2023-24 QIP Narrative

Overview

Joseph Brant Hospital (JBH) is pleased to present its 2023-24 Quality Improvement Plan (QIP). Despite the challenging circumstances of the past three years, JBH has continued to execute improvement initiatives to improve performance and maintain gains aligned to its strategic priorities, Accreditation standards, care and service best practices, mitigation of organizational risks, and the feedback that we receive from our patients, families, and community.

This year, JBH has again developed a QIP that both meets the requirements of the Excellent Care for All Act (ECFAA), and aligns to and reinforces our ongoing improvement priorities. In addition to the three indicators that Ontario Health Quality has identified as priorities for hospitals, JBH has committed to four additional indicators for this year:

Hospital Priority Indicators Identified by Ontario Health	
Dimension	Indicator
Safety	**Proportion of patients discharged from hospital for whom medication reconciliation is provided**
	Number of workplace violence incidents
Patient-Centred	**Proportion of patients who felt that they received enough information when they were discharged from the hospital**
Additional Indicators Selected by JBH	
Dimension	Indicator
Safety	**Rate of patient falls with harm**
Efficient	**Percentage of inpatient days with an alternate level of care designation**
	Percentage of discharge summaries to community care providers within 48 hours of discharge
Effective	**Rate of mental health or addiction re-visits to an Emergency Department within 30 days**

Patient/client/resident engagement and partnering

Despite the unprecedented demands, disruptions and constraints that came with the COVID-19 pandemic, JBH stayed the course in implementing its Patient and Family Advisory Council (PFAC) Roadmap. Although JBH had a solid track record of engaging patients, families and caregivers in advisory and co-design through a number or approaches, the launch of a formal PFAC in October 2020 represented achievement of the “gold standard” of Patient and Family engagement. The pinnacle achievement on the PFAC Roadmap was the appointment of a Patient and Family Advisor to the Quality Committee of the JBH Board of Directors in September 2022. This appointment has brought the voice of patients, families, and caregivers to a table that oversees and influences our organizational quality and patient experience priorities, and provides recommendations to the Board of Directors on key decisions related to quality and patient experience, including what we measure and what we improve (i.e, the QIP, Strategic Scorecard Indicators).

A second organizational achievement in which the PFAC has played an important role is the publication of our JBH Patient and Family Guide. This is a handbook that provides information and education a wide range of topics that are very relevant to patients admitted to JBH, and to their families and caregivers. Topics include patient safety, privacy, patient rights and responsibilities, transitioning home, and other useful information such as parking, way finding information and contact numbers. The PFAC provided valuable insights and input into the Guide at numerous point throughout its development. The PFAC will also play an important role as we evaluate the Guide over coming months and co-design improvements for the next edition.

Provider experience

These have been difficult times for all healthcare providers. Throughout the COVID-19 pandemic, JBH has provided support to other hard-hit areas of the province despite staffing shortages and other local challenges. The most recent wave (Omicron variant) of the COVID-19 pandemic impacted our region more severely than most. The prevalence in our community, in turn, further depleted available staffing. In addition to losing the on-site support of our large corps of volunteers, limits to the onsite presence of patient loved-ones who often act as care partners further compounded the elevated the workload of staff on-site.

The COVID-19 pandemic has necessitated decisions and policies to mitigate transmissions to our patients, visitors, staff and physicians. Staff and physicians have had to absorb additional infection control precautions and practices into their daily work, and ensure that patients and their loved ones are following necessary but, at times, not well-received policies and protocols. This latter issue has grown over the past year as people have become COVID-fatigued, and some have become frustrated and impatient with requirements and restrictions both in hospitals and the external environment. Tired staff and physicians have been on the receiving end of organized protests in the community and criticism on social media. While most patients and their loved ones are supportive and grateful for the precautions taken to ensure their safety while hospital, those who disagree or seek exceptions have presented questions, challenges and complaints on a daily basis.

JBH has, from the start of the COVID-19 pandemic, has been robust in its execution of its Emergency Operations Centre (EOC) approach. Based upon published best practices for emergency and disaster management, the EOC is chaired by the CEO, and is the top priority for key leaders and subject matter experts. It has been a table for timely situational analysis and for directing timely action. The EOC has been critical to anticipating, identifying, monitoring, and responding to the experiences of our staff and physicians throughout the COVID-19 pandemic.

The physical and psychological safety of our staff has been of the utmost importance. During the COVID-19 pandemic, messaging regarding workplace violence and harassment has been reinforced through internal and public facing communications. There has been an enhanced presence of hospital security services at hospital screening points of entry in anticipation of changes to visitation protocols and restrictions. JBH leaders have increased their visibility and support across all areas of the hospital, both in response to particularly challenging changes and events, and on a scheduled proactive rounding basis.

