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

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

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**	Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital.	% / Discharged patients	Hospital collected data / Most recent 3 month period	Hospital	CB	CB	Collecting baseline for first year	1)Collect baseline data and develop action plan for improvement with involvement from clinical management, physician and health records. Pilot at St. Joseph's Hospital Geriatric Assessment & Rehabilitative Care Inpatient program.	Baseline data to be collected for six week period starting April 2017 to inform development of improvement plan.	Time from discharge date to dictation date; Time from dictation date to transcription date	to be determined	
		Discharges from St. Joseph's Hospital to Seniors' Supportive Housing where discharge planning has occurred with supportive housing staff	% / Discharged clients	In house data collection / April to Dec 2016	Hospital	91.00	95.00	Internal target to improve on current performance	1)Continue to monitor discharge planning communication between St. Joseph's Hospital and SJCG Seniors'Supportive Housing.	Supportive Housing Manager will track each discharge from hospital. When measure not met, both Directors (Hospital Inpatient, Supportive Housing) will be advised.	Communication occurs 48 to 72 hours prior to discharge	95% of discharges meet time	

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	Effective Transitions	Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long term care residents.	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / October 2015 - September 2016	Bethammi Nursing Home	30.87	23.60	Target based on improving performance to provincial average of 23.6	1)Understand the complexities and common reasons for current ED visits to avoid future transfers.	Review ED transfer data at monthly Director/Physician/Administrator meeting to identify opportunities for improvement.	% ED transfers reviewed	100%	
									2)Physicians provide education to families at admission and annual care conferences	Establish a consistent care conference agenda. ED Transfer added to care conference agenda/checklist	% Care conferences where ED transfer checked is reviewed	100%	
									3)Provide registered staff with education to enhance knowledge, skills and judgement when assessing and managing the most common reasons for avoidable ED transfer	Nurse Practitioner to conduct registered staff training on non-urgent services that are available in house (hypodermoclysis, lab services, Nurse Led Outreach Program, CCAC,communication with physicians)	% Registered staff educated to understand internal resources and use skills & judgement before transfer to ED	100%	
		Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long term care residents.	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / October 2015 - September 2016	Hogarth Riverview Manor	20.99	19.00	Current performance is better than provincial average, target based on continued improved performance by 10%	1)Understand the complexities and common reasons for current ED visits to avoid future transfers.	Review ED transfer data at monthly Director/Physician/Administrator meeting to identify opportunities for improvement.	% ED transfers reviewed	100%	
									2)Physicians provide education to families at admission and annual care conferences	Establish a consistent care conference agenda. ED Transfer added to care conference agenda/checklist	% Care conferences where ED transfer checked is reviewed	100%	
									3)Provide registered staff with education to enhance knowledge, skills and judgement when assessing and managing the most common reasons for avoidable ED transfer	Nurse Practitioner to conduct registered staff training on non-urgent services that are available in house (hypodermoclysis, lab services, Nurse Led Outreach Program, CCAC,communication with physicians)	% Registered staff educated to understand internal resources and use skills & judgement before transfer to ED	100%	

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Efficient	**Access to right level of care**	Total number of alternate level of care (ALC) days contributed by ALC patients within the specific reporting month/quarter using near-real time acute and post-acute ALC information and monthly bed census data	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July – September 2016 (Q2 FY 2016/17 report)	Hospital	40	32	Target based on closure of TTCU unit, improving performance by 20% last quarter of 2017-18, moving towards provincial average of 13%	1)Close Temporary Transitional Care Unit (TTCU)	Upon completion of Hogarth Riverview Manor expansion, work closely with community partners to implement closure plan.	Leadership Team monitor plan progress.	TTCU plan completed by April 2017.	This plan was delayed in 2016 and will now be implemented in 2017.
									2)Work with community partners to increase availability of supportive housing.	Review how the wait lists for HAGI, Jasper, PR Cook and Lelia Greco are prioritized; Confirm average wait times; Support conversations with the LHIN for service	Wait list system will be transparent and average wait times for each location will be identified	Fall 2017	Plan will be dependent upon funding from the LHIN
Client-centred	**Person experience**	"Would you recommend the program to others?" Yes, Definitely	% / Survey respondents	In-house survey / 2016-17	Hospital	74	77.00	Target based on current internal target for improving client experience	1)Increase Opportunities for Clients to Provide Feedback	a)Explore feasibility of surveying clients more frequently either using existing Client Satisfaction Survey Tool or through specific client population measurement tools being recommended provincially; b)Explore options to obtain qualitative feedback through facilitated focus groups in enhancing therapeutic relationships and/or providing feedback to programs.	Client Satisfaction Improvement Working Group explore and develop options.	Complete analysis with options by September 2017	SJCG currently administers an Annual Client Satisfaction Survey through SJCG Centre for Applied Research (CAHR).
									2)Improving Therapeutic Relationships	Enhance inter-professional staff's capacity for establishing therapeutic relationships based on self-awareness, self-knowledge, and empathy. Client Satisfaction Improvement Working Group develop change ideas from SJCG RNAO Best Practice Guidelines Gap Analysis.	Each division implement a minimum of one practice change idea. Client Satisfaction Survey "How often did staff involve you in planning your (or your family member's) care" Always 2016 Result 66%;	Practice Change ideas implemented; 70% Always	

