fiscal 2018-2019 **Q4**

4th quarter ended March 31, 2019

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

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 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

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

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

Kingston Health Sciences Centre

Centre des sciences de la santé de Kingston

Q4 FY2019 Quality Improvement Plan Report

Strategic Direction	2019 Outcome	Indicator	18-Q4	19-Q1	19-Q2	19-Q3	19-Q4
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	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?" (inpatient) (KHSC QIP)	G	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?" (UCC) (KHSC QIP)	Y	Y	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)	G	G	G	G	G
		Medication reconciliation at discharge (KHSC QIP)	N/A	G	G	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	G	Y	G	G
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	N/A	N/A	N/A	N/A
		Readmission QBP (COPD) (KHSC QIP)	Y	G	R	R	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 %	Q3 %	Q4 %	Q4 #	Q1 %	Q2 %	Q3 %	Q4 %	Q4 #	Q1 %	Q2 %	Q3 %	Q4 %	Q4 #
R	0%	14%	14%	14%	2	0%	0%	12%	13%	1	35%	26%	26%	41%	28
G Y	100%	86%	86%	86%	12	100%	100%	88%	88%	7	61%	70%	70%	57%	39
N/A	0%	0%	0%	0%	0	0%	0%	0%	0%	0	4%	4%	4%	3%	2
					14					8					69

Kingston Health Sciences Centre

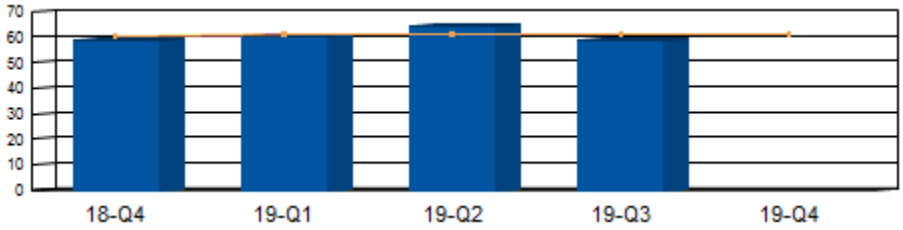
Centre des sciences de la santé de Kingston

Q4 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-Q4	58.9	**60**
19-Q1	60.4	**61**
19-Q2	64.7	**61**
19-Q3	59.2	**61**
19-Q4		**61**

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

We review the results of surveys at our departmental meetings and displace results in the unit for staff to see both the compliments and concerns; we discuss and use this information to look for trends and improvement initiatives. Our tactics have been increasing the use of Section F, to improve flow and ensure that those patients with low acuity issues can be seen and discharge by a Nurse Practitioner outside of the emergency department general area. They are seen in a clinic type area in the waiting room. We continue to work with the flow coordinator to assist with internal hospital flow, so that those needing admission are placed in a inpatient bed as soon as possible, there for ensuring the space in ED is available for the next patient. Our team is working with patient experience advisors to improve our patient information pamphlets.

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) report 59.2 % of the patients that responded to the survey indicated "definitely yes" that they would recommend the hospital to family and friends. Coordination of care was the number one compliment and concerns we received from patients in the surveys. Comments related to wait times were seen associated with both. We have seen a decline in the number of patients that responded "definitely yes" this quarter. We know from surveys a major patient satisfier in the ED is reduced wait times we continue to work on these and know that Q 4 usually is our highest volume period and traditionally has corresponding lower rates for resounding definitely yes.

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 did not meet the target in Q3. We will continue to look for opportunities identified by our patient from there feedback to improve the experience in the emergency department. We have noticed a decline in the definitely yes both this last quarter and with the new surveys that takes only the top choice definitely yes and not "definitely yes" and "probably yes". This new survey is one source of information regarding patient experience at KGH. The challenge is how we move people from 'probably' to 'definitely'. The perception may be that 'definitely' does not allow room for improvement. We continue to work on improving access and flow through the emergency department as wait times are associated with satisfaction. We have been working to increase access for all patients by improving the flow to in-patient beds therefore improving access to space with-in the ED for patients to be seen. This includes use of additional chairs when beds were not needed for certain patients. We continue to use chairs for patients to wait once minor testing is done. We are working on signage for the waiting areas as well, patient feedback has requested been that clearer signage.

