Kingston General Hospital

DRAFT

Q4 FY2017 Quality Improvement Plan Report

Strategic Direction	2016 Outcome	Indicator	16-Q4	17-Q1	17-Q2	17-Q3	17-Q4	F2017 Overall
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)	R	Y	Y	Y	R	
		"Would you recommend this ED to your friends and family?" (QIP)	R	R	Y	Y	N/A	
		"Would you recommend this hospital (inpatient care) to your friends and family?" (QIP)	R	R	R	Y	N/A	
		90th Percentile ED Wait Time - All Admitted Patients (hrs.) - (QIP)	R	Y	R	R	R	
		Hand Hygiene Compliance - (QIP)	Y	G	G	G	G	
		Medication Reconciliation at Admission (QIP)	Y	Y	Y	G	Y	
		Reduction in level 1 to 4 falls with a focus on level 3 and 4 falls (QIP)	Y	R	G	G	Y	
		Percent ALC Days (QIP)	R	R	R	R	G	
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)	R	N/A	N/A	N/A	N/A	N/A

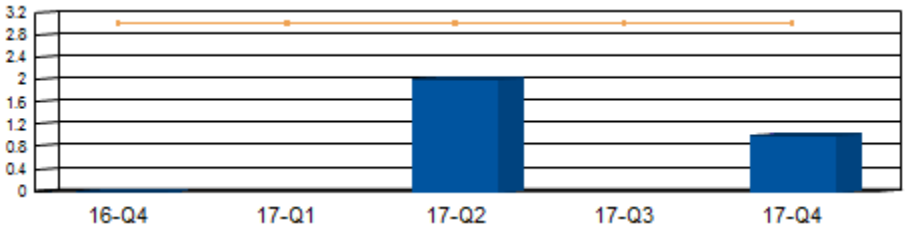
	Strategy					QIP					Supporting				
	F17					F17					F17				
	Q1 %	Q2 %	Q3 %	Q4 %	Q4 #	Q1 %	Q2 %	Q3 %	Q4 %	Q4 #	Q1 %	Q2 %	Q3 %	Q4 %	Q4 #
R	0%	0%	0%	0%	0	33%	33%	22%	22%	2	23%	23%	29%	35%	39
G Y	100%	100%	100%	100%	10	56%	56%	67%	67%	6	77%	77%	71%	65%	74
N/A	0%	0%	0%	0%	0	11%	11%	11%	11%	1	0%	0%	0%	0%	0
					10					9					113

Q4 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-Q4	0	**3**
17-Q1		**3**
17-Q2	2	**3**
17-Q3		**3**
17-Q4	1	**3**

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

The QIP was to demonstrate a 25% reduction on three specific floors; K6, C10 and K2ICU. The pressure injury prevalence study conducted in February only demonstrated K2ICU as meeting target. K2ICU has shown significant improvement from a 37.5% (Feb 2016) prevalence to 7.4% facility acquired pressure ulcer prevalence. The organization as a whole went from a 21% (Feb 2016) prevalence to a 14.8% prevalence. Reasons for this great improvement include improved documentation of pressure ulcers on admission to hospital (which allows us to recognize which pressure injuries are facility acquired vs from preceding care institution) as well as improved skin and risk assessment. Over the last year we have transitioned from a skin program in just three areas to a corporate wide approach to pressure ulcer prevention. In Q4 a third learning module for skin care was released to all regulated nurses.

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

Moving forward we will focus on the entire organization and our strategies will focus on those areas of high pressure injury rates as well as continuing to sustain rates across the organization. We have already started to reach out to those areas where pressure injury was reported as high and target prevention in those areas. We will continue to perform 2 hospital wide prevalence studies, Quarter 2 and Quarter 4, which will inform us of our progress. Strategies being looked at include continued audit and feedback of documentation, continued education, device related pressure injury and care plan development for those at risk. Hospital-wide results are demonstrating a significant improvement; however, the above metric was originally measuring only three inpatient units.

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

We did not fully achieve our target with respect to the specific skin ulcer indicator that we are tracking. However our focus has shifted from work on the 3 units we are tracking to an organization-wide approach to reducing the incidence of skin ulcers. On an organization-wide basis, the incidence of skin ulcers made a significant improvement from 21 to 14.8 per cent from February 2016 to February 2017.

