fiscal 2016-2017 **Q3**

3rd quarter ended December 31, 2016

KGH this quarter

QIP Performance Report

Kingston General Hospital

Outstanding care, always

KGH Quality Improvement Plan (QIP) Performance Report Fiscal 2017

Kingston General Hospital

DRAFT

Q3 FY2017 Quality Improvement Plan Report

Strategic Direction	2016 Outcome	Indicator	16-Q3	16-Q4	17-Q1	17-Q2	17-Q3	
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	R	Y	Y	Y	↑
		"Would you recommend this ED to your friends and family?" (QIP)	R	R	R	Y	N/A	↑
		"Would you recommend this hospital (inpatient care) to your friends and family?" (QIP)	R	R	R	R	N/A	↓
		90th Percentile ED Wait Time - All Admitted Patients (hrs.) - (QIP)	Y	R	Y	R	R	↓
		Hand Hygiene Compliance - (QIP)	Y	Y	G	G	G	↑
		Medication Reconciliation at Admission (QIP)	Y	Y	Y	Y	G	↑
		Reduction in level 1 to 4 falls with a focus on level 3 and 4 falls (QIP)	R	Y	R	G	G	↑
		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	N/A	N/A	N/A	

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

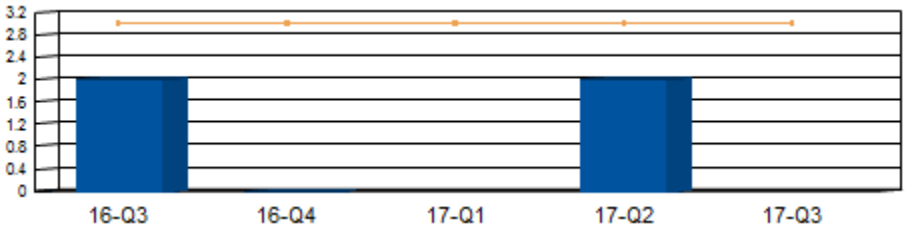
	Strategy					QIP					Supporting				
	F16	F17				F16	F17				F16	F17			
	Q4 %	Q1 %	Q2 %	Q3 %	Q3 #	Q4 %	Q1 %	Q2 %	Q3 %	Q3 #	Q4 %	Q1 %	Q2 %	Q3 %	Q3 #
R	33%	0%	0%	0%	0	42%	44%	33%	44%	4	37%	32%	39%	44%	50
G Y	67%	100%	100%	100%	10	58%	56%	67%	56%	5	63%	68%	61%	56%	63
N/A	0%	0%	0%	0%	0	0%	0%	0%	0%	0	0%	0%	0%	0%	0
					10					9					113

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

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

Concentration this quarter on risk assessments and completion within 24 hours. This will allow for better understanding of facility acquired pressure injury. September prevalence study demonstrated that best opportunities included improved documentation and pressure injury related to devices. Both of these have been focus of quarter 3.

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 new prevalence study this quarter to report outcomes; next scheduled for February 2017. Skin assessment and daily risk assessments continue to maintain a 90% completion rate. Concentration on completion within 24 hours has improved to 85%; continuing to build performance with this in order to report facility acquired pressure injury.

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 by years end. Will perform prevalence study in February to examine outcomes.

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.

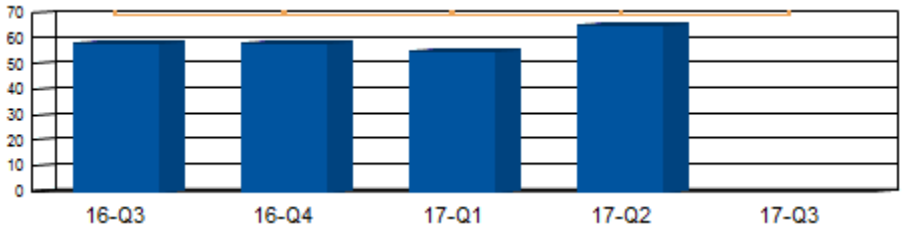
Target: Target 2015/16: 25% reduction Perf. Corridor: Red 1 or no units achieve Green Status, Yellow 2 units achieve Green Status, Green 3 of 3 units achieve green status, Target 2016/17: 3 of 3 units achieve 25% reduction Perf. Corridor: Red No units achieve green status, Yellow 1 or 2 units achieve Green Status, Green 3 of 3 units achieve green status

Q3 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: "Would you recommend this ED to your friends and family?" (QIP)



	Actual	Target
16-Q3	58.2	**69.3**
16-Q4	58.0	**69.3**
17-Q1	55.0	**69.3**
17-Q2	65.5	**69.3**
17-Q3		**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 including real time surveys as close to the end of the patient visit as possible.

