fiscal 2017-2018 **Q1**

1st quarter ended June 30, 2017

KHSC this quarter

QIP **Performance** Report

Hôpital Hotel Dieu Hospital

Hôpital Général de Kingston General Hospital

Kingston Health Sciences Centre

Centre des sciences de la santé de Kingston

KHSC Quality Improvement Plan (QIP) Performance Report Fiscal 2017-18

Strategic Direction 1

Improve the patient experience through a focus on compassion and excellence

Outcome: KHSC is a top performer on the essentials of quality, safety & service

KHSC Quality Improvement Plan (QIP) Performance Report Fiscal 2017-18

Strategic Direction 3

Enable clinical innovation in complex-acute and specialty care

Outcome: KHSC is positioned as a leading centre for complex-acute & specialty care

Strategic Direction 4

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

Outcome: KHSC if fully engaged with our community partners to support patients with complex-acute and chronic conditions

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Q1 FY2018 Quality Improvement Plan Report

			18-Q1	18-Q2	18-Q3	18-Q4	19-Q1
Improve the patient experience through a focus on compassion and excellence	KHSC is a top performer on the essentials of quality, safety, & service	"Would you recommend this ED to your friends and family?" (KGH QIP)	N/A	N/A	N/A	N/A	N/A
		Percent of patients that respond "definitely yes" or "probably yes" to the question, "Would you recommend this Emergency Dept to your friends and family?" (HDH QIP)	N/A	N/A	N/A	N/A	N/A
		Percent of patients that rate their care during this emergency room visit as 7 or higher (on 10-point scale) (HDH QIP)	N/A	N/A	N/A	N/A	N/A
		90% UCC Length of Stay (LOS-hrs) for complex patients (CTAS 1,2,3) (HDH QIP/HSAA)	G	N/A	N/A	N/A	N/A
		90th Percentile ED Wait Time - All Admitted Patients (hrs.) - (KGH QIP)	G	N/A	N/A	N/A	N/A
		Medication Reconciliation at Admission (KGH QIP)	Y	N/A	N/A	N/A	N/A
		# of eligible clients receiving formal med rec upon admission to mental health clinics/by total # of eligible clients admitted for the quarter (HDH QIP)	G	N/A	N/A	N/A	N/A
		# of eligible clients receiving formal med rec upon admission to EPACU for total joint arthroplasty/by total # of eligible clients admitted for the quarter (HDH QIP)	Y	N/A	N/A	N/A	N/A
		# of eligible clients receiving formal med rec upon admission for bariatric surgery/by total # of eligible clients admitted for the quarter (HDH QIP)	G	N/A	N/A	N/A	N/A
		# of eligible patients receiving Best Possible Medication Discharge Plan (BPMDP) at discharge/by total # of eligible patients discharged for the quarter (HDH QIP)	G	N/A	N/A	N/A	N/A
		Reduce percent of patients with facility acquired pressure injury (KGH QIP)	G	N/A	N/A	N/A	N/A
		Percent ALC Days (KGH QIP)(KGH HSAA)	Y	N/A	N/A	N/A	N/A
		Percent of palliative care patients discharged from hospital with the discharge status "Home with Support". (KGH QIP)	G	N/A	N/A	N/A	N/A

			18-Q1	18-Q2	18-Q3	18-Q4	19-Q1
		Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital? (KGH QIP)	N/A	N/A	N/A	N/A	N/A
		Percent of patients who wanted information that respond "very confident" that they have the information they need and/or know who to contact after they leave their appointment (HDH QIP)	G	N/A	N/A	N/A	N/A
		Percent of patients in adult ambulatory clinics that rate the quality of care and services received as 'excellent' or 'very good'. (HDH QIP)	G	N/A	N/A	N/A	N/A
Enable clinical innovation in complex-acute and specialty care	KHSC is positioned as a leading centre for complex-acute & specialty care	[(# of regular clinics held + # of special clinics held) / (# regular clinics assigned)] x 100 (HDH QIP)	G	N/A	N/A	N/A	N/A
		# days from clinic appointment until dictated clinic letter has been verified [Result verification date - Clinic appointment date] (HDH QIP)	Y	N/A	N/A	N/A	N/A
Create seamless transitions in care for patients across our regional health-care system	KHSC is fully engaged with our community partners to support patients with complex-acute and chronic conditions	Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with COPD (QBP cohort) (KGH QIP)	G	N/A	N/A	N/A	N/A
		Patient Journey Process maps as developed by each organization (presented to HCT COPD Clinical Steering Team) Best Practice and QBP Guidelines. (HDH QIP)	G	N/A	N/A	N/A	N/A

	SPR		QIP		SAA	
	F18		F18		F18	
	Q1 %	Q1 #	Q1 %	Q1 #	Q1 %	Q1 #
R	0%	0	0%	0	32%	21
G Y	100%	15	80%	16	65%	43
N/A	0%	0	20%	4	3%	2
		15		20		66

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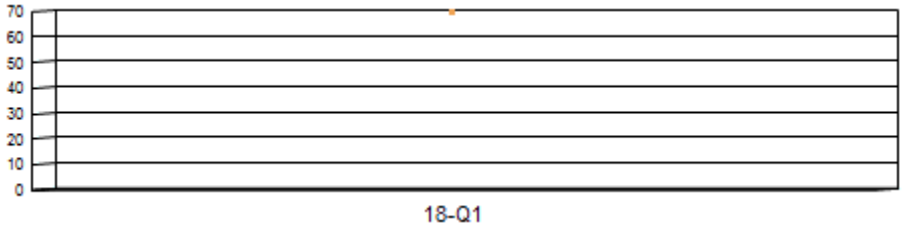
Improve the patient experience through a focus on compassion and excellence

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

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



	Actual	Target
18-Q1		69.3

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

In April 2016, KGH moved to the patient experience survey from 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.

