2018/19 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	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
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) A= Additional (do not select from drop down menu if you are not working on this indicator) C = custom (add any other indicators you are working on)														
Effective	**Effective transitions**	Percentage of patients discharged from hospital for which the discharge summaries are dictated within 48 hours of patient's discharge from hospital.	C	% / All acute patients	Hospital collected data / Monthly tracking	974*	80	80.00	Currently tracking this indicator and having difficulty keeping rate up to 80%. More work needed to keep the momentum going on this	1)Continue to monitor discharge summary 48 hour turn around time	Conduct monthly audits	Evaluate if departments are meeting target	80% of departments will meet their targets.	
										2)Continue to report updates to acute medical leaders and the department members.	Standing agenda item at department meetings and monthly check ins with medical leaders.	Track number of reports provided to medical leaders and department members.	100% of department meetings will receive a report regarding their	
Efficient	**Access to right level of care**	Total number of ALC days contributed by ALC patients within month/quarter using near real time acute and post-acute information and monthly bed census data.	C	% / All acute patients	WTIS, CCO, BCS, MOHLTC / monthly tracking	974*	18.64	18.45	ALC at census continues to rise creating pressures on our beds. It is important to aim for a reduction however there are many barriers in our catchment to finding housing for our ALC patients and so	1)ELOS process standardization	•Mapping of current and future state •Simplexity (problem solving method) to engage stakeholders in process improvement •Implementation of process improvement initiatives	•80% accuracy ELOS/ALOS •80% whiteboard audits	80% of patients admitted to hospital will have an estimated length of stay	
										2)Review current ALC patients at complex discharge rounds	Review current barriers to discharge for ALC patients and advocate for supports to transition them to appropriate housing	5% increase in discharges of those patients currently identified as ALC	100% of ALC patients will be reviewed at complex discharge rounds	
										3)Community partner committee in place to address barriers in the community	•Develop Terms of Reference for committee •Develop Workplan for committee	5% decrease in ALC occupancy at NBRHC	25% of the partner committee's workplan items will be completed by the end of this	
		Total number of ALC days contributed by ALC patients within month/quarter using near real time mental health post-acute information and monthly bed census data.	C	% / Mental health patients	WTIS, CCO, BCS, MOHLTC / Monthly tracking	974*	73.3	69.63	ALC at census continues to rise creating pressures on our beds. It is important to aim for a reduction however there are many barriers in our	1)To establish a clear process for establishing the EDD upon admission.	Hospital staff and physicians are clear on how early discharge planning is incorporated into the admission process and monitored.	Monthly clinical team meetings including family and community partners to monitor progress and address issues/barriers as they arise.	Clinical team meetings are being held monthly to address barriers.	
										2)Establish a clear discharge destination prior to admission.	1) Social Work attends ALC rounds and comes prepared to participate in a discussion on the barriers to discharge for clients, and of potential discharge delays/issues. 2) Social Work to coordinate case conferences with family and community partners to	Monthly case conferences are held with clinical team, family and community partners to prepare for transition to discharge destination.	70% of patient goals are progressing to support discharge plan	
Patient-centred	**Person experience**	Number of process improvements that include patient/family voice where they are identified as a stakeholder.	C	Number / All relevant patients	Internal tracking / Monthly tracking	974*	23	30.00	The organization wishes to promote a culture of patient involvement and so are increasing last year's target in order to sustain current	1)Develop patient involvement tracking tool	Build in existing Manager tracking tool	Results will be reported on organizational scorecard	100% of departments are tracking their patient involvement in the	
										2)Enhance communication to better sustain involvement of patients in initiatives	Encourage teams to track their patient involvement	# of departments who are tracking their patient involvement	100% of departments are tracking their patient involvement	
Safe	**Workplace Violence**	**Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.**	**M A N D A T O R Y**	**Count / Worker**	**Local data collection / January - December 2017**	**974***	**CB**	**CB**	**The goal is to promote a culture of reporting. We are not yet aiming to decrease the number of incidents in order to develop a good baseline for our reporting.**	**1)Introduce Corporate monitoring and reporting**	**Improve incident reporting data collection and analysis process**	**Establish reporting structure to include regular progress reports**	**100% of reporting structure will be implemented by end of fiscal year.**	**There are 1465 FTE at NBRHC.**
										2)Determine the need for a workplace violence prevention council	Strike council based on buy in from essential stakeholders, formalize leadership, membership and objectives with terms of reference.	Committee membership will be set Frequency of council meetings will be set	Full membership will be in place and meetings functioning by end of fiscal year.	
										3)Realigning Human resource structure to better support workplace violence prevention programs and initiatives	Review and define role clarity within Human Resources to focus on prevention.	Establish clear accountability structures with deliverables	100% of accountability deliverables will be in place by end of fiscal	
		Number of workplace incidents reported which resulted in moderate to severe injury.	C	Number / Worker	Hospital collected data / Monthly	974*	16	0.00	The organization wishes to minimize staff injuries related to workplace	1)Review current staff duress system	Conduct regular stakeholder meetings to determine evaluation criteria	Evaluation team will test and approve device (s)	By end of fiscal year the staff duress system will be reviewed and options	