fiscal 2018-2019 **Q2**

2nd quarter ended September 30, 2018

KHSC this quarter

QIP Performance Report

Hôpital Hotel Dieu Hospital

Hôpital Général de Kingston General Hospital

Kingston Health Sciences Centre

Centre des sciences de la santé de Kingston

KHSC Quality Improvement Plan (QIP) Performance Report

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Strategic Direction 1

Improve the patient experience through a focus on compassion and excellence

Outcome: KHSC is a top performer on the essentials of quality, safety & service

Strategic Performance Indicators	
% of patients that respond in the 'top box' to the question, "Would you recommend this hospital to your friends and family?" (ED) (KHSC QIP)	2
% of patients that respond in the 'top box' to the question, "Would you recommend this hospital to your friends and family?" (inpatient) (KHSC QIP)	3
% of patients that respond in the 'top box' to the question, "Would you recommend this hospital to your friends and family?" (UCC) (KHSC QIP)	4
Percent of patients requiring palliative care that are discharged from hospital with the discharge status of 'Home with support" (KHSC QIP)	5
Medication Reconciliation at discharge (KHSC)	6
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? (KHSC QIP) (LQ2F)	7

Strategic Direction 3

Improve the experience of our people through a focus on work-life quality

Outcome: Out people are inspired and proud to be part of the KHSC community

# of workplace violence incidents reported by workers within a 12-month period (KHSC QIP)	8

Strategic Direction 3

Enable clinical innovation in complex-acute and specialty care

Outcome: KHSC is positioned as a leading centre for complex-acute & specialty care

Strategic Performance Indicators	
# days from clinic appointment until dictated clinic letter has been verified [Result verification date - Clinic appointment date] (KHSC QIP)	9
Readmission QBP (COPD) (KHSC QIP)	10

KHSC Quality Improvement Plan (QIP) Performance Report

Strategic Direction 4

Create seamless transitions in care for patients across our regional health-care system

Outcome: KHSC is fully engaged with our community partners to support patients with complex-acute and chronic conditions

Strategic Performance Indicators

Readmission: Mental Health and Addiction (KHSC QIP) **11**

Indicator Status Legend **12**

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Q2 FY2019 Quality Improvement Plan Report

Strategic Direction	2019 Outcome	Indicator	18-Q2	18-Q3	18-Q4	19-Q1	19-Q2
Improve the patient experience through a focus on compassion and excellence	KHSC is a top performer on the essentials of quality, safety, & service	% of patients that respond 'definitely yes' to the question, "Would you recommend this hospital to your friends and family?" (ED) (KHSC QIP)	Y	Y	Y	Y	N/A
		% of patients that respond in the 'top box' to the question, "Would you recommend this hospital to your friends and family?" (inpatient) (KHSC QIP)	Y	Y	G	Y	N/A
		% of patients that respond in the 'top box' to the question, "Would you recommend this hospital to your friends and family?" (UCC) (KHSC QIP)	Y	R	Y	Y	N/A
		Percent of patients requiring palliative care that are discharged from hospital with the discharge status of "Home with Support" (KHSC QIP)	Y	G	G	G	G
		Medication reconciliation at discharge (KHSC QIP)	N/A	N/A	N/A	G	G
		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? (KHSC QIP) (LQ2F)	Y	Y	Y	Y	N/A
Improve the experience of our people through a focus on work-life quality	Our people are inspired and proud to be part of the KHSC community	# of workplace violence incidents reported by workers within a 12-month period (KHSC QIP)	N/A	N/A	N/A	G	Y
Enable clinical innovation in complex-acute and specialty care	KHSC is positioned as a leading centre for complex-acute & specialty care	# days from clinic appointment until dictated clinic letter has been verified [Result verification date - Clinic appt. date] (KHSC QIP)	Y	Y	Y	N/A	N/A
		Readmission QBP (COPD) (KHSC QIP)	R	Y	Y	G	N/A
Create seamless transitions in care for patients across our regional health-care system	KHSC is fully engaged with our community partners to support patients with complex-acute and chronic conditions	Readmission: Mental Health and Addiction (KHSC QIP)	N/A	N/A	N/A	N/A	N/A