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

Kingston Health Sciences Centre

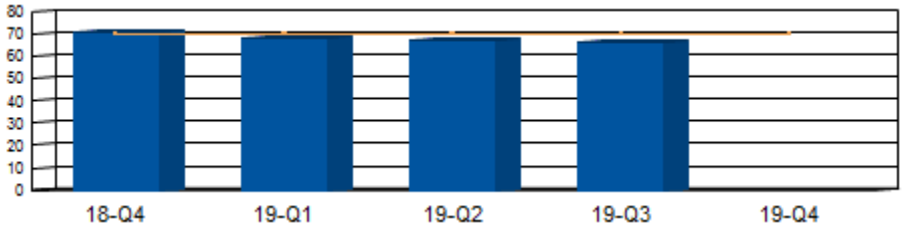
Centre des sciences de la santé de Kingston

Q4 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-Q4	70.7	**70**
19-Q1	68.5	**70**
19-Q2	67.3	**70**
19-Q3	66.0	**70**
19-Q4		**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 "the C's" related to their inpatient experience including: Cleanliness, Cuisine (Food), Care, Comfort (pain control), Communication, Care Coordination, Calm Environment (Quiet) and Compassion. 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 twice per year by each clinical program. This feedback stimulates initiatives, broadly divided into "clinical" and "non-clinical" categories.

The major ongoing clinical initiatives addressing this indicator are:
• "My Discharge Plan" - a patient-oriented discharge summary for patients in all programs except for Mental Health which uses clear and easy to understand language and helps patients prepare for self-care after discharge. New templates for programs are added regularly, most recently, orthopedic surgery.
• Training for staff 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
• Post-discharge follow-up phone calls within 48-72 hours for all patients discharged from General Internal Medicine units
• 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
• 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 that the majority of comments on patient surveys are related to the environment (cleanliness) and to the food that is provided 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.

In addition, 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:

The commentary relates to Q3 data due to a delay in data availability while results are obtained from the patient and family satisfaction surveys. The Q3 result is slightly lower than the Q2 result but due to insufficient data points may not necessarily indicate a trend. In fact, the mean for last fiscal year was 67.4% and the mean for this fiscal YTD is 67.2%.

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. More data points are required to understand the impact of the interventions above on the patient experience and what changes need to be made to attain the target result.

Definition: DATA: Pam Pero COMMENTS: Mike McDonald EVP: Mike McDonald 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%

Kingston Health Sciences Centre

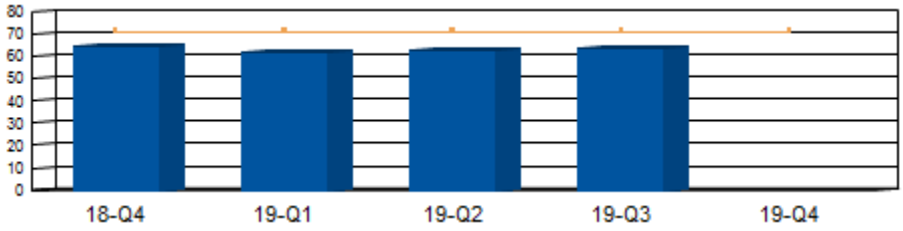
Centre des sciences de la santé de Kingston

Q4 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-Q4	64.2	71
19-Q1	61.6	71
19-Q2	63.1	71
19-Q3	63.4	71
19-Q4		71

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

We have increased the use of 2 triage nurses when possible, to ensure less time spent at the triage waiting area. We have been sharing results of Emergency Department Patient Experience of Care (EDPEC) surveys with staff and patient care advisors. We have been reviewing with the goal of looking for opportunities to improve the experience. We have been trialing some internal work-flow changes to assist with over-all flow..

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 for Urgent Care showed 68.8 % of patients would " recommend this hospital to your friends and family" in Q4. This indicates 68.8 % 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. Results and commentary we received from patient's feedback indicated coordination of care and access to care where the top concerns while coordination of care and respect where the top compliments. Patients indicated in comments we received that waits for test results and some requesting a triage system that saw first come first seen as a wish.

