fiscal
2015-2016 **Q4**
4th quarter ended March 31, 2016

KGH this quarter

Quality Improvement Plan (QIP)

Performance Report

Kingston General Hospital
Outstanding care, always

KGH Quality Improvement Plan (QIP) Performance Report Fiscal 2016

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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

C-Difficile (QIP)	3
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All three phases of the surgical safety checklist are performed (Briefing, time out, and Debriefing)(QIP)	8
Twenty-Five percent fewer patients experience skin ulcers on the 3 units (across 3 programs - medicine/surgery/critical care (K6, C10, K2, ICU)) - (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

30 Day Readmission Rate Outperforms its Expected MOH rate (QIP) 12

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

Total Margin (QIP) 13

Status Legend 14

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Strategic Direction	2016 Outcome	Indicator	15-Q4	16-Q1	16-Q2	16-Q3	16-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	Y	Y	Y	↓
	All preventable harm to patients is eliminated	C-Difficile (Reported Quarterly) (QIP)	R	R	R	G	R	↑
		Hand Hygiene Compliance - (QIP)	R	R	Y	Y	Y	↓
		Hospital Standardized Mortality Ratio (HSMR) (QIP)	R	N/A	N/A	N/A	N/A	↓
		Medication Reconciliation at Admission (QIP)	R	R	R	Y	Y	↑
		The Number of Patient Falls in Level 3 and Level 4 categories - (QIP)	R	R	G	R	G	↑
		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	Y	Y	Y	R	↓
	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	G	G	Y	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	30 Day Readmission Rate Outperforms its Expected MOH rate (QIP)	Y	G	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 ↓

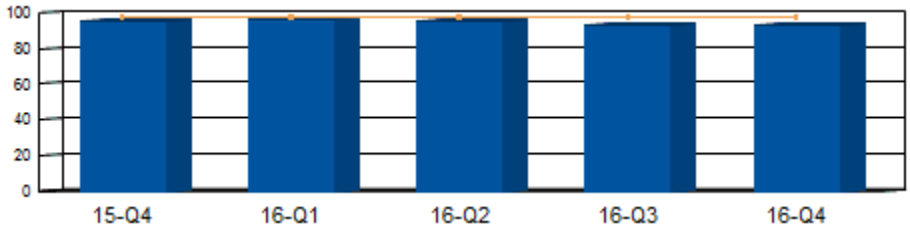
	Strategy					QIP					Supporting				
	F16					F16					F16				
	Q1 %	Q2 %	Q3 %	Q4 %	Q4 #	Q1 %	Q2 %	Q3 %	Q4 %	Q4 #	Q1 %	Q2 %	Q3 %	Q4 %	Q4 #
R	37%	26%	22%	33%	9	50%	33%	25%	42%	5	39%	36%	28%	37%	28
G Y	63%	74%	78%	67%	18	50%	67%	75%	58%	7	61%	64%	72%	63%	47
N/A	0%	0%	0%	0%	0	0%	0%	0%	0%	0	0%	0%	0%	0%	0
					27					12					75

Q4 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 intiatives

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



	Actual	Target
15-Q4	95	**97**
16-Q1	97	**97**
16-Q2	95	**97**
16-Q3	93	**97**
16-Q4	93	**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%

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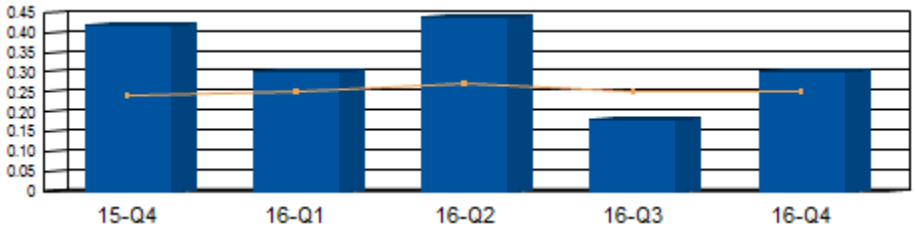
Indicator: C-Difficile (Reported Quarterly) (QIP)



	Actual	Target
15-Q4	0.42	**0.24**
16-Q1	0.30	**0.25**
16-Q2	0.44	**0.27**
16-Q3	0.18	**0.25**
16-Q4	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 was to continue to build on 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 Inpatient Program 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:

There were 12 cases this quarter; January there were 6 cases; February there were 3 cases; and again in March there were 3 cases. Overall for 2015 - 2016, we had 46 cases of CDI. In comparison in 2014 - 2015 we had 50 cases; in 2013 - 2014 we had 77 cases and in 2012 - 2013 we had 88 cases.