	SPR			QIP			SAA		
	F19			F19			F19		
	Q1 %	Q2 %	Q2 #	Q1 %	Q2 %	Q2 #	Q1 %	Q2 %	Q2 #
R	0%	14%	2	0%	0%	0	35%	26%	18
G Y	100%	86%	12	100%	100%	8	61%	70%	48
N/A	0%	0%	0	0%	0%	0	4%	4%	3
			14			8			69

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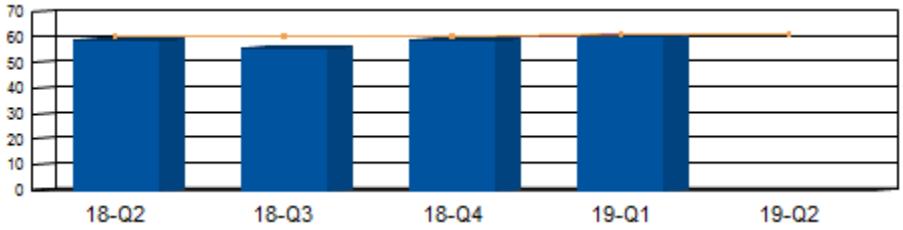
Q2 FY2019 Quality Improvement Plan Report

Improve the patient experience through a focus on compassion and excellence

KHSC is a top performer on the essentials of quality, safety, & service

Indicator: % of patients that respond 'definitely yes' to the question, "Would you recommend this hospital to your friends and family?" (ED) (KHSC QIP)



	Actual	Target
18-Q2	59.0	**60**
18-Q3	55.6	**60**
18-Q4	58.9	**60**
19-Q1	60.4	**61**
19-Q2		**61**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

Staff in the Emergency Department is working to provide exemplary care. Our patient experience survey results are reviewed with staff , patient experiences advisors and our Patient Relations and Quality Advisor at our quarterly departmentally meetings: there we looked at opportunities for improvement noted . We have been working on improving communication; the patient experience advisors with staff have developed an updated brochure to highlight some of the most common questions. We have been working on flow in the department, as waits and lengths of stay correlate often with satisfaction.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

Patient experience survey results from the Emergency Department Patient Experience of Care (EDPEC) survey are always somewhat delayed; thus, the Q2 results will be reported in Q3. The reported results from Q1 indicate improvements from 58.9 %to 60.4 %. We have been working on internal flow through the ED with increased use of chair space, for those that do not need a bed to seen by a Health Care Professional. The Nurse Practitioner has been seeing patients in our face track areas during the day.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

We are on track , as volumes and wait times increase in Q3 and Q4 satisfaction can decrease , we are adding a Nurse Practitioner to the mid-day and evening hours to assist with the traditionally influx of low acuity patients that arrive during this time. We continue to work on improvements in flow and communication.

Definition: DATA: Pam Pero COMMENTS: Carol McIntosh EVP: Mike McDonald REPORT: QUALITY IMPROVEMENT PLAN (QIP)

"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 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.

Target: Target 18/19: 61% Perf. Corridor: Red <51% , Yellow 51% - 60%, Green >=61%

Prior Targets:
- Target 17/18: 60% Perf. Corridor: Red <54% , Yellow 54%-59%, Green >=60%
- Target 16/17: 69.3% Perf. Corridor: > 10% quarterly teach. Target, Yellow Within 10% of quart. Teach. Target, Green At or above the teach avg. /quarter

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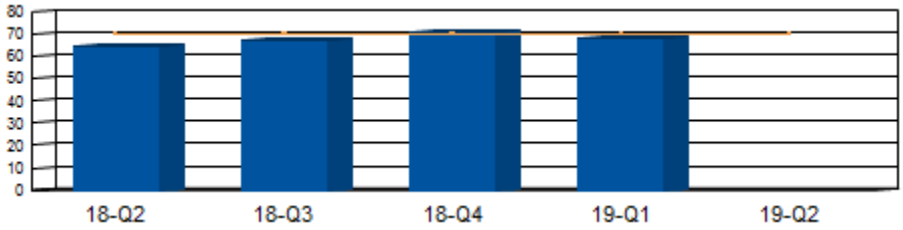
Q2 FY2019 Quality Improvement Plan Report

