Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

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 HQO (if required) in the format described herein.
Overview

Kingston General Hospital 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 almost 500,000 people through its Kingston facility and 24 regional affiliate and satellite sites. Fully affiliated with Queen’s University, KGH is a research and teaching hospital which is home to 2,400 health-care students and 175 health researchers. KGH has been ranked since 2011 as one of Canada’s Top 40 Research Hospitals by Research Infosource. The KGH 2015 strategy for achieving Outstanding Care, Always, has lead the organization on a journey of quality improvement enabling our vision to be a top performer making Outstanding Care, Always a reality for every patient, every day. KGH has maintained an unyielding focus on four strategic directions to achieve this goal:

1. Transform the patient experience through a relentless focus on quality, safety and service
2. Bring to life new models of interprofessional care and education
3. Cultivate patient-oriented research
4. Increase our focus on complex-acute and specialty care

The QIP 2014-15 will focus on 8 priority measures as suggested by Health Quality Ontario (HQO):

1. Reduce emergency department wait times
2. Improve organizational financial health
3. Reduce unnecessary deaths in hospital
4. Reduce unnecessary time spent in acute care
5. Reduce unnecessary hospital admission
6. Improve patient satisfaction
7. Increase the proportion of patients receiving medication reconciliation upon admission
8. Reduce hospital acquired infection rates

Our commitment to transforming the patient experience and providing care that is consistently safe and patient-centered is deeply rooted into the QIP 2014-15. Along with the principles that guide our work – respect, engagement, accountability, transparency and value for money – our QIP 2014-15 clearly resonates with the Excellent Care For All Act and its goal of fostering a culture of continuous quality improvement and integration where the needs of patients come first.

Integration & Continuity of Care

Health care in the South East LHIN, is actively undergoing transformation in the way that all providers integrate health service delivery in the region. Through a collaborative stakeholder consultation involving KGH, its partner hospitals and the Community Care Access Centre (CCAC), the Clinical Services Roadmap (CSR) was developed. The CSR focuses on seven areas of improvement to find better ways to improve access to care and streamline the continuity of care between providers while simultaneously improving quality of care and the patient experience. These areas of focus and resulting work plans include:
1. **Cardiovascular care** (focusing on chronic heart disease management and a reduction in readmission to hospital following a cardiac incident),
2. **Emergency department wait times** (and the need to improve processes that will reduce the amount of time people wait to receive care),
3. **Healthcare acquired infections (HAI)** (to reduce the number and severity of infections caught in health care settings; focus on hand hygiene compliance and regional initiatives),
4. **Mental health & addiction services** (ensuring patients receive the right care at the right time in the right place),
5. **Restorative care** (focused on coordinating care between health-care providers, rehabilitation specialists, and managing chronic continuing care),
6. **Maternal and high-risk newborn care** (to ensure the latest treatments and services are used when caring for high-risk mothers and their babies), and
7. **Surgical services** (creating a regional, collaborative plan to manage effective inter-hospital care, including repatriation protocols).

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

Within KGH, our Patient and Family Centred Care (PFCC) approach has firmly taken root over the past four years, and continues to flourish. Its evolution has been with the full support of our Board of Directors and senior leadership and has garnered national and international recognition. The concept is articulated in the KGH 2015 Strategy, and milestones and measures have been incorporated into the performance management system.

**Challenges, Risks & Mitigation Strategies**

KGH is the only hospital in the SE LHIN providing adult tertiary complex-acute care. As a result, high occupancy levels remain an ongoing challenge. The increasing frequency of gridlock status has prompted KGH to make improving patient flow a top corporate priority. An extensive continuous improvement process with broad stakeholder engagement has identified many process improvement cycles encompassing key QIP metrics including emergency department flow including length of stay, readmissions, medication reconciliation and infection control.

Nevertheless, there are challenges and risks we face in relation to the proposed QIP:

1. **External challenges and risks:**
   - Fiscal challenges with the implementation of a new funding model and new QBP initiatives
   - Resource requirements to support the new Ministry initiative known as Health Links
   - Ongoing support for the SE LHIN Clinical Services Road Map

2. **Internal challenges and risks:**
   - Rising volume of ED activity and admissions over the last fiscal year impacting ED wait times
   - Sustainability of the targets we have reached and organizational capacity to meet any additional external challenges and risks
Information Management Systems

KGH tracks 116 indicators in depth on a quarterly cycle. Each indicator is purposely aligned to improvement priorities and milestones that are set annually to support the KGH 2015 strategy. Programs with continuous-improvement tactics manage priorities specifically linked to the QIP. Each indicator has its own stretch target based on best practice, provincial best or theoretical best achievement. Corporate accountability for review lies with the Quality of Patient Care Committee of the Board.

