Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 28, 2024

OVERVIEW

Working Together to Build a Healthier Community

We acknowledge that the Brant Community Healthcare System (BCHS) is located on the traditional land of the Huron-Wendat, the Haudenosaunee, and the Mississaugas of the Credit First Nations and today is home to many Indigenous people. This land is governed by the Dish with one spoon covenant between the Haudenosaunee Confederacy and the Confederacy of Ojibway and Allied Nations. This covenant is an agreement to share, work and protect this land together in harmony.

As an organization we are committed to working together with Indigenous peoples to address health inequities and creating a care environment that is free from discrimination and racism against Indigenous patients, families and staff. We are committed to creating a culturally safe care environment valuing Indigenous healing practices and medicines, promoting cultural competency and creating opportunities for Indigenous health practitioners.

BCHS is a large, two-site community healthcare system serving Brantford, Brant County, Six Nations of the Grand River, Mississaugas of the Credit First Nation and surrounding communities. With a total of 324 beds, the BCHS is an affiliated teaching site of McMaster University Michael G. DeGroote School of Medicine. Brantford General Hospital is a regional acute health centre and the Willett site provides urgent care and ambulatory services.

A full service community hospital system, BCHS offers health programming in the following areas:

Brantford General Hospital:
- Emergency Care
- Cancer Treatments
- Complex Care
- Diagnostic Imaging
- Geriatric Services
- Labour & Delivery
- Indigenous Medicine
- Integrated Stroke Unit
- Inpatient Rehabilitation
- Laboratory Medicine
- Medicine
- Mental Health
- Neonatal Intensive Care
- Palliative Care
- Pediatrics
- Pharmacy
- Surgery

The Willett, Paris:
- Urgent Care
- Post-Acute Care Beds

At BCHS, we are working together to build a healthier community. Our vision is to provide exceptional care by exceptional people, grounded through our “CARE” values of compassion, accountability, respect and equity.

We are proud to have been Accredited with Exemplary Standing by Accreditation Canada in November 2023. We are a high performing health care organization that is responding to the community’s exponential growth, increasing demands and expectations for health care services. As we look to the future, we continue our focus on providing exceptional care to the community through the implementation of our 2020-2025 Strategic Plan, where quality, safety, people, partnerships, and health equity play integral roles.

Our Quality Improvement Plan Goals & Actions

- Reducing Emergency Department wait times: Through March 31, 2025, BCHS will improve the wait times in the Emergency Department (ED) for admitted patients from our current performance of 32 hours to 28 hours.

- Improving access to care: By March 31, 2025, BCHS will improve the rate of patients who receive hip fracture surgery within 48 hours of first inpatient admission by 19% to meet the 80% provincial performance.

- Reducing hospital acquired pressure injuries: In 2024/25, BCHS will complete the current state assessment for hospital-acquired pressure injuries.

- Providing effective care: Through March 31, 2025, BCHS will improve existing internal and external referral processes to community based and BCHS’s Outpatient Mental Health & Addictions programs to reduce the percentage of patients attempting to access mental health and addictions related care through BCHS’s Emergency Department.

- Improving patient occupancy: Through March 31, 2025, BCHS will

improve the designation and utilization practice for ALC to reduce the percentage of inpatient ALC days from our current performance of 19.89% to 17% in collaboration with our community partners.

• Creating safe and inclusive spaces: Our aim is to ensure that by the end of the 2024/25 period, 100% of executive, director, and manager-level leaders at BCHS complete comprehensive diversity, equity, inclusion, and belonging (DEI-B) training. Leveraging both Halogen online modules and in-person training sessions, we seek to equip our leadership team with the necessary knowledge and skills to foster a more inclusive workplace culture and effectively address DEI-B challenges within the healthcare environment. This initiative aligns with our strategic objectives to enhance equity and inclusivity at BCHS, aiming to cultivate a leadership culture that prioritizes diversity, equity, and inclusion, ultimately leading to improved organizational outcomes and patient care.