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. The result of 65.5% in Q2 is the number of positive responses to the question for those who answered definitely yes (n=87). An additional 21 respondents said probably yes which put the result at 90%. 5 respondents said probably no and 4 respondents said definitely no.

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).

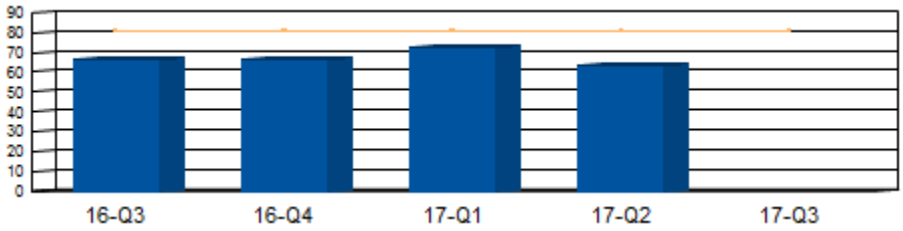
Target: Target 16/17: 69.3% Perf. Corridor: > 10% quarterly teach. Target, Yellow Within 10% of quart. Teach. Target, Green At or above the teach avg. /quarter

Q3 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: "Would you recommend this hospital (inpatient care) to your friends and family?" (QIP)



	Actual	Target
16-Q3	66.3	**80.7**
16-Q4	66.9	**80.7**
17-Q1	72.5	**80.7**
17-Q2	63.1	**80.7**
17-Q3		**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. This is one question in the inpatient survey.

Tactics to address this indicator include reviewing the narrative comments from the surveys to determine themes that can be addressed as well as reviewing all the dimensions of care to determine specific areas of concern to improve overall patient satisfaction with inpatient care.

Other tactics include the implementation of shift handover at the bedside in critical care areas and referrals to Health Links to ensure post-discharge follow up for patients with multiple medical conditions. These tactics will improve communication and information sharing.

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

Data is always a quarter behind to allow for the survey return and analysis. In Q2 there were 271 responses to the inpatient survey. The Q2 data show that the KGH inpatient care score is 63.1% (n=171). This result reflects the "definitely yes" responses only to the question "Would you recommend this hospital to your friends and family?" If "probably yes" is included, the result is 94.8% (n=171+86). Consideration should be given to including "probably yes" scores in the overall 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?

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).

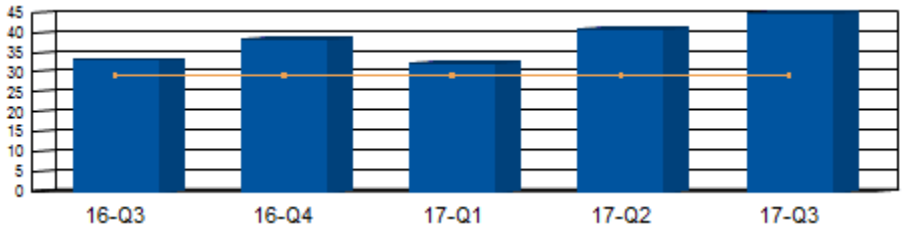
Target: Target 16/17: 80.7% Perf. Corridor: > 10% quarterly teach. Target, Yellow Within 10% of quart. Teach. Target, Green At or above the teach avg. /quarter

Q3 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: 90th Percentile ED Wait Time - All Admitted Patients (hrs.) - (QIP)



	Actual	Target
16-Q3	33	**29**
16-Q4	39	**29**
17-Q1	32	**29**
17-Q2	41	**29**
17-Q3	45	**29**

