2015/16 Quality Improvement Plan for Ontario Hospitals
"Improvement Targets and Initiatives"

Joseph Brant Hospital 1230 North Shore Boulevard

Priority indicators	AIM		Measure								Change				
	Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Priority level	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
1	Access	Reduce wait times in the ED	ED Wait times: 90th percentile ED length of stay for Admitted patients.	Hours / ED patients	CCO iPort Access / Jan 1, 2014 - Dec 31, 2014	718*	63.15	39	Target set for 2014/15 as current performance is higher than target performance.		1) Maintain daily 'take one patient' strategy in programs to facilitate patient flow	Daily 'pull one' of one appropriate admitted patients from the ED to designated space on inpatient units	One appropriate patient pulled from ED to other inpatient unit(s) each morning	Implement 'pull one' 7-days per week and establish baseline measures for future improvements	
											2) Enhance daily patient rounds on all medical units	Complete pilot of bullet rounds and patient board by September 2015	Pilot complete and bullet rounds conducted on all medical units Mon-Fri.	Implement bullet rounds 7-days per week on medical units and establish baseline measures for future improvements	
											3) Performance Improvement Project (PIP) on patient turnaround times through "real-time" order-entry (O/E) of discharges from all inpatient units	a) Review current O/E rates for opportunities b) Establish improvement plan to meet enhanced targets c) Re-measure and adjust plan as necessary across all units	a) Rates reported weekly at the Quality Wall b) PDSA cycles for improvements in measures	YTD average of 82% of discharges O/E as per established timelines	
2	Effectiveness	Improve organizational financial health	Total Margin (consolidated): % by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expense, excluding the impact of facility amortization, in a given year.	% / N/a	OHRS, MOH / Q3 FY 2014/15 (cumulative from April 1, 2014 to December 31, 2014)	718*	-0.43	0	Provincial Mandate; consistent with provincial performance standard.		1)Management of costs and mitigate budget deficit risks	Containment of discretionary budget and non-critical capital spending; Monthly variance analysis and development of mitigation strategies to ensure timely correction of any budget deficits	Monthly programmatic budget reviews are in place and reported to Senior Management	Monthly financial reporting and corrective action plans	Achieve and maintain 0% Total H-SAA Margin
3	Integrated	Reduce unnecessary time spent in acute care	Percentage ALC days: Total number of acute inpatient days designated as ALC, divided by the total number of acute inpatient days. *100	% / All acute patients	Ministry of Health Portal / Oct 1, 2013 - Sept 30, 2014	718*	22.62	17	Target set to work towards achieving Corporate and LHIN priority that is linked to patient flow initiatives		Implement patient introductory letter upon admission and 48-hr conversation with MRP	a) pilot model with hospitalist team for completion by September 2015 b) following initial pilot, implement model across medicine program with focus on patient introductory letter and 48-hr conversation	48-hr conversation and distribution of patient introductory letter taking place as per policy	Establish baseline measures for 48-hr conversations with patient/family and provision of patient letter	Focus on pilot for learning and change opportunities before broader roll-out

