Let's Make Healthy Change Happen.

Quality Improvement Plan (QIP) Narrative for Kingston General Hospital

Kingston General Hospital
Outstanding care, always™

3/24/2016

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

Kingston General Hospital (KGH) is a community of people dedicated to transforming the patient and family experience through innovative and collaborative approaches to care, knowledge and leadership. As southeastern Ontario's leading centre for complex-acute and specialty care and home to the Cancer Centre of Southeastern Ontario, KGH serves the South East LHIN through its Kingston facility and 24 regional affiliate and satellite sites. Fully affiliated with Queen's University, KGH is a research and teaching hospital where 2,400 health-care students learn and 175 health researchers work. Research Infosource has ranked KGH as one of Canada's Top 40 Research Hospitals since 2011. The KGH strategy for achieving Outstanding Care, Always, has lead the organization on a journey of quality improvement and helped KGH to stand out as a leading centre for patient- and family-centred, complex-acute and specialty care, research and teaching.. KGH's refreshed strategy for 2016-18 builds on our foundation of strong performance to maintain an relentless focus on six strategic directions:

1. Transform the patient experience through a relentless focus on quality, safety and service
2. Transform the workplace experience through a focus on work-life quality
3. Drive clinical innovation in complex-acute and specialty care
4. Create seamless transitions in care for patients across our regional health-care system
5. Maximize our research and academic health sciences potential
6. Create a high performing regional health-care system with our partners

The KGH Quality Improvement Plan (QIP) 2016-17 will focus on the following eight objectives in the five quality domains:

1. Effective Care:
   (i) Reduce readmission rates for patients with Chronic Obstructive Pulmonary Disease (COPD)

2. Efficient Care:
   (ii) Reduce unnecessary time spent in acute care

3. Patient--Centred Care:
   (iii) Improve patient satisfaction

4. Safe Care:
   (iv) Avoid patient falls
   (v) Increase proportion of patients receiving medication reconciliation upon admission
   (vi) Reduce hospital acquired infection rates
   (vii) Reduce the prevalence of skin integrity incidents

5. Timely Care:
   (viii) Reduce wait times in the Emergency Department

Our commitment to transforming the patient experience and providing care that is consistently safe and patient-centred is deeply rooted within the improvement objectives. Along with the principles that guide our work (respect, engagement, accountability, transparency and value for money), our QIP 2015-16 fosters a culture of continuous quality improvement and integration where patient needs come first.

QI Achievements from the Past Year

The KGH QIP for 2015-16 contained twelve indicators. Significant progress was attained over this last year. From Q1 to Q3, our performance on the percentage of QIP indicators that are on target improved from 50 per cent to 75 per cent. Indicators each have one or more tactics with an assigned ‘most responsible person’ (MRP) and executive lead. Patient Experience Specialists are embedded into the program councils that are accountable for each of the tactics and indicators. The greatest achievement at the end of Q3 was within the '90th percentile Emergency Department (ED) wait time' indicator. Over the last four quarters, the 90th percentile wait time decreased from 42.7 hours to a low of 27.6 hours.

This year we implemented a 'Get Out Of Gridlock (GOOG)' initiative. This project engaged all clinical directors, managers and charge nurses in twice daily huddles to analyze live data on ED volumes and wait times, ED length of stay (LOS) and ward and critical care bed availability. Opportunities driven by the project engaged physicians to drive earlier discharge times, earlier indication that a bed is read and a trial of an ED surge protocol. The surge protocol enabled patients to move into previously identified hallway locations on all wards. A committee of the clinical program leaders called "The Patient Flow Task Force" oversees and supports the initiative. The committee membership includes regional partner hospital clinical leaders and a Patient Experience Advisor. With help from Decision Support and program management, analysis of the daily bed census, ED LOS and volumes by the GOOG team, in addition to monthly tracking of the data, has provided invaluable insight into opportunities for process improvement.

Integration & Continuity of Care

Health care in the SE LHIN is undergoing a major restructuring project with the development of a sustainable regional model of hospital care. With a vision to improve access to high quality care through the development of regional systems of integrated care, KGH is partnering with its six regional partner hospitals and CCAC to develop options for joint services integration and reconfiguration. This will include integration of administrative, support and clinical services. Options will be developed based upon evidence and leading practice models. Engagement with patients during all phases of the project will inform the process. The outcome will be an improved, high quality and sustainable regional model of hospital care.

