Let's Make Healthy Change Happen.

Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

3/29/2018

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a Quality Improvement Plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein.

Overview

St. Joseph's Health Care London (St. Joseph's) is pleased to share its annual Quality Improvement Plan (QIP), which is guided by the voices of our patients and residents and reflects our passion for excellence – always. St. Joseph's QIP reflects goals in our new Strategic Plan for 2018-2021 to advance the quality and safety of the care we provide as well as the health and safety of employees and physicians, including the prevention of workplace violence.

This plan builds on previous QIPs plans to improve our performance in patient safety and medication safety, and adds goals for workplace violence prevention and safety. A new indicator, medication reconciliation on admission with best possible medication history (BPMH) completed prior, adds a focus on the quality of medication reconciliation. Our targets for completion of a team debrief following use of seclusion and restraints in our mental health patient population have increased in 2018-2019, and focus on use of best practices.

At Mount Hope Centre for Long Term Care (Mount Hope), our long-term care workplan includes indicators related to resident experience, as well as goals related to ensuring resident safety and a focus on effective care.

New goals continue in 2018-2019 to enhance our partnerships with patients, residents and their family caregivers, in the design, measurement and improvement of care. St. Joseph's values the opinions of patients, residents and family caregivers about the care and service we provide, and regularly obtains their feedback. We have included a new indicator related to patient experience at care transitions in our 2018-2019 QIP for our rehabilitation patient population. The wait time for an initial consult in St. Joseph's Pain Management Program continues the focus on timely access to care.

St. Joseph's QI Achievements in 2017-2018:

Relentless Pursuit of Safety

Many change ideas were successfully implemented that contributed to sustaining our goals and are summarized in our Progress Reports. Improved analytics for medication reconciliation also supported follow-up with specific areas close to real time. A 95 per cent corporate target for hand hygiene compliance (moment 1), as well as medication reconciliation at admission have been sustained in 2017-2018.

We exceeded our 2017-2018 target of achieving 85 per cent completion of debriefs following episodes of seclusion and restraint at our two mental health care sites in all quarters. Our success was facilitated by the availability of real-time performance reports, which allowed for follow-up if debriefs were missing and supported the efforts to ensure this practice was followed, including development of action plans to support compliance. A 95 per cent target has been set for 2018-2019 as we continue to strive for consistent compliance with this practice.

Care Partnership – partnering with our patients, residents and family caregivers

Through our strategic plan, St. Joseph's has committed to partnering with patients, residents and family caregivers in the design, measurement and improvement of care. In 2017-2018, this commitment level was enhanced through the adoption of a Care Partnership Framework, developed in consultation with those we serve.

Grounded in our Statement of Patient, Resident and Family Values, this framework depicts best practice in partnering with patients, residents and family caregivers. Within three main areas of focus – direct care, our programs and initiatives, and advocacy – we aim to inform, consult, involve, collaborate with and empower our patients, residents and their family caregivers.

Improving Care Together
Under the corporate focus of the Care Partnership, in 2017 St. Joseph's partnered with the Change Foundation on a three year project to improve family caregiver engagement and experiences across the organization. The Improving CARE Together project utilizes experience-based co-design for quality improvement.

In 2017-2018, the project team interviewed 90 patients and family caregivers and 140 staff members to further understand current experiences with engaging family caregivers in care planning. The team also held a successful co-design event with 70 participants.

Together the participants identified three priorities for improvement:

- communication and enhancing caregiver involvement in decision-making;
- family caregiver involvement at transition points (admissions and discharges); and
- education and support initiatives including workshops and resources for family caregivers.

These priorities will be the focus of the project teams' work moving forward in 2018-2019.

Mount Hope Achievements

Mount Hope not only continues to focus on resident safety and effectiveness of care, but embraces the opportunity to improve the quality of life of our residents through lived experiences.

A multi-year continuous quality improvement strategy has been developed to support quality of care and resident safety, with a primary focus on clinical programs, including; skin integrity management and pressure ulcer prevention, restraint use and reduction and prescribing of antipsychotic medication without diagnosis. We have seen significant success with the improvement strategies put into place related to restraint usage and reduction. Through assessment and intervention strategies, we saw a steady decline in restraint usage in the 2017 calendar year.

Mount Hope has also introduced and implemented a leisure and well-being model through a therapeutic recreation program, to improve resident's lived experience and quality of life.

Mount Hope will continue to set targets and benchmark quality, with a goal of sustainable quality improvement.

Resident, Patient and Client Engagement

In developing our new three year Strategic Plan for 2018-2021, there was a comprehensive engagement strategy that involved consultation (focus groups, open forums, electronic communication) with patients, families and community partners. The development of our 2018-2019 QIP included sharing our progress over the past year and input for the 2018-19 QIP from patients, residents and families through the following councils:

- Mental Health Quality and Recovery Advisory Council
- Mental Health Patient and Family Councils
- St. Joseph's Hospital Patient Council
- Parkwood Institute Patient and Family Caregiver Advisory Council
- Parkwood Institute Resident's Council
- Mount Hope Centre for Long Term Care Resident Council
- Mount Hope Centre for Long Term Care Family Council

Discussion of proposed goals, indicators and targets for the 2018-2019 QIP, supports opportunity for feedback and ongoing input from these councils.

Collaboration and Integration: Electronic Clinical Documentation

As part of the organizations 2018-2021 Strategic Plan, St. Joseph's is focused on improving digital health technology to better support patient care. St. Joseph's, together with London Health Sciences Centre (LHSC) and regional hospital partners, is undertaking a major initiative to develop a fully electronic clinical health record through a project called Clinical Documentation. An electronic health record will improve quality and patient safety.

Phase 1 and 2 of the Clinical Documentation project will include moving physician, nursing and other health discipline documentation from paper to electronic records and developing ways to better plan and deliver more personalized, standardized patient care.