Improve the patient experience through a focus on compassion and excellence

KHSC is a top performer on the essentials of quality, safety, & service

Indicator: % of patients that respond in the 'top box' to the question, "Would you recommend this hospital to your friends and family?" (inpatient) (KHSC QIP)



	Actual	Target
18-Q2	64.1	**70**
18-Q3	67.2	**70**
18-Q4	70.7	**70**
19-Q1	68.5	**70**
19-Q2		**70**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

Patients and families will recommend KHSC to friends and family based on satisfaction in a variety of different domains related to their inpatient experience including: staff responsiveness to their needs, quality and timeliness of communication with care providers with respect to their condition, plan of care, medications and discharge plan, attention to pain control, quietness and cleanliness of the environment and quality of food. Valuable patient and family feedback in these domains is gathered directly through patient surveys, the Patient Relations Program, and Patient and Family Feedback Forums which are held by clinical programs. This feedback stimulates initiatives, broadly divided into "clinical" and "non-clinical" categories.

The major new and ongoing clinical initiatives addressing this indicator are:
• Fully implementing "My Discharge Plan" (launched April 4th, 2018) for patients in all programs except for Mental Health. MDP is a patient-oriented discharge communication tool which uses clear and easy to understand language and helps patients prepare for self-care after discharge
• Training over 1640 staff (over 500 in Q2) in health literacy techniques such as using plain language and using the "Teach Back" method in order to improve effectiveness of patient and family education
• Implementing post-discharge follow-up phone calls commencing Sept 4th to all patients discharged from General Internal Medicine units
• Continuing "bedside handovers" in Critical Care units in order to engage patients and families in their care
• Monitoring and adjusting noise levels via noise monitoring devices embedded in care areas
• Implementing/continuing Care Navigator/NP roles for specific patient populations and/or affiliated with specific programs who work with physicians and the interprofessional team to assist with care planning and coordination, patient and family education, discharge planning, follow-up care and communication with the patient's Primary Care provider.

With respect to non-clinical initiatives addressing this indicator it is important to note:
• The majority of comments on patient surveys are related to the environment (cleanliness) and to the food that is serviced to inpatients.
• Each quarter, the patient care programs review the inpatient survey results and comments and Patient Relations feedback related to cleanliness and food in order to identify opportunities for improvement and involve other departments and services as needed.
• Each program continues to monitor adherence to the patient and family-centred care standards by performing regular audits of the standards which include: hourly rounding, identification badges worn at chest level, updated patient white boards, introductions with each patient interaction and patient led feedback forums. Results are reported to all stakeholders on a regular basis. Each program makes one improvement per quarter and ensures the standards meet or exceed the set target.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

Results for this indicator are reported for the quarter previous. In Q1 the result was below the target. This means 68.5% of discharged inpatients report that they would recommend KHSC to friends and family. The mean of the existing data points is 67.4% so although the Q1 result is below the target it is the second consecutive data point above the mean. Many of the improvement initiatives listed above were not implemented or did not reach full spread until Q2 and beyond. We will continue to track this indicator to see if initiatives above have resulted in improvement.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

Unknown. We will continue the above clinical and non-clinical strategies and associated measures in order to continue focusing our efforts on the main drivers of patient and family satisfaction which contribute to the likelihood that our patients and families will recommend this hospital to their friends and family.

Definition: DATA: Pam Pero COMMENTS: Mike McDonald, Reg Hart EVP: Mike McDonald, Silvie Crawford REPORT: QUALITY IMPROVEMENT PLAN (QIP)

Percentage of respondents who responded positively to the following question: Would you recommend this hospital to friends and family?

1. The majority of comments on patient surveys are related to the environment (cleanliness) and to the food that is serviced 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.
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.