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

A new bed map that would consolidate patient cohorts resulting in increased efficiency for care teams is being partially implemented in January 2017. Efficiencies include timelier rounding with optimal participation of all care providers, earlier decisions and arrangements for discharges resulting in more timely bed availability. A focus on admission avoidance strategies will also help to improve on this indicator. NP led clinics have just been initiated through 'Pay for Results' funding. The goal is to create an environment that supports timely access to patient assessment and follow up outside of an ED environment. These types of clinics have proven to be successful in some sub specialties (cardiac) and hence the expansion to medicine. In addition, there is another strategy being implemented this month that creates surge capacity for the ED by more consistent use of OPPU thus reducing the use of section C.

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 44.7 hours is over the 29 hour target. Based on Q3 admission volumes of 2,875, 287 patients waited more than 44.7 hours in the ED for an inpatient bed. Admission rate from the ED in Q3 was 19% which is higher than the average Ontario teaching hospital rate of 15%. 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 Q3: LHSC = 21.8, HHSC = 31.6, SMH = 25.4, SHSC = 26.9, TOH = 33.4, TBRHC = 36.4, teaching hospital group 30.5. 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 61 for current performance and 62 for improvement out of 74 hospitals as of the end of November 2016 (based on the calendar year).

There have been a number of influences that have impacted these results. KGH is experiencing an increase of patients being seen in the ED especially within the medical specialty that are being admitted. A comparison for Q3 2016 to Q3 2017 shows an increase of 396 patients more requiring admission. The LOS has remained consistent and slightly less as it is currently 6.3 compared to 6.5 for the same period in 2016.

Although OR cancellations due to no bed availability have only slightly decreased from 47 patients in Q3- 2016 to 34 in Q3-2017, the numbers of avoided scheduled surgery cancellation requiring PACU overnight stays has increased from 127 to 159 patients for the same time period.

This has resulted in a delay of patient transitions across the organization: ED, ICU and PACU.

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

There are a number of strategies that are being implemented in Q4 in efforts to impact the results. A significant improvement in patients transferring to inpatient beds is required below the 29 hour target for the remaining quarter.

Definition: DATA: Decision Support - Alex Ungar COMMENTS: Silvie Crawford 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.

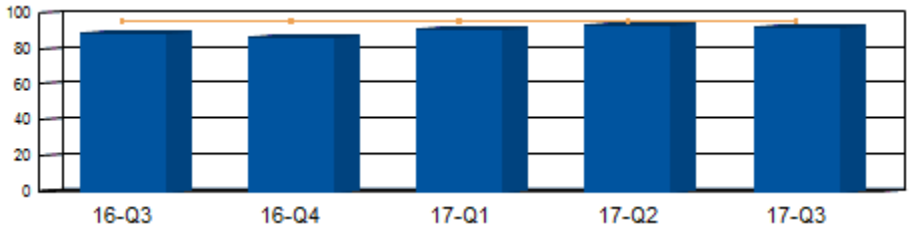
Target: Target 11/12: 31 Hours, Target 12/13: 22 Hours, Target 13/14: 25 Hours Perf. Corridor: Red >31 Yellow 28-31 Green <28, Target 14/15: 25 Hours Perf. Corridor: Red >31 Yellow 28-31 Green <28, Target 15/16: 29 Hours Perf. Corridor: Red >33 Yellow 30 - 33 Green <30, Target 16/17: 29 Hours Perf. Corridor: Red >33 Yellow 30 - 33 Green <30

Q3 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: Hand Hygiene Compliance - (QIP)



	Actual	Target
16-Q3	88.0	**95**
16-Q4	86.0	**95**
17-Q1	91.0	**95**
17-Q2	92.6	**95**
17-Q3	92.0	**95**

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

This is the third quarter for 2016-2017 where we have maintained our "Before Moment (M1)" above 90%. This result is from 5,410 observed opportunities. The LMS module for Hand Hygiene was released. In addition, IPAC Service continues to work directly with Programs, attend staff meetings to clarify Patient Environment vs. Hospital Environment.

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 is the third straight quarter with >90% compliance reflecting an organizational awareness and changing culture towards the significance of HH.