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 did not meet the target of 71; we are encouraged thought as this is the highest result we have seen in 8 quarters. We will continue to look for initiatives to improve our performance. We continue to open 2 triage areas when peak arrival times occur (we have seen a trend of higher volumes of arrivals in short time frames at certain times of the day: mid-morning, after 4 pm and just prior to 8 pm).

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%

Kingston Health Sciences Centre

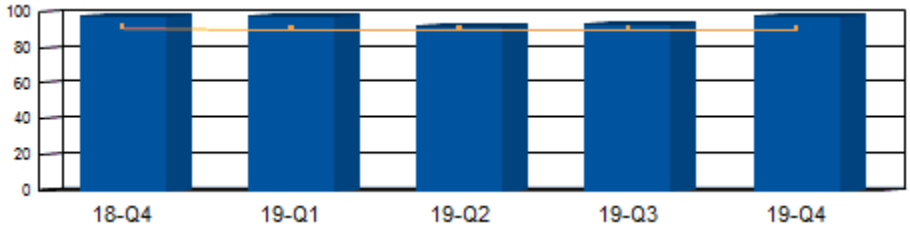
Centre des sciences de la santé de Kingston

Q4 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: Percent of patients requiring palliative care that are discharged from hospital with the discharge status of "Home with Support" (KHSC QIP)



	Actual	Target
18-Q4	97	**91**
19-Q1	97	**90**
19-Q2	92	**90**
19-Q3	93	**90**
19-Q4	98	**90**

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

KHSC continues to monitor this indicator as part of the strategic initiative to expand access to Palliative Medicine and a palliative approach to care. Efforts this past quarter have included additional outreach to leadership in the area of internal medicine to ensure support for the upcoming improvement initiative, and selection of a Goals of Care Designation Form for trial use in the QI initiative. Further work is underway to conduct a baseline review of clinical documentation processes in an effort to inform improvement efforts through educating clinicians, which will ultimately improve data quality.

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 have improved over last quarter. This is reflective of continued efforts to maintain awareness and promote early identification of patients requiring palliative care and ensuring their continued support at home post discharge. There have been no major changes to processes this past 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?

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.

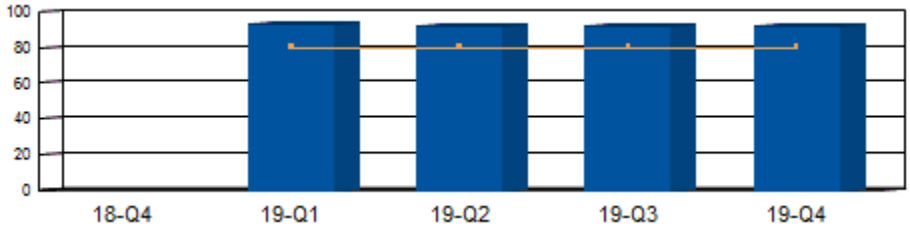
Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

Q4 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: Medication reconciliation at discharge (KHSC QIP)



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

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

In Fiscal 2018-19 quarter 4, the KHSC medication reconciliation on discharge process was completed by prescribers for 92% of patients admitted to the Hospital (F19 Q2 and Q3 were also 92%) with 55% of the patients having a best possible medication history (BPMH) or home medication history completed or verified by Pharmacy staff (F19 Q3 was 54% and F19 Q2 was 62%), with Pharmacy staffing challenges continuing this past quarter).

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 January to March 2019, 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). 55% 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 exceeded target of 80% by year end demonstrated that the medication reconciliation process is now embedded in care providers workflow. The goal for next Fiscal year is 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%

Kingston Health Sciences Centre

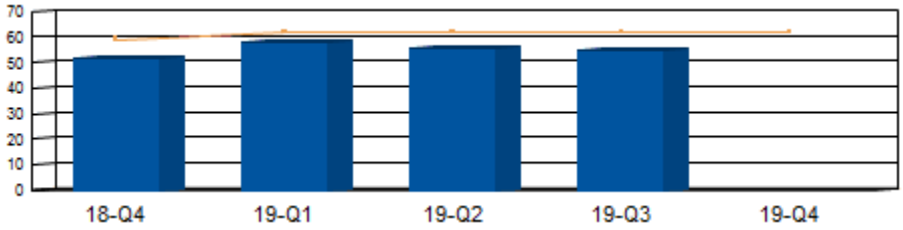
Centre des sciences de la santé de Kingston