Target: Target 18/19: 70% Perf. Corridor: Red <60%, Yellow 60% - 69%, Green >=70%

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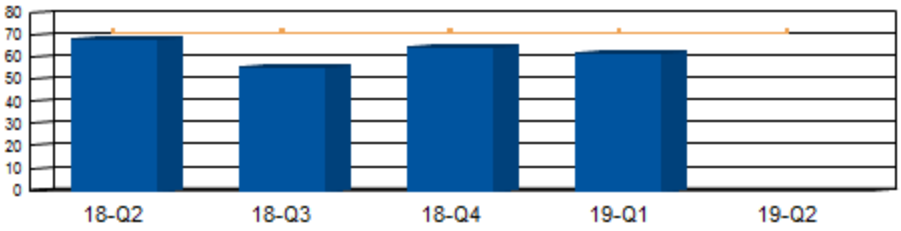
Q2 FY2019 Quality Improvement Plan Report

Improve the patient experience through a focus on compassion and excellence

KHSC is a top performer on the essentials of quality, safety, & service

Indicator: % of patients that respond in the 'top box' to the question, "Would you recommend this hospital to your friends and family?" (UCC) (KHSC QIP)



	Actual	Target
18-Q2	68.5	71
18-Q3	55.6	71
18-Q4	64.2	71
19-Q1	61.6	71
19-Q2		71

Describe the tactics that were implemented in this quarter to address the achievement of the target:

We continued to modify the triage area, after initial modifications completed with staff and patient experience adviser input we received additional feedback from patients that continued modification where needed, we have added new privacy screens, increased the use of two triage nurses when possible, to ensure less time spent at the triage waiting area. Staffs have been highlighting patient feedback related to satisfaction and privacy in staff meetings and looking for opportunities to improve the experience

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

Patient experience survey results from the Emergency Department Patient Experience of Care (EDPEC) survey are always somewhat delayed; thus, the Q1 results are being reported in the Q2 scorecard. This indicates 61.6 % of patients felt that they would pick 10 on a scale of 0 to 10 (0 being the worst hospital/facility and 10 being the best) when asked would you recommend this hospital/facility.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

We are on track, Q3 & Q4 are traditionally higher volumes and we are looking at inanities to improve flow in the Urgent Care during the winter flu and cold season to ensure wait times do not increase. The department is looking at expanding the Nurse Practitioner's role to assist with the flow of lower acuity patients.

Definition: DATA: Pam Pero COMMENTS: Carol McIntosh EVP: Mike McDonald REPORT: QUALITY IMPROVEMENT PLAN (QIP)

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.

Target: Target 18/19: 71% Perf. Corridor: Red <61%, Yellow 61% - 70%, Green >=71%

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Improve the patient experience through a focus on compassion and excellence

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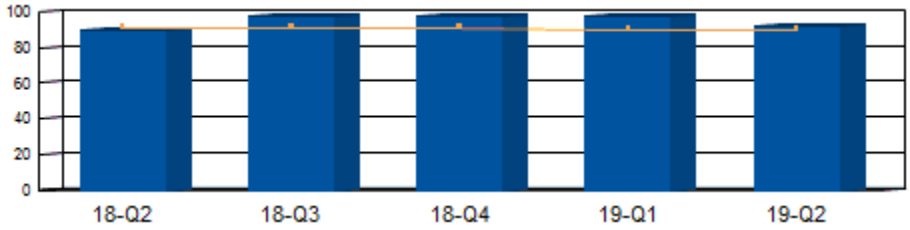
Indicator: Percent of patients requiring palliative care that are discharged from hospital with the discharge status of "Home with Support" (KHSC QIP)



	Actual	Target
18-Q2	90	**91**
18-Q3	97	**91**
18-Q4	97	**91**
19-Q1	97	**90**
19-Q2	92	**90**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

A new process to automate the identification of individuals requiring a palliative approach to care and/or a palliative care consult is being established using a validated tool. In the meantime, as part of a quality improvement project through IDEAS, a chart audit was conducted to identify areas of opportunity for improvement to ensure proper discharge planning is put in place. Three potential change ideas were identified: 1. early identification and notification to the H&CC coordinator, 2. effective navigation and coordination of discharge plan and referrals, and 3. in-person coordinator assessment prior to discharge. A working group has convened to establish the parameters to test the change ideas in a controlled setting (unit/area to be confirmed). KHSC continues to monitor this indicator as part of the strategic initiative to expand access to Palliative Medicine and a palliative approach to care.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

The result is somewhat lower this quarter compared to the last 3 quarters. This may be due to a number of factors a cyclical change (lower activity in Q2 timeframe), more individuals being identified as requiring a palliative approach to care, and/or fewer discharges with the status of "home with support". The metric continues to sit above the target of 90 and will continue to be monitored.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

Yes.