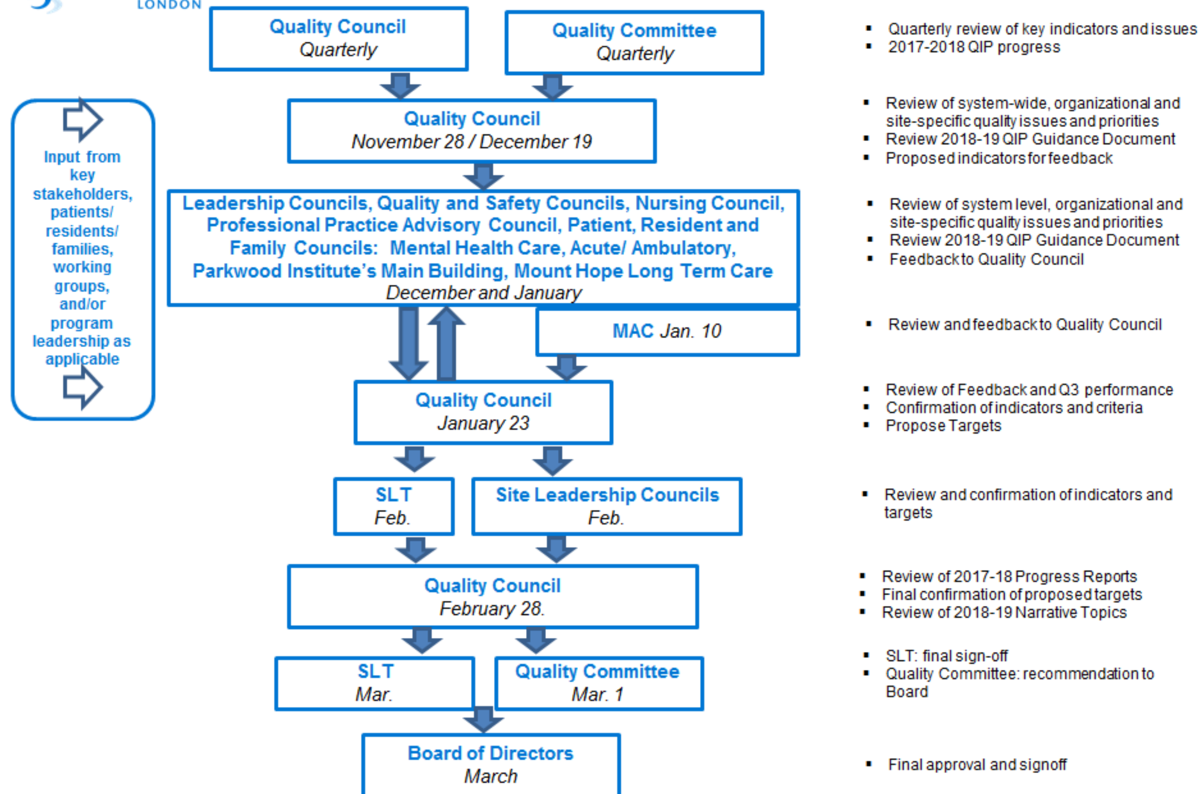
In 2018-2019 clinical teams will be engaged in the design and implementation of electronic clinical documentation at St. Joseph's in:

- our inpatient areas, (nursing only)(excluding long- term care);
- the Urgent Care Centre (physician and other health disciplines);
- inpatient and ambulatory mental health services;
- anesthesia (device integration for central monitors).

The Clinical Documentation project will build on learning from past initiatives. A key to the success of the project is the full engagement of our staff and physicians in partnership with our patients and families. St. Joseph's is seeking direction, advice and recommendations from our patient and family councils on the electronic health record, to ensure we hear and respond to their needs. As part of the project, we will launch a patient portal and in 2018-2019 and will focus on patients served by St. Joseph's Breast Care Program.

Engagement of Clinicians, Leadership & Staff

St. Joseph's has a structured and collaborative approach to determining its strategic quality improvement priorities for the organization. St. Joseph's process involves regular review of strategic indicators and progress on quality priorities. QIP development includes patient/family, staff, physician, operational, senior leader and board engagement (see diagram below).



Population Health and Equity Considerations

St. Joseph's expands mental health services for veterans, military and RCMP
St. Joseph's Operational Stress Injury Clinic (OSI Clinic) at Parkwood Institute is one of 10 outpatient clinics across Canada providing specialized mental health services to members of the Canadian Armed Forces (CAF), Royal Canadian Mounted Police (RCMP) and veterans experiencing mental health challenges as a result of their operational service. The clinic also provides services to families in support of their loved one's recovery. St. Joseph's OSI Clinic has satellite sites in Toronto and Hamilton, serving clients from across Ontario including Southwestern Ontario, the Greater Toronto Area, Hamilton and Niagara and portions of Northern and Western Ontario.

Since 2015, the OSI Clinic has seen a 57 per cent increase in referrals for its services. In addition, the clinical team identified the need to increase awareness of their services to referral sources, clients and their families. Current clients and families shared their frustration at not knowing mental health services were available to them sooner.

To meet the increased demand, St. Joseph's, in partnership with Veterans Affairs Canada, renovated and expanded its main clinic at Parkwood Institute doubling its size. This renovation offered an opportunity to hold a grand re-opening event to widely promote the services of the clinic through various external channels, with great engagement results. Future plans include an expansion of the satellite OSI Clinic in Toronto in the next year.

Partnering to care for victims of human trafficking
A novel partnership between St. Joseph's Regional Sexual Assault and Domestic Violence Treatment Program (RSADVTP) and London Police Service (LPS) is shedding new light on the toll of human trafficking on victims and how best to provide care and support for these girls and young women.

