2016/17 Quality Improvement Plan

"Improvement Targets and Initiatives"

St. Joseph's Care Group 35 North Algoma Street Box 3251

AIM		Measure							Change				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Org ID	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
Effective	To Reduce Potentially Avoidable Emergency Department Visits for LTC Residents	Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	% / Residents	Ministry of Health Portal / Oct 2014 – Sept 2015	Bethammi Nursing Home	18.24	15.00	Current performance below ON average of 24.6%. Target based on reducing visits by 18%	1)Ensure regular operational meetings with medical director and nurse practitioner to review data and discuss	Tracking tool to be used by manager to monitor ED transfers	Monthly meetings with MD & NP to occur	100%	VP/DIR review monthly; include Seniors' Care Medical Director
		Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	% / Residents	Ministry of Health Portal / Oct 2014 – Sept 2015	Hogarth Riverview Manor	22.76	19.00	Current performance below ON average of 24.6%. Target based on reducing visits by 15%.	1)Ensure regular operational meetings with medical director and nurse practitioner to review data and discuss	Tracking tool to be used by manager to monitor ED transfers	Monthly meetings with MD & NP to occur	100%	VP/DIR review monthly; include Seniors' Care Medical Director
	To Reduce the Inappropriate Use of Anti psychotics in LTC	Percentage of residents receiving antipsychotics without a diagnosis of psychosis. Exclusion criteria are expanded to include those experiencing delusions.	% / Residents	CCRS, CIHI (eReports) / July – September 2015 (Q2 FY 2015/16 report)	Bethammi Nursing Home	24.14	21.00	Currently below ON Prov average of 25%, target based on reducing by 13% from current performance.	1)Physician, NP,RN, Pharmacist to complete all quarterly medication reviews	Completed through resident care conferences.	Quarterly reviews completed	100%	VP/DIR review monthly; include Seniors' Care Medical Director
									2)Review indicator at Long-Term Care Pharmacy & Therapeutics (P&T).	Manager to track number of residents on anti-psychotic medication without diagnosis of psychosis using tracking form	Quarterly Meeting reviews	100%	
		Percentage of residents receiving antipsychotics without a diagnosis of psychosis. Exclusion criteria are expanded to include those experiencing delusions.	% / Residents	CCRS, CIHI (eReports) / July – September 2015 (Q2 FY 2015/16 report)	Hogarth Riverview Manor	34.7	30.00	Target based on reducing by 15% to move towards ON Provincial Average of 25%.	1)Physician, NP,RN, Pharmacist to complete all quarterly medication reviews	Completed through resident care conferences.	Quarterly reviews completed	100%	VP/DIR review monthly; include Seniors' Care Medical Director
									2)Review indicator at Long-Term Care Pharmacy & Therapeutics (P&T).	Manager to track number of residents on anti-psychotic medication without diagnosis of psychosis using tracking form	Quarterly Meeting reviews	100%	

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	Improve Financial Health	Total Hospital Margin % by which total revenues exceed or fall short of total expense, excluding impact of facility amortization.	% / Hospital sector	Hospital collected data / April-Dec 2015	Hospital	1.13	0.00	Maintain minimum of zero based on hospital accountability target	1)Evaluate performance of complex care, rehabilitation and mental health under health system funding reform and make improvements as required.	Leadership complete review and implement changes by Mar 31/17	Regular progress reviews will happen at Leadership Team meetings.	Changes implemented by March 2017.	This indicator continues to be a priority measure based on our current performance under HBAM.
									2)Implement case costing for hospital inpatient services.	Planning & Performance to lead case costing and implement by March 31/17	Project reviews will occur at Leadership Team Infrastructure meetings	Monthly progress reviews will occur between Sept 2016 and March 2017	
	Improve Transitions in Care	Percent of discharges to SJCG Seniors' Supportive Housing where discharge planning has occurred with Supportive Housing staff	% / Complex Care and Physical Rehab	Hospital collected data / 2015-16	Hospital	Collect Baseline	95.00	Interim target moving towards 100%	1)Ensure discharge planning communication and documentation occurs between St. Joseph's Hospital and Seniors' supportive housing staff 48 to 72 hours prior to discharge.	Supportive Housing Manager to track each discharge from hospital to PR Cook and Sister Leila Greco Apartments.	Number of discharges to supportive housing where discharge communication and documentation has occurred between hospital and supportive housing staff	95%	
	Reduce Hospital Length of Stay for Inpatient Rehabilitation (Hip Fracture)	Hip Fracture Active Rehab LOS (Average). Number of days from admission date to date ready for discharge (excluding ALC and Service Interruption days) divided by total number of discharges for same period.	Days / Rehab	CIHI eReporting Tool / Q2 2015-16	Hospital	27.4	26.00	Target based on reducing by 4% to move towards ON average	1)Set LOS targets and ensure a process is in place to monitor each client's LOS and implement a case review when LOS exceeds the target	Manager and QBP clinical lead to support process. Manager will track cases requiring a review.	Percent of case reviews completed when LOS exceeds target. VP and Director will monitor on quarterly basis.	80%	
									2)Explore co-locating complex care and rehabilitation beds on same unit to facilitate transfers between services while keeping same care team	Director leading review of bed co-location	Review complete.	Review completed by August 2016	