Q4 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: 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-Q4	51.6	**59**
19-Q1	57.9	**62**
19-Q2	55.7	**62**
19-Q3	54.7	**62**
19-Q4		**62**

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

The primary tactics to address this indicator are:
- teach back methodology provided to nurses on inpatient units in order to improve effectiveness of discharge teaching and address gaps in health literacy
- My Discharge Plan - a patient-oriented discharge summary with a highlighted section instructing patients on action steps should symptoms or complications occur, including when to seek medical assistance
- Post-Discharge calls within 72 hours for all patients discharged from inpatient medicine units conducted by Health Literacy Nurses. Via this call the Nurse can ascertain whether the patient requires further medical assistance, education in self-management, and can coordinate community supports to address the patient's issue as required which may prevent an unnecessary hospital admission.

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 reflects Q3 performance due to a delay in accessing data. The result of 54.7 is slightly lower than the Q2 result of 55.7% and is well below our target of 62%. However, the mean YTD for this fiscal of 56.1% represents an improvement versus the mean of last fiscal of 55.6%. We continue to strive to reach and exceed the target in this indicator.

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. The tactics described above once fully implemented and spread should begin to improve this indicator in the next fiscal. Taking into consideration the reporting delay of one quarter, improvements may not be realized until Q2 or Q3 of the new fiscal year.

Definition: DATA: Pam Pero (CPES-IC) COMMENTS: Mike McDonald EVP: Mike McDonald 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.

Kingston Health Sciences Centre

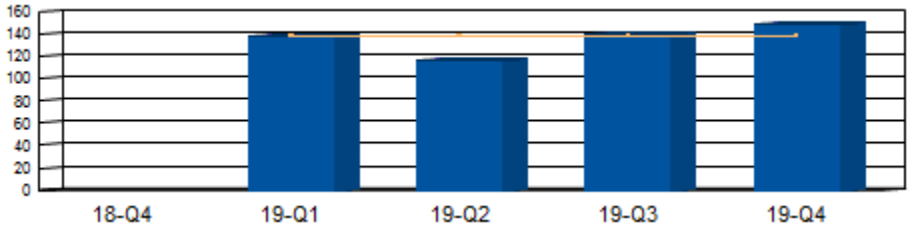
Centre des sciences de la santé de Kingston

Q4 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-Q4		
19-Q1	138	**138**
19-Q2	116	**138**
19-Q3	140	**138**
19-Q4	149	**138**

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

The majority of the items on the 2018-19 QIP Workplace Violence Action Plan were on track at the end of Q4 with the exception of the improvement plan to be developed to address the gaps identified in the WVP program corporate review and the security program corporate review. It is anticipated that they will be completed in Q1 and taken to stakeholders for review.

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

Of the 149 staff who reported physical violence/physical threat in Q4, 16 staff (11%) indicated they had sustained an injury and of these, 1 sought health care and 1 lost time from work (critical injury). 90% of the violence prevention initiatives attached to the QIP were on track at the end of Q4.

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, the annual target was met however an awareness campaign is planned for 2019-20 to further increase reporting.

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

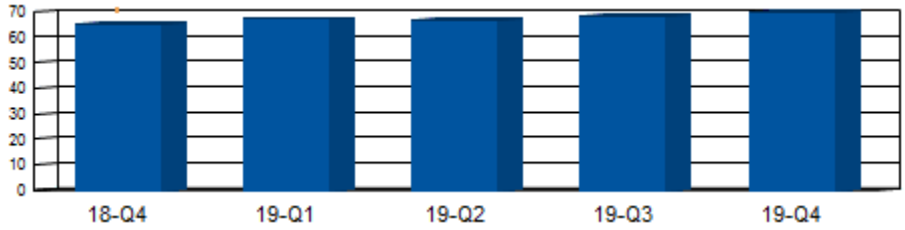
Centre des sciences de la santé de Kingston

Q4 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-Q4	65.0	**70**
19-Q1	67.1	
19-Q2	67.0	
19-Q3	68.0	
19-Q4	70.0	

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:

This result suggests a significant opportunity for improved communication.

