2014/15 Quality Improvement Plan for Ontario Hospitals
"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	Priority level	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
Access	Reduce wait times in the ED	ED Wait times: 90th percentile ED length of stay for Admitted patients.	Hours / ED patients	CCO iPort Access / Q4 2012/13 – Q3 2013/14	2003	27.95	25	COMMENT This is the current SJHH internal target; previously set by HNHB LHIN as part of its Pay for Results Program. We continue to work to reduce wait times as part of business operations and are pleased to have achieved a very low 'time to initial physician assessment' and very low rates of 'left without being see by a physician'.	Maintain					
Effectiveness	Improve organizational financial health	Total Margin (consolidated): % by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expense, excluding the impact of facility amortization, in a given year.	% / N/a	OHRS, MOH / Q3 2013/14	4054	0.49	0	COMMENT: Our corporate goal is to maintain a low current ratio. We are committed to continuing our strong track record in balancing our books. The current ratio is within our acceptable range.	Maintain					
	Reduce unnecessary deaths in hospitals	HSMR: Number of observed deaths/number of expected deaths x 100.	Ratio (No unit) / All patients	DAD, CIHI / 2012/13	674*	93	93	COMMENT: The HSMR is below 100 - meaning that there are fewer deaths than expected, given the serious illnesses faced by some of our patients. Many of our 25 quality improvement projects contribute to a reduction in deaths and we use this indicator to look for opportunities to improve.	Maintain					
Integrated	Reduce unnecessary time spent in acute care	Percentage ALC days: Total number of acute inpatient days designated as ALC, divided by the total number of acute inpatient days.	% / All acute patients	Ministry of Health Portal / Q3 2012/13 – Q2 2013/14	674*	14.87	11	COMMENT: This indicator suggests that there are patients in hospital who could be discharged home, or to a nursing home, sooner than they currently are. We continue to work with our community partners to move closer to our goal, and the goal of the HNHB LHIN, by improving discharge processes and building capacity in the community.	Maintain					
	Reduce unnecessary hospital readmission	Readmission to any facility within 30 days for selected CMGs for any cause: The rate of non-elective readmissions to any facility within 30 days of discharge following an admission for select CMGs.	% / All acute patients	DAD, CIHI / Q2 2012/13-Q1 2013/14	674*	19.22	15	COMMENT: Plans are being developed to reduce readmission rates, but are not ready for this cycle of our Quality Improvement Plan (QIP). We have already achieved reductions for specific patient groups as part of our project with St. Joseph's Home Care called 'Integrated Coordinated Care (ICC) Project' which was funded as part of the Ministry of Health and Long Term Care's commitment to the Excellent Care for All Act (ECFAA).	Maintain					
Patient-centred	Improve patient satisfaction	In-house survey (if available): provide the % response to a summary question such as the "Willingness of patients to recommend the hospital to friends or family" (Please list the question and the range of possible responses when you return the QIP).	% / Other	In-house survey / Other	674*	93	85	COMMENT: We have developed an in-house patient satisfaction tool that allows: a rapid turnaround so that our clinical units can get feedback fast; a section for clinical units to ask their own questions; and flexibility in the method of surveying with options such as mail out, hand to patients or use with smart phones.	Maintain					
Safety	Increase proportion of patients receiving medication reconciliation upon admission	Medication reconciliation at admission: The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital.	% / All patients	Hospital collected data / Most recent quarter available (e.g. Q2 2013/14, Q3 2013/14 etc)	674*	67	100	Our goal is to improve medication reconciliation on admission to our Rehabilitation Unit. This is one step in our plan to improve medication reconciliation across the organization. (This indicator addresses only 'admission' but as part of our broader plan we also include improvements to medication reconciliation on discharge.)	Improve	1)Medication will be reconciled for 100% of patients admitted to Rehabilitation Services.	Implemented a focused medication reconciliation strategy. When completed properly, medication reconciliation reduces the possibility that medications will be omitted inadvertently, duplicated or incorrectly ordered at transitions of care.	1. Planning, training, and implementation of admission MR for patients in the rehabilitation service. 2. Outcome indicator – completion rate for patients admitted to Rehab Services in February/March 2015.	1. Process indicator – planning, training, implementation of admission MR for all patients in the rehabilitation service. 2. Outcome indicator – completion rate of 100% for patients admitted to Rehab Services in February/ March 2015.	