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	Reduce Hospital Length of Stay for Inpatient Rehabilitation (Stroke)	Stroke (1100 Severe) Active Rehab LOS (Average). Number of days from admission date to date ready for discharge (excluding ALC and Service Interruption days) divided by total number of discharges for same period.	Days / Rehab	CIHI eReporting Tool / Q2 2015-16	Hospital	54.9	48.90	Target based on Quality Based Procedure, clinical best practice.	1)Set LOS targets and ensure a process is in place to monitor each client's LOS and implement a case review when LOS exceeds the target	Manager and QBP clinical lead to support process. Manager will track cases requiring a review.	Percent of case reviews completed when LOS exceeds target. VP and Director will monitor on quarterly basis.	80%	
									2)Explore co-locating complex care and rehabilitation beds on same unit to facilitate transfers between services while keeping same care team	Director leading review of bed co-location	Review Complete	August 2016	
Efficient	**Reduce unnecessary time spent in hospital**	Total number of ALC inpatient days contributed by by ALC patients within a specific reporting period (open,discharged and discontinued cases) divided by the total number of patient days per Bed Census summary in same period.	% / All patients	WTIS, CCO, BCS, MOHLTC / Oct-Dec 2015	Hospital	39	22.00	Target for Jan-Mar 2017, based on assumption Bethammi Nursing Home remains open, thereby increasing long-term care home capacity.	1)Proposal developed to keep Bethammi Nursing Home in operation.	SJCG working closely with NW LHIN and community partners to develop plan.	Leadership Team monitors ALC rate % on weekly and monthly basis on scorecard report.	Bethammi Nursing Home remains open.	ALC continue to be a challenge within Thunder Bay, especially around long-term care home capacity.
									2)Close Temporary Transitional Care Unit (TTCU).	SJCG working closely with community partners to develop closure plan.	Leadership Team monitors ALC rate % on weekly and monthly basis on scorecard report.	October 2016 unit closed.	
									3)Continue to work closely with NW CCAC to increase admissions from community to Assess and Restore inpatient beds	With NW CCAC Director, continue to refine the flags used by NW CCAC Coordinators when completing the Community RAI to identify clients who are most appropriate for admission to an inpatient Geriatric Assessment and Rehabilitation bed. Tracked quarterly through Enhanced Transitional Care Services reporting to NW LHIN.	Percent referrals from community	30%	
									4)Increase admissions from emergency department to Geriatric Assessment & Rehabilitative Care, avoiding acute care inpatient admission and potential decrease in functional decline.	With TBRHSC as the lead agency, develop a Frail Senior Pathway that is initiated in the ED, with one pathway being direct admission to SJH Geriatric Assessment and Rehabilitative Care unit. Once pathway is developed and functional, reserve one bed on unit for urgent admissions from the ED. Tracked quarterly through Enhanced Transitional Care Services reporting to NW LHIN.	Pathway developed.	March 2017	