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.

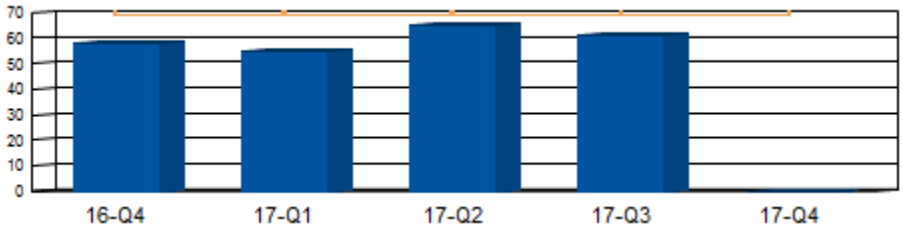
Target: Target 2015/16: 25% reduction Perf. Corridor: Red 1 or no units achieve Green Status, Yellow 2 units achieve Green Status, Green 3 of 3 units achieve green status, Target 2016/17: 3 of 3 units achieve 25% reduction Perf. Corridor: Red No units achieve green status, Yellow 1 or 2 units achieve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

Q4 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-Q4	58.0	**69.3**
17-Q1	55.0	**69.3**
17-Q2	65.5	**69.3**
17-Q3	61.0	**69.3**
17-Q4		**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.

In Q4, daily discharge rounds were implemented in the ED. In March 2017, the team completed rounds on 29 patients. Nineteen of these patients were deemed to be 'crisis placement' patients. Eighteen of these patients were discharged home with a safe discharge plan to wait for a bed in long term care. One patient went directly to long term care. The rounds offer opportunity to improve communication between the team and the patient and family or caregivers.

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 61% in Q3 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 97%. Of 100 respondents, 2% said probably no and 1% 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 challenge is how do we move people from 'probably' to 'definitely'. The perception may be that 'definitely' does not allow room for improvement.

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. The ED continues to look for new tactics that would improve satisfaction including decreasing time to IP bed.

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

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

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

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

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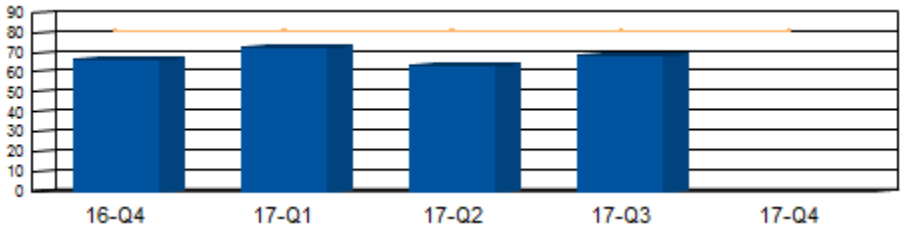
Indicator: "Would you recommend this hospital (inpatient care) to your friends and family?" (QIP)



	Actual	Target
16-Q4	66.9	**80.7**
17-Q1	72.5	**80.7**
17-Q2	63.1	**80.7**
17-Q3	68.2	**80.7**
17-Q4		**80.7**

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

KGH has been 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 since April 2016. 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 (scheduled for implementation in F18 Q1) and referrals to Health Links to ensure post-discharge follow up for patients with multiple medical conditions (currently referring medicine patients and inpatient Mental Health patients). These tactics will improve communication and information sharing.

Common themes are food, communication, information about discharge, cleanliness and long waits to IP bed.

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. The Q3 data show that the KGH inpatient care score is 68.2%. 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 95.5%. Consideration should be given to including "probably yes" scores in the overall result.

The areas of improvement are information sharing and coordination of care - both related to communication. Communication is also the most common these with patient relations feedback 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?

