fiscal 2016-2017 **Q1**

1st quarter ended June 30, 2016

KGH this quarter

QIP Performance Report

Kingston General Hospital

Outstanding care, always

KGH Quality Improvement Plan (QIP) Performance Report Fiscal 2016

Kingston General Hospital

Q1 FY2017 Quality Improvement Plan Report

Strategic Direction	2017 Outcome	Indicator	16-Q1	16-Q2	16-Q3	16-Q4	17-Q1	
Transform the patient experience through a relentless focus on quality, safety and service	KGH is a top performer on the essentials of quality, safety, & service	Twenty-five percent fewer patients experience skin ulcers on the 3 units (across 3 programs - medicine/surgery/critical care (K6, C10, K2 ICU)) - (QIP)	Y	Y	Y	R	Y	↓
		"Would you recommend this ED to your friends and family?" (QIP)	Y	R	R	R	N/A	↓
		"Would you recommend this hospital (inpatient care) to your friends and family?" (QIP)	R	Y	R	R	N/A	↓
		90th Percentile ED Wait Time - All Admitted Patients (hrs.) - (QIP)	G	G	Y	R	Y	↓
		Hand Hygiene Compliance - (QIP)	R	Y	Y	Y	G	↓
		Medication Reconciliation at Admission (QIP)	R	R	Y	Y	Y	↑
		Reduction in level 1 to 4 falls with a focus on level 3 and 4 falls (QIP)	Y	R	R	Y	R	↓
		Percent ALC Days (QIP)	R	R	R	R	R	↓
Create seamless transitions in care for patients across our regional health-care system	Patient navigation pathways and partnerships are established for complex-acute and chronic patient populations	Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with COPD (QBP cohort) (QIP)	G	R	G	N/A	N/A	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

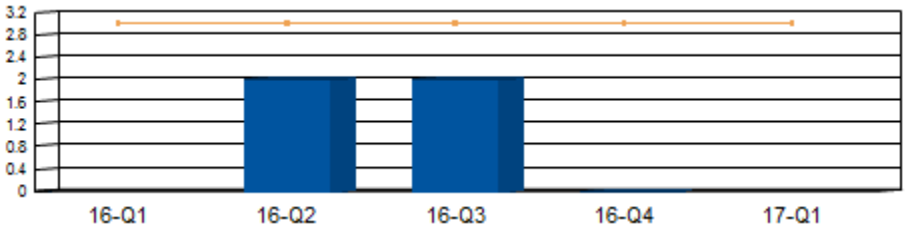
	Strategy					QIP					Supporting				
	F16			F17		F16			F17		F16			F17	
	Q2 %	Q3 %	Q4 %	Q1 %	Q1 #	Q2 %	Q3 %	Q4 %	Q1 %	Q1 #	Q2 %	Q3 %	Q4 %	Q1 %	Q1 #
R	26%	22%	33%	0%	0	33%	25%	42%	33%	4	36%	28%	37%	32%	37
G Y	74%	78%	67%	100%	10	67%	75%	58%	67%	5	64%	72%	63%	68%	76
N/A	0%	0%	0%	0%	0	0%	0%	0%	0%	0	0%	0%	0%	0%	0
					10					9					113

Q1 FY2017 Quality Improvement Plan Report

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

KGH is a top performer on the essentials of quality, safety, & service

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
16-Q1		**3**
16-Q2	2	**3**
16-Q3	2	**3**
16-Q4	0	**3**
17-Q1		**3**

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

We continue to monitor the strategies put in place last year. Risk assessment completion daily has reached a sustained 90% or greater completion rate across the organization. Q1 saw us developing documentation to support the completion of risk assessment and skin assessment within 24hrs of admission. When the three units were assessed, there was an 87% completion rate of risk assessment within 24 hours by these three units. Safe reporting of skin events has improved but is still not a reliable indicator of skin events. We are awaiting Hil ROm to come and present information regarding international prevalence study that we participated in last February.

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

No prevalence studies done this quarter--next planned for September (end fo 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?