One of the patient experience survey questions asks if the respondent would recommend this Emergency Department (ED) to her or his friends and family. The result captures only those responses that are 'definitely yes' and does not include any responses that were 'probably yes'.

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 for Q1 is not yet available. Data is always a quarter behind to allow for the survey return and analysis.

The result of 58.2% in Q4 of last fiscal year is the number of positive responses to the question for those who answered definitely yes. Additional respondents said probably yes which put the result at 86.8%. Of 91 respondents, 9% said probably no and 3% 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?

Going forward the provincial standards from the new surveys should be released by end of next quarter. This will allow us to track our performance more closely and allow us to compare our results to other hospitals. None the less we are including a Patient Relations Specialist on our Emergency Department program council to ensure front line have more interactions and a better understanding of the patient feedback. We ae working with frontline staff to ensure they are involved in the process in a productive manner.

Definition: DATA: Astrid Strong & Katie Ireland COMMENTS: Carol McIntosh EVP: Mike McDonald 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 17/18: 60% Perf. Corridor: Red <54% , Yellow 54%-59%, Green >=60%

Previous fiscal year - 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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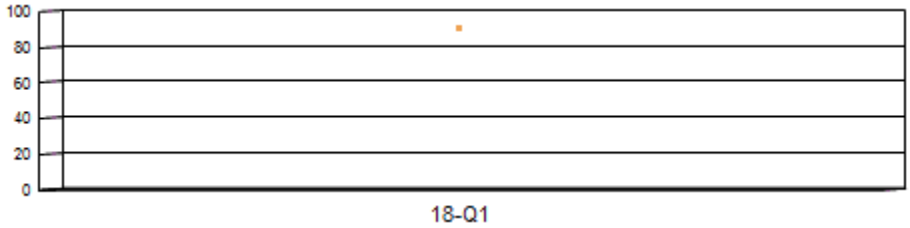
Indicator: Percent of patients that respond "definitely yes" or "probably yes" to the question, "Would you recommend this Emergency Dept to your friends and family?" (HDH QIP)



	Actual	Target
18-Q1		90

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

Data is not currently available for this indicator.

The Q4 result for Hotel Dieu Hospital (HDH) site from the last fiscal year was 97%.

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

We are awaiting the results of Q1 and our goal is that 90% of patients will say they would definitely or probably recommend the HDH site Urgent Care Centre to their friends and family, the use of Emergency Department Patient Experience survey is new, and previously we had used the National Research Corporation Canada survey. The questions and rating scales were different than the current survey and the scores are not comparable. Ontario data from the new survey is not yet comparable across organizations and the Ontario Hospital Association is recommending that we do not use comparator data yet. We will continue to strive for a high level on these surveys.

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

Data unavailable at this time but we will continue to work towards ensuring our patients feel they would recommend this UCC to their friends and family.

Definition: DATA: Ontario Emergency Department Patient Experience of care Survey (OEDPEC) - Janine Schweitzer COMMENTS: Carol McIntosh EVP: Mike McDonald REPORT: QUALITY IMPROVEMENT PLAN (QIP)

Patient satisfaction with UCC has been high. The goal is to maintain positive performance. Target based on Apr - Jun 2016 Performance.Target based on Apr - Jun 2016 performance. New survey and new rating scale. Target may be adjusted by UCC leaders once survey has been longer. Renovate triage area and implement new volunteer position. Performance is review quarterly.

Target: Target 17/18: 90% Perf. Corridor: Red <80% , Yellow 80%-89% , Green >=90%.

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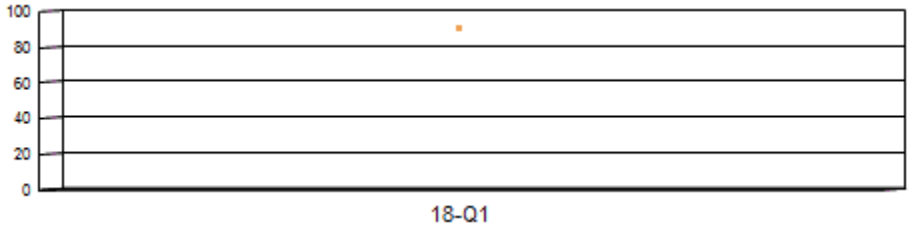
Indicator: Percent of patients that rate their care during this emergency room visit as 7 or higher (on 10-point scale) (HDH QIP)



	Actual	Target
18-Q1		90

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

Q1 data is not available. Previous Hotel Dieu Hospital (HDH) Q4 result was 86% of patients rated their care during this UCC (categorized as an emergency room) visit as 7 or higher out of 10. This result was based on the Emergency Department Patient Experience survey. HDH recently completed a redesign of its triage area to address patient feedback that triage area was a source of confusion and an area of congestion. Staff and patient experience advisors were consulted in the re-design to improve the entrance and natural flow of patients entering the Urgent Care Centre. Volunteers were introduced in the waiting room to assist in flow and with way finding. With the re-design an additional triage nurse can easily assist when high volumes of patients arrive. Prior to re-design the area used for additional triage was inside the unit.

