fiscal
2015-2016 **Q3**

3rd quarter ended December 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 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

Q3 FY2016 Quality Improvement Plan Report

Strategic Direction	2016 Outcome	Indicator	15-Q3	15-Q4	16-Q1	16-Q2	16-Q3	
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	Y	N/A	↑
	All preventable harm to patients is eliminated	C-Difficile (Reported Quarterly) (QIP)	R	R	R	R	G	↑
		Hand Hygiene Compliance - (QIP)	R	R	R	Y	Y	↑
		Hospital Standardized Mortality Ratio (HSMR) (QIP)	R	R	N/A	N/A	N/A	↓
		Medication Reconciliation at Admission (QIP)	R	R	R	R	Y	↑
		The Number of Patient Falls in Level 3 and Level 4 categories - (QIP)	R	R	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	Y	Y	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)	Y	R	G	G	Y	↓
		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	N/A	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 ↓

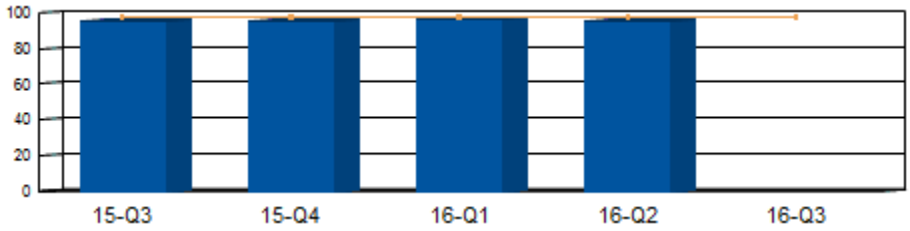
	Strategy					QIP					Supporting				
	FY15	FY16				FY15	FY16				FY15	FY16			
	Q4 %	Q1 %	Q2 %	Q3 %	Q3 #	Q4 %	Q1 %	Q2 %	Q3 %	Q3 #	Q4 %	Q1 %	Q2 %	Q3 %	Q3 #
R	37%	37%	26%	22%	6	50%	50%	33%	25%	3	34%	39%	36%	28%	22
G Y	63%	63%	74%	78%	21	50%	50%	67%	75%	9	66%	61%	64%	72%	53
N/A	0%	0%	0%	0%	0	0%	0%	0%	0%	0	0%	0%	0%	0%	0
					27					12					75

Q3 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-Q3	95	**97**
15-Q4	95	**97**
16-Q1	97	**97**
16-Q2	95	**97**
16-Q3		**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. Training was revamped in Q2 to a hybrid delivery model using e-learning and in-class skills practice. 294 trainees completed the e-learning module in Q3 and 68 of those trainees completed the in-class skills practice. To improve sustainability, HEART training has been added to the inter-professional orientation to engage staff upon entry into the workplace.

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

Most current reported performance is Q2 which sits at 95% which is 2% below the current target for fiscal 15/16.

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: 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%

Kingston General Hospital

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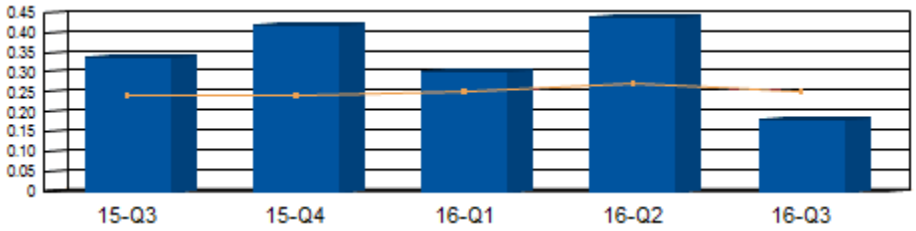
Indicator: C-Difficile (Reported Quarterly) (QIP)



	Actual	Target
15-Q3	0.34	**0.24**
15-Q4	0.42	**0.24**
16-Q1	0.30	**0.25**
16-Q2	0.44	**0.27**
16-Q3	0.18	**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 continue current strategies implemented to prevent outbreaks including diligent surveillance by IPAC Service of all query and confirmed CDI cases; daily ICP presence on the units and in ED who work 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 lead to 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 October there were 4 cases of CDI, in November there was 1 case and in December there were 2 cases for a total of 7 cases in Q3. This is 9 fewer cases than in Q2.