In 2017, the RSADVTP team began working with LPS's Human Trafficking Unit, providing initial examination, testing, and medical and psychological care for victims rescued by police. In this ongoing collaboration, the RSADVTP team is the first point of-care for these individuals. Located at St. Joseph's Hospital, the RSADVTP is one of the first such treatment programs in Ontario to take on this role and recently presented their experience to date at the International Conference on Forensic Nursing Science and Practice.

Care provided by the RSADVTP to victims of human trafficking has been comprehensive while respecting the wishes of the survivors. It has included: assessment and care for medical and physical needs; the collection of forensic evidence; providing reassurance and a safe place for victims to share their story; safety planning in collaboration with the police; follow-up care; facilitating contact with families; offering support and education about human trafficking to family members of victims; and more.

The team is currently working with LPS to use an interview space within the RSADVTP so that victims don't have to go to the station to give their statements.

Wrap-around support for individuals with acquired brain injury
St. Joseph's Acquired Brain Injury (ABI) Rehabilitation Program is part of a pilot project – the ABI and Corrections Collaborative – aimed at enhancing support for individuals identified in the correctional system with an ABI.

Born out of a similar initiative in Hamilton, a sub-committee of the Acquired Brain Injury Network of Southwestern Ontario was formed to develop a rapid response, wrap-around, case management-style program to be trialed out of the Elgin Middlesex Detention Centre (EMDC). In June 2017, the first pilot participant was welcomed into the ABI and Corrections Collaborative trial. The individual was released from the EMDC on July 27 and, since then, has been receiving enhanced, wrap-around supports from the collaborative partners in the community. Three additional participants have been selected and are also in the community receiving support.

Since the pilot began, more than 20 males have been screened at EMDC for the pilot by the coordinator of St. Joseph's ABI Rehabilitation Program. Those deemed appropriate to participate either receive care from the collaborative partners or are offered supports that already exist in the community.

During the pilot, many lessons have been learned and homelessness has been identified as a reality for a majority of the participants to date. Discussions are now underway to possibly expand the partnership with a view to provide housing to the pilot's participants.

Opioid Prescribing for the Treatment of Pain and Opioid Use Disorder

Opioid related morbidity and mortality has quadrupled in the past 25 years. St Joseph's is a regional leader in ambulatory care, and as such has a prominent responsibility in prescribing opioids and related medications to treat acute pain.

The organization's Medical Advisory Committee (MAC) recognized the role of St. Joseph's, to increase awareness of this issue and guide stewardship of opioid prescribing. An Opioid Stewardship Working Group (OSWG) was established in November 2017 to ensure our practices for acute pain medication prescribing are at the highest quality levels, conform to World Health Organization (WHO) best practice guidelines and align with Health Quality Ontario's (HQO) pending Quality Standards related to opioid prescribing for acute pain in individuals 15 years of age and over.

The OSWG consists of physician and non-physician leaders, pharmacists, physicians from anesthesiology and emergency medicine, information technology specialists, representatives from key nursing stakeholder groups and family caregivers. Consideration is primarily being given to prescribing for acute pain, with the focus on the three major areas in St. Joseph's Hospital where prescribing for acute pain takes place, the Urgent Care Centre, the operating room and ambulatory clinics.

The goals of the OSWG are to:

1) Improve education for prescribers about responsible use of opioids, WHO and HQO guidelines for pain, and alternatives to opioid medication.
2) Alter the hospital's technology system to ensure guiding of mindful physician prescribing.
3) Ensure patients receive educational material about the risks of opioids, other methods of pain management, and responsible disposal of unused tablets.

In addition, St. Joseph's Urgent Care Centre is part of the Adopting Research To Improve Care Mentoring, Education, and Clinical Tools for Addiction: Primary Care-Hospital Integration protocol, where opiate users are treated with Suboxone and referred to the Rapid Access Addiction Medicine (RAAM) Clinic for further evaluation and treatment.

Workplace Violence Prevention

Building a culture of patient, staff and physician safety continues to be embedded within St. Joseph's strategic plan. Workplace violence prevention is a priority specifically noted as a key area of focus in improving staff and physician safety. Lost time injuries is currently a strategic indicator reported to St. Joseph's Board of Directors. St. Joseph's has a target to reduce the number of incidents that result in significant harm/injury (require medical aid and/or time away from work to recover).

In 2017-18, we implemented an electronic system for reporting workplace violence events, replacing a paper-based system. Strategies have been implemented to encourage and support staff to report incidents in the new electronic system. It is anticipated that there will be an increase in reported incidents of workplace violence toward staff and physicians in 2018-19, and research supports there is an under-reporting of workplace violence in health care.

A key focus for staff, student and physician safety will be to continue to build a culture of reporting all incidents, including near misses and incidents that result in minimal harm. Reporting these incidents can be an early indicator of the need to augment care plans with measures to improve safety of others, and/or to enhance training of care providers to prevent/manage behaviours that may lead to harm.

The primary goal for St. Joseph's 2018-19 QIP is to increase our reporting of workplace violence incidents, and a reporting target has been set in our hospital workplan. Incidents at Mount Hope are also reported and reviewed, and will be monitored for future target setting.

Many quality improvement initiatives are underway aimed to improve the ability to recognize the potential for responsive and/or violent behaviours. Working with our patients and families, once risk is identified, care plans can be enhanced to ensure the safety of our staff and patients. Other initiatives involve assessment and improvement of staff education to meet the changing clinical and behavioural needs of the patients we serve.

Performance Based Compensation

At St. Joseph's, leaders at all levels (coordinator, director, executive) have clearly established goals for 2018-2019 and where applicable, goals are aligned with QIP priorities. Targets, 90 day plans, and monthly tracking of progress are conducted with leaders.