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

We are awaiting Q1 results. The use of Emergency Department Patient Experience survey is new. Previously HDH had used the National Research Corporation Canada survey. The questions and rating scales are different; thus, the scores are not comparable. The Ontario Hospital Association (OHA) advised that Ontario data from the EDPEC survey is too new to be comparable across hospitals and OHA is recommending not using comparator data yet to set targets.

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

Our result from Q1 will include the time frame of construction. We expect construction and a temporary entrance may affect results to some extent but with the additions of volunteers and added triage capability we are hoping to meet previous level of 86% or more.

Definition: DATA: Ontario Emergency Department Patient Experience of care Survey (OEDPEC) - Janine Schweitzer COMMENTS: Carol McIntosh EVP: Mike McDonald REPORT: QUALITY IMPROVEMENT PLAN (QIP)

Patient satisfaction with UCC has been high. The goal is to maintain positive performance. Target based on Apr - Jun 2016 Performance.Target based on Apr - Jun 2016 performance. New survey and new rating scale. Target may be adjusted by UCC leaders once survey has been longer. Renovate triage area and implement new volunteer position. Performance is review quarterly.

Target: Target 17/18: 90% Perf. Corridor: Red <80% , Yellow 80%-89% , Green >=90%.

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Indicator: 90% UCC Length of Stay (LOS-hrs) for complex patients (CTAS 1,2,3) (HDH QIP/HSAA)

	Actual	Target
18-Q1	4.8	6

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

In Q1, multiple measures were taken including redesign of triage to allow ease of redeploying staff to triage during times of high volumes and renewed emphasis and training on the use of medical directives. (Medical directives allow a nurse to "fast track" specific work within specific parameters such as ordering Tylenol for a patient with fever or ordering x-rays on a suspected broken ankle while awaiting the physician's assessment. This ensures care is expedited and doesn't slow down while awaiting the physician.)

We engaged staff in the re-design efforts to ensure work flow was maintained and improved. Staffing was adjusted to increase numbers later in the evening to correlate with higher volume activity times. We worked with Imaging Services to extend the evening shift hours and put in a process that when a radiology test is ordered in the evening, the test is expedited and the technician completes the test prior to end of shift to prevent need for transfer or return. The Rapid Access clinic for patients with chronic disease prevented prolonged stays and admissions for patients who would benefit from a timely referral to a physician or nurse practitioner. An ear, nose and throat scope was acquired to provide the ability to perform procedures that previously required a transfer to acute care by ambulance. The availability of this scope decreases the need to stay in Urgent Care Centre (UCC). This allows UCC to provide the service immediately and requires transfer to acute care only when admission or consult is required.

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

We continue to use chairs and fast track principles although we do not have a designed fast track area within the physical space. This allows resources and staff to be allocated appropriately to higher acuity needs. The continued emphasis on medical directives allows timely initiation of care that allows the length of stay targets to be achieved.

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 a 4.8 hour length of stay for complex patients.

Definition: DATA: Decision Support - David Barber COMMENTS: Carol McIntosh EVP: Mike McDonald REPORT: QUALITY IMPROVEMENT PLAN (QIP)

Maintain current performance.

Target: Target 17/18: 6 Perf. Corridor: Red <8 , Yellow >6-8 , Green <=6.

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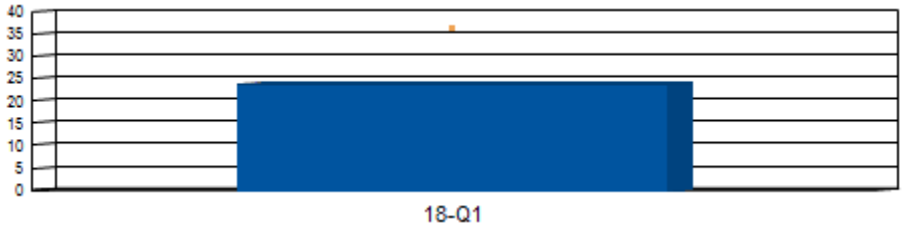
Indicator: 90th Percentile ED Wait Time - All Admitted Patients (hrs.) - (KGH QIP)



	Actual	Target
18-Q1	23.9	**36**

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

Traditional lower quarter one admission rates (18.6% this Q1) compared to Q4 rates (19.5% Q4) along with multiple tactics that were taken in the previous quarters have resulted in improved length of stay (LOS) in the Emergency Department (ED) for admitted patients in this quarter.

The tactics included the new bed map initiated in Feb. 2017, the 9 bed Admission & Transfer Unit (ATU) for admitted patients, 11 additional medicine beds, and the nurse practitioner-led chronic disease clinic that allows the ED and Urgent Care Centre (UCC) to discharge sooner with the knowledge that follow up care will occur within 24 to 72 hours. Other initiatives are on-going to ensure medical directives are used to facilitate timely care (allows nurses to begin elements of care under pre-approved circumstances while awaiting the physician's assessment to keep care moving quickly) and to improve LOS in the ED. The Home First philosophy - which involves a team in the ER identifying patients at risk of being unable to go home safely so they can work with the patient and family to develop a plan for more services/supports within the home/community and/or moving them to nursing home wait list while they go home with more support - has positively impacted the admissions rates. Previously patients admitted as a result of challenges in placement who had prolonged stays are now discharged safely and appropriately from the ED with plans developed by the interprofessional Home First team.