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 the target. IPAC service will continue to support the program.

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%

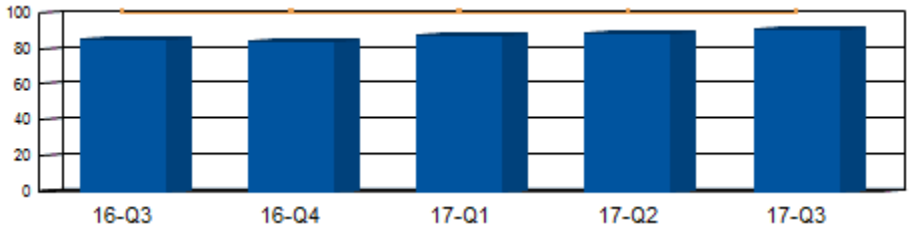
Kingston General Hospital

Q3 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: Medication Reconciliation at Admission (QIP)



	Actual	Target
16-Q3	85	**100**
16-Q4	84	**100**
17-Q1	87	**100**
17-Q2	88	**100**
17-Q3	91	**100**

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

In F17 Q3, the Pharmacy manager contacted prescribers when EntryPoint admission order sets were not used to write medication orders for patients with a decision to admit to the hospital. The manager provided one on one education on new Hospital requirements for medication reconciliation on admission and discussed barriers to compliance with the prescribers.

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 continues to increase steadily each quarter with a rate of completion of 91% for all admitted patients in Fiscal 17 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?

Target of >= 90% achieved for the first time this quarter.

Risk for F17 Q4: As of January 2017, the Orthopedics service has resumed handwriting admission orders.

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.

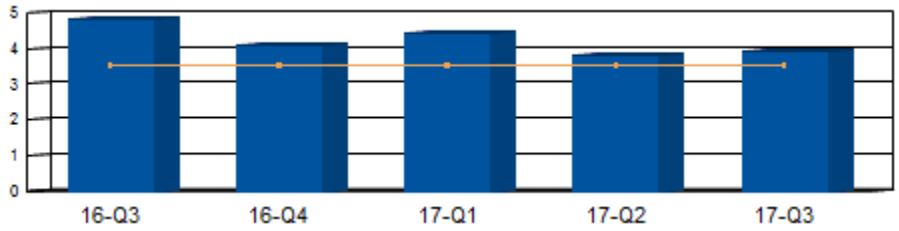
Target: Target 14/15: 100% Perf. Corridor: Red <= 80% Yellow 80%-89% Green >=90%, Target 15/16: 100% Perf. Corridor: Red <= 80% Yellow 80%-89% Green >=90%, Target 16/17: 100% Perf. Corridor: Red <= 80% Yellow 80%-89% Green >=90%

Q3 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: Reduction in level 1 to 4 falls with a focus on level 3 and 4 falls (QIP)



	Actual	Target
16-Q3	4.8	**3.5**
16-Q4	4.1	**3.5**
17-Q1	4.4	**3.5**
17-Q2	3.8	**3.5**
17-Q3	3.9	**3.5**

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

Audit and feedback of documentation and adherence to falling star process continues. Continue to try and move tactics forward but this has been difficult due to volume of patients on units and competing priorities. Continue to move this work forward. Education on organizational resources to reduce impact of those who do fall was started and is ongoing.

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

Falls rate 3.9 per 1000 patient days within target. We continue to stress importance of risk assessment and care plan integration. Daily risk assessments continue to be completed in 90% of audits. We evaluated risk assessment completion within 24 hours of admission; this is completed within 24 hours 85% of the time (we have a goal of 90%).

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 with greatest threat to this being volume of patients. We will continue to emphasize the importance of continued vigilance and compliance with process despite volumes of both fall prevention and harm reduction.

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.