Engagement of Clinical Staff & Broader Leadership

The initiatives and performance targets set out for the 2014-15 QIP are the outcome of a comprehensive planning process, priority setting and engagement. A recent staff and physician NRC engagement survey has 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 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 set out in the annual corporate plan. 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.

Accountability Management

KGH has a comprehensive performance management program. Each year, KGH creates an Annual Corporate Plan (ACP) that includes: performance milestones, annual targets, and tactical plans to deliver on our hospital’s strategy. The QIP targets and initiatives are also incorporated into the Annual Corporate Plan. Regular reporting of progress against the plan is delivered to leaders, staff members, the Board and our community. Quarterly reviews of the ACP are completed by the executive and Board.

Executive compensation is linked to the QIP. Each executive, including the President and CEO, has pay at risk that is tied to achieving QIP goals for 2014-15. The amount of pay at risk for executives ranges from three to seven percent of total cash compensation. The payment of pay at risk related to the QIP 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 in the Executive Performance Agreements that align to the Quality Improvement Plan.
Health System Funding Reform

HSFR has been a significant transformational change for health-care organizations. As a result of some of the changes underway, KGH has utilized materials and toolkits through the Ministry's Health Data Branch to provide the programs with tools to meet the obligations of Quality Based Procedures (QBP) throughout fiscal 2013-14. The complexity of maintaining the additional QBP programs in fiscal 2013-14 and the next two waves in 2014-15, has prompted a redesign at KGH. A QBP toolkit recently released from the OHA to support implementation of QBPs has provided KGH with new tools to refresh and realign accountability of the working groups to a central steering committee. This will ensure internal action plans adopt clinical best-practice pathways while aligning to QIP improvement tactics.

Working with our regional partners and the SE LHIN, service capacity planning for orthopedics and ophthalmology, in addition to the CSR will support and be supported by our QIP priorities to mitigate admissions and time spent in the hospital.

Sign-off

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

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

Tom Buchanan
Board Chair

Geoffrey Quirt
Quality Committee Chair

Leslee Thompson
President & CEO

Instructions: Enter the person's name. Once the QIP is complete, please export the QIP from Navigator and have each participant sign on the line. Organizations are not required to submit the signed QIP to HQO. Upon submission of the QIP, organizations will be asked to confirm that they have signed their QIP, and the signed QIP will be posted publicly.
### 2014/15 Quality Improvement Plan for Ontario Hospitals

#### Kingston General Hospital 76 Stuart Street

<table>
<thead>
<tr>
<th>Measure</th>
<th>Objective</th>
<th>Unit / Population</th>
<th>Source / Period</th>
<th>Org Id</th>
<th>Current perfor.</th>
<th>Target perfor.</th>
<th>Priority level</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce wait times in the ED</td>
<td>All wait times; 90th percentile ED length of stay for Admitted patients.</td>
<td>ED / ED patients</td>
<td>2013/14</td>
<td>1</td>
<td>0</td>
<td>Improve</td>
<td>3</td>
<td>Based on SouthEast LHIN LHSA negotiated targets</td>
</tr>
<tr>
<td>Improve HSMR</td>
<td>In year, deaths in hospitals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3</td>
<td>HSMR: Number of observed to expected mortality adjusted for factors affecting mortality, which is calculated through a vertically oriented system that has indicated a mortality rate and the overall average rate. An HSMR greater than 100 suggests the local mortality rate is higher than the overall average whereas a HSMR less than 100 suggests the local mortality rate is lower than the overall average. It is important to note that the HSMR is not designed for comparisons between hospitals. It is intended to track a hospital's trend</td>
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<tr>
<td>Improve PDSA processes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3</td>
<td></td>
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</table>

### Comments

- **Effectiveness**

  - **Improve organizational financial health**
    - Total Margin (consolidated): % by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expenses excluding the impact of facility amortization, in a given year.
    - N/A / N/A
    - 2013/14
    - 2012/13
    - Not specified
    - Maintain
    - 0
    - The variance between the actual financial position and budgeted financial position measures the accuracy of the planning model and management's ability to live within the available financial resources.

