2017/18 Quality Improvement Plan
"Improvement Targets and Initiatives"

Hôpital général de la baie Georgienne
GEORGIAN BAY
General Hospital

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AIM		Measure						
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification
Effective	Effective transitions	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?	% / Survey respondents	CIHI CPES / April - June 2016 (Q1 FY 2016/17)	726*	90.5	80.00	GBGH uses in-house survey. Our baseline is based on only one month of data and we are setting our target in a conservative fashion related to a lack of robust baseline data to assess performance effectively.
		Percentage of patients discharged from hospital for which discharge summaries are	% / Discharged patients	Hospital collected data / Most recent 3 month period	726*	6.2	20.00	Foundational work is planned over 17/18 to facilitate improvement in

		delivered to primary care provider within 48 hours of patient's discharge from hospital.						this indicator.
		Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort)	Rate / COPD QBP Cohort	CIHI DAD / January 2015 – December 2015	726*	21.93	15.50	Set target the same this year as unsuccessful last year with delayed data(used 2015 for performance)

Efficient	**Access to right level of care**	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	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July – September 2016 (Q2 FY 2016/17 report)	726*	15.71	13.32	Year over year improvement is desired until Provincial best performance targets are reached. Rate was not reached in 16/17
Patient-centred	**Palliative care**	Percent of palliative care patients discharged from hospital with the discharge status "Home with Support".	% / Palliative patients	CIHI DAD / April 2015 – March 2016	726*	81.48	85.00	Improvement over baseline performance

	Person experience	"Would you recommend this hospital to your friends and family?" (Inpatient care)	% / Survey respondents	CIHI CPES / April - June 2016 (Q1 FY 2016/17)	726*	94.9	95.00	Year over year sustain improvement for 17/18 - goal is to increase response rate.
Safe	**Medication safety**	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	Rate per total number of admitted patients / Hospital admitted patients	Hospital collected data / Most recent 3 month period	726*	92	90.00	Year over year sustainability of this indicator
		Medication reconciliation at discharge: Total number of discharged patients for whom a	Rate per total number of discharged patients / Discharged	Hospital collected data / Most recent quarter available	726*	0.6	50.00	Electronic BPMHDP is safer and more sustainable. Current manual

		Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged.	patients					process established on CCC/Rehab unit will serve as pilot unit.
Timely	**Timely access to care/services**	Total ED length of stay (defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ED) where 9 out of 10 complex patients completed their visits	Hours / Patients with complex conditions	CIHI NACRS / January 2016 – December 2016	726*	6.7	6.70	Year over year sustainability during ED construction program.

Change				
Planned improvement initiatives (Change Ideas)	**Methods**	**Process measures**	**Target for process measure**	**Comments**
1)Customize and pilot the Patient Oriented Discharge Summary (PODS) tool - organizational spread (scaling up) targeted for	1. Assemble GBGH site team, including a local Family Health Team representative. 2. Initiate current state assessment to determine how PODS fits into current processes. 3. Modify current processes and tailor the PODS tool as needed. 4. Conduct PDSA cycles on	1. By October 2017, first patient(s) will be discharged with PODS. 2. By March 2018, the organization will have conducted a series of PDSA cycles on a small scale to fine tune the PODS process at GBGH.	By March 31, 2018, GBGH will be prepared to spread PODS across the organization	
2)Standardize the inter-professional discharge planning process to improve patient safety, the patient experience, enhance inter-	1. Value-stream map current and desired state of the discharge planning process. 2. Engage members of the inter-professional team (PFNs, Social Work, Nursing, OT, PT, etc.) to define staff roles and responsibilities for discharge planning. 3. Develop and approve standard	1. By the end of September 2017, value-stream mapping and standardized work processes will be completed. 2. Finalize improvements to standardized discharge rounds by December 31, 2017. 3. Implement the seven day per week PFN model by April 30, 2017. 4. PDSA cycles will	1. The inter-professional discharge planning process will be implemented	
3)Creation and implementation of a standardized discharge checklist to ensure the discharge is conducted	1. Review and update existing discharge checklist and align the checklist with the Patient Oriented Discharge Summary (PODS)tool. 2. Communicate the process for completing the checklist to internal stakeholders. 3. Engage internal stakeholders in conducting PDSA cycles	1. The existing discharge checklist will be updated and aligned with the PODS tool by September 30, 2017. 2. By December 31, 2017 PDSA cycles will be conducted on the inpatient units in collaboration with front-line staff. 3. The checklist will be revised in accordance with best	1. A standardized discharge checklist will be approved and ready for implementation	
4)Ensure the Expected Date of Discharge (EDD), where it is known with reasonable certainty, is put on the patient's in-room white	1. Engage staff in ensuring EDD is put on the patient's in-room white board through timely identification of EDD at admission, and reassessment at daily discharge rounds. 2. Work with IT to include EDD on the electronic patient census list.	1. Engage staff in ensuring EDD is put on the patient's in-room white board by March 31, 2017. 2. Work with IT to include EDD on the electronic patient census list by June 30, 2017.	1.60% of patients where EDD is known within reasonable certainty will have	
1)Implement a policy that defines accountability for the timely distribution of discharge summaries.	1. Develop a policy in consultation with physicians and applicable stakeholders which sets the expectation for the timely distribution of discharge summaries (within 48 hours) within GBGH. 2. Identify the resources required in order to implement and sustain the policy	1. By December 31, 2017 the discharge summary policy will be approved. 2. Resources required to implement and sustain the policy will be identified, evaluated and secured by December 31, 2017. 3. Education will be provided to physicians and stakeholders on the policy by	1. Increase in the percentage of patients discharged from GBGH for which discharge	