EQUITY AND INDIGENOUS HEALTH

In BCHS' 2020-2025 Strategic Plan, Championing Health Equity is identified as a key goal. Our specific key outcomes for this period include:
• Building and strengthening relationship with local Indigenous peoples and communities by developing partnership to provide navigation and a culturally safe environment.
• Providing staff, physicians and volunteers with cultural safety and diversity, inclusion and anti-racism training.
• Improving care for identified populations including children, seniors, and those living with mental health and addictions issues.

Health Equality means that everyone who comes to BCHS has access to the same health services no matter who they are and where they live. Our 2024-2025 QIP goals recognize that when patients come to us for care, we are serving some of the most vulnerable people in our communities. As such, goals such as those outlined are aimed at improving access, enhancing safety, providing education, and connecting patients with services that are important to help prevent illness as well as treat.

In 2023, we were pleased to welcome a Director of Diversity, Equity, Inclusion and Belonging (DEI-B) to our team at BCHS. This role is integral to supporting our organizational learning, and support system changes towards a more inclusive BCHS. In December 2023, we launch a DEI-B Engagement Survey across the organization. This survey is a critical step toward understanding the experiences, perspectives, and needs of our staff, professional staff and volunteers. Our goal is to create an environment where every individual feels safe, valued, and empowered to express themselves openly without fear of judgment or reprisal. We look forward to reviewing the results and developing a DEI-B Roadmap in the coming year.

We also welcomed the addition of an Indigenous Health Lead, and two new Indigenous Patient Navigators to the Indigenous Health Services Team. These roles work collaboratively with leadership, staff, and physicians to improve the Indigenous patient experience at BCHS and advance the ideals of cultural safety therein.

To learn about our progress on these goals, visit our website at www.bchsys.org.
• Indigenous Health Services
• Geriatric Medicine Service
• 2020-2021 Annual Report

• 2021-2022 Annual Report
• 2022-2023 Annual Report

PATIENT/CLIENT/RESIDENT EXPERIENCE

BCHS has established a Patient and Family Advisory (PFA) Program to enable the community and patients and families to assist us in the co-design of our services. Patient and Family Advisors assist us in the design of key processes that impact patients in the hospital.

Our CEO's Patient and Family Advisory Committee meets monthly, and all Program Councils have a Patient Advisor sitting at the table, bringing the patient and family voice to each discussion and decision.

This QIP was presented to the CEO's Patient Family Advisory Committee to solicit input on whether:

• The goals and planned improvement initiatives selected address key patient concerns;
• Our incremental approach to target setting was reasonable given our current environment; and,
• How best to communicate this plan and our progress externally.

Notably, over the past year, our Patient and Family Advisors developed BCHS' "People-Centered Framework". People-centered care at BCHS is an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families. Our framework defines how we partner with patients, people with lived experiences, and the community to drive a person-centered care approach.

To learn more about our Patient and Family Advisor Program, visit www.bchsys.org/pfa.

PROVIDER EXPERIENCE

At BCHS, we continue to prioritize the provider experience, as we know caring for those who care for others is essential to ensure we are proving high-quality and safe care to patients.

Over the past year, there has been much focus on supporting and empowering our staff. We were proud to launch our internal Peer Support Program last year. The BCHS Peer Support Program is an emotional support program that works to improve the psychological health and safety, resiliency, well-being, and sustainability of all employees, volunteers, and learners at BCHS.

Our Wellness and Recognition Committees also provide much appreciated resources to our frontline staff, including wellness and staff, professional staff and volunteer recognition events. This past year, we were happy to continue our Annual Recognition Awards Night, where we could celebrate and recognize the dedication and successes of our exceptional healthcare workers.

A cornerstone of BCHS' engagement plan with staff includes the annual "BCHS Culture Survey". The culture survey includes the full Accreditation Canada Patient Safety Culture Survey. We utilize this information to inform what we are doing well, and where opportunities lie to enhance all aspects of the quintuple aim of healthcare: improving patient experience, population health, reducing costs, care team well-being and health equity. The data from this survey is analyzed and shared back with all levels of the

organization. Additionally, we hear from our staff and physicians through Quality & Safety Huddles, Senior Leader Rounding, Manager Rounding, Town Halls, and our Virtual Suggestion Box.