Our executives' compensation is linked to performance in the following ways:

- President and Chief Executive Officer (CEO) has five per cent of annual salary compensation at risk related to achievement of annual QIP indicator targets outlined below.
- All executives (senior leaders reporting directly to CEO) have three per cent of their current annual salary compensation at risk related to the achievement of annual QIP indicator targets outlined below.
- Integrated executives (those who work at both St. Joseph's and London Health Sciences Centre) will have the three per cent of their annual salary at risk evenly split between each organization (50 per cent St. Joseph's and 50 per cent London Health Sciences Centre).
- The CEO and executives reporting to the CEO will have the same targets.
- The following three indicators will be tied to performance-based compensation:
    - Medication reconciliation at admission with Best Possible Medication History (BPMH) occurring prior
    - Medication reconciliation at discharge
    - Reduction of medication errors involving wrong patient / wrong drug

Compensation will be awarded as follows:

- The three indicators carry equal weight (each one is worth 33.3 per cent)
- For each indicator:
    - Less than 50 per cent of target achieved = none of the compensation at risk will be awarded for that indicator
    - 50 to 99 per cent of target achieved = compensation at risk will be awarded for that indicator pro-rated
    - based on per cent of target achieved
    - 100 per cent or more of target achieved = 100 per cent of compensation awarded for that indicator

Indicator	Current	50 percent of Target	Target
Medication Reconciliation at Inpatient Admission *and BPMH completed prior* (Percent of inpatient admissions where medication reconciliation was complete at admission and BPMH was completed prior)	43%	51%	60%
Medication Reconciliation at Inpatient Discharge (Percent of inpatient discharges where medication reconciliation was complete at discharge)	76%	80%	85%
Medication Safety: Reduce Medication Errors involving Wrong Patient/Wrong Drug	5 per quarter	3	0

Contact Information

Vivian Capewell
Director, Quality Measurement and Clinical Decision Support

Sign-off

I have reviewed and approved our organization’s Quality Improvement Plan

Margaret Kellow
Chair, Board of Directors

Brenda Lewis
Chair, Quality Committee of the Board

Dr. Gillian Kernaghan
President and Chief Executive Officer

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

St. Joseph's Health Care London - Hospital QIP

AIM		Measure							Change				
Quality dimension	**Issue**	**Measure/Indicator**	**Unit / Population**	**Source / Period**	**Current performance**	**Target**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**	**Comments**
Effective	**Effective transitions**	Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?	% / Survey respondents, Rehabilitation inpatients	CIHI CPES / October 2016 - September 2017 (4 Quarter average, Q3 FY 2016-17 through Q2 FY 2017-18)	46.6	52.00	5% increase from the Baseline	1)Q1 - Team Communication and Engagement (including patients/family)	1.1) Directors and coordinators in the Specialized Geriatrics Services (SGS) and Rehabilitation Programs will inform/engage staff of new QIP indicator through staff meetings, unit councils and team meetings. 1.2) This indicator will be on all Leader Evaluation Manager (LEM) leadership goals for 2018-19. Examples of change ideas to be reviewed include follow up phone calls, written discharge instructions, pamphlets, etc.	1.1) The number of staff reached in information meetings out of total staff. 1.2) The number of inpatient Coordinators and Directors that will have this initiative on their Q1 LEM.	1.1) 75% of staff reached. 1.2) 100% will have this indicator on their LEM by April 27th, 2018.	We will maximize results of Changing Care Project workgroup #3 which is focused on transition.
								2)Q2 - Select one improvement activity and plan	2.1) Specialized Geriatrics Services (SGS) and Spinal Cord Injury (SCI) will work with the Changing Care team to select an improvement activity that specifically targets information patients/families receive at discharge.	The number of improvement activities brainstorming sessions completed; plan for selected activity organized.	One improvement activity selected by July 27, 2018; planning developed by September 28, 2018.	
								3)Q3 - Implement one improvement activity	3.1) Specialized Geriatrics Services (SGS) and Spinal Cord Injury (SCI) will work with the Changing Care team to implement the improvement activity that specifically targets information patients/families receive at discharge.	The percentage of patients that were discharged who participated in the improvement activity.	75% of discharged patients will have received the new activity by December 31st, 2018.	
								4)Q4 - Measure and Evaluate	4.1) Review results from NRC Health survey to determine feedback from patients to determine if the improvement activity impacted the results.	The percentage of patients responding "completely" to the question of having received enough information at discharge.	52% of patients will report they received enough information by March 31st, 2019.	Potential to utilize improved analytics through Quality Improvement Analytics project to support this change initiative will be explored during this phase.

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

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AIM		Measure						Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Patient-centred	**Person experience**	Improving Care Together: Project Development Milestone Goals	Milestone Goals / Corporate	Hospital collected data / 2017-18 FY	CB	CB	The target reflect a multi-year vision to build on the previous QIP to achieve all Change Foundation project goals.	1)Develop corporate Family Presence Policy	1.1) Form a Family Presence Policy working group; 1.2) Determine standardized language and current state analysis; 1.3) Support the application of a corporate Policy at each site.	Family Presence Policy and key messages on website; common language across all "presence policy" documents.	Corporate policy implemented by end of Q4.	
								2)Staff and Physician Engagement and Communication Strategies.	2.1) Form co-design working group to produce content for education tool; 2.2) Engage Organizational Development and Learning Services (ODLS) to determine implementation strategies; 2.3) Educational tool determined and created.	Resources developed; number of staff trained; number of family caregivers engaged.	Develop education by end of Q2; Training implemented by Q3.	
								3)Continue to implement Family Caregiver Experience survey.	3.1) Gather baseline data about family caregiver experience from staff and family caregivers; 3.2) 3-4 months later; repeat survey.	Measure overall experience of staff and family caregivers.	Pre-post survey will be completed in at least 4 targeted areas across the organization by end of Q4.	
								4)Co-Design Working Group.	4.1) Form co-design working groups for each identified priority area; 4.2) Create resources/ strategies to improve family caregiver experiences; 4.3) Implement resources/strategies in Specialized Geriatric Services (SGS) and Spinal Cord Injury (SCI).	Number of resources/ strategies developed for staff and family caregivers; successful uptake of new resources.	Development of strategies completed by Q1;Implementation plan of identified strategies in place – specific to SGS and SCI – completed by Q2.	
								5)Review of best practices for patient and family councils.	5.1) Identify common principles/processes for councils.	Implement common principles/ processes for councils across organization.	Completed by end of Q4.	
								6)Continue co-design process in the next identified population.	6.1) Conduct focus group interviews with staff and patients/families at next site; 6.2) Bring together staff, patient and families together in half-day facilitated workshops to discuss findings.	Complete 10-15 discovery phase sessions; Co-design session completed with staff and family caregivers.	Population identified by end of Q1; Key family caregiver experience priorities (3-5 priorities) identified in Q3.	