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 is 23.9 hours for 90th percentile LOS for admitted patients in the ED and this surpasses the goal of 36 hours. This is a result of multiple initiatives including the Home First, ATU and new medicine beds. There was a 1% decrease in admissions from ED that most likely decreased ED wait time as well.

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 have met the target. The challenge will be to continue when the traditionally higher admission rates occur in quarters 3 & 4, and ensure initiatives keep their momentum.

Definition: DATA: Decision Support - Alex Ungar COMMENTS: Carol McIntosh EVP: Mike McDonald 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 17/18: 36 Perf. Corridor: Red >39 , Yellow 37 - 39 , Green <=36.

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

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Indicator: Medication Reconciliation at Admission (KGH QIP)

	Actual	Target
18-Q1	92	**96**

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

Medication reconciliation reduces medication discrepancies at interface of care and prevents patient harm. Medication reconciliation on admission requires the documentation of the complete home medication list or Best Possible Medication History (BPMH) on the admission orders. Standardized admission order sets support the process by prompting the prescribers to document the BPMH on the admission orders.
Admission order sets including the medication reconciliation process are now available in an electronic format via EntryPoint for all prescribers to access online. The department of Orthopedics implemented EntryPoint admission order sets for hip and knee replacement surgery.

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 received medication reconciliation at the time of admission to the Hospital (KGH site only) increased this quarter with a rate of completion of 92% for all admitted patients in Fiscal 18 Q1, an increase of 4% from the F17 Q4 compliance rate of 88%.
New corridor has been set for Fiscal 2017/18.

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 >= 96% is a stretch target for this fiscal year. Pharmacy leadership has met with the Chief of Staff to develop a communications strategy to remind prescribers of hospital policy. Compliance will be monitored in Q2. Based on the results of Q2, consideration will be given to enforcing the KHSC policy requiring prescribers to use admission order sets including the medication reconciliation process completed for all patients admitted to the hospital.

Definition: DATA: Decision Support - David Barber COMMENTS: Veronique Briggs EVP: Troy Jones REPORT: QUALITY IMPROVEMENT PLAN (QIP)

The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital.

Target: Target 17/18: 96% Perf. Corridor: Red < 86% , Yellow 86%-95% , Green >=96%

Previous fiscal year - Target 16/17: 96% Perf. Corridor: Red <= 80% Yellow 80%-89% Green >=90%

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Indicator: # of eligible clients receiving formal med rec upon admission to mental health clinics/by total # of eligible clients admitted for the quarter (HDH QIP)

	Actual	Target
18-Q1	99	**90**

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

The best possible medication history (BPMH) is completed by intake nurses at Hotel Dieu Hospital (HDH) site in both adult and child mental health programs. This is part of the initial telephone intake and screening process. The medication reconciliation process is completed by the psychiatrist or the nurse practitioner at the first visit.

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 medication reconciliation process has been embedded into the clinical flow, with some programs using an electronic system. Prescribers find it helpful to have the most up to date complete medication history available and appreciate improved medication safety for patients, which contribute to continued high rate of compliance.

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 achieve target.

Definition: DATA: Decision Support - David Barber COMMENTS: Michelle Mathews EVP: Mike McDonald REPORT: QUALITY IMPROVEMENT PLAN (QIP)

The number of eligible clients receiving formal med rec upon admission to mental health clinics divided by total the number of eligible clients admitted for the quarter (HDH QIP).

Target: Target 17/18: 90% Perf. Corridor: Red <80% , Yellow 80%-89% , Green >=90%.

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Indicator: # of eligible clients receiving formal med rec upon admission to EPACU for total joint arthroplasty/by total # of eligible clients admitted for the quarter (HDH QIP)

	Actual	Target
18-Q1	93.75	**100**

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

The Pre-surgical screening (PSS) team along with the EPACU and Orthopedic teams have created processes to ensure that there is medication reconciliation in place. This begins the process at PSS and verifies at time of surgery that medication has been reconciled. Processes continue to be reviewed to ensure compliance.

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

Over 90% of all arthroplasty patients are receiving safe medication reconciliation 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?

Efforts are underway to ensure this metric will be achieved.

Definition: DATA: Decision Support - David Barber COMMENTS: Laurie Thomas EVP: Silvie Crawford REPORT: QUALITY IMPROVEMENT PLAN (QIP)

The number of eligible clients receiving formal med rec upon admission to EPACU for total joint arthroplasty divided by total the number of eligible clients admitted for the quarter (HDH QIP).

Target: Target 17/18: 100% Perf. Corridor: Red <90% , Yellow 90%-99% , Green >=100%.

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Q1 FY2018 Quality Improvement Plan Report

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Indicator: # of eligible clients receiving formal med rec upon admission for bariatric surgery/by total # of eligible clients admitted for the quarter (HDH QIP)

	Actual	Target
18-Q1	92.6	**90**

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

The entire bariatric team has worked in a collaborative effort to ensure that an accurate medication reconciliation process is in place to support this patient population.

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 bariatric pre-assessment clinic closely monitors the patient medications and makes the appropriate corrections as required to ensure safe medication practices, both pre and post-op.

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 is on track. We will continue to achieve this target.

Definition: DATA: Decision Support - David Barber COMMENTS: Laurie Thomas EVP: Silvie Crawford REPORT: QUALITY IMPROVEMENT PLAN (QIP)

The number of eligible clients receiving formal med rec upon admission for bariatric surgery divided by total the number of eligible clients admitted for the quarter (HDH QIP).