Areas of focus and resulting work plans include:

1. Business Function/Corporate Services
    a. Finance
    b. Human Resources
    c. Information Technology
    d. Hotel Services

2. Diagnostic and Therapeutics
    a. Diagnostic Imaging
    b. Laboratories
    c. Pharmacy

3. Clinical
    a. Urgent/Emergent
    b. Complex Chronic Care/Frail Elderly
    c. Elective
    d. Tertiary/Quaternary Services

KGH, Kingston and the region are actively involved in Health Links. The SE LHIN has seven Health Links that are looking at ways to connect family physicians and their patients with hospital specialists and community supports. The Kingston and Kingston Rural Health Link will develop plans and measure results to:

- Improve access to care for patients with multiple, complex conditions
- Reduce avoidable emergency department visits
- Reduce unnecessary readmission to hospitals shortly after discharge
- Reduce the wait time for referral from the primary care doctor to a specialist

The South East LHIN CCAC and Hospital Executive Forum (SECHEF) which is composed of LHIN, hospital and CCAC leaders, meet monthly to address issues affecting patient care in the south east. The members will jointly begin to address readmissions as a combined quality improvement initiative. Timely acquisition of data and a review process with full engagement of all hospital partners will be the measure of success in the first year of implementation.

In this QIP, KGH is partnering with all its LHIN partners to address readmission rates for patients suffering with Chronic Obstructive Pulmonary Disease (COPD). The SECHEF clinical table will empower a working group to oversee analysis to optimize and standardize care across the SE LHIN. Development of a regional care map will initiate a LHIN wide focus on acute care, repatriation and linkage to Health Links.

Engagement of Leadership, Clinicians and Staff

The initiatives and performance targets set out for the 2016-17 QIP are the outcomes of a comprehensive planning, priority setting and engagement process. Success and challenges with the QIP 2015-16 have guided selection of QIP initiatives with identified action plans that have been established with stretch goals and targets. The QIP is integrated into an ongoing cycle of planning and performance management at KGH and fully embedded within the annual corporate plan of the hospital. The rigor of this process enables leaders to be held accountable for results. Systems have been put in place to monitor our progress and communicate results to all levels of the organization, the community and Ministry. All programs and departments will be formulating tactical plans using continuous improvement principles to address the QIP and initiatives. A quarterly leadership review of the corporate strategic and QIP indicators ensures all clinical leaders and physicians are aware of gaps in performance against the targets. Physicians working through the Medical Advisory Committee's (MAC) Quality Committee have created clinical department-specific QIP's that align to the KGH QIP. Commitment to drive quality of care into the clinical departments is evident with physician specific metrics focusing on patient care.

Patient/Resident/Client Engagement

KGH is a national and international leader in patient- and family-centred care. Patient Experience Advisors have been incorporated into all operational and clinical program committees engaged in hospital decision-making. Patient Experience Advisors also sit on the selection committee for all key leadership positions at KGH. The QIP 2016-17 Steering Committee membership included a representative from the Patient and Family Advisory Council. The steering committee led the development of the QIP and selection of improvement initiatives, targets and change priorities. The process for approval of the QIP includes support from the Patient and Family Advisory Council.

Performance Based Compensation

Executive compensation is linked to the Integrated Annual Corporate Plan and to the QIP targets and initiatives within that plan. Each executive, including the President and CEO, has pay-at-risk that is tied to achieving QIP goals for 2016-17. The amount of pay-at-risk for executives ranges from approximately 3 per cent to 25 percent of total cash compensation. The payment of pay-at-risk occurs following the fiscal year-end evaluation of results. The amount awarded will be based upon the Board of Directors' evaluation of performance against specific thresholds.