In the development of this year's QIP, patient advisors, managers, directors, and physicians leaders had a comprehensive opportunity to craft the planned improvement initiatives with support from administration. The structure of this engagement included the establishment of a QIP working group that involved an inter-disciplinary team of professionals that assessed previous BCHS QIPs; examined the QIPs of peer hospitals within our region and across Ontario; and, selected a set of goals and planned improvement initiatives that matched the clinical practices of our physicians and staff. This working group also examined the data and selected metrics we will focus on and the targets we aim to achieve. The work of the group was shared with all managers and staff through a variety of forums including local Program Councils, the CEO's Patient and Family Advisory Committee, and the Quality & Operations Committee.

SAFETY

Advancing quality and safety is our top priority at BCHS. Incident reporting of patient/visitor safety events (including near misses/good catches) is crucial to the continuous quality improvement process and is intended to improve the overall system of safety. As such, all BCHS staff and physicians must report all patient and visitor safety incidents in the incident management system (Safety Incident Management System/"SIMS").

BCHS promotes a 'just culture' and utilizes a 'systems' approach to incident reviews. We have chosen to adopt the Canadian Incident Analysis Framework (Canadian Patient Safety Institute) as a best practice tool for reviewing and learning from incidents at BCHS. We have developed algorithms and decision-making tools and resources to support team members and leadership in managing, disclosing, and reviewing incidents.

Learning from patient safety incidents and preventing recurrences drive continuous quality improvement at BCHS. Incident reports for each program are reviewed by leaders and the quality and risk team to monitor for trends or concerns. Any identified trends or concerns are shared with the Program's Quality Council and brought to the attention of Quality & Operations Committee, Senior Team and/or the Quality Committee of the Board as per the established reporting schedule. Quality & Patient Safety Learning Stories are circulated in staff newsletters on a regular basis (quarterly) to support organizational learning from incidents and share improvement initiatives. Learning from incidents and actions for improvement are also shared at Program Quality Councils and at team Quality & Safety Huddles.

Patient stories serve as catalysts for change across our organization. These stories, sourced from feedback received by the Patient Experience Office—be it compliments, complaints, or inquiries—are shared at the onset of various meetings throughout the organization. The Patient Experience Office crafts stories from emails or telephone conversations that recount concerns, positive experiences, or inquiries. These stories, carefully selected based on prevalent trends, provide a platform to highlight areas for improvement. The profound impact of patient stories resonates throughout the organization, propelling us toward continuous improvement in quality, safety, and patient experience.

EXECUTIVE COMPENSATION

As the Brant Community Healthcare System Board of Directors is currently onboarding a new President and Chief Executive Officer, executive compensation will be determined by the Board of Directors at a later time.

CONTACT INFORMATION/DESIGNATED LEAD

If you have any questions, comments or concerns about our QIP or the hospital in general you can reach at us at the following contact points:

The Brantford General
200 Terrace Hill Street
Brantford, ON
N3R 1G9
519-751-5544

The Willett, Paris
238 Grand River St. North
Paris, ON
N3L 2N7
519-442-2251

You can also learn more about us at our website at:
www.bchsys.org or follow us on social media.

SIGN-OFF

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan on **March 28, 2024**

Mr. Peter Quinlan, Board Chair

Dr. Mackenzie Slifierz, Board Quality Committee Chair

Ms. Bonnie Camm, Chief Executive Officer

Other leadership as appropriate

Access and Flow

Measure - Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Alternate Level of Care (ALC) days expressed as a percentage of all inpatient days in the same period.	C	% / All inpatients	CIHI DAD / April 1, 2024 to March 31,2025	19.96	17.00	The provincial average is 17.1%, so we are targeting to meet the provincial average. We will be working collaboratively with our community partners to address the identified needs within our community to reduce our percentage of ALC days.	Home and Community Care Support Services (HCCSS), Brantford and Brant Retirement Homes

Change Ideas

Change Idea #1 Identify and leverage the expertise of the integrated healthcare team and maximize the engagement of community partners to support our proactive discharge planning process.