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

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

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

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

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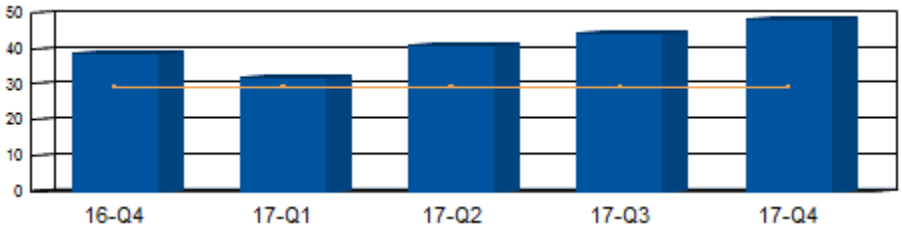
Indicator: 90th Percentile ED Wait Time - All Admitted Patients (hrs.) - (QIP)



	Actual	Target
16-Q4	39	**29**
17-Q1	32	**29**
17-Q2	41	**29**
17-Q3	44	**29**
17-Q4	48	**29**

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

A new bed map was implemented in February 2017 to consolidate patient cohorts and increase efficiency for care teams. Efficiencies include timelier rounding with optimal participation of all care providers, earlier decisions and arrangements for discharges resulting in more timely bed availability. A focus on admission avoidance strategies will also help to improve on this indicator. NP led clinics were initiated through 'Pay for Results' funding and continue into next fiscal year. 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 that was implemented in Q4 to create surge capacity for the ED by more consistent use of OPPU thus reducing the use of section C. The 9 bed Admission and Transfer Unit (ATU) opened in March 2017 to facilitate the move of admitted patients from ED to a physical space outside the ED while the patients wait for an inpatient bed.

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

The Q4 result of 48.3 hours for 90th percentile ED wait time does not meet the target of 29 hours.

Admission rate from the ED in Q4 was 19.5% compared to fiscal 16 Q4 at 18.7%.

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. Our funding rank for admitted patients is not yet available.

There have been a number of influences that have impacted these results. A comparison for Q4 2016 to Q4 2017 shows an increase of 34 patients more requiring admission. This is an increase of 1% in admissions compared to last year. Although not significant, it continues to impact the wait time for an IP bed.

The year overall 90th percentile ED wait time for all admitted patients was 42hrs.

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

No. There are a number of strategies that are being implemented in effort 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: Cynthia Phillips EVP: Silvie Crawford REPORT: QUALITY IMPROVEMENT PLAN (QIP)

This indicator measures the amount of time 9 out of 10 patients (90th percentile) spend in an ED being diagnosed, receiving treatment and waiting for admission to a hospital bed. Most patients spend less time, while 1 out of 10 patients will spend more time. The time being measured is defined as when a patient registers until the time when the patient is admitted to an inpatient hospital bed. For this indicator, 9 out of 10 patients (for all admitted patients at all levels of complexity) will spend no more than 31 hours within the ER from the time they arrive and register to the time they leave the ED.

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

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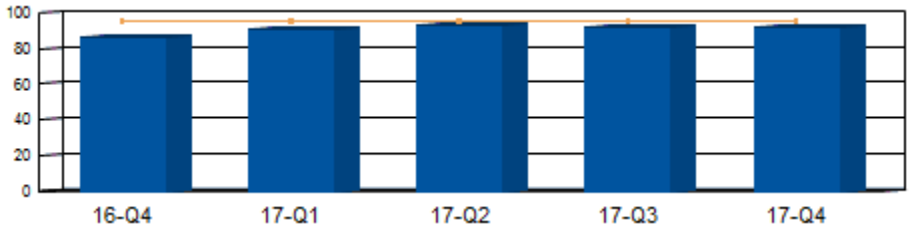
Indicator: Hand Hygiene Compliance - (QIP)



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

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

The tactics for 2016-2017 included the continuation of hand hygiene audits and monthly reporting of results to KGH Leadership Team which include the individual unit results, discipline specific results and our corporate Moments 1 through 4. Quarterly new reports developed by IPAC Service and are sent out through Decision Support which incorporates hand hygiene results for each unit with their individual nosocomial infection incidence. Annual reporting to MOHLTC was done in March. A new LMS module for Hand Hygiene was also developed by IPAC and E-Learning. The module was initially launched and sent out as mandatory to all KGH staff, with all clinical and support services staff being required to complete it annually. In addition, IPAC Service also continued their work directly with Programs, attending staff meetings to clarify Patient Environment vs. Hospital Environment questions.

