Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

Quality Improvement Plan (QIP) Progress Report for 2018/19

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.

Measure/Indicator from 2018/19 QIP	Current Performance stated on 18/19 QIP	Target stated on 18/19 QIP	Current Performance 18/19 (Q2)
"Would you recommend this emergency department (ED) to your friends and family?" (KGH - ED)	58.8%	61.0%	**64.7%**

Change Ideas from Last Year's QIP (QIP 2018/19)	Was this implemented?	Lessons Learned
1. ED patient care team will work with Patient Relations and Patient Experience Advisors to review patient experience data and patient relations data to identify improvement opportunities and gauge improvement.	**Yes**	In FY 18/19 Patient Relations introduced a quarterly patient experience infographic which summarizes patient relations and patient surveying data. This report highlights the top three areas for improvement and initiatives being undertaken within the program to improve the patient experience. This report is shared with the ED leadership and staff and at Program Council and ED Clinical Care & Quality Management meetings. Patient Experience Advisors participate in the Program Council and are able to provide feedback on the report. One area of recent success is the addition of a Nurse Practitioner in the ED to see patients in the fast track section during daytime hours.

Measure/Indicator from 2018/19 QIP	Current Performance stated on 18/19 QIP	Target stated on 18/19 QIP	Current Performance 18/19 (Q2)
"Would you recommend this hospital to your friends and family?" (KGH Inpatient Care).	67.6%	70%	**67.3%**

Change Ideas from Last Year's QIP (QIP 2018/19)	Was this implemented?	Lessons Learned
1. The majority of comments on patient surveys are related to the environment (cleanliness) and to the food that is served to inpatients. Each quarter, review the Medicine inpatient survey results and comments as well as the Patient Relations feedback related to cleanliness and food. Find opportunities for improvement within those two areas. Involve other departments and services as needed.	**Yes**	In FY 18/19 Patient Relations introduced a quarterly patient experience infographic which summarizes patient relations and patient surveying data. This report highlights the top three areas for improvement and initiatives being undertaken within the program to improve the patient experience. This includes those related to physical environment, nutrition as well as other dimensions.
2. Continue to report on the PFCC standards by performing regular audits of the standards. Standards include: hourly rounding, identification badges worn at chest level, updated patient white boards, introductions with each patient interaction and patient led feedback forums.	**Yes**	PFCC audits are completed to monitor adherence to hourly rounding, ID badges worn at chest level, updated patient white boards, introductions with each patient interaction and patient led feedback forums.

Measure/Indicator from 2018/19 QIP	Current Performance stated on 18/19 QIP	Target stated on 18/19 QIP	Current Performance 18/19 (Q2)
"Would you recommend this hospital to your friends and family? (HDH –Urgent Care Centre)?	69.7	71.0	**63.1%**

Change Ideas from Last Year's QIP (QIP 2018/19)	Was this implemented?	Lessons Learned
1. Urgent Care Centre (UCC) patient care team will work with Patient Relations and Patient Experience Advisors to review patient experience data and patient relations data to identify improvement opportunities and gauge improvement.	**Yes**	In FY 18/19 Patient Relations introduced a quarterly patient experience infographic which summarized patient relations and patient surveying data. This report highlights the top three areas for improvement and initiatives being undertaken within the program to improve the patient experience. This report is shared with the ED leadership, staff, Program Council, ED Clinical Care & Quality Management meetings. Patient Experience Advisors participate in the Program Council and are able to provide feedback on the report.

Measure/Indicator from 2018/19 QIP	Current Performance stated on 18/19 QIP	Target stated on 18/19 QIP	Current Performance 18-19 (Q3)
# days from clinic appointment until dictated clinic letter has been verified (Includes only clinic letters that are dictated using the central hospital dictation system; Excludes letters that are dictated by physician offices and not transcribed into the Patient Care System (PCS).	CB	CB	**CB**

Change Ideas from Last Year's QIP (QIP 2018/19)	Was this implemented?	Lessons Learned
1. Clearly communicate the rationale and expectations for this indicator to all KHSC physicians and demonstrate a hospital-wide commitment to review, understand, discuss, and improve performance.	**Partial**	In Q3 the average number of days from the patient's clinic appointment until the dictated letter was verified was 68 (days). There is some discrepancy with this metric as not all clinics have a dictated letter and not all letters are generated at KHSC. This metric is still being examined to determine baseline for future reporting. This initiative was not fully implemented due to a number of factors including competing priorities, changes in staff and a focus on other approved indicators. Education with physicians on timely completion of dictated clinical letters and follow up to referring physicians was completed.
2. Gain endorsement from the Medical Advisory Committee (MAC) to develop a policy to guide when a dictated clinic letter is expected.	**No**	This initiative was reviewed by the Medical Advisory Committee (MAC) and the Patient Records subcommittee. Due to competing priorities this change idea was not completed.