2)Enhance communication with external partners to support safe and effective transitions in care.	1. Provide H/L staff with timely access to discharge summaries for flagged H/L patients through GBGH's electronic health record system.	1. Work with IT to provide Health Link staff access to GBGH's electronic health record system by December 31. 2017.	1. Health Link staff will have immediate access to flagged H/L patients' discharge	
3)Develop an education module for physicians and applicable staff which focuses on a review of the literature related to	1. Engage a physician champion. 2. Conduct a literature review on the timeliness and quality of discharge summaries and the impact on safe and effective transitions in care and prepare a curriculum module . 3. Determine an appropriate mechanisms/forums to	1. Secure a physician champion by June 30, 2017. 2. Conduct a literature review and prepare the education module by December 31, 2017. 3. Engage physicians and staff in the educational intervention by March 31, 2018.	1. Host a minimum of one educational session for physicians by March 31, 2018. 2.	
4)Develop performance monitoring mechanisms to ensure accountability and promote learning.	1. Develop a mechanism (i.e. eNotifications of discharges for all physicians participating with HRM) for timely progress reporting to physicians and health record staff. 2. Create a timely reporting mechanism for the Senior Team to ensure accountability to the policy.	1. A mechanism will be developed for timely progress reporting to physician by March 31, 2017. 4. A performance monitoring mechanism to ensure accountability will be created and approved by Senior Team by March 31, 2017.	Increase in the percentage of patients discharged from the hospital for which discharge	
1)Focus PODS project pilot on COPD patient cohort.	1.GBGH PODS site team will conduct current state assessment to determine how PODS fits into current processes and will work to tailor the PODS tool as needed. 2.Initiate staff engagement and training. 3. Conduct PDSA cycles on COPD patient cohort.	1. By the end of September 2017, the PODS tool will be finalized and staff engagement and training will be complete. 2. By October 2017, first patient(s) will be discharged with PODS. 3. By March 2018, the organization will have conducted a series of PDSA cycles	1. Decrease in the risk-adjusted 30-day all-cause readmission rate for patients with	
2)Optimize utilization of services for COPD patients at GBGH.	1. Maximize linkage of COPD patients to CCAC services for rapid response nursing, and the telehomecare program. 2. Continue to increase knowledge of internal stakeholders on all services available to the COPD patient population. 3. Increase patient engagement in	1. Provide education sessions for physicians, and additional stakeholders on the expanded services (Health Link, CCAC Tele Homecare) available to COPD patients to optimize safe care transitions.	1. Increase in referrals to the Telehomecare program for COPD patients. 2. > 50%	CCAC will provide referral data and we will monitor this at the collaborative QIP
3)Explore Central North Correctional Centre (CNCC) patient populations who access services at GBGH to identify opportunities for	1. Obtain data on types of patients, readmission rates, number and types of ED visits in order to establish an understanding of how to improve transitions, readmission rates, and decrease the number ED visits.	1. By September 30, 2017, obtain and analyze data and identify opportunities for improvement and collaboration with CNCC leadership and staff.	1. A minimum of 1 improvement opportunity will be identified through increased	
4)Strengthen the linkage between GBGH PFNs and Healthlink Navigators to improve communication and support ED admission	1. Healthlink to establish a working group (H/L, GBGH, and CCAC)focused on ED admission avoidance when Healthlink patients present to the ED.	1. By June 2017, the working group will be established.	1. Optimize communication and collaboration between partners to minimize	
5)Conduct chart audits on COPD patients readmitted to GBGH within 30 days of discharge.	1. Pull COPD patient charts that were flagged as readmitted to GBGH within 30 days of discharge. 2. Identify themes and opportunities for improvement. 3. Engage physicians and staff in improvement activities to optimize services provided to provided to COPD	1. Chart audits will be conducted when monthly internal performance is greater than established target.	1. Decrease in the risk-adjusted 30-day all-cause readmission rate for patients with	

