fiscal 2014-2015 **Q4**

4th quarter ended March 31, 2015

KGH this quarter

Quality Improvement Plan (QIP)

Performance Report

Kingston General Hospital

Outstanding care, always

KGH Quality Improvement Plan (QIP) Performance Report Fiscal 2015 Q1

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Strategic Direction 1

Transform the patient experience through a relentless focus on quality, safety and service

Outcome 1:

Patients are engaged in all aspects of our quality, safety, and Service improvement initiatives

Strategic Performance Indicators

Overall, how would you rate the care you received at the hospital? (QIP)	2

Outcome 2:

All preventable harm to patients is eliminated

Strategic Performance Indicators

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Rate of 5-day in-hospital mortality following surgeryper 1000 major surgical cases (QIP)	5
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Achieve zero patient falls in Level 3 and Level 4 categories (QIP)	8
All three phases of the surgical safety checklist are performed (Briefing, time out, and Debriefing)(QIP)	9

Outcome 3:

All preventable delays in the patient journey to, within, and from KGH are Eliminated

Strategic Performance Indicators

90th Percentile ED Wait Time (All Admitted Patients) (Hrs) - (QIP)	10
Percent ALC Days (QIP)	11

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Strategic Direction 4

Increase our focus on complex-acute and specialty care

Outcome 6:

KGH services are well aligned and integrated with the broader health care system

Strategic Performance Indicators

Readmission within 30 days for selected CMGs to any facility (QIP) 12

Strategic Direction 8

Finances

Outcome 11:

Our operation budget is balanced and we are able to allocate $20 million a year to capital expenditures

Strategic Performance Indicators

Total Margin (QIP) 13

Status Legend 14

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Strategic Direction	2015 Outcome	Indicator	14-Q4	15-Q1	15-Q2	15-Q3	15-Q4	
Transform the patient experience through a relentless focus on quality, safety and service	Patients are engaged in all aspects of our quality, safety and service improvement initiatives	Overall, How Would You Rate the Care You Received at the Hospital? (QIP)	G	G	G	G	N/A	↑
	All preventable harm to patients is eliminated	C-Difficile (Reported Quarterly) (QIP)	Y	G	R	R	R	↓
		Hand Hygiene Compliance - (QIP)	R	R	R	R	R	↑
		Rate of 5-day In-Hospital Mortality Following Major Surgery per 1000 Major Surgical Cases (QIP)	N/A	G	R	R	Y	↑
		Hospital Standardized Mortality Ratio (HSMR) (QIP)	G	G	R	R	N/A	↓
		Medication Reconciliation at Admission (QIP)	R	R	R	R	R	↑
		Achieve Zero Patient Falls in Level 3 and Level 4 Categories - (QIP)	R	Y	R	R	R	↓
		All Three Phases of the Surgical Safety Checklist are Performed (Briefing, Time Out, and Debriefing) - (QIP)	G	G	G	G	G	↑
	All preventable delays in the patient journey to, within, and from KGH are eliminated	90th Percentile ED Wait Time - All Admitted Patients (hrs.) - (QIP)	R	R	R	R	R	↓
		Percent ALC Days (QIP)	R	R	R	R	R	↓
Increase our focus on complex-acute and specialty care	KGH services are well aligned and integrated with the broader health care system	Readmission Rate within 30 Days for Selected CMG's to Any Facility (QIP)	Y	Y	Y	N/A	N/A	↓
Finances	Our operating budget is balanced and we are able to allocate $20 million a year to capital expenditures	Total Margin (QIP)	G	G	G	G	G	↑

Indicates improving performance to target over the past 5 quarters ↑ Indicates worsening performance to target over the past 5 quarters ↓

	Strategy					QIP					Supporting				
	Q1 %	Q2 %	Q3 %	Q4 %	Q4 #	Q1 %	Q2 %	Q3 %	Q4 %	Q4 #	Q1 %	Q2 %	Q3 %	Q4 %	Q4 #
R	30%	52%	44%	41%	11	33%	67%	67%	58%	7	28%	33%	31%	33%	27
G Y	33%	48%	56%	59%	16	67%	33%	33%	42%	5	65%	66%	69%	67%	56
N/A	37%	0%	0%	0%	0	0%	0%	0%	0%	0	7%	1%	0%	0%	0
					27					12					83

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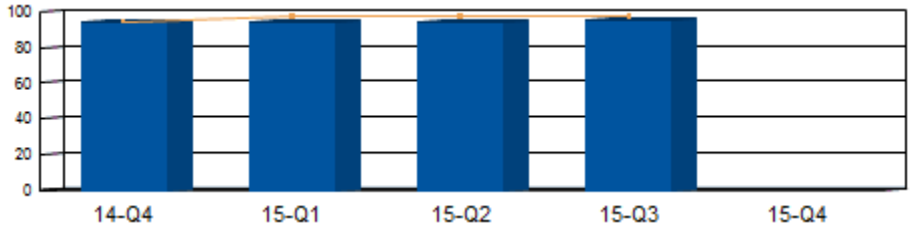
Q4 FY2015 Quality Improvement Plan Performance Report

Transform the patient experience through a relentless focus on quality, safety and service

Patients are engaged in all aspects of our quality, safety and service improvement initiatives

Indicator: Overall, How Would You Rate the Care You Received at the Hospital? (QIP)



	Actual	Target
14-Q4	93.8	**94**
15-Q1	94.0	**97**
15-Q2	94.0	**97**
15-Q3	95.0	**97**
15-Q4		

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

KGH has licensed Communicate with H.E.A.R.T which is a service excellence program created by the Cleveland Clinic. Communicate with HEART uses a common sense approach of interacting with others. It's a healthcare-focused model that will provide all KGH staff, along with volunteers and physicians with the practical knowledge to help them address patient concerns. It will also help staff to communicate with patients, families and coworkers with empathy. By engaging our patients with consistent empathetic communication, we hope to address any concerns or question a patient or their family experiences over the course of their care. We hope patients will as a result feel more positive about their experience with KGH.