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

The regional HIS will enhance digital communication between providers. In the interim, when results are verified, it will be shared with the Ambulatory Care Committee.

Definition: DATA: Decision Support - David Barber COMMENTS: Mike Fitzpatrick 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%.

Kingston Health Sciences Centre

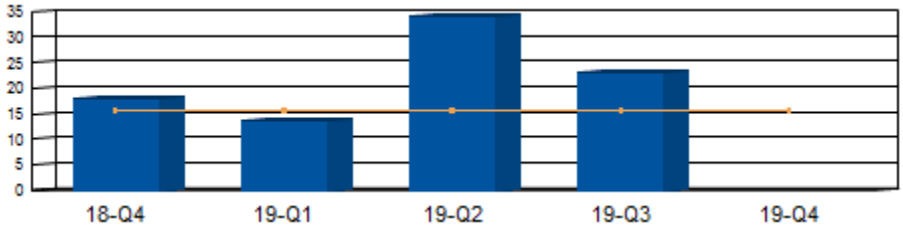
Centre des sciences de la santé de Kingston

Q4 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: Readmission QBP (COPD) (KHSC QIP)



	Actual	Target
18-Q4	18.0	**15.5**
19-Q1	13.6	**15.5**
19-Q2	34.2	**15.5**
19-Q3	23.0	**15.5**
19-Q4		**15.5**

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

The tactical work plan to address this QBP is described in the COPD QBP (COPD Nurse Navigator for optimization, self-management education, intensive smoking cessation intervention, care coordination/discharge planning, staff education and capacity building, standardized order sets). This position is now permanent.

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 reflects Q3 performance as data availability for this indicator demonstrates a delay. For Q3 the result is red, which means the actual result exceeds the target. However, there has been a significant improvement since Q2. It's too early to tell if this is a trend - more data points are needed. Overall the mean readmission rate for last fiscal is 23.5% and for this fiscal YTD it is 23.6% indicating no change (expected). However, there are some positive lead measures that should result in a positive change in the next fiscal year. COPD Order Set compliance has improved since the introduction of the COPD Nurse Navigator - currently 50.6% since the introduction of the navigator and previously 33.3% before the Navigator. This important standardization work should improve the readmission rate in the next fiscal.

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

Q4 results may show some impact of the comprehensive COPD interventions that were initiated in Q3 but due to the delay of data reporting by one quarter as described above it is likely that we may not see impact until Q2 of the next fiscal and beyond.

Definition: DATA: Decision Support - Alex Ungar COMMENTS: Deanna Abbott-McNeil EVP: Mike McDonald, 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

Kingston Health Sciences Centre

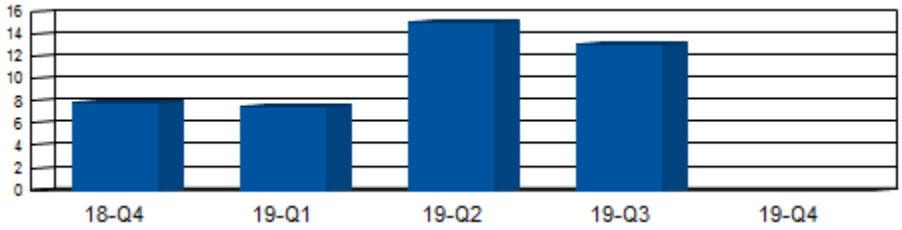
Centre des sciences de la santé de Kingston

Q4 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-Q4	7.9	
19-Q1	7.5	
19-Q2	15.0	
19-Q3	13.0	
19-Q4		

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

Data not yet available for this quarter

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

AMHS-KFLA has been under LHIN appointed supervision for several months, with significant service restructuring under way. Staff turn-over is high at present with a number of vacant positions within ACTT and Crisis services which may impact inpatient admission and readmissions

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

No established target.

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

Kingston Health Sciences Centre

Centre des sciences de la santé de Kingston

Q4 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