1)Implement an ALC Designation policy for GBGH	1. Develop and approve an ALC designation policy for GBGH. 2. Provide education to stakeholders on the medical directive. 3. Monitor data on ALC patient population and classifications of ALC. 4. Explore medical models i.e. designated physician/NP for ALC patients.	1. GBGH's ALC designation policy will be approved by June 30, 2017. Education will be provided to all appropriate stakeholders on the policy by September 30, 2017. 2. Data will be reviewed bi-weekly by GBGH leadership and appropriate stakeholders during	1. Decrease in the % of total number of ALC days	
2)Continue to strengthen the partnership and collaboration with NSM CCAC.	1. Advocate for increased, and equitable CCAC services and improved communication aimed at optimizing patient flow by creating conditions that support safe and effective transitions in care. 2. Continue to include CCAC in planning and development of GBGH's	1. By April 30, 2017, CCAC will be actively engaged in GBGH's standardization of inter-professional discharge planning initiative. 2. By April 30, 2017, GBGH will actively work with CCAC to improve communication through standardized electronic documentation	1. CCAC Hospital to Home services realignment which provides equitable supports and	
3)Implement the 7 day a week PFN staffing model	1. Create 7 day a week PFN schedule. 2. Establish communication mechanisms to ensure timely and efficient transfer of information during staffing transitions i.e. weekends. 3. Communicate staffing model changes to staff, physicians, internal and external	1. Implement the 7 day a week PFN staffing model by April 30, 2017.	1. Decrease in the % of total number of ALC days	
4)Continue to align GBGH practices and policies with the North Simcoe Muskoka LHIN Regional ALC strategies.	1. Actively contribute to the work of the LHIN wide ALC Standardization Task Force charged with leading the implementation of recommendations from the NSM LHIN ALC review. 2. Continue to explore LHIN wide "basket of services" to ensure all stakeholders at GBGH	1. Ensure GBGH's ALC priorities for action align with and support the 5 high priority LHIN wide ALC recommendations for action.	1. GBGH ALC strategies and policies are in alignment with LHIN wide	
5)Implement an ALC status board to track needs and barriers within the ALC population and streamline efforts that support safe and	1. Create an ALC status board. 2. Increase the frequency of ALC rounds which include members of the inter-professional team. 3. Monitor ALC patient population - early identification and mitigation of needs and barriers to facilitate safe and timely transitions.	1. Create an ALC status board by June 30, 2017. Increase the frequency of ALC rounds by September 30, 2017. 3. Continuous monitoring of ALC patient population as evidenced by an ongoing ALC action plan.	1. Decrease in the % of total number of ALC days	
1)Public Awareness campaign targeted at education on palliative verses end of life and services available within the	1. Provide education for patients and families regarding Advanced Care Planning, palliative care and end of life, Long Term Options, etc.	1. Explore the feasibility of members of the collaborative QIP working group to host public education sessions by December 31, 2017.	1. Host a minimum of 1 public education session by March 31, 2018.	
2)Provide health care providers at GBGH with the tools required to facilitate and engage in the process of advance care planning and	1. Develop comfort care guidelines. 2. Educate and reinforce criteria between GBGH palliative and CCC palliative. 3. Educate staff on advance care planning and community resources and how to link patients and families. 4. Review of patient trajectory and “Things to	1. Develop a implement palliative care education intervention for GBGH health care providers by March 31, 2017.	1. Improved communication with patients and families around goals of palliative	
3)Early referrals for CHF/COPD patients to CCAC, Health Link and the Palliative Care Network	1. Promote earlier referrals for CHF/COPD patients through early identification at daily discharge rounds. 2. Education to HCP on end stage disease processes and the appropriateness of referrals for end of life/palliative care for this cohort of patients. 3. Support Health Link in	Consistent identification of COPD/CHF for referral to the Palliative Care Network and CCAC services at discharge rounds as evidenced by feedback from discharge team members and community partners.	COPD/CHF patients will be referred in a timely fashion for the most appropriate	