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

As of March 31st, 2015, 866 staff, learners and volunteers have completed the Communicate with HEART training. This represents 173% of the corporate target for F14/15. 539 of the attendees required backfill. In applying a PDSA cycle to the training program at the end of Q3 in-class training time was reduced from 4 hours to 2.5 hours. This allowed us to exceed the target while staying within the allotted budget for the year.

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

There is a stretch goal for improving the overall patient satisfaction by 2%. We have targeted the training program to the medicine program with the hope of having significant impact on patient satisfaction within that group. We believe we are on target to achieve this target by year end. The Q2 data is the most recent.

Definition: DATA: Astrid Strong COMMENTS: Astrid Strong STRATEGY REPORT

The patient's perception of overall care received and is based on a single question (#44) on the National Research Corporation of Canada (NRCC) Acute Inpatient survey. Possible responses to this question include poor, fair, good, very good and excellent. The percent positive score represents the combined responses of good, very good and excellent.
Ambulatory Care is reported separately, with Oncology reported bi-annually and Emergency Care reported quarterly.

Target: Target 12/13: PTAOB, Target 13/14: PTAOB Perf. Corridor: Red <=80% Yellow 80%-89% Green >=90%,Target 14/15: PTAOB Perf. Corridor: Red <=80% Yellow 80%-89% Green >=90%

Q4 FY2015 Quality Improvement Plan Performance Report

Transform the patient experience through a relentless focus on quality, safety and service

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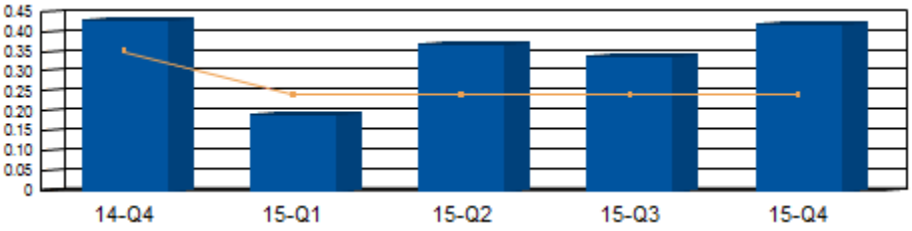
Indicator: C-Difficile (Reported Quarterly) (QIP)



	Actual	Target
14-Q4	0.43	**0.35**
15-Q1	0.19	**0.24**
15-Q2	0.37	**0.24**
15-Q3	0.34	**0.24**
15-Q4	0.42	**0.24**

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

Efforts to sustain this improving trend included: ICP presence on the units and in ED every day, working collaboratively with each of the Programs to ensure prompt initiation of "Contact Precautions" for any patient with diarrhea and obtaining a specimen for testing; ASP pharmacists ongoing assessments of orders and promotion of the CDI order set with SOPs; ongoing collaboration with the Laboratory and ensuring the appropriate use of sporicidal cleaners by Environmental Services to reduce the environmental load of spores.

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 KGH incidence rate for the fourth quarter was 0.42 cases per 1000 patient days; a modest increase from the third quarter. In January we had 6 cases of CDI. In February we had 7 cases and in March there were 3 cases giving us a total of 16 cases. Overall for 2014 - 2015, we had 50 cases of CDI. In comparison in 2013 - 2014 we had 77 cases and in 2012 - 2013 we had 88 cases. The following are CDI rates for Ontario teaching hospitals for the month of March 2015: KGH .24, LHSC .25, HHSC .48, Ottawa .47, St Michaels .39, Sunnybrook .52. It is worth noting that KGH had the lowest rate in the month of March.

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

Although our target was not met, we continue a steady downward trend in the number of CDI cases acquired nosocomial which has been sustained for > 3 years and are now 35 months without a CDI outbreak. We had 27 fewer patients develop a nosocomial CDI this year, than last and 38 fewer than the year before.
Tactics for 2015 - 2016 including ensuring the sustainability of the close collaboration between Programs and IPAC in identification and management of both suspect and confirmed cases of CDI; increasing awareness of the CDI Order Set and SOP's; and working with ES on daily cleaning or terminal cleaning procedures for patient's environment, equipment and bathroom.

Definition: DATA: Darlene Campbell COMMENTS: Dr.Gerald Evans STRATEGY REPORT

Clostridium difficile is a spore-forming bacterium that may be present in the environment and can colonize the intestinal tract in up to five per cent of adults in the community without causing symptoms. It can cause an infectious diarrhea in both community and health care settings. It is the single most common cause of antibiotic-associated diarrhea (AAD) accounting for 15-25% of all episodes.
All Ontario hospitals are required to report to the MOHLTC and publicly on the rates and the number of new nosocomial CDI cases associated with the reporting facility.
The CDI count is the number of new nosocomial cases of CDI by month.
The rate of CDI is calculated as follows: The number of new nosocomial cases of CDI associated with the reporting facility multiplied by 1000, then divided by the number of patient days. This rate represents the incidence rate of nosocomial CDI associated with the reporting facility per 1000 patient days.

