2024/25 Quality Improvement Plan
"Improvement Targets and Initiatives"

Bingham Memorial Hospital 507 Eighth Avenue Box 70, Matheson , ON, P0K1N0

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
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) O= Optional (do not select if you are not working on this indicator) C = Custom (add any other indicators you are working on)														
Access and Flow	Efficient	Alternate level of care (ALC) throughput ratio	O	Ratio (No unit) / ALC patients	WTIS / July 1 2023 - September 30, 2023 (Q2)	723*	X	1.00	We are aiming to achieve equal or greater than 1 (provincial target 1)	1)Identify barriers with ALC process and develop strategies for improvement to reduce overall ALC	Use a screening process or tool to identify patients at risk of delayed transitions in care	% admitted patients with Blaylock score of 10 (or greater) who are seen by the Care Transitions Coordinator	90% of admitted patients with a Blaylock score of 10 or greater will be seen by the Care Transitions Coordinator	
										2)Ensure consistent application of the ALC definition	Provide training to ensure clarity about when to recommend an ALC designation (CIHI Job Aid)	% staff who received education on ALC designation	80% of staff will receive education on ALC designation	
										3)Deliver senior-friendly care interventions throughout admission	Provide quality care and support to patients with, or at risk of responsive behaviors or personal expressions. (CAM screening, Functional Decline, BSO)	% patients, 65 years of age and over with completed CAM screening tool on admission	% patients, 65 years of age and over with completed CAM screening tool on admission	
Equity	Equitable	Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and belonging (including anti-racism) education	O	% / Staff	Local data collection / Most recent consecutive 12-month period	723*	27	60.00	We are aiming to achieve 60% compliance	1)Provide Equity, Inclusion, Diversity and Belonging (including Anti-Racism) education to increase awareness and support equity planning	a. Executive Team to review and select recommended course/program b. Coordinate delivery of education with Education Lead. This includes preferred learning platform, roll out and timeframe to complete c. Monitor compliance and share results	% active staff who received EDIB education	60% of active staff will receive EDIB education	This indicator will be tied to Executive Compensation
Experience	Patient-centred	Percentage of respondents who responded "YES" to the following statement: "Written information, about what to look out for after I leave the hospital, was provided to me"	C	% / All inpatients	Local data collection / Jan-Dec	723*	76.7	80.50	We are aiming to improve our compliance by 5%	1)Monitor the use of Patient Oriented Discharge Summary (PODS)	Monitor compliance of the PODS at to ensure completeness and appropriateness	% discharged patients with completion of PODS	70% of discharged patients will have a completed PODS	
										2)Monitor and evaluate Post Discharge phone calls	a. Establish data collection on the implementation of Post Discharge calls. b. Modify or tweak script of process to ensure phone calls are prompting the completion of the experience survey.	% discharged patients who received post-discharge phone call	80% of discharged patients who qualify, will receive a post-discharge phone call	
Safety	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.	O	% / Discharged patients	Local data collection / Most recent consecutive 12-month period	723*	89	90.00	We are aiming to achieve equal or greater than 90%	1)Introduce eMedRed as per Meditech Expanse	Introduce eBPMH (electronic best possible medication history) education to nursing staff who are receiving Meditech Expanse Training	% nurses who received education	80% of nursing staff will receive education on the completion of eBPMH	
										2)Introduce eMedRed as per Meditech Expanse	Review and update Medication Reconciliation Policy to define new process	% policy implemented	100% policy on eMedRec will be completed	
										3)Conduct monthly audits on medication reconciliation to ensure completeness	a. Continue to review quality of auditing process and make necessary changes as needed b. Share results with multidisciplinary team and identify opportunities for improvement	# audits completed	Audits will be performed quarterly	
	Safe	Rate of workplace violence incidents resulting in lost time injury	O	% / Staff	Local data collection / Most recent consecutive 12-month period	723*	0	0.00	Maintain zero incidents resulting in lost time injury	1)Timely assessment of "at-risk" patient or family members	Develop audit tool or process to monitor the compliance with the Violence Assessment Tool (VAT)	% audit tool developed	100% audit tool or process will be developed	
										2)Promote the completion of debriefs immediately following any incident of workplace violence	Debrief to be completed immediately (or as soon as possible) after an incident of workplace violence (code white, code silver)	% of completed debriefs following an incident of workplace violence	80% for all incidents of Workplace Violence will be debriefed	
										3)Enhance workplace safety culture to support staff in the management of workplace violence	Implement the use of personal alarms along with supporting policy	% policy developed	100% policy will be developed	This performance measure will be tied to Executive Compensation
										4)Build staff capacity and knowledge to avoid/minimize workplace violence	Provide education to In-Patient and Emergency Department staff regarding use of personal alarms	% In-Patient and Emergency Department staff and Inpatient unit staff with education on the use of personal alarms	70% staff will receive education	