Map current process for obtaining med history, BPMH; Assess processes and resources necessary to complete BPMH; Provide training, implement tools and support staff to achieve target. Target will be achieved by Sept. 30, 2017.

Target: Target 17/18: 90% Perf. Corridor: Red <80% , Yellow 80%-89% , Green >=90%.

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Indicator: # of eligible patients receiving Best Possible Medication Discharge Plan (BPMDP) at discharge/by total # of eligible patients discharged for the quarter (HDH QIP)

	Actual	Target
18-Q1	93.75	**90**

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

The SPA program continues to examine medication reconciliation best practices in order to ensure safe discharges for our patients.

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 metric is being achieved. Medication reconciliation is known to decrease the risk of medication errors for our patients and improve quality of care.

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 have achieved the target.

Definition: DATA: Decision Support - David Barber COMMENTS: Laurie Thomas EVP: Silvie Crawford REPORT: QUALITY IMPROVEMENT PLAN (QIP)

The number of eligible patients receiving Best Possible Medication Discharge Plan (BPMDP) at discharge divided by total the number of eligible patients discharged for the quarter (HDH QIP).

Target: Target 17/18: 90% Perf. Corridor: Red <80% , Yellow 80%-89% , Green >=90%.

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Indicator: Reduce percent of patients with facility acquired pressure injury (KGH QIP)

	Actual	Target
18-Q1	14.8	**17**

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

This quarter we addressed units that higher pressure ulcer prevalence rates and are looking at unit specific root cause analysis and strategies to address. (Examples of strategies include reviewing unit-specific demographics, understanding staff assignments, types of procedures and type of patient population per unit in examining pressure ulcer prevalence, as well as ensuring units and individual staff are aware of their performance and need to improve). Review of Q4 study data and comparison to other organizations has been undertaken.

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 target only receives data in Q2 and Q4. The data from Q4 (16/17) demonstrated a 14.8% corporate wide pressure ulcer prevalence rate, which was within our current target. We are showing a steady year over year improvement in the prevalence of pressure ulcers across the organization. (15/16 prevalence rate for Q4 was 21%) Assessment on admission and daily risk assessments along with a cultural sense of urgency and education around this issue have been the core of the initiative and will continue to be in the future.

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 target to meet this indicator, but must continue to demonstrate leadership of the fundamentals of the initiative while addressing the performance of individual units.

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

Mini continuous-improvement cycles focused at particular inpatient units as indicated by the compliance data collected. Other continuous improvement techniques and tools, audit and feedback will be critical. Specifically, each unit in cooperation with professional practice and nursing unit leadership will conduct a prescribed number of monthly audits with respect to incidence of pressure injuries and compliance with documentation and communication protocols.

Completion of required admission documentation (i.e. risk assessments, strategies documented on kardex). Gap analysis of how closely the planned strategies match the assessment, and how consistently they are implemented and documented.

Target: Target 17/18: 17% Perf. Corridor: Red >19%, Yellow 18%-19%, Green <=17%.

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Improve the patient experience through a focus on compassion and excellence

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Indicator: Percent ALC Days (KGH QIP)(KGH HSAA)

	Actual	Target
18-Q1	13.4	**13.2**

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

In Q1, there was dedicated focus on the patient flow initiatives in the Emergency Department and the inpatient units. Our work is aligned to the SE LHIN patient flow action plan to ensure consistent practices exist across the region.

All patient care programs are utilizing the ALC escalation guideline (implemented in F17 Q3). This procedure requires manager, SE LHIN Home & Community Care manager and director level approval prior to designating a patient as ALC for long term care to ensure all other discharge destinations have been explored and are not viable options to discharge.

The SE LHIN approved a Pay for Results proposal for a refresh of the Home First philosophy to end of fiscal year 2018. A specialist is focused to work with each patient care area to ensure all opportunities for discharge home are explored rather than designating patients as ALC for long term care (LTC). This work requires support from our internal and external stakeholders and education regarding this philosophy was delivered at the end of the quarter to incoming residents at their orientation session. The education session was the same one that all care providers received last fiscal year to ensure consistent messaging to our patients, their families and the primary care teams.
The specialist is also focused on discharge planning in the Emergency Department. The specialist leads a team including the social worker, nurse practitioner, physiotherapist and nurses at daily morning rounds to plan complex discharges back to the community to prevent admissions for patients at risk of being designated ALC-LTC.

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

On average, in Q1 there were 59 patients waiting for beds at other destinations.

There is a lot of flow happening with our ALC patients. We started Q1 with 78 patients designated as ALC waiting for different destinations. Twenty nine of these patients (37%) were waiting for beds at a LTC home. We ended Q1 with 64 patients designated as ALC with 30 patients (47%) waiting for LTC. During the quarter, we discharged 192 ALC patients and five of these patients went to LTC.

This clarifies the assumption that it is the same ALC patients waiting at KHSC for beds at other facilities.

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

At this time, we are on track to meet our target. This success if based on the provision of SE LHIN funding for the Home First specialist to assist with ensuring patients are returning to the community rather than waiting at KHSC for their next destination.