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	Resident experience	"Would you recommend the program to others?" Yes, Definitely	% / LTC home residents	In house data collection / 2016/17	Bethammi Nursing Home	61	65.00	Improve current performance by 6.5%	1)Improve Culture	Work collaboratively with unions, front line and management to identify factors that will contribute to improving staff culture. Conduct one-day facilitated session for union, front-line and management staff to establish working groups.	Working Groups Established and plan in place	Plan complete and implemented	
									2)Implement Quarterly Family Support Groups	Social work and spiritual care staff will co-lead quarterly sessions	Family Support Groups held each quarter	100%	
									3)Utilize Resident and Family Council to identify two change ideas for improvement of Resident/Family Satisfaction	Director will attend Resident and Family Council meeting to work with councils to identify two change ideas.	Change ideas identified and implemented	100%	
		"Would you recommend the program to others?" Yes, Definitely	% / LTC home residents	In house data collection / 2016/17	Hogarth Riverview Manor	52	55	Improve current performance by 6.5% to internal target set for long-term care	1)Improve Culture	Work collaboratively with unions, front line and management to identify factors that will contribute to improving staff culture. Conduct one-day facilitated session for union, front-line and management staff to establish working groups.	Working Groups Established and plan in place	Plan complete and implemented	
									2)Implement Quarterly Family Support Groups	Social work and spiritual care staff will co-lead quarterly sessions	Family Support Groups held each quarter	100%	
									3)Utilize Resident and Family Council to identify two change ideas for improvement of Resident/Family Satisfaction	Director will attend Resident and Family Council meeting to work with councils to identify two change ideas.	Change ideas identified and implemented	100%	

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Safe	Medication safety	Percentage of residents who were given antipsychotic medication without psychosis in the 7 days preceding their resident assessment	% / LTC home residents	CIHI CCRS / July - September 2016	Bethammi Nursing Home	14.73	14.00	Current performance better than provincial average of 21.3, target based on continuing improvement by 5%	1)All residents prescribed anti-psychotic medication will be reviewed and reassessed at quarterly meetings with Pharmacist and Physician.	The Pharmacist and Physician will monitor on a quarterly basis pharmacy reports for residents on anti-psychotic medications and appropriate diagnoses.	% residents prescribed anti-psychotic medications reviewed quarterly.	100%	
		Percentage of residents who were given antipsychotic medication without psychosis in the 7 days preceding their resident assessment	% / LTC home residents	CIHI CCRS / July - September 2016	Hogarth Riverview Manor	26.73	21.30%	Target based on moving towards provincial average of 21.3%	1)All residents prescribed anti-psychotic medication will be reviewed and reassessed at quarterly meetings with Pharmacist and Physician.	The Pharmacist and Physician will monitor on a quarterly basis pharmacy reports for residents on anti-psychotic medications and appropriate diagnoses.	% residents prescribed anti-psychotic medications reviewed quarterly.	100%	
	Medication safety	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	Rate per total number of admitted patients / Hospital admitted patients	Hospital collected data / Most recent 3 month period	Hospital	89	95.00	Continuing with internal target set at 95%.	1)Provide refresher Medication Reconciliation education to staff through Medworxx learning management system.	Medication Reconciliation Sub Group to develop content and work with corporate learning to implement module.	Percentage of staff completing this assigned module as monitored by the Medication Reconciliation Sub Group.	95%	
									2)Develop and implement Medication Reconciliation education materials for clients and families.	Pharmacy staff to research and develop content for education materials. Program managers to assist with implementation.	Percentage of inpatient areas implementing education materials for clients and families.	100%	
									3)Improve accessibility of medication reconciliation information to staff by creating an iNtranet page dedicated to medication reconciliation resources.	Pharmacy staff will develop page and keep content updated.	iNtranet page developed and implemented.	Implemented by April 2017.	
									4)Develop medication reconciliation flow sheet to guide staff in completing the medication reconciliation process.	Pharmacy to develop draft flow sheet and trial in all inpatient areas for feedback before implementation in Meditech patient care system. Medication Reconciliation Sub Group to receive progress updates.	Percentage of inpatient areas using flow sheet	100%	