We need to have continued monitoring of this quality indicator. In September we are bringing back together the skin champions for further education and networking; specifically we are ensuring the skin champions are educated on the new wound products that are in place after product changes as a result of contract changes as well as ensuring that they are able to perform a hospital wide prevalence study that is scheduled for September 20th.

Definition: DATA: Leanne Wakelin COMMENTS: Leanne Wakelin EVP: Silvie Crawford REPORT: QUALITY IMPROVEMENT PLAN (QIP)

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, Target 2016/17: 3 of 3 units achieve 25% reduction Perf. Corridor: Red No units achieve green status, Yellow 1 or 2 units achieve Green Status, Green 3 of 3 units achieve green status

Q1 FY2017 Quality Improvement Plan Report

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

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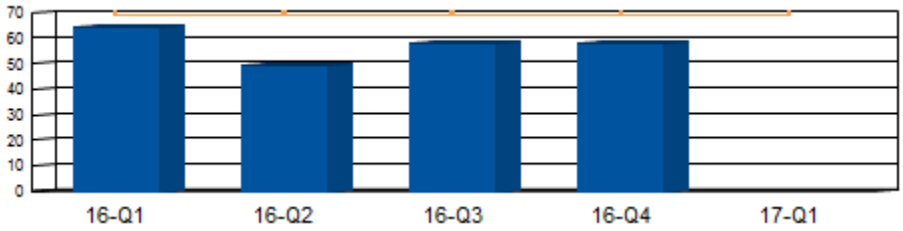
Indicator: "Would you recommend this ED to your friends and family?" (QIP)



	Actual	Target
16-Q1	64.6	**69.3**
16-Q2	49.4	**69.3**
16-Q3	58.2	**69.3**
16-Q4	58.0	**69.3**
17-Q1		**69.3**

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

As of April 2016, KGH is now using a pan-Canadian patient experience survey developed with Canadian Institute for Healthcare Improvement and endorsed by Accreditation Canada, Ontario Hospital Association (OHA) and Canadian Patient Safety Institute. National Research Corporation Canada (formerly known as Picker) continues to administer the survey on behalf of the OHA.

The "would you recommend" is a question on the new survey. The previous indicator centred around "overall care received". Tactics are being developed within the ED Program to include real time feedback.

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

Quarterly data is always a quarter behind to allow for the survey return and analysis. As of August 25th, preliminary data for April & May 2016 show that the KGH ED score is 57.4% with a response rate of 31%.

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

This new survey is one source of information regarding patient experience at KGH. The ED is currently looking at tactics that would be of most value in relation to patients and families responding to questions about recommending our ED to others. Discussions include using current real time feedback such as that from the Patient Led Feedback Forums and opportunities to bring more patient related feedback data from Patient Relations to the ED Program.

Definition: DATA: Astrid Strong & Katie Ireland COMMENTS: Julie Caffin EVP: Silvie Crawford REPORT: QUALITY IMPROVEMENT PLAN (QIP)

"Would you recommend this ED to your friends and family?" add the number of respondents who responded "Yes, definitely" (for NRC Canada) or "Definitely yes" (for HCAHPS) and divide by number of respondents who registered any response to this question (do not include non-respondents).

Target: Target 16/17: 69.3% Perf. Corridor: > 10% quarterly teach. Target, Yellow Within 10% of quart. Teach. Target, Green At or above the teach avg. /quarter

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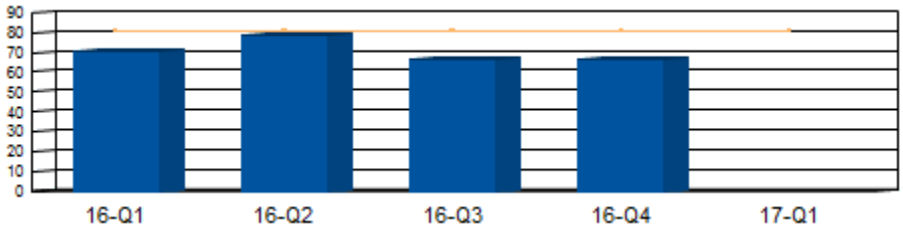
Indicator: "Would you recommend this hospital (inpatient care) to your friends and family?" (QIP)