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Client-centred	Improve Overall Client Satisfaction	How would you rate the overall quality of care you, or your family member, have received? Responses to Excellent.	% / Complex Care,Physical Rehabilitation & Mental Health & Addictions	In-house survey / 2015	Hospital	76	77.00	Keep 15-16 target to sustain response rate to Excellent	1)Incorporate revised Client Bill of Rights into all program areas	Managers implement in all program areas by March 31, 2017 as monitored by Clinical Services Integration Committee.	Percent of program areas implementing revised Client Bill of Rights	100%	
									2)Conduct client & family focus groups in targeted areas for improvement, implementing change ideas	Directors and Client Relations coordinate client & family focus groups and implementation of change ideas.	Percent of targeted areas implementing change ideas as reported to Client Satisfaction Improvement Working Group. Feedback provided to client & family regarding change ideas.	100% by June 30, 2016	
									3)Implement Client & Family Compliments & Concerns Feedback Database System	Client Relations will train management staff on new responsibilities to manage feedback and record follow-up in the Feedback Database. Each site will have a Feedback Station which will provide information for client and families on opportunities to report feedback The station will communicate the availability of an online feedback form and make hard copy forms available. Communications and Engagement will present an aggregate summary of feedback date to Leadership Quality and Board Quality Committees.	Percent of Management Staff Trained; Feedback Stations Implemented; Reporting initiated	50% Management Staff trained by May 1, 2016; 100% sites have feedback stations by May 2016; Reporting initiated by June 2016	
									4)Explore Dignity, Conserving Care Concepts (developed by Dr. Harvey Chochinov) and develop implementation plan.	The first component is to increase our understanding and knowledge of Dignity Conserving Care across SJCG (clinical and non-clinical) and all levels. Then we have to determine how that model will align with our work and our care and service processes and finally implement our own model with a corporate-wide education plan. This work will be directed by the Client Satisfaction Improvement Working Group.	Implementation Plan is developed	March 31, 2017 plan is developed.	
Client-Centred	Improve Overall Client Satisfaction	How would you rate the overall quality of care you, or your family member, have received? Responses to Excellent.	% / Residents	In-house survey / 2015	Bethammi Nursing Home	23	50.00	Interim target based on improving to 50% response	1)Participate in focus groups to obtain resident feedback	Resident Engagement Coordinator coordinate focus groups	Percent of targeted areas implementing change ideas as reported to Client Satisfaction Improvement Working Group. Feedback provided to client & family regarding change ideas. Percent satisfaction to Excellent results on monthly rolling survey reviewed by Resident Engagement Coordinator.	Focus groups and change ideas completed by June 30/16; Excellent Response 50%	

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									3)Explore Dignity, Conserving Care Concepts (developed by Dr. Harvey Chochinov) and develop implementation plan.	The first component is to increase our understanding and knowledge of Dignity Conserving Care across SJCG (clinical and non-clinical) and all levels. Then we have to determine how that model will align with our work and our care and service processes and finally implement our own model with a corporate-wide education plan. This work will be directed by the Client Satisfaction Improvement Working Group.	Implementation Plan is developed	March 2017	
									4)Use a standardized feedback form to close the loop with resident concerns	Standardized feedback form implemented by manager	You Spoke We Listened Form incorporated for all resident/family concerns. Documented when completed	Mar 2017	Reviewed at monthly manager/Director meetings
		How would you rate the overall quality of care you, or your family member, have received? Responses to Excellent.	% / Residents	In-house survey / 2015	Hogarth Riverview Manor	24	50.00	Interim target based on improving response to 50%.	1)Participate in focus groups to obtain resident feedback.	Resident Engagement Coordinator to coordinate focus groups.	Percent of targeted areas implementing change ideas as reported to Client Satisfaction Improvement Working Group. Feedback provided to client and family regarding change ideas. Percent satisfaction to Excellent results on monthly rolling survey reviewed by Resident Engagement Coordinator.	Focus groups and change ideas completed by June 30, 2016; Excellent Response 50%	
									2)Implement Complaints & Concerns Feedback Database System.	Client Relations will train management staff on new responsibilities to manage feedback and record follow-up in the Feedback Database. Each site will have a Feedback Station which will provide information for client and families on opportunities to report feedback. The station will communicate the availability of an online feedback form and make hard copy forms available. Communications and Engagement will present an aggregate summary of Feedback Database to Leadership Quality and Board Quality	Percent of Management Staff Trained; Feedback Stations Implemented; Reporting Initiated	50% Management Staff trained by May 1, 2016; 100% sites have feedback stations by May 2016; Reporting initiated by June 2016	

