fiscal 2015-2016 **Q1**

1st quarter ended June 30, 2015

KGH this quarter

Quality Improvement Plan (QIP)

Performance Report

Kingston General Hospital

Outstanding care, always

KGH Quality Improvement Plan (QIP) Performance Report Fiscal 2016

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

Outcome 2:

All preventable harm to patients is eliminated

Strategic Performance Indicators

Outcome 3:

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

Strategic Performance Indicators

KGH Quality Improvement Plan (QIP) Performance Report Fiscal 2016

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

Strategic Direction 5

Enable High Performance

Outcome 11:

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

Strategic Performance Indicators

Kingston General Hospital

Q1 FY2016 Quality Improvement Plan Report

Strategic Direction	2016 Outcome	Indicator	15-Q1	15-Q2	15-Q3	15-Q4	16-Q1	
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	G	↑
	All preventable harm to patients is eliminated	C-Difficile (Reported Quarterly) (QIP)	G	R	R	R	R	↑
		Hand Hygiene Compliance - (QIP)	R	R	R	R	R	↓
		Hospital Standardized Mortality Ratio (HSMR) (QIP)	G	R	R	N/A	N/A	↓
		Medication Reconciliation at Admission (QIP)	R	R	R	R	R	↑
		The Number of 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	↑
		Twenty-five percent fewer patients experience skin ulcers on the 3 units (across 3 programs - medicine/surgery/critical care (K6, C10, K2 ICU)) - (QIP)	N/A	N/A	N/A	N/A	Y	
	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	G	↑
		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	30 Day Readmission Rate Outperforms its Expected MOH rate (QIP)	Y	Y	Y	N/A	N/A	↓
Enable High Performance	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				
	FY15			FY16		FY15			FY16		FY15			FY16	
	Q2 %	Q3 %	Q4 %	Q1 %	Q1 #	Q2 %	Q3 %	Q4 %	Q1 %	Q1 #	Q2 %	Q3 %	Q4 %	Q1 %	Q1 #
R	48%	44%	37%	37%	10	58%	67%	50%	50%	6	33%	34%	34%	39%	29
G Y	52%	56%	63%	63%	17	42%	33%	50%	50%	6	66%	66%	66%	61%	46
N/A	0%	0%	0%	0%	0	0%	0%	0%	0%	0	1%	0%	0%	0%	0
					27					12					75

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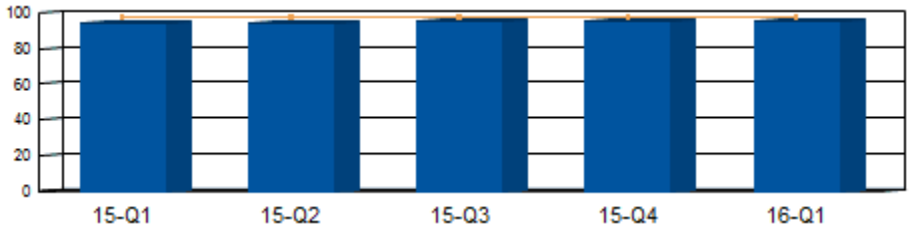
Q1 FY2016 Quality Improvement Plan Report

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
15-Q1	94	**97**
15-Q2	94	**97**
15-Q3	95	**97**
15-Q4	95	**97**
16-Q1	95	**97**

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 patients or their families experience 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:

243 participants completed the training in Q1.Added to the 866 staff, learners and volunteers from the previous fiscal year, a total of 1109 people have completed the Communicate with HEART training.
The 243 trainees in Q1 represent 16% of the target of 1500 trainees for F15/16. We are further enhancing the training through a PDSA cycle combining an e-learning module with an in-class skills practice. The goal of this is to deliver the same learning with improved accessibility for learners.

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%. As the Communicate with HEART concepts are shared with more of staff, learners, volunteers and credentialed staff, we hope to have a significant impact on patient satisfaction. We believe we are on target to achieve this target by year end.

Definition: DATA: Astrid Strong COMMENTS: Astrid Strong EVP: Silvie Crawford REPORT: 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.