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		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.	Rate per total number of discharged patients / Discharged patients	Hospital collected data / Most recent quarter available	Hospital	57	70.00	This is an interim target moving towards 95% completion.	1)Provide refresher Medication Reconciliation education to staff through Medworxx learning management system.	Medication Reconciliation Sub Group to develop content and work with corporate learning to implement module.	Percentage of staff completing this assigned module as monitored by the Medication Reconciliation Sub Group.	95%	
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	Safe care	Percentage of residents who were physically restrained every day during the 7 days preceding their resident assessment	% / LTC home residents	CIHI CCRS / July - September 2016	Bethammi Nursing Home	16.45	15.00	Improve current performance by 9% moving towards provincial average of 5.5	1)Review restraint use at long-term care home falls and restraints committee meetings to determine if restraints are still required.	The committee will review rationale for the use of restraint, identify alternatives, or determine if restraint can be removed. Information from Audit tool and Medecare reporting will be used in the review. Review results will be presented to Seniors Health Quality Safety and Risk Committee for discussion and follow up.	% of residents with a restraint reviewed	100%	
									2)Provide education for residents and families around the risks of restraint use.	Add restraint use education to care conference agenda/checklist.	% of care conferences where restraint education is provided	% of care conferences where restraint education is provided	100%
		Percentage of residents who were physically restrained every day during the 7 days preceding their resident assessment	% / LTC home residents	CIHI CCRS / July - September 2016	Hogarth Riverview Manor	30.76	27.7	Improve performance by 10% moving towards provincial average of 5.5%	1)Review restraint use at long-term care home falls and restraints committee meetings to determine if restraints are still required.	The committee will review rationale for the use of restraint, identify alternatives, or determine if restraint can be removed. Information from Audit tool and Medecare reporting will be used in the review. Review results will be presented to Seniors Health Quality Safety and Risk Committee for discussion and follow up.	% of residents with a restraint reviewed	100%	
									2)Provide education for residents and families around the risks of restraint use.	Add restraint use education to care conference agenda/checklist.	% of care conferences where restraint education is provided	% of care conferences where restraint education is provided	100%

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Timely	**Timely access to care/services**	Hip Fracture Active Rehab Length of Stay - Number of days from admission date to date ready for discharge divided by total number of discharges for same period. (excludes ALC and service interruption days)	Days / Discharged rehabilitation clients	CIHI NRS / April to Sept 2016	Hospital	26.6	26.00	Target based on sustaining improvement made in length of stay from 37.5 days (2014-15) to current performance of 26.6	1)Continue to monitor length of stay to internal target. A case review by manager and director will occur when clinical team identifies that length of stay may exceed target.	QBP clinical lead will support process. Business Intelligence system will be used to support analysis.	Percentage of case reviews completed when length of stay exceeds target.	80%	
		Severe Stroke Active Rehab Length of Stay - Number of days from admission date to date ready for discharge divided by total number of discharges for same period. (excludes ALC and service interruption days)	Days / Discharged rehabilitation clients	CIHI NRS / April to Sept 2016	Hospital	61.4	48.90	Target based on QBP Provincial Target.	1)Continue to monitor length of stay to internal target. A case review by manager and director will occur when clinical team identifies that length of stay may exceed target.	QBP clinical lead will support process. Business Intelligence System used to support analysis	Percentage of case reviews completed when length of stay exceeds target.	80%	