Target: Fiscal 2011/12 - QIP Goal = 0.30, QIP Target for Compensation = 0.77 Fiscal 2012/13: 0.3, Target 13/14: 0.37 Perf. Corridor: Red >0.42 Yellow 0.38-0.41 Green <=0.37, Target 14/15: 0.24 Perf. Corridor: Red >0.26 Yellow 0.25-0.26 Green <=0.24

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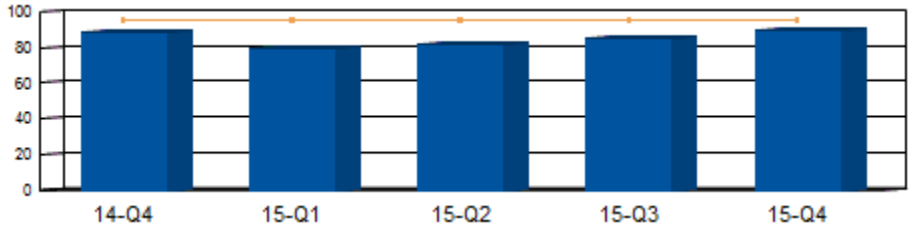
Indicator: Hand Hygiene Compliance - (QIP)



	Actual	Target
14-Q4	88.2	**95**
15-Q1	79.7	**95**
15-Q2	82.0	**95**
15-Q3	85.0	**95**
15-Q4	89.4	**95**

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

Significant efforts within Programs this year to improve the number of audits being conducted and observed opportunities resulted in increases to the denominator each quarter. The Hand Hygiene Working Group continued to meet to develop new strategies to improve compliance rates. A new Resource Tool provides clear guidance on what is Patient Environment vs. what is Hospital Environment. In addition, support for increasing the role of the auditor from being an observer only, to providing "Just in Time" education has been developed and is rolling out.

The Hand Hygiene Working Groups has identified new improvements that will contribute to further improving compliance rates and optimize patient's safety by reducing opportunities for the transmission of organisms via healthcare workers hands. New initiatives will target education on the appropriate usage of gloves and enhance the understanding of hospital environment and patient environment parameters.

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

Overall corporate HH rate for this quarter was 89.4%. The before moment for Quarter 4 was 87.5%, an increase from Quarter 3's 85%; the after moment was 92.3% also an increase from Quarter 3's 90%. These rates are the reflection of 4,304 observed opportunities. Total opportunities for 2014 - 2015 were 18,037, a significant increase from 2013 - 2014 when our total opportunities were 11, 257. There was also an important increase in the number of HCW observed, in 2014 - 2015, 14,048 HCW were audited; in 2013 - 2014 there were 7,801 HCW audited. The increase of 6,780 HCW observed provides a broader representation of staff.

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 target of 95% was not met this year. Efforts within the Programs and from IPAC Service to support auditors resulted in the roll out of a training manual for all new auditors, and ongoing support for trouble-shooting with devices resulted in the number of observed opportunities significantly increased. The further roll out of the new Resource Tool and the "Just in Time" intervention training and education supported by The Hand Hygiene Working Group (HHWG) will contribute to further improving compliance rates and optimize patient's safety by reducing opportunities for the transmission of organisms via healthcare workers hands. In addition, the HHWG has begun discussions on another new initiative that will target education on the appropriate usage of gloves.

Definition: DATA: Infection Control COMMENTS: Dr.Gerald Evans STRATEGY REPORT

The single most common way of transferring health care-associated infections (HAIs) in a health care setting is on the hands of health care providers. Health care providers move from patient to patient and room to room while providing care and working in the patient environment. This movement provides many opportunities for the transmission of organisms on hands that can cause infections. Hand hygiene is the act of cleaning one's hands. There are two ways to clean hands; using an alcohol-based hand rub (ABHR) or, when hands are visibly soiled, using soap and running water. Monitoring hand hygiene practices is vital to improving rates and, in turn, reducing HAIs.
Hospitals will post on their web sites, on an annual basis and by hospital site, the compliance rate for: hand hygiene before initial contact with the patient/patient's environment for all health care providers as well as hand hygiene after contact with the patient/patient's environment for all health care providers.
Before Initial Patient/Patient Environment contact :
# of times hand hygiene performed before initial patient/patient environment contact
---
observed hand hygiene indications before initial patient/patient environment contact
x 100
After Patient/Patient Environment contact :
# of times hand hygiene performed after patient/patient environment contact
---
observed hand hygiene indications after patient/patient environment contact
x 100
Hospitals will also report their data to the Ministry of Health and Long-Term Care through an online template captured by a central database. The ministry will post this information on its public website.
Links to Outcomes & Initiatives:
Clinical Quality & Outcomes: Patient Safety, Care Pathways and Practice and Interprofessional Collaborative Practice Model (ICPM).