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									3)Explore Dignity, Conserving Care Concepts (developed by Dr. Harvey Chochinov)and develop implementation plan.	The first component is to increase our understanding and knowledge of dignity Conserving Care across SJCG (clinical and non-clinical) and all levels. Then we have to determine how that model will align with our work and our care and service processes and finally implement our own model with a corporate-wide education plan. This work will be directed by the Client Satisfaction Improvement Working Group.	Implementation Plan is developed.	March 2017	
									4)Use a standardized feedback form to close the loop with resident concerns	Standardized feedback form implemented by manager	You Spoke We Listened Form incorporated for all resident/family concerns. Documented when completed	Mar 2017	Reviewed at monthly manager/Director meetings

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Safe	**Increase proportion of patients receiving medication reconciliation upon admission**	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	% / All patients	Hospital collected data / most recent quarter available	Hospital	94	95.00	Continue with existing target of 95% moving towards theoretical best of 100%	1)Provide education to nursing staff to improve accuracy of BPMH (best possible medication history)	Pharmacy staff to provide BPMH training. Training rates to be monitored by Medication Safety Committee.	Percent of nursing staff trained.	80%	
									2)Continue regular monitoring of medication reconciliation completion rates	Daily medication reconciliation reports reviewed by managers and monthly reporting reviewed by Leadership Quality Committee through scorecard report	Percent Medication Reconciliation Completed on Admission	95%	
	Reduce hospital acquired infection rates	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI during the reporting period, divided by the number of patient days in the reporting period, multiplied by 1,000.	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / January 2015 – December 2015	Hospital	0.10	0.08	Interim target for 2016-17 to move towards theoretical best of 0	1)Conduct regular audits related to use of personal protective equipment (PPE) and provide staff education as required.	Infection Control staff to conduct PPE audits and provide staff education. Audit results to be reported to the Infection, Prevention, Control Committee.	Percent of staff wearing PPE when required.	65% Interim target has been set.	
	To Reduce Falls	Resident Falls Injury Rate. Total number of falls resulting in moderate or serious injury for the period divided by total resident days for same period multiplied by 1000	Rate per 1,000 patient days / Residents	Internal Safety Reporting System / Jan-Dec 2015	Hogarth Riverview Manor	0.23	0.21	Target based on reducing falls with injury by 5% from current performance.	1)Implement HELPP - Help patient to the toilet; Environmental - ensure clear path to the bathroom; Leave personal items/call bell within reach; Pain addressed; Personal needs attended to, ask client "Is there anything else you need before I go?"	Falls Steering Committee will support implementation of HELPP.	Percentage of resident areas implementing HELPP.	100% by March 2017	Change idea based on the SAFE Program; Safer Healthcare Now
									2)Update falls prevention toolkit and provide education to staff.	Manager to review falls during staff huddles to focus on individualized strategies; Clinical education to update toolkit	Toolkit updated; Percentage of staff receiving education.	June; 100%	
		Resident Falls Injury Rate. Total number of falls resulting in moderate or serious injury for the period divided by total resident days for same period multiplied by 1000	Rate per 1,000 patient days / Residents	Internal Safety Reporting System / Jan-Dec 2015	Bethammi Nursing Home	0.40	0.38	Target based on reducing falls with injury by 5% from current performance. Current rate has increased from previous year.	1)Implement HELPP - Help patient to the toilet; Environment-ensure clear path to the bathroom; Leave personal items/call bell within reach;Pain addressed; Personal needs attended to, ask client: "Is there anything else you need before I go?"	Falls Steering Committee will support implementation of HELPP.	Percentage of resident areas implementing HELPP.	100% by March 2017	Change idea based on the SAFE program, Safer Healthcare Now
									2)Update falls prevention toolkit and provide education to staff.	Manager to review falls during staff huddles to focus on individualized strategies; Clinical education to update toolkit	Toolkit updated; Percentage of staff receiving education.	June; 100%	