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

St. Joseph's Health Care London - Hospital QIP

AIM		Measure						Change				
Quality dimension	**Issue**	**Measure/Indicator**	**Unit / Population**	**Source / Period**	**Current performance**	**Target**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**	**Comments**
Safe	**Safe care / Medication safety**	Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged.	Rate per total number of discharged patients / Discharged patients	Hospital collected data / October – December (Q3) 2017	75.6	85.00	Continue to build on improvements in 2017-18 QIP	1)Implement standardized workflow for revised discharge medication reconciliation (med rec) processes.	1.1) Engage with Stakeholders to define and align discharge processes for St. Joseph's; 1.2) Develop a workplan to implement standardized med rec discharge across all sites at St. Joseph's; 1.3) Engage with London Health Sciences Centre (LHSC) to review current state and processes for med rec discharge; 1.4) Develop standardized definitions and current/future state processes city-wide.	Workflow process map completed; Policy updates completed; City wide guidelines included in St. Joseph's policy.	Standardized workflow and aligned policy will be developed by end of Q3.	
								2)Ensure regular review of Quality Improvement Analytics.	2.1) Provider level reports; 2.2) Daily update report functionality; 2.3) Distribution process implemented.	Self serve report usage statistics by program. The percentage of providers below target with follow-up.	100% of inpatient clinical areas will have processes for sharing provider and unit level compliance.	
		Medication Reconciliation at Inpatient Admission and Best Possible Medication History Completed Prior	Rate per total number of admitted patients / Hospital admitted patients	Hospital collected data / October to December (Q3) 2017	42.8	60.00	Admission Medication Reconciliation compliance consistently at or above 95%. Additional criteria related to BPMH has been added. The focus for 2018/19 will be on the quality of medication information for admissions from the community and those hospitals without electronic medication list transfers.	1)Implement standardized workflow for revised admission medication reconciliation (med rec) and Best Possible Medication History (BPMH) processes where possible across all sites	1.1) Engage with Stakeholders to define and align med rec and BPMH sequencing during med rec admission process for St. Joseph's; 1.2) Review process for medication lists of patients transferring from a Cerner hospital 1.3) Develop a work plan to implement revised workflow; 1.4) Develop an education plan for revised process highlighting roles and responsibilities.	Admission Medication Reconciliation and BPMH policy and workflow process map completed; Education plan completed.	Standardized workflow and and aligned policy will be developed by end of Q3.	
								2)Develop Quality Improvement Analytics.	2.1) Develop compliance reports with site and provider level drill down.	Report development completed.	Report completed by Q1.	
								3)Utilize patient safety event review to identify additional med rec quality issues.	3.1) Analysis of Patient Safety Reporting System (PSRS) and Cerner data; 3.2) Chart audits.	Percentage of medication events with comprehensive review completed.	100%	

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

St. Joseph's Health Care London - Hospital QIP

AIM		Measure						Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Safe	Safe care / Medication safety	Number of Medication Errors: Wrong Patient/Wrong Drug	Number / All inpatients receiving medication administration	Patient Safety Reporting System / October - December (Q3) 2017	5	0.00	Best possible performance	1)Continue to improve compliance with Closed Loop Medication Administration (CLMA) processes and enhanced medication administration processes.	1.1) Re-education on using CLMA and the built in safety with compliance to the technique; 1.2) Education interventions based on stakehoilder feedback from "medication safety blitzes".	Barcode scanning (medication and patient) compliance rates; Targeted education and intervention strategies e.g., Interruptions.	95% barcode scanning compliance; 100% of targeted areas receive education.	
								2)Enhanced medication error review at the unit level focusing on "lessons learned" for all Wrong Patient (WP)/Wrong Drug (WD) errors with pharmacy and nursing leaders and sustainable process in place for review of errors at a system level.	2.1) Standardized follow-up and review form to be used by all teams across St. Joseph's for all WP/WD medication errors; 2.2) Addition of learning opportunities section in the Patient Safety Reporting System (PSRS) to collect data and disseminate learnings.	Standardized template for medication error review; PSRS changes tested by target date; Report development finalized and rolled out.	100 % of WP/WD medication errors have been reviewed; Report development completed in Q3.	
		Percentage of Seclusion and Restraint Episodes with Staff Debriefing Completed	% / Parkwood Institute Mental Health Care Building and Southwest Centre for Forensic Mental Health inpatients with an order for seclusion and restraint	Hospital collected data / October - December (Q3) 2017	86.9	95.00	2017-18 target achieved. Target is increased to continue to drive excellence and consistent hardwiring of this practice across all teams at both mental health sites.	1)Enhance accountability at unit level through quarterly reporting to the VP.	1.1) Quarterly reporting of team debrief performance by each mental health team with remediation plans identified for teams not meeting target.	Percentage of leaders with quarterly review of their performance related to their team's debrief completion.	100% of leaders review performance reports quarterly in 2018-19	
								2)Improve the quality and content of the team debrief.	2.1) All teams have debrief exemplars reviewed; 2.2) Modified debrief tool is reviewed with all teams; 2.3) Debrief facilitators receive refresher training.	Percentage of staff completing review of exemplars and modified debrief tools; Percentage of debrief leaders who have received refresher training.	80% of full time staff have completed and signed off on review of exemplars; 100% of old debrief tools are replaced with the modified tools; 100% of coordinators, officers in charge and Monday to Friday Unit Leaders have received refresher training.	
								3)Optimize the practice of patient debriefing follow episodes of seclusion and restraint.	3.1) Patient Debrief current state and root cause analysis of barriers; 3.2) Unit level data collection and establish baseline; 3.3) Test and implement changes to address barriers; 3.4) Establish target for patient debrief completion; 3.5) Implement performance reports for patient debrief.	Baseline patient debrief percentage established; Number of barriers to completion of patient debriefs identified; Number of changes tested to address barriers; Target for completion of patient debriefs set; Report development completed with Unit level completion percentage.	Baseline by September 2018; Two high priority barriers confirmed and countermeasures tested by end of Q3; Target for patient debrief set by December 2018 and reports in place by December 2018.	Conducting a review of peer hospital practices, targets and strategies around patient debriefing will assist in establishing a realistic target and strategies to achieve same.