Target: Target 11/12: 90% Target 12/13: 95%, Target 13/14: 98% Perf. Corridor: Red <90% Yellow 90%-95% Green >=95%,Target 14/15: 95% Perf. Corridor: Red <90% Yellow 90%-94% Green >=95%

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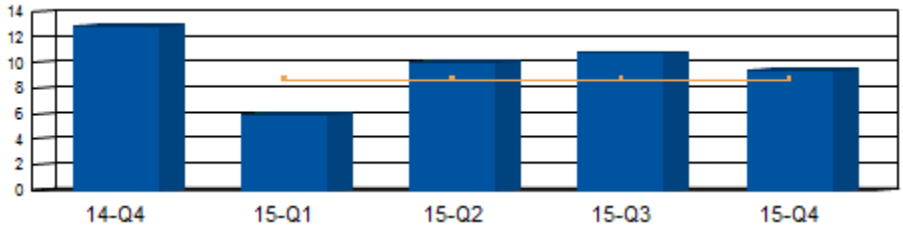
Indicator: Rate of 5-day In-Hospital Mortality Following Major Surgery per 1000 Major Surgical Cases (QIP)



	Actual	Target
14-Q4	12.90	
15-Q1	5.90	**8.68**
15-Q2	10.07	**8.68**
15-Q3	10.74	**8.68**
15-Q4	9.40	**8.68**

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

All 5-day in hospital mortalities are reviewed by Clinical Departments similar to the standard mortality process. The mortality reviews are discussed at JQUIC and MAC.

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 current Q4 rate is greater than the provincial target. Mortality reviews have not found issues/concerns with care or process. There were 8 deaths in 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?

No, however it is important to note that everyone one of these deaths is subject to a mortality review by the relevant surgical service. This process will continue for fiscal 15/16 an indicators will become a supporting indicator.

Definition: DATA: Decision Support COMMENTS: Dr. David Zelt STRATEGY REPORT

This indicator measures the rate of in-hospital deaths due to all causes occurring within five days of major surgery.

· Unit of analysis: The measuring unit of this indicator is a single admission. The indicator is expressed as a rate of in-hospital deaths within five days of major surgery per 1,000 major surgical cases.
· Denominator: Hospitalizations with major surgery performed between April 1 and March 25 of the fiscal year.
· Numerator: Cases within the denominator where an in-hospital death occurred within five days of major surgery.

Target: Target 14/15: 8.68 Perf. Corridors: Red >=9.55 Yellow 8.69-9.54 Green <=8.68

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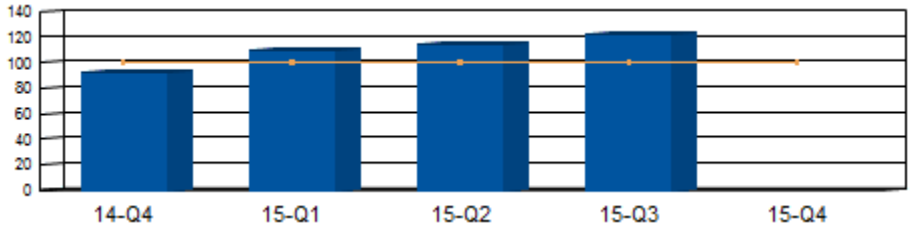
Indicator: Hospital Standardized Mortality Ratio (HSMR) (QIP)



	Actual	Target
14-Q4	93	**100**
15-Q1	109	**100**
15-Q2	115	**100**
15-Q3	122	**100**
15-Q4		**100**

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

The Hospital Standard Mortality Ratio (HSMR) is an important quality of care measurement tool that provides a starting point to assess mortality trends, identify opportunities for improvement and track progress. The HSMR is adjusted for factors affecting mortality, such as age, sex, and length of stay. An HSMR equal to 100 suggests that there is no difference between the hospital's mortality rate and the overall average rate. An HSMR greater than 100 suggests that the local mortality rate is higher than the overall average whereas a HSMR less than 100 suggests that the local mortality rate is lower than the overall average. It is important to note that HSMR is not designed for comparisons between hospitals; it is intended to track a hospital's trend over time. Currents tactics underway to address the HSMR are as follows: Mortality reviews in all KGH clinical departments (Medicine - focus on Sepsis, Surgery - all plus post major surgery, other Departments - all deaths), application of the VAP prevention protocol including a checklist, and conducting MRSA admission screening on all admissions.

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

CIHI has just released the Q2 and Q3 data for this fiscal year. The HSMR data set was recently readjusted to a new baseline. HSMR data is no longer compared to 100. Instead, HSMRs are compared with the current national HSMR. Quarterly morality reviews are on-going by the clinical departments. No concerns or trends have been reported to the MAC's Joint Quality and Utilization Committee. The 5-day post major surgical death reviews have also not identified any concerns regarding quality of care. There were 44 palliative deaths (10%) included in the data calculations. Inclusion of palliative deaths because of coding protocols at CIHI continues to be a difficulty in analysis. A coding review with respect to the capture and accuracy of comorbidities is planned. There is concern this is under-represented/documented in the chart.

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. The HSMR data will be reviewed to reassess trending within the medical/surgical groups to see were the current increase in HSMR may have increased.

Definition: DATA: Decision Support COMMENTS: Dr. David Zelt STRATEGY REPORT

The Hospital Standardized Mortality Ratio (HSMR) is an overall quality indicator and measurement tool used by all acute care hospitals and regions in Canada (excluding Quebec). HSMR has been used by many hospitals in several countries to help improve quality of care and enhance patient safety. The HSMR is based on diagnosis groups that account for 80% of all deaths in acute care hospitals and is adjusted for factors such as diagnosis group, age, sex, length of hospital stay, admission category, comorbidities (having multiple illnesses at once) and transfers. The Formula for HSMR is equal to the number of observed deaths divided by the number of expected deaths, multiplied by 100.