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		Client Falls Injury Rate. Total number of falls resulting in moderate or serious injury for the period divided by total patient days for same period multiplied by 1000	Rate per 1,000 patient days / Complex Care, Physical Rehabilitation, Mental Health	Internal Safety Reporting System / Jan-Dec 2015	Hospital	0.13	0.11	Target based on reducing falls with injury by 10% from current performance.	1)Implement HELPP - Help patient to the toilet; Environment-ensure clear path to the bathroom; Leave personal items/call bell within reach;Pain addressed; Personal needs attended to, ask client: "Is there anything else you need before I go?"	Falls Steering Committee will support implementation of HELPP.	Percentage of inpatient areas implementing HELPP.	100% by March 2017	Change idea based on the SAFE program, Safer Healthcare Now!
	To Reduce the Use of Restraints	Percentage of residents who were physically restrained	% / Residents	CCRS, CIHI (eReports) / July – September 2015 (Q2 FY 2015/16 report)	Bethammi Nursing Home	17.71	15.00	Interim target reduction by 15%, to move towards ON Prov average of 6.7%	1)Review & update Least Restraint toolkit	Clinical education and manager responsible for updating.	Toolkit updated; Education provided to staff	April 2016	
									2)Ensure coding of restraint in RAI assessment aligns with restraint definition	RAI Coordinator to audit RAI assessment	Quarterly Audit completed	100%	
									3)Review restraint usage monthly with Medical Director	Director and manager will review with Medical Director	Monthly review to occur	100%	
		Percentage of residents who were physically restrained	% / Residents	CCRS, CIHI (eReports) / July – September 2015 (Q2 FY 2015/16 report)	Hogarth Riverview Manor	25.42	20.00	Interim target reduction of 20% to move towards ON Provincial Average of 6.7%.	1)Review & update Least Restraint toolkit	Clinical education and manager responsible for updating.	Toolkit updated; Education provided to staff	April 2016	
									2)Ensure coding of restraint in RAI assessment aligns with restraint definition	RAI Coordinator to audit RAI assessment	Quarterly Audit completed	100%	
									3)Review restraint usage monthly with Medical Director	Director and manager will review with Medical Director	Monthly review to occur	100%	

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	To Reduce Worsening of Pressure Ulcers	Percentage of residents who had a pressure ulcer that recently got worse	% / Residents	CCRS, CIHI (eReports) / July – September 2015 (Q2 FY 2015/16 report)	Bethammi Nursing Home	7.05	5.00	Interim target for 16-17 to move towards ON Prov average of 3%	1)Review and update Skin and Wound Care Toolkit and provide staff training.	Manager and clinical education will update toolkit;	Toolkit updated; Education provided to staff	June 2016; 100%	
									2)Implement reporting of newly acquired pressure ulcers through client safety reporting system	Manager and client safety to implement	Reporting implemented	May 2016	
									3)Continued implementation and training of wound tracker module in Medecare	Manager and client safety to implement	Percentage of residents assessed as high risk (Braden or PURS)Interventions documented in care plan and wound tracker module; Staff trained	100% Registered staff trained in wound tracker module	
									4)Access SJCG Telewound Program offered through Ontario Telemedicine Network (OTN).	Clinical manager to support process with staff	Number of referrals; staff trained	100% RN staff trained in accessing telewound	
		Percentage of residents who had a pressure ulcer that recently got worse	% / Residents	CCRS, CIHI (eReports) / July – September 2015 (Q2 FY 2015/16 report)	Hogarth Riverview Manor	6.78	5.00	Interim target for 16-17 to move towards ON Provincial Average of 3%.	1)Review and update Skin and Wound Care Toolkit and provide staff training.	Manager and clinical education will update toolkit;	Toolkit updated; Education provided to staff	June 2016; 100%	
									2)Implement reporting of newly acquired pressure ulcers through client safety reporting system	Manager and client safety to implement	Reporting implemented	May 2016	
									3)Continued implementation and training of wound tracker module in Medecare	Manager and client safety to implement	Percentage of residents assessed as high risk (Braden or PURS)Interventions documented in care plan and wound tracker module; Staff trained	100% Registered staff trained in wound tracker module	
									4)Access SJCG Telewound Program offered through Ontario Telemedicine Network (OTN).	Clinical manager to support process with staff	Number of referrals; staff trained	100% RN staff trained in accessing telewound	

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	Reduce Medication Errors	Medication Error Rate. Total number of medication errors for the period divided by patient days for the same period multiplied by 1000.	Rate per 1,000 patient days / Complex care, Physical Rehabilitation and Mental Health	Hospital collected data / Jan-Dec 2015	Hospital	2.34	2.00	Reduce by 10% from current performance	1)Trial a Daily Medication Administration Record MAR on one unit (5 South)	Pharmacy staff to support trial of daily MAR	Nurse satisfaction with Daily MAR process	80% of nurses satisfied	This change idea supports plan of implementing unit-dose medication administration system in 2017-18.