Kirkland and District Hospital 2016/17 Quality Improvement Plan (QIP)
Work Plan for Improvement Targets and Initiatives

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
Efficient	Reduce unnecessary time spent in acute care	To reduce readmission and ER visits, measure the total number of patients requiring primary care follow up who received an appointment within 7 days of discharge	Number / All acute patients	In-house data / 2016	696*	CB	CB	To improve the continuity of care for patients	1)In partnership with the Family Health Teams, Centre de Sante Communautaire and the Canadian Mental Health Association (CMHA), the hospital will provide information resources to support any patient requiring follow up with the primary care provider will obtain appointments within 7 days of discharge.	Endorsement by all key team members and communication with all primary care providers	Notification to the primary care providers will be initiated for those patients requiring follow-up care post discharge. An email will be sent to the Executive Director at the Kirkland Lake FHT for any patients without a primary care provider to ensure follow-up opportunities are accessible. Data will be monitored on a monthly basis with the use of discharge summaries	Ensure all patients receive follow-up discharge care by their primary care provider to ensure continuity of care.	KDH has a strong working relationship with the Family Health Team, the Centre De Sante Communautaire and the CMHA. We will continue to build this relationship with enhanced communication for ultimate patient care.
Patient-centred	Improve patient satisfaction	Develop a Patient Experience Partner Program	Annual evaluation of program / All patients	In-house / April 1, 2016	696*	CB	4.00	To have a fully implemented Patient Experience Partner Program with 4 patient representatives across both hospital sites	1)Develop a formal program that involves patients and their families in hospital operations	Recruit patient and or family members of patients that have had care in the hospital in the past year.	Number of projects and policies reviewed by patients and families in the fiscal year	To have all major policy change and major renovations have the involvement of patients and families to provide the patient perspective.	This Patient Experience Partner Program (PEP) will be an Integrated program for the Kirkland and Englehart District Hospitals
		In-house discharge summary: identify those patients who answered no to the question "Overall, are you satisfied with your patient experience for your hospital stay?"	% / All acute patients	In-house / 2015	696*	6	80.00	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 their patient experience	Nursing staff will upon discharge provide an opportunity for patients to express satisfaction of patient experience with their hospital stay. All Discharge Records will be forwarded to Quality Manager for review. Data from the question " Overall, are you satisfied with your patient experience?" 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 satisfied or not satisfied with care outcomes. This data will be shared at the Quality Committee meetings as per work plan and Nursing Unit staff meetings. Unanswered question data will also be communicated with the Nursing Team as a reminder to provide the patient with the opportunity to share their experience.	Meet with 80% of those patients who indicated no to resolve any concerns to ensure a favourable patient experience	If we receive a "No" answer for satisfaction, follow up contact with the patient will be initiated by the Quality Manager in partnership with the Nursing Manager
		Integration of the Kirkland and Englehart District Hospitals	Progress of Integration / All patients	In-house / 2016	696*	CB	80	Have both hospitals Management teams fully integrated to build upon strategic priorities and commitment to quality patient care by the strengthening of partnerships, leadership, integration, financial accountability and transparency	1)Shared Governance Structure for both Hospital Board	Endorsement by all key team members	A reorganization of current Board Committees and a standardization of Board policies	To align the strategic direction for both Hospitals	This restructuring of the Board Governance will allow Integration work across both hospitals and reduce duplication of reporting indicators
									2)Standardization of Policy	Review both Englehart and Kirkland District Hospitals policies to move to integrated polices	The Nursing group policies will be reviewed and policy will be grouped to eliminate duplication. All policies will reference Best Practice Guidelines to ensure quality care.	To move 70 % of all policies to integrated polices by March 31, 2017.	Standardization of policy will allow for Managers, staff and Physicians to work at both hospital sites.
									3)Fully Integrated Departments for both Hospitals	Endorsement by team members through departmental analysis and the development of an action plan	Evaluate the integration process on a monthly basis at Leadership meetings	To begin this transitions, Hospital Managers will be integrated across both sites, followed by non-union staff. Goals & Objectives, departmental anaylsis will be developed.	Integration of all Managers is almost complete. Shared on-call is an example of elimination of duplicated services between the hospitals.

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Safe	**Avoid patient falls**	Implement Best Practice guidelines in Falls Prevention	% / All patients	In-house / 2016	696*	CB	CB	To have a fully implemented Best Practice Fall program	1)Rounding* by staff to reduce falls	Track number of times per day that rounding was completed by staff	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 Management system RL Solutions in order to provide the safest hospital environment and stay for the patient	Educate all staff on Rounding and the benefits for excellent patient care	We have identified that most falls in our hospital are associated with toileting and patient balance
									2)Move-On*program for all patients	Train staff with the Move-On program	The Move-On program will allow the Nursing staff to support and strengthen the patients ability to gain mobility.	To have all Nursing staff trained in the Move-On program to support patients for mobility in conjunction with Physiotherapy	We have identified that most falls in our hospital are associated with toileting and patient balance.
	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	100	In order to formalize the process of medication reconciliation with discharge, our target population will continue to be complex patients	1)The Pharmacist and the Primary Care Nurse will complete the medication reconciliation together. 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. 2) Pharmacy Third Party Consultation to Identify areas for improvement	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 100% of complex patient medication reconciliation at discharge by March 31, 2017.	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.

CB = Collecting Base Line Data

Medication reconciliation is a formal process in which healthcare providers work together with patients, families and care providers to ensure accurate and comprehensive medication information is communicated consistently across transitions of care. Medication reconciliation requires a systematic and comprehensive review of all the medications a patient is taking (known as a BPMH) to ensure that medications being added, changed or discontinued are carefully evaluated. It is a component of medication management and will inform and enable prescribers to make the most appropriate prescribing decisions for the patient.

Proactive Patient Rounding involves nursing staff, leaders and managers using questions to ask patients on a regular basis about care needs and checking the patient environment to ensure that it is clean and uncluttered and that everything is in reach of the patient.

Move On (Mobilization of Vulnerable Elders in Ontario), is to ensure that seniors get out of bed and move, as often as is feasible given their physical state. A decline in mobility can start within 2 days of hospitalization.