The organization has submitted a proposal to the SE LHIN for a transitional unit for patients designated as ALC for destinations other than LTC. These patients would benefit from an off site location with restorative therapy services while complex discharge planning is ongoing. A decision from the MOHLTC is expected in Q2

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: Target 17/18: 13.2% Perf. Corridor: Red >14.6% Yellow 13.3%-14.6% Green <=13.2%

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

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Indicator: **Percent of palliative care patients discharged from hospital with the discharge status "Home with Support". (KGH QIP)**

	Actual	Target
18-Q1	93.5	**91**

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

A Palliative Care Redesign Team is in place to develop and implement pathways to expand access to Palliative Medicine and palliative care approaches for specific life-limiting illnesses (CHF, CKD, COPD, Metastatic Cancer (breast, colon, pancreas and lung).

Leaders are working with SE LHIN Home and Community Care and Primary Care to determine length of response time to receive services and ways to ensure and enhance a discharge pathway for this patient population. With a standard approach to identifying and coordinating care planning including discharge, we can maximize efforts to discharge palliative care patients home with support.

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

93.5% of patients diagnosed or receiving inpatient palliative service were discharged home with support. KHSC-CCSEO monitors this indicator and associated descriptive data as part of the strategic initiative to expand access to Palliative Medicine and palliative care approaches for admitted KHSC patients.

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

Yes

Definition: DATA: Christine Knott COMMENTS: Brenda Carter EVP: Brenda Carter REPORT: QUALITY IMPROVEMENT PLAN (QIP)

This year, we are aiming to create a comprehensive, well-coordinated set of care pathways for patients, families and care providers. Based on consultation with stakeholders we developed a plan and performance management framework for enhancing palliative care at KGH. We are working with stakeholders in the oncology, renal, respirology and cardiology programs to map out draft palliative care pathways for their patient populations. We are developing draft pathways for the four areas. Together with clinical leaders we are reviewing the pathways to determine next steps and action items with a view to creating an implementation plan.

In addition to meeting all project milestones, a measurement plan for the performance of palliative care pathway will be developed and act as a template for measuring the performance of other pathways. The measurement plan will include the voice of the patient. Referral time to palliative care will also be measured and monitored.

Target: Target 17/18: 91 Perf. Corridor: Red <= 72.8 , Yellow 72.9 - 81.9 , Green >=91.

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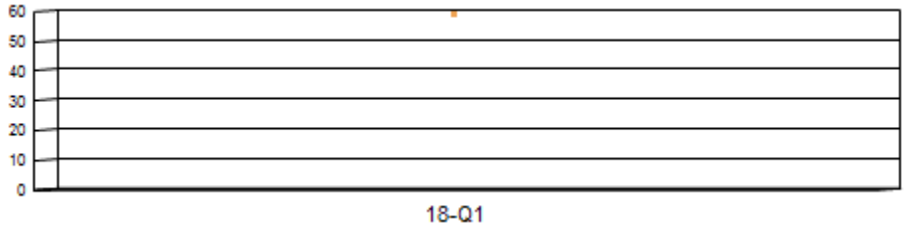
Indicator: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital? (KGH QIP)



	Actual	Target
18-Q1		59

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

A health literacy environmental scan completed last fiscal year identified areas across the organization where there are opportunities to reduce health literacy burden for patients and families. The scan led to several key recommendations to improve communication with patients and families.

One evidence-based health literacy strategy is the teach-back system. This year we are aiming to implement the teach-back system, which provides members of the care team with the tools to reduce health literacy barriers through patient-centered communication. Implementation of teach-back will begin with an initial focus in several areas. Staff and physicians in the Renal Program will receive education related to teach- back methodology to enable the use of this strategy with patients with chronic kidney disease. A teach-back education plan aimed to augment our existing falls prevention program is under development.

Another component of KHSC's health literacy strategy is the Patient Oriented Discharge Summary (PODS). The PODS is an easy to read, understandable, and usable discharge summary for patients, their families and their care providers. It focuses on using the teach-back method when providing important discharge information to patients and families. KHSC was selected as one of two SE LHIN sites to implement the PODS. A registered nurse is dedicated to this project and funding was provided by the Registered Nurses Association of Ontario/Associated Medical Services fellowship grant and the Adopting Research to Improve Care (ARTIC) Program.

A steering committee and working group with representation from all health disciplines as well as patient experience advisors have been working on the development of the discharge process and summary and involving Information Management for their technical expertise. The PODS will be incorporated into the discharge summary that the medical team completes and gives to the patient before discharge.

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 first patient will receive PODS by the beginning of Q3.This year, a minimum of 1,225 patients will be discharged with a PODS. This is one quarter of the yearly discharge amount for medicine patients. Our goal is that all internal medicine patients will be discharged with PODS. This represents an annual discharge volume of approximately 4,900 patients.

We are also working on a web-enabled plain language dictionary that describes medical and medically related terms in everyday language. This project will align with the PODS project and the organization's focus on health literacy.

There is clear evidence in the literature that lack of patient involvement in care decisions and not receiving written discharge instructions are associated with unplanned readmissions. It is expected that the PODS will provide patients, families and care providers with the information they need to manage their health care needs and minimize unplanned visits to the Emergency Department and admissions to the hospital.

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

Our goal is to successfully implement PODS in a sustainable way in the internal medicine populations of patients this fiscal year then to spread the discharge summary across the organization.