Methods	Process measures	Target for process measure	Comments
1. Define the roles and responsibilities of the integrated team to support timely referral. a. Identify processes (internal and external) to facilitate timely access to services (e.g., assessments to support discharge readiness). 2. Explore opportunity to develop an electronic flagging system to trigger discharge planning in alignment with the Home First Philosophy timelines.	• Project milestone completion (definition of roles and responsibilities of the integrated health care team) • Establish baseline data for interdisciplinary referrals within 48 hours of admission. • Time of referral to time of assessment completion (for interdisciplinary team & HCCSS)	• Collect baseline • Time of referral to time of assessment completion is less than 48 hours	

Change Idea #2 Enhance the ALC assessment process to improve designation practice.

Methods	Process measures	Target for process measure	Comments
1. Launch updated ALC designation form and Toolkit. 2. Establish a sustainable auditing process to evaluate ALC designation practice.	• % of accurate ALC designations • # of patients discharged with Unknown or TBD designation	• 90% of patients with an accurate ALC designation • Zero (0) patients discharged with Unknown or TBD designation	

Change Idea #3 Develop a standard process for identification, referral, and assessment of patients requiring community placement and/or community services.

Methods	Process measures	Target for process measure	Comments
1. Define roles and responsibilities, and timelines as part of the standard process for community placement (e.g., Retirement Home, Group Home). 2. Develop a collaborative forum with community partners to facilitate timely and appropriate transfers. a. Develop a Memorandum of Understanding with community partners.	• Project milestone completion (definition of roles and responsibilities of the integrated healthcare team). • Launch of collaborative community forum	• 100% of resources (roles & responsibilities) completed by September 2024 • Collaborative forum established by September 2024	

Measure - Dimension: Timely

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department wait time to inpatient bed	O	Hours / ED patients	CIHI NACRS / ERNI hospitals: December 1st 2022 to November 30th 2023. Non-ERNI hospitals: April 1st 2023 to September 30th 2023 (Q1 and Q2)	30.72	28.00	The provincial average is 33 hours. We have seen an improvement in wait time over the past 2 fiscal years with a performance improvement of 3.7 hours (from 35.48 hours to 32.04 hours).	

Change Ideas

Change Idea #1 Improve the communication mechanisms to support a reduction in time between bed assignment and the time patient arrives on the assigned Inpatient Unit.

Methods	Process measures	Target for process measure	Comments
1. Explore alternatives to current process for notification of bed assignment. a. Identify opportunities to integrate electronic automation. 2. Evaluate current Transfer of Accountability (TOA) process to identify opportunities for improvement. a. Current state map of TOA process (roles and responsibilities, workflow) 3. Develop a strategic workplan to guide improvement over the next 2-3 years.	Evaluation milestone completion	Completion of strategic workplan	

Change Idea #2 Refresh and relaunch the BCHS Discharge Planning Process to improve communication between the interdisciplinary team and the patient (and/or their representative) to support timely discharge or transition in care.

Methods	Process measures	Target for process measure	Comments
1. Enhance documentation of patient readiness for discharge to support informed discharge practice (i.e., avoid delays on day of discharge by ensuring that patient assessments and/or evaluations are completed prior to day of discharge). 2. Enhance the process (i.e., roles and responsibilities) for ensuring the Estimated Date of Discharge (EDD), discharge plan, and discharge expectations are communicated to the patient (and/or their representative) and develop an escalation process for patients with a length of stay greater than the EDD. a. Early identification of discharge needs to support proactive referral (e.g., early referral to internal and external supports). b. Ongoing documentation in health record to support readiness for discharge. c. Establish a sustainable auditing process to evaluate EDD	• Medicine ALOS:ELOS – Direct; Medicine ALOS:ELOS – Transferred in • % of patients with completed EDD	• ALOS:ELOS target of 1.21 • 80% of patients with documented EDD within 48 hours of admission • 90% of patients with accurate documented EDD	

Change Idea #3 Enhance the discharge process (i.e., patient physical departure) from the Inpatient Unit to allow discharge to occur early in the day.