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, overall we had 4 fewer patients develop CDI this year compared to last year. The downward trend has been sustained for > 4 years. Plans for 2016 - 2017 include continued collaboration between In-patient Programs and IPAC Service to ensure the prompt identification and initiation of Contact Precautions on the units; reporting of suspect cases to IPAC. IPAC continues to promote the CDI Order Set and appropriate discontinuation of precautions. IPAC will continue to notify ES of inpatient rooms and bathrooms requiring twice daily cleaning. A sporicidal cleaner will continue to be used by ES for discharge cleaning on identified units.

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

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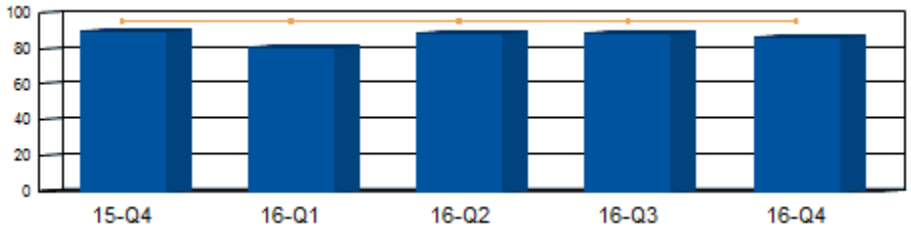
Indicator: Hand Hygiene Compliance - (QIP)



	Actual	Target
15-Q4	89.4	**95**
16-Q1	81.0	**95**
16-Q2	88.0	**95**
16-Q3	88.0	**95**
16-Q4	86.0	**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 auditors, working directly with Programs, attending staff meetings to clarify Patient Environment vs. Hospital Environment. The supporting Resource Tool were developed and posted on each in-patient unit, Renal Unit and Cancer Clinic. Hand Hygiene LMS module was developed and roll-out across the organization has begun this quarter. It will be mandatory of 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:

Q4 the average was 86% for Moment 1 a decrease from Q3 and Q2 when the average was 88%. Total opportunities observed in Q4 also decreased from Q3 6,818 opportunities to 6,126.

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 was not met. Further roll out of the new LMS module and "Just in Time" intervention education by the auditors will need to continue in 2016 - 2017. The Hand Hygiene Working Group (HHWG) will continue to research and identify new initiatives to improve compliance rates and optimize patient's safety by reducing opportunities for transmission of organisms via the healthcare workers hands.

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%

Q4 FY2016 Quality Improvement Plan Report

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

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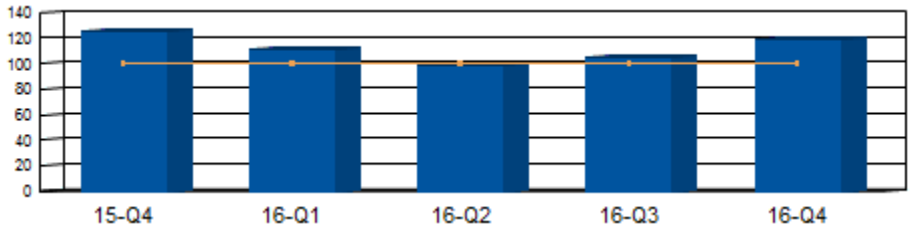
Indicator: Hospital Standardized Mortality Ratio (HSMR) (QIP)



	Actual	Target
15-Q4	126	**100**
16-Q1	112	**100**
16-Q2	99	**100**
16-Q3	105	**100**
16-Q4	119	**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 changed is methodology in assessing the HSMR and no longer calculates confidence limits and hence the significance of the quarterly HSMR cannot be determined. Hence the current methodology to track the HSMR can no longer be translated into our metric evaluation criteria. Nevertheless, the quarterly tracking suggests concern. Mortality reviews have thus far shown no concern. Working with Patient Records and Decision Support, a deeper dive on the quality of documentation is underway with the concern that co-morbidities that increase risk of mortality are not documented adequately to inform data extraction.