Measure/Indicator from 2018/19 QIP	Current Performance as stated on 18/19 QIP	Target as stated on 18/19 QIP	Current Performance 18/19 (Q2)
Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital (KGH Inpatient)?	58.42	62.00	**55.7%**

Change Ideas from Last Year's QIP (QIP 2018/19)	Was this implemented?	Lessons Learned
1. Implement a patient oriented discharge summary called My Discharge Plan (MDP) on specified patient populations.	**Yes**	Approximately 12,000 MDPs have been generated (as of Nov 31 2018). Several programs have created standardized templates that will prepopulate patient information based on diagnosis. Other programs are currently developing templates.
2. Include a focus on the use of plain language and the 'teach-back' method, recommended health literacy best practices shown to enhance provider and patient communication.	**Yes**	Plain language and teach-back education has been provided to approximately 2000 staff, learners and volunteers throughout the organization. Partnerships to share health literacy information have been developed with community organizations such as the Seniors Association. This education is now included in the interprofessional orientation and as part of the PCA orientation as it applies to fall prevention. The use of plain language and teach-back is included as part of the fall prevention strategy and policy for engaging with patients and families.
3. Submit a Pay 4 Results proposal for a redesigned discharge process that includes the combined use of evidence-based health literacy strategies, My Discharge Plan and post discharge phone calls to be completed within 24 to 48 hours following discharge of Internal Medicine patients.	**Yes**	Planning for the discharge phone calls occurred in Q1 and Q2 with the co-production and step-wise implementation of an evidence-based transition toolkit founded on health literacy principles. The toolkit was designed to identify risk factors for hospital reutilization, standardize interventions, improve patient preparation for discharge and ensure access to appropriate and timely aftercare. Toolkit strategies include My Discharge Plan, the use of plain language and teach-back for patient communication and education, and scripted follow-up phone calls 48-72 hours after discharge. Development of partnerships with healthcare providers and agencies has been essential. Health Literacy Nurse positions (1.5 FTE) were staffed in September 2018. Post discharge calls began in September 2018. Data collection of specific metrics is ongoing, including LACE scores (predictive of readmissions with patient populations at general hospitals), and Care Transition Measure – 3 (a validated and reliable patient self-report measure of the quality of transitions). The post discharge calls were implemented at the end of Q2 and therefore would impact patient satisfaction surveying results for Q3 onwards which are not reflected in the performance noted above.

Measure/Indicator from 2018/19 QIP	Current Performance as stated on 18/19 QIP	Target as stated on 18/19 QIP	Current Performance 18-19 (Q4)
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.	57.04	80	**92.4%**

Change Ideas from Last Year's QIP (QIP 2018/19)	Was this implemented?	Lessons Learned
1. Increase compliance rate by 5% quarterly by increasing the number of Pharmacy technicians certified in Medication Reconciliation. The total number of discharged patients for whom a Best Possible Medication Discharge Plan (BPMDP) was created as a proportion of the total number of patients discharged increases to 65% in F19 Q1, 70% in F19 Q2, 75% in F19 Q3 and to 80% in F19 Q4.	**No**	The QIP indicator (*total number of discharged patients for whom a Best Possible Medication Discharge Plan (BPMDP) was created as a proportion of the total number of patients discharged*) rose to 92% in F19 Q1 and was maintained in Q2 and Q3.This score was unexpected and resulted from the broad adoption by prescribers of the enhanced e-discharge summary tool including forcing functions such as the completion of medication reconciliation.
2. Continuously review and improve the pharmacy procedures for conducting medication reconciliation including optimizing support and resources for staff.	**Yes**	The quality of medication reconciliation is highly dependent on staff training and education on expected procedures. Staff certification and audit programs maintain quality and compliance.
3. Evaluate the extension of the pharmacy software system for home medication documentation that would provide transferable data and auditing capabilities.	**No**	The software and interface systems required to deliver an efficient, robust and reliable medication reconciliation process at care transitions requires significant investment in resources.

Measure/Indicator from 2018/19 QIP	Current Performance as stated on 18/19 QIP	Target as stated on 18/19 QIP	Current Performance 18/19 (Q4)
Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.	496	550 (by Q4)	**542 (Q4)**