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 target by year end.

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

Q3 FY2016 Quality Improvement Plan Report

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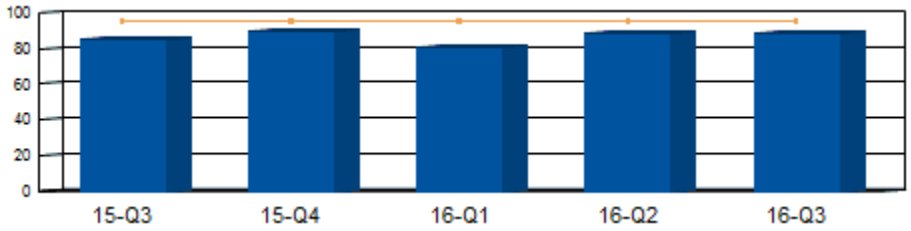
Indicator: Hand Hygiene Compliance - (QIP)



	Actual	Target
15-Q3	85	**95**
15-Q4	89	**95**
16-Q1	81	**95**
16-Q2	88	**95**
16-Q3	88	**95**

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

The tactic work plan for 2015-2016 continues, supporting new auditors, working directly with Programs, attending staff meetings to clarify Patient Environment vs. Hospital Environment. The Hand Hygiene LMS module has been finalized. 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:

Q3 average was 88%, sustaining the momentum achieved in Q2 (88%) improving from Q1 (81%). Total Opportunities observed increased in Q3 by 2,365 from 4,453 in Q2 to 6,818 in Q3.

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 target.

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%

Q3 FY2016 Quality Improvement Plan Report

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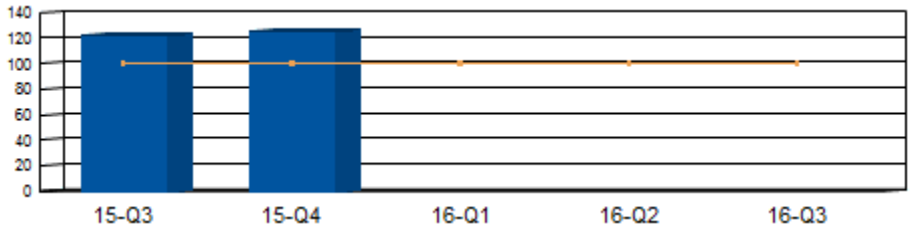
Indicator: Hospital Standardized Mortality Ratio (HSMR) (QIP)



	Actual	Target
15-Q3	122	**100**
15-Q4	126	**100**
16-Q1		**100**
16-Q2		**100**
16-Q3		**100**

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

Despite the fact that we have not yet received the most recent data form CIHI (Q1 and Q2 due in February) efforts are underway to improve the completeness and accuracy of our diagnosis and diagnosis type coding and abstraction from the medical chart. Chart audits from the Q3 and Q4 data suggest that compared to our peers we are not coding to the same level of specificity. Beginning in Q1 of this year, our medical records department has undertaken a very thorough review to ensure our procedure, diagnosis, and diagnosis type coding and abstraction is as complete and accurate as possible. Next steps are to work closely with physicians and other providers to improve the quality and accuracy of charting.

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

Q1 and Q2 results will not be made available from CIHI until February 2016 (Q3).

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 assumed with the improvements to charting accuracy and completeness the target will be met by year end.

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

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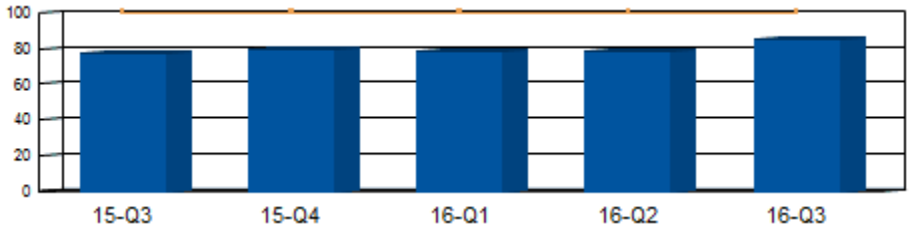
Indicator: Medication Reconciliation at Admission (QIP)



	Actual	Target
15-Q3	77	**100**
15-Q4	79	**100**
16-Q1	78	**100**
16-Q2	78	**100**
16-Q3	85	**100**

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

Fiscal 2015-16 Integrated Annual Corporate Plan Tactic to implement a prescriber education program for medication reconciliation. Education to Surgical residents (Orthopedics, General Surgery and Urology residents) on the process of medication reconciliation on admission completed. MAC approved mandatory education for physicians. LMS module for all physicians in development by Pharmacy and Leadership and Learning.