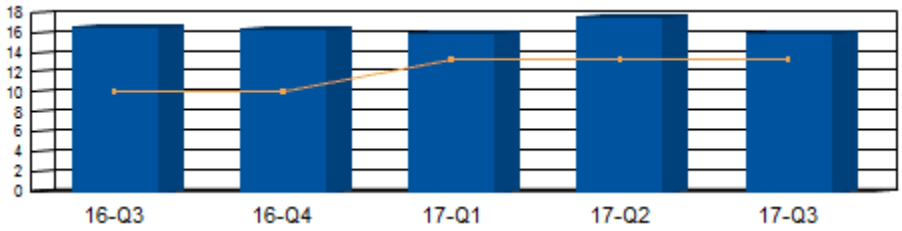
Target: Target 16/17: 3.5 Perf. Corridor: Red >=4.4, Yellow 4-4.3, Green <=3.9

Q3 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: Percent ALC Days (QIP)



	Actual	Target
16-Q3	16.5	**10.0**
16-Q4	16.3	**10.0**
17-Q1	16.0	**13.2**
17-Q2	17.5	**13.2**
17-Q3	16.0	**13.2**

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

In Q3, 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.

The ALC escalation guideline was implemented in Q3. This procedure requires director level 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 requires support of our internal & external stakeholders and education regarding this philosophy was delivered to all care providers across the organization.

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 affordable housing 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 is a different calculation than prior years. This indicator now excludes Emergency Department days. The Q3 result of 16% indicates that, on average, there were 67 inpatients at KGH whose acute care stay was complete and who were waiting for access to one of the destinations listed below. In Q3, there were 165 patients who were designated as ALC and 159 of these patients were discharged to other destinations. At the end of December, there were 73 remaining ALC patients and 41 of these patients were waiting for LTC. Although the numbers are high, they do not reflect a stagnant patient population; there is alot of movement of ALC patients to other facilities.

Historically, KGH designates 73 new ALC cases per month and discharges 62 ALC cases. In Q3, on average, we designated 55 new ALC cases and discharged 53 ALC cases per month. Although we are early in our project implementations, it is clear that there is a difference. The change can be attributed to the collaboration with community partners at the CCAC and the Community Support Services and the temporary addition of another health professional to the KGH patient flow team as part of the Pay 4 Results funding.

In November 2016, there were 6 long stay ALC patients who were discharged. Their length of stays ranged from 206 days to 806 days. Since this indicator reflects discharged days, these discharges actually cause an increase in the result - in other words, the result is not as low as expected due to the discharge of the 6 long stay patients in the same quarter.

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.

Fifty percent of ALC patients are awaiting transfer to a long term care home. The Home First philosophy ensures that patients return home to wait for their next destination.

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

Q3 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

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 Link and reduce avoidable hospital admission from long term care homes or retirement homes. KGH staff members are participating in a LHIN-based patient flow task team to standardize policies and processes across all SE LHIN organizations. The focused effort on these initiatives is contributing to the improvements we are seeing in the ALC data. On average, there were 67 patients designated ALC in Q3. This represents a decrease of 1.5% ALC days from the previous quarter.

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%

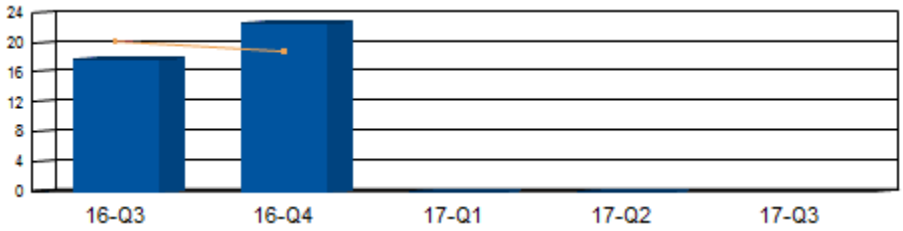
Kingston General Hospital

Q3 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-Q3	17.63	**20**
16-Q4	22.70	**19**
17-Q1		
17-Q2		
17-Q3		

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

This indicator relates to a future improvement through the work of Healthcare Tomorrow. Work is being completed related to the regional mapping of patient-care processes relating to patients with COPD (Chronic Obstructive Pulmonary Disease).

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

Data is not reported until next fiscal year when the improvement initiatives will be implemented to affect a positive change in the readmission rate.

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 with the process mapping work of Healthcare Tomorrow.

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

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.

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

Q3 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