Methods	Process measures	Target for process measure	Comments
1. Increase the number of early discharges to facilitate timely transfer of patients from ED to Inpatient Unit. a. Change the time of discharge from 1100h to 1300h. b. Review current practices surrounding discharge processes to decrease the time between physician discharge order and time patient leaves the hospital. 2. Create a culture of discharge readiness that includes collaboration with patients and/or their representatives to facilitate timely discharge. 3. Review the current utilization of the EAU: explore the opportunity to utilize space in the EAU as a discharge lounge (chairs vs. beds/stretchers to maximize space) for discharged patients awaiting transportation. 4. Explore the opportunity to utilize the space at the end of the Inpatient Units as a discharge lounge for discharged patients who are awaiting transportation.	• % of discharges by 1300h • Evaluation milestone completion (review of current practice surrounding discharge processes and review of space utilization) • % of patients identified for discharge 24 hours in advance (proactive planning)	• 50% of discharges by 1300h • Initiate quality improvement (QI) project (discharge practice) • 50% of patients proactively identified for discharge 24 hours in advance	

Measure - Dimension: Timely

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Emergency Department visit as the first point of contact for MHA-related care	C	% / All patients	CIHI DAD,CIHI OHMRS,MOH TLC RPDB / April 1, 2024 through March 31, 2025	23.70	22.00	This is a system measure that the hospital has indirect influence over. However, as a good system partner, we are aligning initiatives to support community organizations including primary care. Both BCHS (23.7%) and the BBNOHT (22.7%) are currently performing better than the provincial average for 2023/24 (24.7%). As such, the aim for 2024/25 is to improve/maintain organizational performance over previous period.	

Change Ideas

Change Idea #1	Improve and standardize the discharge process from Inpatient Mental Health to support successful patient transitions to community/outpatient services.		
Methods	Process measures	Target for process measure	Comments
• Standardize engagement with community mental healthcare services via in person and/or virtual mechanisms during patient discharge plan (e.g. facilitating a “warm hand-off” between services) • Develop an up-to-date index of community mental health and addictions services which can be utilized by the Inpt MH & ERMH teams during discharge planning • Incorporate BBNOHT Navigation tool into standard discharge planning processes • Consistently engage patients and families (where consent is provided) during patient discharge planning with the Inpt MH team	• Reduction in off-hour discharges (after 4pm) • Increase the # of patients that followed up with referrals to BCHS outpatient mental health services	• Number of off hour discharges (after 4pm) is < than 20% • # of patients that followed up with referrals to BCHS outpatient mental health services is = 90	

Change Idea #2	Support ED avoidance through collaboration with local crisis services (e.g. COAST, MCRRT) to leverage outpatient services at BCHS as a first point of contact for clients requiring specialized services.		
Methods	Process measures	Target for process measure	Comments
• Create pathways that community crisis services (COAST, MCRRT) can use to refer clients directly to BCHS’s outpatient MH/Addictions services without accessing BCHS’s Emergency Department for referral • Socialize scope and design of outpatient services at BCHS with community partners • Develop ongoing knowledge sharing opportunities with communities partners	• Increase in the number of client’s referred to BCHS’s outpatient programs through community services • Decrease in the % of No Show rates for outpatient programs	• = 914 referrals from community services • % of No Show rates < 10%	

Change Idea #3	Improve and standardize the referral process from BCHS's Emergency Department to support successful patient transitions to BCHS's outpatient services.