Target: Baseline 08/09: 111 , Target 09/10: 100, Target 10/11: 100, Target 11/12: 106. Target 12/13: 100, Target 13/14: 100 Perf. Corridor: Red Statistically Significant Results Yellow N/A Green Statistically not Significant, Target 14/15: 100 Perf. Corridor: Red Statistically Significant Results Yellow N/A Green Statistically not Significant

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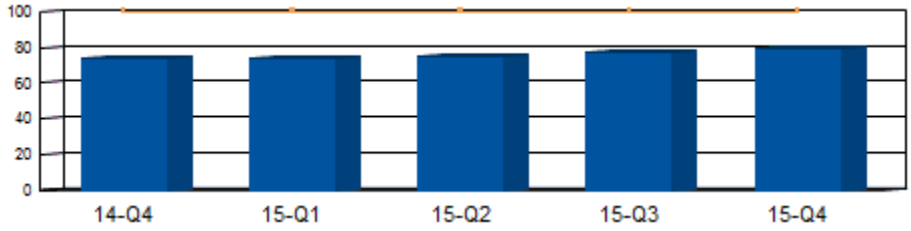
All preventable harm to patients is eliminated

Indicator: Medication Reconciliation at Admission (QIP)



	Actual	Target
14-Q4	74	**100**
15-Q1	74	**100**
15-Q2	75	**100**
15-Q3	77	**100**
15-Q4	79	**100**

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

A standard Surgery Admission Order Set embedding the medication reconciliation process endorsed by the Executive Committee of the Division of Surgery and the Surgical Program Council was approved by the Order Set Committee and distributed to all areas of the hospital where admission orders for surgical patients are written in March 2015.

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 percentage of patients who receive medication reconciliation at the time of admission to the Hospital has increased from 77% in F15 Q3 to 79% in F15 Q4, a slow but steady and constant increase since implementation of this indicator in F14 Q1 (65%).

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

With the implementation of the surgery admission order set in March 2015, the total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital should exceed 80% in F16 Q1. A one month post-implementation audit showed 50% compliance. Medication reconciliation is now a component of the post-operative surgical safety checklist. The F16 KGH tactics include prescriber engagement and education. Implementation of EntryPoint in the surgical program is also planned for F16 which will improve prescriber access to the admission orders. KGH is partnering with HDH to review the documentation of home medications for elective surgical patients in the pre-surgical clinics at HDH..

Definition: DATA: Decision Support COMMENTS: Veronique Briggs STRATEGY REPORT

The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital.

Target: Target 14/15: 100% Perf. Corridor: Red <= 80% Yellow 80%-89% Green >=90%

Q4 FY2015 Quality Improvement Plan Performance Report

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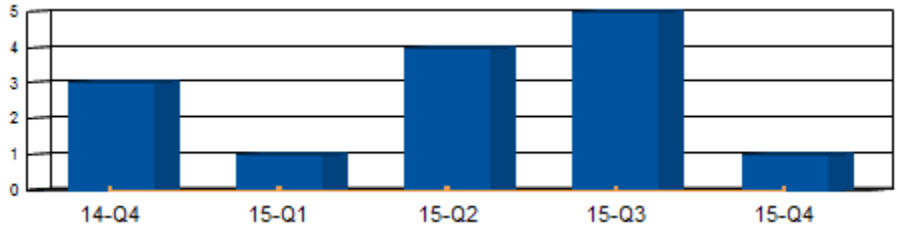
Indicator: Achieve Zero Patient Falls in Level 3 and Level 4 Categories - (QIP)



	Actual	Target
14-Q4	3	**0**
15-Q1	1	**0**
15-Q2	4	**0**
15-Q3	5	**0**
15-Q4	1	**0**

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

All patient falls present a risk of injury. Hospitalization increases risk of falls due to an unfamiliar environment, illness, and reduced mobilization and medication side effects. Through falls risk identification and frequent early mobilization of all patients we are proactively addressing patient falls. The Falling Star program focuses on the assessment, documentation, communication and knowledge of patient risk. Move ON focuses on the increased frequency of safe mobilizations of patients. Education on both programs was successfully delivered to all clinical area implementation teams by end of Quarter 1. Units who received the education were to establish improvement teams to support increased consistency of use of the Falling Star Program and identify improvement cycles to support safe mobilization of patients. All this work was to be completed by end of Q2. Q3 was planned to support 'sustainability' of the Falling Star and Mobilization improvements for each unit. Q4 was used to identify the next step of improvement cycles.

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

One level 3 fall occurred in the fourth quarter & zero level 4. This fall was reviewed at the Program level to identify causal factors that can be used to support improvements. The fall involved an ambulating patient. After review the it was determined that the appropriate levels of supports were in place. There were no specific gaps in the safeguards identified.

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 deliver zero level 3 or 4 falls within the fiscal year. All improvement cycles were completed. We will develop further improvements, risk identification and screening standards for the coming year. Significant other achievements are the procurement and installation of over 100 new beds through the hospital, all of which are now in place and aid in alerting care teams of patient movement (bed alarms) and enable reduced fall heights. It is of note that this completes year one of a three year bed replacement plan.

Definition: DATA: Decision Support COMMENTS: Richard Jewitt STRATEGY REPORT

Using our incident reporting system we have identified that Falls are one of the top three sources of preventable harm to patients for 2012-13 at KGH.Our aim is to eliminate actual level 3 (moderate harm) and level 4 (severe/critical harm) patient falls.