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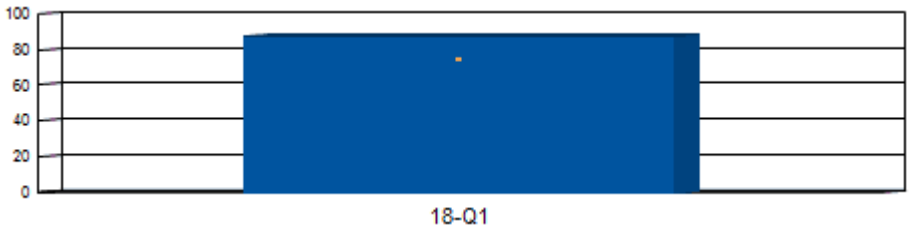
Definition: DATA: CIHI CPES (Darlene Bowman) COMMENTS: Cynthia Phillips EVP: Mike McDonald REPORT: QUALITY IMPROVEMENT PLAN (QIP)

This year we are aiming to implement the 'teach-back' system, which provides members of the care team with the tools to improve health literacy through patient-centered communication. We will introduce the topic of health literacy in the CKD program and discuss how to introduce the concept in the pre-dialysis clinic. In addition, KGH has been accepted as a partner site with University Health Network to implement an ARTIC-funded Patient-Oriented Discharge Summary (PODS) starting with the medicine program. This is a innovative discharge communication tool that meets the health literacy needs of patients and their families and includes our teach-back method as a component.

As per ARTIC project plan deliverables.The ARTIC project will start April 1st 2017. KGH is just receiving materials for the Project Coordinators and are in the pre-planning phase of this work.

Target: Target 17/18: 59% Perf. Corridor: Red <53% , Yellow 53%-58% , Green >=59.

Indicator: Percent of patients who wanted information that respond "very confident" that they have the information they need and/or know who to contact after they leave their appointment (HDH QIP)



	Actual	Target
18-Q1	87	74

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

During each quarter the Hotel Dieu Hospital (HDH) site administers at least one point of care patient experience survey; these surveys are rotated between different clinics at the HDH site as resources permit. In Q1 surveys were conducted in diagnostic clinics. Survey results are reviewed and shared with staff to identify unit specific initiatives that may be undertaken to improve patient experience.

Questions are asked related to patient education and information sharing. Historically, at the HDH site clinics collaborated with patient experience advisors and Education & Organizational Development to develop learning material to assist the staff to meet the needs of patients.

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

Eighty seven percent of the patients surveyed felt that they were confident that they received the information they required. Each quarter the survey is asked in another unit and we continue to gear our efforts to the results of each survey. Patient safety and quality patient care depend on patients being able to ask questions and have confidence they have the necessary information after leaving their clinic appointments.

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 our target by end of year.

Definition: DATA: Jennifer Sawyer COMMENTS: Carol McIntosh EVP: Mike McDonald REPORT: QUALITY IMPROVEMENT PLAN (QIP)

Performance reviewed by mangers, physicians, and leaders quarterly to identify strengths and improvement opportunities. Patients' response to this question has traditionally been positive; goal is to maintain positive performance, understand improvement opportunities.

Target: Target 17/18: 74% Perf. Corridor: Red <64% , Yellow 64%-73% , Green >=74%.

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Indicator: Percent of patients in adult ambulatory clinics that rate the quality of care and services received as 'excellent' or 'very good'. (HDH QIP)

	Actual	Target
18-Q1	93	**82**

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

During each quarter the Hotel Dieu Hospital (HDH) site administers at least one point of care patient experience survey; these surveys are rotated between different clinics at the HDH site as resources permit. Results of each survey are reviewed to identify unit specific initiatives that are undertaken to improve patient experience. Overall trends are also monitored such as the patient requests for Wi-Fi.

In one clinic patients identified the desire to have updates on the flow of the clinic. Now the Orthopedic Clinic updates the waiting room regularly on clinic flow. One clinic requested additional reading material in the waiting room for family; volunteers were contacted to add more updated material. Surveys have continuously mentioned the desire for Wi-Fi which is presently being introduced.

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 target of 82 % was reached and surpassed with 93% of patients in ambulatory clinics rating care as excellent or very good.

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 our target by the end of the year.

Definition: DATA: Jennifer Sawyer COMMENTS: Carol McIntosh EVP: Mike McDonald REPORT: QUALITY IMPROVEMENT PLAN (QIP)

Maintain aggregate ratings of 'excellent' and ' very good' on point-of-care survey in adult clinics. Performance is reviewed quarterly to identify strengths and improvement opportunities.

Target: Target 17/18: 82% Perf. Corridor: Red <72% , Yellow 72%-81% , Green >=82%.

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Enable clinical innovation in complex-acute and specialty care

KHSC is positioned as a leading centre for complex-acute & specialty care

Indicator: [(# of regular clinics held + # of special clinics held) / (# regular clinics assigned)] x 100 (HDH QIP)

	Actual	Target
18-Q1	99.8	**85**

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

Data is reviewed quarterly to understand reasons for variation and identify improvement opportunities. Tactics include (i) Recycling of available free clinic time within divisions and (ii) if available clinic time is not used up within 4 weeks of the clinic date by the division, it automatically becomes available to all physicians in the organization who wish to perform an additional clinic.

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

Achievement of this target demonstrates efficient utilization of resourced clinic space and staffing resources.

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. This is a highly efficient process.

Definition: DATA: Decision Support - David Barber COMMENTS: Mike Fitzpatrick EVP: Mike Fitzpatrick REPORT: QUALITY IMPROVEMENT PLAN (QIP)

Maintain 2016-17 target to accommodate possible variations in physician resources. Clinic utilization is multi-faceted. Goal is to understand reasons for variation. Ensure efficient clinic utilization.

