2018/19 Quality Improvement Plan
"Improvement Targets and Initiatives"

ST. JOSEPH'S HOSPITAL

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

AIM		Measure							Change				
Quality dimension	Issue	Measure/Indicator	Type	Unit / Population	Source / Period	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Effective	**Effective transitions**	Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?	C	% / Survey respondents	In house data collection / Apr 2018-March 2019	CB	CB	Collecting Baseline	1)Collect baseline data from inpatient programs, evaluate data and develop change ideas for 2019-2020.	Develop process with SJCG Centre for Applied Health Research and Clinical Directors to administer survey question upon discharge.	Process developed and implemented.	May 31, 2018	
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	P	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July - September 2017	35	32%	Current target (based on opening 64 beds at Hogarth Riverview Manor)	1)Establish four to six additional mental health high support housing spaces by May 2018.	Move plan implemented with staff and clients.	High support housing is in place with 100% occupancy.	May 2018	
									2)Open 64 long-term care beds at Hogarth Riverview Manor	Meet long-term care home compliance requirements and have staffing in place.	Beds open with 100% occupancy.	July 2018	
									3)Work with community partners to establish additional housing and support options.	Clinical Vice-Presidents explore further opportunities to establish housing and support options for clients who are experiencing chronic homelessness and additional supportive housing for seniors. Connect quarterly with the NW LHIN, Home & Community Care and District of Thunder Bay Social Services Board to determine upcoming opportunities and develop proposals.	Percentage of quarterly meetings attended.	100%	

AIM		Measure							Change				
Quality dimension	**Issue**	**Measure/Indicator**	**Type**	**Unit / Population**	**Source / Period**	**Current performance**	**Target**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**	**Comments**
Patient-centred	**Person experience**	"How would you rate the overall quality of care you (or your family member) have received?" Excellent (complex care, rehabilitation, addictions & mental health services)	C	% / Survey respondents	In house data collection / 2017	71	73.00	Improve current performance of top box rating "excellent"	1)Increase opportunities for client satisfaction feedback in Addictions & Mental Health using additional survey tools.	Utilizing the Ontario Perception of Care Tool- Mental Health & Addictions (OPOC-MHA) at Sister Margaret Smith Centre (SMSC) results from the OPOC tool will inform further implementation of the tool in other clinical services.	First Phase roll out complete	June 30, 2018	This is a continued change idea from 2017-18
									2)Improve therapeutic relationships.	Working group to analyze baseline data collected using the Star-P Survey Tool from clients in complex care and rehabilitation inpatient services. Develop and implement change ideas.	Change ideas identified and implemented	March 2019	This is a continued change idea from 2017-18. Improving therapeutic relationships aligns with our work as a Best Practice Spotlight Organization.
									3)Extend survey administration period.	SJCG Centre for Applied Health Research will extend survey period to six weeks to increase response rate	Survey period extended.	October 2018	Current survey administration is once per year
Safe	**Safe care/Medication safety**	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.	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / October – December (Q3) 2017	65.14	70.00	This is an interim target to move towards theoretical best of 100%.	1)Educate clients and families about importance of medication reconciliation and their role in process.	The Medication Reconciliation Committee will Implement the ISMP 5 Question poster (5 questions to ask about your medications when you see your doctor, nurse or pharmacist) to educate clients and families about the importance of medication reconciliation and their role in the process.	Percentage of inpatient areas imlementing the posters.	100%	
									2)Improve discharge process.	Formalize and communicate the transfer/discharge policy & procedure. Modify the medication reconciliation intervention in Meditech to facilitate completion of Best Possible Medication Discharge Plan	Policy and procedure implemented and communicated to staff. Medication Reconciliation intervention modifications completed.	April 2018	
									3)Provide staff education.	Develop an on-line module (video) for new staff orientation and annual staff education refresher focused on practical training on how to perform medication reconciliation.	Percentage of staff completing education	95%	

AIM		Measure							Change				
Quality dimension	**Issue**	**Measure/Indicator**	**Type**	**Unit / Population**	**Source / Period**	**Current performance**	**Target**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**	**Comments**
									4)Improve quality of Best Possible Medication Discharge Plan Process	Pharmacy and clinical supervisors conduct audits using Accreditation Canada Required Organization Practices tests of compliance. Results of audits reported to Medication Reconciliation Committee.	Quarterly reporting completed	100%	
									5)Conduct Medication Reconciliation Process Improvement Review	Medication Reconciliation Committee conduct process improvement review to identify areas to improve.	Process review complete.	October 2018	
	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	62	62	Target based on not exceeding current performance.	1)Communication to all program areas to schedule and complete an assessment of risks of violence for their area.	1) Workplace Violence Assessments will be scheduled and conducted within a 12 month period beginning Fall 2017 to identify the risk of violence. The assessments with be scheduled and facilitated by Occupational Safety Department, and a cross representation of each team will be present for the assessment.	1) Violence Risk assessments will be completed within 12 month period.	75% of risk assessments will be completed by March 31, 2019	FTE=721
									2) Complete a Code White evaluation after each code white incident.	2) A code white evaluation to be completed by teams involved after each code white incident and submitted to Occupational Safety Department. Communication to managers and teams will be provided on the requirement to complete code white evaluation forms after each code white and submitted to Occupational Safety. A survey will be conducted of all departments to determine compliance.	Percentage of managers responding to Code White Audit Survey. Percentage of code white incidents with evaluation completed.	100% of manager responding to code white survey. 100% of code white incidents with evaluation completed.	
Timely	**Timely access to care/services**	Time in days from date of referral from Thunder Bay Regional HSC (acute care) to admission to inpatient complex care and physical rehabilitation (excluding hospice, transitional care and mental health).	C	90th percentile / Admitted inpatients excluding hospice and transitional care	In house data collection / October to December 2017	7	5	Reduce by 28% moving towards 3 day benchmark set by Rehabilitative Care Alliance.	1)Improve discharge planning process to reduce delays in discharge	1)Refresh setting estimated date of discharge (EDD) on admission process and posting EDD on whiteboard. On monthly basis, JDOT committee review list of clients exceeding EDD with reasons.	Percentage of monthly reviews completed by JDOT.	100%	This indicator is also impacted by ALC days due to system capacity for long term care and supportive housing.