	Actual	Target
16-Q1	70.8	**80.7**
16-Q2	78.4	**80.7**
16-Q3	66.3	**80.7**
16-Q4	66.9	**80.7**
17-Q1		**80.7**

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

As of April 2016, KGH is now using a pan-Canadian patient experience survey developed with Canadian Institute for Healthcare Improvement and endorsed by Accreditation Canada, Ontario Hospital Association (OHA) and Canadian Patient Safety Institute. National Research Corporation Canada (formerly known as Picker) continues to administer the survey on behalf of the OHA.

The "would you recommend" is a question on the new survey. The previous indicator centred around "overall care received". Tactics are being developed within the Patient Care Programs to include real time feedback.

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

Quarterly data is always a quarter behind to allow for the survey return and analysis. As of August 25th, preliminary data for April & May 2016 show that the KGH inpatient care score is 71.5% with a response rate of 38%. A focused group is being struck to better understand what is influencing this performance and create strategies to further address.

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

This new survey is one source of information regarding patient experience at KGH. The Patient Care Programs are currently looking at tactics that would be of most value in relation to patients and families responding to questions about recommending our hospital to others. Discussions include using current real time feedback such as that from the Patient Led Feedback Forums and opportunities to bring more patient related feedback data from Patient Relations to the Patient Care Programs.

Definition: DATA: Astrid Strong & Katie Ireland COMMENTS: Silvie Crawford EVP: Silvie Crawford REPORT: QUALITY IMPROVEMENT PLAN (QIP)

"Would you recommend this hospital (inpatient care) to your friends and family?" add the number of respondents who responded "Yes, definitely" (for NRC Canada) or "Definitely yes" (for HCAHPS) and divide by number of respondents who registered any response to this question (do not include non-respondents).

Target: Target 16/17: 80.7% Perf. Corridor: > 10% quarterly teach. Target, Yellow Within 10% of quart. Teach. Target, Green At or above the teach avg. /quarter

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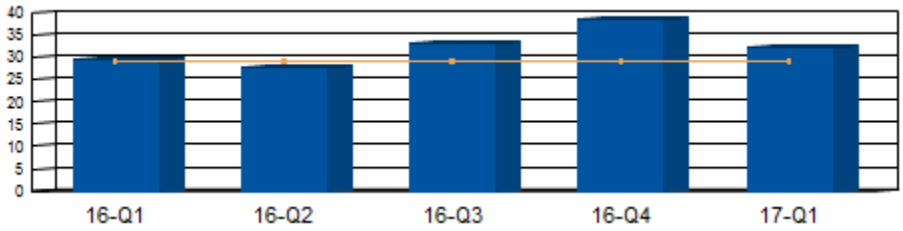
Indicator: 90th Percentile ED Wait Time - All Admitted Patients (hrs.) - (QIP)



	Actual	Target
16-Q1	29.7	**29**
16-Q2	27.6	**29**
16-Q3	33.0	**29**
16-Q4	38.5	**29**
17-Q1	32.1	**29**

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

GOOG (Get out of Gridlock) huddles continue once 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. In April, we were able to cohort 35 patients requiring LTCE. 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 Q1 result of 32.1 hours is over the 29 hour target. Based on Q1 admission volumes of 2821, 254 patients waited more than 32.1 hours in the ED for an inpatient bed. Admission rate from the ED in Q1 was 18.9% which is higher than the average Ontario teaching hospital rate of 14.9%. 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 Q1: LHSC = 20, HHSC = 28.3, SMH = 23.4, SHSC = 26.6, TOH = 30.9, TBRHC = 28.6, teaching hospital group 28.1. We are not performing as well as any of our peers which puts us at risk for Pay for Results Funding. Our funding rank for admitted patients is 57 for current performance and 62 for improvement out of 74 hospitals as of the end of May (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?