Definition: DATA: Decision Support - Alex Ungar COMMENTS: Lori Van Manen EVP: Brenda Carter REPORT: QUALITY IMPROVEMENT PLAN (QIP)

Patients with advanced life-limiting illnesses and who receive palliative care often require new/enhanced home supports to ensure a safe discharge and continuity of care. Our objectives are:
1. to determine the percentage (%) of admitted patients determined as requiring palliative (discharge diagnosis) care that return to their own homes with home supports;
2. to review cases (charts) of patients that did not receive home support at the time of discharge;
3. to 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; and
4. to 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.

Target: Target 18/19: 90% Perf. Corridor: Red <= <80% , Yellow 80%-89% , Green >=90%

Prior Targets:
- Target 17/18: 91 Perf. Corridor: Red <= <82% , Yellow 82%-90% , Green >=91.

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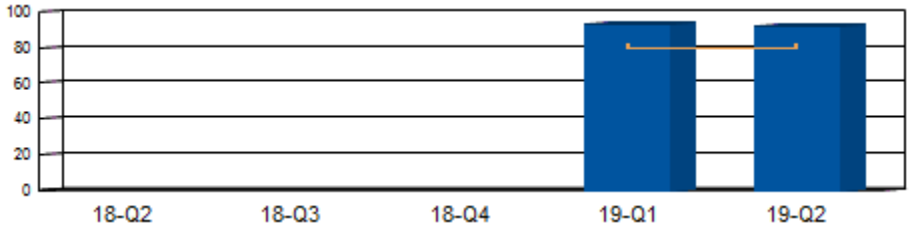
Indicator: Medication reconciliation at discharge (KHSC QIP)



	Actual	Target
18-Q2		
18-Q3		
18-Q4		
19-Q1	93	**80**
19-Q2	92	**80**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

In Fiscal 2018-19 quarter 2, the KHSC medication reconciliation on discharge process was completed by prescribers for 92% of patients admitted to the Hospital (F19 Q1 was 93%) with 62% of the patients having a best possible medication history (BPMH) or home medication history completed or verified by Pharmacy staff (F19 Q1 was 66%, a drop related to Pharmacy staffing challenges in September 2018 that will be resolved on F19 Q3).

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

During the period July to September 2018, 92% of all patients admitted to KHSC (at both KGH and HDH sites) received, on discharge from the Hospital, detailed medication information and instructions on the medicines they should continue to take at home as well as a list of home medications that were stopped or changed as a result of the Hospital stay and also a list of the new medications that were started (with a prescription for their community pharmacy). 62% of the patient home medication lists were gathered or verified on admission with the patient and/or family by Pharmacy staff for patient safety.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

We are on track to meet the target by year end with goal to increase the percentage of patient's BPMH completed or verified by Pharmacy staff to 80% with either an increase in staffing or the implementation of the BDM Axis software system.

Definition: DATA: Shawn Doyle (via Decision Support - David Barber) COMMENTS: Veronique Briggs EVP: Troy Jones REPORT: QUALITY IMPROVEMENT PLAN (QIP)

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.

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.
2. Continuously review and improve the pharmacy procedures for conducting medication reconciliation including optimizing support and resources for staff.
3. Evaluate the extension of the pharmacy software system for home medication documentation that would provide transferable data and auditing capabilities.

Target: Target 18/19: 80% Perf. Corridor: Red <70% Yellow 70%-79% Green >=80%

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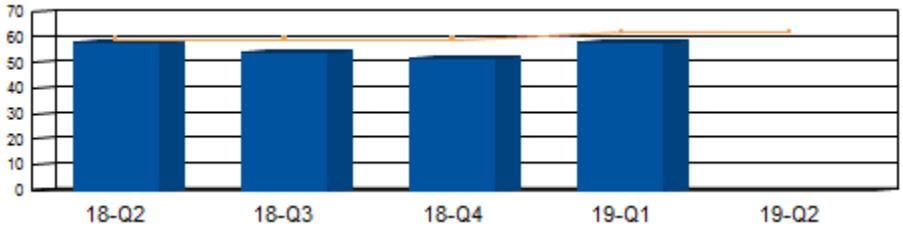
Indicator: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital? (KHSC QIP) (LQ2F)



