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

North Bay Regional Health Centre 50 College Drive, P.O. Box 2500

AIM		Measure							Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Effective	Effective transitions	% 30 Day Readmission Mental Health	% / Mental health patients	In house data collection / (2017/18)	974*	8.9	8.00	Continue to meet or exceed provincial benchmark. OMHRS	1)Likely reasons for readmission include: Placement breakdown.Lack of community capacity to meet patients' needs. Brief	Further enhancement of care plans. Ensure sense of security and partnership with receiving agencies/community providers.	Care plans to be mindful of audience's (agencies/providers) perspective and available resources and will include de-escalation and risk mitigation strategies. Engage with community agencies/providers throughout inpatient stay, identify	Improvement initiatives implemented and evaluated by March 2018.	
Efficient	Access to right level of care	% Alternate Level of Care Days (ALC)	% / All acute patients	CIHI DAD / (2017-18)	974*	12.7	14.20	Continue to meet or exceed provincial benchmark. Difficult to	1)Develop and implement identified priorities ALC work plan in collaboration with the LHIN and the Northeast CCAC.	Work plan developed and relevant policies revised to clarify processes internally	100% of work plan implemented.	By March 31, 2018 100% of the ALC workplan will be implemented.	
		ALC Joint Metric with NBRHC & NECCAC. 100% of the time, patients with an RFD (Ready for Discharge) of 5 days or greater will be reviewed at multidisciplinary rounds. (NECCAC will maintain a	% / All inpatients	In house data collection / (2017-18)	974*	CB	100.00	Expected that the review will become standard work 100% of the time	1)Establishing standard work through multidisciplinary rounds.	In-servicing	Number of patients with Medworxx completed divided by number of patients >5 days RFD who have been reviewed.	Patients discharged with resources to support Home First philosophy.	
									2)Participating in multidisciplinary rounds. Escalate complex cases to monthly NBRHC/CCAC Director/Manager meetings	Meetings	Number of patients referred to CCAC divided by the number of patients who have had an assessment within 24 hours	Assessments completed in a timely manner and resources arranged to facilitate safe	
Patient-centred	Person experience	% Projects that include patient/family voice where they are identified as a stakeholder	% / All patients	In house data collection / (2017-18)	974*	88	90.00	Stretch target given capacity to onboard patients.	1)Simplify process for Project Managers to include patients/families in their projects.	Develop a field in iReport to capture patients and families who would be interested in becoming involved in projects and provide in-servicing to Quality Coordinators/Project Managers.	Completion of iReport method and standard work.	100% Complete	
									2)Encourage more involvement at all levels including Managers.	Provide in-servicing to Managers to populate the database.	All Managers trained on iReport process. All Quality Coordinators trained on iReport database. Audits & PDSA cycles completed to ensure process sustainability.	>90% Projects include patients and families where they are identified as a stakeholder.	
Safe	Medication safety	Best Possible Medication History (BPMH) on Admission - Two Sources	% / All inpatients	In house data collection / (2017-18)	974*	59.5	65.00	Increase over previous year.	1)RHC908 form revisions based on trail feedback	Create SAMPLE BPMH. Post / communicate at huddles: physician & nurses	100% SAMPLE BPMH. Post / communicate at huddles: physician & nurses completed	85% BPMH complete within 24 hours. 65% BPMH with > 2 sources. 65% BPMH verified	
									2)Education for BPMH process clarity	FAQ interpretation: Communicate by huddles & posters	100% FAQ interpretation: Communicate by huddles & posters completed.	Same as above.	
									3)Signal when follow-up in ED required	ADD 4th color to existing tracker for designated signal.	Addition of 4th color to existing tracker for designated signal completed.	Same as above.	
									4)Evaluate impact of changes when pharm tech hours are not extended.	BPMH Audits and workload analysis for February 2017.	100% of BPMH Audits and workload analysis for completed for April 2017.	Same as above.	
									5)Build business case to extend pharmacy tech time in ED	Utilize data analysis, best practice to demonstrate rationale, benefits and consequences for extending pharmacy tech hours.	Complete Case for Support by utilizing e-data analysis, best practice to demonstrate rationale, benefits and consequences for extending pharmacy tech hours.	Same as above.	
Timely	Timely access to care/services	Average Length of Stay (ALOS) Days - Clinical Acute	Days / All acute patients	In house data collection / (2017-18)	974*	5.2	5.70	Continue to meet or exceed provincial benchmark. Mix of service and complexity is changing.	1)Review how Medworxx data will be utilized and reported.	Determine how Medworxx data will be utilized and reported.	100% of the medworxx improvement plan following review is implemented.	By March 31, 2018 100% of the Medworxx improvement plan will be	
									2)Audit effectiveness bullet round improvement .	Conduct audits from bullet rounds to sustain improvements x 6 months. Re-establish audits in September after a summer break to ensure sustainability.	Audit Tool: 100% nursing staff attend daily bullet rounds. 100 % other disciplines attend daily bullet rounds. 100% discussions focused on discharge.	By March 31, 2018 bullet rounds improvements will be rolled out throughout clinical	
		Average Length of Stay (ALOS) Days - Mental Health	Days / Mental health patients	In house data collection / (2017-18)	974*	23.91	19.38	Continue to meet or exceed provincial benchmark.	1)ALC days contribute to a longer LOS on AIPU, therefore strategies to effectively limit ALC days should be explored	Focus on ALC avoidance and how to limit ALC days. Early identification of clients that present as high risk for being designated ALC.	Staff familiar with ALC policy and patient flow supports. The hospital uses a screening process (based on known ALC predictors) for early identification of clients that present a high risk for being designated ALC. The clients barriers to discharge are aggressively case managed.	Improvement initiatives implemented and evaluated by March 2018	