Maybe. A new protocol for pulling admitted patients out the ED within 24 hours will be implemented in July, which, if successful should greatly improve our performance.

Definition: DATA: Decision Support - Alex Ungar COMMENTS: Julie Caffin EVP: Silvie Crawford REPORT: QUALITY IMPROVEMENT PLAN (QIP)

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, Target 16/17: 29 Hours Perf. Corridor: Red >33 Yellow 30 - 33 Green <30

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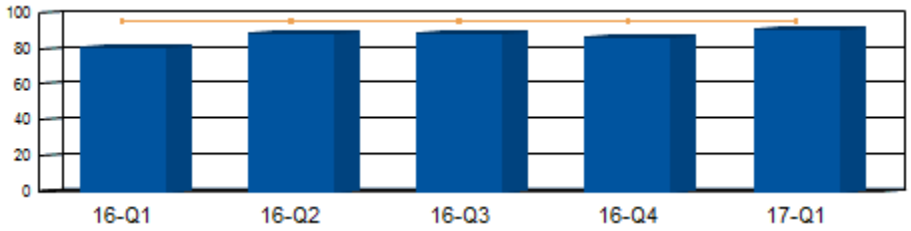
Indicator: Hand Hygiene Compliance - (QIP)



	Actual	Target
16-Q1	81	**95**
16-Q2	88	**95**
16-Q3	88	**95**
16-Q4	86	**95**
17-Q1	91	**95**

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

The tactic work plan initiated for 2016-2017 indicates the need to continue supporting auditors, working directly with Programs, attending staff meetings to clarify Patient Environment vs. Hospital Environment. The Resource Tool developed has now been posted on each in-patient unit, Renal Unit and Cancer Clinic. The Hand Hygiene LMS module has been roll-out across the organization 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:

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: Infection Control COMMENTS: Dr.Gerald Evans EVP: David Zelt REPORT: QUALITY IMPROVEMENT PLAN (QIP)

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%, Target 16/17: 95% Red <84% Yellow 84% - 89% Green >= 90%

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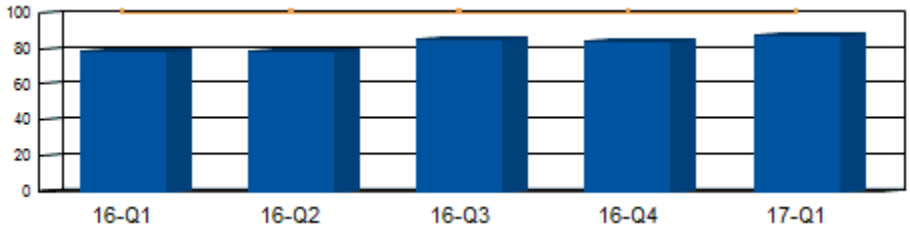
Indicator: Medication Reconciliation at Admission (QIP)



	Actual	Target
16-Q1	78	**100**
16-Q2	78	**100**
16-Q3	85	**100**
16-Q4	84	**100**
17-Q1	87	**100**

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

KGH Administrative policy 14-300 Medication Reconciliation at Care Transitions (Acute Care) approved.
Prescribers education module implemented. Education ongoing.
Admission order sets for Pediatric Surgery implemented.

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 seen in Fiscal 16 in the percentage of patients who receive medication reconciliation at the time of admission to the Hospital continues each quarter with a rate of completion of 87% for all admitted patients in Fiscal 17 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?

With the adoption of KGH Administrative policy 14-300 Medication Reconciliation at Care Transitions in June 2016, the Hospital is on track to meet a target of > 90% by end of Fiscal year. Policy requires that:
1. All patients admitted to the Hospital have medications reconciled on admission.
2. Prescribers obtain and document an accurate home medication list (BPMH) on admission and use the BPMH to order Hospital medications on admission.
2.

