2015/16 Quality Improvement Plan for Ontario Hospitals
"Improvement Targets and Initiatives"

Kirkland and District Hospital 145 Government Road East Postal Bag 3000

AIM		Measure							Change				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	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 / Jan 1, 2014 - Dec 31, 2014	696*		3	The Kirkland & District Hospital has not been identified by the NELHIN and the MOHLTC as a hospital with wait time challenges. However, Patient experience is important to our hospital and hence will continue to closely monitor wait times in the ED.	1)Continue to work on patient flow	Monitor wait times in the ED for all patients	Evaluate wait times of ED patients discharged to medical surgical and home by reviewing wait times and CATS	To ensure that all patients are discharged in a timely manner.	The Kirkland & District Hospital continues to work hard to improve the flow of patients and to reduce the length of time that patients are waiting in the Emergency Department(ED) for diagnostics, treatment, transfer to an in-patient bed or discharge. Data collected by Health Quality Ontario reported that on average, 90% of Ontarians, spend a maximum of 28 hours in the Emergency Department before being admitted to an in-patient bed. The Kirkland & District Hospital ED average wait time for a ED patient to be admitted to an in-patient bed is under 3 hours. Although this continues to be a priority for the hospital, we have not been identified by the NELHIN and the MOHLTC as a hospital with wait time challenges.
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 FY 2014/15 (cumulative from April 1, 2014 to December 31, 2014)	696*	-1	0	Our Financial target for fiscal year 2015/16 is the submission of a zero deficit budget.	1)Continue to monitor financial information monthly and make changes accordingly.	Financials are reviewed monthly by all departments and any discrepancy must be defined	Monthly review by Finance to ensure targets are met	To maintain a zero deficit budget	Participation in a Pier to Pier Benchmarking exercise allowed our hospital to compare financial information and performance and develop strategies. In accordance to the request of the NELHIN, the Kirkland & District Hospital has submitted a zero-deficit budget for the upcoming fiscal year.
	Improve Organizational Health & Safety Management System (HSMS)	Areas identified as non-conforming in the HSMS Audit are to be addressed in a JOHSC Continual Improvement Plan.	% / N/a	In-house / Calendar year 2015	696*	92	100	To meet conformity in areas identified in the HSMS Audit as addressed in the Continual Improvement Plan for the JOHSC.	1)Identified areas of non-conformity will be addressed in a Continual Improvement Plan that will be reviewed by the JOHSC and Senior Management. A work plan will also be established to ensure timelines are met and responsibility is assigned for accountability.	Progress will be tracked on a monthly basis with the use of the CIP	All non-conformities will be given a percentage of conformity. The non-conformity will be complete once it is established by the JOHSC that it is at 100% conformity.	All areas of the audit will conform	The CIP and work plan will provide direction for the Kirkland & District Hospital and the JOHSC in achieving a continual safe workplace.
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. *100	% / All acute patients	Ministry of Health Portal / Oct 1, 2013 - Sept 30, 2014	696*	32.83	22	To achieve the NELHIN target of 22%	1)Weekly multi-disciplinary meetings will identify those patients who are ALC. Discharge plans and any progress will be discussed to assist with appropriate discharge of the patients	Endorsement by all key team members	At weekly meetings	Change initiatives with Readmissions will contribute to reducing ALC days.	Our challenge continues with ALC patients. For ALC patients waiting placement in a LTC facility: Recognizing that only 2 LTC facilities are located in our community, beds are not always available when required. In addition, for ALC patients waiting to return home: in order to support the safe return to home, community support services are organized prior to discharge and may not be readily available resulting in delay of discharge.
	Reduce unnecessary hospital readmission	Readmission within 30 days for Selected Case Mix Groups	% / All acute patients	DAD, CIHI / July 1, 2013 - Jun 30, 2014	696*	15.46	15	To work towards the NELHIN average target of 15%	1)To continue with the Health Links Initiative and the monitoring of all Admissions to the hospital	With the use of the LACE tool, all admissions are screened. If specific criteria are met, an Integrated Coordinated Care Plan (ICCP) is offered to the patient to assist in the management of their healthcare.	Review number of LACE tools completed and the number of ICCP that are accepted by the patient. Monitor the success of the ICCP by monitoring admissions to the Emergency Department.	To ensure that activated ICCPs are monitored for effectiveness leading to decreased hospital readmissions.	KDH is working closely with the Family Health Team (FHT) and the Centre De Sante Communautaire du Temiskaming to develop these plans. All daily admissions and discharges are shared with FHT and the CST. Representation from the FHT on our weekly Interdisciplinary case review rounds assist with the discharge planning
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 / October 2013 - September 2014	696*	98	99	To exceed our current performance to ensure overall patient satisfaction with outcome of hospital care	1)Capturing patient satisfaction upon discharge from hospital by providing every patient the opportunity to express satisfaction of outcome of hospital care	Nursing staff will upon discharge provide an opportunity for patients to express satisfaction of outcome of hospital care. If the discharge question is missed, the Nursing team will contact discharged patient to the best of their abilities to determine satisfaction. All Discharge Records will be forwarded to Quality Manager for review. Data from the question " Overall, are you satisfied with the outcome of you hospital care ?" will be collected in an Excel spreadsheet format. All patient comments will also be captured within the tool.	Monthly, this data will be tabulated as a percentage of discharged patients that were satified or not satisfied with care outcomes. This data will be shared at the Quality Committee meetings as per workplan and Nursing Unit staff meetings. Unanswered question data will also be communicated with the Nursing Team in order to achieve compliance	To have each patient indicate satisfaction with outcomes of hospital care upon discharge	If we receive a "No" answer for satisfaction, follow up contact with the patient will be initiated by the Quality Manager in patnership with the Nursing Manager
									2)Develop an in-house survey to distribute to Emergency Department with a possible expansion to include the in-patient population.	Surveys will br deployed from the hospital and data will collected at the hospital. On-line surveys will be made available on the hospital website.	Completed survey will be tabulated and shared at Quality and Unit Staff Meeting	By simplifying the survey, our goal would to be to collect data that allows our hospital the opportunity for change ideas. We value the people of our community and aim to support an environment of high performing, patient-centerer healthcare at our hospital.	

