Georgian Bay General Hospital
2019-20 Quality Improvement Plan " Improvement Targets and Initiatives"

Hôpital général de la baie Georgienne
GEORGIAN BAY
General Hospital

AIM		Measure								Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Theme I: Timely and Efficient Transitions	Timely	The time interval between the Disposition Date/Time (as determined by the main service provider) and the Date/Time Patient Left Emergency Department (ED) for admission to an inpatient bed or operating room.	MANDATORY	Hours / All patients	CIHI NACRS / October 2018 – December 2018	726*	15.58	14.20	Represents a 10% reduction as part of multi-year strategy to achieve 8 hour provincial benchmark for this indicator.	1)1. Optimize the current inpatient bed allocation process to reduce the time from the bed need is identified to time bed assigned.	Create a multidisciplinary team to evaluate the efficiency and effectiveness of the current bed allocation process	Bed Allocation process improvement project complete	Bed Allocation project completed by Sept 30, 2019	
										2)Informing patients of the estimated date they can expect to be discharged will assist patients and families in preparing for discharge.	Trial the use of patient handbook inserts with specific individual patient information re: diagnosis and expected date of discharge(EDD).	PDSA Trial complete	Conduct trial on two inpatient units by Sept 30, 2019.	Trial to include documentation of provider/patient conversation re: EDD
										3)Implement onsite rapid testing for MRSA, VRE and C.Difficile. This will assist with reducing number of isolations and also reduce the time from decision to admit to the time the patient receives a bed.	Rapid Polymerase Chain Reaction(PCR) testing for MRSA, VRE and C-Difficile.	Turn around time for onsite rapid testing.	Turnaround time for onsite rapid testing of 3 hours by March 31, 2020.	
										4)Working toward a standardized discharge time (before noon) will improve patient flow. Improved patient flow will reduce the time patients admitted in the Emergency Department wait for an inpatient bed.	Improve the proportion of patients on acute medicine units who are discharged before noon. Plan-Do-Study-Act (PDSA) trial on GBGH acute medicine units.	Trial completed	Conduct trial on acute medicine units by March 31, 2020	
										5)The "home first" philosophy supports a multi-disciplinary approach to discharge planning. It is a system of people and processes to facilitate timely discharge from hospital.	Include education on "home first" philosophy in orientation for all clinical hires.	The percent of clinical hires who receive education on the "home first" philosophy during GBGH orientation.	100% of clinical hires will receive "home first" philosophy education by March 31, 2020.	

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Theme II: Service Excellence	**Patient-centred**	Percentage of respondents who responded positively 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?	P	% / Survey respondents	CIHI CPES / Most recent consecutive 12-month period	726*	79	80.00	GBGH tracks % positive response using Top 2 positive responses. This allows us to trend our data over time. Our 2019-20 target is set using this methodology.	1)Continue to monitor and report on percent of Patient Oriented Discharge Summaries (PODS) generated.	Develop a compliance reporting system.	Compliance reporting system in place.	Reporting system in use on all units by March 31, 2020.	
										2)2019-20 focus on the quality of the information provided to our patients in the Patient Oriented Discharge Summary (PODS).	Develop audit tool and auditing schedule.	Quality audit tool and schedule completed.	Conduct 10 quality audits per quarter by March 31, 2020.	
										3)Scale and spread the practice of providing 48 hour post discharge follow up phone calls from the surgical services program to include one additional patient population (TBD) in 2018-19.	Establish which patient population to trial follow up phone calls with 48 hours of discharge from GBGH.	Percent of phone calls completed.	50% of target population receives a follow up phone call within 48 hours of discharge by March 31, 2020.	
Theme III: Safe and Effective Care	**Effective**	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.	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / October - December 2018	726*	93.33	85.00	We are proposing a target less than our 2018-19 Quarter 3 performance as we feel that the transition from manual to electronic data collection with include a larger denominator and will be more reflective of our compliance rates.	1)Partner with our Information Systems and nursing staff to develop an accurate electronic report that captures the total number of discharged patients for whom a Best Possible Medication Discharge Plan was provided.	Develop and deliver education on electronic data collection reporting. Deliver practice hint and unit huddle education on clinical units.	Percent of education completed.	100% of education completed by June 30, 2019.	
										2)Continue to evaluate and improve the Medication Reconciliation Statistics report.	Medication Reconciliation working group to review monthly.	Number of monthly reviews.	Monthly reviews occur April 1 - March 31, 2020.	The availability of consistent, reliable data will support the multi-disciplinary team to track and assess performance and to make any necessary course corrections in near real time.
										3)Ensure that the denominator (patients discharged from home or to another care facility) is accurately captured.	The results of the electronic report match the results of the quarterly manual report.	Consistent weekly statistics.	Weekly statistics produced 95% of the time by March 31,2020.	
										4)Perform regular audits to evaluate the accuracy, completeness of the Best Possible Medication Discharge Plan and share those results with relevant stakeholders.	Develop quality audit tool.	Number of audits completed in fiscal 2019-20.	Complete 20 quality audits per quarter in fiscal 2019-20.	

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	Safe	Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.	MANDATORY	Count / Worker	Local data collection / January - December 2018	726*	37	55.00	We anticipate that improved reporting systems and increase awareness about workplace violence will result in an improved reporting culture at GBGH. An improved reporting culture will result in an increase in reporting of workplace violence incidents as defined by the Occupational Health and Safety Act.	1)An effective and efficient Joint Health and Safety Committee (JHSC) will result in reduced number of workplace violence incidents.	Evaluate and improve the functioning of the Joint Health and Safety Committee.	Workplace violence incident reviews included in the JHSC meeting minutes.	100% of workplace violence incidents are reviewed and any required actions included in JHSC meeting minutes by Sept 30, 2019.	FTE=642
										2)Develop an action plan following the implementation of 2019-20 Wall-to-Wall Workplace Violence Assessment tool.	Create a WPV action plan.	Percent of action plan items completed	100% of required actions with target dates prior to March 31, 2020 are completed.	
										3)Implement the Just Culture Framework to ensure that staff feel psychologically safe in their work environment and understand the framework by which decisions are made within the organization.	Roll out of the Just Culture Framework.	Roll out completed.	Complete the roll out of Just Culture Framework by Sept 30, 2019.	
										4)Develop a cascading quarterly workplace violence incident reporting system.	Develop quarterly reporting system.	Quarterly report distribution.	Quarterly reports are distributed to identified stakeholders by June 30, 2019.	