  - **Improve PDSA processes**
    - Hospital Standard Mortality Ratio (HSMR) is an important quality of care measurement tool that provides a starting point to assess mortality trends, identify opportunities for improvement and track progress. The HSMR is adjusted for factors affecting mortality, such as age, sex, and length of stay. An HSMR equal to 100 suggests that there is no difference between the hospital's mortality rate and the overall average rate. An HSMR greater than 100 suggests that the local mortality rate is higher than the overall average whereas a HSMR less than 100 suggests the local mortality rate is lower than the overall average. It is important to note that the HSMR is not designed for comparisons between hospitals. It is intended to track a hospital's trend.

  - **Improve ICU mortality**
    - Sepsis Mortality Review: The Dept of Medicine has the largest patient activity and bed occupancy. ICU mortality review is a process based upon probability of death from the HSMR data set has not seen value to process improvement or quality of care.
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### Change ideas

- **Bedmap redesign**
  - Hospital bed occupancy rate varies greatly amongst admitting services with ranges of 120%.
  - Despite the availability of beds during a Gridlock status, service mismatches to bed location is a quality of care risk due to a care provider expertise mismatch (off service). A bed map redesign will be be implemented to increase bed availability in clinical services having a high occupancy rate to mitigate extended stays in ED waiting for bed availability and get patients admitted to the best location.

- **Sepsis Mortality Review**
  - The Department of Medicine has the largest patient activity and bed occupancy. Sepsis mortality review is a process based upon probability of death from the HSMR data set has not seen value to process improvement or quality of care.
  - A PDSA analysis will be conducted for key consulting services viz. Medicine, General Surgery and Orthopedic Surgery. Areas of opportunity will be identified and put into place and effect of consults times noted.

- **Improve ED specialist consult time**
  - ED length of stay is the time encompassing the time of registration to leaving the ED. Many maps in this process have opportunities for reducing time in the continuum of care. The length of time it takes the consultant to arrive in the ED is one of these opportunities.

- **Implement discharge planning**
  - Discharge planning FDSA 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. One medical and one surgical unit have piloted the discharge prediction process.

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**Measure**

| Measure/Indicator | Unit/Source | Current perf. | Target | Priority Level | Change
|-------------------|-------------|---------------|--------|---------------|--------|
| Readmission to any facility within 30-days for selected CMGs for any reason | N/A | 12.9 | 9.46 | | Improve
| Readmission management partnership with CCAC for ED patients | N/A | 9.46 | 8.76 | | Improve
| Adoption of e-Discharge tool to improve the discharge summaries sent to the primary care providers within 72 hours of patient discharge | N/A | 77% | 85% | | Improve
| 2)Two Health Links have been initiated in the immediate vicinity of KGH: the Kingston Health Links and the Rural Kingston Health Links. Focus is on supporting the Family Physicians/Health team on identification of chronic disease patients frequenting the emergency department of KGH. The two primary chronic diseases are COPD and CHF. | N/A | | | |

**Goal for change ideas**

- Improve patient satisfaction
  - Remove patient and family centered care standards in every clinical area
  - Reduce unnecessary time spent in acute care
  - Reduce unnecessary hospital readmission

**Comments**

- Percent e-Discharge summaries completed (electronically signed off) within 72 hour. Current performance 85%
- Zero Level 3 and 4 falls within each quarter
- 85% compliance within each of the 5 standards across clinical areas
- 100% attendance
- 100% of admissions for all patients with primary diagnosis of ALC status made within 72 hours of admission.
**Safety**

**Objective**
Increase proportion of patients receiving medication reconciliation upon admission

<table>
<thead>
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<th>Target</th>
<th>Target justification</th>
<th>Priority level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication reconciliation at admission</td>
<td>% / All patients cared</td>
<td>Hospital collected data / Most recent quarter available (e.g. Q2 2015/16, Y1 2013/14 etc.)</td>
<td>009*</td>
<td>72</td>
<td>100</td>
<td>Internal stretch target</td>
<td>Improve</td>
</tr>
</tbody>
</table>

**Change Plan**
Providing all patients with the best possible medication history (PMH) has been actively supported by dedicated Pharmacy Technicians in the ED for all admissions. Alternate admission points to the hospital are being addressed through the development of Order Sets (standardised preprinted orders). Expansion of the order set to all clinical programs will be initiated.

**Goal for change ideas**
Hospital wide compliance with medication reconciliation on admission will be monitored. Current performance is 72%. Achieved goal by March 31, 2015.