Two-way communication with senior leadership is another element that has been critical to supporting our staff and physicians. Weekly virtual “Town Halls” have provided regular opportunities for staff and physicians to ask questions and convey concerns, and have provided insight as to what is most important to their well-being. This is also an opportunity for everyone at JBH to feel heard, and to feel acknowledged for going over and above for our patients, their families and our community.

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Workplace Violence Prevention

In addition to its inclusion in our annual QIP, workplace violence (WPV) has been explicitly called out in our JBH Strategic Annual Objectives. Reported WPV incidents can be entered by any JBH staff or physician at any time into our electronic safety incident reporting system and by doing so is brought to the attention of our leaders and human resource professionals for follow-up by both. Like many hospitals has continued to focus on education and awareness to promote not only safety, but also to achieve fulsome reporting of all WPV incidents. Our QIP and Strategic Scorecard targets reflect our effort to achieve a culture of reporting and fully understanding the problem so that we can act accordingly and understand the impact of our efforts.

In the coming year, 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.

Patient safety

JBH utilizes an electronic safety incident reporting system (IRS) that is accessible to all staff and physicians. In reviewing reported patient safety incidents, JBH applies a "*Just Culture*" approach that the Canadian Patient Safety Institute (CPSI) describes as *balancing an understanding of system failure with professional accountability*. Consistent incident reporting is essential to understanding and improving safety. To ensure that we are capturing and learning from patient safety incidents at every opportunity, our IRS allows incidents to be entered with identification, or anonymously. In addition to patient safety incidents, the JBH IRS is also used to capture and manage staff safety incidents, compliments and complaints that have been received by the Patient Experience Office, and emergency code events.

Every entry into the IRS triggers a review and follow-up response by the relevant JBH leader. For patient safety incidents, a level of harm is assigned by at the time of reporting. In reviewing those incidents, leaders will either confirm or adjust the harm level based upon their review.

Higher levels of harm trigger automatic email notices to more-senior leaders, and in some cases may be identified for review as potential "Critical Incidents". These review meetings follow a standardized process and include the Chief of Staff, Chief Nursing Executive and the Director and Physician Chief of the relevant program/department, and the Manager of the unit. If the incident is determined not to have been the result of the patient's underlying medical conditions nor a result from a known risk inherent in providing the treatment, it is considered a Critical Incident (as per Regulation 965 of the *Public Hospitals Act*).

Regardless of whether it is considered a Critical Incident, errors and process failures are disclosed to the patient, and the patient is engaged to share their perspective and experience of the incident with hospital Patient Experience Office staff. Critical Incidents undergo formal Quality of Care Reviews whereby staff

and physicians involved in the incident discuss root causes and make recommendations to improve processes to prevent recurrence in the further. The patient's perspective and experience is shared at this table. The patient is offered an opportunity to receive a verbal report back on the resulting recommendations.

Executive Compensation

The Excellent Care for All Act (ECFAA, 2010) requires that executive compensation be linked to the QIP. The selection of QIP indicators and work plan initiatives to be tied to Executive Pay-at-Risk remains at the discretion of each Hospital. The JBH QIP Pay-at-Risk allocation for each fiscal year is based on the achievement of selected QIP work plan deliverables (process measure targets). These are reviewed and recommended by the JBH Senior Leadership Team and the Human Resources Policy and Compensation Committee (HRPCC) for Board approval. Payment of the Pay-at-Risk is evaluated at year end and paid out subject to Board approval. For 2023-24 the carve-out for QIP Pay-at-Risk is 5%.

Executive Pay-at-Risk for 2023-24 has been aligned to indicators as summarized in the table below.

Quality Dimension	Indicator	2023-24 YE Deliverables	2023-24 YE Target	Pay at Risk
Safe	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.	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 Medication Reconciliation as a Strategic Priority and Medication Reconciliation at Care Transitions are identified as "met" in Final Accreditation Report.	85.0%	**1.25%**
Timely	Discharge summary sent from hospital to community care provider within 48 hours of discharge.	100% of Physician Service Chiefs receiving monthly provider level reports in order to provide feedback during 2023-24.	92.0%	**1.25%**
Efficient	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	At least two Home First patient and family education strategies will be implemented YE 2023-24	8.0%	**1.25%**
Safe	Patient falls with harm level of Moderate or worse per 1000 inpatient days	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	0.12	**1.25%**
			Total Pay-at-Risk Allocation	**5.0%**

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Sign-off

I have reviewed and approved our organization's Quality Improvement Plan.

Board Chair, Randy Smallbone	**ORIGINAL SIGNED**
Quality Committee Co-Chair, Deanna L. Williams	**ORIGINAL SIGNED**
Quality Committee Co-Chair, Omer Aziz	**ORIGINAL SIGNED**
President & Chief Executive Officer, Eric Vandewall	**ORIGINAL SIGNED**

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