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

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

| Aim | | Measure | | | | | | |
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| Quality dimension | Issue | Measure/Indicator | Type | Unit / Population | Source / Period | Organization Id | Current performance | Target |

M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) A= Additional (do not select from drop dow

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| **Effective** | **Coordinating care** | Implement the After Visit Summary (Patient Oriented Discharge Summary) | C | % / Hospital admitted patients | Hospital collected data / 2018/19 | 674* | 7.2 | 90.00 |
| | **Effective transitions** | Decrease the percent of patients who re-visit the Emergency Department for Mental Health | C | % / Mental health patients | CIHI NACRS / 2018/19 | 674* | 22 | 16.30 |
| | | Decrease the percent of patients who revisit the Emergency Department for Substance Use | C | % / Mental health patients | CIHI NACRS / 2018/19 | 674* | 36.22 | 22.40 |
| | | Reduce 30-day readmissions for patients with complex wounds and/or ostomies. This is a | C | Rate / Hospital admitted patients | CIHI DAD / 2018/19 | 674* | 7.3 | 7.30 |

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| | | Reduce readmissions for patients with CHF (Congestive Heart Failure). | C | Rate / CHF QBP Cohort | CIHI DAD / 2018 | 674* | 23 | 15.50 |
| | | Reduce readmissions for patients with COPD (Chronic Obstructive Pulmonary Disorder) | C | Rate / COPD QBP Cohort | CIHI DAD / 2018 | 674* | 24.2 | 15.50 |
| **Patient-centred** | **Person experience** | Standardize patient/family communication boards in 2 General Internal medicine | C | % / Hospital admitted patients | Hospital collected data / 2018/19 | 674* | 0 | 95.00 |
| **Safe** | **Safe care/Medication safety** | As we are working towards a zero suicide organization, this indicator is part of this overall | C | % / ED patients | Hospital collected data / 2018/19 | 674* | 49 | 100.00 |
| | | Increase the percent of ED patients with sepsis who receive first dose of antibiotic within 2 hours of first | C | % / ED patients | Hospital collected data / 2018/19 | 674* | 35 | 80.00 |

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| | **Workplace Violence** | **Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.** | **MANDATORY** | **Count / Worker** | **Local data collection / January - December 2017** | **674*** | **756** | **831.00** |

| | Change | | | |
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| **Target justification** | **Planned improvement initiatives (Change Ideas)** | **Methods** | **Process measures** | **Target for process measure** |
| n menu if you are not working on this indicator) C = custom (add any other indicators you are working on) | | | | |
| This is per our Memorandum of Understanding through the ACRTIC | 1)To implement the After Visit Summary on seven inpatient units according to the PODS (Patient Oriented Discharge Summary) | Working collaboratively with Patient and Family Advisors and staff, to design the After Visit summary in a way that is useful for Patients and their families. | Ensuring After Visit Summaries are fully completed through audits. | 90% of After Visit Summaries are fully completed. |
| This is the provincial target. | 1)Drop in DBT low barrier group in close proximity to ED weekly for 8 week trial | Run trial for 8 weeks at a time. | Number of patients completing trial. | That patients who participate in the trial will have fewer ED re-visits. |
| This is the provincial target. | 1)Create individualized care plans for patients with frequent vists. | Work with Health Links team to prepare care plans. | Number of patients with completed care plans. | High users have care plans completed. |
| The first year of the project will be to identify causes for readmission and | 1)Reduce 30-day readmissions for patients with complex wounds and/or ostomies. | Complete a full review of discharge practices for patients with complex wounds and/or ostomoies. | Year 1 process is to complete a review of the process and create a project plan. | Completation of project plan. |

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| This is the provincial target. | 1)Implement and apply a CHF care pathway. | Using the EMR, embed into clinical documentation. | Number of CHF patients with applied care path. | Care path to be applied to 90% of CHF patients. |
| | 2)Develop and implement a CHF virtual care team. | Virtual care team would meet 4-5 times per week and review all CHF patients and ensure all had comprehensive discharge plans. | Percent of patients part of virtual care team. | 80% of patients would be part of virtual care team. |
| This is the provincial target. | 1)Implement and apply a COPD care pathway and incorporate into EMR documentantation | Incorporate documentation into EMR for the COPD care pathway | Number of patients with care pathway applied. | 90% of COPD patients to have care pathway applied. |
| We are aiming to have as close to full compliance on this as possible. | 1)Standardize communication board design. | GIM quality council to finalize design and present to Patient and Family Advisory Council. | Final design of board. | Communication boards installed by June 30, 2018 |
| The goal of achieving zero suicides means not missing a single person | 1)Complete the Columbia Suicide Risk Screening Tool for all patients deemed to be at risk during triage in the Emergency Department | Triage process will be adjusted so that patient history is incorporated into the assessment. | Percent of patients receiving the assessment as appropriate. | 100% of patients at risk receive the Suicide Risck Screening Tool. |
| Current performance will be improved by 45%. Achieving this target will | 1)Increase the percent of ED patients with sepsis who receive first dose of antibiotic within 2 hours of first notigication of septic | Triage process will be adjusted so that all patients wtih a low blood pressure and SIRS positive will receive a lactate screening. If lactate comes back positive, the patient will be immediately assessed by the physician for septic symptoms. | Percent of patients receiving first dose of antibiotic within 2 hours. | 80% of patients to receive first dose of antibiotic within 2 hours of notification of |

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| **There was over 100% increase in reporting from 2016 to 2017. The anticipated improvement to 2018 is 10%.** | **1)Increase the reporting of healthcare worker violence incidents.** | **- Support to Report campaign launched in 2017 will continue into 2018. Joint leadership and Joing Health and Safety Committee promotion of reporting all incidents, hazardour situations and near misses. - Occupational Health and Safety follow-up of every incident report ss well as monitor trending on a monthly basis - to review the on-line healthcare incident report for improvements and implement changes as necessary.** | **The process measure that will be tracked is the reported number of incidents.** | **Increase the number of reported incidents by 10% in 2018.** |

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| Comments |
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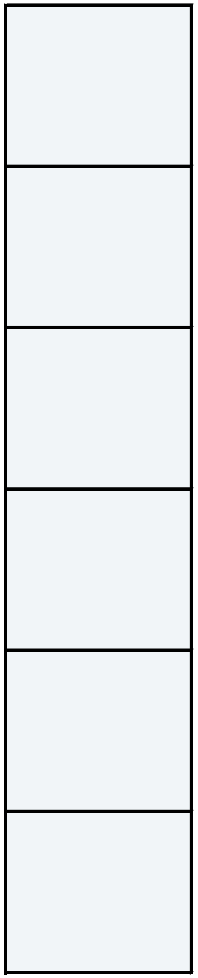

FTE=3562 SJHH achieved over a 100% increase in reported incidents from 2016 to 2017. We expect to continue to see an increase again from 2017 to 2018 however at a