Sign-off

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

Board Chair: Scott Carson

Quality Committee Chair: Diane Kelly

Chief Executive Officer: Jim Flett

2016/17 Quality Improvement Plan
"Improvement Targets and Initiatives"

Kingston General Hospital 76 Stuart Street

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
Effective	**Reduce readmission rates for patients with COPD**	Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with COPD (QBP cohort)	% / COPD QBP Cohort	DAD, CIHI / January 2014 – December 2014	693*	20.84	17.08	MoH risk adjusted expected rate.	1)With the support of SECHF develop a regional care plan for COPD patients in the SE LHIN for the purpose of reducing the acute care readmission rate for COPD patients.	A plan comprised of phases of work will be developed and implemented across the SE LHIN. The initial phase of work will be to establish a working group to oversee analysis and provide advice on process. Subsequent phases of work will focus on building a retrospective care continuum at the patient level. This will include visits across acute care sites and other venues of care. The purpose of which is to better understand the current state of regional COPD care. The final phase of work will be to develop system level recommendations aimed at optimizing COPD care in the SE LHIN.	Are project milestones being met.	Establish a working group. Conduct current state analysis on COPD care in the region. Make recommendations for change.	This indicator is intended to be included in each of the 2016/17 QIPs of all providers in the SE LHIN and contain a common set of planned improvement initiatives, process measures, and goals for change ideas.
Efficient	**Reduce unnecessary time spent in acute care**	Total number of ALC inpatient days contributed by ALC patients within the specific reporting period (open, discharged and discontinued cases), divided by the total number of patient days for open, discharged and discontinued cases (Bed Census Summary) in the same period.	% / All acute patients	WTIS, CCO, BCS, MOHLTC / July 2015 – September 2015	693*	14	13.20	Assigned by SE LHIN as per 2016-17 HSAA agreement.	1)Work on reducing ALC inpatient days continues from QIP 15/16. Planned for 16/17 is to develop a regional approach to solving the problem. This will involve cooperation from regional care partners as well as the SE LHIN.	Continuous improvement methods will be used (e.g. value stream mapping) to assist with understanding and improving patient flow issues on a regional level. Internally (KGH) our multidisciplinary twice daily patient flow meetings (Get out of Gridlock (GOOG) will continue for the purpose of improving communication and patient flow on a daily basis.	Complete the activities outlined in the KGH Patient Flow Action Plan. The 18 month plan was approved by SE LHIN Executive Forum in October 2016.	There are 3 areas of focus: inflow & ED diversion; intra-hospital flow; and outflow & discharge planning. Each area of focus has a number of activities with set timelines.	