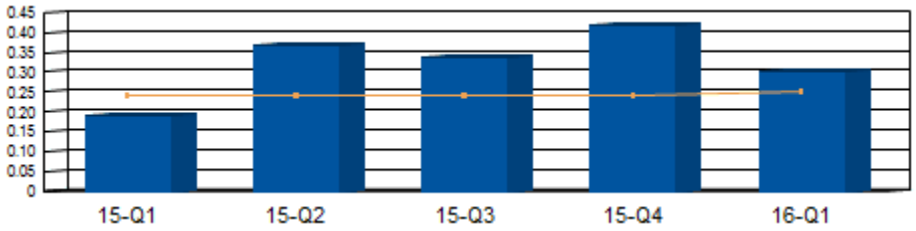
Target: Target 12/13: PTAOB, Target 13/14: PTAOB Perf. Corridor: Red <=80% Yellow 80%-89% Green >=90%,Target 14/15: PTAOB Perf. Corridor: Red <=80% Yellow 80%-89% Green >=90%, Target 15/16:97% Perf. Corridor: Red <=85% Yellow 85%-96% Green >=97%

Q1 FY2016 Quality Improvement Plan Report

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

All preventable harm to patients is eliminated

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



	Actual	Target
15-Q1	0.19	**0.24**
15-Q2	0.37	**0.24**
15-Q3	0.34	**0.24**
15-Q4	0.42	**0.24**
16-Q1	0.30	**0.25**

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

The tactic work plan for 2015-2016 will see the continuation of strategies that have significantly contributed to the improving trend. These include diligent surveillance by IPAC of all confirmed and query CDI cases; daily ICP presence on the units and ED, working collaboratively with each Program/unit to ensure prompt initiation of "Contact Precautions" for any patient with diarrhea, notification of IPAC and timely specimen collection. Ongoing communication with the Microbiology Laboratory enhancing the reporting to IPAC of results including a lab generated 24 hour CDI report, pushed and printed in IPAC. Continued efforts between IPAC and Environmental Services to ensure appropriate use of sporicidal cleaners and prompt initiation of enhanced cleaning when clusters are identified.

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

In Q1 we identified 11 nosocomial cases; an incidence rate of 0.3 cases per 1000 patient days. Comparator hospitals had an average of 0.4 for this same time period. There was 1 case in April; in May there were 4 cases and in June there were 6 cases. The 6 cases in June included a cluster of 4 on one unit, the other 2 cases occurred on 2 separate units. Enhanced cleaning was done on the unit to address evidence of ongoing transmission and identified gaps in cleaning. In addition, education was provided for the nursing staff on the importance of cleaning shared equipment and the Program Manager designated PCA's would clean all shared equipment each evening. The importance of hand hygiene in the prevention of nosocomial transmission was also emphasized by the ICP and PM. No further transmission has been identified on this unit.

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 of 0.25 was not met, we continue a steady downward trend in the number of CDI nosocomial cases. The trend has been sustained for > 3 years; as of the end of June we marked 37 months without a CDI outbreak. In 2014 - 2015, we had 50 cases of CDI; in 2013 - 2014 we had 77 cases and in 2012 - 2013 we had 88 cases.
New tactics to improve the current trend for 2015 - 2016 includes the introduction of a change in processing CDI specimens in Microbiology Laboratory; increasing awareness of the CDI Order Set; and collaborating with ENSE on ensuring standardized isolation cleaning and discharge/terminal cleaning procedures for CDI patient's environment, equipment and bathroom are in place.

Definition: DATA: Darlene Campbell COMMENTS: Dr.Gerald Evans EVP: David Zelt REPORT: 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, Target 2015/16: 0.25 Red:>10% of Provincial Rate Yellow: Within 10% of Provincial Rate Green <= Provincial Rate

Q1 FY2016 Quality Improvement Plan Report

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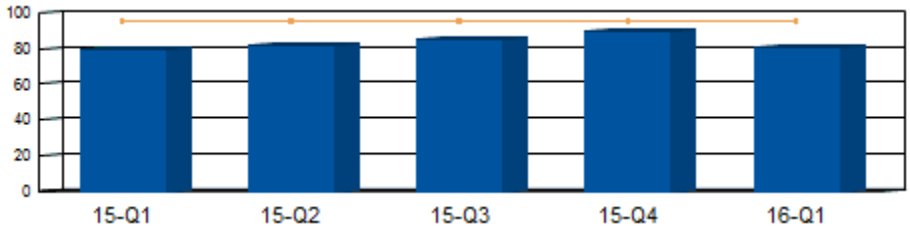
Indicator: Hand Hygiene Compliance - (QIP)



