Kingston Health Sciences Centre

Centre des sciences de la santé de Kingston

KHSC 2019/20 Quality Improvement Plan

Indicator Workplan

Hôpital Hotel Dieu Hospital

Hôpital Général de Kingston General Hospital

Emergency department wait time for inpatient bed (Mandatory)

Description: This indicator measures the time interval (hours) between the Disposition Date/Time (as determined by the main service provider) and the Date/Time Patient Left Emergency Department (ED) for admission to an inpatient bed or operating room.

Quality Domain:	**Timely**		
MRP:	T. Hart	**Executive Sponsor:**	M. McDonald
Current Performance:	28.9 hours (FY 18/19 Q3) FY 18/19: 19.1(Q2), 18.5(Q1) FY 17/18: 21.9(Q4)	**19/20 Target:**	**Q1: 17.6 Q2: 18.1** **Q3: 27.5 Q4: 20.8**
Target Justification:	Time to bed is greatly influenced by seasonal variability. The target represents a 5% improvement from the previous fiscal year's performance during the same time period.		

Planned Improvement Initiatives	**Methods**	**Process Measures**	**Target for Process Measure**	**Comments**
Enhance the Operations Manager (ACO) role and staff 24 hours a day/ 7 days a week.	Conduct an analysis (PDSA) of the 12 month ACO pilot. Review current state and identify future state opportunities for improvement to improve efficiency.	Completion of pilot assessment and opportunities for improvement identified.	Assessment completed in Q1.	A full-time ACO position has been piloted for the last 12 months as a result of Pay for Results (P4R) funding. Previous to this design there was siloed management of inpatient beds resulting in suboptimal use of clinical resources. Issues included delays in patient transfers out of the ED and critical care due to late discharges stemming from inpatient overcapacity. This resulted in a backlog of admitted patients who remain in the ED because an inpatient bed is not available. The ACO helps to coordinate and expedite patient transfer to wards as discharge processes are underway so that ED bed space can be vacated in support of new emergency arrivals. During the pilot KHSC experienced its highest number of ED visits, ED admitted patients and average number of ALC patients per day in over 3 years. The ACO role has proven pivotal in managing patient flow pressures to ensure an equitable and safe care environment in which large number of patients are not boarded solely in the ED.

Planned Improvement Initiatives	Methods	Process Measures	Target for Process Measure	Comments
	Implementation plan generated with opportunities for improvement from PDSA. Opportunities identified thus far include bed utilization protocols, 24 hour breach protocol (when a patient has remained in the ED for more than 24 hours) and the elective admission process (HARF).		100% of improvement opportunities identified completed by Q4.	

Number of workplace violence incidents (Mandatory)

Description: This indicator measures the number of reported workplace violence incidents by hospital workers (inclusive of affiliates such as learners and physicians) within a 12-month period.

Quality Domain:	**Safety**		
MRP:	J. Noonan	**Executive Sponsor:**	S. Carlton
Current Performance:	Q3: 149 incidents	**19/20 Target:**	**Q3: 165 incidents** **FY Target: >660 incidents**
Target Justification:	As indicated below, the change ideas for this indicator are likely to have a polarizing impact on the target. As a result a modest target of a 10% increase in the number of reported incidents per quarter as compared to the 18-19 baseline quarter has been selected. This would result in a total of >660 incidents reported in FY 2019-2020. • Although we have seen a steady increase in our reported incidents of workplace violence over the past several years, we know that violence incidents continue to be underreported. Actions to improve staff awareness of workplace violence are likely to result in an increase in the number of incidents reported. • Actions to make the workplace environment safer will decrease episodes of workplace violence and reported incidents. Indicator data includes the number of actual physical incidents of violence, or threats thereof, and verbal violence where staff indicates they felt they were at risk of physical injury. The definition of "staff" includes by hospital employees and affiliates (i.e. students and physicians). Note - one violence incident may result in an incident report that identifies more than one staff member being affected. Our incident metric captures the number of all affected staff to meet the intended requirement of reporting each staff incident.		

Planned Improvement Initiatives	Methods	Process Measures	Target for Process Measure	Comments
Revise the current "Risk Reduction Plan" required for patients with an active Behavioural Crisis Alert (BCA) flag, to make it more comprehensive.	Occupational Health & Safety will lead this initiative with support from professional practice, clinical learning specialists and consultation with stakeholder groups (i.e. The Mental Health Program Working Group, Joint Health & Safety Committee (JHSC) and the Workplace Violence Prevention (WVP) Working Group).	Progress on the completion of the risk reduction plan will be provided quarterly until the revisions are complete.	Risk Reduction Plan revised by the end of Q1.	

