# 2017/18 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 | 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** | Risk-adjusted 30-day all-cause readmission rate for patients with CHF (QBP cohort) | Rate / CHF QBP Cohort | CIHI DAD / January 2015 - December 2015 | 674* | 23.47 | 19.50 | Overall, we would like to reach the HNHB LHIN target of 15.5%, this is a | 1)Development and implementation of care pathway. | With the implementation of a new electronic health record, this is a great opportunity to develop a care plan for this group of patients. | Development and use of care pathway. | CHF care pathway is used for 80% of CHF patients by February 2018. | |
| | | Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort) | Rate / COPD QBP Cohort | CIHI DAD / January 2015 – December 2015 | 674* | 20.65 | 15.50 | 15.5% is the HNHB LHIN and provincial target. | 1)Revise care pathway for COPD patients. | While implementing new IT system, this is a great opportunity to review the current care pathway and revise in order to meet our current challenges. | Measure and monitor use of care pathways. | COPD care pathway used for 75% of COPD patients. | |
| | | | | | | | | | 2)Standardize education for COPD patients. | Engage patients and staff to develop comprehensive education. | 70% of COPD patients will receive an education package and Action Plan for discharge while in hospital. | 70% of patients. | |
| | | Implement Standards of Practice for Transitions on Seniors Mental Health and Complex Care units. | % / Hospital admitted patients | In house data collection / 2017/18 | 674* | CB | 85.00 | This is a new standard of practice which includes multiple elements and responsibilities across team members. This is deemed to be a realistic target. | 1)Identify resources and work-flow for 48-hour post-discharge phone calls. | Develop work flow by end of summer 2017 | Approved template reported to steering committee. | End of summer 2017 | |
| | | | | | | | | | 2)Identify topic areas for mandatory use of teach-back method. | Review literature and engage staff and patients. | Monitored by Steering Committee | Topic areas identified by June 15, 2017 | |
| | | | | | | | | | 3)Develop toolkits and educational materials for staff. | Review literature, connect with colleagues, engage staff and patients. | To be monitored by Steering Committee. | Completion of education by September 15, 2017 | |
| **Patient-centred** | **Person experience** | To ensure that newly admitted patients participate in a conversation regarding their plan | % / Mental health patients | In house data collection / 2017/18 | 674* | CB | 80.00 | This is a new practice for these units. | 1)To integrate the 48-hour conversation into standard practice on these units. | Components of conversation will include 1) diagnosis or process for arriving at a diagnosis, 2) treatment plans and process for treatment planning, 3) possible barriers to discharge and methods for dealing with those barriers, 4) an expected discharge date | Educational material developed for staff with staff and patient involvement. | Will be monitored by Steering Committee. | |
| **Safe** | **Medication safety** | Improve antimicrobial use in General Surgery. | % / Hospital admitted patients | In house data collection / 2017/2018 | 674* | CB | 75.00 | This will build on the antimicrobial stewardship work already | 1)Implement a systematic process to complete and document day-3 antibiotic reviews on the General Surgery floor (for surgical | An important piece of this work is incorporating documentation in to daily work flows. This will involve engagement of staff. | Monthly audits beginning April 2017. | Expect to achieve 50% by October 2017, and full implementation by March 2018. | |
| | | Increase the number of patients receiving medication reconciliation at admission in 2 acute | % / Mental health patients | In house data collection / 2017/18 | 674* | 53 | 90.00 | This builds on the work already being done through the organization to | 1)Implement a systematic process to complete and document admission medication reconciliation on 9 and 10 acute mental | Use a standardized process for Best Possible Medication History (BPMH) collection. | Monthly audits beginning April 2017. | To have full implementation by March 2018. | |
| | **Staff Safety** | Implementation of the Safewards program on 10 Mental Health and Addiction units. | Number / Mental health patients | In house data collection / 2017/2018 | 674* | 5 | 15.00 | The organization has a goal to implement this program to all of our Mental | 1)This model by Len Bowers in the UK has gained international attention for its simplicity and effectiveness. There are 8 | Education for staff is the main method of this implementation. | Will be monitored by the Steering Committee | The first 4 modules will be implemented by June 2017 and the second 4 modules | Attention to sustainability will be required on an on-going basis. |
| **Timely** | **Timely access to care/services** | Decrease the percent of patients who re-visit the Emergency Department for Mental Health or Substance Use concerns within 30 days of initial visit by April 2019. Year 1: establish LHIN | % / Mental health patients | CIHI NACRS / 2018/19 | 674* | 21.6 | 16.30 | This initiative will be implemented over a 2-year period. | 1)Reduce unnecessary ED visits via EMS presentation for individuals with MH needs. | To be determined through collaboration with LHIN steering committee. | Will be monitored by the Steering Committee | Model proof of concept by June 2017 | |
| | | | | | | | | | 2)Provide a safe alternative to ED for patients presenting with primarily alcohol intoxication. | exact methods to be determined by LHIN steering group | To be monitored by the Steering committee | Proof of concept to be launched by Fall 2017 (pending approval of proposal) | |