	Actual	Target
18-Q2	58.3	**59**
18-Q3	54.0	**59**
18-Q4	51.6	**59**
19-Q1	57.9	**62**
19-Q2		**62**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

This indicator is related to one question on the patient survey asking if the patient received enough information about what to do if she or he had any concerns related to condition or treatment after leaving the hospital. The question relates to receiving the information in an easy to understand format. A health literacy environmental scan completed last year identified areas across the organization where there are opportunities to reduce health literacy burden for patients and families. The scan led to several key recommendations to improve communication with patients and families.
For associated tactics and progress related to this indicator, please refer to the three main health literacy initiatives as described in the indicator “Before you left the hospital did you have a clear understanding about all of your prescribed medications including those you were taking before your hospital stay”.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

Results for this indicator are reported for the quarter previous. The data for Q1 shows that we are not meeting the set target. The improvement initiatives described above did not reach full implementation or intended spread until Q2 and Q3. Because of this we will expect improvements to be reflected in results for Q2, Q3 and later.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

Unknown. Health Literacy initiatives commencing in Q1, accelerated in Q2, and achieving full intended implementation and spread in Q3 are likely to result in ongoing improvements in this indicator.

Definition: DATA: Pam Pero (CPES-IC) COMMENTS: Mike McDonald, Reg Hart EVP: Mike McDonald, Silvie Crawford REPORT: QUALITY IMPROVEMENT PLAN (QIP), LQ2F INDICATOR

1. Implement a patient oriented discharge summary called My Discharge Plan (MDP) on specified patient populations.
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.
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.

Target: Target 18/19: 62% Perf. Corridor: Red <52% , Yellow 52% - 61% , Green >=62%

Prior Target:
- Target 17/18: 59% Perf. Corridor: Red <53% , Yellow 53%-58% , Green >=59.

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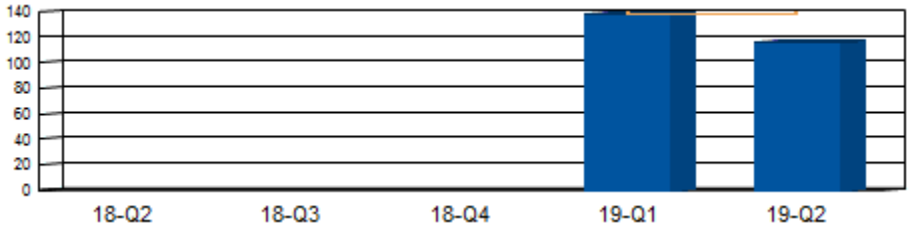
Q2 FY2019 Quality Improvement Plan Report

Improve the experience of our people through a focus on work-life quality

Our people are inspired and proud to be part of the KHSC community

Indicator: # of workplace violence incidents reported by workers within a 12-month period (KHSC QIP)



	Actual	Target
18-Q2		
18-Q3		
18-Q4		
19-Q1	138	**138**
19-Q2	116	**138**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

The QIP Workplace Violence Prevention workplan continues with 9 of the 10 tactics on track for completion this fiscal. Two action items completed this quarter were the Workplace Violence Prevention Program assessment and Security Program assessment using PSHSA's tools that were recently launched as part of Ontario's Workplace Violence Healthcare Leadership Table. Action plans will be formulated based on identified gaps, considering as well the recommendations coming from the 3rd party Security/Safety Risk Assessments in the ED, UCC, and Mental Health Program. These recommendations will soon be forthcoming.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

This quarter saw a 16% reduction in the number of reported incidents of violence as opposed to the desired 10% increase. Of the total reported incidents, 7.7 % (n=9) injuries were reported and of these 3.4% (n=4) required first aid treatment or above. This is a measure of incident severity and is less than last year where 7% of reported incidents resulted in injury. The reduced number of incidents corresponds to other indicators we saw improvement (e.g. reduced number of code whites, increased completion of Risk Reduction plans).