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 to 85% in F16 Q3.

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

Unlikely to achieve target of 90% by F16 Q4.
Development of a medication reconciliation policy in progress.
Admission order sets continue to be developed/updated to include the medication reconciliation process.
Pediatric Surgical Admission Order set to be submitted to the Order Set Committee in February 2016.

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%

Q3 FY2016 Quality Improvement Plan Report

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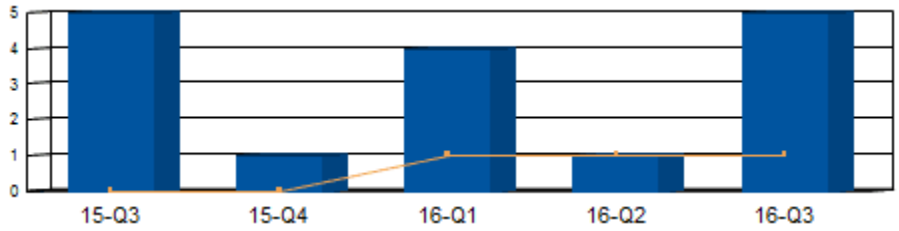
Indicator: The Number of Patient Falls in Level 3 and Level 4 categories - (QIP)



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

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

Surveillance and risk assessments processes are in place and available across the hospital as planned. Usage audits of these on sample units shows good levels of usage. The resultant assessments provide invaluable information to have available to the patients' care team in developing plans to mitigate risk and safely support early and continued mobilization of patients. In Q4 further improvement initiatives are being identified and planned.

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

We have seen 5 Level 3 falls in the quarter. Each incident was fully investigated at a program level and no particular causal factor was identified. Risk assessments were appropriately completed and mitigation strategies in place. The incidents occurred in different units, indicating no 'clustering'; in 3 of the 5 incidents the patient fell in the presence of staff or family member. This further highlights the potential for harm from any fall in circumstances where one would not particularly expect it.

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

Since tracking started, 3 of 7 quarters met the target we have set. Significant amounts of work and improvement, education and learning has taken place. We do continue to see falls occur and work continues to identify further improvements and supports to reduce frequency of all falls and thus the chance of a L3 or L4 occurring.

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 and average of 3 to 1 per quarter.

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

Q3 FY2016 Quality Improvement Plan Report

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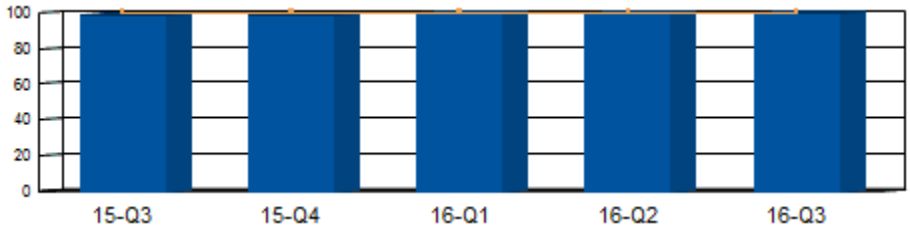
Indicator: All Three Phases of the Surgical Safety Checklist are Performed (Briefing, Time Out, and Debriefing) - (QIP)



	Actual	Target
15-Q3	99.0	**100**
15-Q4	99.0	**100**
16-Q1	99.6	**100**
16-Q2	99.8	**100**
16-Q3	99.7	**100**

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

The Surgical Perioperative Anesthesia (SPA) program leaders continue to monitor the indicator on a monthly basis.

The Maternal Child program will be reviewing the surgical safety checklist processes with clinical staff to ensure that all 3 phases are electronically documented for each caesarean section.

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 continues to meet the green target corridor. There were 2,217 patients were received surgery been October and December. The main OR's compliance for the Surgical Safety checklist 3 phases were the following: Briefing- 99.9%, Timeout-99.8%, and Debrief- 99.8%. There were three emergent surgery cases (1- Emergency A case, 2 Emergency B cases) that did not complete the surgical safety check list that influenced this target.