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

Given the change in methodology at CIHI, the current metric cannot be properly graded. Data is being further analyzed to review documentation od comorbidities.

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

Q4 FY2016 Quality Improvement Plan Report

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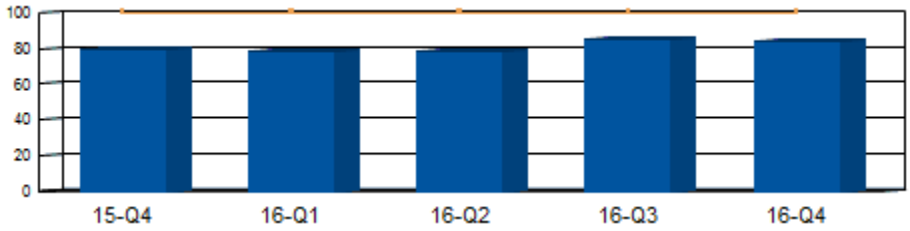
Indicator: Medication Reconciliation at Admission (QIP)



	Actual	Target
15-Q4	79	**100**
16-Q1	78	**100**
16-Q2	78	**100**
16-Q3	85	**100**
16-Q4	84	**100**

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

Fiscal 2015-16 Integrated Annual Corporate Plan Tactics are achieved:
1. Ensure physician engagement in the medication reconciliation process
   MAC approved mandatory annual education for physicians

2. Implement a prescriber education program for medication reconciliation
   LMS module for physicians completed by Pharmacy and Leadership and Learning.

3. The medication reconciliation process is embedded as part of all admission order sets.
   Revised template approved by the Order Set Committee.
Medication Reconciliation at Care Transitions (Acute Care) policy drafted.

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 increase in the percentage of patients who receive medication reconciliation at the time of admission to the Hospital that was achieved in F16 Q3 continues in F16 Q4 at 84%.

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 of 90% compliance by F16 Q4 not achieved.
Enforcement of requirement for medication reconciliation on admission for all patients by policy will support the Hospital achieve target in F17.
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 April 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%

Q4 FY2016 Quality Improvement Plan Report

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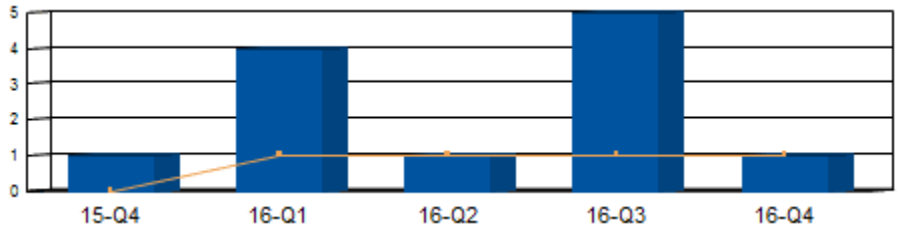
Indicator: The Number of Patient Falls in Level 3 and Level 4 categories - (QIP)



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

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

This quarter an assessment of the program was completed by looking at the completion of risk assessment which remains at about 90% across the organization. The falling star program is in place and there is good reporting of falls in our reporting system. The safe reports have been analyzed with a consistent theme of falls occurring in bathrooms or surrounding toileting. The falls working group is engaged at the present time with 2 patient experience advisors to assist us to understand falls from the patient's perspective. We are also looking at patient falls and any correlation with injuries to staff as a result of falls.

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

This quarter we had one fall that resulted in a level 3 report in the inpatient population that did result in significant injury. A complete review was completed regarding this event and strategies put in place to mitigate future falls.

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

Looking at workflow on the nursing units with special emphasis on patient needs regarding toileting will be of primary concern for the upcoming year. Occupation Health has done significant work looking at equipment and training of staff that will impact this indicator. There will be continued auditing of application of our falling star program and its affect at preventing injury from falls with an emphasis on reducing preventable harm due to fall. We are actively reaching out to other organizations to learn strategies that could improve our program.