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

In Q4 for 2016-2017 we maintained our monthly "Before Moment (M1)" at or above 90% for the 11 months. Our "After Moment (M4) was also at or above 90% for 11 months. The results are the outcome of 5,891 observed opportunities during the quarter and our annual total was 24,321 observed opportunities.

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

We did miss the target of 95% however we did see an increase from 86% for 2015-2016 to 92% for 2016-2017. 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%

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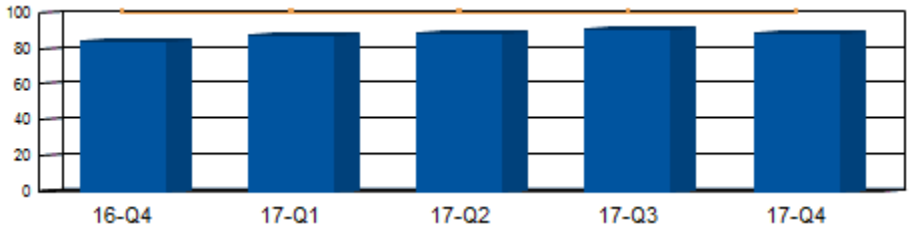
Indicator: Medication Reconciliation at Admission (QIP)



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

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

In January 2017, the Hospital finalized the conversion of all paper order sets to electronic EntryPoint order sets to improve prescriber access to standardized admission order sets including the medication reconciliation on admission process for all patients admitted to the Hospital.
The Chief of Staff and the Department Head of Orthopedics addressed the implementation of EntryPoint admission order sets for hip and knee replacement surgery and hip fracture.

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 decreased this quarter with a rate of completion of 88% for all admitted patients in Fiscal 17 Q4, a decrease from the F17 Q3 results of 91%.
The following area contributed to the reduction:
Orthopedics Service compliance rate decreased from 88% in Fiscal 17 Q3 to 58% in Fiscal 17 Q4, due to lack of availability of EntryPoint admission order sets for hip and knee replacement surgery and hip fracture.
The Orthopedics Service started using EntryPoint Admission Order set for hip and knee replacement surgery. The EntryPoint admission order for hip fractures is pending.

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% not achieved this quarter.
Efforts are underway to remind prescribers of Hospital policy.

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%

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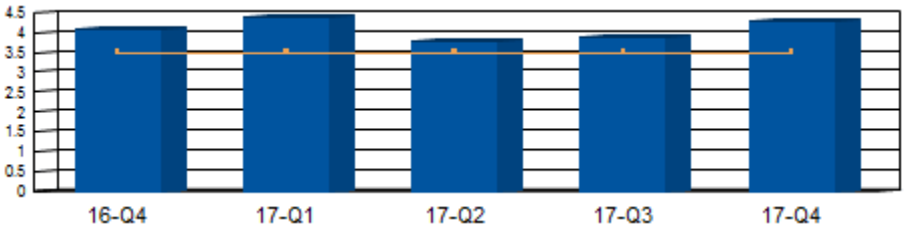
Indicator: Reduction in level 1 to 4 falls with a focus on level 3 and 4 falls (QIP)



	Actual	Target
16-Q4	4.1	**3.5**
17-Q1	4.4	**3.5**
17-Q2	3.8	**3.5**
17-Q3	3.9	**3.5**
17-Q4	4.3	**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. We are targeting units showing higher falls rates to determine strategies that may specifically work on those units. We continue to look at toileting/partnering with families/fall debriefs and care planning rounds as strategies to address. Falls are now broken down into unit by unit results which are shared with the Management and front line staff of the units.

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

Auditing demonstrated that the falls risk assessment was completed 86 % of time which is a slight decrease from previous 3 quarters of greater than 90%. This did coincide with an increase in falls in the organization.

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

A reminder blitz is underway to ensure front line staff understand the correlation between reduced risk assessment and increase in falls. This issue has been taken to Nursing Practice Council to try and understand the decrease in risk assessment. Continued vigilance in monitoring this tactic will continue to ensure that falls continues to be seen as an important measure for our patients.

Definition: DATA: Leanne Wakelin and Dana MacPhail 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.

All reported falls (excluding those from Emergency Program) AND any actual severity level 0 divided by all nursing unit inpatient days (excluding NICU).