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

Possibly not. When we set out QIP goal to increase reporting we were seeing a continued increase in incidents and wanted to encourage a culture of reporting. In review of our incident data now however, we believe the spike in reporting has already occurred (Oct 2017-March 2018) and as a result of continuous improvement and attention to preventing and managing violence, we are starting to see reduced incidents.

Definition: DATA: Joanna Noonan COMMENTS: Joanna Noonan EVP: Sandra Carlton REPORT: QUALITY IMPROVEMENT PLAN (QIP)

1. Conduct a review of the organization's Workplace Violence Prevention Program and develop an action plan to address gaps/areas for improvement.
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.
3. Reassess our existing staff training program across both sites and prepare a proposal for a revised training program for approval.
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.
5. Explore the feasibility of real-time incident analysis for incidents of violence.
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.
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.
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
9. Revise the existing patient Risk Reduction/Care plan.
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.

Target: Target 18/19: Increase the number of reported incidents by 10% (> 550 incidents) (Quarterly targets: Q1 – Q3: 137/quarter; Q4: 139) Perf. Corridor: Red <495 (<123 (Q1-3)) , Yellow 495-549 (123-136 (Q1-3)), Green >=550 (>=137 (Q1-3))

Kingston Health Sciences Centre

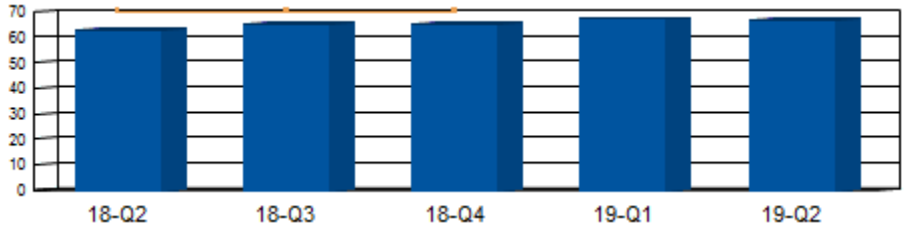
Centre des sciences de la santé de Kingston

Q2 FY2019 Quality Improvement Plan Report

Enable clinical innovation in complex-acute and specialty care

KHSC is positioned as a leading centre for complex-acute & specialty care

Indicator: # days from clinic appointment until dictated clinic letter has been verified [Result verification date - Clinic appt. date] (KHSC QIP)



	Actual	Target
18-Q2	63.0	**70**
18-Q3	65.0	**70**
18-Q4	65.0	**70**
19-Q1	67.1	
19-Q2	67.0	

Describe the tactics that were implemented in this quarter to address the achievement of the target:

In the past there has been 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.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

Still validating baseline as described above.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

Once baseline is verified there may be a need to take the information back to the Ambulatory Care Committee and department heads for further conversation.

Definition: DATA: Decision Support - David Barber COMMENTS: Christine Wilkinson EVP: Mike Fitzpatrick REPORT: QUALITY IMPROVEMENT PLAN (QIP)

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)[Result verification date - clinic appt. date]

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.
2. Gain endorsement from the Medical Advisory Committee (MAC) to develop a policy to guide when a dictated clinic letter is expected.

Target: Target 18/19: TBD Perf. Corridors: Red TBD, Yellow TBD, Green TBD

Prior Targets:
- Target 17/18: > 70% of dictated letters signed off by 2 wks post clinic Perf. Corridor: Red <60%, Yellow 60%-69%, Green >=70%.

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Enable clinical innovation in complex-acute and specialty care

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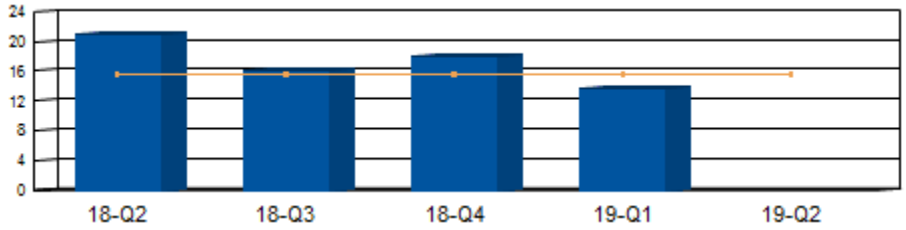
Indicator: Readmission QBP (COPD) (KHSC QIP)