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

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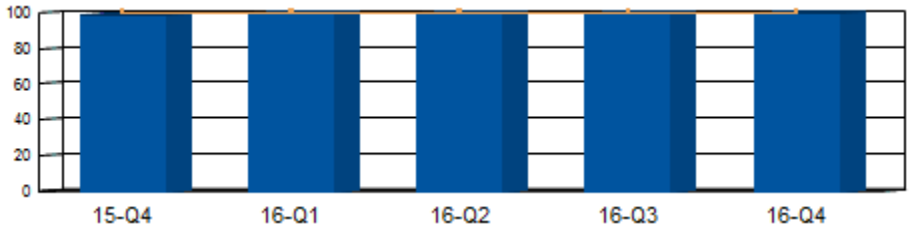
Indicator: All Three Phases of the Surgical Safety Checklist are Performed (Briefing, Time Out, and Debriefing) - (QIP)



	Actual	Target
15-Q4	99.0	**100**
16-Q1	99.6	**100**
16-Q2	99.8	**100**
16-Q3	99.7	**100**
16-Q4	99.8	**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 the 4th quarter this indicator continues to meet the green target corridor. There were 2,183 surgical cases completed in this quarter in the main operating rooms. The compliance for the Surgical Safety checklist 3 phases were the following: Briefing- 99.9%, Timeout-99.8%, and Debrief- 99.9%.

The Connell 5 Labour & Delivery operating rooms completed 138 caesarean sections this quarter. The compliance for this area for the 3 phases of the checklist was the following: Brief:=98.6%, Timeout=97.8% and Debrief=96.4%. Education review for staff on the importance of completion is being implemented.

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

Overall target is met.

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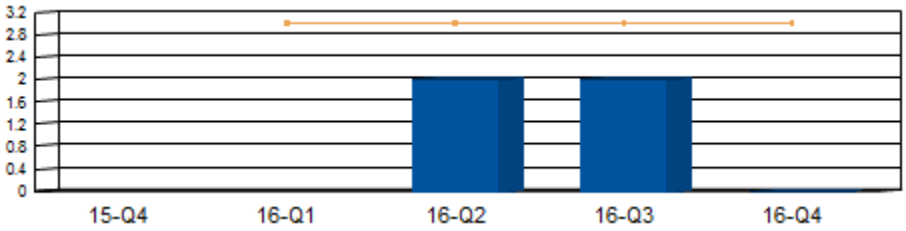
Indicator: Twenty-five percent fewer patients experience skin ulcers on the 3 units (across 3 programs - medicine/surgery/critical care (K6, C10, K2 ICU)) - (QIP)



	Actual	Target
15-Q4		
16-Q1		**3**
16-Q2	2	**3**
16-Q3	2	**3**
16-Q4	0	**3**

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

This quarter, a second Learning module for all registered nursing staff (completion rate of 43% at end of quarter) as well as a learning module for patient care assistants (completion rate of 42% at end of quarter) was launched. Weekly in-services on the targeted units continued throughout the quarter. The skin champions were brought back together with education on how to do pressure ulcer prevalence study and staging of pressure ulcer education completed. The heel ulcer prevention working group conducted a trial of heel offloading boots which is 50% completed on the orthopedic unit. A patient and family pressure ulcer prevention education pamphlet was created to assist patients and family with understanding of how they can participate in their care and prevent pressure ulcers was created and should be ready to launch in May. As well, KGH participated in our first ever international pressure ulcer prevalence study. This study is conducted by each facility doing pressure ulcer prevalence on the same day of the year. It is international, but 70% of the participants were from Ontario with last years study. This will not only give us information about our own organization, but will allow us to understand what the pressure ulcer prevalence is in other organizations. We should be receiving final results in May.

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

This quarter we did not meet target in any of the targeted areas making our performance Red for this quarter. Our target was to have a 25% reduction in the prevalence of pressure ulcers as compared to the Feb 2014 data. Two areas achieved targets less than the prevalence we had been measuring against but we did not succeed in reducing the incidence by 25% on any of the units. K2ICU had a prevalence of 47% in Feb/14 and Q4/16 prevalence was 40%. K6 prevalence Feb14 was 27% with Q4/16 prevalence of 24% and C10 prevalence Feb 14 was 35% with Q4/16 of 36%. The increase in prevalence was increased the last two months of the quarter in all three areas. This continued variability in the prevalence rates provides us with evidence of the continued need to reinforce consistent sustainable practices.