**Rehab hospital acquired infection rates**

<table>
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<th>Target</th>
<th>Target justification</th>
<th>Priority level</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDR rate per 1,000 patient days</td>
<td>Rate per 1,000 patient days / All patients</td>
<td>Publicly Reported, MOH / 2013</td>
<td>009*</td>
<td>0.35</td>
<td>0.37</td>
<td>Target is set quarterly based on provincial average</td>
<td>Improve</td>
</tr>
</tbody>
</table>

**Change Plan**
Expansion of the Antibiotic Stewardship program to all critical care areas of the hospital. Compliance and process will be monitored by the Infection Control and Service and Infection Committee.

**Goal for change ideas**
Antibiotics dispensed quarterly to ED and admitted patients per 1,000 patient days. Current performance = 243. 45% reduction in antibiotic defined days close.

**Hand hygiene compliance before patient contact**

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<tbody>
<tr>
<td>Hand hygiene compliance before patient contact</td>
<td>% / Health providers in the entire facility</td>
<td>Publicly Reported, MOH / 2013</td>
<td>009*</td>
<td>97</td>
<td>95</td>
<td>Target is based on desired improvement</td>
<td>Improve</td>
</tr>
</tbody>
</table>

**Change Plan**
Monthly hand hygiene audits on all units and wards. Auditors will collect hand hygiene compliance for all moments of care. Data will be collected electronically using the audit tool and recorded by provider group and clinical unit. Monthly data will be reviewed at the Patient Safety Quality and Risk Committee and MAC.

**Goal for change ideas**
Unit and provider rates will be tracked. Education on hand hygiene compliance and value will be supplemented on all units by the Infection Prevention Team Specialists. Percent compliance by clinical unit will be posted publicly on the unit, and overall hospital compliance will be posted at main entrances. Percent compliance by provider will be reviewed at the Patient Safety Quality and Risk Committee and MAC. Unit educators will support education to staff.

**Goal for change ideas**
Achieve goal of 95% compliance by March 2015.

**Reduction rates of deaths and complications associated with surgical care**

<table>
<thead>
<tr>
<th>Measure/Indicator</th>
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<th>Source/Period</th>
<th>Org. Id</th>
<th>Current perf.</th>
<th>Target</th>
<th>Target justification</th>
<th>Priority level</th>
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<tbody>
<tr>
<td>5-day inhosp mortality</td>
<td>Rate per 1,000 major surgical cases / All patients with major surgery</td>
<td>CPRS - Reporting Tool / 2015/16</td>
<td>009*</td>
<td>10.52</td>
<td>8.68</td>
<td>Current performance and target based upon most recent data from CIHI (Fiscal 11/12)</td>
<td>Improve</td>
</tr>
</tbody>
</table>

**Change Plan**
UI formal mortality review will be conducted on all patients dying within 5 days of major surgery. The same format as the existing Clinical Incident Reviews conducted under the ECFAA, recommendation will be made focusing on process improvement opportunities.

**Goal for change ideas**
Mortality reviews for all mortality within 5 days of major surgery will be conducted by the respective department's quality committee. All recommendations will have a MRP assigned for implementation/completion. Completion rates for reviews will be monitored by the MAC's Joint Utilization and Quality Committee.

**Goal for change ideas**
Reaching goal of 100% completion of the mortality reviews.

**Goal for change ideas**
100% NOTE: 11/12 - performance based on current data. 10.52, peer target 8.68. Waiting for updated data from CIHI.

**Surgical Safety Checklist: number of times all three phases of the surgical safety checklist was performed (briefing, time out and debriefing) divided by the total number of surgeries performed, multiplied by 100 - consistent with publicly reportable patient safety data.**

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<th>Target justification</th>
<th>Priority level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical Safety Checklist completion</td>
<td>% / All surgical procedures</td>
<td>Publicly Reported, MOH / 2013</td>
<td>009*</td>
<td>84.73</td>
<td>100</td>
<td>Target is based on best performance</td>
<td>Improve</td>
</tr>
</tbody>
</table>

**Change Plan**
Compliance for all three phases of the surgical safety checklist by all surgical disciplines will be monitored with daily reporting of compliance with each phase for all surgical procedures.

**Goal for change ideas**
Reporting will be separated by discipline and sent to the respective Department or Division for review and comment.

**Goal for change ideas**
Compliance with performance on all 3 phases of the surgical safety checklist.