	Actual	Target
15-Q1	80	**95**
15-Q2	82	**95**
15-Q3	85	**95**
15-Q4	89	**95**
16-Q1	81	**95**

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

The tactic work plan for 2015-2016 will see further roll out to auditors, the new resource tool (laminated poster) developed to clarify what is considered Patient Environment vs. what is considered Hospital Environment to provide "Just in Time" education. Additional units and their auditors have been identified for the next phase of the roll once changes are finalized based on feedback from those involved in the initial phase. Ensuring ongoing support is available to auditors as they continue to develop their comfort level and expertise using the device and observation skills.
The Hand Hygiene LMS module updates are being finalized. Additional information incorporated speaks to the importance of Moment 1 hand hygiene to patient safety; and appropriate use of gloves i.e. task specific and must include hand hygiene prior to putting them on and taking them off. Once uploaded, the module will be assigned as a mandatory session for all KGH employees.

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

In Q1 the corporate average for before patient/patient environment contact (M1) was 81%; the after moment (M4) was 90%. This is a decrease in our compliance rate from Q4 2014 - 2015 when our rate for M1 was 89.4%. These rates are the reflection of 3,140 HCW being observed which created 4,173 observed opportunities with compliance met in 3,550 of these opportunities. The increase in the number of 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?

Although our target of 90% was not met, the Hand Hygiene Working Group is continuing to meet to identify new strategies to refine efforts within the Programs and supports from IPAC Service to reach all staff. The further roll out of the new Resource Tool and the "Just in Time" intervention training and education 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 tactics to improve the current trend for 2015 - 2016 includes making the revised LMS module mandatory for all staff annually; changes to PGY 1 Workshop will focus on hand hygiene with interactive sessions that included appropriate hand hygiene, donning and doffing of PPE including gloves; revised the Infection Prevention and Control Manual Glove policy was sent to both the Joint Health & Safety Committee and the KGH/HDH Infection Control Committee in May for endorsement; policy to go to MAC for approval in September.

Definition: DATA: Infection Control COMMENTS: Dr.Gerald Evans EVP: David Zelt REPORT: 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%, Target 15/16: 95% Red <84% Yellow 84% - 89% Green >= 90%

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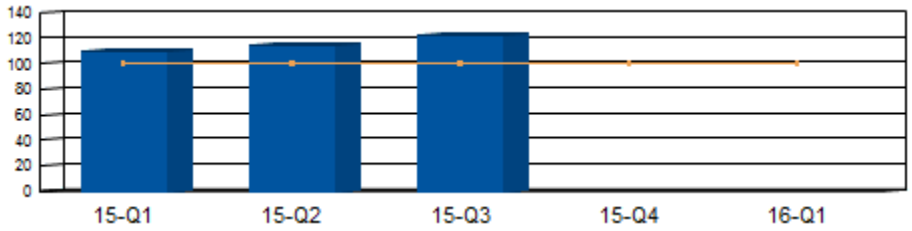
Indicator: Hospital Standardized Mortality Ratio (HSMR) (QIP)



	Actual	Target
15-Q1	109	**100**
15-Q2	115	**100**
15-Q3	122	**100**
15-Q4		**100**
16-Q1		**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 reajusted to a new baseline. HSMR data is no longer compared to 100. Instead, HSMRs are compared with the current national HSMR strengthening the comparisons that can be made between hospitals. 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 included in the data calculations. Inclusion of palliative deaths because of coding protocols at CIHI continues to be a difficulty in analysis.

In Q3 there were 167 deaths based upon 1862 cases used in the HSMR calculation. The 75th percentile HSMR for Peer Group is 101.