											2) Improve ALC Gridlock process with defined member roles and responsbilities and defined timelines for actions	Complete joint LEAN project with CCAC to improve ALC escalations	Roles and responsibilities of team members and timelines are defined	Redefined escalation process in place by March 31, 2016	Promotes shared accountability among JBH and community providers
											3) A family brochure is developed that outlines options for discharge	Patients admitted to an inpatient bed in the medical program are provided with a copy of the brochure	Patients and/or families have a copy of the family brochure for information purposes	Average 80% YTD appropriate patients receive family brochure	
4		**Reduce unnecessary hospital readmission**	Readmission within 30 days for Selected Case Mix Groups	% / All acute patients	DAD, CIHI / July 1, 2013 - Jun 30, 2014	718*	16.65	8	as target set for 2014/15 as current performance is higher than target		Participate in Health Links strategy with CCAC	Work with community partners to identify risk factors that result in frequent ED visits, whether clinical or social in nature	JBH representatives participate in selected working groups to facilitate care and services directed to selected patient population as per Health Links Business Plan	JBH participation at All Partner table, communication/integration work group and client selection group	Patients with frequent ED visits can benefit from consistency in approach
		JBH Specific Indicator	Readmission within 30 days for selectd CMG's to JBH	% / All acute patients	DAD, CIHI / Q2 2013/14 to Q1 2014/15	718*	20.4	19	Improve performance for COPD readmissions to JBH		Roll-out of the INSPIRED model of care to support management of hospitalized COPD patients as they transition back to the community	Strategies to include focus specifically on management of the COPD patient as they transition from hospital to home with CNS, COPD educator and physician follow-up	a) number of patients who meet criteria for program as they present to hospital b) number of patients seen in program c) readmits of patients in the program	80% YTD moderate-severe COPD patients assessed for INSPIRED program participation as per criteria	
5	**Patient-centred**	**Improve patient satisfaction**	From NRC Canada: "Overall, how would you rate the care and services you received at the hospital (inpatient care)?" (add together % of those who responded "Excellent, Very Good and Good").	% / All patients	NRC Canada / October 2013 - September 2014	718*	91.1	93	To meet or exceed Ontario Community Hospital Average (OCHA)		"Patient focused care" defined for all patient populations, including ED	Use existing feedback and the objectives of the Opening Day view to engage team and define 'patient focused care'	Develop action plans consistent with objectives set out in the Opening Day view for the patient experience	100% of all programs have patient centered care action plans developed that align with the Opening Day view	Promotes shared accountability in the patient experience
6	**Safety**	**Increase proportion of patients receiving medication reconciliation upon admission**	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.	% / All patients	Hospital collected data / most recent quarter available	718*	11.3 physician sign-off BPMH (best possible medication history); 89% completed but not signed off by physicians	70	As target set for 2014/15 as target not met		1)Focus on mental health inpatient population	e-Documentation for PCS to 'go live' in October 2015 and will enable BPMH completion in electronic format	Number of completed BPMH (best possible medication history) upon admission compared to number of admissions	Accreditation requirement of 100% completion of med rec in all areas by April 2018	Start with specifically defined population

								Establish baseline measures in 15/16			2) Focus on Surgical Pre-admit clinic in ongoing roll-out of Medication Reconciliation upon admission	Review current medication reconciliation plan for Surgical Pre-admit clinic against BPMH best practices	Plan reviewed, revised and resources identified for implementation	Ongoing roll-out of Med Rec upon admission across the organization	Use results from evaluation of current processes to build new processes
7		**Reduce hospital acquired infection rates**	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1,000 - Average for Jan-Dec. 2014, consistent with HQO's Patient Safety public reporting website.	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / Jan 1, 2014 - Dec 31, 2014	718*	0.26	0.26	Consistent with provincial target			1)Maintain current practices in relation to surveillance, monitoring, environmental cleaning, hand hygiene and antimicrobial stewardship	Current practices are based on PIDAC guidelines to reduce incidence of hospital-acquired infections and monitored through the Infection Prevention and Control Committee	Maximum of 3 hospital-acquired cases of C. difficile monthly	Long term goal is 0 per 1,000 patient days	Rate established to be in line with provinical targets
											2)Continue to report hand hygiene and c-diff rates weekly at the Quality Wall and in patient care areas	a) Hand hygiene and c-diff rates to target by unit are reported weekly b) Provider hand hygiene rates to target are reported monthly	Weekly reports include discussion of corrective actions required to meet or exceed target when below target	To meet or exceed target for hand hygiene and c-diff rates	Inadequate hand hygiene is recognized as a factor in hospital-acquired infections
8			Hand hygiene compliance before patient contact: The number of times that hand hygiene was performed before initial patient contact divided by the number of observed hand hygiene indications for before initial patient contact multiplied by 100 - consistent with publicly reported patient safety data.	% / Health providers in the entire facility	Publicly Reported, MOH / Jan 2014 - Dec 2014	718*	92.14	93	Able to meet 2014/15 target and higher than provincial performance			1)Update hand hygiene strategies and plans to sustain momentum and increase consistent compliance	Strategies to focus on provider engagement, visual cues and to optimize social media as a means to reach a broader audience	Updated Hand Hygiene Workplan developed and approved by June 2015	Sustain visual reminders and introduce new strategies to engage patients and staff in hand hygiene practices, including ED, inpatient and outpatient areas	Awareness and participation in process improvement initiatives is critical to success
											2) Continue to report hand hygiene rates weekly at the Quality Wall and in patient care areas; and monthly at MAC	Weekly reporting increases departmental accountability for improvement strategies, enhances visibility of metrics and encourages sharing of challenges and successes among leaders	Weekly reports include discussion of corrective actions required to meet or exceed target when below target	Leader attendance at weekly reporting at the Quality Wall and 100% weekly audit results are posted on unit/departmental Quality Boards	awareness and participation in process improvement results in ownership for outcomes