Planned Improvement Initiatives	Methods	Process Measures	Target for Process Measure	Comments
Develop a mechanism for the risk reduction plan to be accessible to staff for patients who are readmitted. This will provide staff with important historical information to help manage patient behaviors.	OHS will lead this initiative with support from Professional Practice, IT, Privacy Department, and Medical Records, with consultation with the appropriate stakeholder groups (i.e. Mental Health Program Working Group, JHSC and the WVP Working Group).	All Risk Reduction Plans are retained electronically and accessible to staff.	A technological solution is determined by the end of Q2.	
Improve compliance with the completion of Risk Reduction Plans for patients with active BCA flags.	OHS to lead this initiative with support from the Quality Professional Practice (QPP) Working Group, clinical learning specialists, program managers, and unions.	Quarterly audits on the completion of Risk Reduction Plans for patients with active BCAs.	≥65% completion rate of completed risk reduction plans on the charts of patients with an active BCA by end of Q4.	Audits of completed risk reduction plans over the last 4 quarters have had a compliance rate ranging between 40 – 65%. We anticipate steady improvement over the 19-20 fiscal year.
Plan and implement an internal Workplace Violence Prevention (WVP) campaign.	OHS, in consultation with Communications, WVP related working group, JHSC and Senior Leadership will develop a Workplace Violence Prevention Campaign. The campaign will include multiple initiatives over the 12 month period. Key deliverables include the revision of the workplace violence prevention posters for both sites and profiling 2 initiatives in KHSC Now.	Campaign initiatives identified.	Campaign initiatives successfully completed by end of fiscal year.	

Planned Improvement Initiatives	Methods	Process Measures	Target for Process Measure	Comments
Actively work through the 2019-20 Mental Health (MH) and Corporate Workplace Violence Risk Registry to develop and implement an action plan.	The newly established Mental Health Program Working Group (inclusive of front line staff and union representation) will develop an action plan inclusive of MRPs and timelines/deliverables for the recommended actions on the risk registry.	Completion rate of WVP risk registry recommendations.	By end of Q1, 80% of recommendations will be identified as “on track” for completion as per their established timelines.	The Mental Health (MH) and Corporate WVP Action Risk Registry is the result of recommendations stemming from an external MH and Emergency Department safety/security assessment as well as an internal self-assessment completed by Security Program.
Modify the electronic Violence Reporting Form to include workplace specific workplace violence definitions as per the Occupational Health & Safety Act.	OHS to configure the reporting software and test with front line staff.	Configuration status (in progress, in test and complete).	Modifications completed by end of Q1.	Currently all reported hazards/incidents/near misses that are of a physical or verbal nature are included in the QIP. For incidents of verbal abuse, the electronic form does not currently include a field to document if the staff member felt there was a threat of physical violence (as per the QIP WP violence indicator). This software modification will include a question on each incident report that asks whether the employee felt there was a threat of violence.

Early identification of patients requiring palliative care support (Custom)

Description: This indicator measures the proportion of hospitalizations in the most recent 6 months where patients were identified at risk of dying and in need of palliative care.

Quality Domain:	**Effective**		
MRP:	L. Van Manen	**Executive Sponsor:**	B. Carter
Current Performance:	CB	**19/20 Target:**	**CB**
Target Justification:	Last fiscal year KHSC focused on identifying patients that could benefit from palliative care resources using a discharge disposition of “home with support”. Performance over the last 4 quarters exceeded the target of 90%. We believe that the implementation of an automated process using a validated tool to identify patients requiring a palliative approach to care will ensure a robust denominator that reflects the true extent of the target population.		

Planned Improvement Initiatives	Methods	Process Measures	Target for Process Measure	Comments
Implement the HOMR tool (modified Hospital One-Year Mortality risk Model) to electronically identify inpatients that would benefit from palliative care services.	Source the HOMR tool and estimate the resources and costs required for implementation.	Completion of feasibility review.	Feasibility review completed by Q2.	The HOMR tool identifies admitted patients at elevated risk of death in the coming 12 months, and prompts clinicians to assess and address their unmet palliative needs. The tool is based on the HOMR score, which uses administrative data available in the electronic record at the time of admission (e.g. age, sex, admitting service, number of recent emergency department visits) to predict 12-month mortality. The electronic application automatically retrieves this data and calculates each patient’s mortality risk upon admission. If any patient’s mortality risk exceeds a predefined threshold, a message is sent to their clinical team prompting them to assess and address unmet palliative needs. Sourcing of this tool is a critical first step as it will identify whether this tool will interface with the KHSC electronic health record or a regional health information portal.
	Identify the appropriate platform, i.e. South East Hospital Integrated Information Portal (SHIIP), Patient Care System (PSC) ConnectingOntario.			
	Create implementation plan with appropriate milestones and timelines.	Completion of project milestones.	HOMR implemented by end of Q4	

ALC Conversion Rate (Custom)

Description: This indicator measures the number of new ALC patients (excluding ALC-Mental Health & ALC-Palliative patients)/ the total number of new adult admissions.

Quality Domain:	**Efficient**		
MRP:	TBD	**Executive Sponsor:**	M. McDonald
Current Performance:	**Q3 – 5.5%**	**19/20 Target:**	**CB**
Target Justification:	This indicator is a multi-year initiative. The focus of this fiscal year will be to use a structured QI science approach to create a corporate mobilization strategy inclusive of an implementation plan.		

Planned Improvement Initiatives	Methods	Process Measures	Target for Process Measure	Comments
	A dedicated team will create a plan inclusive of key milestones that need to be achieved in the creation of a corporate mobilization strategy. Milestone progress will be reported on quarterly.	Completion of project milestones.	Corporate mobilization strategy created by end of Q4.	Literature indicates that older patients admitted to hospital are at an increased risk for hospital-acquired morbidity related to immobility which could result in complications such as delirium, ulcers, pneumonia and muscle atrophy. It's estimated that each day spent immobile is associated with 1% - 5% loss of muscle strength in an older person. We anticipate that a corporate mobilization strategy will result in improved patient outcomes resulting in patients being more successful in returning to their pre-hospital destination and not being converted to ALC in hospital.