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 EVP: Dr. David Zelt REPORT: 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, Target 15/16: 100 Perf. Corridor: Red Statistically Significant Results Yellow N/A Green Statistically not Significant

Kingston General Hospital

Q1 FY2016 Quality Improvement Plan Report

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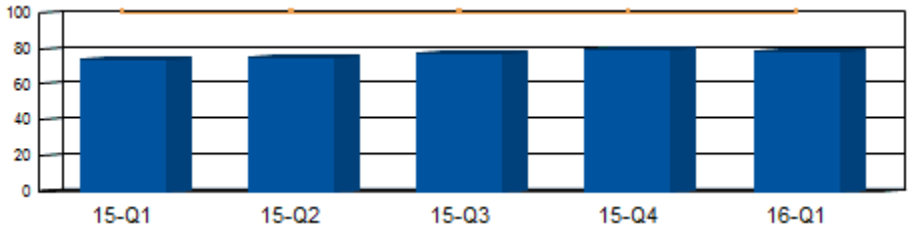
Indicator: Medication Reconciliation at Admission (QIP)



	Actual	Target
15-Q1	74	**100**
15-Q2	75	**100**
15-Q3	77	**100**
15-Q4	79	**100**
16-Q1	78	**100**

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

Three new tactics aligning with Hospital target: "Every patient receives medication reconciliation at admission" are included in the Fiscal 2015-16 Integrated Annual Corporate Plan Tactic worksheet:
1. Ensure Physician engagement in the medication reconciliation process
2. Implement a prescriber education program for medication reconciliation
3. The medication reconciliation process is embedded in all admission order sets

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 decreased from 79% in F15 Q4 to 78% in F16 Q1.

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

Physician education program and medication reconciliation policy in progress.
Admission order sets continue to be developed/updated to include the medication reconciliation process

Definition: DATA: Decision Support COMMENTS: Veronique Briggs EVP: Dr. David Zelt REPORT: 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%, Target 15/16: 100% Perf. Corridor: Red <= 80% Yellow 80%-89% Green >=90%

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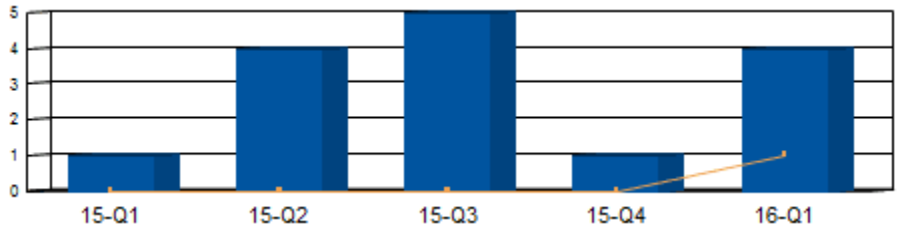
Indicator: The Number of Patient Falls in Level 3 and Level 4 categories - (QIP)



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

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

The current work involves assessment of the two main areas of focus for this fiscal year; patient risk assessment (for falls) and mobility plans being in place for all patients. This work shows approximately 80-90% levels of achievement.

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 Q1 results show four Level 3 falls were recorded, one in Critical Care, two in Mental Health and one in Medicine. As with all Level 3 and Level 4 incidents investigations are undertaken to review the circumstances related to the incidents and any lessons to be learned from those most closely involved in the event. Work will begin in Q3 focusing on increasing the percentage of risk assessments and mobility plans being completed for all patients.

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

Reducing to the average of 1 L3 or L4 fall per quarter is achievable; effort that teams are making to raise awareness of patients at risk and plans to mitigate is positive.

Definition: DATA: Decision Support COMMENTS: R. Jewitt EVP: Silvie Crawford REPORT: 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 reduce actual level 3 (moderate harm) and level 4 (severe/critical harm) patient falls from an average of 3 to 1 per quarter.

Target: Target 15/16: 1/qtr Red >3 Yellow 2-3 Green <=1

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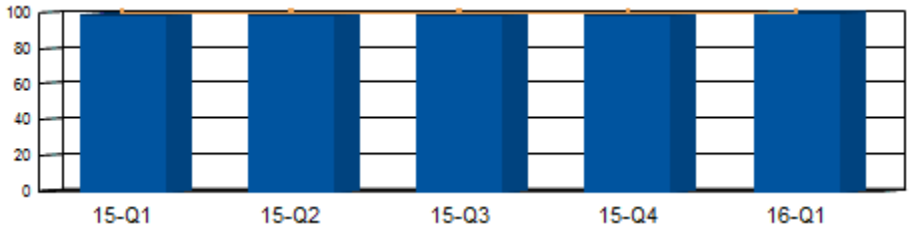
Indicator: All Three Phases of the Surgical Safety Checklist are Performed (Briefing, Time Out, and Debriefing) - (QIP)



	Actual	Target
15-Q1	99.0	**100**
15-Q2	99.0	**100**
15-Q3	99.0	**100**
15-Q4	99.0	**100**
16-Q1	99.6	**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.