Target: Target 13/14: 0 Perf. Corridor: Red >3 Yellow 1-3 Green 0,Target 14/15: 0 Perf. Corridor: Red >6 Yellow 4-6 Green <4

Q4 FY2015 Quality Improvement Plan Performance Report

Transform the patient experience through a relentless focus on quality, safety and service

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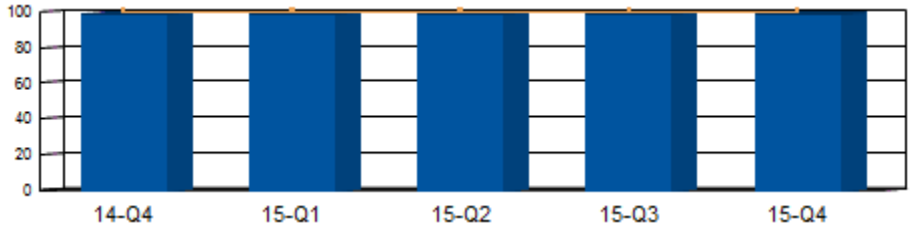
Indicator: All Three Phases of the Surgical Safety Checklist are Performed (Briefing, Time Out, and Debriefing) - (QIP)



	Actual	Target
14-Q4	99	**100**
15-Q1	99	**100**
15-Q2	99	**100**
15-Q3	99	**100**
15-Q4	99	**100**

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

The monthly review of the Surgical Safety Checklist metrics by the Program council and at OR staff meetings continue to assist in the sustainability of meeting this target. In the 4th quarter and adjustment to the current electronic system to add mandatory screens will assist in future of ongoing success of meeting this quality and safety metric.

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

For Q4 YTD, this indicator continues to meet the green target corridor. There were 9,125 patients who received surgery at KGH this year. The OR team's compliance for the Surgical Safety checklist 3 phases overall were the following: Briefing- 99.5 %, Timeout-99.2%, and Debrief- 99.6%.

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

Target continues to be in the green range.

Definition: DATA: Kathleen Wattie Barnett COMMENTS: Kellie Kitchen STRATEGY REPORT

The Surgical Safety Checklist (SSC) compliance indicator is a process measure that is part of the hospital's QIP. It refers to the percentage of surgeries in which a three-phase surgical safety checklist was performed correctly and appropriately for each surgical patient. All surgeries carried out in a fully equipped operating room are eligible to report the use the SSC. The SSC is considered performed when the designated checklist coordinator confirms that surgical team members have implemented and/or addressed all of the necessary tasks and items in each of the three phases-'Briefing', 'Time Out' and 'Debriefing'-of the checklist, based upon the Canadian Patient Safety Institute (CPSI)'s Surgical Safety Checklist.

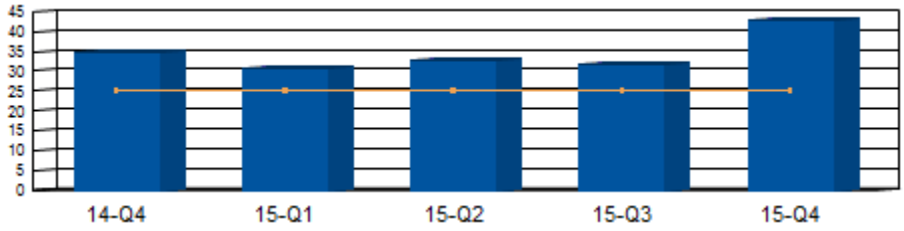
Target: Target 2012/13: 100% Target 2013/14: 100% Perf. Corridor: Red <95% Yellow 95%-97% Green >97%,Target 2014/15: 100% Perf. Corridor: Red <95% Yellow 95%-97% Green >97%

Q4 FY2015 Quality Improvement Plan Performance Report

Transform the patient experience through a relentless focus on quality, safety and service

All preventable delays in the patient journey to, within, and from KGH are eliminated

Indicator: 90th Percentile ED Wait Time - All Admitted Patients (hrs.) - (QIP)



	Actual	Target
14-Q4	35.0	**25**
15-Q1	30.7	**25**
15-Q2	32.6	**25**
15-Q3	31.6	**25**
15-Q4	42.7	**25**

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

GOOG (Get out of Gridlock) was implemented on February 9th with the goal of getting out of gridlock by March 31. KGH had been in Gridlock since October 23, 2014. The GOOG project focused on implementing individual improvement cycles developed as a result of opportunities identified in the VSM in May 2013, simultaneously. Gridlock indicators were used as a measure of success - defined as 2 of 3 indicators in green. The Patient Flow Task Force, which has representation from across all programs and services as well as CCAC and Providence Care, has oversight of these initiatives and receives updates twice a month. The new bed map was implemented on January 26.

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 Q4 result of 42.7 hours is 17.7 hours longer than the 25 hour target. Twenty percent of all patients admitted through the ED waited 42.7 hours or longer to be transferred to an inpatient bed. Based on Q4 admission volumes of 2676, 268 patients waited 42.7 hours or longer in the ED for an inpatient bed. Of note, the performance in January was particularly high at 49.8 hours at the 90th percentile. Inpatient days in the ED are 1243 this quarter which is the equivalent of 14 beds. This has a negative impact on the ability to see, assess and treat other patients within the recommended time and poses a risk for patients in the waiting room for long periods of time. Patients in the ED for this length of time are in the wrong place to receive optimum care. Providers in the ED are forced to work in a fraction of the department to care for the sickest patients. LOS in the ED is continuously monitored in real time with EDIS, and supports timely and factual communication with inpatient units to support planning. Our performance is different from our peers this quarter with each of the following hospitals seeing an improvement in Q4 over Q3. Our result of 42.7 is the highest amongst our peers. LHSC = 35.6, HHSC = 30.9, SMH = 23.6, SHSC = 31.6, TOH = 30.5, TBRHC = 38.6

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. The target for this year was not met. The target is not a reasonable target and the SE LHIN has acknowledged this and changed the target to 29 hours in 15/16.

