2016/17 Quality Improvement Plan
"Improvement Targets and Initiatives"

St. Joseph's Healthcare Hamilton

St. Joseph's Health Care System-Hamilton 50 Charlton Avenue East

AIM		Measure							Change				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
Effective	**Reduce readmission rates for patients with COPD**	30-day All Cause Readmission rate for Patients with COPD (QBP cohort)	% / COPD QBP Cohort	DAD, CIHI / 2 year baseline - FY 2012-2014	674*	21	19.00	This is a 10% reduction.	1)Continued work with patients enrolled in the Integrated Comprehensive Care Program (ICC)	Evaluation consists of the monitoring of ICC enrolled patients and their readmission rate.	Number of enrolled patients, readmission rate.	Continue to optimize the program.	
									2)Reinforce teach-back education methodology.	Education and engagement of staff.	Teach-back performed and documented for COPD patients prior to discharge.	Teach-back will enhance the comprehension of education provided to	
									3)Ensure all eligible and interested patients are enrolled in Caring for my COPD -a community based program.	Standardize process to identify and refer patients into the program.	Number of patients successfully enrolled into the program.	COPD patients enrolled in this community-based program have additional support	
	Enhance transition to the community - Schizophrenia Services	Percent of planned discharges that receive all components of the "Keys to Discharge"	% / Mental Health / Addiction patients	Hospital collected data / Fiscal	674*	0	100.00	The program strives to work with all patients collaboratively on their	1)Implement the "Keys to Discharge" program in the Schizophrenia Community Integration Services on Harbour North 2.	Implementation of program.	Percent of planned discharges who receive all components of the program.	100% of planned discharges receive all components of the program.	
Efficient	**Reduce unnecessary time spent in acute care**	Total number of ALC inpatient days contributed by ALC patients within the specific reporting period (open, discharged and discontinued cases), divided by the total number of patient	% / All acute patients	WTIS, CCO, BCS, MOHLTC / July 2015 – September 2015	674*	14	9.47	We aim to achieve the provincial target of 9.47%	1)Avoid admission of patients in the Emergency Department who could be cared for in the community.	Daily rounding of all patients in the Emergency Department by hospital and CCAC staff.	Number of patients with an intent to admit who were instead initiated on enhanced community services. Balancing with re-admission to the emergency department.	To avoid admission of patients who do not require acute care.	tbd
									2)Fully implement home first philosophy.	Key milestones in the Home First Refresh include the 48 hour conversation, a family meeting (formal or informal such as a phone call), ALC designation as appropriate with a CCAC referral happening beforehand.	48 hour conversation, family meetings, ALC designation	reduction in ALC days	
Patient-centred	**Improve Patient Experience**	Percent of patients that have a conversation with their healthcare provider within 48	% / All acute patients	Hospital collected data / March 2017	674*	50	80.00	This will build on the work done in 2015/16 to achieve 50%, increasing to	1)Continued roll-out of the 48-hour conversation	Continued engagement with healthcare providers, frequent follow-up and support from the front-line staff.	Documentation of the 48-hour conversation	To increase documented 48 hour conversation from 50% to 80%	
Safe	**Increase proportion of patients receiving medication reconciliation upon admission**	Medication reconciliation at admission: The total number of patients with medications	% / All patients	Hospital collected data / most recent quarter available	674*		90.00	90% of patients admitted to ICU, MSDU, nephrology inpatient units	1)Expand medication reconciliation into our Critical Care areas (ICU and Medical Step Down) as well as to inpatient Nephrology	This will be accomplished by establishing a process for obtaining and documenting this information.	Completed and documented medication reconciliation for 90% of patients admitted to these units.	Increased documentation of medication reconciliation upon admission to these	
	Enhance antibiotic stewardship in General Internal Medicine	Enhance appropriate antibiotic usage and timely cessation of antibiotics in the General Internal	Number / All acute medical patients	Hospital collected data / March 2017	674*	CB	75.00	75% of patients on acute medicine units who are prescribed	1)Enhance appropriate antibiotic usage and timely cessation of antibiotics.	Develop a standardized approach and documentation for 3-day reviews.	Percent of patients receiving a 3-day review.	To ensure that patients on antibiotics are receiving a review. That all acute	
	Implement Early Warning Score	To implement an early warning score as part of the vital signs reporting tool for nursing.	Number / Acute nephrology, medical patients	Hospital collected data / Fiscal	674*	0	3.00	The early warning system will be implemented for 100% of patients	1)Implement Early Warning System on nephrology inpatient unit as well as 2 General Internal Medicine units.	Implementation of Early Warning scoring system as part of vital signs nursing documentation.	The implementation of the system.	To implement the system for 100% of patients on 3 inpatient units.	
Timely	**Improve Access for Mental Health patients referred to Dual Diangosis Clinic**	Percent of patients seen within 60 days of referral.	Days / Mental Health / Addiction patients	Hospital collected data / March 2017	674*	48.6	61.00	This target aligns with planned process improvements related to the	1)Improvements in intake process as well as clinic structure.	A multidisciplinary approach to process improvement.	Improvements related to the intake process.	To reduce wait time and ensure that 61% of clients have their first appointment with	