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 Q1 this indicator continues to meet the green target corridor. There were 2,295 surgical cases completed in this quarter. The compliance for the Surgical Safety checklist 3 phases were the following: Briefing- 99.9%, Timeout-99.7%, and Debrief- 99.9%. The unscheduled/emergent cases continue to influence this metric. There were 2 “A” cases and 3 “B” cases that did not complete the 3 phases of the checklist this 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?

On track to meet this target.

Definition: DATA: Kathleen Wattie Barnett COMMENTS: Kellie Kitchen EVP: David Zelt REPORT: 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%, Target 15/16: 100% Red <85% Yellow 85%-94% Green: >95%

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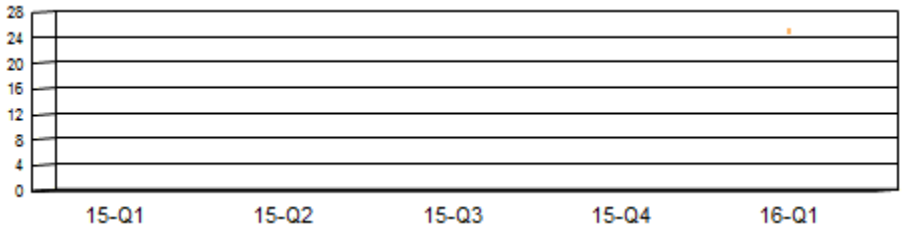
Indicator: Twenty-five percent fewer patients experience skin ulcers on the 3 units (across 3 programs - medicine/surgery/critical care (K6, C10, K2 ICU)) - (QIP)



	Actual	Target
15-Q1		
15-Q2		
15-Q3		
15-Q4		
16-Q1	25	

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

Supports have been put in place to allow documentation, safe reporting and auditing of risk assessment. Staff resource to start in July to enable pressure ulcer prevalence data and auditing data.
Changes will include documentation of actionable interventions based on the Braden risk assessment; addition of skin & wound integrity category in Safe Reporting System; and mandatory learning module for staff.

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 three units (Kidd 6 general surgery, Connell 10 medicine and Kidd 2 ICU critical care) were chosen because these units had the highest wound prevalence in the February 2014 study (Kidd 6 27%; C10 35%; K2 ICU 47%).
Prevalence data and risk assessment/skin assessment data will be available starting July. First of the monthly pressure ulcer prevalence studies has been completed and is being analyzed at this time.

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 targets by year end by having supports in place and ability to collect and monitor data.

Definition: DATA: Leanne Wakelin COMMENTS:Leanne Wakelin EVP: Silvie Crawford REPORT: STRATEGY REPORT

Twenty-five per cent fewer patients experience skin ulcers on the 3 units (across 3 programs - medicine/surgery/critical care (K6, C10, K2 ICU)) with the highest prevalence. This will result in 4 less incidents in the ICU, 2 on C10, and 2 on K6.

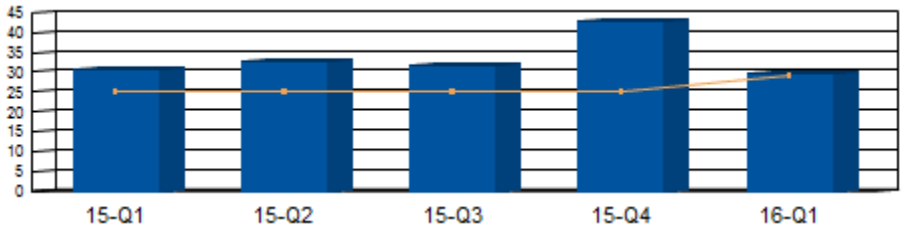
Target: Target 2015/16: 25% reduction Perf. Corridor: Red 1 or 2 units achieve Green Status, Yellow 1 or 2 units achieve Green Status, Green 3 of 3 units achieve green status

Q1 FY2016 Quality Improvement Plan 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
15-Q1	30.7	**25**
15-Q2	32.6	**25**
15-Q3	31.6	**25**
15-Q4	42.7	**25**
16-Q1	29.7	**29**

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. Having met this goal, the focus now is to sustain gains made and identify further opportunities to reduce bed empty time which will result in a reduced ED LOS for patients who are admitted. The Patient Flow Task Force, which has representation from across all programs and services as well as CCAC and Providence Care, continues to meet twice a month and has oversight of patient flow within KGH as well as transfers to other organizations and discharges home with support.