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

St. Joseph's Health Care London - Hospital QIP

AIM		Measure						Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Safe	Workplace Violence	Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.	Count / Worker	Local data collection / January - December 2017	218	285.00	Based on current evidence of under-reporting, and a goal of increased reporting by staff and physicians in 2018-19.	1)Utilize Patient Safety Reporting System (PSRS) analysis of aggression events to identify events that should be in the Workplace Occurrence Reporting System (WORS).	1.1) PSRS notifications of aggression events to Occupational Health and Safety (OHSS) for individual follow-up; 1.2) Monthly analysis of PSRS aggression events to OHSS to identify patterns and areas for follow-up.	Percentage of PSRS notifications with follow-up; Percentage of follow-up meeting criteria with a workplace event entered in WORS; Percentage of programs with discrepancies with follow-up.	90% of notifications have follow-up within 48 hours; 80% of follow-up have a WORS entered by end of Q2; 100% of programs with discrepancies over 3 months are reviewed.	FTE=2596
								2)Integrate the requirements to report incidents into all education programs related to workplace violence, existing or in development.	2.1) Written standards established for reporting near miss and incidents of a threat, attempt to harm, actual harm related to violence and responsive behaviors; 2.2) Use existing education offerings related to workplace violence to educate staff on importance of reporting in accordance with requirements.	Percentage of identified education programs related to workplace violence (prevention and response) with content included about reporting requirements.	100% of education programs related to workplace violence have content included about reporting requirements.	
								3)Complete assessment of current training needs and ensure appropriate training is being provided for prevention and intervention in crisis situations.	3.1) Conduct a gap analysis and identify training offerings/methods to address all gaps for all main clinical programs and key support services.	Percentage of clinical programs evaluated with identified required training implemented.	Assessments completed by end of Q1; Training (enhancements or new) implemented by end of Q2; 90% of staff trained by April 1, 2019.	
								4)Integrate reminders of requirements to report into standardized procedures following an incident.	4.1) Add questions to confirm reporting completed, if appropriate, into standard template for safety huddle/debrief post incident.	Percentage of incidents with safety huddle/debrief completed post incident involving harm to a staff member/physician; Percentage of safety huddles/debriefs with documentation confirming reporting requirements were assessed.	100% of incidents resulting in harm to staff member or physician (health care or lost time claim) have a post incident safety huddle/debrief; 100% of safety huddles/debrief record indicate reporting requirements were reviewed.	
								5)Utilize Code White information and Cerner Violent Behavior Alert (VBA)/Behavior Safety Alert (BSA) to identify events that should be in WORS.	5.1) Code White events to Occupational Health and Safety (OHSS) for assessment of need for WORS; 5.2) Assessment of feasibility of notification to OHSS of newly added VBA/BSA in Cerner.	Percentage of Code Whites with notifications to OHSS; Percentage of codes that meet criteria for WORS entry, with a WORS entry; Percentage of situations with newly added VBA/BSA reviewed by OHSS; Percentage of situations with new VBA/BSA due to current act of aggression with a WORS.	100% of Code Whites have notification to OHSS by end of Q2; 100% of Code Whites reviewed by OHSS for relevance for WORS report by end of Q2; 100% of VBA/BSA reviewed to determine if WORS is required, by end of Q4; 100% of VBA/BSA reviewed where it is determined a WORS is required have a WORS event, by end of Q4.	
								6)Focus on reporting incidents by physicians.	6.1) Develop communication plan with Medical Affairs/Medical Advisory Committee (MAC) on reporting requirements with focus in mental health.	Strategy in place to discuss and communicate reporting requirements.	All physicians are informed on reporting requirements; Events are reported by physicians - baseline established.	

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

St. Joseph's Health Care London - Hospital QIP

AIM		Measure						Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Timely	**Timely access to care/services**	The median number of days from referral to the first appointment with a clinician in the Pain Management Program	Days / St. Joseph's Hospital Pain Management Program, New Patients	Hospital collected data / October - December (Q3) 2017	174	150.00	Based on a decrease in Q3 FY 2017-18, following an increase in wait time in Q1 and Q2 due to physician vacancies.	1)Improve active review of discharged patient data and number of days from intake to discharge to inform clinic and physician processes.	1.1) Department and physician level reports.	Review department level reports at Pain Advisory Council. Medical Director review physician level reports.	Review quarterly starting in Q2. Review 100% of physician level reports quarterly starting in Q2.	
								2)Enhance Registered Nurse (RN) role with new patients.	2.1) Develop nursing record for new patients.	Audit charts for nursing record.	100% of all new patients.	