The Connell 5 Labour & Delivery Operating rooms completed 131 caesarean sections this quarter. Their compliance for the checklist was the following: Brief- 98.5%, Timeout-96.9% and Debrief-96.9%. There were 3 scheduled and 4 emergency cases that did not complete all three phases.

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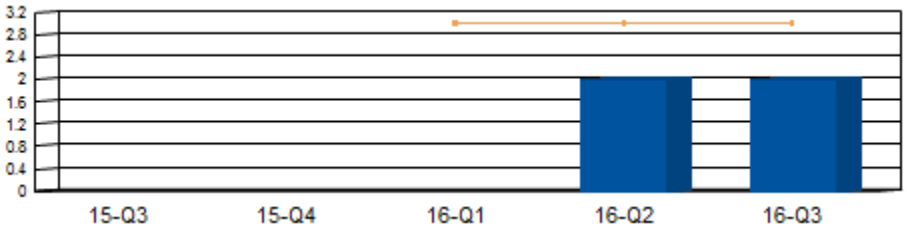
Indicator: Twenty-five percent fewer patients experience skin ulcers on the 3 units (across 3 programs - medicine/surgery/critical care (K6, C10, K2 ICU)) - (QIP)



	Actual	Target
15-Q3		
15-Q4		
16-Q1		**3**
16-Q2	2	**3**
16-Q3	2	**3**

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

This indicator remains yellow but is only 2% away on one unit to obtain green status. This quarter has been heavily invested with education for front line providers. LMS released with 50% of front line nursing staff having completed the module. Face to face education continues and education and development of skin champions has started. 50 skin champions attended an all-day education event with excellent feedback. Working group about heel ulcers (2nd most common type of pressure ulcer) met and forwarded recommendations.

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

We continue to focus on the three targeted units, K6, C10 and K2ICU.

For K6, 2/25 pts experienced pressure ulcers with a prevalence rate of 8% in October, 2/28 pts experienced pressure ulcers with a prevalence rate of 7% in November, and 2/25 pts experienced pressure ulcers with a prevalence rate of 8% in December with a quarterly average pressure ulcer prevalence of 7.7% (goal of 20.5% pressure ulcer prevalence rate). This unit has performed beyond expectations this quarter and has prevented 18 patients from developing a pressure ulcer this quarter

For Connell 10 9/29 pts had pressure ulcer with a prevalence rate of 31% in October, 6/31 patients had a pressure ulcer with a prevalence rate of 19% in November and 7/27 pts had a pressure ulcer with a prevalence rate of 26% in December . The average quarterly prevalence rate was 25% (target 27%) This unit has also met target and prevented 4 patients from developing pressure ulcers this quarter.

K2ICU had 11/26 patients with a pressure ulcer with a prevalence rate of 42% in October, 8/27 patients with a prevalence rate of 19% in November and 11/27 pts with a prevalence rate of 41% in December. The average quarterly prevalence rate is 37.5% (target 35%) This unit is just shy of target, but compared to the February 2014 data, they still prevented 2 patients from developing pressure ulcers.
The work done has collectively prevented 24 pressure ulcers for our patients on these three units this quarter compared to February 2014 data.

This indicator is very close to target, and education has been cornerstone of this quarters work. Strategies have been put in place to assist K2ICU to meet target for the next quarter; these include enlisting an ICU physician to champion the skin imitative and review of ICU documentation and assessment tools.
Moving forward, we will continue to educate with a focus on the patient care assistant (PCA). This class of unregulated care provider is performing many of the day to day personal care for patients, and has not been included in the initial education. This quarter we will also be participating in the Hill-Rom international Pressure Ulcer Prevalence Survey for the first time. This will allow KGH to benchmark with other organizations across Canada, and use of this yearly survey will provide yearly data to ensure we sustain our progress. The newly trained skin champions will be trained and utilized for this survey giving us a continued group of staff who can continue to provide this service.

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 this target. Documentation tools have been addressed for those areas that were lacking and education continues to occur, including education for patient care assistants.