4)Support the Ontario Palliative Care Network (PCN) Expression of Interest for the Telepalliative Care project	1. Keep updated on the last developments and status of the project and update GBGH stakeholders as required. 2. Identify ways GBGH can support the initiative through the project life cycle. 3. Support project implementation by providing education to GBGH physicians and staff as	Support project implementation by March 31, 2018.	1. GBGH is a fully integrated partner within the Telepalliative Care program and	
1)Implement an electronic patient satisfaction survey within all patient care areas.	1. Continue to implement the electronic patient satisfaction survey. 2. Engage volunteers in administering the survey with patients prior to discharge. 3. Engage front line staff and provide education to support the implementation and ongoing	1. Full implementation of electronic patient satisfaction survey across the organization by December 31, 2017.	Response rate = 20% of yearly discharges (n= 3004); 601 completed surveys	
2)Implement purposeful rounding and leadership rounding across the organization to strengthen communication with	1. Update purposeful rounding A3 which defines the goals and objectives for the project. 2.Value-stream map current and desired state of the purposeful rounding process and establish standardized work to ensure consistency. 3. Plan organizational wide	1. Update purposeful rounding A3 by April 30, 2017. 2.Value-stream map current and desired state of the purposeful rounding process and create standardized work by December 31, 2017. 2. 3. Plan organization wide implementation by March 31, 2018.	1. Purposeful rounding and leadership rounding implemented	
3)Engage and partner with our patients and families in organizational planning at GBGH.	1. Train staff in PFCC. 2. Identify potential members for a Patient Advisory Committee. 3. Hold initial meetings to establish and engage leadership in the development of the committee terms of reference. 4. Develop an action plan and establish three priorities for the	1. Minimum of three potential candidates will be approached to be members of the Patient Advisory Committee by the end of April 2017. 2. The first meeting will take place by the end of September 2017. 3. Terms of Reference for the committee will be approved by the	Patient Advisory Committee fully functioning by March 31, 2018.	
1)Secure ongoing resources for Medication Reconciliation on Admission	Move pharmacy technician/pharmacist budget currently supporting Med Rec from P4R to Pharmacy operations budget	Business case completed to support increase to pharmacy budget for April 2017	90% of all admitted patients at GBGH will have med rec performed as soon as possible after	
2)Engage all HCP and the patient in the various steps of medication reconciliation	Ensure that standard work of ward clerks and registration staff in ED is followed.	1. Audit standard work and provide feedback to ward clerks and registration staff who support the pharmacy technician to collect pharmacy/ODB profiles. 2. Audit documentation (confirm with IS that this is possible)	1. Maximize the number of BPMHs that can be performed proactively in ER by	
3)Develop strategies to meet surge and track all patients to minimize those who are not seen.	Techs and Pharmacists monitor and document patients needing BPMH at beginning and end of day.	Escalate the number of patients needing BPMH to the Pharmacy Manager to determine best plan to meet the need if staffing predicted to be inadequate.	No BPMHs outstanding at end of Med Rec Shift each day 90% of the time.	
1)To ensure accuracy of the BPMHDP. Integrate the pharmacy profile and the MAR by developing a 24hr cMAR.	1. If resources approved, ensure order entry in pharmacy by a technician and verification by a pharmacist. 2. Engage nursing and Health Records in the implementation of a daily cMAR. 3. Create a process for nursing verification and double check that includes	OE and verification of 90% of physician's orders.	50% Reduction in reported Transcription errors that reach the patient.	