Methods	Process measures	Target for process measure	Comments
• Develop pathways for referring patients to BCHS's outpatient services, to be utilized by the ED team at BCHS • Socialize scope and design of BCHS's outpatient services and community partners with core ED stakeholders • Explore opportunities to document treatment plans within current EMR, and begin tracking the number of treatment plans completed by the ED clinical team	• Referral rates to internal outpatient programs from the emergency department at BCHS • Decrease in the % of No Show rates for outpatient programs	• = 227 referrals to internal outpatient programs from BCHS's emergency department • No show rate < 10%	

Measure - Dimension: Timely

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Access to Hop Fracture Surgery within 48 Hours	C	% / All patients	CIHI NACRS / April 1, 2024 through March 31, 2025	61.00	80.00	Match with provincial performance	Norfolk General Hospital, West Haldimand General Hospital

Change Ideas

Change Idea #1	Understand inclusion and exclusion criteria for the database that would represent patients that require Hip Fracture Surgery within 48 Hours		
Methods	Process measures	Target for process measure	Comments
1. Develop a process to document the date/time of fracture upon admission to any hospital that will allow for clarity with the clinical team on when the 48 Hr window for access to Inpatient Hip Fracture Surgery begins a. Revise communication document b. Define individual(s) responsible for collecting times from referring sites	1. Completion and uptake of communication document 2. Performance improvement toward provincial target 3. Clarity for physicians and staff on accurate start time	1. Performance improvement by Q2 (toward target of 80%)	

Change Idea #2	System improvement: Complete and implement a new practice within the urgent/emergent booking policy to change the classification for fractured hip patients		
Methods	Process measures	Target for process measure	Comments
1. Update urgent/emergent booking policy a. Educating clinical team on new booking policy 2. Build a new measure within the Perioperative Scorecard to align with new category of “2B”	1. Performance improvement toward provincial target 2. New measure added in perioperative scorecard	1. Performance improvement by Q2 (toward target of 80%)	

Change Idea #3	System Improvement: Internal audit to review barriers and factors that impact BCHS’s ability to complete Hip Fracture Surgery within 48 Hrs of first inpatient admission		
Methods	Process measures	Target for process measure	Comments
1. Allocate resource to track real time admission to the OR a. Identify barriers to access b. Liaison with physicians and MRP surgeons to investigate c. Tracking mechanism to identify trends and reporting out	1. Performance improvement toward provincial target	Performance improvement by Q2 (toward target of 80%)	

Change Idea #4 System Improvement: Revisit of external fracture process (Those that present from outside of BCHS) from referral to time of surgery			
Methods	Process measures	Target for process measure	Comments
1. Process to define criticality of patient with surgeon to appropriately determine priority of fracture a. Create process to expedite patient from referring centre to the OR (Testing, transportation, bed availability, patient review and surgical approach decision) b. Time of Blue Slip Booking	Performance improvement toward provincial target (Specific to external referrals)	Performance improvement by Q2 for both referring centres and in-house targets	

Change Idea #5 Patient Factor Improvement: Review literature about practice for performing hip fracture surgery on anti-coagulant patients. In Calendar year 2023, 8% or 17 patients did not receive surgical intervention due to Anti-coagulation status.			
Methods	Process measures	Target for process measure	Comments
Literature review and Peer to Peer comparison related to practice of performing Hip Fracture surgery on Anti-coagulated patients.	1. Compare anti-coagulated patients who did and did not have surgery within 48 Hours 2. Literature review complete 3. Consider change in practice	80% reduction of the number of patient delayed for surgical intervention due to anti-coagulation status.	

Equity

Measure - Dimension: Equitable

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	O	% / Staff	Local data collection / Most recent consecutive 12-month period	CB	100.00	This target is established to align with our commitment to fostering an inclusive workplace and addressing DEI-B challenges effectively. Currently, there is a gap in leadership's understanding and application of equity, diversity, inclusion, cultural safety, and anti-racism principles, hindering our ability to create meaningful change. By ensuring all leaders complete relevant education, we aim to enhance their capacity to champion DEI-B initiatives and create a more inclusive organizational culture.	

Change Ideas

Change Idea #1 Implement Halogen modules for relevant education.

