Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2016/17 QIP

The Progress Report is a tool that will help organizations make linkages between change ideas and improvement, and gain insight into how their change ideas might be refined in the future. The new Progress Report is mostly automated, so very little data entry is required, freeing up time for reflection and quality improvement activities.

Health Quality Ontario (HQO) will use the updated Progress Reports to share effective change initiatives, spread successful change ideas, and inform robust curriculum for future educational sessions.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
1	Develop a Patient Experience Partner Program (Annual evaluation of program; All patients; April 1, 2016; In-house)	696	CB	4.00	3.00	We have recruited 3 Patient Advisors. We have revamped our Quality Program and are in the process of incorporated the role of the patient advisors and how to recruit for more patient advisors.

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Change Ideas from Last Years QIP (QIP 2016/17)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Develop a formal program that involves patients and their families in hospital operations	Yes	The formal program involves our Patient Advisors involved in events at both hospital sites. Our Patient Advisors have participated in our Joint Hospital Strategic Planning, Renovations Footprint, QCIPA review and QIP planning. Our program will also incorporate a focus group to review the Accreditation Canada standards for Patient Centered Care.

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2	Implement Best Practice guidelines in Falls Prevention (%; All patients; 2016; In-house)	696	CB	100.00	100.00	We have a fully integrated Falls Prevention and Least Restraint program in place. All admissions are assessed for Fall Risk on admission and with any falls. Interventions are initiated for all patients at risk. All falls are reviewed and analyzed for types of falls and contributing factors.

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Rounding by staff to reduce falls	Yes	The rounding program was initiated at the Englehart site and is still in progress for Kirkland Lake. Our target population was the Medical Surgical floor. We have a new Manager in that area and plan to start the program prior to the end of March.
Move-On program for all patients	Yes	The Move On program was initiated at the Kirkland site. The staff was trained to provide bed exercises and mobility to patients over the weekends. We faced a challenge with staffing in the physiotherapy department. We have now since hired a Kinesiologist. They are actively involved with the mobility of our patients and the planning of exercise programs.

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3	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; 2015; In-house)	696	6.00	80.00	99.00	On discharge, patients are asked if they are satisfied with their hospital stay. We have received an overwhelming positive response. Patients have referred to our hospital a "Jem of the North" with caring, compassionate and professional staff. If the patient indicates no or makes a less than favourable comment, they are contacted to discuss their hospital stay. Comments made include: cold at night, noisy and difficult to sleep. These comments are shared with the staff in an effort to raise awareness to the patient's needs.

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Capturing patient satisfaction upon discharge from hospital by providing every patient the opportunity to express satisfaction of their patient experience	Yes	This is a repeat indicator. We will for the 2017_18 be providing a discharge call to in-patients post discharge of 48 hours. During that call, they will be asked if they would like someone to contact them regarding their hospital stay.

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4	Integration of the Kirkland and Englehart District Hospitals (Progress of Integration; North Central Timiskaming District; 2016; In-house)	696	CB	80.00	100.00	We are fully integrated with the Englehart District Hospital. We share a common Management team and an Integrated Board. As of September 2016, we have an Integrated Quality and Strategic Planning Committee and an Integrated Resource and Audit Committee. Our Committee have an equal number of board members to represent the voice of each hospital.

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Shared Governance Structure for both Hospital Board	Yes	A shared governance structure is in place for the Kirkland and Englehart District Hospitals. This came into place over the summer of 2016.
Standardization of Policy	Yes	Infection control, Quality, Feedback, Risk Management are some the areas that share integrated policies.
Fully Integrated Departments for both Hospitals	Yes	The Management team is fully integrated. A challenge for some of the managers is that the employees belong to different unions. Crossing over of staff will only occur if the hospitals decide to amalgamate.

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5	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 ; Most recent quarter available; Hospital collected data)	696	CB	100.00	80.00	Medication Reconciliation at discharge is reported on the discharge summary sheet. In reviewing of the data, Med Rec on discharge is completed for complex patients and those patients who have medications at home. We have analyzed the data and noted that 20%, staff indicated that Med Rec was not applicable. In hindsight, although Med Rec should be completed 100% of the time, our target was unrealistic. As Med Rec is considered for 100% of the patients we need to focus on the population that are identified as no or not applicable. For the QIP 2017_18, we will review all charts of those patients that the staff have indicated not applicable or no to understand why that option was chosen and then to ensure that the process is complete and accurate.

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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	Yes	The pharmacist works with Primary Care Nurse for the complex cases for Med Rec. North West Tele-pharmacy was also introduced during this QIP to provide after-hours support and will now complete Medication Rec for all direct admissions patients for both hospital sites.

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6	Number of times that hand hygiene was performed before initial patient contact during the reporting period, divided by the number of observed hand hygiene opportunities before initial patient contact per reporting period, multiplied by 100. (%; Health providers in the entire facility; Jan 2015 - Dec 2015; Publicly Reported, MOH)	696	CB	CB	91.00	We continue to meet our goal with the understanding that the hand hygiene process can only be improved.

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7	Percent of palliative care patients discharged from hospital with the discharge status "Home with Support". (%; Palliative patients; April 2014 – March 2015; CIHI DAD)	696	75.00	75.00	90.91	We are fortunate to have a Palliative Care program housed at our hospital. The Palliative Care Coordinator is a shared employee with our hospital. We have a palliative care hospice suite that was granted a quality award of mention for our existing model. Our Palliative Care model has been shared with the hospitals of the NELHIN as a model of excellence.

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8	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; 2016; In-house data)	696	CB	CB	CB	We continue to strengthen our relationship with the Kirkland District Family Health Team (KDFHT) and the Centre de Santé Communautaire du Temiskaming (CSCT). We have participation from both the KDFHT and the CSCT at our weekly multi-disciplinary meetings via in person and by OTN. We also have provided IT access to MediTech in order for the partners to have access to reports for visits to the ER and hospital admissions. The data for this indictor was collected by our partners and will be reported in their respective QIPs.

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In partnership with the Family Health Teams, Centre de Santé 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.	Yes	We have a discharge planner that coordinates with all health partners to ensure the continuity of care planning continues when the patient leaves the hospital.

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9	Total number of inpatient days where a physician (or designated other) has indicated that a patient occupying an acute care hospital bed has finished the acute care phase of his or her treatment, divided by the total number of inpatient days in a given period x 100. (%; All acute patients; October 2014 – September 2015; CIHI DAD)	696	33.50	22.00	37.66	We continue to have a high ALC rate in our hospital. The contributing factor is placement for Long Term Care. We have 2 long term care homes in our community and 1 home is preferred due to accommodations and the age and structure of the home. Our patients are only required to choose 1 Long Term Care home. This poses a challenge as wait times can exceed 365 days.

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