Definition: DATA: Decision Support (NACRS) COMMENTS: Julie Caffin STRATEGY REPORT

This indicator measures the amount of time 9 out of 10 patients (90th percentile) spend in an ED being diagnosed, receiving treatment and waiting for admission to a hospital bed. Most patients spend less time, while 1 out of 10 patients will spend more time. The time being measured is defined as when a patient registers until the time when the patient is admitted to an inpatient hospital bed. For this indicator, 9 out of 10 patients (for all admitted patients at all levels of complexity) will spend no more than 31 hours within the ER from the time they arrive and register to the time they leave the ED.

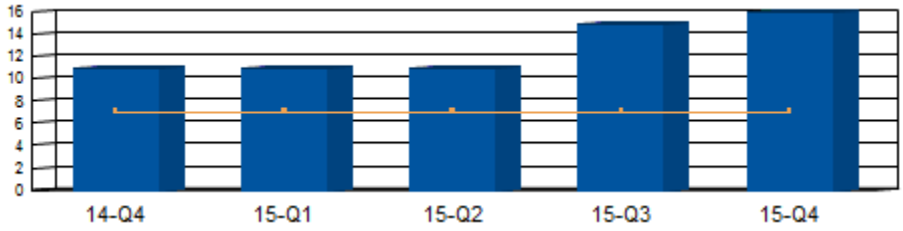
Target: Target 11/12: 31 Hours, Target 12/13: 22 Hours, Target 13/14: 25 Hours Perf. Corridor: Red >31 Yellow 28-31 Green <28, Target 14/15: 25 Hours Perf. Corridor: Red >31 Yellow 28-31 Green <28

Q4 FY2015 Quality Improvement Plan Performance Report

Transform the patient experience through a relentless focus on quality, safety and service

All preventable delays in the patient journey to, within, and from KGH are eliminated

Indicator: Percent ALC Days (QIP)



	Actual	Target
14-Q4	11.0	**7**
15-Q1	11.0	**7**
15-Q2	11.0	**7**
15-Q3	14.8	**7**
15-Q4	16.0	**7**

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

KGH and regional partners have committed to a renewed focus on ALC and as a result, a number of initiatives are underway. Within KGH, steps that are being taken include:
o A registered nurse has been seconded to be the KGH point of contact for ALC patients.
o A 'tiger team' meets weekly to look at the current status of ALC patients at KGH, to review & revise any processes and to advise on steps to support consistent adoption of ALC designation processes. The Tiger Team is aligning its effort to the work happening on a LHIN-wide basis to ensure standardization to the degree possible. Policies being revised are: 1.Discharge Policy (including escalation process); 2. Emergency/Primary Care-Discharge of Non-Admitted Patients to Supportive Care Settings Policy;
3. Patient Transfer to Supportive Care Settings (Inpatients) Policy; 4. Alternate Level of Care Policy;
5. Alternate Level of Care Co-Payment Policy
o The ALC designation process is being refreshed to include the development of a message that supports exploring all options for transition of care or discharge.
o Current order set for ALC designation is being revised to introduce a new inter-disciplinary process for assessment and decision making regarding ALC for long term care.
o Working closely through a regional Peer to Peer group that is made up of representatives from all hospitals, the CCAC and SE LHIN to develop best practice approaches for managing ALC and improving key processes and policies that will support ALC patients reach their best destination in a timely way thereby reducing overall time in an acute care setting. Also the SELHIN Peer to Peer Group has been asked to make hospital site visits in the SE to bring forward recommendations to drive change and improvement based on best practices in place across the region. No visit dates have been set yet.

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 indicator is described as the percentage of inpatient days that patients' occupying an acute care hospital bed has finished the acute phase of his/her treatment. The total number of ALC days is influenced by both the number of ALC patients and their ALC-specific lengths of stay. The F16 target is 10% ALC days compared to 7% in F15.

The Q4 result of 16% indicates that, on average, there were more than 65 inpatients at KGH whose acute care stay was complete and who were waiting for access to one of the destinations listed below.
A high number of ALC days generally reflect the lack of timely access to destinations outside of KGH once the patients' acute care stay is complete. The provincially mandated ALC discharge destinations include: long term care homes, retirement homes, rehabilitation, home, supportive/assisted living, complex care, convalescent care, and mental health. The majority of ALC patients are awaiting transfer to a long term care home.

All partners are experiencing the same issues. Data from across the SE LHIN indicates that there are upwards of 200 ALC patients occupying an acute care bed at any one time. Depending on the total number of beds, ALC can represent between 10-60percent of total acute care beds being occupied by ALC patients. As indicated this equals 16% of ALC days at KGH in 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?

We did not meet the target of 7% ALC days in F15. Despite significant efforts across hospitals and the SE CCAC, ALC rates remain high. Efforts continue in earnest to implement internal process improvements and maximize opportunities, working collaboratively with our partners across the LHIN, to support individuals in need get to the most appropriate destination once they have completed the acute phase of their journey. As we know, this is a system issue requiring system solutions. There is strong commitment throughout KGH to reduce ALC rate moving closer to the QIP target in F16. The target for F16 has been changed to 10%.