Methods	Process measures	Target for process measure	Comments
Schedule completion deadlines for each Halogen module Provide access and support for leaders to complete modules	Percentage of leaders who complete each Halogen module by the designated deadline	Achieve 100% completion of the LDI session by the end of October 2024 among targeted leaders	

Change Idea #2 Conduct Leadership Development and Inclusion (LDI) sessions.			
Methods	Process measures	Target for process measure	Comments
Organize in-person LDI training sessions for executive, director, and manager-level leaders. Incorporate hands-on scenarios to reinforce learning Invite medical leaders to participate	Percentage of targeted leaders who complete the LDI session	Achieve 100% completion of the LDI session by the end of October 2024 among targeted leaders	

Change Idea #3 Organize a Community/Region-wide DEI-B Education Summit for Healthcare Providers			
Methods	Process measures	Target for process measure	Comments
Collaborate with relevant organizations to plan and execute the summit Tailor the summit content for medical professionals Ensure accreditation for attendees to earn education credits	Number of attendees at the summit	Ensure a substantial turnout at the summit and positive feedback from attendees to indicate successful engagement with the target audience	

Safety

Measure - Dimension: Safe

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of inpatients who experience a hospital acquired pressure injury.	C	% / All inpatients	EMR/Chart Review / April 1, 2024 to March 31, 2025	CB	CB	The 2023/24 baseline data assessment demonstrated previous measures are not indicative of current pressure injury situation at BCHS, therefore for 2024/2025 we will reestablish specific measures and mitigation strategies to prevent pressure injuries at BCHS.	

Change Ideas

Change Idea #1 Review and revise current documentation standards in Meditech to support the reduction of hospital acquired pressure injuries. Primary focus on Braden Scale interventions (therapeutic surfaces), as well as compliance in documentation on pressure injury on admission to hospital.

Methods	Process measures	Target for process measure	Comments
1. Launch revised Braden Scale with clear and specific interventions 2. Update therapeutic surfaces offered at BCHS in the Braden Scale intervention 3. Monitor compliance of Braden scale completion with interventions charted (Moderate to high-risk patients) 4. Change wording from “Wound Present on Admission” to “Wound Present on Admission to Hospital” in Meditech	1. Completion of revised Braden Scale and updated therapeutic surfaces at BCHS 2. % of patients with pressure injury wound presence documented on admission to hospital 3. Improvement in compliance with interventions charted for patients with moderate to high risk on the Braden Scale (15 and below) a. Current state, 44% of all patients with moderate to high risk do not have surfaces charted	1. 90% of patients will have a skin assessment indicating presence of pressure injury on admission to hospital documented. 2. 90% of patients with moderate to high-risk scores denoted on the Braden Scale will have charted surface and interventions.	

Change Idea #2	Develop and implement education program for skin and wound assessment standards of documentation to support early identification and prevention of pressure injuries.		
Methods	Process measures	Target for process measure	Comments
1. Create and launch Halogen Training for Nursing Staff (RN, RPN) 2. Educational huddle blitzes towards skin/wound assessments and interventions, pressure injury staging and quality of life impacts for those living with pressure injuries	1. Completion of Halogen Training and manager support to monitor compliance inclusive of RN's, RPN's 2. Educational huddle blitzes once per month, increased blitzes for programs with higher pressure injury prevalence (Relation to Change Idea #3)	1. Launch of Halogen training for Pressure Injuries 2. Completion of huddle blitzes for all inpatient floors	

Change Idea #3	Develop and conduct an auditing process on the inpatient units to improve data quality and access to baseline pressure injury prevalence to compare with existing DAD (Discharge Abstract Database) data		
Methods	Process measures	Target for process measure	Comments
1. Create automated patient chart data audit tool 2. Explore opportunity for use of web-based tool to support data collection for overall skin/wound care prevalence a. Clarify requirements for auditing and resources (Who audits and frequency) 3. Create a Pressure Injury Dashboard on the BI tool, and education to management on usage and interpretation a. Pressure Injury Dashboard will be built into the PIPSC meeting frequency	1. Completion of automated patient chart data audit tool 2. Decide on technology for auditing tool 3. Complete Pressure Injury Dashboard on the BI Tool a. Link dashboard review as standing agenda in PIPSC meeting	1. Launch of automated patient chart data audit tool 2. Decision on web-based tool to support data collection 3. Rollout of Pressure Injury Dashboard and incorporation as standing agenda item in monthly PIPSC Meeting	