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

St. Joseph's Health Care London - Mount Hope Centre for Long Term Care QIP

AIM		Measure						Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Effective	**Effective Transitions**	Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / October 2016 - September 2017	28.63	28.00	Continue improvement	1)Internal Data Collection Process	1.1) Establish internal monitoring system to track and trend ED visits. Establish source and understanding of external data.	1.1) The number of ED visits and review of data on monthly, quarterly basis; the number of reports reviewed and analysis presented to Professional Advisory Committee and Quality Council on a quarterly basis; the number of action items out of those committees .	100% of ED visits reviewed.	
								2)Ensure access to appropriate resources, services, assessment and treatment.	2.1) Review internal physician communication plan in collaboration with Medical Director and attending physicians to ensure access and timely reporting of resident condition/changes. Review internal physician rounds and on call program. 2.2) Clinical assessment education for registered staff.	2.1) The number of physicians that participated in communication plan review; the percentage of reviews conducted on physician rounds and on call to ensure adequate access and timely assessment and treatment of resident condition/changes; the percentage of residents that received care and/or treatment post physician communication; the wait times for internal assessment and treatment post physician communication. 2.2) The percentage of registered staff who attended clinical assessment education.	2.1) 75% physician participation Q1; 25% of each physician rounds and on call to be reviewed by end of Q2; 100% of residents; 24-hour non-emergent wait times. 2.2) 100% of all registered staff - 25% Q1, 25% Q2, 25% Q3, 25% Q4.	

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

St. Joseph's Health Care London - Mount Hope Centre for Long Term Care QIP

AIM		Measure						Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Effective	**Wound Care**	Percentage of residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4 since their previous resident assessment	% / LTC home residents	CIHI CCRS / July - September 2017	4.03	3.00	Continue improvement	1)Ensure Skin Integrity and Wound Care Program is current and in alignment with best practice.	1.1) Review policies and procedures related to Skin Integrity and Wound Care Program. Collaborate with external partners to establish alignment with external best practices within the Long Term Care sector. 1.2) Develop monthly auditing program to ensure policy and program is in place.	1.1) The number of policies, procedure and program revisions required. 1.2) The number of monthly audits completed.	1.1) Review and revision by end of Q1. 1.2) Auditing program developed and in place Q2 - 100% compliance rate.	
								2)Capacity building of registered staff related to Skin Integrity management and Wound Care.	2.1) Education on Skin Integrity and Wound Care Program; 2.2) Training and development on wound care management in collaboration with external partners.	2.1) The number of education sessions provided; the percentage of registered staff trained on the new program/revisions. 2.2) The percentage of registered staff attending level 3 wound care management for all registered staff .	2.1) Revised program education by end of Q2, 2.2) 100% of all Registered staff will have completed wound care education - 25% Q1, 25% Q2, 25% Q3, 25% Q4.	
								3)Capacity building of Personal Care Partners (PCP) related to Skin Integrity management.	3.1) Training and development on Skin Integrity management in collaboration with external partners.	The number of education sessions provided; the percentage of PCP staff attending level 1 Skin Integrity management education.	100% of all PCP staff will have completed level 1 Skin Integrity management education - 25% Q1, 25% Q2, 25% Q3, 25% Q4.	
								4)Ensuring appropriate resources and infrastructure are in place to support Skin Integrity and Wound Care Program.	4.1) Implementation and standardization of the wound care nurse role with development of expertise; 4.2) Development of the Skin Integrity and Wound Care Committee; 4.3) Development and standardization of wound care processes and supplies across all resident units.	4.1) The number of reviews conducted; the number of established routines and accountabilities; the number of participants and weekly rounding conducted. 4.2) The number of Skin Integrity and Wound Care Committee members; the number of meetings, evaluations, treatment outcomes and actioning items. 4.3) The number of standardized processes and supplies across all resident units; the percentage of weekly individual resident wound care audits.	4.1) Role review Q1; Weekly rounds Q1. 4.3) Standardization Q2; Weekly individual resident wound care audits, 100% compliance.	
								5)Ensure data accuracy of clinical assessment and coding Resident Assessment Instrument - Minimum Data Set 2.0 (RAI-MDS 2.0).	5.1) Review and establish data accuracy of assessment and coding in RAI-MDS 2.0.	The percentage of assessments audited; the number of evaluations and reviews for coding accuracy in RAI-MDS 2.0; the number of visits with external partner for data quality reviews; the number of reviews with 100% data accuracy.	25% of assessments audited quarterly; monthly visits with external partner.	
								6)Annual Program Review	6.1) Reviewing program annually	The number of developed auditing tools and review processes for Skin Integrity and Wound Care Program; the percentage of weekly, monthly and quarterly audits documented and reviewed at rounds, monthly committee meetings and shared with Professional Advisory Committee and Quality Council; the number of audits, stats, outcomes and action plans reviewed annually with a summary report completed.	50% of all wounds audited and reviewed Q1, Q2, Q3. Annual review Q4.	