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 no units achieve Green Status, Yellow 2 units achieve Green Status, Green 3 of 3 units achieve green status

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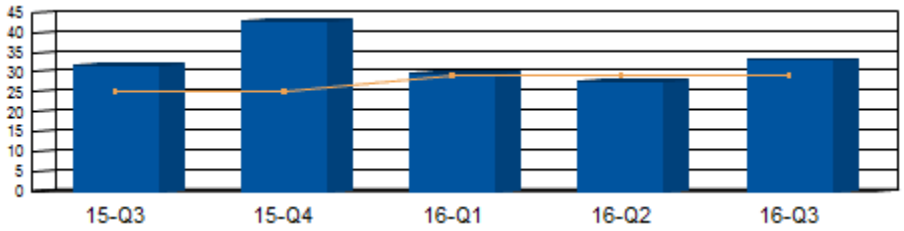
All preventable delays in the patient journey to, within, and from KGH are eliminated

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



	Actual	Target
15-Q3	31.6	**25**
15-Q4	42.7	**25**
16-Q1	29.7	**29**
16-Q2	27.6	**29**
16-Q3	33.0	**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 in Q1 & Q2 the focus has been on sustaining gains made and identifying further opportunities to reduce bed empty time which will result in a reduced ED LOS for patients who are admitted. This includes earlier discharge times, earlier indication of bed ready flag, and trial of a surge protocol. The Patient Flow Task Force, which has representation from across all programs and services as well as CCAC, HDH 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 Q3 result of 33 hours is above the 29 hour target. Based on Q3 admission volumes of 2805, 252 patients waited more than 32.9 hours in the ED for an inpatient bed. Admission rate from the ED is 20.1% in Q3 which is higher than the average Ontario teaching hospital rate of 15.6%. 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 = 19.8, HHSC = 29.2, SMH = 24.2, SHSC = 27.6, TOH = 26.2, TBRHC = 28.4, teaching hospital group 27.3. We are not performing as well as our peers which puts us at risk for Pay for Results Funding. Our funding rank for admitted patients is 55 for current performance and 63 for improvement out of 74 hospitals as of the end of November (based on the calendar 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?

Yes. We need to continue to sustain gains made through GOOG initiatives and continue to fine tune processes resulting in reduced bed empty time and expedited movement out of the ED after decision to admit.

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.

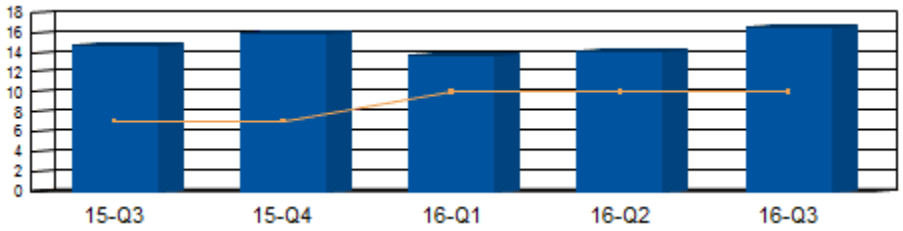
Target: Target 11/12: 31 Hours, Target 12/13: 22 Hours, Target 13/14: 25 Hours Perf. Corridor: Red >31 Yellow 28-31 Green <28, Target 14/15: 25 Hours Perf. Corridor: Red >31 Yellow 28-31 Green <28, Target 15/16: 29 Hours Perf. Corridor: Red >33 Yellow 30 - 33 Green <30

Q3 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: Percent ALC Days (QIP)



	Actual	Target
15-Q3	14.8	**7**
15-Q4	16.0	**7**
16-Q1	13.7	**10**
16-Q2	14.2	**10**
16-Q3	16.5	**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 Alternate Level of Care (ALC) and there are a number of initiatives underway.

In October 2015, an 18 month patient flow action plan was approved by the SE LHIN Executive Forum. Three areas of focus are the inflow & Emergency Department diversion; intrahospital patient flow; and outflow including patient discharge planning. There are 12 to 20 projects/activities associated with each area of focus. The work is aligned to the LHIN wide action plan to drive change in patient flow across the region.

We are re-educating staff about the Home First philosophy to promote the expectation that patients will be discharged back home to make decisions regarding long term care rather than waiting in the hospital.
November Learning Rounds featured a presentation on Health Links and how we play a role in this regional initiative and December Learning Rounds focused again on Home First.

An ALC escalation guideline is near completion. This procedure will require senior leadership approval prior to designating a patient ALC for long term care to ensure all other discharge destinations are not viable options.