Patient-centred	**Improve patient satisfaction**	"Would you recommend this ED to your friends and family?" add the number of respondents who responded "Yes, definitely" (for NRC Canada) or "Definitely yes" (for HCAHPS) and divide by number of respondents who registered any response to this question (do not include non-respondents).	% / ED patients	NRC Picker / October 2014 – September 2015.	693*	49.4	69.30	Ontario teaching hospital avg	1)Adoption of the Cleveland Clinic's Communicate with H.E.A.R.T. (SM) Model. KGH has shown itself to be a leader in the patient centred model of care. The H.E.A.R.T. program will clearly take that foundation of the patient experience to the next level and be very complimentary to existing systems including the Patient and Family Advisory Committee and the Patient Advisors participating on all corporate committees of the hospital. Continue with daily patient flow meetings and analysis (GOOG). Continue with IFPCC. Continue with hourly rounding. Realign PSQR staff to focus 2 FTEs on just patient relations.	Communicate H.E.A.R.T. (SM) will be rolled out to all staff with a series of training sessions. Focus will be on the creation of staff awareness of the impact of every patient, visitor and employee interaction. In addition, creating an understanding of the role of caregivers in providing world class care through 9 service behaviours will be emphasized (Acknowledge the other person, introduce self and role, Use person's preferred name, clearly communicate expectations, offer to resolve concerns or move to the appropriate person, use active listening, communicate empathy, use common courtesy and offer help). 3x daily bed allocator reports are e-blasted to the organization indicating where patient flow issues are occurring by location and the overall state available beds. Frequency of IFPCC meetings is reported quarterly as a KPI. Frequency of hourly rounding is reported as corporate KPI.	The number of staff participating in the training sessions.	1500 staff will participate in the training sessions by March 31, 2017.	
		"Would you recommend this hospital (inpatient care) to your friends and family?" add the number of respondents who responded "Yes, definitely" (for NRC Canada) or "Definitely yes" (for HCAHPS) and divide by number of respondents who registered any response to this question (do not include non-respondents).	% / All patients	NRC Picker / October 2014 – September 2015	693*	78.3	80.70	Ontario teaching hospital avg.	1)Adoption of the Cleveland Clinic's Communicate with H.E.A.R.T. (SM) Model. KGH has shown itself to be a leader in the patient centred model of care. The H.E.A.R.T. program will clearly take that foundation of the patient experience to the next level and be very complimentary to existing systems including the Patient and Family Advisory Committee and the Patient Advisors participating on all corporate committees of the hospital. Continue with daily patient flow meetings and analysis (GOOG). Continue with IFPCC. Continue with hourly rounding. Realign PSQR staff to focus 2 FTEs on just patient relations.	Communicate H.E.A.R.T. (SM) will be rolled out to all staff with a series of training sessions. Focus will be on the creation of staff awareness of the impact of every patient, visitor and employee interaction. In addition, creating an understanding of the role of caregivers in providing world class care through 9 service behaviours will be emphasized (Acknowledge the other person, introduce self and role, Use person's preferred name, clearly communicate expectations, offer to resolve concerns or move to the appropriate person, use active listening, communicate empathy, use common courtesy and offer help). 3x daily bed allocator reports are e-blasted to the organization indicating where patient flow issues are occurring by location and the overall state available beds. Frequency of IFPCC meetings is reported quarterly as a KPI. Frequency of hourly rounding is reported as corporate KPI.	The number of staff participating in the training sessions.	1500 staff will participate in the training sessions by March 31, 2017.	
Safe	**Avoid patient falls**	Reduction in level 1 to 4 falls with a focus on level 3 and 4 falls	Rate per 1,000 / All acute patients	Hospital collected data / Quarterly	693*	4.4	3.50	A 20% reduction in the rate set as an internal stretch target based on published best practice.	1)Reduction in Level 3 and Level 4 Falls: Recent Critical Incident Reviews have identified falls as a serious patient safety concern	1) Every patient upon admission will have a Falls Risk Assessment form completed including daily updates. 2) Apply the Falling Star protocol/assessment with every patient in the hospital 3) Using the Move On approach, have a safe, mobilization plan for every inpatient.	Falls Risk Assessment form completion compliance, daily assessment compliance, and high risk patients are appropriately identified (Falling Star) and have a documented/actioned mobilization plan.	100% compliance with assessment form completion, falling star identification, and documented and actioned mobilization plan	

Increase proportion of patients receiving medication reconciliation upon admission	Medication reconciliation at admission: The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital	% / All patients	Hospital collected data / most recent quarter available	693*	85	100.00	Tied to Accreditation Canada targets which focuses on care transitions (i.e. at admission, internal transfer and at discharge) for all Services and Programs using the same Accreditation Canada Qmentum Service standard.	1)Providing patients with the best possible medication history (BPMH) has been actively supported by dedicated Pharmacists and Pharmacy Technicians for patient admissions to the Medicine and Cardiac adult Programs including Internal Medicine, Gastroenterology, Nephrology, Neurology, Cardiology and Cardiac Surgery as well as the Oncology inpatient program including the Hematology Oncology, Radiation Oncology and the Palliative Care services. All other services are being addressed through the development of Order Sets (standardized preprinted orders) requiring physicians to obtain and document the BPMH on admission order sets. Expansion of the order set to all clinical programs is undergoing.	Order Set development the includes the BPMH with a standard set of admission orders will continue to rolled out to all patient medical services.	Hospital wide compliance with medication reconciliation on admission will be monitored. Current performance is 85%.	100% by March 31, 2017.	
Reduce hospital acquired infection rates	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	Publicly Reported, MOH / Jan 2015 - Dec 2015	693*	88	95.00	Internal stretch target set to be leader among Ontario teaching hospital peers	1)Monthly hand hygiene audits on all inpatient care units in clinic areas.	Auditors will collect hand hygiene compliance for all 4 moments of patient care. Data will be collected electronically using the audit tool. Data will be recorded and provided by provider group and clinical unit. Monthly data will be reviewed at the Patient Safety Quality and Risk and Infection Control Committee and MAC. Emphasis will be placed on identifying teachable moments to provide education and guidance on appropriate hand hygiene and glove usage.	Unit and provider hand rates will be tracked. Education on appropriate hand hygiene including patient work with hospital environment will be included in a mandatory LMS module and supplemented on all units by the IPAC service. compliance and value will be supplemented on all units by the Infection Prevention Team Specialists. Each clinical unit's compliance rate will be publically posted on the units. Percent compliance by clinical unit will be posted publicly on the units and overall hospital compliance will be posted at main entrances. Percent compliance by provider will be reviewed at the Patient Safety Quality and Risk and Infection Control Committee and MAC. Unit educators will support education to staff.	Achieve goal of 95% compliance by March 2017.	

