St. Joseph's Hospital

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

St. Joseph's Care Group 35 North Algoma Street Box 3251, Thunder Bay , ON, P7B5G7

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
Access and Flow	Timely	90th percentile Acute Care wait time for a Rehabilitative Care Bed. The time in days from date of acute care referral to date admitted to rehabilitative care bed	C	90th percentile / Rehab Care Inpatients	Local data collection / April to December 2023	Hospital	6	4.00	Improved performance to reach provincial target	1)Further develop and implement acute/post-acute care process improvements that support client transitions in collaboration with all system partners, e.g Thunder Bay Regional Health Sciences Centre, Long-term Care, Home and Community Care Services	1. Expand Joint Transitions in Care Committee to include Long-term Care, Mental Health Services, and Supportive Housing to facilitate client flow 2. Prioritize and implement MOH Operational Direction - Rehabilitation and Complex Continuing Care Capacity and Flow strategies	1. Structured Transitions in Care workplan that supports client flow and improves processes, practices and pathways for clients requiring alternate levels of care is complete 2. Number of improvement opportunities identified and prioritized by Q4 and the top priority implemented by Q4 based on the gap analysis which addressed on MOH Direction - Rehabilitation and Complex Continuing Care Care Capacity and Flow Inpatient Rehab.	1. Time in days from date of acute care referral to date admitted to rehabilitative care bed 2. Occupancy Rate >95% 3. ALC throughput >1
Equity	Equitable	Number of referrals for Indigenous Traditional Healing and Medicine	C	Number / All patients	Local data collection / April to December 2023	Hospital	57	62.00	Improve current performance by 10 percent	1)Self-ID implementation, department/program education (services/referral pathways)	1. Meet with department directors and program managers to establish a process to roll out Self-ID. 2. Share information about the Self-ID process and Indigenous Health/Traditional Healing programs/services.	1. Individual program processes established. 2. All departments/programs are aware of the Self-ID process and Indigenous Health department/Traditional Healing services	Self-ID rolled out in 95% clinical areas by June 2024
		Percentage of staff who have completed relevant equity, diversity, inclusion, anti-racism education - Repairing the Sacred Circle 2 (Management)	C	% / Management	In house data collection / 2024	Hospital	CB	75.00	first year data collection	1)Develop communication and promotion strategy to all management of the identified education.	Implementation/communication plan: 1. Leadership Team messaging of QIP indicator. 2. Communication to Management Team of QIP indicator and 24/25 targets.	Communication plan complete by Q2.	100% communication/promotion roll out complete by end of Aug 2024
		Percentage of staff who have completed relevant equity, diversity, inclusion, anti-racism education - Wake the Giant (all staff)	C	% / Staff	Local data collection / 2023	Hospital	73	90.00	Improve current performance	1)Develop communication and promotion strategy for all staff	Communicate during spring hire and summer BBQ's	Communication plan complete by Q2	100 % promotion activities complete by Q3
Experience	Patient-centred	"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? Response: Completely	C	% / Rehab Care Inpatient	In-house survey / April-Dec 2023	Hospital	51	54.00	5% improvement on current performance	1)Evaluate PODS audits, post-discharge call back and remote care monitoring data to identify gaps and develop and implement improvement strategies that address priorities	1. Working group - including CFP and front line staff to review data and identify priority area's for improvement. 2. Develop action plan that included the top 2 identified priorities 3. Implement priorities	1. Data reviewed and priority areas for improvement identified 2. Action plan developed 3. Priorities implemented	1. Process completed May 2024 2. Action plan developed by July 2024 3. Priorities implemented by Sept 2024
		"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? Response: Completely	C	% / Mental health patients	In-house survey / 2023	Hospital	45	47.00	5 percent improvement on current performance	1)Monitor discharge calls from Social Work within 7 days of discharge to support questions and provide information or resources post discharge.	Monitor number of calls made monthly rather than quarterly to mitigate challenges to achieving the proposed target. Identify challenges in reaching clients in the proposed time period and enhance process information to clients at immediate discharge to support follow-up in 7 days.	Number of Post Discharge calls made each month	Achieve 100% of calls within 7 days of discharge

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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
		"Do you feel that you can raise a concern about staff without it negatively affecting your (or your family members') care? Response: Yes Definitely	C	% / Inpatient Rehab and Mental Health	In-house survey / 2023	Hospital	32	34.00	5% improvement on current performance	1)Develop and implement a standardized promotion/communication strategy that informs clients and families about how to raise a concern.	Implement the following strategies: 1. Develop and post signage in common spaces and clinical areas that outline the options to raise a concern 2. Develop scripted messaging that staff can provide clients with at and throughout admission to hospital regarding the raising a concern process 3. Include the processes to raise a concern in admission packages where applicable	1. Signage is posted 2.Scripted message developed and shared with staff. 3. Admission package includes " how to raise a concern"	100 % strategies in place by September 2024
		"How often did staff involve you in planning your (or your family members') care?" Response: Always	C	% / rehab care inpatients	In-house survey / 2023	Hospital	52.5	55.00	5% improvement on current performance	1)Revise and standardize care planning processes to ensure that they are client-centred, timely and goal-oriented based on 2023/24 QIP care planning improvement initiatives.	1) Identify gaps, apply care planning principles and implement process redesign across all inpatient rehab units to ensure care plans are client-centred, timely and goal oriented	Number of Inpatient Rehab. Units that implement/integrate new care planning principles and processes	Implementation/ integration of new care panning principles and processes on 100% of Inpatient Rehab Units
		"How often did staff involve you in planning your (or your family members') care?" Response: Always	C	% / mental health inpatient	In-house survey / 2023	Hospital	62	65.00	5% improvement on current performance	1)Continue to initiate Wellness planning within 4 weeks of admission	Monitor number completed monthly rather than quarterly to mitigate challenges to achieving the proposed target	Number of Wellness plans reported by staff and tracked by the PSR Coordinator	80% completion of Wellness planning within 4 weeks of admission.
		"How often did staff listen carefully to you?" Response: Always	C	% / in patient	In-house survey / 2023	Hospital	50.8	53.00	5% improvement on current performance	1)Formalize a process utilizing the client white board to promote listening and enhance communication with clients and their care team. When done collaboratively the white boards enhance equal partnership in clients plan of care	1. Working group- including CFP to formalize white board process 2. Education 3. Formal whiteboard audits 4. Identify priority area's for improvement based on audits	1. Formal process in place to utilization of white boards 2. Share education at all QPCs 3. Collect baseline data 4. Establish an action plan	1. Process complete May 2024 2. 100% June 2024 3. Collected- June 2024 4. Action plan complete- Sept 2024
Safety	**Safe**	Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.	C	Number / Staff	In house data collection / Jan-Dec 2023	Hospital	60	67.00	Reduce 10% from current performance	1)Develop a Policy and Procedure (P&P) for Responsive Behaviours for Rehabilitative Care Division	The P&P will be developed with input from membership of the Responsive Behaviour QI Working Group, and other relevant stakeholders.	Policy and Procedure is drafted, completed and approved, and rolled out	Policy complete and rolled out to all clinical staff by Dec 31/24)