	Actual	Target
18-Q2	21.0	**15.5**
18-Q3	16.0	**15.5**
18-Q4	18.0	**15.5**
19-Q1	13.6	**15.5**
19-Q2		**15.5**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

For information related to this indicator and associated tactics and progress please refer to the QBP COPD indicator in this report.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

Data is not yet available for this quarter. In the last quarter, we met and exceeded the expected target. We also expect Q2 results to be favourable since there are significantly less COPD exacerbations during spring and summer months than during the fall and winter. There are insufficient data points to support a robust analysis, however, it is promising to note the trend towards improvement in the past three quarters and that our Q1 result this fiscal is significantly improved over last fiscal Q1. Going forward, in light of the seasonality factor of disease presentation which is linked to the Q3 and Q4 'flu' season, in order to identify improvements it will not only be important to analyze data chronologically from quarter to quarter but also by comparison of the result to the corresponding quarter.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

Unknown. We will work to meet the set target of 15.5% this fiscal year. The navigator will follow up with patients and ensure a plan is in place to manage symptoms and decrease re-visits to the hospital.

Definition: DATA: Decision Support - Alex Ungar COMMENTS: Mike McDonald EVP: Mike McDonald, Silvie Crawford, Mike Fitzpatrick REPORT: QUALITY IMPROVEMENT PLAN (QIP)

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.
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 e INSPIRED program. The INSPIRED program includes self-management support education, action plans, telephone help line, home visits & advance care planning where needed.

Target: Target 18/19: 15.5% Perf. Corridors: Red >10% of the expected Rate, Yellow Within 10% of the expected Rate, Green <= Expected Rate

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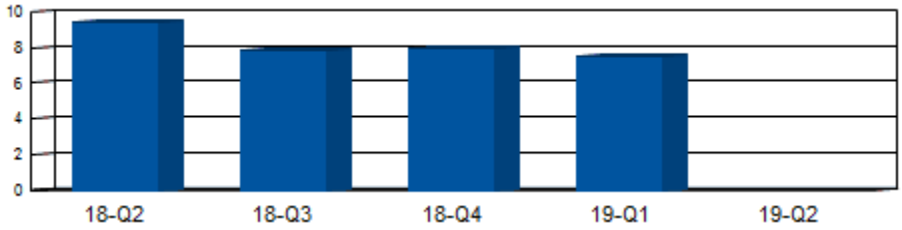
Q2 FY2019 Quality Improvement Plan Report

Create seamless transitions in care for patients across our regional health-care system

KHSC is fully engaged with our community partners to support patients with complex-acute and chronic conditions

Indicator: Readmission: Mental Health and Addiction (KHSC QIP)



	Actual	Target
18-Q2	9.4	
18-Q3	7.8	
18-Q4	7.9	
19-Q1	7.5	
19-Q2		

Describe the tactics that were implemented in this quarter to address the achievement of the target:

This is a new indicator and baseline year for data collection. We are working with decision-support to understand trends with re-admission rates according to diagnostic categories that will help inform tactics moving forward.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

We believe data analysis will identifying high risk patients that require assertive community treatment teams (ACTT) to be effectively supported in the community. Current performance reflects early work with community partners in AMHS-KFLA and PCC ACTT to ensure referrals are in place prior to discharge.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

Baseline data, target to be established.

Definition: DATA: Decision Support - David Barber COMMENTS: Michelle Matthews EVP: Mike McDonald REPORT: QUALITY IMPROVEMENT PLAN (QIP)

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.

1. 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.
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.
3. Assess current inpatient discharge planning process for high risk patients, identify opportunities to strengthen process.

Target: Target 18/19: TBD Perf. Corridors: Red TBD, Yellow TBD, Green TBD

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Q2 FY2019 Quality Improvement Plan Report

Status:

N/A	Currently Not Available
	Green-Meet Acceptable Performance Target
	Red-Performance is outside acceptable target range and require
	Yellow-Monitoring Required, performance approaching