Safety	**Increase proportion of patients receiving medication reconciliation upon 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.	% / All patients	Hospital collected data / Most recent quarter available	696*	CB	80	In order to formalize the process of medication reconciliation with discharge, our target population will be complex patients.	1)The Pharmacy will be notified in advance of all complex patient discharges. The Pharmacist and the Primary Care Nurse will complete the medication reconciliation together. This change idea presents an opportunity for increased education in the process of medication reconciliation and overall medication knowledge for the Primary Care Nurse. This knowledge will then be shared by the Primary Care Nurse with patient teaching upon discharge. This process will continue to strengthen our community strategy with the pharmacists of the Family Health Team, community Pharmacies and the Long-Term Care Homes.	Pharmacy involved medication reconciliation at discharge will be recorded and the data will be reviewed quarterly to ensure target is met.	Percentage of completed complex patient discharge	To meet projected target of 80% of complex patient medication reconciliation at discharge by December 31, 2015 and to achieve 100% medication reconciliation at discharge for all patients by April 30, 2016.	In an effort to improve patient safety and safe medication practices, KDH has identified medication reconciliation at discharge as a priority with the goal of medication reconciliation at discharged embedded into the normal processes of care.
	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. 2014, consistent with HQO's Patient Safety public reporting website	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / Jan 1, 2014 - Dec 31, 2014	696*	0	0	To maintain our current performance and not to exceed the provincial average of 0.34	1)Continue with our current isolation protocol	Isolate patients as per policy	Track all infection in Meditech with Critical Indicators	To continue to promote the proper isolation protocols, proper PPE usage and hand hygiene.	CDI rates are publicly reported. Our hospital isolation protocol is diligent. We continue to strive for zero cases of acquired CDI. Our protocol is to isolate any newly admitted patient with diarrhea and any in-patient with diarrhea. We continue to promote proper PPE procedures and Hand Hygiene practices. Identified CDI patients have their rooms cleaned twice daily with a terminal cleaning upon discharge as per PIDAC protocol.
	Avoid Patient falls	Percent of in-patients (65 and older) who fell in the last 30 days	% / In-patients over the age of 65	In house / 2014	696*	7.4	6.4	Reduce hospital rate of falls by 1% per annum to reach a goal of 3% or less.	1)Monitor all in-patient falls for those patients over the age of 65 with the use of incident report tracking and trending and meditech alerts for fall risk rates	Trend falls for patients over the age of 65 to identify risk areas	As fall(s) occur, immediate review of the incident by the multi-discplinary team will identify immediate risks to the patient. Environment, medications and patient health acuity will be reviewed and trended with Incident Managemeny system RL Solutions in order to provide the safest hospital environment and stay for the patient.	Minimize fall risk for all patients over the age of 65	Our hospital has an active Falls Prevention and Senior Friendly Committee. We have included community partners to align with district initiatives for seniors.