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

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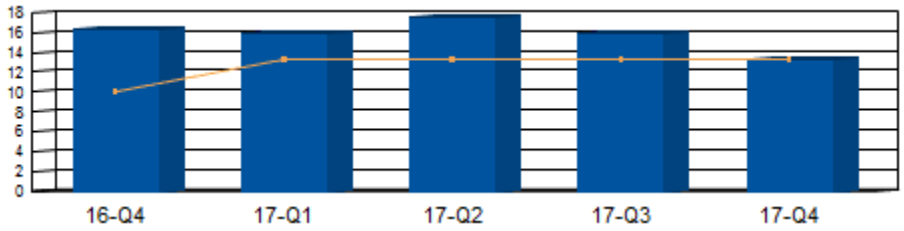
Indicator: Percent ALC Days (QIP)



	Actual	Target
16-Q4	16.3	**10.0**
17-Q1	16.0	**13.2**
17-Q2	17.5	**13.2**
17-Q3	16.0	**13.2**
17-Q4	13.3	**13.2**

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

In Q4, there was progress on a number of initiatives in the patient flow action plan. Three areas of focus are the inflow & Emergency Department diversion; intrahospital patient flow; and outflow including patient discharge planning. There are 12 to 20 projects/activities associated with each area of focus. The work is aligned to the LHIN wide action plan to drive change in patient flow across the region.

The ALC escalation guideline was implemented in Q3 and in place across the organization in Q4. 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.

In Q4, daily discharge rounds were implemented in the ED as part of the Home First refresh. In March 2017, the team completed rounds on 29 patients. Nineteen of these patients were deemed to be 'crisis placement' patients. Eighteen of these patients were discharged home with a safe discharge plan to wait for a bed in long term care. One patient went directly to long term care. The rounds offer opportunity to improve communication between the team and the patient and family or caregivers.

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 Q4 result of 13.3% indicates that, on average, there were 58 inpatients at KGH whose acute care stay was complete and who were waiting for access to one of the destinations listed below. In Q4, there were 222 patients who were designated as ALC and 186 of these patients were discharged to other destinations. At the end of March, there were 67 remaining ALC patients and 31 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 Q4, on average, we designated 74 new ALC cases and discharged 63 ALC cases per month.

In Q4, there were 18 long stay (>100 days) ALC patients who were discharged to long term care. Their length of stays ranged from 88 days to 893 days with average LOS of 335 days for these 18 patients. There were also 9 long stay (>100 days) ALC patients who were discharged to other destinations (mental health, palliative, rehabilitation, complex medical care, home, supported/assisted living) or died. Their length of stay ranged from 100 to 281 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 27 long stay patients in the same quarter.

A high number of patients waiting for alternate destinations 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.

Q4 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

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 came close the target of 13.2% this quarter with a rate of 13.3 being within the upper green corridor. 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.

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. The Q4 result of 13.3% represents a decrease of 2.7% 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.

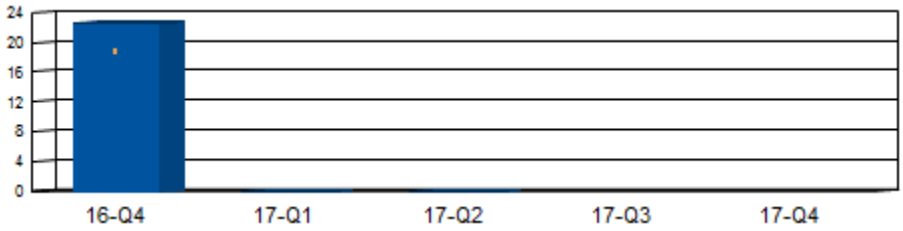
Target: 11/12 Target: 10% 12/13 Target: 10%, Target 13/14: 7% Perf. Corridor: Red >10% Yellow 8%-10% Green <=7%, Target 14/15: 7% Perf. Corridor: Red >9.5% Yellow 8%-9.5% Green <=7%, Target 15/16: 10% Perf. Corridor: Red >13% Yellow >10%-13% Green <=10%, Target 16/17: 13.2% Perf. Corridor: Red >13% Yellow >10%-13% Green <=10%

Q4 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-Q4	22.7	**19**
17-Q1		
17-Q2		
17-Q3		
17-Q4		

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

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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