Definition: DATA: Decision Support COMMENTS: Cynthia Phillips STRATEGY REPORT

When a patient occupies a hospital bed and does not require the intensity of resources/services provided in the acute care setting, the patient must be designated alternate level of care (ALC) by the physician or his/her delegate. The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination, or when the patient's needs or condition changes and the designation of ALC no longer applies. The percent of ALC days (total ALC days/total inpatient days) is calculated to better understand the proportion of ALC days for a given period of time.

Target: 11/12 Target: 10% 12/13 Target: 10%, Target 13/14: 7% Perf. Corridor: Red >10% Yellow 8%-10% Green <=7%, Target 14/15: 7% Perf. Corridor: Red >9.5% Yellow 8%-9.5% Green <=7%

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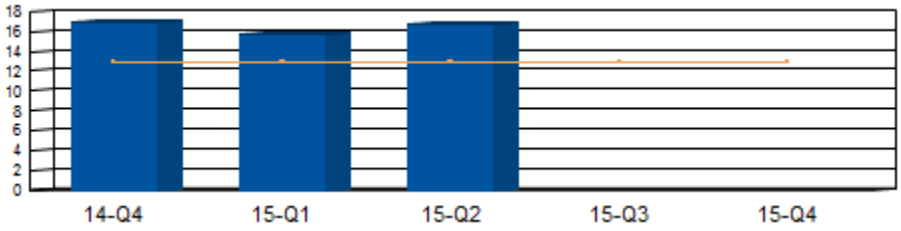
Q4 FY2015 Quality Improvement Plan Performance Report

Increase our focus on complex-acute and specialty care

KGH services are well aligned and integrated with the broader health care system

Indicator: Readmission Rate within 30 Days for Selected CMG's to Any Facility (QIP)



	Actual	Target
14-Q4	17.04	**12.9**
15-Q1	15.80	**12.9**
15-Q2		**12.9**
15-Q3		**12.9**
15-Q4		**12.9**

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

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

Definition: DATA: Decision Support COMMENTS: Dr. David Zelt STRATEGY REPORT

This indicator is calculated by the MOH and supplied to KGH via the Ministry LHIN Performance agreement (MLPA – a performance agreement that focuses on system performance and financial accountabilities. This indicator is best described as the number of patients readmitted to any facility for non-elective inpatient care, compared to the number of expected non-elective readmissions using data from all Ontario acute hospitals. The number of patients readmitted to any facility for non-elective inpatient care is defined as the observed number of patients, discharged with specific CMG's within calendar year, readmitted to any facility for any non-elective patient care within the specified number days of discharge for index admission.

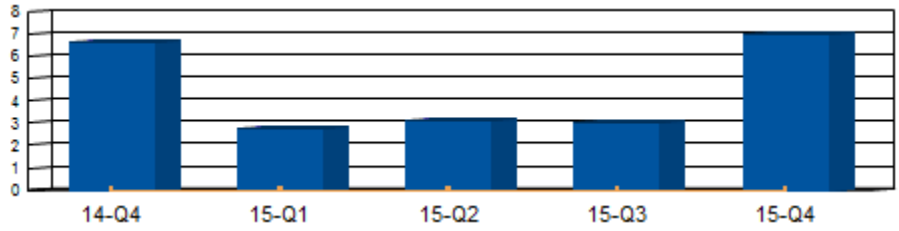
Target: Target 11/12: 12.9%, Target 12/13: 12.9%, Target 13/14: 12.9% Perf. Corridor: Red >18% Yellow 14.3%-18% Green <=14.2%, Target 14/15: 12.9% Perf. Corridor: Red >18% Yellow 14.3%-18% Green <=14.2%

Q4 FY2015 Quality Improvement Plan Performance Report

Finances

Our operating budget is balanced and we are able to allocate $20 million a year to capital expenditures

Indicator: Total Margin (QIP)



	Actual	Target
14-Q4	6.67	**0**
15-Q1	2.77	**0**
15-Q2	3.08	**0**
15-Q3	2.99	**0**
15-Q4	7.03	**0**

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

Monthly financial reporting and analysis support continued to be provided to those with budget responsibility. Senior leadership continued to focus on working within budgeted parameters.

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

Essentially all identified operational efficiencies incorporated in the approved budget were auctioned. Unplanned funding increases and miscellaneous revenue sources and the recognition of prior years' revenue upon program settlement offset negative operating variances aligned to increased patient care activity.

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 hospital has developed a balanced operating budget for fiscal 2016 assuming a return to normal occupancy levels. Monitoring of patient care activity and implementation of planned operational efficiencies will be a key area of focus.

Definition: DATA: J'Neene Coghlan COMMENTS: J'Neene Coghlan STRATEGY REPORT

Operating margin "measures total operating revenues in excess of total expenses". It is a measurement of management's efficiency and the hospital's ability to live within available financial resources. Calculated as: Operating Surplus/(Deficit) divided by Operating Revenue. To ensure consistency in calculation between hospitals, the Province has provided a specific definition based on the Hospitals MIS Chart of Accounts. It is inclusive of all fund types (fund 1, 2, and 3), but excludes facility amortization).

Target: Baseline 08/09: (3.9%), Target 09/10: (4.0), Target 10/11: (2.17), Target 11/12: 0, Target 12/13: 0, Target 13/14: 0% Perf. Corridor: Red <0 Yellow N/A Green >=0, Target 14/15: 0% Perf. Corridor: Red <0 Yellow N/A Green >=0

Kingston General Hospital

Q4 FY2015 Quality Improvement Plan Performance 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