Change Ideas from Last Year's QIP (QIP 2018/19)	Was this implemented?	Lessons Learned
1. Conduct a review of the organization's Workplace Violence Prevention Program and develop an action plan to address gaps/areas for improvement.	**Yes**	The assessment was completed in August 2018. We are currently finalizing the Action Plan to incorporate the recommendations from the external security/safety assessment that was undertaken in the Mental Health (MH) & Emergency Programs.
2. Assess the organization's security program in relation to the prevention and management of workplace violence and develop an action plan to address gaps/areas for improvement.	**Yes**	The assessment was completed in August 2018. We are currently finalizing the Action Plan to incorporate the recommendations from the external security/safety assessment that was undertaken in the Mental Health & Emergency Programs.
3. Reassess our existing staff training program across both sites and prepare a proposal for a revised training program for approval.	**Yes**	Management of Resistive Behaviour (MORB) training from Stay Safe was assessed as an alternative to the current NVCI training by a core group with representation from Security, Occupational Health & Safety, MH and Emergency Department (ED), and G4S. The 2 day training program was customized for KHSC with a pilot rolled out to a group of 20 MH & ED staff in January 2019. We are assessing the evaluations and will put together our proposal/business case.
4. Develop a scorecard that is specific to workplace violence that includes comprehensive data that is collected quarterly and reported to stakeholder groups including the JHSCs and the Violence Working Group.	**Yes**	A scorecard tracking both leading and lagging indicators is produced quarterly and shared with the Workplace Violence Prevention Working Group and the Joint Health & Safety Committee (JHSC).
5. Explore the feasibility of real-time incident analysis for incidents of violence	**Yes**	It was determined that this would only be feasible in Code White situations. When a Code White incident occurs the manager, Occupational Health & Safety (OH&S), and security attend and a post Code White debrief. Moving forward to facilitate real-time discussion/ investigation, the incident investigation tool will be used to ensure improvements/changes being made to prevent recurrence/enhance safety can be captured for incident investigation purposes.

Change Ideas from Last Year's QIP (QIP 2018/19)	Was this implemented?	Lessons Learned
6. Implement an environmental health & safety checklist in the Mental Health Program to ensure potential issues with the physical environment are promptly identified and resolved; evaluate its use for possible reapplication to other high risk units.	**Yes**	This was implemented in Quarter 1 but is now under review for revisions to the process based on feedback from staff/union.
7. Implement a new model for regular crisis debriefing/stress management for staff in the Mental Health Program to support psychological health & safety in the workplace.	**Yes**	Monthly sessions were initially implemented in Quarter 1. The model changed and spiritual care now provides support more regularly on the unit, as a component of their day to day work (including post code white situations).
8. Renew training with all clinical staff who use voceras to reaffirm understanding of the procedures to be followed to activate the double tap feature to summon immediate assistance.	**Partial**	The goal is for vocera emergency procedures (double tap) to be included in the "Know the Codes" e-learning which is done annually by all staff (e-learning development is led by Protection Services). Activation of the double tap panic feature is currently demonstrated in clinical orientation and will be added to corporate orientation starting in January 2019 so that non-clinical/support staff using vocera is also aware.
9. Revise the existing patient Risk Reduction/Care plan.	**No**	Meetings with stakeholders (i.e. Mental Health Program, Medical Records, Professional Practice, Risk Management, etc.) were undertaken to determine options. Legal and HIROC opinions were obtained on whether we could scan the current Risk Reduction Plan into the patient's electronic record (PCS). Advice was to make the RRP a legal document inclusive of staff signatures. Over the next fiscal year we will continue this work to develop a mechanism for the risk reduction plan to be accessible to staff for patients who are readmitted.
10. Integrate the individual KGH and HDH site violence prevention policies that are specific to patient violence and develop new supporting materials (e.g. public posters, Violence Prevention Guide for Patients, Families, and Visitors, etc.) so that content and messaging is standardized across KHSC.	**Partial**	This change idea is currently in progress. The KHSC Harassment & Discrimination, Flagging, Violence Prevention, and Domestic Violence Policies and related processes are in revision to be integrated and launched by end of Quarter 4 across both sites.

Measure/Indicator from 2018/19 QIP	Current Performance as stated on 18/19 QIP	Target as stated on 18/19 QIP	Current Performance 18/19 QIP (Q3)
Percent of palliative care patients discharged from hospital with the discharge status "Home with Support".	83%	90%	**93%**

Change Ideas from Last Year's QIP (QIP 2018/19)	Was this implemented?	Lessons Learned
1. Determine the percentage (%) of admitted patients determined as requiring palliative care (by diagnosis) that return to their own homes with home supports.	Yes	This was completed and each quarter's performance target was exceeded.
2. Distinguish the accuracy of completing the discharge disposition—i.e., understanding "home" to mean private community residence and not a location where there is managed care.	No	This was not a focus of the work undertaken this fiscal year.
3. Inform the development of a discharge pathway and standards for this high risk population, in collaboration with the South East LHIN Home and Community Care and other stakeholders.	Partial	KHSC and the South East LHIN Home and Community Care (SE LHIN HCC) participated in an IDEAS Project (Cohort 15) focused on a discharge pathway to improve the patient and caregiver experience and the transition process for patients with advanced cancer and non-cancer illnesses at discharge from KHSC-KGH to home with SE LHIN HCC services. Quality improvement methods were used to map the discharge pathway for patients. A chart audit was conducted (see above). Tests of change were identified to improve the following processes i) early identification and ii) communication between organizations. Work is ongoing.
4. Review cases (charts) of patients that did not receive home support at the time of discharge	Yes	Chart audits were performed once as part of the IDEAS project (noted above). This audit revealed that all patients had home support at discharge.