	Reduce the prevalence of skin integrity incidents	The number of inpatient units that achieve a 25% reduction in skin ulcers.	Counts / all patients per selected inpatient unit	Hospital collected data / Monthly	693*	3	5.00	Set as an internal stretch target. Twenty-five per cent fewer inpatients experience skin ulcers on the 3 units (across 3 programs - medicine/surgery/critical care (K6, C10, K2 ICU)) with the highest prevalence. This will result in 4 less incidents in the ICU, 2 on C10, and 2 on K6.	1)Twenty-five per cent fewer patients experience skin ulcers on the 3 units (across 3 programs - medicine/surgery/critical care (K6, C10, K2 ICU)) with the highest prevalence. This will result in 4 less incidents in the ICU, 2 on C10, and 2 on K6.	1) Braden score completed on admission for 100 per cent of in- patients Braden score and skin assessment completed daily for all patients with documentation in chart.	Published compliance with Braden score at admission. Braden score and skin assessment daily. Incident checks on each patient on each of the 3 units will occur on a daily basis.	100 % compliance with Braden scores on admission, 100% compliance with daily assessments and 25% reduction in the prevalence of pressure ulcers on inpatients.	
Timely	**Reduce wait times in the ED**	ED Wait times: 90th percentile ED length of stay for Admitted patients.	Hours / ED patients	CCO iPort Access / January 2015 - December 2015	693*	31.8	29.00	Current performance is above target	1)Discharge Prediction on all clinical units: GRIDLOCK is a state of total congestion where patient need (inputs) far outweighs available bed capacity combined with an inability to move patients out of the ED to an inpatient bed in the necessary timeframes. KGH is committed to ensuring timely transfer of patients from the ED to an inpatient bed. Patients approaching a 24 LOS from decision to admit will be the priority for the next most appropriate bed. Patients requiring isolation will be reviewed daily to ensure all possible cohorting occurs reducing the number of private rooms and blocked beds for isolation reasons. Earlier rounds and prediction of discharge date is a key component of knowing what resources are available on a daily basis to initiate processes to make the bed available in a timely fashion.	Twice daily GOOG huddles are attended by managers and directors with a focus on patient flow. Patients waiting greater than 24 hours in any area that is considered to be the wrong level of care will be the priority for transfer. IPAC representation is also at the daily huddles so that decisions around isolation requirements happen in real time . A discharge prediction PDSA has been initiated to identify all steps in the discharge prediction process. A bed utilization flow sheet is updated every 8 hours and electronically circulated to all program leaders, directors and managers. The predicted discharge initiative will aim to have all discharges predicted in the subsequent 24 hours listed on the bed utilization. As well, it is expected that all pending discharges are put into PCS as soon as they are known as this triggers the bed ready notification. It will be expected that patients will start to move before the bed clean is completed.	The percent of inpatient discharges (i.e. departures) between 0600 and 1200 each day.	Calendar 2016 year-to-date December is at 29.2%. The target is set for 40% to be achieved by yearend.	Successful discharge prediction, coupled with earlier rounding on Medicine wards (0900 versus 1100), is expected to result in discharges earlier in the day. This will improve access to ED stretchers as admitted patients move to inpatient units near or before midday, when ED arrivals begin to approach their daytime peak.