Target: Target 17/18: 85% Perf. Corridor: Red <75% , Yellow 75%-84% , Green >=85%.

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Enable clinical innovation in complex-acute and specialty care

KHSC is positioned as a leading centre for complex-acute & specialty care

Indicator: # days from clinic appointment until dictated clinic letter has been verified [Result verification date - Clinic appointment date] (HDH QIP)

	Actual	Target
18-Q1	68	**70**

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

Timely communication between specialists and primary care physicians following patients' appointments ensures that primary care physicians have current information about patients' care plans and can support patients to achieve goals of care. Results are discussed at the Ambulatory Care Committee and disseminated to department heads and division chairs and program medical directors who, in turn, then share the data with individual physicians. Physician groups identify delays in dictation and sign-offs, identify process improvements, and continue to examine opportunities to improve clinic communication processes.

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

If performance falls below target metric, physicians whose latency to sign-off exceeds two weeks will be notified and encouraged to achieve the 2-week sign-off.

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

Yes, we are.

Definition: DATA: Decision Support - David Barber COMMENTS: Mike Fitzpatrick EVP: Mike Fitzpatrick REPORT: QUALITY IMPROVEMENT PLAN (QIP)

Increase data quality auditing to identify long queues out outstanding clinic letters of 14 days or more; Oversight by Medical Admin; Leadership by department heads, division chairs to review and understand performance relative to target; continue to implement improvements. % of dictated clinic letters that are verified within target each quarter.

Target: Target 17/18: > 70% of dictated letters signed off by 2 wks post clinic Perf. Corridor: Red <60%, Yellow 60%-69%, Green >=70%.

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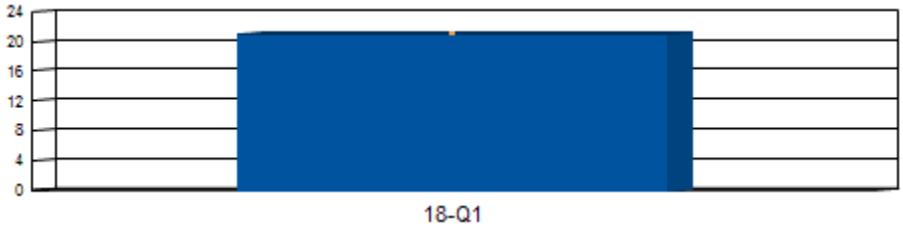
Create seamless transitions in care for patients across our regional health-care system

KHSC is fully engaged with our community partners to support patients with complex-acute and chronic conditions

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



	Actual	Target
18-Q1	21	**21**

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

This indicator relates to work of the Health Care Tomorrow team.

The team is working on a regional map of the patient care processes related to patients presenting with chronic obstructive lung disease (COPD).

A plan comprised of phases of work will be implemented across 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:

The initial phase of work was 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.

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

Yes, we are on track to meet the target set for this fiscal year.

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

Note: Due to the 3 quarter delay in results we have created a non-risk-adjusted proxy readmission rate for those quarters whose results are yet to be realized.

Target: Target 17/18: 21 Perf. Corridor: Red >10% of the expected Rate Yellow Within 10% of the expected Rate Green <= Expected Rate

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

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

KHSC is fully engaged with our community partners to support patients with complex-acute and chronic conditions

Indicator: Patient Journey Process maps as developed by each organization (presented to HCT COPD Clinical Steering Team) Best Practice and QBP Guidelines. (HDH QIP)

	Actual	Target
18-Q1	1	**1**

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

The 2016-17 target was partly met. A regional working group was formed and current-state analysis conducted. Work continues in 2017-18. The goal is to develop regional COPD care plan for patients in SE LHIN to improve consistency of care, reduce need for hospital admission, urgent/emergent care. The original plan developed in 2016-17 has been modified to include implementation of the INSPIRED COPD program, thus involving community care providers. The long-tem goal is to reduce readmission rates for patients with COPD in the SE LHIN (INSPIRED is a LHIN-wide evidence based care project focused on care in the community)

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

It is hoped that the patient journey map will be implemented for patients admitted with COPD exacerbations before the end of fiscal 2018, at KHSC.

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 SELHIN CFV-COPD Steering Committee has endorsed the care algorithm for acute exacerbation of COPD (AECOPD) and the care map at discharge. Discussions are now taking place at each hospital site within the SELHIN between the steering committee members and hospital CEO's to facilitate implementation of the care map at each hospital site. Introduction will be an iterative process, starting with 1 or 2 hospital sites. We anticipate having this program in place at KHSC by year end.

Definition: DATA: Mike Fitzpatrick COMMENTS: Mike Fitzpatrick EVP: Mike Fitzpatrick REPORT: QUALITY IMPROVEMENT PLAN (QIP)

Develop regional COPD care plan for patients in SE LHIN to improve consistency of care, reduce need for hospital admission, urgent/emergent care. The original plan developed in 2016-17 has been modified to include implementation of the INSPIRED COPD program, thus involving community care providers.

Target: Target 17/18: See change plan Perf. Corridor: Red No = 0, Yellow In progress = BLANK with Yellow Status, Green Yes = 1.

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Status:

N/A	Currently Not Available
	Green-Meet Acceptable Performance Target
	Red-Performance is outside acceptable target range and requires improvement
	Yellow-Monitoring Required, performance approaching target