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

St. Joseph's Health Centre Guelph 100 Westmount 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
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)															
Theme II: Service Excellence	**Patient-centred**	Percent of residents who have two assessments completed per month by the most responsible physician	C	% / LTC home residents	Local data collection / December 2018	51950*	38	75.00	97% improvement is a stretch goal for the organization		1)Improve the completion of admission and/or annual physical assessments within 7 days of admission/annual date by 12% from 76% to	Physicians to complete admission and/or annual physical assessments within 7 dyas of admission/annual date	Audit of new admissions with completed physical assessments within 7 days of admission	85% of residents	
											2)Increase the percent of residents with quarterly medication reviews completed by 14% from 83% to 95% by March 31,	Physicians to complete quarterly medication reviews	Audit of residents quarterly medication review completions	95% of residents	
											3)Improve communication with physicians regarding completion rates by March 31, 2020	Implement a process to communicate with physicians their completion rates of admission assessments, twice monthly assessments and quarterly medication reviews	Communication system to be implemented	Communication of rates completed to physicians at least 3 times	
		Percent of residents whose mood from symptoms of depression worsened on: 2 North, 3 North, 4 North, 3 East and 3 West (2N, 3N, 4N, 3E & 3W)	C	% / LTC home residents	In house data, interRAI survey / Oct-Dec 2018	51950*	18.2	14.50	20% improvement is a stretch goal for the third year of this project		1)To improve staff understanding of Section E of the Resident Assessment Instrument: Minimum Data Set by March 31, 2020	Educate all staff working on 2N, 3N, 4N, 3E and 3W on Section E of the Resident Assessment Instrument: Minimum Data Set (RAI-MDS)	Percent of active staff on 2N, 3N, 4N, 3E and 3W that complete training	90% completion rate	
											2)To increase resident engagement activities by March 31, 2020	Implement a daily engagement task based on a resident's DRS score of 3 of more for Personal Support Worker (PSW) roles on 2N, 3N, 4N, 3E and 3W	Percent of assigned tasks completed	75% of assigned tasks will be completed	
											3)To increase resident engagement opportunities by March 31, 2020	Implement an engagement task at a minimum of once per week for residents with a DRS of 5 or more for recreation team or designate roles on 2N, 3N, 4N, 3E and 3W	Percent of assigned tasks completed	75% of assigned tasks will be completed	
											4)To improve communication with physicians regarding their residents mood by March 31, 2020	Provide quarterly updates and communication to most responsible physician (MRP) for residents who have a DRS of 5 or greater on 2N, 3N, 4N, 3E and 3W	Number of quarterly updates placed in MRP communication book	3 quarterly updates placed in MRP Communication book	
	Patient-centred	To increase the percent of patients who respond positively to the respect and dignity dimensions of the patient satisfaction survey by 10% from 61.7% to 67.5% by March 31, 2020.	C	% / All inpatients	NRC Picker / April-December 2018	666*	61.7	67.50	10% improvement is a stretch goal for patient satisfaction and will achieve the Rehab average for the respect and dignity dimension.		1)To increase client and family engagement in the operations of the hospital by March 31, 2020.	Engage patients and families in improving hospital activities through the Patient and Family Advisory Council (PFAC)	Activities related to hospital to go to PFAC for input and engagement	Minimum of 2 hospital related activities	
											2)Improve responsiveness to patient needs by reducing the number of call bell rings over 15 minutes by March 31, 2020.	Reduce the number of call bell rings over 15 minutes	Number of call bell rings over 15 minutes per month	Collecting Baseline	
											3)Improve responsiveness to patient needs by decreasing the average duration of call bell rings by March 31, 2020.	Decreasing the average duration of call bell rings	Average call bell ring time duration	Decrease to less than 5 minutes	
											4)Improve team understanding of person-centred care through educational patient and staff engagement videos by	Produce a patient and staff engagement video	Patient and staff engagement videos	Produce one additional patient video	

											5)Improve team understanding of person-centred care through education on person-centred care by March 31,	Provide education on person-centred care to staff	Percent of active full and part time staff who complete the education	90% of active full and part time staff	
											6)Improve communication with patients and families by standardizing the communication boards in all patient rooms by March 31,	Establish standardized communication on the communication boards in the patient's room	Audit to ensure that the nurse's name is on the communication board in the patient's room	90% of the time communication boards will include the nurse's name	
Theme III: Safe and Effective Care	**Safe**	Number of workplace violence incidents reported by workers (as by defined by OHSA) within a 12 month period.	C	Count / Worker	Local data collection / January to December 2018	51950*	66	78.00	Organization is focused on further building a reporting culture and therefore target is to increase the number of reported incidents of workplace violence against staff as per OH&S Act definition by 20%.	St. Joseph's Health Care System Hamilton	1)To improve staff sense of safety by improving current ID badges by March 31, 2020.	Refresh current ID badges (name tags) to include staff first name and position only.	Percent of staff with revised ID badges	Target for initiative is 80%	
											2)To increase reporting and improve trending reports through implementation of an online reporting system by March 31, 2020.	Implement new online reporting system for workplace violence to facilitate and increase staff identification of workplace violence and reporting.	Implement online reporting system for Employee Incident reports.	System implemented	
											3)To improve the safety of the building by improving external access control by March 31, 2020.	Establish external access control to all entrances in the Health Centre.	Implement external access control at all entrances	External access control implemented	
											4)To reduce incidents of workplace violence by engaging clients and families in education by March 31, 2020.	Provide education to clients and families regarding workplace violence	Develop communication for clients and families regarding workplace violence in conjunction with the Patient and Family Advisory Council	Communication developed and disseminated	
	Safe	**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 2018**	**666***	**8**	**10.00**	**Organization is focused on further building a reporting culture and therefore target is to increase the number of reported incidents of workplace violence against staff as per OH&S Act definition by 20%.**		**1)Number of full time employees in the hospital**	**Number of full time employees in the hospital**	**Number of full time employees in the hospital**	**Number of full time employees in the hospital**	**FTE=211**
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