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

St. Joseph's Health Care London - Mount Hope Centre for Long Term Care QIP

AIM		Measure						Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Patient-centred	**Person experience**	Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	% / LTC home residents	In house data, NRC Health survey custom question / April 2017 - March 2018	75	78.00	Continue improvement	1)Ensure understanding of Residents Rights and Person Centered Care.	1.1) Development of education program for residents on their rights - presented on admission and annually; 1.2) Senior Friendly training roll-out all long term care staff.	1.1) The number of external partners collaborated with to develop and establish education program for residents on their rights; the number of educational opportunities provided to residents and families on admission and annually; the number of residents and families attending the educational opportunities. 1.2) The percentage of staff attending the roll-out of Senior Friendly education.	1.1) 100% of admission and offered 3 times per year; 25% resident and family attendance annually. 1.2) 100% of all staff Senior Friendly education.	
								2)Ensure Complaints Management Program and follow-up is effective.	2.1) Review of complaints management program.	2.1) The number of developed and implemented auditing tools to evaluate compliance with policy; the percentage of audits demonstrating 100% compliance rate; the number of complaints tracked on a monthly basis, trend, analyze and action on a quarterly basis.	100% with compliance to policy; 25% reduction in overall complaints tracked; 25% reduction in repeat complaints; 100% of all complaints tracked and reviewed.	
	Resident experience: "Overall satisfaction"	Percentage of residents who responded positively (% Yes) to the question: "If longstay care were needed for another family member or friend, would you recommend this facility?"	% / LTC home residents	In house data, NRC Health survey question / April 2017 - March 2018	79.9	83.00	Continue improvement	1)Provide a living environment that supports the quality of life of our residents.	1.1) Adaptation and implementation of the Person Centered Care Program, with education to all staff; 1.2) Extending/education of the Leisure and Well-Being Model to leadership and front line staff; 1.3) Adaptation and implementation of the Pleasurable Dining Program, with education to all staff.	1.1) Percentage of staff provided Person Centered Care Program education; 1.2) Percentage of staff provided Leisure and Well-Being model education; 1.3) Percentage of staff provided Pleasurable Dining Program education.	1.1) 25% each quarter; 1.2) 25% each quarter; 1.3) 25% each quarter.	
								2)Provide opportunities for communication that foster engagement and accessibility.	2.1) Redevelopment of the Residents Council Committee format, providing opportunity for each Mount Hope Centre for Long Term Care (Mount Hope) unit to have a representative that sits on the committee to provide greater insight into resident lived experience, needs, wants and concerns; 2.2) Introduction of Fireside chats with the Executive Director (ED), a monthly evening open forum with the ED to provide access to residents, as well as families who are unable to be at Mount Hope during business hours.	2.1) The number of resident representatives for each unit; the number of resident representatives attending each monthly meeting; the number of concerns brought forward from each unit. 2.2) The number of evening open forums provided, the number of residents and families in attendance.	2.1) 10 representatives; 10% reduction in concerns. 2.2) 1 open forum monthly; 10% participation.	

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"Improvement Targets and Initiatives"

St. Joseph's Health Care London - Mount Hope Centre for Long Term Care QIP

AIM		Measure						Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Safe	**Medication safety**	Percentage of residents who were given antipsychotic medication without psychosis in the 7 days preceding their resident assessment	% / LTC home residents	CIHI CCRS / July - September 2017	15.23	15.00	Continue improvement	1)Ensure appropriate prescribing of antipsychotic medication based on diagnosis.	1.1) Screening pre-admission and on admission to identify antipsychotic medication without diagnosis; Regular medication reviews and communication.	The percentage of residents screened on pre-admission and on admission; the percentage of residents with admission, quarterly and return from hospital medication reviews.	90% screened; 100% admission, 90% quarterly, and 100% return from hospital medication reviews.	
	Safe care	Percentage of residents who were physically restrained every day during the 7 days preceding their resident assessment	% / LTC home residents	CIHI CCRS / July - September 2017	9.61	7.00	Continue improvement	1)Ensure Restraints Management and Reduction Program is current and aligned with best practice.	1.1) Review current restraints program and process framework within Mount Hope Centre for Long Term Care and revise as necessary; Collaborate with external partners to establish alignment of program with best practices within the Long Term Care sector.	The number of external partners consulted and number of best practice processes reviewed; The percentage of staff completing education related to program revisions.	Complete current state and best practices review by end of Q1 and complete implementation by end of Q2; 90% of staff educated by end of Q3.	
								2)Ensure Resident safety needs are being met.	2.1) Re-establish individual resident reviews of those resident's with noted restraints; 2.2) Initiate restraint reduction program including restraint alternatives for individual residents who are appropriate; 2.3) Develop and implement a monthly auditing program and review audit results at monthly Restraint Committee meetings.	2.1) The percentage of residents with an identified restraint or Personal Assistive Device (PAD) that have a review completed each quarter; 2.2) The percentage of eligible residents with reduction measures and restraint alternatives implemented as appropriate; 2.3) The percentage of monthly meetings with audit reviews completed and action items assigned.	2.1) 100% of applicable residents; 2.2) 80% of eligible residents have changes initiated; 2.3) 100% of monthly meetings have audit review and action items assigned.	
								3)Education and building capacity of registered staff and Personal Care Partners (PCP).	3.1) Re-education of staff on restraint program usage, reduction, Personal Assistance Service Devices (PASDs) and education for staff on restraint alternatives; 3.2) Development and implementation of education on restraints and reduction for residents and families.	3.1) The percentage of staff completing training initiatives; 3.2) Education material for resident and family completed and distributed.	3.1) 90% of staff trained by the end of Q2; 3.2) Education materials completed and distributed by end of Q3.	
								4)Increase understanding of restraints and safety for residents and families.	4.1) Development of restraints brochure for pre/admission packages; 4.2) Development of an education module based on external best practices for pre/admission resident and families.	4.1) The number of external partners consulted for brochure and education module development; 4.2) The number of resident and family feedback opportunities related to education module development; The number of education opportunities offered in Q3 and Q4, 2018-19.	4.1) 3 external partners consulted by the end of Q1 and brochure developed by end of Q2; 4.2) 6 stakeholder engagement sessions offered in Q2; 10 education sessions offered to residents and families in Q3 and Q4.	