2)Engage Physicians, nurses and NPs,Information Systems and Pharmacy staff in the development of the electronic, integrated	1. Continue to work with RVH to capitalize on work completed to date. 2.Develop and execute a project plan that includes: *IS to build MIS dictionaries to enable functionality, *Pharmacy to build Rxm dictionaries and links to each PHA dictionary	By September 30, 2017, convert current manual, pharmacist driven Discharge Med Rec prescription process on CCC/Rehab to a Physician/NP driven electronic BPMH Discharge Plan process. 2. By December 31, 2017, GBGH is prepared to spread the	1. Fully functional electronic BPMHDP by March 31, 2018.	
3)Improve Patient Safety by educating staff and patients regarding the importance of accurate communication and documentation of	1. One on one pharmacist /physician training in use of electronic system. 2. Formal education of nursing staff regarding the BPMHDP and how to review it with patients at discharge.	1. 80% of nursing and pharmacy staff/physician on 1N /CCC completed education process. 2. Satisfaction survey to patients and community partners (LTC facilities)	1. 100% of patients discharged from 1North will receive BPMHDP. 2. Provide CCC	
4)Initiate the development a manual paper-based BPMH discharge plan process if a viable electronic option is not secured and actioned by	Explore options and resources required to create, implement and sustain a manual paper-based BPMH process at discharge.	1. Options and resources required to create, implement and sustain a manual paper-based BPMG process at discharged are identified and secured by January 31, 2018.	1. 50% medication reconciliation at discharge by March 31, 2018.	
1)Develop and implement an ED Admission Avoidance policy for GBGH to ensure patients receive the most appropriate care at the right	1. Create and approve an ED Admission Avoidance policy for GBGH. 2. Identify resources necessary to sustain the policy and create ED admission avoidance standardized work processes. 3. Provide education to staff and physicians on the policy. 4.Explore the	1. GBGH's ED Admission Avoidance policy will be approved by December 31, 2017. 2. Standardized work processes will be completed by March 31, 2018. 3. Education to staff and physicians will be provided by March 31, 2018. 4. The seven day a week PFN model	1. Create a baseline for successful ED admission avoidance cases. 2. Increase number of	
2)Increase utilization of Health Link for patients with multiple conditions and complex needs.	1. Develop and implement a tool based on HQO H/L patient identification criteria to support earlier H/L referrals through the ED for patients not currently receiving support (H/L Screening Tool).	Proactive management of patients with chronic conditions, especially those with multiple comorbidities and high users of our services. .	1. 100% of active Healthlink patients are flagged within Meditech.	
3)Enhance the coordination of care for Health Link patients by ensuring up-to-date hard copy coordinated care summaries for all active	1. Formalize the process for Health Link providers to update the hard copy coordinated care summaries in the ED. 2. Communicate the process to applicable acute care stakeholders. 3. Solicit feedback from acute care stakeholders and work with H/L staff to identify and	1. A formalized process to update Health Link coordinated care summaries in the ED by will be completed by December 31, 2017. 2. Communication to applicable acute care stakeholders will be completed by January 31, 20178. 3. As improvement opportunities are	1. 100% of active Healthlink patient's coordinated care summaries are available to GBGH	
4)Optimize resources to reduce the amount of time complex patients wait for diagnostic testing and follow-up treatment in the ED.	1. Work with DI to ensure complex patients receiving treatment in the ED are given appropriate priority for diagnostic testing to prevent delays in follow-up care. 2. Explore the possibility of increasing POC testing in the ED to facilitate faster results. 3. Explore the possibility of	1. Work with DI to develop a process that facilitates access to diagnostic testing to prevent delays in follow-up care by December 31, 2017. 2. Explore the possibility of increasing POC testing in the ED to facilitate faster results by December 31, 2017. 3. By March 31, 2018,	1. Decreased ED LOS for complex patients.	
5)Formalize the linkage between GBGH PFNs and Health Link Navigators to improve communication and support effective ED	1. Health Link to establish a working group (H/L, GBGH, and CCAC)focused on ED admission avoidance when Health Link patients present to the ED. 2. Develop and implement a protocol to support this work.	1. The working group will be established by June 30, 2017. 2. A protocol will be created by December 31, 2017 to guide admission avoidance efforts for H/L who present to the ED.	Optimize communication and collaboration between partners to minimize	