Theme I: Timely and Efficient Transitions

Dimension: Timely

Measure

Indicator #1	Type	Unit	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Total # of Alternative Level of Care (ALC) days contributed by ALC patients within the reporting period	C	%	Hospital collected data / April - December 2020	47.60	47.60	We feel that the goal of maintaining is appropriate considering the fact that the % of ALC patients varies and our community demographics, resources and availability of LTC/ Rehab 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 PATH, NELHIN, Home & Community Care

Change Ideas

Change Idea #1 Hospital to approach the HELPLINE for Crisis 1A status when ALC rates reach 45%

Methods	Process measures	Target for process measure	Comments
Contact the NELHIN representative to organize a conference call to review status	# of times weekly 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 requested	The consideration on the type of accommodations required (Basic or preferred) required by the patient for LTC placement will influence the success of being granted Crisis 1A status from the NELHIN

Change Idea #2 Continue to work in partnership with the Red Cross PATH program to increase discharges

Methods	Process measures	Target for process measure	Comments
Red Cross PATH will continue to monitor the # of patients referred monthly and the # of patients who access the service	# of patient referrals sent to the PATH program	100% of patients who consent to the referral to Red Cross will access the service	

Change Idea #3 Continue with ALC Avoidance Rounds to strategically and address/remove barriers to discharge home from hospital

Methods	Process measures	Target for process measure	Comments

Meet weekly for ALC Avoidance Discharge Rounds	# of positive Blaylock Screens (12 or higher) that avoided ALC designation	70% of patients with a score of 12 or higher on the Blaylock Screen will avoid ALC designation by December 31, 2020	This strategy has been extremely valuable in shifting our thinking when planning for discharge

Theme II: Service Excellence

Dimension: Patient-centred

Measure

Indicator #2	Type	Unit	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of complaints acknowledged to the individual who made a complaint within five business days.	P	%	Local data collection / Most recent 12 month period	94.12	95.00		

Change Ideas

Change Idea #1 Continue to promote the presence and accessibility of the Patient Relations Officer(PRO)

Methods	Process measures	Target for process measure	Comments
PRO will provide education to staff in general orientation regarding the role of the PRO	# of general orientations the PRO attends	100% of all general orientation sessions	

Change Idea #2 Improve the knowledge of the Patient Relations Officer role for the public who access hospital services

Methods	Process measures	Target for process measure	Comments
Distribute pamphlets to departments, post in pubic areas, and provide to patients & families	# of departments who have the information accessible	100% of departments have information displayed or available to the public	

Measure

Indicator #3	Type	Unit	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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 instructions related to my visit".	C	%	In-house survey / January to December 2020	90.00	94.00	We feel a 4% increase is a reasonable target	

Change Ideas

Change Idea #1 Develop a separate discharge medication reconciliation form (Discharge Medication Prescription for the patient) to provide a comprehensive list of medications and to highlight new medications prescribed on discharge from hospital

Methods	Process measures	Target for process measure	Comments
Develop a "discharge medication prescription" form to complete medication reconciliation upon discharge	The "discharge medication prescription" form is developed	The "discharge medication prescription" form is developed by September 1, 2020	Follow up telephone calls with discharged patients revealed a misunderstanding with the current medication reconciliation form- Patients did not understand that this was their discharge prescription.

Change Idea #2 The Clinical Educator will educate nursing staff on teh new process and form

Methods	Process measures	Target for process measure	Comments
Education will be delivered by arranging huddles, attend staff meetings, communication through news letter and via 1:1 education with staff	% of nursing staff trained in new form and process	75% of nursing staff will be trained on the new form and process by Nov 30, 2020 and 90% by December 31, 2020	

Theme III: Safe and Effective Care

Dimension: Effective

Measure

Indicator #4	Type	Unit	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percent of unscheduled repeat emergency visits following an emergency visit for a mental health condition.	P	%	CIHI NACRS / April - June 2019	17.92	17.92	Currently we are below the provincial average of 21.6 and maintaining our current performance is a reasonable goal	The Oaks Treatment Centre, Counselling Centre of East Algoma, East Algoma Mental Health

Change Ideas

Change Idea #1 Develop a process for support for referral and counselling services when patients present in the ER for mental health.

Methods	Process measures	Target for process measure	Comments
Work in collaboration with The Oaks Centre and ER physicians/ staff to develop a procedure for accessing specialized drug & alcohol / mental health counselling for patients who present to the ER department and consent to accessing services	# of patients who access the counselling services	100% of patients who consent to receive specialized drug & alcohol / mental health counselling access the service in the ER by December 31, 2020	

Measure

Indicator #5	Type	Unit	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Hand Hygiene compliance before patient contact- The % of hand hygiene performed before initial contact	C	%	In-home audit / January to December 2020	86.00	88.00	The previous QIP 2019/20, we had an increase of 6%, we feel with continued efforts and education we can reasonably achieve a 2% increase	

Change Ideas

Change Idea #1 IPAC Manager will attend General Orientation for new employees to provide education on hand hygiene and use the "wash & Glow" to demonstrate proper technique.

Methods	Process measures	Target for process measure	Comments
# of employees in general orientation who received the education	# of employees who completed the general orientation education and " wash & Glow"	100% of new staff that attended general orientation will received hand hygiene education by December 31, 2020	

Change Idea #2 Develop Infection Control quality boards to display and communicate results of hand hygiene audits and education

Methods	Process measures	Target for process measure	Comments
Install quality boards on units and departments	The # of quality boards implemented on units and departments	100% of clinical unit/departments will have a infection control quality board by December 31, 2020	

Measure

Indicator #6	Type	Unit	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.	M	Count	Local data collection / Jan - Dec 2019	3.00	10.00	Last year our data was suppressed because our occurrence rate is less that 5% we feel maintaining 5% or less is a reasonable target	

Change Ideas

Change Idea #1 Update the Organizations Code White procedures

Methods	Process measures	Target for process measure	Comments
The Emergencies Procedures Committee will complete the research and revisions	The completion of the updates to the Code White procedures	100% of the updates to the Code White procedures will be completed by Dec 31, 2020	FTE=204 FTE = 204

Change Idea #2 Education on the revised Code White Emergency Procedure

Methods	Process measures	Target for process measure	Comments
Emergencies procedures committee will develop a process for providing education to all staff which can include read & sign, attending staff meetings, and running mock drills	The % of staff educated on the revised Code White in a set period of time	80% of all staff will be educated with the Code White procedure by Dec 31, 2020	

Change Idea #3 Provide staff with Non-Violent Crisis Intervention Training

Methods	Process measures	Target for process measure	Comments
Trained facilitators will deliver 2 day workshops on a monthly basis for 2 years in order to provide the opportunity for staff to access the training	The % of staff who attended the Non-Violent Crisis Intervention Training over a 2 year delivery period	50% of all staff have attended the Non-Violent Crisis Intervention Training in year 1	