Reduce hospital acquired infection rates	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1,000 - Average for Jan-Dec. 2013, consistent with publicly reportable patient safety data.	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / 2013	674*	0.59	0.39	Our goal is to reduce CDI rates through a variety of infection control methods. For this years plan we will focus on improvement management of antibiotics.	Improve	1)Introduce best practices that reduce the need for antibiotics Our goal is to introduce best practices that reduce the need for antibiotics during hospital care. The use of antibiotics is a major risk factor for CDI. For 2014/15 our focus will be on a reduction in the use of urinary catheters because they increase the risk of urinary tract infections that require antibiotics used to treat them.	We will introduce a protocol to standardize the assessment of the need for a urinary catheter and changes in practice that will reduce the use of catheters in total joint replacement surgery and colorectal surgery. We will further reduce the risk of infection by switching to pre-assembled catheters.	• protocol to standardize the assessment of the need for a urinary catheter • reduction in the use of urinary catheters in total joint replacement surgery • reduction in the use of urinary catheters in colorectal surgery • switch from manually assembled urinary catheters to pre-assembled urinary catheters	• introduction of protocol to standardize needs assessment for urinary catheters • a 25% reduction in the use of urinary catheters in total joint replacement surgery • a 25% reduction in the use of urinary catheters in colorectal surgery • pre-assembled urinary catheters used where clinically appropriate.	
Patient Shadowing Project	Completion of a Patient Shadowing Project. The project will be co-designed by hospital staff and members of our Patient and Family Advisory Council.	Project Completion / All patients	Project Report Out / Q4	674*	0	1	Our Patient and Family Advisory Council, our Board, our Executive and other leaders in the organization have highlighted 'Patient Shadowing' as a best practice we should introduce as part of our commitment to engaging patients and families as active partners in quality improvement.	Improve	1)Introduce patient shadowing using a pilot project. Patient shadowing will provide a mechanism to identify improvement opportunities from the bedside perspective of our patients and their families. The direct involvement of our Patient and Family Advisory Council as co-designers brings a powerful added dimension and face validity to the project.	This is a joint pilot project led and co-designed by our Patient and Family Advisory Council and hospital staff. Volunteers from the project team will join patients and families to share their experience in hospital minute-by-minute, and day-by-day. The project team will then take the lessons learned to our staff so that they can make service improvements that are truly grounded in the needs of patients and families.	Completion of Project	Completion of Project	
Reduce seclusion in mental health	The number of seclusions in 3 phase one clinical units as measured in Quarter 4 of the fiscal year. Seclusions are measured by clinical staff who use hand held electronic tablets to conduct assessments and to monitor the health and well-being of patients at regular intervals.	Counts / Mental Health Patients in Three Clinical Units	See definition above. / Q4	674*	CB		We have selected a target reduction of 25% in the number of seclusions in our three Phase 1 Clinical Units. Each Phase 1 Clinical Unit will implement a debriefing after every seclusion incident.	Improve	1)Our goal is to reduce Seclusion Incidents in Mental Health by debriefing with the clinical teams involved after every seclusion.	We will introduce seclusion debriefings after every seclusion in three clinical units as phase one of our plan to introduce seclusion debriefings as a standardized practice. Debriefing will allow the teams to learn from seclusion incidents so that future seclusion incidents can be prevented. The debriefing process will also provide a mechanism to sustain the improvement.	Number of Preventable Seclusions on Phase 1 Units	25% Reduction in Preventable Seclusions in the three Phase 1 Units	