse per 1000 inpatient days**	**0.12**	Education and regular feedback based upon process auditing results to improve alignment of Falls Prevention practice to new corporate Falls Prevention Policy. Integration of bed alarm system into clinical unit technology and processes. Implementation of communication materials such as the "JBH Patient and Family Guide" information handbook that includes education content related to falls prevention.	Weekly patient-level audits of compliance with assessment and intervention processes. Audit results analyzed and discussed at unit level during Quality Improvement Board Huddles, and at Program Quality Committee Meetings led by Managers and Educators, supported by Directors and Physician Chiefs. Organizational audit results included in JBH Strategic Scorecard and reviewed at monthly JBH Corporate Quality Committee.	Weekly audit completion on relevant units. Monthly feedback based upon audit results provided to relevant units. Completion of bed alarm integration.	Weekly audits completed on 100% of relevant units during 2023-24 Monthly feedback based upon audit results reviewed by 100% of relevant units during 2023-24 100% completion of bed alarm integration by YE 2023-24	Director - Acute Medicine & Post Acute
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Effective	**Percent of unscheduled repeat emergency visits following an emergency visit for a mental health condition.**	**20.9%**	Simplify and expedite referral process from ED to PHAST/Urgent Care Services (Mental Health & Addiction program community services). Change to Psychiatric Emergency Services Unit model of care such that Mental Health staffing is in place 24/7, and ED Physicians may refer direct, rather than send patients home to return the next day. Enhancements to data shared at Burlington Ontario Health Team (BOHT) MH&A Table to identify further process improvements to decrease ED revisits for MH&A	PHAST program is tracking response time and disposition of referrals from ED. Data analyzed and reviewed at monthly MH&A Program Quality Committee led by Director and Physician Co-Chiefs. Data shared at Burlington Ontario Health Team (BOHT) MH&A Table via Business Intelligence Tool developed by JBH Decision Support Team.	Percentage of referrals from ED to PHAST/Urgent Care Services (Mental Health & Addiction program community services) that meet response time targets.	100% of referrals from ED to PHAST/Urgent Care Services (Mental Health & Addiction program community services) confirmed as urgent meet response time targets (48 -72 hours).	Director - Mental Health & Addictions; Physician Co-Chiefs of Mental Health & Addictions
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Timely	**Discharge summary sent from hospital to community care provider within 48 hours of discharge.**	**92.0%**	Leverage new JBH policy with clear escalation process to improve compliance with expectation of same-day dictation of Discharge Summaries. Increase frequency of provider-level reports to monthly. Include expectation of same-day dictation of Discharge Summaries in JBH Physician orientation.	Provider-level compliance data is available electronically and is analyzed monthly. Monthly reports are utilized by Physician Service Chiefs to administer feedback according to provider-level results.	Percentage of Physician Service Chiefs receiving monthly provider level reports in order to provide feedback.	100% of Physician Service Chiefs receiving monthly provider level reports in order to provide feedback during 2023-24.	Director - Health Information Services; Physician Chair of Health Records Committee
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Efficient	**Total number of alternate level of care (ALC) days contributed by ALC patients**	**8.0%**	Develop and implement a patient and family education and messaging campaign based upon the Home First philosophy. Collaborate with the Burlington Ontario Health Team (BOHT) to implement initiatives identified through a March 2023 BOHT-JBH ALC optimization event.	Data is collected throughout each patient hospital stays and is analyzed to study the consistency and effectiveness of ALC avoidance strategies. These results are regularly reviewed by initiative leads, and acted upon to inform improvements. The ALC rate is included in scorecards reviewed at both Program-level and Corporate Quality Committees.	Implementation of Home First patient and family education strategies.	At least two Home First patient and family education strategies will be implemented YE 2023-24	Director - Acute Medicine, Post Acute, & Patient Flow