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 our patients are occupying an acute care hospital bed once the acute phase of his/her treatment is finished. The total number of ALC days is influenced by both the number of ALC patients and their ALC-specific lengths of stay.

The Q3 result of 16.5% indicates that, on average, there were 70 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. Q4 actions to address will include enhances LHIN engagement to create processes to better understand system challenges.

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.

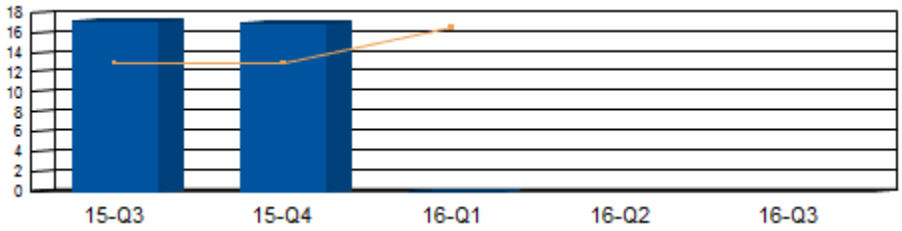
Target: 11/12 Target: 10% 12/13 Target: 10%, Target 13/14: 7% Perf. Corridor: Red >10% Yellow 8%-10% Green <=7%, Target 14/15: 7% Perf. Corridor: Red >9.5% Yellow 8%-9.5% Green <=7%, Target 15/16: 10% Perf. Corridor: Red >13% Yellow >10%-13% Green <=10%

Q3 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-Q3	17.18	**13**
15-Q4	16.89	**13**
16-Q1	0.00	**16**
16-Q2		
16-Q3		

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 through the provision of enhances community based services. Pharmacist-led project medication reconciliation at discharge is an 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 above target; however it is worth noting that this performance dates back to Q4 of last fiscal year. The current target for F 15/16 is higher than previous fiscal and is based on an expected rate. The Q4 KGH rate of 16.89 is below the expected rate of 17.14 which would make our performance green. 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.

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 most recent data for Q4 F 14/15 indicates that we did not make the target of 12.9. However, if the expected rate for Q4 F14/15 were to be compared we would be below target or green.

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.

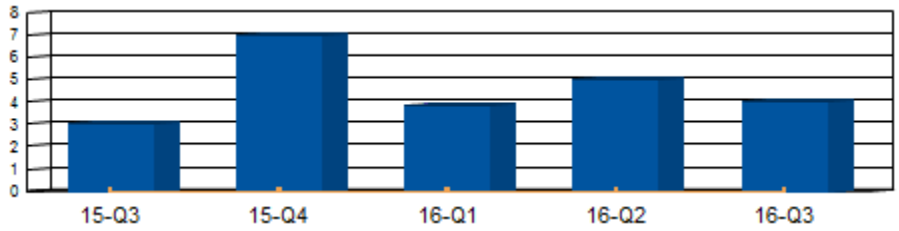
Target: Target 11/12: 12.9%, Target 12/13: 12.9%, Target 13/14: 12.9% Perf. Corridor: Red >18% Yellow 14.3%-18% Green <=14.2%, Target 14/15: 12.9% Perf. Corridor: Red >18% Yellow 14.3%-18% Green <=14.2%, Target 15/16: Quarterly expected MOH rate Perf. Corridor: Red > 10% of expected Yellow plus 10% expected Green At or below expected

Q3 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-Q3	2.99	**0**
15-Q4	7.03	**0**
16-Q1	3.86	**0**
16-Q2	5.04	**0**
16-Q3	4.02	**0**

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

The hospital continued to provide financial analysis monthly to those with budget responsibility throughout the last quarter. Discussions were also undertaken at the end of the second quarter relative to projecting the year-end financial position. These process informed decision making.

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 hospital is operating in excess of a balanced budget position through three quarters of the fiscal year, thus the favourable total margin result.

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 positive variance year-to-date will offset the HBAM funding reduction for the last quarter of fiscal 2016. Senior leadership is projecting a balanced operating position. Monthly financial reporting and analysis support will continue to be provided monthly to allow those with budget responsibility to make informed decisions relative to actions necessary to ensure that the operational activity throughout the next three months occurs within the budget fiscal constraint. High-level summary results by category will continue to be provided to the KGH senior leadership team to inform discussion and decisions made by the hospital Planning and Performance Committee.

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

Q3 FY2016 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