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 our target this year. We have ongoing strategies that will assist us as we move into the new fiscal year. K2ICU is implementing a "turn team" strategy that will ensure all patient are turned on a regular q2H basis. The ER is doing training with the ER nurses in April to ensure that all admitted patients receive a skin and pressure ulcer risk assessment with in the first 24 hours. A third education module for pressure ulcer prevalence will be launched for the registered nursing staff in May. The skin champions are feeling more comfortable with their knowledge and the ability to support the nurses on their units. They are able to articulate what they are doing on the units to support pressure ulcer prevention and are networking with one another about strategies and projects that will assist. The next pressure ulcer prevalence study will be completed in September of 2016. For the next year we will be continuing to roll out the program across the entire organization, continue to build the skin champions to increase capacity for pressure ulcer prevention at the unit level, and through audit and feedback, we will focus on ensuring every inpatient receives a skin assessment, pressure ulcer risk assessment and plan of care based on the risk assessment within 24 hours of admission.

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.

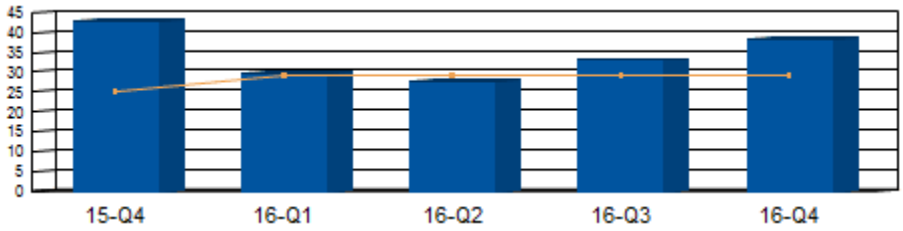
Target: Target 2015/16: 25% reduction Perf. Corridor: Red 1 or no units achieve Green Status, Yellow 2 units achieve Green Status, Green 3 of 3 units achieve green status

Q4 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-Q4	42.7	**25**
16-Q1	29.7	**29**
16-Q2	27.6	**29**
16-Q3	33.0	**29**
16-Q4	38.5	**29**

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

GOOG (Get out of Gridlock) huddles continue twice daily to discuss patient flow. Focus this quarter has been on the creation of a new bed map that would consolidate patient cohorts resulting in increased efficiency for care teams. Efficiencies include timelier rounding with optimal participation of all care providers, earlier decisions and arrangements for discharges resulting in more timely bed availability.

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 38.5 hours is well over the 29 hour target. Based on Q4 admission volumes of 2676, 241 patients waited more than 38.5 hours in the ED for an inpatient bed. Admission rate from the ED in Q4 was 20% 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 in Q4: LHSC = 37.1, HHSC = 30.9, SMH = 23.6, SHSC = 31.6, TOH = 30.5, TBRHC = 38.6, teaching hospital group 35.6. While ED wait time in this group appears to be up in all of our peer centres, 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 62 for improvement out of 74 hospitals as of the end of December (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?

The year end result is 33.6 hours, 4.6 hours above target

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.

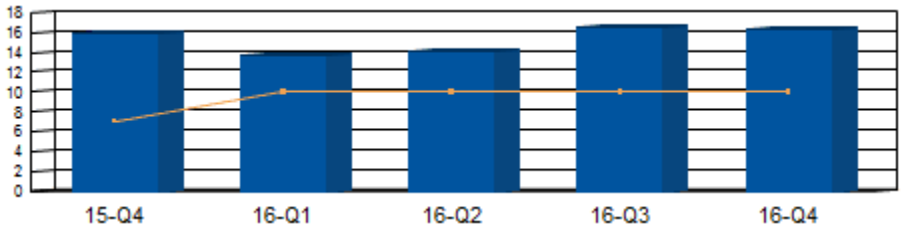
Target: Target 11/12: 31 Hours, Target 12/13: 22 Hours, Target 13/14: 25 Hours Perf. Corridor: Red >31 Yellow 28-31 Green <28, Target 14/15: 25 Hours Perf. Corridor: Red >31 Yellow 28-31 Green <28, Target 15/16: 29 Hours Perf. Corridor: Red >33 Yellow 30 - 33 Green <30

Q4 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-Q4	16.0	**7**
16-Q1	13.7	**10**
16-Q2	14.2	**10**
16-Q3	16.5	**10**
16-Q4	16.3	**10**

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

In Q4, there was progress on a number of initiatives in the patient flow action plan. 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 completing the ALC escalation guideline and this will be implemented in Q1. 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.

