2019/20 Quality Improvement Plan
"Improvement Targets and Initiatives"

St. Joseph's General Hospital 70 Spine Road

AIM		Measure									Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Theme I: Timely and Efficient Transitions	**Efficient**	Total number of Alternate Level of Care (ALC) days contributed by ALC patients within the reporting period.	C	% / All patients	In house data collection / April - December 2019	650*	46	45.00	We feel that the goal of reducing by 1% is appropriate considering the fact that the % of ALC patients varies and our community demographics, resources and availability of LTC beds significantly impacts our daily ALC rate. SJGHEL is not a paid for performance hospital therefore we do not meet volumes to report rates.	Red Cross, North East Local Health Integration Network	1)Hospital to approach the NELHIN for Crisis 1A status when ALC rates reach 45%.	Organize a conference call with the NELHIN	# of times ALC rates reach 45% or higher and a conference call is organized	The hospital will be granted Crisis 1A status 100% of the time when the call is initiated	The consideration of the type of accommodations required in LTC will influence success of being granted Crisis 1A status
											2)Continue to work in partnership with the RED Cross PATH program to increase referrals	Red Cross PATH will continue to monitor the number of patients referred monthly and those who access the service.	# of patients referrals sent to the PATH program	PATH will continue to meet their targets sent by Red Cross	Our goal is to continue to increase referrals to the PATH program
											3)Continue to work with the NELHIN on our ALC Avoidance Strategies such as implementing a risk stratification tool -Blaylock screen to identify patients at high risk for ALC designation and to remove/ address barriers to patients being discharge home	Meet weekly for ALC Avoidance Rounds which includes the multidisciplinary team and external partners such as Home & Community Care.	The number of positive Blaylock screens (12 or higher) that avoided ALC designation	75% of patients with a score of 12 or higher on the Blaylock screen will avoid ALC designation by Dec 31, 2019	
Theme II: Service Excellence	**Patient-centred**	Percentage of complaints received by the Patient Relations Officer are acknowledged with in 5 business days to the individual who made the complaint.	C	% / All patients/ families/ visitors	In house data collection / April 1 to Dec 31, 2019	650*	CB	CB	This is a new indicator for the organization		1)Patient Relations Officer will establish a process for receiving complaints via telephone, email, or in person to be accessible in multiple ways	Develop a method of gathering data on when a complaint is received and acknowledged	% of complaints acknowledged within 5 business days	80% of complaints received by the Patient Relations Officer will be acknowledged within 5 business days by Dec 31, 2019	
											2)Promote the presence and accessibility of the Patient Relations Officer	Patient relations Officer (PRO) will provide education to staff regarding the role of the PRO and distribute the pamphlet to provide to patients/families and visitors	# of staff meetings attended to provide staff education	Attend 4 staff meetings by Dec 31, 2019	

M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) C = custom (add any other indicators you are working on)

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		Percentage of individuals who indicate they "agree" to the following question on the Patient Experience Survey: " I was provided and understood the follow up or discharge instruction related to my visit".	C	% / Survey respondents	In-house survey / 2019	650*	94	95.00	We feel increasing positive responses by 1% is a reasonable goal considering we have achieved 94% last year		1)Continue to improve discharge process and tools to ensure patients better understand medications upon discharge	Develop a separate discharge medication reconciliation form (Discharge medication prescription) to highlight changes in medication prescription	Development of a "discharge medication prescription" form to complete medication reconciliation on discharge	The "discharge medication prescription" form is developed by September 1, 2019	Telephone follow up survey results indicate that the majority of questions or misunderstandings that discharged patients have relate to medications
											2)Education to nursing staff on the "Discharge Medication Prescription" form	The Clinical Educator will educate nursing staff on the new form and process	% of nursing staff trained	75% of nursing staff will be trained on the new form and process by Nov 30, 2019 and 90% by Dec 31, 2019	
Theme III: Safe and Effective Care	**Effective**	Hand hygiene compliance before patient contact - The % hand hygiene performed before initial patient contact.	C	% / All clinical staff	In-home audit / April 1 to Dec 31, 2019	650*	77	80.00	This is a reasonable goal to increase compliance by 3% considering that last year there was a 12% increase		1)Continue " Wash & Glow" hand hygiene education to enable staff and physicians to test their own hand washing technique	IPAC Manager will randomly attend departments and have staff and physicians use " wash & glow" , then wash their hands to assess the effectiveness of their hand hygiene technique. The manager will also educate on proper hand hygiene technique	# of completed "Wash & Glow" hand hygiene education sessions provided	Complete 10 "wash & glow" hand hygiene education sessions testing 60 staff by Dec 31, 2019	
											2)Complete education on hand hygiene for staff which provides an in-depth understanding of the importance of proper hand hygiene in the 4 moments	Attending staff meetings, displaying posters, providing education at new hire orientation sessions and provide an annual education blitz	# of staff that attended staff meetings and orientation sessions	100% of new staff that attend orientation session will receive hand hygiene education by Dec 31, 2019	
											3)Develop quality boards to display and communicate results of hand hygiene audits and update quarterly	Install quality boards on units and in departments	The number of quality boards implemented on units and in departments	100% of units/departments will have a quality board displaying quarterly hand hygiene audit results by Dec 31, 2019	
	Safe	**Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.**	**M A N D A T O R Y**	**Count / Worker**	**Local data collection / January - December 2018**	**650***	**X**	**10.00**	**Last year our data was suppressed because our occurrence rate is less that 5% we feel maintaining 5% or less as a reasonable target**		**)Update the organizations Code White Emergency Procedure**	**The Emergency Procedures Committee will complete the research and revisions**	**The completion of the updates to the Code White Emergency Procedure**	**100% of the updates to the Code White Emergency Procedure will be completed by June 1, 2019**	**FTE=204**
											2)Complete Education for all staff on the revised Code White Emergency procedure	The Emergency Procedures Committee will develop a process for providing education to all staff which can include read and signs, attending staff meetings, and running mock drills	The % of Staff educated on the revised Code White Emergency procedure in a set period of time	80% of staff are trained in the revised Code White Emergency procedure by December 31 , 2019	

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