Definition: DATA: Decision Support - David Barber COMMENTS: Veronique Briggs EVP: Dr. David Zelt REPORT: QUALITY IMPROVEMENT PLANE (QIP)

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%, Target 16/17: 100% Perf. Corridor: Red <= 80% Yellow 80%-89% Green >=90%

Kingston General Hospital

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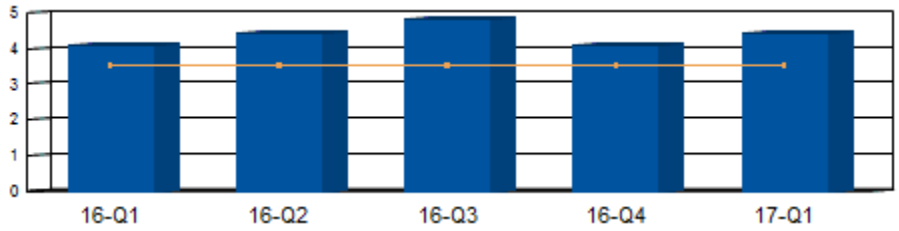
Indicator: Reduction in level 1 to 4 falls with a focus on level 3 and 4 falls (QIP)



	Actual	Target
16-Q1	4.1	**3.5**
16-Q2	4.4	**3.5**
16-Q3	4.8	**3.5**
16-Q4	4.1	**3.5**
17-Q1	4.4	**3.5**

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

When we drill down the data to look at falls per 1000 patient days per unit we are able to look at units with greater rates vs those with lower rates. Both medicine and orthopedics have higher rates mostly due to patient population, and starting in Q3 professional practice will be working with these units to look at strategies that could impact the falls rate. These strategies will be built on the falls program we already have in place. Risk assessment for falls is already imbedded into practice with a sustained 90% or greater completion rate corporately. Auditing of care planning post fall has improved but continues to require monitoring to sustain in practice. Moving forward, 4 strategies will be used: 1. Quick debrief after fall occurs to ensure falling star program in place and strategies are communicated and documented, 2. Care planning rounds where risks identified by risk assessments are discussed in a group setting to ensure planning in place before a fall, 3. Targeted toileting, and 4. Partnering with patient and family. An essential component of these strategies is working with the staff on each unit to develop approaches which can improve relevance of the strategy to the staff and improve uptake of the practices.

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 have moved from reporting number of level 3-4 falls to reporting number of falls per 1000 patient days. This quarter our falls rate corporately was 4.21 per 1000 patient days. This is important for us to understand as it allows us to look at falls activity throughout the hospital as any fall has the potential to cause injury. We have good opportunity to improve this 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?

Managers of the three units targeted are in agreement and would like to work together to build approaches that meet the 4 targeted strategies. There will continue to be an emphasis on the falls program as it currently stands with monitoring of risk assessment and care plan development, communication, intervention and documentation corporately.

Definition: DATA: Decision Support - Alex Ungar COMMENTS: Leanne Wakelin EVP: Silvie Crawford REPORT: QUALITY IMPROVEMENT PLAN (QIP)

Falls Risk Assessment form completion compliance, daily assessment compliance, and high risk patients are appropriately identified (Falling Star) and have a documented/actioned mobilization plan.

Target: Target 16/17: 3.5 Perf. Corridor: Red >=4.4, Yellow 4-4.3, Green <=3.9

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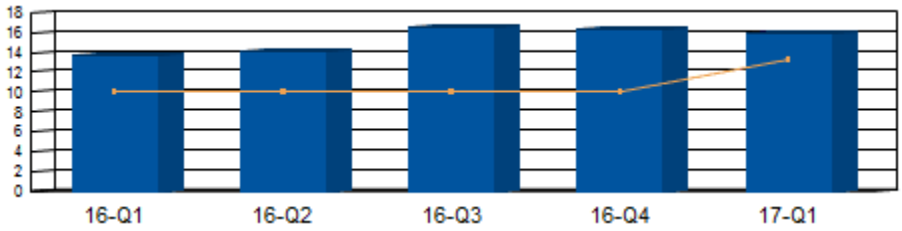
Indicator: Percent ALC Days (QIP)



	Actual	Target
16-Q1	13.7	**10.0**
16-Q2	14.2	**10.0**
16-Q3	16.5	**10.0**
16-Q4	16.3	**10.0**
17-Q1	16.0	**13.2**

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

In Q1, 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 Q2. 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 approved a Pay for Results proposal for a Home First Implementation Specialist to work with each patient care area to ensure all opportunities for discharge home are explored rather than designating patients ALC for Long Term Care (LTC). This Home First Refresh will require support of our internal & external stakeholders and education regarding this philosophy for all care providers across the organization. The project will begin in Q2 and expected completion is end of fiscal year.