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 Q1 result of 29.7 hours is slightly above the 29 hour target. The target for this indicator was changed from 25 hours last year to 29 hours this year. Based on Q1 admission volumes of 2821, 254 patients waited more than 29.7 hours in the ED for an inpatient bed. Admission rate from the ED is just over 20% which is higher than the average Ontario teaching hospital rate of 15.8%. Patients with extended LOS in the ED are in the wrong place to receive optimum care. As well, longer boarding times mean that patients waiting for inpatient beds are occupying a significant percentage of the bed capacity in the ED limiting the number of new patients who can be seen. LOS in the ED is continuously monitored in real time with EDIS, and supports timely and factual communication with inpatient units to support planning. Performance of our peers: LHSC = 25.4, HHSC = 24, SMH = 22.5, SHSC = 24.2, TOH = 24, TBRHC = 29.4, teaching hospital group 25.5. We are meeting our target but we not performing as well as our peers which puts us at risk for Pay for Results Funding. Our funding rank for admitted patients is 56 for current performance and 63 for improvement out of 74 hospitals as of the end of June.

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. We need to continue to sustain gains made through GOOG initiatives and continue to fine tune processes resulting in reduced bed empty time.

Definition: DATA: Decision Support (NACRS) COMMENTS: Julie Caffin EVP: Silvie Crawford REPORT: 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, Target 15/16: 29 Hours Perf. Corridor: Red >33 Yellow 30 - 33 Green <30

Q1 FY2016 Quality Improvement Plan Report

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

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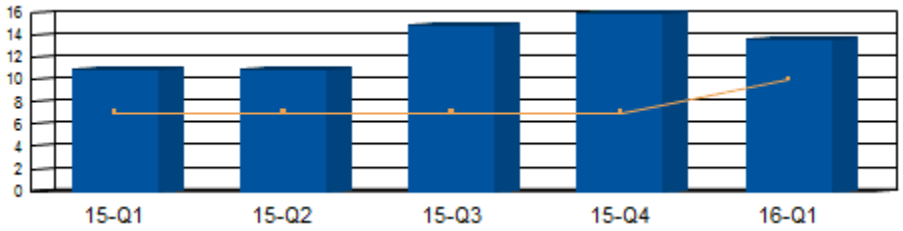
Indicator: Percent ALC Days (QIP)



	Actual	Target
15-Q1	11.0	**7**
15-Q2	11.0	**7**
15-Q3	14.8	**7**
15-Q4	16.0	**7**
16-Q1	13.7	**10**

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

KGH and regional partners have committed to focus on ALC and as a result, a number of initiatives are underway. Within KGH, steps that are being taken include:

- A registered nurse has been seconded to be the KGH point of contact for ALC patients and patient flow issues.
- A 'tiger team' meets bi- 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. Two Patient Experience Advisors have joined the ALC Tiger Team to assist with planning and implementation of various initiatives.
- 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.
- Current order set for ALC designation was revised in June 2015 to introduce a new interprofessional process for assessment and decision making regarding ALC for long term care.
- A value stream map in underway to map the current & future processes that support flow of patients designated ALC to the most appropriate destination.
- Working closely through a regional Patient Flow peer group that is made up of representatives from all hospitals, the CCAC & 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. In Q1, the Patient Flow Peer Group started site visits to each hospital in the SE to bring forward recommendations to drive change and improvement based on best practices in place across the region. Remaining visits to take place in Q2.

CCAC staff are involved in any discharge challenges related to specific patients & work closely with KGH staff members. Monthly meetings with KGH & CCAC leaders will begin in Q2.

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 Q1 result of 13.7% indicates that, on average, there were more than 50 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.

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 10% this quarter. Despite significant efforts across hospitals and the SE CCAC, ALC rates have been escalating over the past year. The continued rise in the numbers of patients designated as ALC is of great concern. The team is discussing options to optimize care of patients with chronic or complex conditions through Health Links and reduce avoidable hospital admission from long term care homes or retirement homes. KGH staff members are participating in a LHIN-based peer to peer patient flow task team to develop policies and processes that will be implemented across all SE LHIN organizations.

