Hôpital général de la baie Georgienne
GEORGIAN BAY
General Hospital

2020-21 Quality Improvement Workplan

Georgian Bay General Hospital 1112 St. Andrew's Drive, P.O. Box 760, Midland , ON, L4R4P4

	Measure							Change				
Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
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, CCO / Oct 2019– Dec 2019**	**16.45**	**14.2**	**Achieve 2019-20 Target as part of a multi-year strategy to achieve provincial benchmark**	Conduct a Lean-based rapid improvement event to design and implement patient flow process changes, reduce variation and eliminate waste.	Quality Improvement Specialist facilitate a Lean Rapid Improvement Event (RIE) to map a patient's journey from time decision to admit is made in the ED to the time the patient is placed in an inpatient bed. Engage all stakeholders in the process in gap analysis, future state mapping and the identification of quality improvement initiatives.	1. Rapid Improvement Event completed	Rapid Improvement Event completed and quality Improvement initiatives identified by June 30, 2020.	
Safe	**Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.**	**MANDATORY**	**Count / Worker**	**Local data collection / Jan - Dec 2019**	**39**	**55**	**We anticipate that improved reporting systems and increase in WPV awareness will result in an increase in reporting of WPV incidents as defined by the Occupational Health and Safety Act.**	Consistent use of a validated tool to identify behaviours and triggers associated with increased risk of violence to assess degree of risk and apply interventions if needed.	1a) Improve utilization of Violence Assessment Tool for risk of violence in the inpatient population. 1b) Improve ultilization of Violence Assessment Tool for risk of violence in the Emergency Department.	1a) % of patients screened using a risk assessment tool within 24 hours of admission. 1b) % of Emergency Department patients screened using a risk assessment tool.	1a) 100% of inpatients who meet the screening criteria will be assessed for risk of violence by March 31, 2021 1b) 100% ofEmergency Department patient who meet the screening criteria will be assessed for risk of violence by March 31, 2021	
								Using the risk rating generated by the violence assessement tool, specific interventions to deal with observed risks and behaviours will be put in place.	2a) Ensure strategies are documented for high risk inpatients. 2b) Ensure strategies are documented for high risk patients in the Emergency Department.	2a) % high risk inpatients with documented strategy. 2b) % high risk patients in the Emergency Department with a documented strategy.	2a) Increase the percentage of high risk inpatients with documented WPV strategies by 25% each quarter in fiscal 2020-21. 2b) Increase the percentage of high risk Emergency Department patients with documented WPV strategies by 25% each quarter fiscal 2020-21.	
								Patients with a known history of violence will have a flag initiated and past history of violent behaviour will be retained in the patient's electronic record. (In accordance with Occupational Healh and Safety Act).	Select and maintain a flagging program for at risk patients that meets requirements under the Occupational Health and Safety Act .	1.GBGH specific workplace violence prevention flagging program selected. 2.GBGH specific workplace violence prevention flagging program implemented.	1. WPV flagging program selected by June 30, 2020. 2. WPV flagging program implemented on all inpatient units and in the Emergency Department by Sept. 30, 2020.	
								In 2019 one third of WPV incidents originated in the Emergency Department. Increasing the number of ED staff receiving non-violence crisis intervention training will better equip staff in this high risk environment.	Provide Non Violent Crisis Intervention Training (NVCI) to all staff working in the Emergency Department.	Percent of staff who work in the Emergency Department who have completed NVCI training.	100% of staff who work in the Emergency Department will complete non violent crisis intervention training by March 31, 2021.	

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Quality dimension	**Measure/Indicator**	**Type**	**Unit / Population**	**Source / Period**	**Current performance**	**Target**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**	**Comments**
Safe	Rale of Falls with Harm per 1000 patient days (inpatient)	CUSTOM	Inpatient Units Medicine Unit Medicine/Surgical Unit CCC/Rehabilitation Unit	Local data collection / Jan - Dec 2019	3.3	2.96	Targeting 10% reduction.	Re-launch purposeful hourly rounding. Focus on compliance to performing scheduled rounds as well as adherence to specific rounding behaviours. - Conduct pilot of purposeful rounding practice on 2North Medicine/Surgical Unit. - Scale and spread purposeful rounding practice to 2East Medicine Unit and 1North Rehab/CCC/Palliative Care Unit.	1. Track compliance to purposeful rounding practice through weekly documentation audits. 2. Clinical Managers (or designate) assess adherence to specific rounding behaviours by auditing patients using a standardized auditing tool. Note* Purposeful Hourly Rounding practice will be implemented in accordance with the GBGH Change Management Framework	1. % of potential patient rounds completed weekly. 2. # of Clinical Manager (or designate) scheduled rounding audits completed.	1. 80% of potential rounds completed on pilot unit 2North by Sept 30, 2020. 2. Clinical Manager (or designate) 2 North conducts 15 patient rounding audits per week by Sept 30, 2020. 3. 90% of potential rounds completed on inpatient units (2N,2East,1North) by March 31, 2021. 4. Clinical Managers (or designate) on inpatient units (2N, 2East, 1North) conduct 15 patient rounding audits per week by March 31, 2021.	
								Increase staff capacity and engagement by establishing unit level Patient Safety Champions.	Patient Safety Champions will be engaged in developing, implementing, monitoring and evaluating falls prevention strategies.	1. # of patient safety champions on each inpatient unit. 2. # of Falls Prevention strategies identified by patient safety champions.	1. Secure at least two patient safety champions for each inpatient unit by May 15, 2020. 2. Patient Safety Champions identify 2 falls prevention strategies related to identified improvement opportunities by Sept 30, 2020	