Measure/Indicator from 2018/19	Current Performance as stated on 19-10 QIP	Target as stated on 18-19 QIP	Current Performance 18-19 QIP (Q2)
Readmission QBP (COPD)	22.70	15.50	**34.2**

Change Ideas from Last Year's QIP (QIP 2018/19)	Was this implemented?	Lessons Learned
1. KHSC will continue to ensure Health Links referrals are made as indicated by the referral criteria. Health Links is an initiative focused on patients with multiple chronic conditions and on seniors to connect them with resources across SE LHIN that can provide them with support in the community. KHSC role is to refer patients who meet criteria. KHSC refers patients admitted to Medicine and Mental Health units and patients in Renal Program. Health Links goal is to provide better care to high users of health care, reduce costs, decrease ED visits and hospital admissions.	Yes	Referrals to Health Links are made by the Nurse Navigators in the Medicine Program for patients meeting the appropriate criteria. KHSC did not meet the annual target of 230 referrals to Health Links.
2. The Health Care Tomorrow pathway for admitted COPD patients across SE LHIN is a regional pathway to ensure consistent care is provided across the region. The goal is to improve care for the COPD patients, ensure these patients have community supports upon discharge in order to avoid visits to the ED and avoid hospital admission. The pathway consists of a standardized order set that reflects COPD QBP. The COPD care navigator will perform follow up post-discharge phone calls and education as needed, and adopt the INSPIRED program. The INSPIRED program includes self-management support education, action plans, telephone help line, home visits & advance care planning where needed.	Yes	KHSC successfully implemented many elements of the INSPIRED program. A pilot COPD Nurse Navigator role went live in October 2018. Key functions of this role include patient assessments, patient and family education, providing suggestions for medical management and referrals to primary care providers and discharge planning. In less than 6 months the COPD Nurse Navigator has assessed over 70 patients in which 98% received education, 92% had a COPD Action Plan created, 68% had suggestions to optimize medical management and 86% consented to be referred to the LHIN Rapid Response Nurse. Additional successes have been the education of over 200 inter-professional KHSC staff on the COPD Inpatient Pathway and the creation of COPD order sets). The Program has identified initial improvement initiatives why will be actioned over the next fiscal year.

Measure/Indicator from 2018/19	Current Performance as stated on 18/19 QIP	Target as stated on 18/19 QIP	Current Performance 18/19 QIP (Q2)
Readmission: Mental Health and Addiction Rate of psychiatric (mental health and addiction) discharges that are followed within 30 days by another mental health and addiction admission.	**CB**	**CB**	**CB**

Change Ideas from Last Year's QIP (QIP 2018/19)	Was this implemented?	Lessons Learned
1. Three improvement initiatives will be undertaken to strengthen discharge supports and community partnerships for successful transfers of care and/or reintegration into community following acute care admission (for optimal patient outcomes), reducing avoidable re-admission t hospital within a 30 day period. Establish baseline data for this indicator. Conduct analysis of current re-admissions by patient unique identifier and diagnostic category. It is important to identify trends of high risk patient groups contributing to re-admission rates in order to target specific interventions.	Partial	KHSC MH readmission rates are being tracked by Decision Support and reported to the Mental Health (MH) program quarterly. At this time the information provided does not include patient identifiers, which does not allow the program to complete a detailed analysis of the patients being readmitted. Work is ongoing to improve the data provided to the MH program. The program endeavours to review a patient's care as readmissions occur. This process is inconsistent due to resources not being available.
2. Assess patient flow between acute care, specialized chronic care and community providers; identify gaps in service for high risk patients develop strategy/action plan.	Partial	KHSC is engaged with community partners to better understand and improve the patient flow between inpatient, specialized care and community mental health and addiction services. A Mental Health Transition Planning Working Group for Kingston Frontenac and Lennox & Addington counties was created. Work has also included direct engagement and focus groups with organizations such as Providence Care Hospital as well as the development of a regional flow dashboard. The key challenge is a lack of a regional data repository to better understand the flow of specific patients and identifying the community and hospital resources a patient is connected to. In future the SHIPP project may provide better data to assist with a detailed analysis of patient flow.
3. Assess current inpatient discharge planning process for high risk patients, identify opportunities to strengthen process.	Partial	High-risk patients are often linked with community services before and/or after their inpatient admission. ACTT team leads participated in weekly patient rounds to assist with the continuity of care for patients from hospital to community. It was identified that this was not frequent enough to catch all high-risk patients. As a result the ACTT was invited to participate in daily patient rounds.