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 ALC rate for fiscal 2017 Q1 is a different calculation than prior years. This indicator now excludes Emergency Department days. The Q1 result of 16% indicates that, on average, there were 68 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 13.2% 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.

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Definition: DATA: Decision Support - Lana Cassidy COMMENTS: Cynthia Phillips EVP: Silvie Crawford REPORT: QUALITY IMPROVEMENT PLAN (QIP)

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.

Total number of ALC inpatient days contributed by ALC patients within the specific reporting period (open, discharged and discontinued cases), divided by the total number of patient days for open, discharged and discontinued cases (Bed Census Summary) in the same period.

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%, Target 16/17: 13.2% Perf. Corridor: Red >13% Yellow >10%-13% Green <=10%

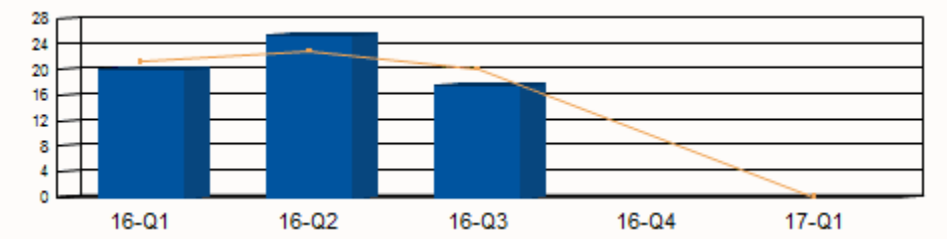
Kingston General Hospital

Q1 FY2017 Quality Improvement Plan Report

Create seamless transitions in care for patients across our regional health-care system

Patient navigation pathways and partnerships are established for complex-acute and chronic patient populations

Indicator: Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with COPD (QBP cohort) (QIP)



	Actual	Target
16-Q1	20.01	**21**
16-Q2	25.55	**23**
16-Q3	17.63	**20**
16-Q4		
17-Q1		

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

Data to measure performance is typically a couple of quarters behind. A plan comprised of phases of work will be developed and implemented across the SE LHIN. The initial phase of work will be to establish a working group to oversee analysis and provide advice on process. Subsequent phases of work will focus on building a retrospective care continuum at the patient level. This will include visits across acute care sites and other venues of care. The purpose of which is to better understand the current state of regional COPD care. The final phase of work will be to develop system level recommendations aimed at optimizing COPD care in the SE LHIN.

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 year we are aiming to develop a regional best practice patient journey for patients presenting with COPD. In Q1, together with patients and families, staff and physicians, we mapped the COPD patient journey from the time a patient presents to our emergency department or HDH's urgent care centre to the time they are discharged. We surveyed stakeholders to validate our recommendations and determine achievable metrics. The same recommendations were submitted to SECHEF for approval. As of Q1, we are have implemented all the milestones we planned to achieve. In Q2, we expect to receive approval to proceed from SECHEF. At that point, we will re-engage stakeholders to review the proposed care pathways, as well as the accompanying order sets and discharge checklists.

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

Unable to assess as current data is not available.

Definition: DATA: Decision Support - John Lott via Don McGinnis COMMENTS: Silvie Crawford EVP: Silvie Crawford REPORT: QUALITY IMPROVEMENT PLAN (QIP)

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Target: Target 16/17: 17.08 Perf. Corridor: Red >10% of the expected Rate Yellow Within 10% of the expected Rate Green <= Expected Rate

Kingston General Hospital

Q1 FY2017 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