Definition: DATA: Decision Support COMMENTS: Cynthia Phillips EVP: Silvie Crawford REPORT: 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.

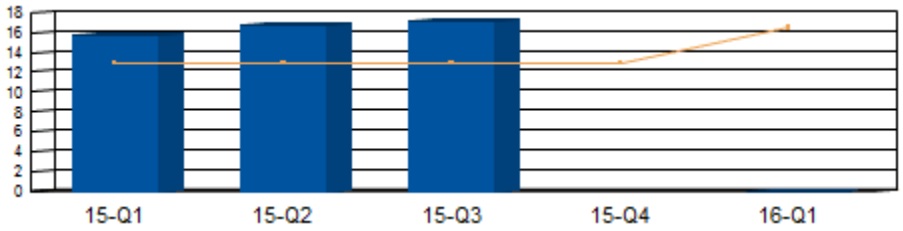
Target: 11/12 Target: 10% 12/13 Target: 10%, Target 13/14: 7% Perf. Corridor: Red >10% Yellow 8%-10% Green <=7%, Target 14/15: 7% Perf. Corridor: Red >9.5% Yellow 8%-9.5% Green <=7%, Target 15/16: 10% Perf. Corridor: Red >13% Yellow >10%-13% Green <=10%

Q1 FY2016 Quality Improvement Plan Report

Increase our focus on complex-acute and specialty care

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

Indicator: 30 Day Readmission Rate Outperforms its Expected MOH rate (QIP)



	Actual	Target
15-Q1	15.80	**12.90**
15-Q2	16.74	**12.90**
15-Q3	17.18	**12.90**
15-Q4		**12.90**
16-Q1		**16.47**

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

The Healthlinks project is ongoing with respect to data analysis and an understanding of patient flow. Efforts are aimed at reducing readmissions and ED visits thought he provision of enhances community based services. A recent Pharmacist-led project identified opportunity for improvement in the completeness of information transfer via the eDischarge summary for patients discharged from hospital on community-based intravenous antimicrobial therapy. Deficiencies in communication and care plan establishment at this transition may lead to unplanned readmissions, Emergency or Urgent Care, or outpatient clinic visits early in the post-discharge period.

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

Current performance is well above target, however it is worth noting that this performance dates back to Q3 of last fiscal year. This readmission rate calculation takes into account readmissions to any hospital, not just the KGH and therefore we cannot replicate this calculation and must wait until it is provided by MoH. Unfortunately it is not clear what our current performance is.

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

It is very unlikely that we will meet this target by year end.

Definition: DATA: Decision Support COMMENTS: Dr. David Zelt EVP: Dr. David Zelt REPORT: 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%, Target 15/16: Quarterly expected MOH rate Perf. Corridor: Red > 10% of expected Yellow plus 10% expected Green At or below expected

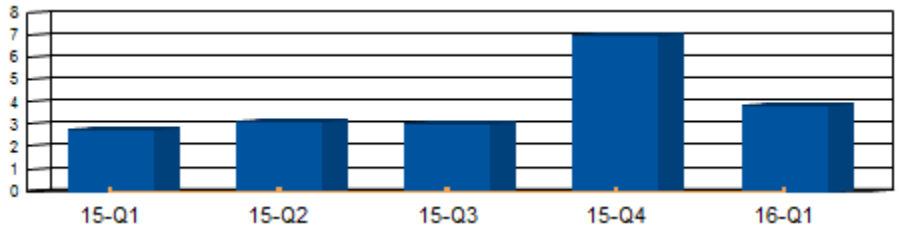
Kingston General Hospital

Q1 FY2016 Quality Improvement Plan Report

Enable High Performance

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

Indicator: Total Margin (QIP)



	Actual	Target
15-Q1	2.77	**0**
15-Q2	3.08	**0**
15-Q3	2.99	**0**
15-Q4	7.03	**0**
16-Q1	3.86	**0**

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

Although greater than 0, the total margin through the first quarter of the fiscal year is slightly lower than planned. The same actions being undertaken to address the negative position to budget will impact the total margin calculation.

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: J'Neene Coghlan COMMENTS: J'Neene Coghlan EVP: Jim Flett REPORT: 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, Target 15/16: 0% Perf. Corridor: Red <0 Yellow N/A Green >=0

Kingston General Hospital

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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