The SE LHIN granted a priority 1A to KGH for 14 days in February where patients designated ALC for long term care (LTC) received priority placement over community patients in order to improve flow; 8 patients were moved to long term care and 6 new patients were designated ALC-LTC during the 1A time frame. Without this priority, our patient numbers would have increased to a greater degree.

A review of long stay ALC patients was performed to determine challenges to discharge. Results were mobility issues, cognitive impairment, family unable to manage care needs, patients lives alone, two person transfer or mechanical lift requirement, and financial concerns where patients cannot afford retirement home or additional care expenses. Work will continue to determine how to overcome these barriers to timely discharge from 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:

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 Q4 result of 16.3% indicates that, on average, there were 71 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. Fiscal 16/17 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.

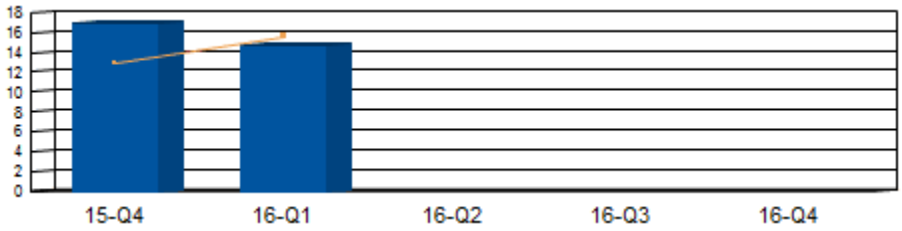
Target: 11/12 Target: 10% 12/13 Target: 10%, Target 13/14: 7% Perf. Corridor: Red >10% Yellow 8%-10% Green <=7%, Target 14/15: 7% Perf. Corridor: Red >9.5% Yellow 8%-9.5% Green <=7%, Target 15/16: 10% Perf. Corridor: Red >13% Yellow >10%-13% Green <=10%

Q4 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-Q4	16.89	**13**
16-Q1	14.74	**16**
16-Q2		
16-Q3		
16-Q4		

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.

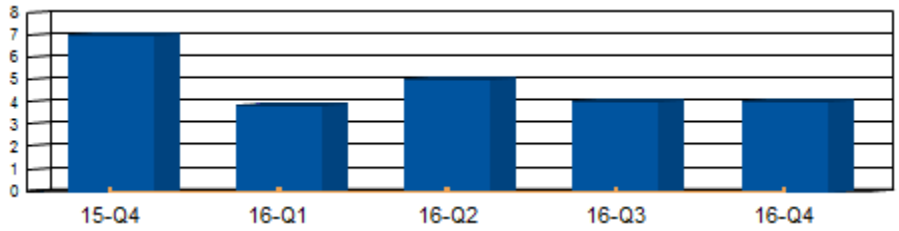
Target: Target 11/12: 12.9%, Target 12/13: 12.9%, Target 13/14: 12.9% Perf. Corridor: Red >18% Yellow 14.3%-18% Green <=14.2%, Target 14/15: 12.9% Perf. Corridor: Red >18% Yellow 14.3%-18% Green <=14.2%, Target 15/16: Quarterly expected MOH rate Perf. Corridor: Red > 10% of expected Yellow plus 10% expected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

Q4 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-Q4	7.03	**0**
16-Q1	3.86	**0**
16-Q2	5.04	**0**
16-Q3	4.02	**0**
16-Q4	4.06	**0**

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

The hospital undertook a review of financial results at the end of Q3 with a view to projecting the year-end fiscal position. The year-end results were slightly more favourable than projected.

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 ended the year with a surplus of revenue over expenses, before building amortization, or approximately $18 million. $5 million of this favourable fiscal result was due to the recognition of higher than planned funding for specific patient care activity volumes. The remaining $13 million resulted from amounts provisioned from the operating budget to provide for capital expenditure.

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

Q4 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